Brighton and Sussex University Hospitals NHS Trust

Meeting of the Board of Directors

11.30-14.15 on Wednesday 25 Sept 2019
Lecture Theatre 1, Euan Keat Education Centre, Princess Royal Hospital,
Lewes Road, Haywards Heath, RH16 4EX

AGENDA – MEETING IN PUBLIC

1.	11.30	**Welcome and Apologies for Absence** Clare Stafford; Jayne Black. To note	Verbal	Chair
2.	11.30	**Declarations of Interests** To note	Verbal	All
3.	11.30	**Minutes of Board Meeting held on 24 July 2019** To approve	Enclosure	Chair
4.	11.35	**Matters Arising from the Minutes** To note	Enclosure	Chair
5.	11.40	**Report from Chief Executive** To receive and note overview of the Trust's activities	Enclosure	Marianne Griffiths
		INTEGRATED PERFORMANCE REPORT		
6.	11.50	**Introduction from Chief Executive** To receive and note overview of the Trust's activities	Enclosure	Marianne Griffiths
7.	11.55	**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.	12.10	**Systems and Partnerships** To receive and agree any necessary actions	Enclosure	Peter Landstrom
9.	12.20	**Sustainability** To receive and agree any necessary actions	Enclosure	Karen Geoghegan
		After these two sections the Chair of Finance and Performance Committee will be invited to provide their report included at item 12 To receive assurance from Committee and recommendations from the Committee		

10.	12.30	**Our People** To receive and agree any necessary actions *At this point the Chairs of the Committee 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 24 Sept** To receive assurance from Committee and recommendations from the Committee	Verbal	Mike Rymer
12.	-	**Reports from Finance and Performance Chair** - **from the meeting on the 27 Aug** To receive assurance from Committee and recommendations from the Committee - **from the meeting on the 24 Sept**	Enclosure Verbal	Mike Rymer Patrick Boyle
		To receive assurance from Committee and recommendations from the Committee		
13.	12.40	**Board Assurance Framework** To approve for publication on the website	Enclosure	Glen Palethorpe
		SERVICE PRESENTATION		
14.	12.45	**Urgent and Emergency Care Service Presentation** To receive assurance over application of patient first processes	Presentation on the day	Malcolm McKenzie, Consultant ED and Clinical Lead
15.	13.00	**Annual Organ Donation Report** To receive activity information for 2018/19	Presentation	Renee van Der Most / George Findlay
		OUR PEOPLE		
16.	13.15	**Annual Workforce Race Equality Standard Submission** To receive and agree any necessary actions	Enclosure	Denise Farmer
17.	13.25	**Nurse Staffing Capacity Report** To receive and agree any necessary actions	Enclosure	Clare Williams
		Quality		
18.	13.35	**2018/19 Infection Prevention and Control Annual report & Presentation** To receive and note	Enclosure	Clare Williams and IPC lead nurse
		OTHER		
19.	13.50	**Any Other Business** To receive and action	Verbal	Chair
20.	13.55	**Questions from the public** To receive and respond to questions submitted by the public	Verbal	Glen Palethorpe

21.	14.00	**Date and time of next meeting:** The next meeting in private of the Board of Directors is scheduled to take place on **27 November 2019** in the **Boardroom, Trust Headquarters, Royal Sussex County Hospital, Brighton**	Verbal	Chair

Trust Board of Directors Quoracy

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

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

Brighton and Sussex University Hospitals NHS Trust

Minutes

Minutes of the Board of Directors (Public) meeting held at 10:30 on Wednesday 24 July 2019 in the Meeting Room, Level 6, Trust Headquarters, Royal Sussex County Hospital, Eastern Road, Brighton

Present:	Alan McCarthy	Non-Executive Director (Chair)
	Lizzie Peers	Non-Executive Director
	Patrick Boyle	Non-Executive Director
	Mike Rymer	Non-Executive Director
	Malcolm Reed	Non-Executive Director
	George Findlay	Chief Medical Officer
	Clare Williams	Interim Chief Nurse
	Jayne Black	Chief Operating Officer
	Joanna Crane	Non-Executive Director Advisor
In attendance:	Glen Palethorpe	Group Company Secretary
	Francesca Carroll	Board and Committee Secretary
	Helen Weatherill	HR Director
	Clare Stafford	Finance Director
	Tasha Gardner	Head of Communications
	Carly Knell	Women and Children's Divisional Director (Item 18)
	Sue Alcock	Head of Midwifery (Item 18)
	Peter Lane	Specialist Divisional Director of Operations (Item 15)
	Dr Owen Boyd	Critical Care Clinical Lead (Item 15)
	Clare McGregor	Critical Care Matron

B/07/19/1 WELCOME AND APOLOGIES **Action**

1.1 The Chair welcomed those present to the meeting. The Chair welcomed Clare Williams to her first board in the capacity of interim chief nurse.

1.2 Apologies for absence were received from Dame Marianne Griffiths, Pete Landstrom, Jon Furmston, Denise Farmer and Karen Geoghegan.

1.3 The Board was confirmed as quorate with over half the board members being in attendance.

B/07/19/2 DECLARATIONS OF INTEREST

2.1 There were no declarations of interest.

B/07/19/3 MINUTES FROM THE PREVIOUS MEETING HELD ON 29 MAY 2019

3.1 The minutes of the meeting held on 29 May 2019 were approved as a correct record.

B/07/19/4 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.

4.2 The Board was advised that the Dementia Strategy, discussed later in the meeting, came straight to Board for approval, rather than through the Quality Assurance Committee noting the Quality Assurance Committee had received information on the development and detail within the Strategy.

B/07/19/5 CHIEF EXECUTIVE'S REPORT

5.1 In Dame Marianne Griffiths' absence, George Findlay presented the Chief Executive's report, drawing out the key events and activities that occurred in June and July.

5.2 **Headlines**
There were multiple celebrations across the Trust to note, including the 'Topping Out' ceremony to mark the erection of the final piece of the framework of the Stage 1 building of the hospital redevelopment.

5.3 The National Guardian's Office visited and provided very positive feedback and recognised the improvements to the processes which enable staff to speak up when they think there is something wrong.

5.4 George welcomed Clare Williams as Interim Chief Nurse, and informed the Board of the departures of Nicola Ranger and Caroline Davies and appointment of new Chief Nurse, Carolyn Morrice.

5.5 BSUH is one of the few Trusts nationally to perform TAVI, which is a prostate operation and the consultants who have performed this quicker and less invasive procedure, have received a mark of excellence.

5.6 **Diary Highlights**
The Board was advised of some key meetings that the Executive team have attended in June and July.

5.7 **Looking ahead**
George provided an update on the progress of the Trust's application to become a Stonewall Top 100 Employer and felt confident that good progress is being made towards this goal.

5.8 The Trust was represented at Disability Pride and Transpride, which were great events; George informed the Board that BSUH will also be represented at Brighton Pride on 3 August and has used all these events to show it is an inclusive employer and that there are great opportunities to join the Trust.

5.9 Patrick Boyle recognised the positive work that is on-going in relation to equality and diversity across the organisation and praised the success of the STAR Awards, which drew out powerful stories of patient care from staff across the Trust.

5.10 The Board **NOTED** the report.

B/07/19/6 INTEGRATED PERFORMANCE REPORT

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

B/07/19/7 QUALITY IMPROVEMENT

7.1 George and Clare Williams presented the Quality Performance to the Board and drew out the following points.

7.2 Although still below the national average, there was a slight increase in HSMR

in June and July and George explained the measures that have been implemented to identify the cause of the increased rates.

7.3 Clare then went on the update the Board on the work being undertaken in respect of falls and pressure care. Clare drew the Board's attention to the rising levels of pressure ulcer and whilst some of this is due to a change in the national definitional rules there were things the Trust had identified it could do to improve its performance. These included the review and revision to the standard operating procedures (SOPs) in operation to reduce the amount of pressure ulcers at the Trust. The Trust is also working with stakeholders and partners to review process outside the hospital to establish the merit of a larger piece of work in this area.

7.4 Clare drew the Board's attention to the continued positive feedback from the Friends and Family Test in A&E but recognised that in other parts of the hospital, there has been a slight deterioration, compared to Quarter 1 in 2018, but that this level of performance remained better than last year.

B/07/19/8 SYSTEMS AND PARTNERSHIPS

8.1 Jayne Black informed the Board that in June, A&E performance was 84%, compared to a national average of 86.4%. There are national challenges but BSUH will continue to work to improve its A&E performance, Jayne also highlighted the increase in ambulances to A&E too.

8.2 The Board were advised of the work that is on-going both internally and with community partners to reduce the number of stranded and super-stranded patients in the hospital, which will also improve the flow of patients across the hospital.

8.3 June Referral to Treatment (RTT) times decreased slightly by 1.4% but the Board noted the overall 4.3% increase in referrals. Jayne confirmed that the Trust has implemented robust plans to improve both RTT and Cancer wait times and expects to start seeing the improvements in the near future.

8.4 Cancer performance remained a challenging area for the Trust, as the Trust is seeing an increase in referrals. Jayne informed the Board that the Trust was compliant with 2 out of 9 cancer metrics.

8.5 There has been a reduced number of patients who have breached the 52 week wait time. The Board was informed that for all of these patients their circumstances have been individually reviewed and everyone has now been booked into clinics.

8.6 Jayne drew the Operational Performance section to a close by confirming that there have been challenges with diagnostics but a number of extra measures have been implemented to reduce the wait time for patients and Jayne confirmed that diagnostics is still working to deliver its improvement trajectory.

B/07/19/9 SUSTAINABILITY

9.1 Clare Stafford informed the Board that the Trust reported a deficit of £5.4m in June, which excluding PSF, MRET and FRF, is in line with its plan and therefore as a result secured a further £1.4m of funding.

9.2 Clare informed the Board that whilst the Trust had delivered against its plan at the end of quarter one there was action needed to maintain a strong underlying position as there remained both activity and cost pressure risks.

9.3 Delivery of the overall control total will require close management and for divisions to ensure that the delivery of their elective activity is in line with their respective plans, in addition to the application of stringent controls over the cost base, particularly with regard to medical pay. Clare reminded the Board that the control of medical workforce pay is a breakthrough objective for 2019/20.

9.4 Clare provided the Committee with further updates in relation to the Efficiency Programme and the position of the capital plan and explained the key elements being closely monitored within both of these areas.

9.5 The Trust's income is behind its planned levels and Clare linked this to the Trust's underperformance in respect of elective activity and informed the Board of the actions that are being taken to improve activity in line with plan.

9.6 Referring back to the medical pay bill, Clare confirmed that significant progress has been made and the action being taken across the divisions are being tracked by a dedicated steering group.

9.7 Clare informed the Board that the Trust had signed the Aligned Incentive Contract in June and anticipates signing the contract with NHSE by the end of July.

9.8 Clare drew the report to a close reminding the Board that delivery in 2019/20 will not be without its challenges but the delivery of the control total is currently forecast.

B/07/19/10 OUR PEOPLE

10.1 Helen Weatherill presented the Board with an update on workforce developments and emphasised the outcome from the annual staff survey and the more frequent Pulse surveys is used to drive improvements based on the captured feedback from staff.

10.2 Helen updated the Board that the breakthrough objectives were reviewed and a decision was taken to update one of these to 'staff recommending BSUH as a place to work' which aligned well with the patient survey feedback reported to a previous Board meeting. Helen explained the work that was underway to focus on the breakthrough objective and advised that an action plan will be brought to a future Board meeting.

10.3 A new campaign titled 'Belong Here' showcasing Trust staff has been launched as part of the larger recruitment campaign for the Trust.

10.4 Helen updated the Board on the activities that have taken place across the organisation in June and July all aimed to provide the Board with a greater understanding of the delivery of the workforce trajectories and highlight any key areas of concern.

10.5 Helen drew the Board's attention to the fact that there has been an improvement to staff turnover of rates reducing to 12.8%, as the Trust progresses forward to the target, which has been set at 12.5%. The Board was then given an update on the activities that have taken place to secure this reduction and those planned to help achieve the set target.

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

10.7 The Committee **NOTED** the update.

B/07/19/11 REPORT FROM QUALITY ASSURANCE COMMITTEE

11.1 Mike Rymer, Quality Assurance Committee Chair provided the Board with an overview of what was discussed at the Committee the previous day.

11.2 Mike informed the Board of the reports they had received in respect of the patients who have waited over 52 weeks to be seen and those patients who were experiencing delays within the Cancer pathway. The Committee received assurance from the Medical Director that each case was reviewed from a quality perspective and there was not any harm caused to any of the patients who faced delays.

11.3 Mike received assurance that good governance is being followed, evidenced by reports from both the Quality Governance Steering Group and the register used to record all external visits to the Trust, which also provided a narrative in relation to any actions that came out of the visits.

11.4 The Committee received assurance on the analysis of mortality rates, which has analysed a wider pool of patients than previously and there was no evidence to suggest that mortality rates increase at weekends.

11.5 Mike added that the Committee reviewed the Board Assurance Framework at the beginning of the meeting to provide an understanding of the risks they have oversight of and their expected mitigations and it was then reviewed again at the end of the meeting, to ensure that what had been discussed in the meeting, did not call for the risk scores to be reconsidered.

11.6 Alan McCarthy asked invited questions this report from Mike or on the quality element of the Integrated Performance report.

11.7 Lizzie Peers suggested it may be more useful for the quality report to contain further information in relation to Trust's progress against the constitutional targets. Jayne assured Lizzie of the different actions that are underway and explained that progress is regularly captured and reported within the performance section of the integrated reporting framework.

11.8 Joanne Crane asked for clarification as to whether the rates of pressure ulcers included in the report related to internally and externally acquired pressure ulcers. Clare Williams confirmed that it did include both; however, her team are conducting a more thorough analysis of the data to identify patients with existing pressure ulcers prior to admission.

11.9 Referring back to Lizzie's question about constitutional standards, Alan asked if there was any key differences in this year than last that may account for the reported performance. Both Jayne and George provided the Board with some examples of differences this year and acknowledged the challenges the Trust is facing in driving forward with its activity plan and concluded with a reminder on the work being undertaken within the key areas of outpatients, theatre usage and bed optimisation plans.

11.10 The Committee **NOTED** the report.

B/07/19/12 REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

12.1 Patrick Boyle, Chair of the Finance and Performance Committee reminded the Board that the Committee had met twice, since the last Board and that it was the report from the June meeting that was enclosed with the papers and that Patrick would provide a verbal update for the meeting held yesterday.

12.2 The Committee in July discussed in detail the financial performance challenges but was assured that there are robust plans in place, which will also be kept under review by the Committee.

12.3 With respect to the delivery of the Trust's efficiency programme the Committee had received information that showing the delivery of the efficiency programme targets. Patrick informed the Board of the detailed work on nursing efficiency plans which assured the Committee of the robustness of that plan. Patrick commented that the Committee was assured that overall the Efficiency programme has been well managed.

12.4 Patrick informed the Board of the assurance provided to the Committee over the comprehensive plans that are in place to resolve performance issues and received assurance that although some forecasted trajectories have slipped, there is a good understanding of these and the factors causing slippage are being actioned.

12.5 The Committee received the BAF and reviewed the risks contained within it and asked QAC to review the qualitative impact of any performance delays. Mike Rymer assured the Board that it was discussed at the Quality Assurance Committee meeting the previous day and the Committee was assured these were being managed.

12.6 Patrick drew the report to a close by reiterating that the Trust is aware of the challenges and that plans are in place to address these, however, the key focus for this year is delivery.

12.7 The Committee **NOTED** the update.

B/07/19/13 REPORT FROM AUDIT COMMITTEE CHAIR

13.1 Lizzie Peers, Chair of the Audit Committee provided the Board with an overview of the Committee's business and the sources of information that provide assurance.

13.2 The BAF was considered to be a really useful tool and the Committee spent time reviewing the BAF to review the sources of listed assurance and the actions listed to secure an improved risk score during the year.

13.3 Lizzie drew the Board's attention to the section in the report informing them of the Internal Auditor's provision pf positive assurances on their reported work which had been focussed on workforce matters.

13.4 Lizzie informed the Board that Philip Major, Local Counter Fraud Specialist had provided the Committee an insight into the work he was undertaking and the Committee felt assured that Philip has a good understanding of the Trust's local fraud risks and is effectively monitoring activity across the Trust.

13.5 Following an action raised at a previous Committee meeting, the Director of IM&T and Head of Information Governance attended to present the Committee with a comprehensive overview of the information governance work that is

being developed. Lizzie informed the Board that the Committee was assured as a result of this comprehensive report that actions had been taken and were continuing to enhance the Trust's information governance environment.

13.6 Lizzie informed the Board that the report included an annual report from the outgoing Audit Committee chair which had included the outcome of a survey where members of the Committee reflected on how the external and internal auditors can be used across the Trust more effectively. The report concluded that the Audit Committee had been effective across the previous year that there was no need to amend the Committee's terms of reference.

13.7 The Committee referred a matter to the Quality Assurance Committee for them to review the progress of actions that were received after the recent JAG accreditation visit and the Board had just been informed by Mike Rymer in his report that this action was completed at the Quality Assurance Committee held yesterday.

13.8 The Board **NOTED** the update.

B/07/19/14 BOARD ASSURANCE FRAMEWORK

14.1 Glen Palethorpe drew the Board's attention to the summary of the key strategic risks within the 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.

14.2 There are 12 risks recorded within the BAF, 6 where the Quality Assurance Committee is the key oversight committee and 6 where the Finance and Performance Committee is the key oversight Committee. Of those where the Finance and Performance Committee have oversight two of these have the
14.3 highest current risk score and these link to the discussions held in the meeting so far and the report from Finance and Performance as being correctly scored at that level, these relating to constitutional target compliance and an inability to flex financial resources given the underlying pressures.

14.4 Referring to risk 1.1 in the BAF, Alan commented that it was good to hear that both the Finance and Performance Committee and the Quality Assurance Committee had recognised the need to review the dimensions of quality and performance in relation to long waiting times on patient experience.

14.5 The Board **NOTED** the Board Assurance Framework.

B/07/19/15 CRITICAL CARE SERVICE PRESENTATION

15.1 Peter Lane, Dr Owen Boyd and Clare McGregor presented the Board with an overview of the critical care areas at both the Royal Sussex County and Princess Royal sites. The presentation commenced with informing the Board on the areas they were most proud of, these being:

15.2 Critical Care staff were in the first cohort of staff that undertook the Patient First training, which gave them to tools to allow staff to develop and improve the care provided to their patients.

15.3 The department has undertaken significant work to reduce both the amount of pressure ulcers and medication errors that occur. Multidisciplinary work has been undertaken and a range of measures have been implemented, as evidenced in the presentation.

15.4 Previously, Critical Care has previously spent approximately £120k per month on agency staff but progress has been made to the recruitment process and the department have reduced the expenditure of agency staff to £30 – 60k per month.

15.5 Since merging services with Hurstwood Park four years ago, significant training has been provided to ensure more nursing staff are neuro-competent, with the aim of all 214 nurses being proficient in this area in the near future.

15.6 Clare then talked the Board through the work that had been completed in relation to a common theme of reported violence against staff. This has culminated in work to review how the department can prevent violence and also protect staff and patients is on-going to reduce these incidents.

15.7 To improve communication, huddles are held on a daily basis at the beginning of each day and night shift, which have received positive feedback and are well attended by all staff who work in critical care.

15.8 Dr Boyd reminded the Board of the results of the CQC inspection and drew the Board's attention to the improved ratings received at the most recent CQC inspection, in which some areas accelerated to be rated as 'outstanding'. The Board were informed of the various improvements that were made that underpinned this move.

15.9 The department previously faced challenges in recruiting critical care specialist Band 6 nurses, so the department has focussed on their own training programme to attract more nurses who can be trained to the high standards the departments critical care staff had set and meet.

15.10 The flow of patients across the hospital and the impact this can have on flow within the critical care wards remains a challenge. Dr Boyd spoke positively about a change in attitude across the Trust that view discharges out of critical care as a Trust wide responsibility.

15.11 Dr Boyd referred to the ICNARC data, which critical care units provide nationally. This data shows that the Royal Sussex County site is the 15th largest intensive care unit in the country, in terms of figures reported and compared to like intensive care units that facilitate neurology patients, the Hospital is the 3rd biggest nationally. Dr Boyd recognised that the Princess Royal site is a smaller hospital and has less critical care beds but it's reporting rates are still very good.

15.12 Recognising the importance of feedback, which is often difficult to obtain from patients in a critical state, Clare explained the alternative ways in which patients and families are made to feel that the care they receive is outstanding and the tools used to capture this feedback.

15.13 Clare added that the Royal Sussex County site now has a 24 hour outreach team who follow up with patients who have been discharged from critical care, these support nursing teams on wards and monitor those who require additional care outside of the critical care wards. The service has been provided at the Princess Royal site 24 hours a day for a longer period of time and is considered invaluable.

15.14 Peter recognised that there are still further improvements that could be made to the critical care wards and summarised the challenges they face and the actions they are taking to address these challenges.

15.15 Mike Rymer asked for further information in relation to violence and aggression. Clare praised the support received from security teams and explained that all staff have received training and have attended study days, which were allow the local team to discuss and develop tailored actions.

15.15 Malcolm Reed asked about the long term strategies, given the difference in ward capacities at both the sites. Dr Boyd explained that neurosciences have moved up to Princess Royal and whilst it is not without challenges to maintain a good service at Princess Royal it is an essential service as the site has an acute A&E. George Findlay confirmed that the critical care services for both sites are embedded in the Trust's clinical strategy.

15.16 The Board thanked the Critical Care Team and **NOTED** the presentation.

B/07/19/16 ANNUAL WORKFORCE DISABILITY EQUALITY STANDARD (WDES)

16.1 Helen Weatherill introduced the report, which looks at the experiences of staff with disabilities; recognising that although the Trust is ahead in some areas, there are some weaker areas that the Trust needs to improve on, which mirror the national position.

16.2 Helen informed the Board that it will receive an update on Workforce, Race and Equality Standard (WRES) in September and will also receive the action plan for WDES survey.

16.3 Helen advised that the Trust cannot yet compare itself to other Trusts until submissions have been made by each Trust. The Board confirmed that they looked forward to receiving national comparisons.

16.4 A focus of the work will also look at ways to encourage staff that have protective characteristics to declare these and highlight the importance of them providing this information is key to the Trust being able to better understand what it can do to improve matters for the staff in the trust with disabilities.

16.5 The Board **APPROVED** the data being submitted.

B/07/19/17 ANNUAL ADULT AND CHILDRENS SAFEGUARDING PRESENTATION

17.1 Clare Williams presented the Committee with an overview of the improvements made and priorities for both Children and Adult safeguarding activates across the Trust. Clare drew the Board's attention to the following key elements of both the Adult and Children's Safeguarding annual reports.

17.2 Clare informed the Board that 92% of staff had completed adult safeguarding training, compared to 82% in the previous year, work is on-going to increase this figure further.

17.3 The safeguarding team use a variety of sources including, patient experience feedback reports, reported incident and audits to monitor and manage safeguarding concerns.

17.4 Children's safeguarding has also seen a number of improvements, predominantly measured through the bi-annual audit which looks at both governance and compliance and has been a driver for improvements in the last 12 months.

17.5 The Board was assured that the detailed monitoring of cases and safeguarding processes are overseen by the Quality Governance Steering Group and any

escalations are referred to the Quality Assurance Committee.

17.6 Kirstin Baker noted the reported challenges around workforce and resources within the reports. Clare informed the Board of the reasons that safeguarding workforce has been a challenge and the action taken and being taken to address these.

17.7 The Board **NOTED** the report.

B/07/19/18 CNST MATERNITY STANDARDS

18.1 George Findlay introduced the report by explaining that that in order for the Trust to receive a maternity standards CNST rebate then the maternity service must demonstrate that 10 nationally set actions must be met and this report provided evidence that they have been met. The certificate of achievement of these is required to be signed off by the Board before being submitted. If centrally NHS Resolution agree that all 10 action have been met, the Trust will be allocated funding through the return of premiums.

18.2 Carly Knell took the Board through the evidence and drew out the key points or each of the 10 standards which confirmed that BSUH Maternity Services are compliant against each of the 10 standards and highlighted the evidence that will be submitted to support each action.

18.3 Mike Rymer referred to section 4 of the paper and asked if there was issues in terms of Junior Doctors staffing and if the responses from the GMC survey relate to one site in particular. Carly advised that generally the identified items were across both sites and advised that maternity are working closely with the Junior Doctor Workforce Transformation Programme to identify solutions to the identified areas for improvement. Malcolm Reed suggested other possible workforce solutions that may be useful to consider, such as the use of physician associates.

18.4 Carly advised that Ryan Watkins, Chief of Service for Women and Children's is conducting a separate piece of work to consider how academic posts are used within maternity.

18.5 The Board **APPROVED** submission of the CNST Maternity Standards certification.

18.6 The Board **APPOINTED** Alan McCarthy or Marianne Griffiths to sign the evidence, prior to submission.

B/07/19/19 DEMENTIA STRATEGY

19.1 Clare Williams provided the Board with the Dementia Strategy, asking for any feedback prior to its approval and its subsequent implementation.

19.2 The Strategy sets out pledges that will be reviewed on a regular basis and contribute to the Trust's wider 3 year plan for dementia.

19.3 Clare explained that she has engaged with key stakeholders, including the Sussex Partnership NHS Foundation Trust, to align this strategy with other system partners who have their own strategies. The strategy has also been through the normal process of review by and the endorsement of the Executive team.

19.4 The Committee agreed that it would be beneficial for Quality Assurance

Committee to maintain oversight of the strategy deployment.
ACTION: Dementia Strategy updates to be added to Quality Assurance Committee cycle of business. **FC**

19.5 Alan McCarthy queried the logo on page 8 of the report. Clare informed the Board that it relates to the nations John's campaign. Alan suggested that the relevance could be made slightly more explicit in the Strategy paper. Clare agreed to make the amendment.

19.6 The Board discussed the pros and cons of including further pledges in relation to the discharge times of patients with dementia within the strategy, George provided assurance that discharge is comprehensively monitored through other channels and the Board agreed that a specific measure for dementia patients was not needed.

19.7 Clare provided clarification regarding the 'This Is Me' document referred to in the strategy, explaining that it is a patient passport, that is kept with the patient and provides further detailing in relation to an individual's needs. The document is used well in the dementia wards but further embedding of the process is required across the Trust.

19.8 Joanna Crane suggested the action plan could include key performance measure that were more readily measurable.
ACTION: Clare to review the action plan and provide the actions and progress in a more quantifiable format. **CW**

19.9 Subject to further confirmation of the key performance indicators being included in the action plan, the Board **APPROVED** the strategy, recognising that oversight of its delivery would be provided by the Quality Assurance Committee.

B/07/19/20 ANNUAL MEDICAL APPRAISAL AND REVALIDATION

20.1 George Findlay provided the Board with the report which provides the Board with context around the revalidation process and compliance at BSUH.

20.2 The appraisal rate is 93% in the previous 12 months, with 138 revalidation recommendations made, there had been some deferrals and 1 non-engagement notification sent to the GMC, however, following this notification and the GMC contacting the doctor this matter has been resolved.

20.3 George recognised that a challenge in respect to the completing of appraisals is the number of appraisers, the Trust currently has 81 but is recruiting for more.

20.4 Alan asked a question in relation the table 2 on page 2 regarding the auditing process over the revalidation evidence and George confirmed that the figures are audited by an independent third party.

20.5 The Board were advised that deferrals are a neutral act from both parties and there are a range of reasons why revalidations are deferred, often relating to not enough evidence has been submitted.

20.6 Although one non-engagement notification was submitted, George assured the Board that non-engagements are much less frequent since the revalidation process has been aligned with appraisals and that non engagement is a neural act and not a patient safety matter.

20.7 The Board **APPROVED** the submission of the compliance statement included in the report and that this and the report itself be submitted to the higher level responsible officer.

B/07/19/21 COMPANY SECRETARY REPORT

21.1 Glen Palethorpe introduced the report, which was submitted for information purposes to provide an overview of activity the Board needed to be aware of but did not need their specific action.

21.2 Glen provided the Board with information on the publication of the Trust's annual report and financial statements along with the Trust's quality account.

21.3 Glen informed the Board that a web link address was included in the report to allow the public to find these documents should they wish to ahead of the Trust's Annual General Members meeting.

21.4 Glen informed the Board of the final element of the report that being the Learning from Deaths update. Glen reminded the Board that the detail behind this report had been discussed in detail at Quality Assurance Committee the previous day and was referenced in the update given by the Chair earlier in the meeting.

21.5 The Board **NOTED** the report.

B/07/19/22 ANY OTHER BUSINESS

22.1 There was no other business discussed.

B/07/19/23 QUESTIONS FROM THE PUBLIC

23.1 A member of the public had previously submitted a question to the Board in relation to beds at the Trust and patient flow.

23.2 Jayne Black responded by confirming that progress has been made, since the matter was previously discussed at the January Board meeting. The Trust is looking at more sustainable ways to manage capacity and improve flow and Jayne confirmed there that the BSUH meets regularly with other stakeholders as part of a systems group who have developed and plan which will be progressed ahead of winter 2019. Jayne confirmed that a system plan has been drafted by the CCG and once approved will be enacted to address the issues of delayed transfer of care patients within the system.

23.3 There were no further questions.

Francesca Carroll
Board and Committee Administrator
July 2019

Signed as a correct record of the meeting

…….Chair

…….Date

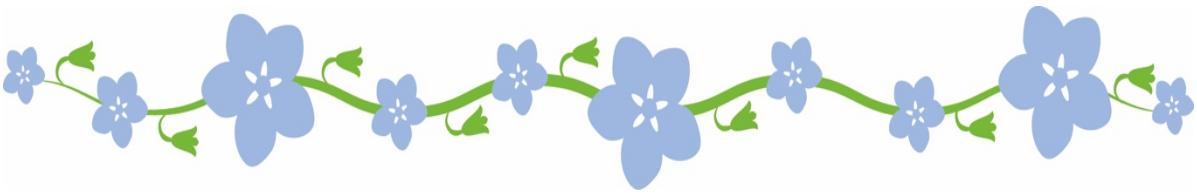
MATTERS ARISING
BSUH Board of Directors (in Public)

AGENDA ITEM: 4

Meeting	Minute Ref	Action	Person Responsible	Deadline	Status
24 July 2019	B/07/19/19.4	**Dementia Strategy:** Quality Assurance Committee to keep regular oversight of the strategy, which will be added to the cycle of business.	Francesca Carroll	Sept 2019	Complete, added to the cycle of business
24 July 2019	B/07/19/19.4	**Dementia Strategy:** Review the action plan and provide the actions and progress in a more quantifiable format.	Clare Williams	Sept 2019	*See Appendices 1 & 2 for update from CW.*

Dementia Strategy

2019 - 2022



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Introduction

Dementia is a global phenomenon and is recognised as one of the most important health care challenges of our generation.

In February 2015 the Department of Health (DH) published the Prime Ministers challenge on Dementia 2020, which set out what should be in place by 2020, in order for England to be:

> *"By 2020 we want to be able to say with pride, that England is the leading country in the world for dementia care and support, for undertaking research into dementia and other neurodegenerative diseases and for people with dementia, their carers and families to live." (Department of Health (DoH), 2016)*

Dementia is a progressive illness for which there is currently no cure and there are around 850,000 people in the UK living with dementia at an estimated cost of £26 billion. People living with dementia occupy around 25% of hospital beds, on average they stay in hospital over a week longer than someone without a dementia diagnosis.

As of May 2019, NHS England estimate that there are 2,784 people aged 65 plus living with dementia in Brighton & Hove CCG. However, there are only 1,944 people aged over 65 with a recorded diagnosis on GP registers across the CCG, representing a potential gap of 840 people living with the symptoms of dementia but without a confirmed diagnosis and not in receipt of the appropriate treatment and support. This equates to a Dementia Diagnosis Rate (DDR) of 69.8%, against the national ambition of 66.7%. Whilst the CCG met the national ambition on DDR in May 2018, performance against this metric previously remained consistently below comparator organisations.

The gap between actual and expected prevalence also exists for those with early onset dementia – whilst there are 54 people aged below 65 with a recorded diagnosis, available data suggests the BHCCG should have between 66 and 76 people formally diagnosed.

With the total number of people diagnosed with Dementia in our locality being 4,661 (CCG, 2019)

Brighton and Sussex University Trust covers Brighton and Hove and parts of East and West and Mid Sussex and is the tertiary centre for trauma and orthopaedics vascular surgery renal, HIV and neurology. This gives the trust unique demographics of people who will access our services and who may require support around their dementia.

It is imperative our vision about how we will develop out services over the next 3 years to support people living with dementia, their carers and the staff that will care for them whilst using our service.

This strategy is aligned to the NHS England transformation Framework. The well pathway for Dementia and strives to shows a vision of forward-thinking Dementia care at Brighton and Sussex university Trust

Dementia Strategy Statement

This strategy has been developed following consultation with relevant stakeholders, from a wide variety of disciplines. These include representatives from Sussex Partnership Foundation NHS Trust, Carers, Dieticians, Consultants in Elderly Medicine, Palliative care nurses Adult Safeguarding team as well as the education and workforce team.

"The strategy will provide a consistent standard of support for people living with dementia, their families / carers with an individualised person-centred care approach delivered by an educated and confident work force that recognises that dementia is as individualised as the person that has it."

Strategy Focuses

Over the next three years we will work with people with dementia and their families to provide excellent care

Coming into Hospital

- A Clear pathway into our specialist dementia wards
- Individualised approach to our outpatient areas
- Completion of the 'This is me' document within 24 hours of a hospital stay
- Consistent dementia care across the hospital site

Ongoing Care/Environment

- Introduce John's campaign to all ward areas
- A reduction in inpatient bed moves
- Individualised care planning with the right profession leading on care
- Partnership working with family , carers and loved ones
- Management of behavioural and psychological symptom's

Discharge Planning and Community Links

- Discharge planning commenced on admission
- Ward staff trained to understand the complexities around discharge planning for people with dementia
- People with dementia are discharge with dignity and their needs clearly communicated
- Understanding and partnership working with our community partners

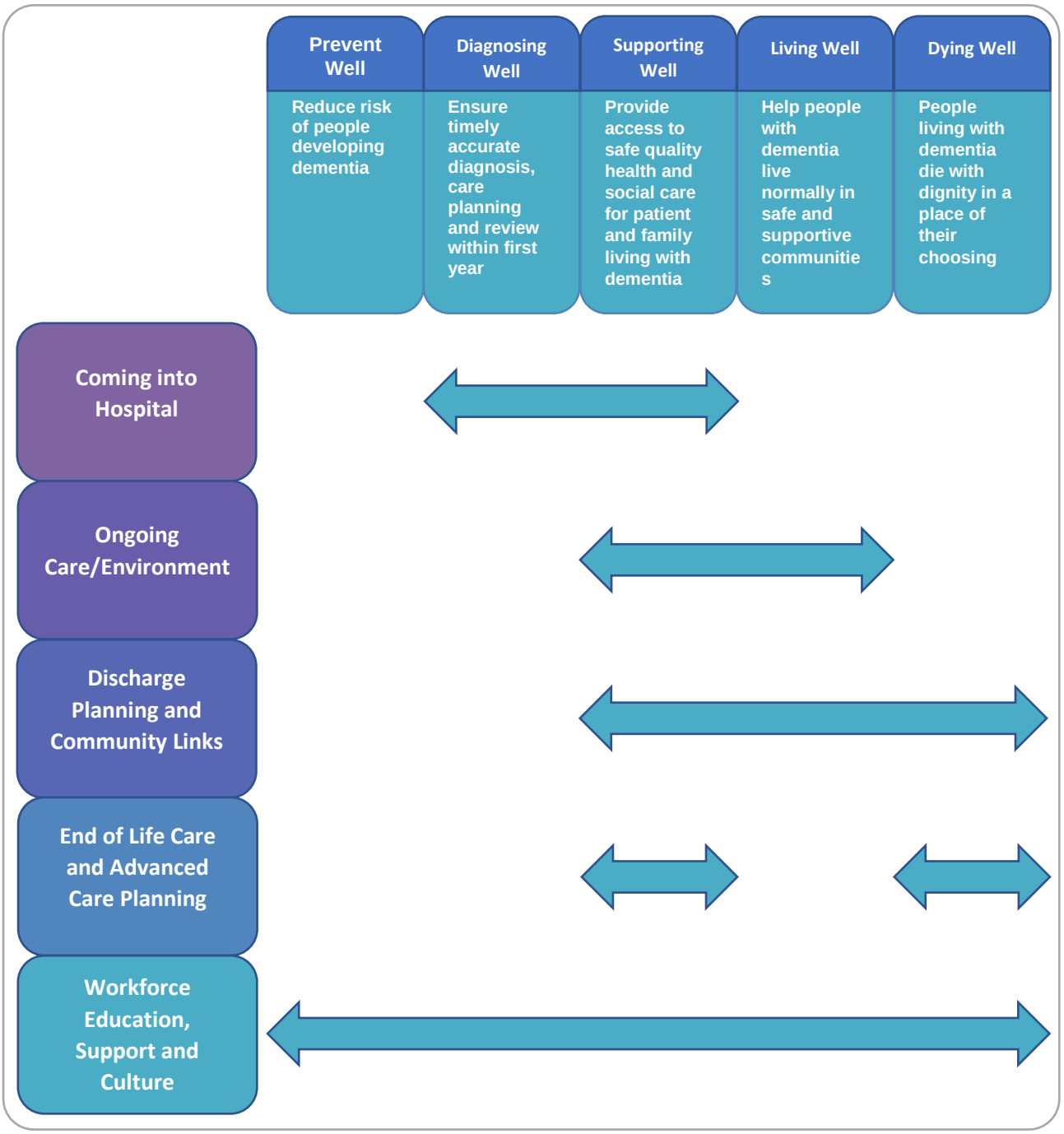
End of Life Care and Advanced Care Planning

- Advance care planning at a stage that the person with dementia is able to make choices
- Honest transparent conversation's about the progression of a person's dementia.
- Staff to feel confident and competent around advance planning and end of life discussion's

Workforce Education, Support and Culture

- 90% compliance of dementia training at tiers 1-2
- Dementia champions in every ward and outpatient area.
- Enhanced training for staff that provide one to one care
- Annual BSUH dementia conference
- Support systems in place for staff after distressing incidents.

Alignment of the Brighton and Sussex University Hospital's Dementia Strategy to the NHS England Transformation Framework: The Well Pathway for Dementia



Brighton and Sussex University Hospitals NHS Trust

Coming into Hospital

Commitment Statement

"We recognise that coming into hospital is a potentially distressing experience for people living with dementia and their carers. We are committed to providing professional, timely assessment for safe personalised care and admission where appropriate."

We Pledge to ensure:

- A clear pathway is developed for people living with dementia to access specialist dementia support and to the dementia specialist wards.
- Individualised approach to Outpatient areas in regard to how they can provide better Dementia care.
- Completion of dementia and delirium assessments on admission.
- 'This is me' support tool will be embedded as an integral part of the admission process and the care of people living with dementia accessing our hospital services by year one all ward areas will have access to their own supply of the support tool and by year 3 there will be an 80% uptake.
- Dementia care will be consistent across all hospital sites no matter what service people access.
- The red bag scheme will be developed with nursing homes that access the acute trust services.

Ongoing Care/Environment

Commitment Statement

"We commit to ensuring that all people with dementia coming to our hospitals receive a personalised and accessible service provided by skilled knowledgeable professionals through all areas of Brighton and Sussex University Hospitals."

We pledge to:

- By year 2 John's campaign is easily recognised and all wards are implementing it.
- Reduce the number of inpatient bed moves a person experiences to a maximum of two unless medically indicated by year 3.
- Provide individualised and responsive person-centred care planning that ensures a person living with dementia that is admitted into the acute trust is understood and their needs are met.
- Ensure the right professional leads on the care of a person with dementia with clear pathways and close working with the Older People's Mental Health (OPMH) services.
- Ensure Family, carers and friends are recognised as partners in the care of their loved one with dementia and are offered support and guidance where needed.
- Develop a trust wide policy for the management of behavioural and psychological symptoms when a person is distressed we will look at psychological intervention first and not pharmacological.
- Provide Meaningful activities are encouraged and available in the acute wards

Discharge Planning and Community Links

Commitment Statement

"We commit to early Multi-disciplinary Team (MDT) involvement, for people who have dementia and needs arounds complex discharge planning.

There will be early intervention with the individual and their chosen advocate. They will be discharged to the most appropriate, least environment at the right time in the right way."

We pledge to ensure:

- Discharge planning is commenced on admission and that the relevant professionals are involved at an early stage to prevent an unnecessary prolonged inpatient stay.
- Ward staff are appropriately trained and supported with understanding the complexities around discharge planning with people living with dementia particularly when the dementia is more advanced and the person may lack capacity in terms of discharge planning.
- Patients are discharged with dignity and clear communication to all those involved in the person's care.
- Improved understanding of the services that are available in the Sustainability and Transformation Partnership (STP) in regards to dementia support to ensure that people are clearly sign posted to the most appropriate services.

End of Life Care and Advanced Care Planning

Commitment Statement

"Care must be person centred and holistic taking into consideration of any advance / future care wishes the person may have expressed or felt important to the individual by their significant others. They are appropriately recognised and diagnosed and nearing the end of their life or actively dying."

We pledge to:

- Undertake advance care planning at a stage that the person with dementia can make choices.
- Have honest transparent conversations about the progression of a person's dementia and what this means before the last admission.
- Support staff feel confident and competent to have conversations about dying, and advance care planning
- Deliver person centred holistic end of life care.
- Provide psychological support for staff who have been supporting a person and their loved ones through the dying and bereavement process.

Workforce, Education, Support and Culture

Commitment Statement

"We will have a skilled workforce who can deliver individualised care treatment and support to people with dementia and their careers. Dementia training will be available across all staff groups."

We Pledge to:

- Maintain 90% compliance at training on tier 1-2 dementia training
- Embed dementia champions in every ward and outpatient areas from a variety of professional groups. The dementia champions will be seen as a valued and recognised role and this will be enhanced by training and a clear role description.
- Provide enhanced training for staff who deliver one to one care.
- Deliver BSUH annual dementia conference.
- Support to staff after distressing incidents and provide an opportunity to debrief.

Acknowledgements

This strategy was authored by:

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We also wish to thank the members of the Brighton and Sussex University Hospitals Dementia Steering group and the Key Stakeholders for their contribution to the development of this strategy:

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Lead OT at PRH, BSUH

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Strategic priority 3-year delivery plan

Coming into Hospital			
We Pledge:	**Year One**	**Year Two**	**Year Three**
A clear pathway developed for people living with dementia to access specialist dementia support and to the dementia specialist wards.	Clear pathways developed into the specialist dementia wards A visible presence in ED and the acute floor from the dementia service to ensure that patients are directed where possible to the dementia specialist wards. This will include a robust live list for the clinical site teams identifying patients requiring the specialist dementia wards enabling timely prioritisation and the right care for the right patient.		A carer's booklet to be provided on admission to sign post carers into the care available for a loved one with dementia and information that may be useful to support them.
An Individualised approach to Outpatient areas in regards to how they can provide better Dementia care.	A yearly focus on separate outpatient areas to ensure that they are equipped to manage the needs of people with dementia utilising them. The focus of year one will be the eye hospital	The focus on year two will be the main outpatient department.	The other tertiary outpatient departments will be the priority.
The Completion of dementia and delirium assessments on admission.	90% targets of dementia and delirium screening to be met	100% screening targets to be met	100% screening targets to be maintained and an embedded culture.

Embed the 'This is me' support tool as an integral part of the admission process and the care of people living with dementia accessing our hospital services.	The "This is Me'' document will become an integral document on every ward within 24 hours of admission	The ''This is Me'' document will form part of the audit process to ensure that there is a 90% compliance in ward areas	Through the completion of audits there will be a 100% compliance in the "This is me" being completed.
Consistent Dementia care across all hospital sites no matter what service people access.	Bespoke training offered to all areas of the trust to ensure that ward areas feel confident to manage a person with dementia and any complex needs they may have.	A dementia awareness month to be held yearly to promote and showcase the achievements around dementia care within the trust	The dementia champions to hold sit and see sessions on their ward around dementia care and feedback any positive changes or issues for collaborative learning.
Ongoing Care/Environment			
We Pledge:	**Year One**	**Year Two**	**Year Three**
To Reduce the number of inpatient bed moves a person experiences	Work with the clinical site teams to understand and work with barriers that may be in place into prevent people living with dementia accessing the most appropriate wards. There will be a robust live list in place to identify people from the acute floor. Monitor bed moves for patients that are reviewed by the outreach service and identify any triggers and recurrent themes.	An engagement programme with ward areas to reduce the number of people requiring a bed move to specialist dementia wards. This will be assisted with the introduction of dementia champions in every ward area to help educate and promote good dementia care.	

	Ensuring that the right patient is in the right place in the hospital.		
Provide individualised and responsive person-centred care planning that ensures a person living with dementia that is admitted into the acute trust is understood and their needs are met.	Dementia champions are recruited for every ward/ area to assist and role model person centred care. A rolling teaching programme will be in place to help enhance their skills and there will also be a targeted engagement and recruitment programme at the annual dementia conference. The Bolton pain assessment chart is used to identify pain management issues with people with a cognitive impairment trust wide	Finger food menus are available on all wards. A personalised bed space with familiar objects, clothing, pictures of a loved one, or things that provide comfort. Care need assessment charts are redesigned based on a (strengths-based model).	Ensure the needs of people with dementia and that are part of the LGBQT community are addressed and met.
Ensure the right professional leads on the care of a person with dementia with clear pathways and close working with the Older People's Mental Health (OPMH) services.	Early sign posting to either the dementia service or the older peoples mental health team from the acute floor with education around the services that each team can offer through education at clinical updates, care certificate and bespoke training sessions. Clear pathways are developed and publicised into the services, ensure pathways are easily available for staff to utilise. Clear guidance on referring into the memory assessment service for clinical practitioners.		

Ensure Family, carers and friends are recognised as partners in the care of their loved one with dementia and are offered support and guidance where needed.	A robust education plan in the spring to ensure that John's campaign is an integral part of the trusts ethos. Consistence ward signage that reflects the ethos of johns campaign .	Carers are encouraged to ask for support and sign posted to services.	A Dementia café to be set up to provide support to carers
Provide meaningful activities are encouraged and available in the acute wards	The recruitment of an activities co coordinator amongst ponying's, Ardingly and Plumpton ward at the Princess Royal Hospital (PRH) An initial roll out of activity boxes/ comfort bags in ED by working with ED and the acute floor to see what would be appropriate.	Comfort bags developed and rolled out to all wards in the trust and outpatient areas.	Investment in the Rita system across wards at PRH and ED.
Ensure consistency in dementia friendly environments	Collaborative working to ensure that the work on the 3Ts project is dementia friendly.	The wards with a high proportion of people with dementia using them to become consistent in dementia friendly decoration.	Maintain and monitor the environment to ensure that it is conforming to dementia friendly standards

Discharge Planning and Community Links			
We Pledge:	**Year One**	**Year Two**	**Year Three**
Discharge planning from admission	The dementia lead nurse contributes and provides feedback to patient experience group and the weekly discharge breakthrough objective huddle. Develop a care pathway to assist in the discharge process for people who have delirium superimposed onto dementia.	Actively working with the discharge team to ensure that the dementia service is involved at the start of someone's hospital journey in order to reduce the length of stay and encourage positive risk taking with a person with dementia	
Ward staff are aware and supported with complexity of discharge planning	Ward staff are aware to contact the dementia service early in person stay enabling the dementia service to support them through complex discharge planning. A nurse to be part of the care home assessment process when assessing people with dementia	Education and training will be provided on the utilisation of mental capacity assessments as part discharge planning and best interest meetings for patient living with dementia. This will be achieved as part of the level 2 and level 3 training programmes.	
Patients are discharged with dignity and clear communication	People with dementia to be discharged with appropriate clothing. Honest and transparent conversations with community and nursing home providers around the needs of people with dementia. Comprehensive handover to new care providers with a comprehensive nursing discharge letter.	Network building with nursing home providers to form trusting relationships and attendance at the care home forum for Brighton and hove	
Improved understanding of availability support services and ensuring these are clearly sign posted.	Initial fact finding and networking within the STP. Relationship building with our local community mental health partners	Work closely with relevant services within the STP to build direct pathways from the acute trust into the services.	

End of Life Care and Advanced Care Planning			
We Pledge:	**Year One**	**Year Two**	**Year Three**
Undertake advanced care planning when the individual can still make decisions.	Early advanced care planning conversations clearly documented at a stage where by the person with dementia is able to make choices.		
Have honest conversations about an individual's progression of dementia and advanced care planning before the final admission.	Conversations become an integral part of care planning around the progression and prognosis of their advancing dementia. Clear documentation of any interventions that they would like ensuring effective communication between health care professionals. Onward care providers are aware of any advanced wishes around the person's end of life care.	Carers are sign posted to community support around dementia and end of life decision making.	
Support staff feel confident and competent to discuss dying and advanced care planning.	Early involvement from the palliative care team prior to the person with dementia actively dying to provide support to the staff, person, family and carers.		
Deliver person centred holistic care end of life care.	Ensure that a person who is end of life is able to choose where in the hospital ward, they want to die. Ensure that pain is recognised early on and that appropriate analgesia is prescribed. Ensure early involvement of the palliative care team to support and ensure that the right pain medication is being used.	Work towards a carer's passport for people visiting someone who is end of life.	
Provide psychological support for staff who have been supporting a person and their loved ones through the dying and bereavement process.	Ensure debrief sessions to be available where staff have supported patients and loved ones they through the dying process, and afterwards through the bereavement process.		

Workforce Education, Support and Culture			
We Pledge:	**Year One**	**Year Two**	**Year Three**
Maintain 90% compliance with tiers 1-2 training	Dementia tier 1 training aligned to the department of health is mandatory on all clinical updates and trust induction. Ensure all staff working in dementia specialist wards or in areas with a high proportion of people with dementia using the service complete the tier 3 training.	Introduction of a one-day tier 2 programme to focus on health care assistants and those clinical staff that do not want to work towards a level 6/7 course	
Have Dementia Champions in every ward and outpatient area	A two-day specialist education programme to enable champions to have the skills and resources to manage people with dementia. in their work areas Dementia champions are easily identifiable, purchase dementia champion pins to aid identification.	Dementia champions are regularly updated on the latest evidence based knowledge around the care of people with dementia. Facilitate a dementia champion forum quarterly.	
Provide enhanced training for staff undertaking one to one care.	Enhanced training around dementia is rolled out to clinical staff that are regularly working on a one to one basis with people with dementia	Additional training is provided to bank staffs that regularly work on a one to basis with dementia.	

Deliver BSUH annual dementia conference	Annual dementia conference to be held to ensure that all staff groups have the opportunity to learn about dementia within our trust and the latest evidence based work around dementia		
Support staff after distressing incidents	Incidents relating to people with dementia are reported and the staff member is given emotional support where review of incidents where required. Structured judgement reviews and AARs are carried out depending on the nature of the incident to support learning and enhance future care.	Dementia team to have undergone hot debrief training in order to initially be able to provide some support to staff in distress.	Continued education on annual updates, the care certificate, preceptorship student programmes to learn from incidents and support colleagues in being able to manage people with complex dementia needs.

Brighton and Sussex University Hospitals NHS Trust

Chief Executive's Report

September 2019

Content

- Headlines: July and August
- Diary highlights
- Looking ahead

Headlines

Taking pride in Pride

Dozens of BSUH staff took to the streets of Brighton last month to take part in Brighton Pride – and what a fantastic day it was!
An estimated 250,000 people saw our BSUH float wind through Brighton's streets, partied to the sounds of our Pride Party playlist and cheered on our parade team. In addition to our colleagues and their partners we also welcomed a number of other guests including Yvonne Coghill (the NHS Director for WRES Implementation) who wanted to spend their Pride with us.

We can be really proud of our involvement with Pride, it's a clear statement about the value we put on inclusion, diversity and equality here at the Trust.

Headlines

BSUH shortlisted for “Acute or Specialist Trust of the Year” in HSJ Awards

We’re delighted to be named as finalists for ‘Acute or Specialist Trust of the Year’ in this year’s Health Service Journal (HSJ) Awards.

The HSJ Awards recognise outstanding commitment to excellence in healthcare. This is a great opportunity for us to celebrate everything we have achieved as a Trust over the last year.

The ‘Acute or Specialist Trust of the Year’ category looks at how NHS trusts have met their challenges head on and created a long term vision of care.
BSUH was selected based on the huge improvements we have made including our ‘Good’ overall and ‘Outstanding’ for caring rating by the CQC, supported by our fantastic Patient First improvement programme.

Judges reviewed our progress across our top five Trust priorities: Quality, Finance, Culture, A&E Performance and 3Ts Development.

BSUH wins Gold Award for supporting armed forces staff

BSUH is proud to be one of 100 employers being recognised by Defence Minister Ben Wallace for our outstanding support for the Armed Forces community by being awarded an Employer Recognition Scheme Gold Award.

The MOD’s Employer Recognition Scheme Gold Awards represent the highest badge of honour available to those that employ and support those who serve, veterans, and their families.

BSUH is one of 13 NHS Hospitals and Trusts to receive this coveted award.

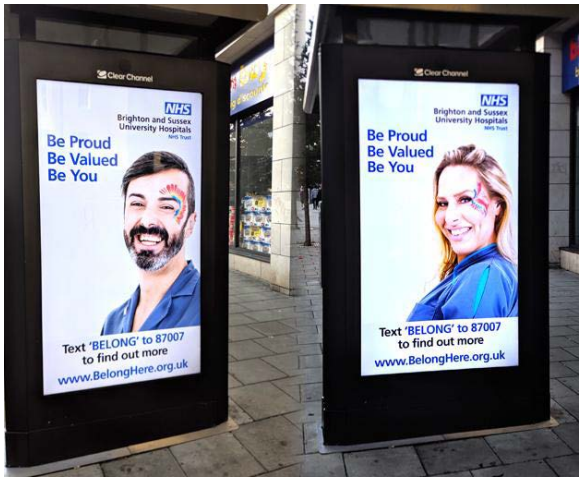
Headlines

#BelongHere campaign

#BelongHere featured 14 colleagues from across the Trust as the faces of this special campaign. It hit the streets just in time for Brighton Pride and more than 4 million people will have seen it over the course of the time it was running – not including the 450,000+ Pride attendees and millions of social media users across the globe.

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 our Trust.

The campaign's dedicated website – www.BelongHere.org.uk – features short stories from each of our models about their experience of working at the trust. The overall message from our colleagues is that it's the people which make BSUH special, which ties in perfectly with our new Breakthrough Objective.



Welcome to BSUH

We welcomed our new cohort of junior doctors this month, as they begin their placements with us. The 250 new starters, which include Foundation Year 2s, GPs, Core, Specialist Trainees and Clinical Fellows, began with an induction day at the Amex Stadium on Monday (12th August).

There was a wide range of important information to support in their new roles, from how to access the Library Service to joining our staff networks and asking any HR related queries before getting stuck into the job.

Headlines

Congratulations to our latest PFIS graduates

Congratulations to Wave 6 teams from the Princess Royal Hospital who have just completed their Patient First Improvement System (PFIS) training , graduating last.

Sixty teams have now completed this 4 month intensive training programme and 10 more teams have just started their PFIS journey at RSCH.

PFIS empowers teams and individuals by providing the tools and processes for making improvements in their areas. No improvement is too small - it's all about 'removing the rocks from our shoes' to improve care and put our patients first.

Transforming the Trevor Mann Baby Unit

Staff and supporters of The Trevor Mann Baby Unit (TMBU) at The County celebrated the completion of refurbishment work and the opening of a new quiet room 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 us to offer them more privacy on the wards .

Diary highlights

- Meetings with partner organisations
- Sustainability and Transformation Partnership
- Acute Network
- University Of Brighton, graduation
- BSUH Cancer Board
- HSJ judges visit

Looking ahead

Staff Survey 2018

The Annual NHS staff survey launches at the beginning of October and is a chance BSUH staff to have their say. It is a completely anonymous survey conducted by an external company - Quality Health. The survey allows members of staff to provide valuable feedback on issues that matter most to them, including:

- Health and wellbeing
- equality and diversity
- morale, management
- quality of appraisals
- quality of care
- workplace environment
- safety culture
- staff engagement.

There will be lots of activity to promote the survey to staff within the Trust. In 2018, we had a 59% response rate and we're looking to increase response in this year's survey. 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.

Protecting our staff and patients from Flu

The annual flu season is fast approaching. From 7th October 2019 to February 2020, the Trust will be offering staff free vaccinations against the flu virus. Frontline NHS healthcare workers are more at risk of being exposed to, and therefore of spreading the flu virus, so vaccination is a vital part of infection control.

The flu vaccination helps to stop the spread of flu to colleagues and their families, as well as protecting vulnerable patients who are at increased risk of complications. We have a team of trained workplace vaccinators within the Trust who will be holding drop-in clinics to distribute the vaccine to staff. Roaming vaccinators will also be on hand to provide the jab to staff on shifts and in their departments.

Integrated Performance Report

September 2019

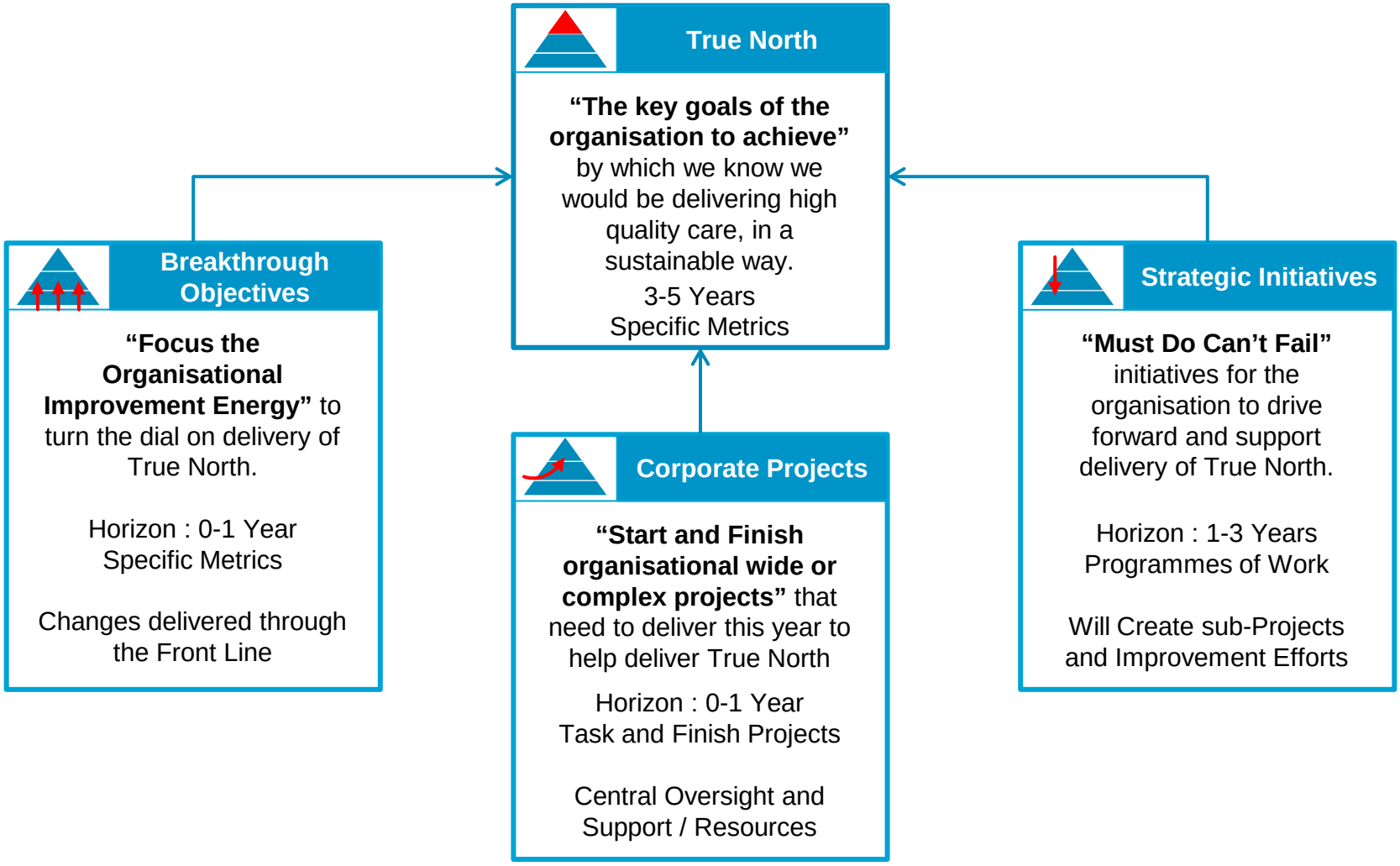
NHS
Brighton and Sussex University Hospitals
NHS Trust

Contents

Structure of the report

Introduction - Patient First
Quality Improvement
Systems and Partnerships
Sustainability
People

Patient First Strategy Deployment Framework



Patient First True North

Key Goals for the Organisation to achieve sustainably

Patient

Patient Satisfaction

Target: Family & Friends Recommend Rate >96%

Sustainability

Financial Management

Target: Break Even

People

Staff Engagement

Target: Engagement Score Top 20% in the Country

Quality

Preventable Mortality

Target: HSMR Top 20% in the Country

Avoidable Harm

Target: Patient Safety Thermometer 99% Harm Free Care

Systems & Partnerships

Non Elective Care

Target: A&E 95% <4hrs

Elective Care

Target: RTT 92% <18wks

Quality Performance

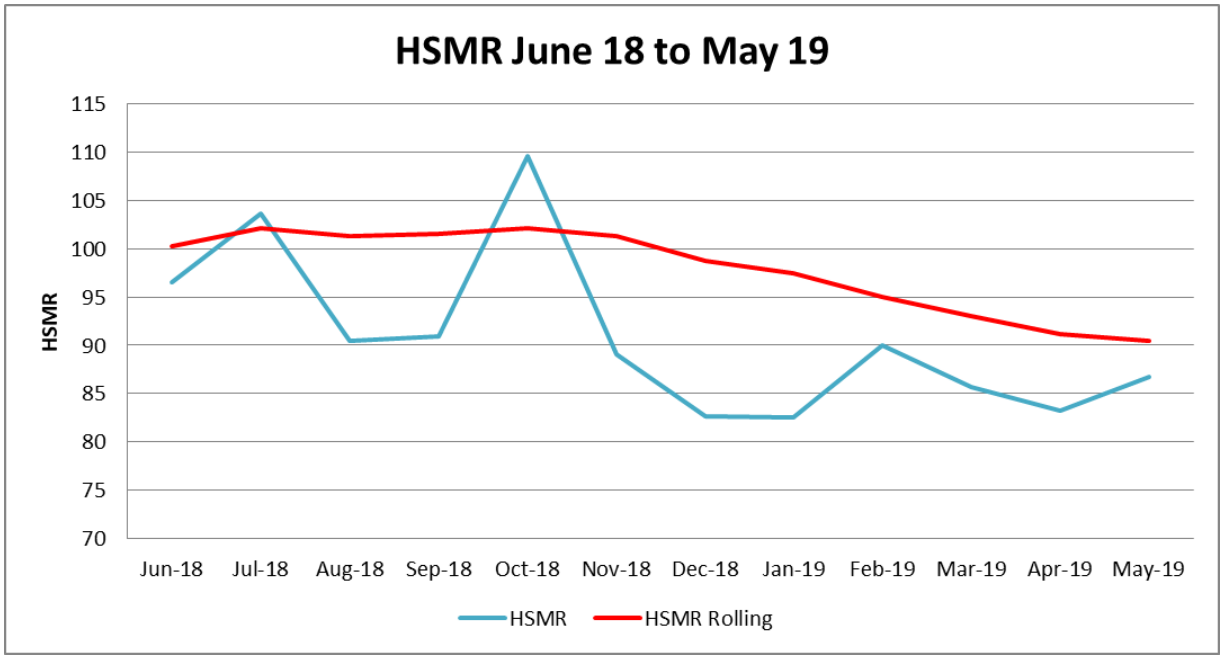
Quality

Preventable Mortality

Target: HSMR Top 20% in the Country

Avoidable Harm

Target: Patient Safety Thermometer 95% Harm Free Care



HSMR data is available up until May19 when the in-month HSMR was 90.42. The rolling 12 month mortality rate continues to fall.
BSUH currently sits just one place outside the top 20%; to achieve this, BSUH requires a HSMR below 90.26.

The harm-free care score for the past 12 months was 94.94% against the target of 95%. The national average is 94.2%.

Quality Performance

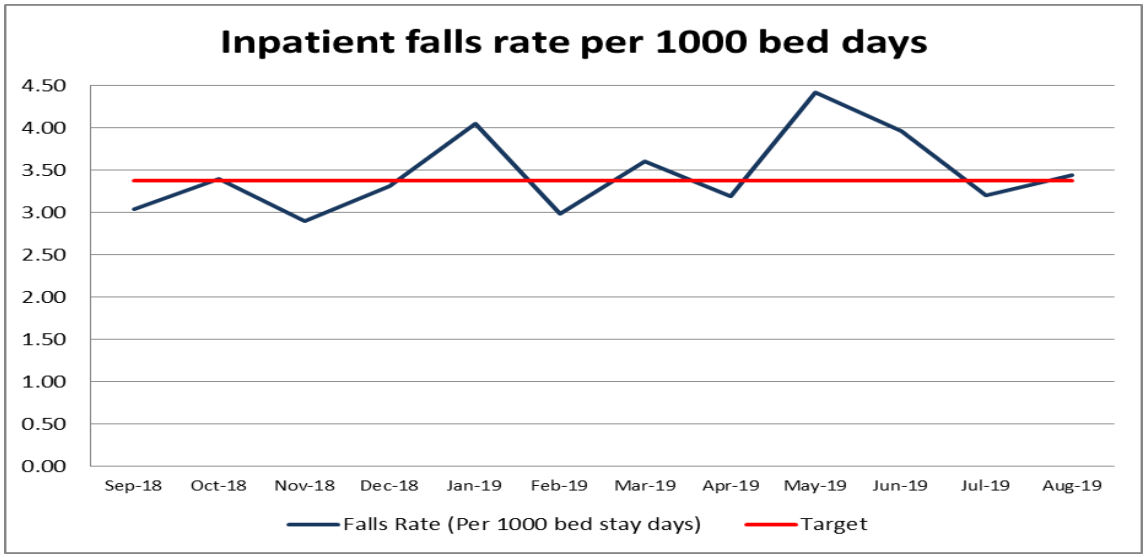
Quality

Inpatient Falls

Target: 3.38 falls per 1000 bed stay days

Pressure Ulcers

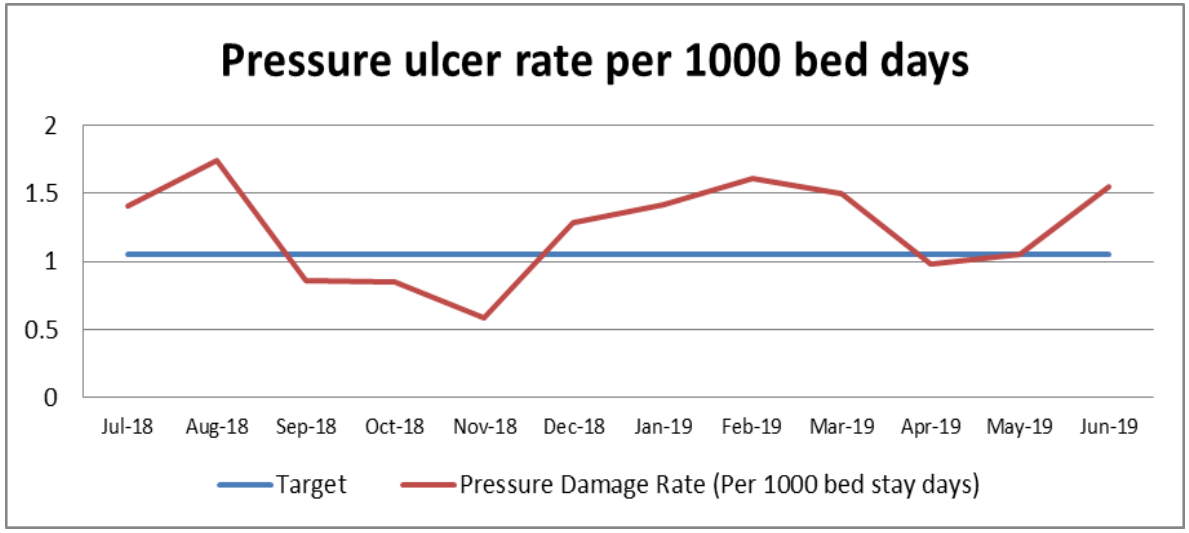
Target: 1.05 rate of acquired pressure ulcers per 1000 bed stay days



The rate of inpatient falls for the past 12 months is 3.32 falls per 1000 bed stay days; in August the falls rate was 3.45 per 1000 bed stay days, and in July was 3.20 per 1000 bed stay days. The National Falls rate is 6.63 falls per 1000 bed days.

The Patient Safety Team sends a monthly report to all inpatient area's detailing the falls on their ward for the past 12 months. This data will form part of the quality and safety dashboard that will be presented at Nursing Midwifery Board monthly from the 1st October 2019 to review the data and reinforce the learning.

Quality Performance



Quality

Inpatient Falls

Target: 3.38 falls per 1000 bed stay days

Pressure Ulcers

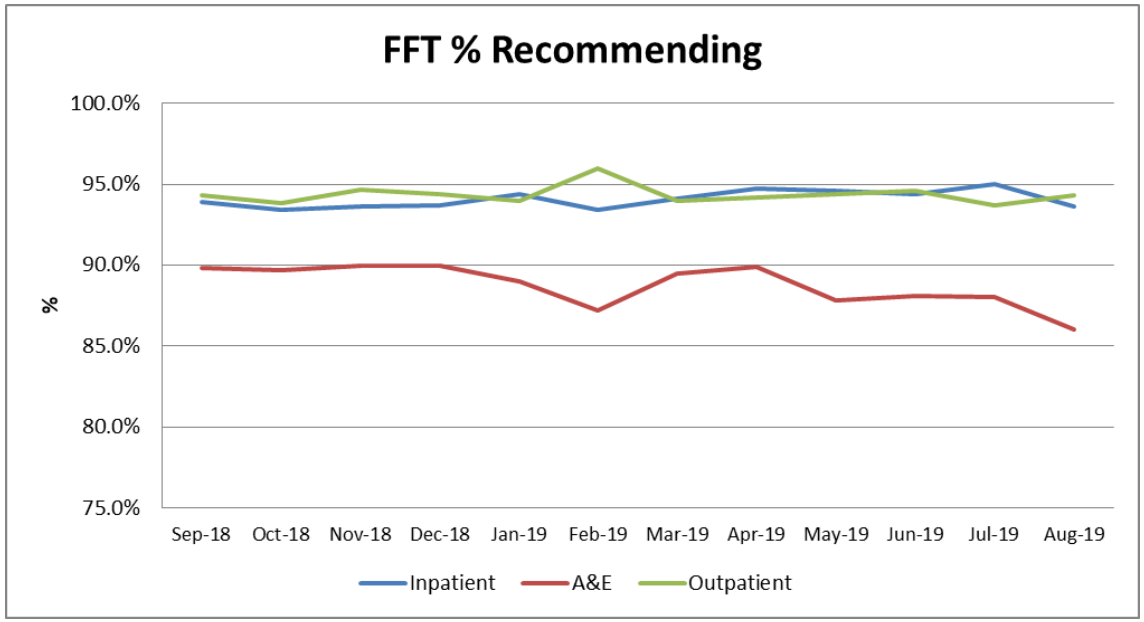
Target: 1.05 rate of acquired pressure ulcers per 1000 bed stay days

The pressure ulcer rate for the past 12 months 1.17 incidents per 1000 bed stay days.

The Head of Nursing for Quality Improvement has undertaken a data cleanse and a review of the current process of reporting. 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. This will commence on the 23rd September 2019.

Following the introduction of changes to grading of Pressure Ulcers. The Training Needs Assessment has been updated with an implementation plan of cross-wide training.

Quality Performance



Our current recommended rates for August are:

Inpatient – 93.6%
A&E - 86%
Outpatient – 93.3%

Breakthrough objective for 19/20 is improvement at discharge

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

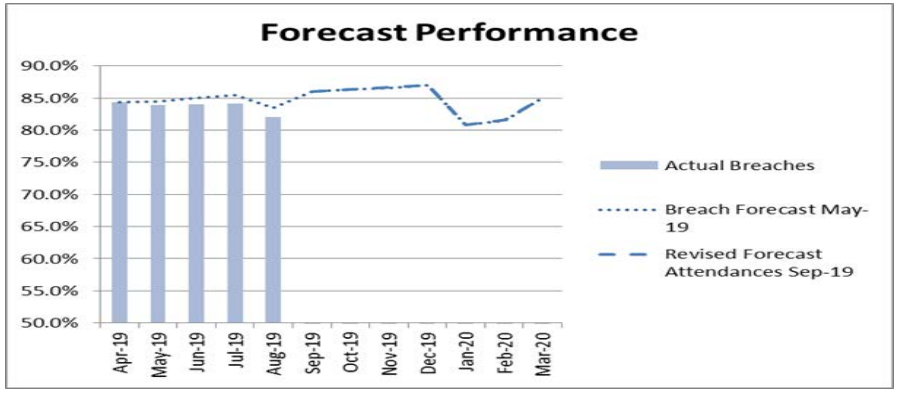
- A&E Performance worsened to 82.0% (acute footprint) in August-19 compared to the national performance of 86.3%.

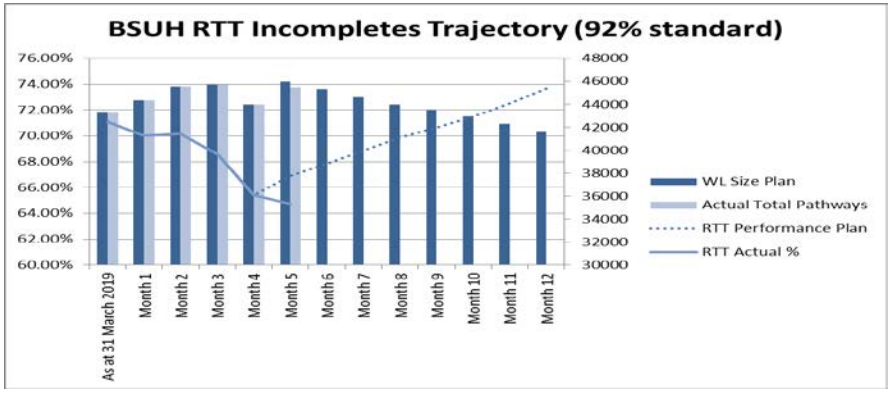
- 62 day cancer performance for GP referral to treatment reduced by 6.1% to 57.9% in July-19 compared to June-19. This was expected as part of the recovery actions to reduce the prospective waiting list size. National average performance (July-19) was 77.6%.

- RTT Performance deteriorated 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 is an increase of 21 on the prior month. National average performance (July-19) was 85.8%.

- Diagnostics 6 week 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%.

Systems and Partnerships – True North Metrics





- Trust A&E Performance for August-19 was 82.0% including the NHSE allocated type 3.
- This 2.4% lower than July-19, 2.1% lower than August-18. The performance is behind the agreed trajectory by 1.5%
- The trust had 3814 4 hour A&E breaches which was 261 (7%) more than the same month last year.
- The trust was below the national average performance of 86.3% in August-19.

- Trust performance for RTT in August-19 was 64.8% for all specialties, a deterioration of 0.6% compared to Jul-19.
- There were 34 52 week waiters at end August-19. This was an increase of 21 since the previous month.
- The RTT incomplete Waiting List fell by 219 waiters August-19 compared to June-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 Trust has launched a live emergency flow dashboard, revised site meeting format and new escalation triggers to deliver further improvement.

Improvement Focus:

- Daily Activity Huddles
- Focussed long waiter management with daily recovery review.
- Specialty level recovery action plans
- Full PTL validation exercise including support from NHSi
- Enhanced RTT dashboard development to aid improvement planning
- The performance governance framework has been reviewed and is being strengthened to include daily oversight meeting with directorate management Teams.

Systems and Partnerships – Cancer

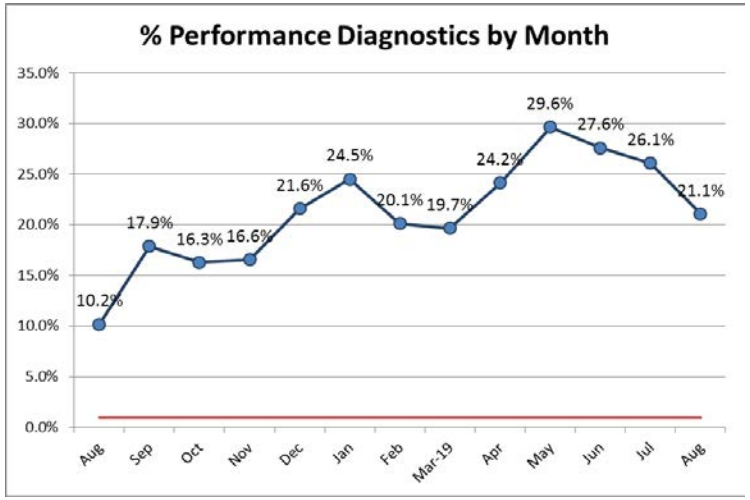
	2019/20		Var-18/19		
	Jul	YTD	Jul	YTD	Target
2 week GP ref to 1st OP	88.1%	79.9%	2.5%	-11.3%	93%
2 week GP ref to 1st OP - breast symptoms	80.8%	79.4%	-16.0%	-17.3%	93%
31 day 2nd or subs trtmnt - surgery	96.0%	94.0%	-4.0%	-6.0%	94%
31 day 2nd or subs trtmnt - drug	100.0%	100.0%	0.0%	0.0%	94%
Cancer: 31 day second or subsequent treatment - radiotherapy	99.5%	100.0%	1.3%	0.0%	94%
31 day diag to trtmnt all cancers	96.0%	92.3%	-3.2%	-7.7%	96%
62 day ref to trtmnt: screening	74.6%	45.2%	6.2%	-15.8%	90%
62 day ref to trtmnt : upgrade	100.0%	79.2%	27.3%	-9.7%	85%
62 days urgent GP ref to trtmnt : all cancers	57.9%	63.2%	-13.0%	-15.5%	85%

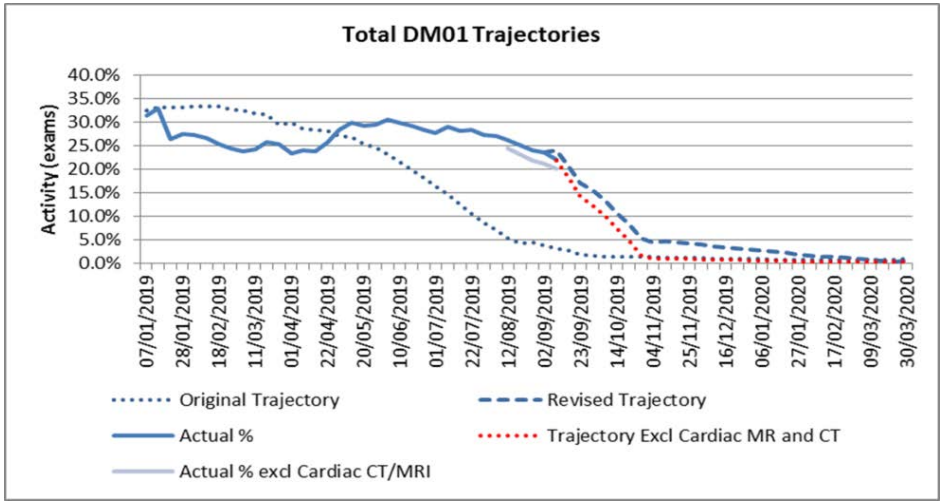
- The Trust was compliant in 4 of 8 reportable cancer metrics in July - 19.
- The Trust was non-compliant against the 62 day urgent referral to treatment target of 85%, with 57.9% of patients commencing treatment within 62 days a 6% reduction as part of Trust plans to reduce prospective long waiters.
- 49 patients were treated past the 62 day breach target out of a total of 115.5 treatments undertaken.
- Significant improvements have been made in reducing the numbers of patients waiting over 2 weeks for an OP appointment and those waiting over 62 days for a definitive action. This will support delivery of an improved percentage compliance in the coming 2-3 months.
- The most challenged tumour sites are colorectal, urology and breast.

19/20 Improvement Actions

- Diagnostic recovery plan to support cancer recovery
- Outsourcing CT reporting to reduce diagnostic delays
- Individual speciality capacity improvements
- 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 5% August-19 compared to the previous month.
- There has been a 713 reduction in non-obsteric ultrasound over 6 week waiters and 102 fewer over 6 week waits for endoscopic modalities since July-19 which are the key drivers of the improved performance.
- Both imaging and Endoscopy are currently accessing additional capacity through the engagement of external companies.
- Further recovery actions in endoscopy are in the process of being finalised.

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.
- Around 500 Non obstetric ultrasound scans are being outsourced to an external provider.
- Extra sessions have been identified through the Superintendents converting admin days into clinical time.
- Additional evening and weekend sessions are running in US/CT/MRI.
- Reviewing cardiac CT protocol to become radiographer led (implementation Nov 19)
- Reviewing Cardiac MRI guidelines

Sustainability - Summary

Sustainability
Financial Management Target: Break Even

- For August, the Trust is reporting a deficit of £3.8m which is slightly better than plan.

- 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 post accounts reallocation PSF

- The Trust is on trajectory to deliver an underlying deficit of £53m; which will earn an additional £25.4m of PSF and FRF funding. This will achieve the year-end deficit control total of £25.7m.

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

Sustainability – Key Metrics

Finance and Use of Resources Risk Rating — A

YTD

	Plan	Actual / Forecast	Variance
Year-to-date	3	3	0
Year-end Forecast	3	3	0

At the end of August the aggregate rating is a 3, in line with the plan. Individual rating components are in line with plan apart from the agency spend rating which is not meeting the plan, as the ceiling has been exceeded.

Control Total (Surplus) / Deficit £k — G

	Plan	Actual / Forecast	Variance
Year-to-date exc PSF/FRF/MRET	25,899	25,864	35
Year-end Forecast exc PSF/FRF/MRET	52,996	52,772	224
Year-to-date	17,933	17,288	645
Year-end Forecast	25,747	24,913	834

The Trust deficit in Month 5, excluding PSF/FRF/MRET is in line with the plan. As a result of delivering the underlying control total the Trust has earned £1.85m of PSF/FRF/MRET in-month (£7.97m 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	7,289	7,094	(195)
Year-end Forecast	27,070	27,070	0

In Month 5, £1.83m of savings have been delivered against a plan of £2.28m. Year-to-date the Trust has delivered £7.09m against a plan of £7.29m and the Trust is forecasting full delivery of the £27.07m requirement.

Capital £k — A

	Plan	Actual	Variance
Year-to-date	49,708	32,478	17,230
Year-end Forecast	166,310	152,037	14,273

There is less spend to date than planned on the 3Ts hospital build. Purchases of medical equipment, IM&T developments and estates infrastructure are progressing as planned.

Sustainability – Key Metrics

Income £k — A

	Plan	Actual / Forecast	Variance
Year-to-date	(258,625)	(256,019)	(2,606)
Year-end Forecast	(631,285)	(628,696)	(2,589)

Income was below plan by £0.59m in-month giving a year-to-date adverse variance of £2.61m. Of this total, £1.55m relates to Patient Care Activities income and £1.06m to Other Operating Income.

Operating Costs £k — G

	Plan	Actual / Forecast	Variance
Year-to-date	268,088	265,050	3,038
Year-end Forecast	646,211	642,821	3,390

In August, operating costs were £0.63m 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 £0.47m, the key driver being medical workforce which is £2.36m above budget, which is our breakthrough objective.

Agency Ceiling £k — A

	Ceiling	Actual / Forecast	Variance
Year-to-date	5,000	5,728	(728)
Year-end Forecast	11,783	11,783	0

Agency expenditure in August was £1.27m, exceeding the agency ceiling target by £0.28m in-month (£0.73m year-to-date).

Cash £k — G

	Plan	Actual	Variance
Year-to-date	3,004	16,347	13,343
Year-end Forecast	3,004	4,544	1,540

At the end of August the consolidated cash balance was £16.35m against a plan of £3.0m. This is higher than planned following receipt of 2018-19 PSF incentive and bonus totalling £10.3m. This has been ring fenced while the Trust reviews options to utilise the cash.

Sustainability - Action & Recommendations

There are no actions required of the Board.

The Board is asked to note the following:

- Emerging pressures on pay budgets for both medical and nursing workforce. The Trust is making some progress on its breakthrough objective of reducing medical expenditure but further significant reductions are required in Q3 and Q4

- 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 so mitigations continue to be developed.

- The Trust is forecasting 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 7.1 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.

STAFF ENGAGEMENT SCORECARD - BSUH

Year Month		Trust Staff Engagement Staff Survey 2018	2018 National Average	Scorecard Average 17/18	Trust Target	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Trend
Number of Responses		4739 (number of staff)		42876		4029	4279	5302	5251	5023	4838	4634	
Question													
Advocacy	I would recommend my organisation as a place to work.	59.1%	61.5%	64.2%		69.8%	68.8%	66.5%	70.2%	66.8%	69.8%	69.5%	
	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	67.9%	70.9%	73.2%		79.5%	75.9%	78.6%	77.3%	74.5%	76.8%	76.1%	
	Care of patients/service users is my organisation's top priority.	76.9%	75.9%	71.7%		70.8%	72.6%	71.3%	66.8%	68.6%	72.7%	77.4%	
Motivation	I look forward to going to work.	56.0%	58.7%	59.4%		64.3%	58.8%	56.9%	64.6%	60.6%	62.3%	66.2%	
	I am enthusiastic about my job.	72.4%	74.3%	75.8%		78.3%	77.9%	74.1%	78.4%	74.9%	74.8%	78.9%	
	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%	
Improvement	There are frequent opportunities for me to show initiative in my role.	72.4%	72.9%	71.1%		70.0%	72.7%	69.6%	72.1%	72.0%	74.1%	75.1%	
	I am able to make suggestions to improve the work of my team/department.	75.3%	74.3%	74.5%		74.0%	75.8%	74.0%	74.1%	75.1%	78.5%	75.4%	
	I am able to make improvements happen in my area of work.	56.2%	55.9%	61.6%		59.8%	62.7%	59.8%	63.1%	62.3%	67.2%	62.4%	
	Overall Staff Engagement Score	6.9	7.0	7.0		7.0	7.0	6.9	7.0	7.0	7.1	7.1	
	Do you believe BSUH takes positive action on Health and Wellbeing	23.4%	28.6%	n/a		n/a	n/a	n/a	n/a	n/a	21.7%	24.2%	
	I have clear work objectives definitely agreed during my appraisal	33.3%	34.3%	n/a		n/a	n/a	n/a	n/a	n/a	21.6%	29.9%	

Key highlights:

- 8 out of the 9 engagement questions are above the 2018 National Average, the engagement question which remains below the 2018 National Average is “Time passes quickly when I am working”.
- 3 of the 9 engagement questions have had an increase in their percentage with “Care of patients/service users is my organisation's top priority” being the biggest increase by 4.7 percentage points.
- There are 6 engagement questions which have seen a decrease in there percentage this month, most significant decreases are “I am able to make suggestions to improve the work of my team/department” by 3.1 percentage points and “I am able to make improvements happen in my area of work” by 4.8 percentage points.

Our People - Improving Staff Engagement

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. 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.
An improvement plan has been developed with staff and leaders. Identified areas of focus include: Leadership Development – and a series of Knowledge and How To courses are being finalised and a Leadership Framework is being developed along side the leadership strategy; whilst re-aligning Communication Pathways to ensure staff feel engaged in what is going on within the Trust. Work has commenced on reviewing and streamlining the "most used" of Trust processes, in line with Patient First principles, for example aligning clinical equipment to areas, improving working environments and reviewing the Trust On-boarding process.

Health & Wellbeing (HWB)

An active Trust wide HWB 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.

2018 Staff Survey feedback focused HWB delivery requirements for Nursing cohorts and in response to this a bespoke Wellbeing programme has been developed and taken out to 5 pilot Wards, showcasing Wellbeing MOTs, Yoga demos, Team breakfasts and Mindfulness Sessions. Full Wellbeing Toolkits are developed, showcasing activities and support options for all staff and are being delivered to all staff areas, including Doctor's Mess, Staff Rooms and Wards. Monthly HWB promotion continues in varies formats including newsletters, screensavers, posters and the Twitter account (159 followers) and Twitter videos which had 557 views.

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 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, exact dates to be confirmed by the Survey coordination centre shortly.

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.

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

Recruitment & Retention
A pilot internal transfer process is now set up to commence in Autumn 2019, the positive impacts of this will be to reduce recruitment processing timeframes and paperwork and more importantly will engage staff in actively “moving” to a new working department thus ensuring internal retention and reduce turnover.

The annual Nursing Rostering Review across all Nursing and HCA areas is scheduled to take place in October and November, this year’s reviews will focus on optimising rostering, aligning rostering to the updated policy, improving flexible working opportunities, e.g. annualised hours and will provide Ward Managers and Matrons with up to date Engagement packs including health, wellbeing and absence management and flexible working opportunities in use in practice e.g. annualised hours in Emergency Department and Care of the Elderly is looking at optimising its flexibility by merging rotas to provide greater flexibility and opportunities across the speciality as opposed to just the ward.

A variety of Trust Benefits Statements, highlighting benefits at different career points and a briefing document highlighting NHS Pension versus Private Pension benefits is currently being reviewed by the Trust’s Pensions Team.

Our People - Improving Staff Engagement and Communications

People

Staff Engagement
Target: Top 20% Engagement Score

The Communications Team have been working on the launch and roll out of Workplace – a mobile and desktop app to support communications and engagement with staff. Training sessions for senior managers and 'champions' have been held and a communications campaign began in August ahead of the launch this month.

Leadership, Culture and Workforce. A number of areas for developing communications have been highlighted by the LCW workstream and work has begun on three of these: increased coverage of improvement work, an infonet refresh and support for winter operational resilience.

The team have promoted work around violence and aggression to ensure colleagues are aware of the new security equipment, training, reporting process and Trust zero tolerance policy.

Communications support for the annual Staff Survey and Flu campaign began in August. These campaigns will be promoted via all internal communications channels over the next two months.

The team issued a number of proactive press releases including: Pride Recruitment Campaign, Hospital Trust Shortlisted for Prestigious Award, Find Out About Your Local Hospitals at our AGM and New Children's Virtual Fracture Clinic Launched.

The Infonet has 39,138 users in August and 197,865 sessions. The website had 47,973 users and 75,123 sessions.

Social media. The number of followers on the Trust's Twitter account has continued to grow – from 4,601 in October 2018 to 5,501 in August 2019 – an increase of 20%. Over the same time period the number of BSUH Facebook followers has also grown – from 2,548 to 3,116 – and increase of 22%.

Our People - Capacity and Capability

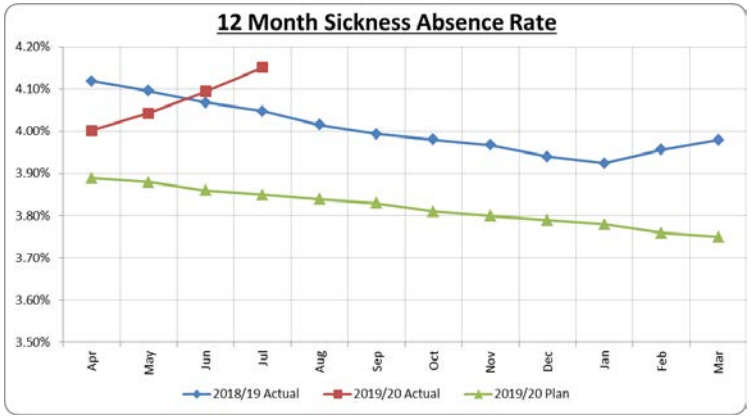
In M5, overall workforce spend was £33.36m against a plan of £32.26m. Year To Date (YTD) workforce spend is overspent by £470k against a plan of £166.7m.

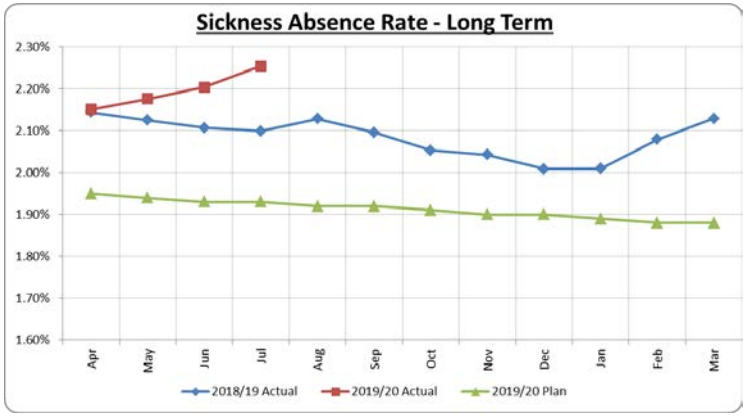
Medical is the key driver of this YTD position with an overspend of £2.36m. The YTD position is partially mitigated by underspends in other staff groups.

		Last Month	This Month	Variance
Worked	wte	8,083	8,310	↑
% Worked to Budget (WTE)	%	94.82	97.29	↑
Temporary Workforce (WTE)	%	7.01%	9.02%	↑
Agency	%	1.23	1.29	↑
Bank	%	5.78	7.73	↑

In August, agency costs of £1.27m represent 3.8% of the total pay bill and exceeded the M5 agency ceiling by £280k.YTD, the Trust has exceeded its agency ceiling by £730k.

Our People – Key Metrics





In July 2019 the 12 month sickness absence rate was 4.15% with continued risk to attaining the sickness absence target of 3.75%. The absence rate is now 0.10 % higher than it was in July 2018 and has been increasing incrementally month on month since January 2019.

Improvement Focus:

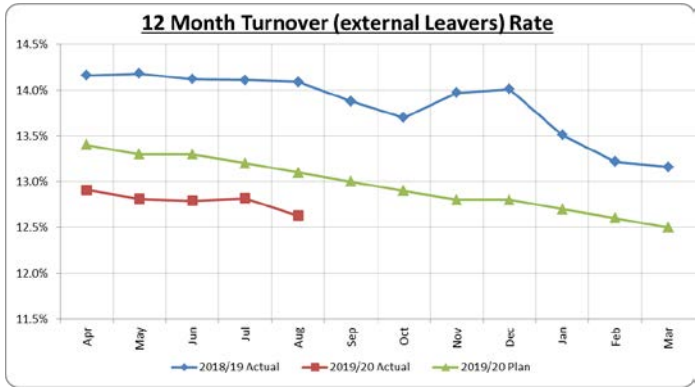
The new Health and Well-being and Management of Sickness Absence Policy has been launched.

Extensive focus within Medicine and Facilities and Estates, focusing on hot spot areas to specifically target long term absence, and further Managerial activities including further training on carrying out return to work interviews, ensuring regular and timely contact with absent staff.

The long term absence rate is 2.25%. All long term absences are reviewed monthly by senior HR representatives and appropriate contact and management is in place, to provide appropriate support to staff, particularly those absent between 3-6 months.

Stress, depression other psychiatric issues accounts for 18% of absence in 12 months and is the single highest reason for absence in the Trust, in response to this the Trust's Lead Psychotherapist in partnership with Sussex Partnership Mental Health Liaison Nurse have developed and delivered a pilot managing mental health ill-health training programme , feedback is in the process of being collated, but it is anticipated that the sessions will be rolled out for all to participate in October 2019.

Our People – Key Metrics

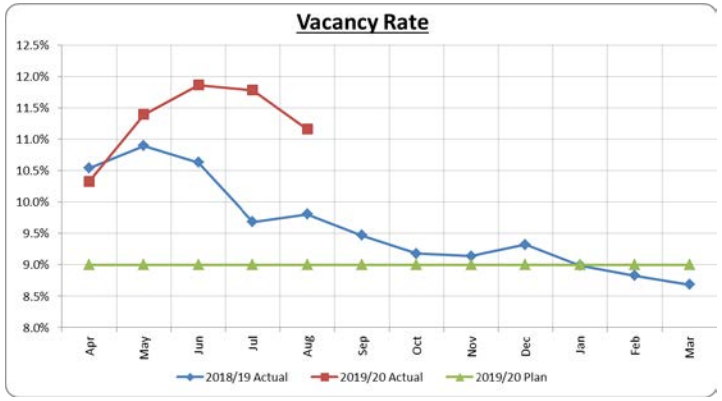


Turnover: In August the Trust's overall turnover rate is 12.6%, an improvement of 0.2% from July at 12.8%, against an overall Trust target of 12.5% by March 2020. The Trust has seen significant improvement since September 2018 when the turnover rate was at its highest for the 12 months at 13.9%.

- **Improvement Focus:**

A full Rostering Review across all Nursing and HCA areas, specific focus on the ICU Rotas , flagged by staff as a reason for higher than average Turnover; actions now include a series of staff engagement sessions and full rota reviews enabling individual buy-in to their own roster and full re-alignment with the Rostering Policy; this pilot, if successful could be rolled out in other areas.

Pilot transfer process set to commence in Autumn 2019, positive impacts will be to reduce recruitment processing timeframes and paperwork and importantly will engage staff in actively "moving" to a new working department thus ensuring internal turnover before external turnover and delivers on a Retention outcome requested by the Nurses.



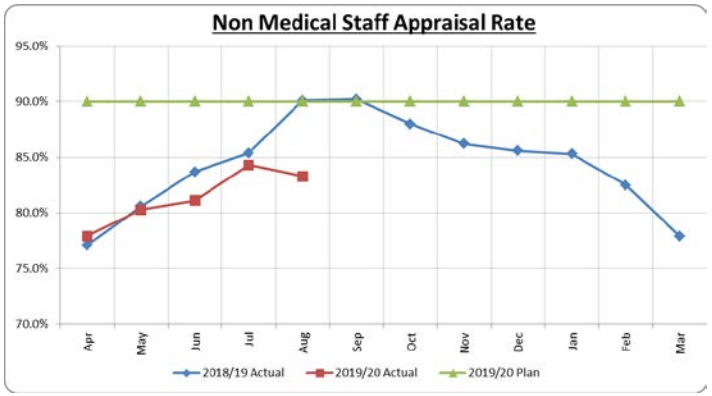
Vacancies: In August the Trust's overall vacancy rate was 11.2% against an overall Trust vacancy target of 9% by 2020 . Children's & Women's have the lowest vacancy rate in August at 5.3%.

Medicine has had a significant improvement from 13.3% in July to 10.9%, and Surgery from 14.8% to 14.1% in August. The vacancy rate in Specialist increased slightly from 9.3% in July to 9.6%, and in Central Clinical Services this remained the same as July at 10.7%

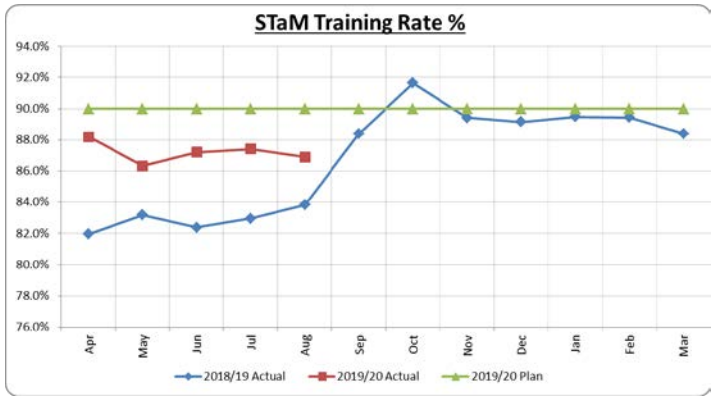
- **Improvement Focus:**

Rotas in high vacancy areas are being reviewed, focusing on identifying peaks/troughs of work and opportunities for more flexible working e.g. Acute Floor is looking at twilights and mid-shifts; Care of the Elderly is looking at options to merge rotas for the speciality as opposed to each individual ward.

Our People – Key Metrics



- The Trust appraisal rate fell by 1% in August, to 83.3%.
- Clinical Divisions were 84.2% compliant (up 4% on June), with Corporate divisions 79.9% compliant (down 4.6% on June).
- Key issues impacting the rates were service pressures over the summer.



- The Statutory and Mandatory (STAM) compliance rate for August is 87.6%, down 0.7% on July.

Improvement Focus - Appraisal:
New Appraisal Policy is in progress linking into Agenda for Change Pay Progression and aims to raise the quality of appraisals, by focussing managers on agreeing clear objectives, making it clearer where development opportunities beyond formal training may exist, including a specific focus on wellbeing and on regular engagement with staff through 121's to ensure any necessary on-going support is provided.

Improvement Focus - STAM:
- Personalised email contact with non-compliant staff has been initiated highlighting their responsibilities to complete their training
- Detailed reports provided to Managers to help ensure adequate release from work to attend
- STAM compliance will be revisited at all Safety Huddles and team briefs, led by Divisional Management teams, followed up at weekly Driver meetings

Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	12	**Meeting:**	**Finance and Performance Committee**	**Meeting Date:**	**27 Aug 2019**
Report Title:	Report from Finance and Performance Committee Meeting Chair				
Sponsoring Executive Director:	Mike Rymer, Non-Executive Director				
Author(s):	Mike Rymer , Non-Executive Director				
Report previously considered by and date:	N/A direct report to Board				
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:

The Finance and Performance Committee met on 27 August was quorate as it was attended by two Non-Executive Directors including the Trust Chair and the Chief Financial Officer, Chief Medical Officer, Chief Nurse and Chief Workforce and Organisational Development Officer. Attending the meeting were also the Finance Director, Chief Operating Officer, Director of Human Resources and Head of Efficiency.

The Committee received its planned items and debated these reports in accordance with its cycle of business.

Key Recommendation(s):

The Board is asked ort **NOTE** the assurances received at the meeting and that based on these the Committee did not refer any matter to any other Committee and did not refer any strategic risk to the Executives for review.

Brighton and Sussex University Hospitals NHS Trust

To: BSUH Private Board

Date: 25/09/19

From: Finance and Performance Committee Meeting Chair

Agenda Item: 12

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Finance and Performance Committee	**27 August 2019**	**Mike Rymer (Chair for this meeting)**	✓	☐

Declarations of Interest Made

There were no declarations of interest

Assurance received at the Committee meeting

- The Committee **RECEIVED** the financial performance reports for Month 4. The Committee was **ASSURED** in respect of the Trust's performance against the plan for Month 4 with the Trust recording a £4.2m deficit excluding PSF, FRF and MRET which is in line with the Trust's approved plan. The Committee agreed to continue to monitor the work being delivered to mitigate the increase in activity levels. The Committee was **ASSURED** over the plans supporting the delivery of the control total.

- The Committee **RECEIVED** the Efficiency Programme update, noting that in Month 4 the programme was on track to meet the end of year total savings of £27m and acknowledged the on-going support given to Divisions that have complex financial schemes. The Committee recognised the increase in delivery required from month 4 and was **ASSURED** that the BAF correctly records this level of risk.

- The suite of operational performance reports was **RECEIVED** by the Committee, which noted the Trust position against constitutional standards and discussed the trajectories in place to improve the Trust's performance. The Committee noted that the Trust was behind its planned trajectories but was on track to delivery diagnostics by the end of September and Cancer by the end of March. The Committee **RECEIVED** a detailed presentation from the Chief Operating Officer on the Cancer performance plan and was **ASSURED** over its robustness. The Committee recognised the demand and activity delivery risks and was **ASSURED** that the BAF correctly records this level of risk.

Actions taken by the Committee within its Terms of Reference

The Committee chose not to refer any of the risks it has oversight for back to the Executives for review as the Committee was assured over the risks current scores based on the business of Committee.

Items to come back to Committee (Items Committee keeping an eye on)

The Committee agreed to receive a deep dive in respect of the Trust's RTT performance plans at its next meeting.

Items referred to the Board or another Committee for decision or action

Item	Referred to
The Committee referred no matters to other Board Committees and referred no matter to the Public Board.	

Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	13	**Meeting:**	Board	**Meeting Date:**	25 Sept 2019
Report Title:	**Board Assurance Framework – 2019/20 – Q2**				
Sponsoring Executive Director:	Glen Palethorpe, Group Company Secretary				
Author(s):	Glen Palethorpe, Group Company Secretary				
Report previously considered by and date:	TEC – 3 Sept 2019, QAC – 24 Sept 2019 F&P – 24 Sept 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 2 at 3 September there have been no changes from the Q1 assessed 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 is 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 Q2 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
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	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	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	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	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	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	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	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 regulatory and supervisory bodies	3	4	**12**	3	4	**12** ↔	3	3	**9**
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**
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**
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	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	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 did not identify any negative assurance that required any risk to be referred back to the Executive for review for being under stated. The Committee at the request of the Finance and Performance Committee considered if there was any quality impact due to the increase in patient waits but were assured that for significant delay each case is clinically reviewed and no issues were identified that would require the quality risks to be increased.

Finance and Performance Committee

The Committee's review of the risks to which they have allocated oversight and their receipt of assurance at their meetings across Quarter 1 and the start of Quarter 2 did not identify any negative assurance that required any risk to be referred back to the Executive for review for being under stated.

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.

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 decide that it would undertake a more detail 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 as the assurances supporting these risks span both Committees.

Trust Executive Committee

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

Organ Donation Activity
BSUH
1st April 2018 – 31st March 2019

Renee van der Most
Clinical Lead for Organ Donation
ICU consultant

Table 1.1 Donors, patients transplanted and organs per donor,
1 April 2018 - 31 March 2019 (1 April 2017 - 31 March 2018 for comparison)

Donor type	Number of donors		Number of patients transplanted		Average number of organs donated per donor			
					Trust		UK	
DBD	10	(11)	23	(32)	2.8	(3.9)	3.5	(3.7)
DCD	6	(4)	12	(9)	2.0	(2.3)	2.7	(2.7)
DBD and DCD	16	(15)	35	(41)	2.5	(3.5)	3.2	(3.3)

Table 1.2 Organs transplanted by type,
1 April 2018 - 31 March 2019 (1 April 2017 - 31 March 2018 for comparison)

	Number of organs transplanted by type											
Donor type	Kidney		Pancreas		Liver		Heart		Lung		Small bowel	
DBD	15	(21)	1	(3)	7	(7)	1	(1)	0	(5)	0	(0)
DCD	12	(8)	0	(0)	0	(1)	0	(0)	0	(0)	0	(0)
DBD and DCD	27	(29)	1	(3)	7	(8)	1	(1)	0	(5)	0	(0)

Key rates on potential organ donation

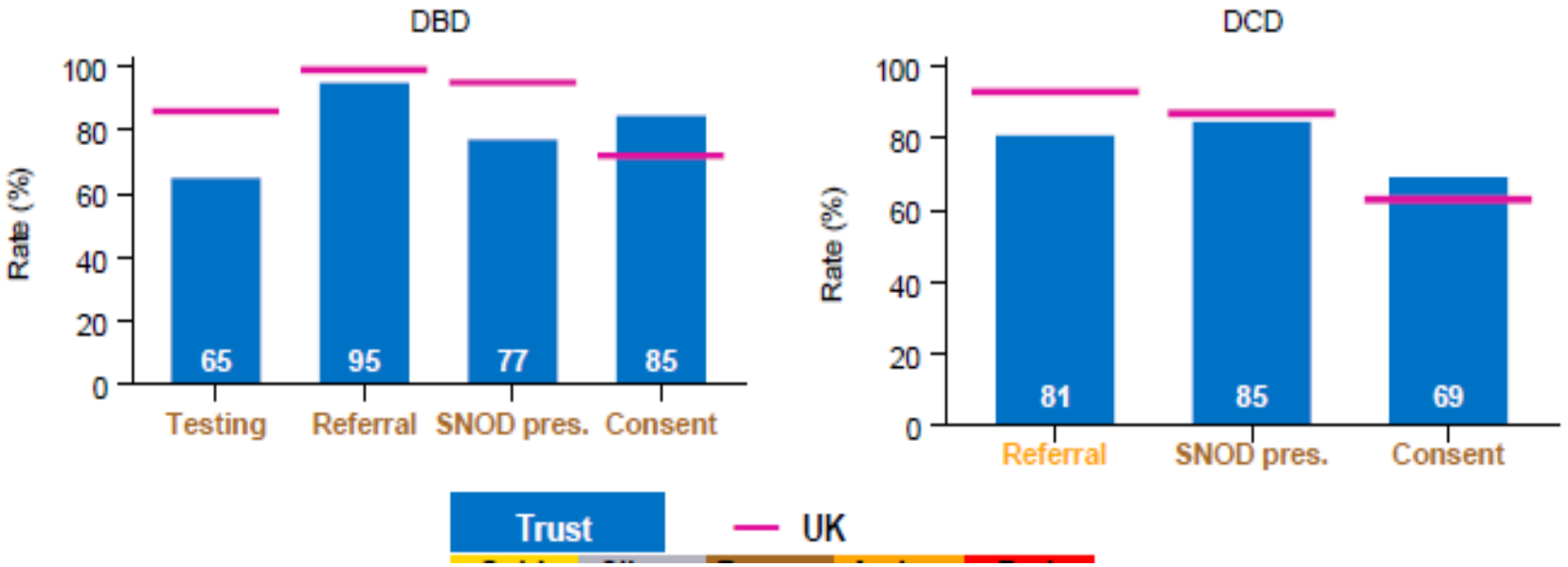
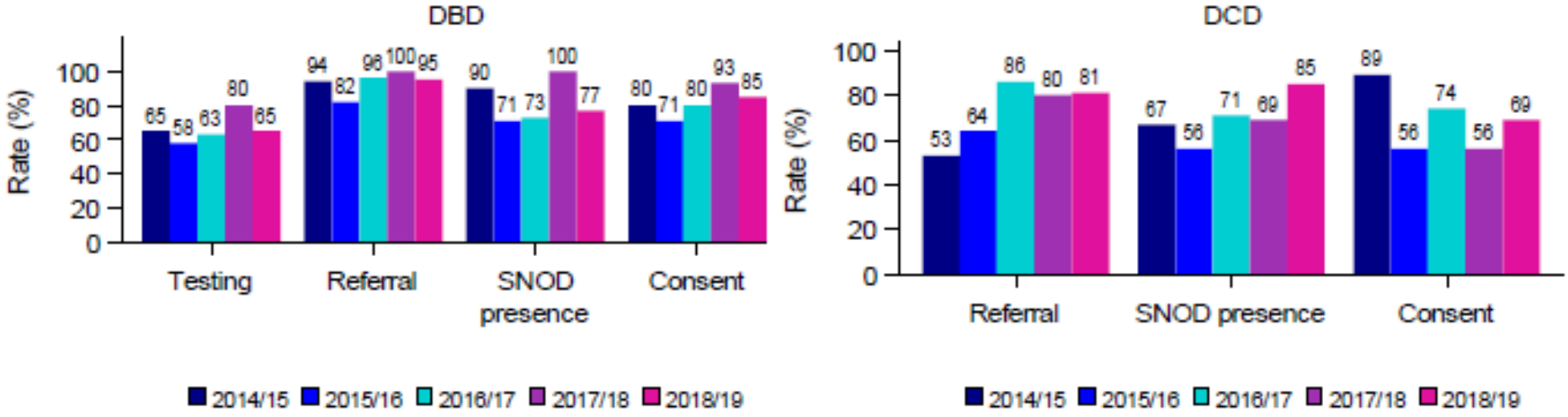


Figure 2.2 Trends in key rates on the potential for organ donation, 1 April 2014 - 31 March 2019



Best Quality of Care in Organ Donation

- Neurological death testing

- Goal: neurological death tests performed whenever possible

Figure 3.1 Number of patients with suspected neurological death, 1 April 2014 - 31 March 2019

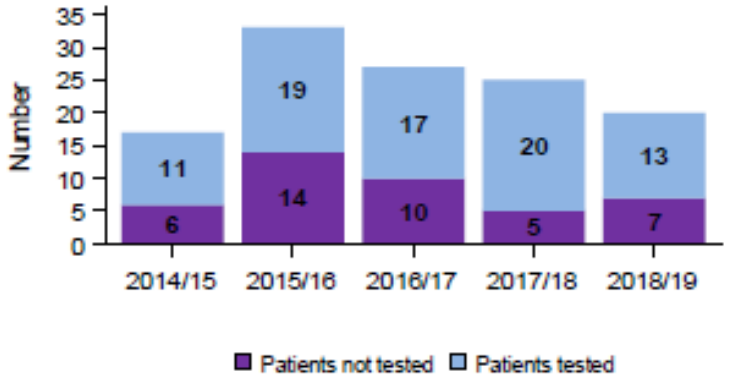
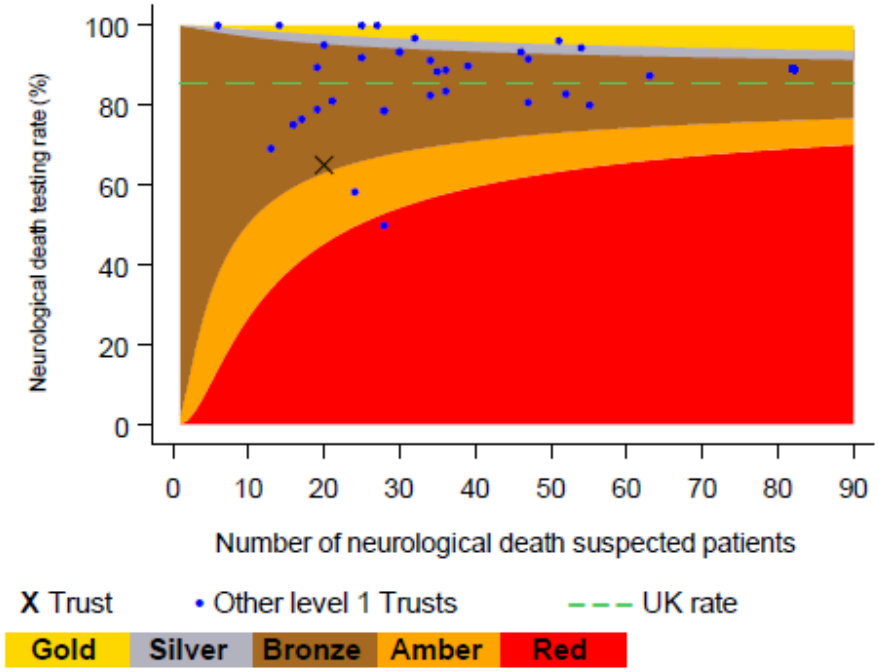


Table 3.1 Reasons given for neurological death tests not being performed, 1 April 2018 - 31 March 2019

	Trust	UK
Biochemical/endocrine abnormality	-	20
Clinical reason/Clinicians decision	1	48
Continuing effects of sedatives	-	14
Family declined donation	2	22
Family pressure not to test	1	35
Inability to test all reflexes	-	13
Medical contraindication to donation	-	10
Other	-	18
Patient had previously expressed a wish not to donate	-	5
Patient haemodynamically unstable	3	80
Pressure on ICU beds	-	1
SN-OD advised that donor not suitable	-	7
Treatment withdrawn	-	11
Unknown	-	5
Total	7	289

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

Figure 4.1 Funnel plot of neurological death testing rate, 1 April 2018 - 31 March 2019



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

Plan

- Continued encouragement to test

Best Quality of Care in Organ Donation

- Referral to Organ Donation Service
- Goal: Every patient who meets referral criteria should be identified and referred to OD Service

Figure 3.2 Number of patients meeting referral criteria, 1 April 2014 - 31 March 2019

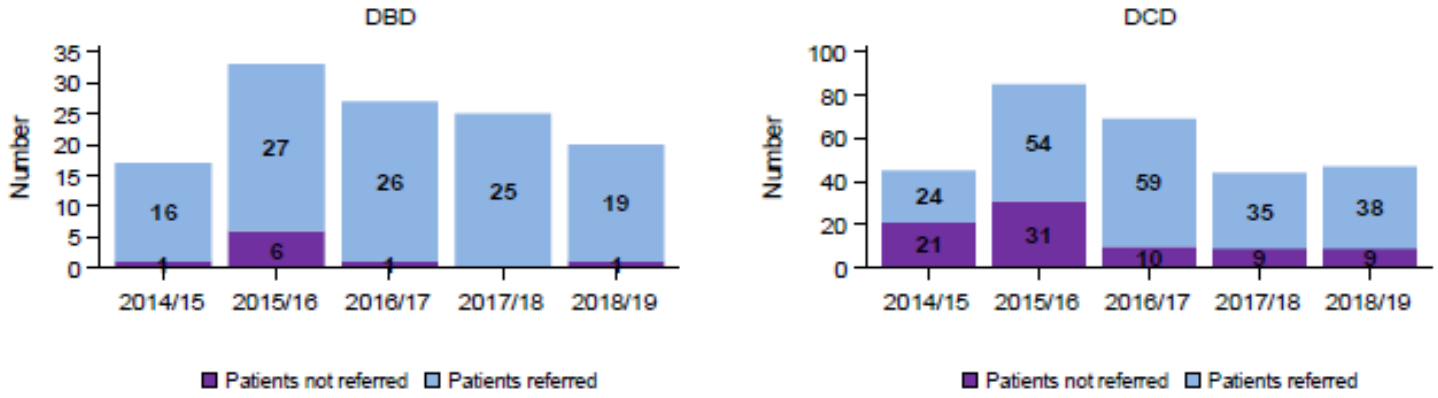
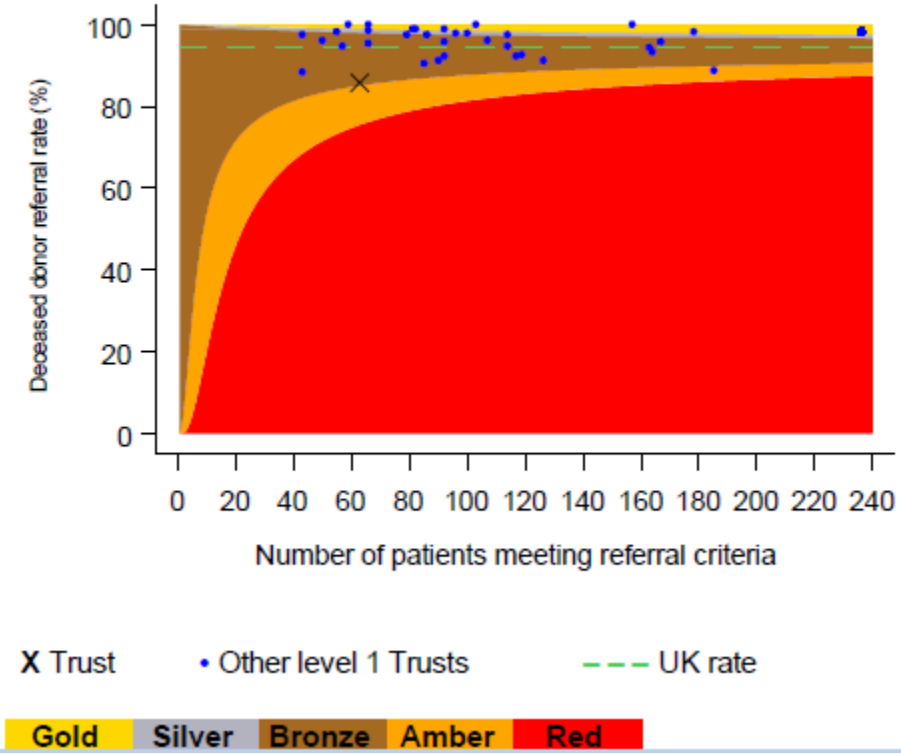


Table 3.2 Reasons given why patient not referred to SNOD, 1 April 2018 - 31 March 2019

	DBD		DCD	
	Trust	UK	Trust	UK
Clinician assessed that patient was unlikely to become asystolic within 4 hours	-	-	-	4
Coroner/Procurator Fiscal Reason	-	1	-	2
Family declined donation following decision to withdraw treatment	-	2	-	15
Family declined donation prior to neurological testing	-	2	-	2
Medical contraindications	-	-	-	56
Not identified as a potential donor/organ donation not considered	-	11	5	215
Other	-	4	1	56
Pressure on ICU beds	-	-	-	3
Reluctance to approach family	-	-	-	2
Thought to be medically unsuitable	1	2	3	78
Thought to be outside age criteria	-	-	-	2
Total	**1**	**22**	**9**	**435**

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

Figure 4.2 Funnel plot of deceased donor referral rate, 1 April 2018 - 31 March 2019



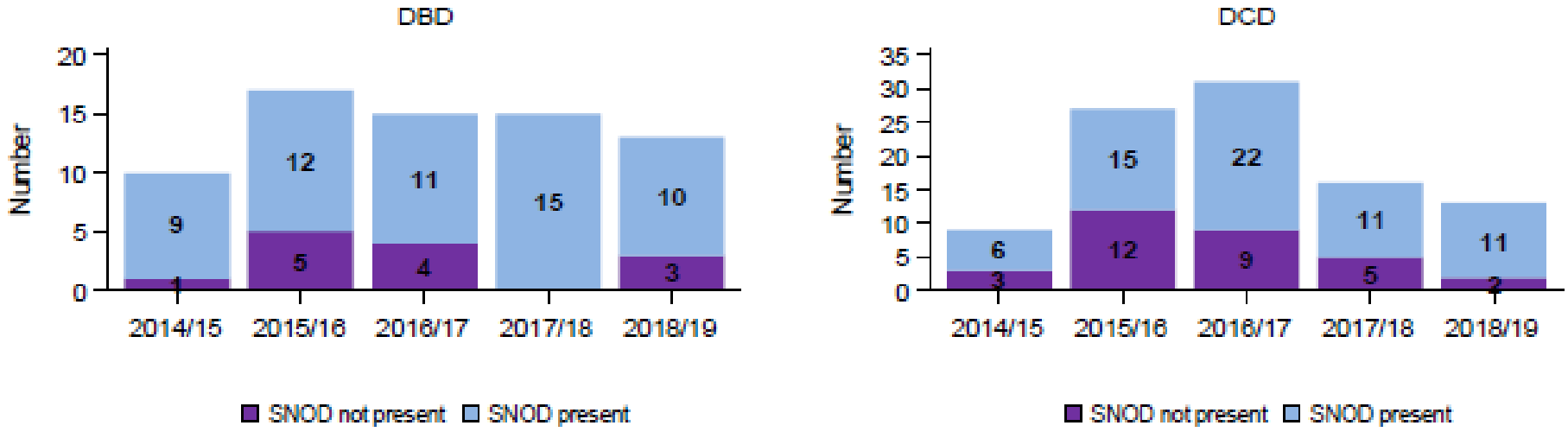
Plan

- Prompt on morning status sheet
- Introduce Nurse Led referral
- SBAR form for nurse led referral
- Feedback to consultants after ‘missed referrals’ to identify barriers to referral
- Increase SNOD staffing

Best Quality of Care in Organ Donation

- SNOD presence
- Goal: A SNOD should be present during the formal family approach

Figure 3.3 Number of families approached by SNOD presence, 1 April 2014 - 31 March 2019



Plan

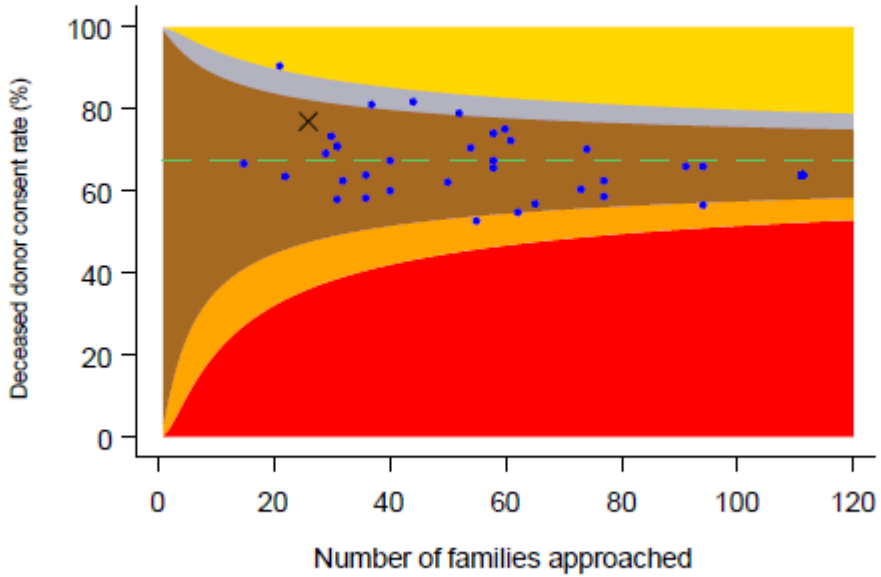
- Encourage earlier referral (see previous)
- Increase SNOD staffing
- Education

Best Quality of Care in Organ Donation

- Consent
- Goal: National targets for DBD and DCD consent/authorisation rates are 78% and 72%

- Trust rates: DBD 85% and DCD 69%
- Our consent rates are excellent with/without SNOD presence

Figure 4.4 Funnel plot of consent rate, 1 April 2018 - 31 March 2019



Future

- 2 new SNODs (+2 further recently recruited)
- Increase in PAs for CLOD – need to advertise
- Further education for nurse led referrals
- Continued review of missed referrals
- Recruit a non-executive board member to support ODC

- Dedicated space for SNODs in ICU in 3T
- Memorial to donors in 3T (?ring fence funds)

Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	16	**Meeting:**	BSUH Public Board	**Meeting Date:**	25/09/19
Report Title:	**Workforce Race Equality Standard (WRES)**				
Sponsoring Executive Director:			Denise Farmer, Chief of OD and Workforce.		
Author(s):			Equality, Diversity and Inclusion Team.		
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	Areas for improvement have been highlighted in the report relating to the experiences of Black and Minority Ethnic (BME) staff at BSUH. Projects will need to be put in place to ensure that any areas for improvement can be met.				
Link to CQC Domains:					
Safe			☐	Effective	☐
Caring			☐	Responsive	☐
Well-led			✓	Use of Resources	☐

Communication and Consultation:

This report has been shared with the WRES Working Group and the Diversity Matters Steering Group (with a recommendation for the report to be approved by the Board).

Executive Summary:

The WRES is mandated into the NHS Standard Contract. The WRES shares similar metrics as the Workforce Disability Equality Standard.

The standard was introduced in 2015 to provide a framework to consistently measure and compare the experiences of BME NHS staff and White staff at the Trust. Historically, BME staff in England have reported poor experiences relating to bullying and harassment, career opportunities and appraisals. The standard will enable the Trust to demonstrate progress over time and to benchmark itself against other NHS organisations.

The report shows areas for improvement including: bullying and harassment, and representation throughout all levels within the Trust.

There are areas where the Trust has improved and these are staff believing the trust provides equal opportunities for career progression or promotion, also we have seen improvement in the number of staff who feel they have experienced discrimination at work from their line manager or team leader.

Key Recommendation(s):

This report has been submitted to the Board for approval – submission of BSUH WRES stats must be uploaded onto our web-site by end of September 2019.

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board Meeting **[25th September 2019]**

From: Denise Farmer, Chief Workforce and Organisational Development Officer

Agenda Item: [16]

FOR INFORMATION

WORKFORE RACE EQUALITY STANDARD (WRES) - UPDATE

1. INTRODUCTION

The Workforce Race Equality Standard (WRES) was established as nationally the evidence was showing that if you were from a Black and Minority Ethnic background you were less likely to be appointed to a role once shortlisted, less likely to be selected for training and development programmes and more likely to experience harassment, bullying and abuse, also you were more likely to be disciplined and dismissed than white staff. NHS organisations have been reporting on this to their Boards and NHS England since 2015 via the Workforce Race Equality Standard.

2. The 2019 WRES Data

Overall the 2019 WRES data (Appendix 1) is indicating that the Trust has either improved or remained broadly the same compared to 2018. This demonstrates that our improvement plan is starting to improve the experience for our BME staff. There is more work to do and this is captured in our three year action plan (Appendix 2) which was co-designed with staff following the two race equality conferences in 2018.

Following the WRES conference a WRES Working Group was established with volunteer staff and managers who had a commitment to improving race equality within the Trust.

The WRES working group has continued to meet monthly to support the implementation of the action plan. The action plan implementation is overseen by the Diversity Matters Steering Group chaired by the Chief Executive Officer.

3. Comparative Data

The section below details the comparison from 2018 and 2019.

- **Indicator 1**: The size of the workforce has increased minimally during the above timeframe (207 whole time equivalents) and the ratio of White staff and BME staff has remained similar. As per last year's report there are some bands with no BME representation.

- **Indicator 2**: There has been an increase in the likelihood of BME candidates being appointed from shortlisting, in 2018 it was 1.27 times less likely and for 2019 is it 1.17 times less likely.
- **Indicator 3**: This has remained static (however this is a 2 year rolling average) and shows that BME staff are 1.35 times more likely to be under formal disciplinary process than White staff.
- **Indicator 4**: This is an area that for the last 2 years has shown that our BME staff are more likely to access non-mandatory/CPD training than their White colleagues.
  Indicator 4: This is an area that for the last 2 years has shown that our BME staff are more likely to access non-mandatory/CPD training than their White colleagues.
- **Indicator 5**: There has been a reduction in the number of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months from 39% to 35% compared to 30% of white staff.
- **Indicator 6**: There has been a marginal increase in the number of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months 30.0% in 2017 and 30.4% in 2018.
- **Indicator 7**: The percentage of staff believing that Trust provides equal opportunities for career progression or promotion. This has increased for BME staff and we are now at the national Acute average for this indicator of 72.3%. There is still a 15.3% difference compared to our White staff (87.6%).
- **Indicator 8**: The percentage of staff in the last 12 months personally experiencing discrimination at work from your Manager/team leader or other colleagues has seen a reduction for BME staff 17.6% in 2017 and 14.8% in 2018 (latest figures). There is a difference of 7.9% in comparison to our White staff.
- **Indicator 9**: This indicator has remained unchanged.

3.0 Next Steps

Plans are in place to accelerate the implementation of the action plan.

A further race equality conference is planned.

Barbara Harris
Head of Inclusion

17th September 2019

Brighton and Sussex University Hospitals NHS Trust

Brighton and Sussex University Hospitals NHS Trust

Workforce Race Equality Standard 2019

Introduction

“It can’t be right that ten years after the launch of the NHS race-equality plan, while 41% of NHS staff in London are from Black and ethnic minority backgrounds, similar in proportion to the Londoners they serve, only 8% of trust board directors are, with two-fifths of London trust boards having no BME directors at all.

Similar patterns apply elsewhere, and have actually been going backwards”.

Simon Stevens, Chief Executive – NHS England. May 2014

The NHS has a workforce of 1.4 million people, of which 20% are from a BME background. Whilst there is good representation of BME people in GP, hospital doctor and nursing and midwifery roles – this does not always translate to career progression. This can be seen by the levels of BME staff in senior management roles in the NHS in England, there are:

- 8 BME CEOs (236 Trusts) as of March 2019
- 9 BME Chairs as of March 2018
- 11 BME Executive Directors of Nursing as of March 2019
- 37 BME Medical Directors as of March 2018
- Less than 6% of very senior managers are from BME backgrounds

The Workforce Race Equality Standard (WRES) helps to shine a light where NHS organisations are doing well and where there is need for improvement. The WRES uses statistical data to demonstrate the experience and outcomes of BME staff compared to white staff through many stages of the employment journey. A requirement of the standard is to develop action plans to address any areas of inequity that has been highlighted by the data.

The WRES is an annual process, and helps NHS organisation demonstrate that they are making progress year-on-year by improving working conditions for BME staff in the NHS.

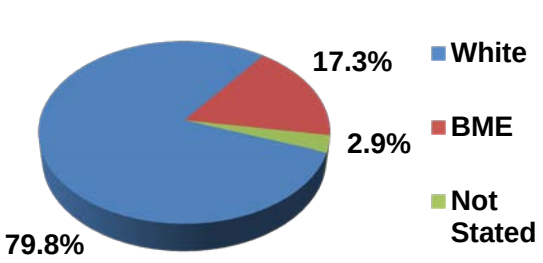
Background Information

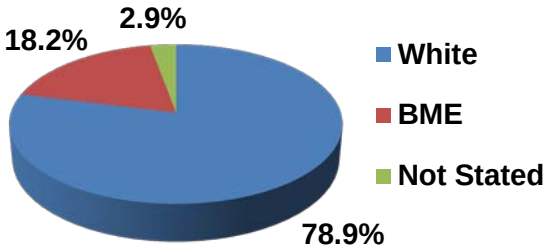
1) Total number of staff:

2018	2019
8321 headcount	8528 headcount

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

	2018		2019	
	Headcount	% of Staff	Headcount	% of Staff
White	6637	79.8%	6729	78.9%
BME	1440	17.3%	1552	18.2%
Not Stated	244	2.9%	247	2.9%
Total	8321	100.0%	8528	100.0%





2018 2019

2) Self-reporting

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

	2018		2019	
	Headcount	% of Staff	Headcount	% of Staff
Ethnicity Declared	8077	97.1%	8281	97.1%
Ethnicity Not Declared	244	2.9%	247	2.9%
Total	8321	100.0%	8528	100.0%

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

We collect information relating to staff ethnicity as part of the recruitment process. Staff that have access to Electronic Staff Records self-service are also able to update that ethnicity at any time.

c) Are any steps planned during the current reporting period to improve the level of self-reporting by ethnicity?

Whilst we appreciate that knowing 97.1% of the workforce's ethnicity is very positive, we recognise there are ways we can improve on this. We will continue to collect information relating to staff ethnicity as part of the recruitment process. In addition to contacting staff where their ethnicity is unknown and encourage them to declare their ethnicity.

3) Workforce Data

a) What period does the organisation's workforce data refer to?

1st April 2018 to 31st March 2019.

4) How is BME Defined under WRES?

In line with the categories taken from the 2001 Census:

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

5) Population Demographic 2011 Census (Southeast England)

	Census 2011
BME	9%
White	91%
Unknown	0%

Workforce Race Equality Indicators

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

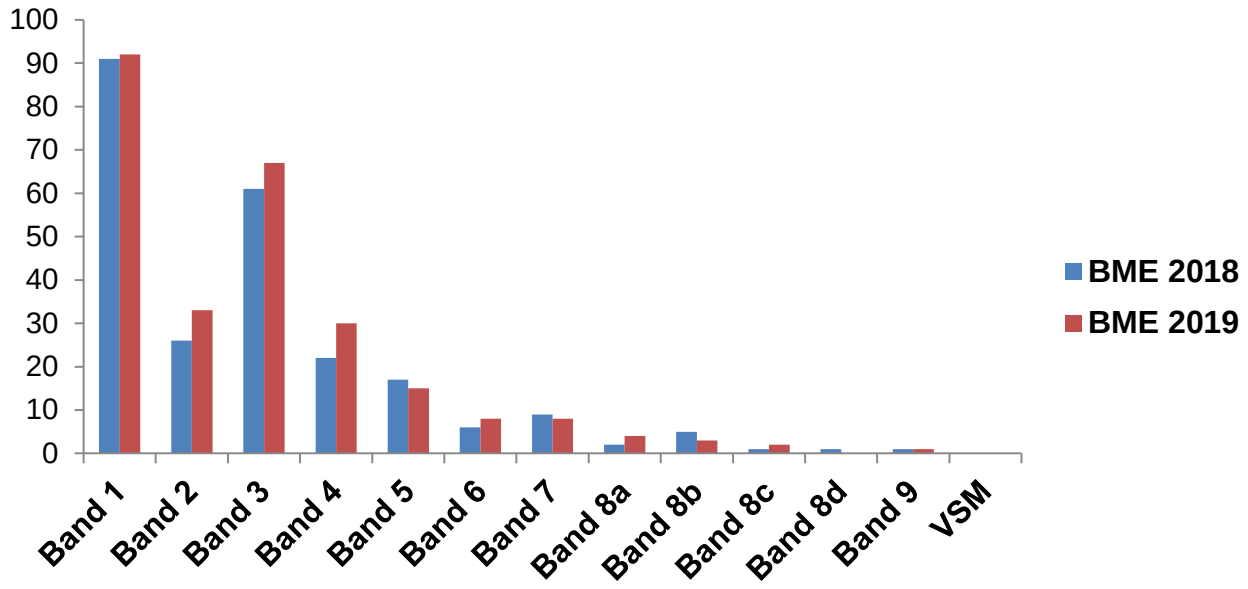
Indicator 1 - Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce

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

	Non-Clinical					
	White	BME	Unknown	Total	White %	BME %
Band 1	281	92	23	396	71.0%	23.2%
Band 2	369	33	16	418	88.3%	7.9%
Band 3	505	67	12	584	86.5%	11.5%
Band 4	385	30	6	421	91.4%	7.1%
Band 5	151	15	3	169	89.3%	8.9%
Band 6	132	8	9	149	88.6%	5.4%
Band 7	101	8	5	114	88.6%	7.0%
Band 8a	50	4	2	56	89.3%	7.1%
Band 8b	49	3		52	94.2%	5.8%
Band 8c	17	2		19	89.5%	10.5%
Band 8d	10			10	100.0%	0.0%
Band 9	7	1	1	9	77.8%	11.1%
VSM	10		2	12	83.3%	0.0%
Local Pay Scale	1			1	100.0%	0.0%
Total	**2068**	**263**	**79**	**2410**	**85.8%**	**10.9%**

What the data tells us:

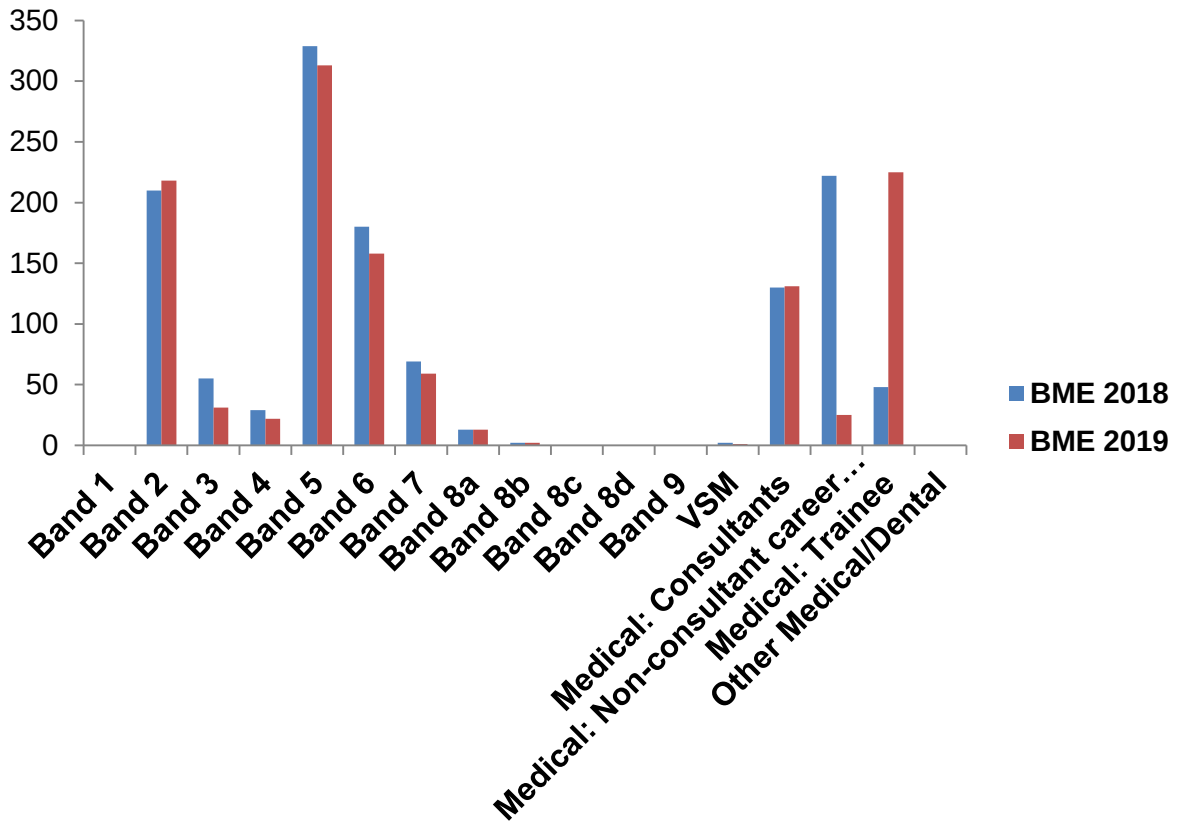
- The overall population of non-clinical BME staff is higher than the overall population statistics in the 2011 Census (10.9%).
- There appears to be a high level of representation at 23.2% of BME staff in the lowest paid roles at Band 1.
- A fair representation can be seen at bands: 3, 8c, and 9.
- All other bands including VSM (very senior manager) appear to be underrepresented by BME staff.
- The comparison of representation of non-clinical BME staff from 2018 to 2019 is represented in this chart:



	Clinical					
	White	BME	Unknown	Total	White %	BME %
Band 1						
Band 2	620	210	29	859	72.2%	24.4%
Band 3	245	55	8	308	79.5%	17.9%
Band 4	138	29	5	172	80.2%	16.9%
Band 5	994	329	45	1368	72.7%	24.0%
Band 6	1017	180	35	1232	82.5%	14.6%
Band 7	596	69	21	686	86.9%	10.1%
Band 8a	158	13	6	177	89.3%	7.3%
Band 8b	56	2	2	60	93.3%	3.3%
Band 8c	17			17	100.0%	0.0%
Band 8d	8		1	9	88.9%	0.0%
Band 9	1			1	100.0%	0.0%
VSM	1	2		3	33.3%	66.7%
Medical: Consultants	318	130	10	458	69.4%	28.4%
Medical: Non-consultant career grade	396	222	6	624	63.5%	35.6%
Medical: Trainee	95	48		143	66.4%	33.6%
Other Medical/Dental	1			1	100.0%	0.0%
Total	**4661**	**1289**	**168**	**6118**	**76.2%**	**21.1%**

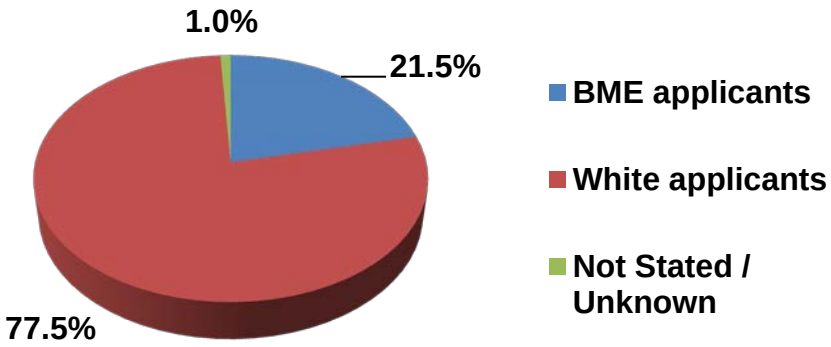
What the data tells us:

- The overall population of non-clinical BME staff is more than the overall population statistics in the 2011 Census (9%).
- There appears to be high levels of representation of BME staff at bands 2 and 5.
- In all agenda for change bands (except 2 and 5) appear to have a lower representation of BME Staff, especially from band 6 and up.
- There is good representation of BME staff in the VSM (very senior managers) level.
- There is a higher than expected representation of BME staff at all levels of medical roles however, this in line with national trends for this staff group.
- The comparison of representation of clinical BME staff from 2018 to 2019 is represented in this chart:



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

	Applicants		Shortlisted		Appointed		Relative Likelihood of being appointed
	Number	%	Number	%	Number	%	
BME applicants	7416	32.81%	1266	24.37%	294	21.52%	**0.2322**
White applicants	14730	65.17%	3900	75.07%	1059	77.53%	**0.2715**
Not Stated / Unknown	456	2.02%	29	0.56%	13	0.95%	**0.4483**
Total	22602	100.00%	5195	100.00%	1366	100.00%	



The likelihood of white candidates being appointed from shortlisting:
1059 / 3900 = 0.2715

The likelihood of BME candidates being appointed from shortlisting:
294 / 1266 = 0.2322

The relative likelihood of white candidates being appointed from shortlisting compared to BME staff is: 0.2715 (white candidates) / 0.2322 (BME candidates) = **1.17 times.**

BME Candidates	1.00
White Candidates	1.17

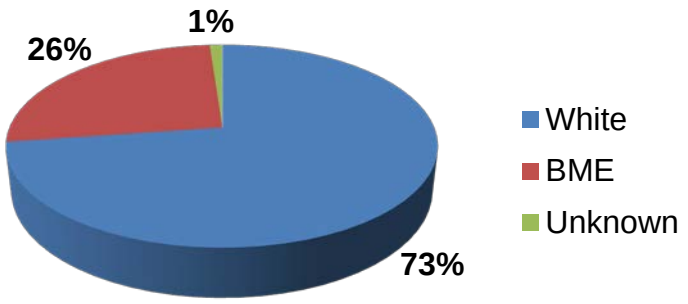
In this instance the data suggests white candidates are more likely than BME candidates to be appointed from shortlisting.

In the 2018 WRES report there was a likelihood of white candidates being appointed over BME candidates of 1.27 times. Compared to this year that has been a slight decrease in this likelihood.

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

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

	Number of Disciplinary Procedures	Number in Workforce	Relative Likelihood of entering procedure
White	64	6729	0.009511071
BME	23	1552	0.014819588
Unknown	1	247	0.004048583



The likelihood of white staff entering the formal disciplinary process:
64 / 6729 = 0.009511071

The likelihood of BME staff entering the formal disciplinary process:
23 / 1552 = 0.014819588

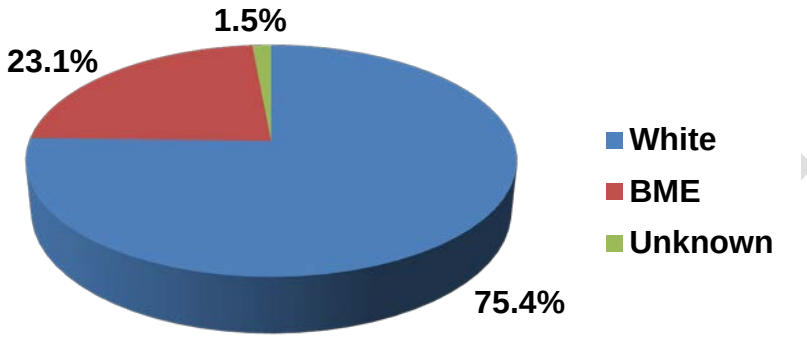
The relative likelihood of BME staff entering the formal disciplinary process compared to white staff is: 0.0148 (BME Staff) / 0.0095 (White Staff) = **1.56 times.**

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

In the 2018 WRES report, it stated that the likelihood for BME staff of 1.35, the 2017 report 0.73, the 2016 WRES report stated there was a likelihood of 1.96 of BME staff entering into a formal disciplinary process over white staff. The 2015 WRES report stated there was a 1.52 likelihood of BME staff entering disciplinary process over white staff.

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

	Number in workforce	No. of staff accessing non-mandatory/CPD training	Relative likelihood of accessing non-mandatory/CPD training
White	6729	258	0.0383415
BME	1552	79	0.050902
Unknown	247	5	0.0202429
Total	8528	342	



The data supplied for 2018-19 related to applications for education funding submitted by allied health professionals, nursing, midwifery, administrative and clerical staff.

Likelihood of white staff accessing non-mandatory/CPD training:
258 / 6729 = 0.0383415

Likelihood of BME staff accessing non-mandatory/CPD training:
79 / 1552 = 0.050902

Relative likelihood of white staff accessing non-mandatory/CPD training compared to BME staff: 0.0383415 (White Staff) / 0.050902 (BME Staff) = **0.75 times.**

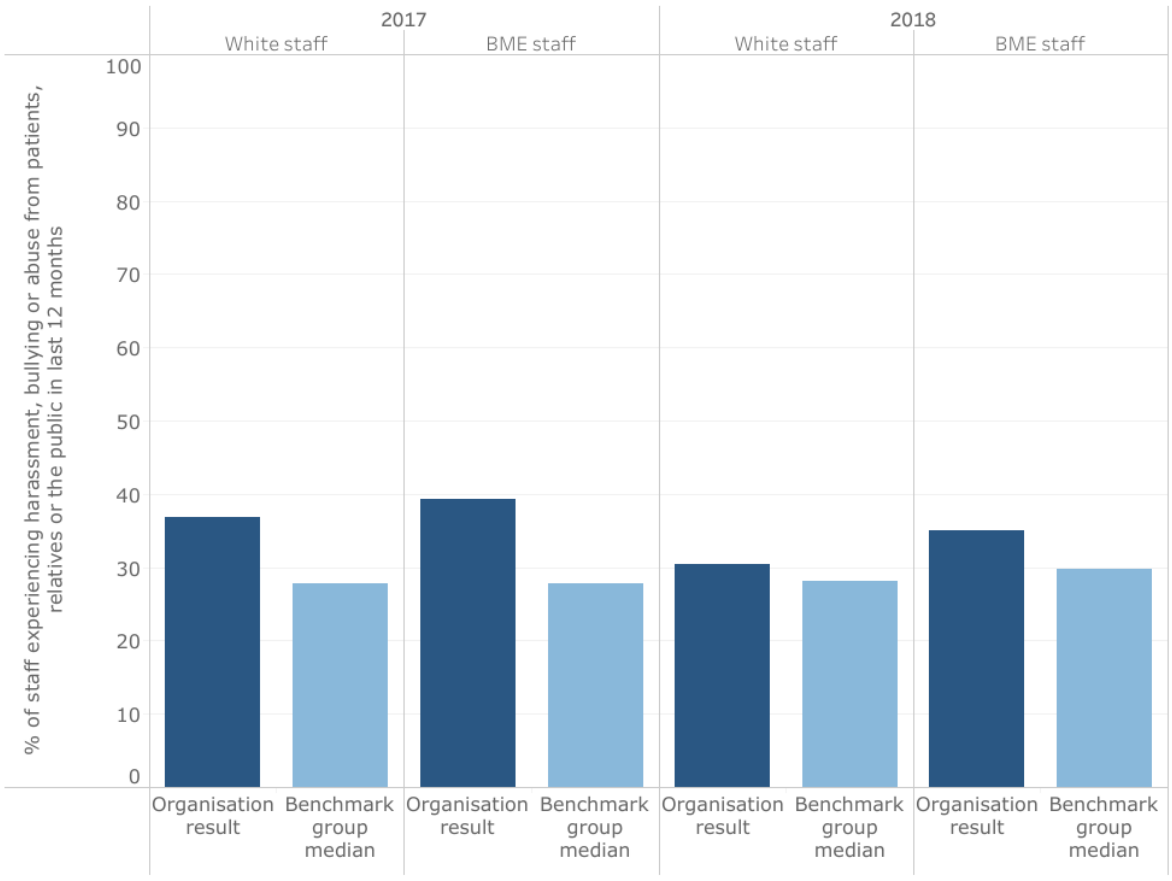
White Staff		0.75
BME Staff		1.00

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

In the 2018 WRES report the likelihood was 0.92, in comparison to this year it would appear that there has been a decrease in likelihood of white staff undertaking non-mandatory/CPD training than BME staff.

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

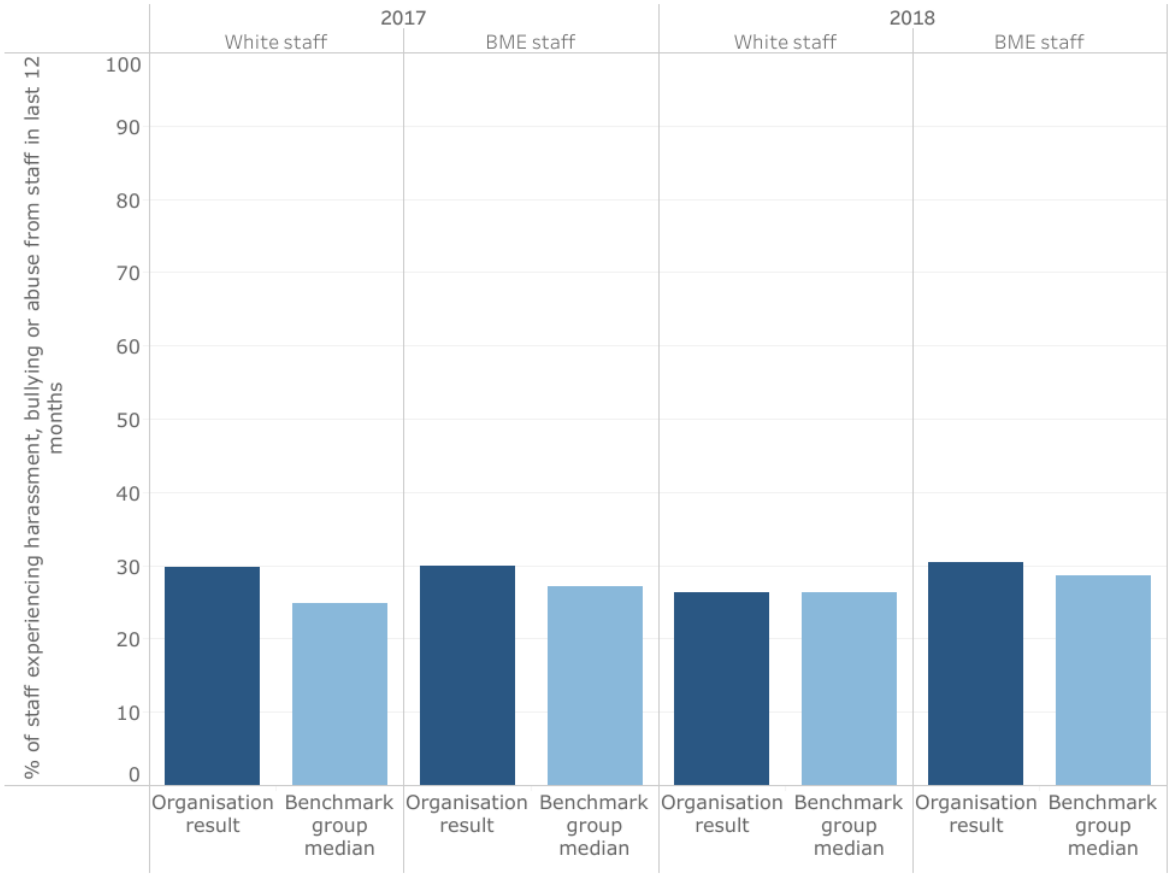
Staff Survey	White Staff		BME Staff	
	BSUH staff	Acute Average	BSUH staff	Acute Average
2017	36.9%	27.8%	39.3%	27.8%
2018	30.5%	28.2%	35.0%	29.8%



There has been an overall reduction for BME staff experiencing harassment, bullying and abuse from patients, relatives or the public, from the 2017 NHS Staff Survey to the 2018 Staff Survey. The overall level of experience is higher than the national acute average for BME staff. The same can be said of the experiences of white staff in the trust.

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

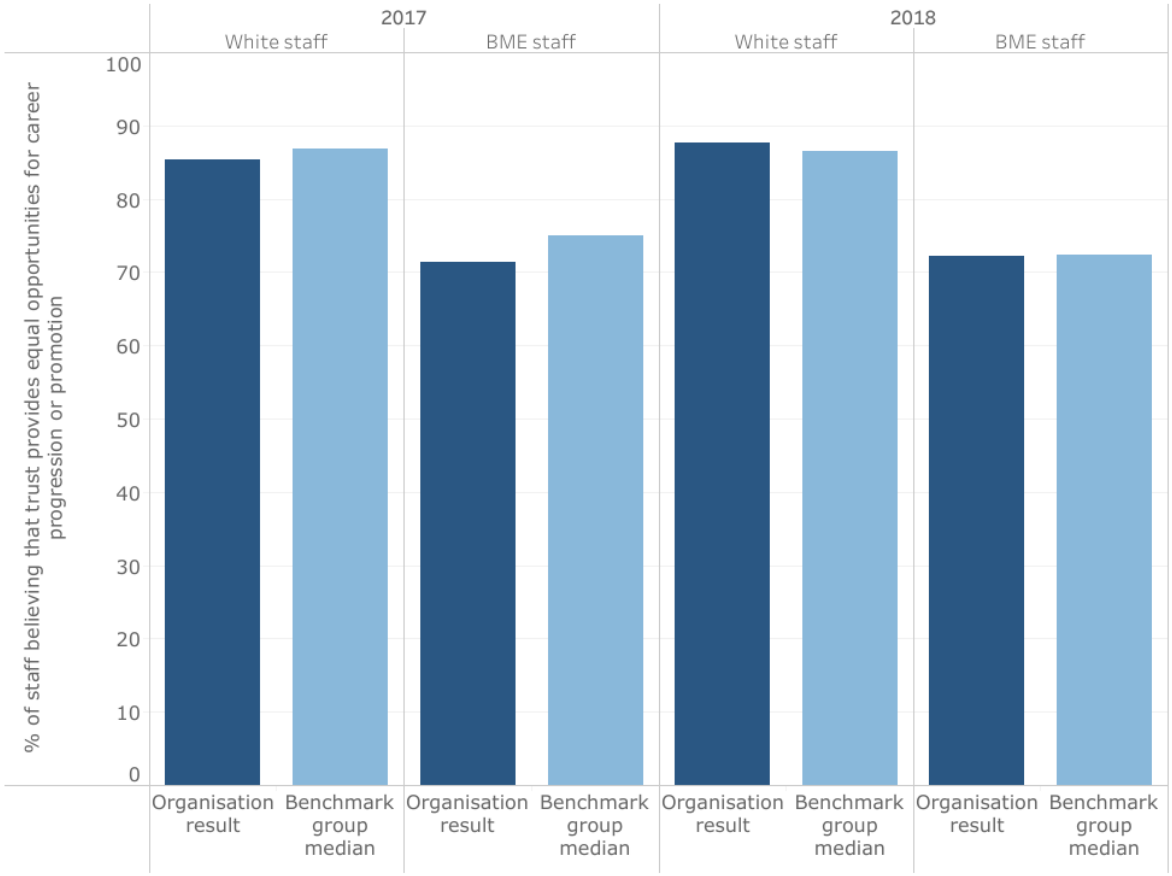
Staff Survey	White Staff		BME Staff	
	BSUH staff	Acute Average	BSUH staff	Acute Average
2017	29.8%	24.8%	30.0%	27.2%
2018	26.3%	26.4%	30.4%	28.6%



There has been a marginal increase in BME Staff experiencing harassment, bullying or abuse from staff, from the 2017 NHS Staff Survey to the 2018. The overall level of experience is higher than the national average for BME staff in acute trusts. However, for white staff there has been a decrease in experience from 2017 to 2018 NHS Staff Surveys which is in line with the national average for white staff in acute trusts.

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

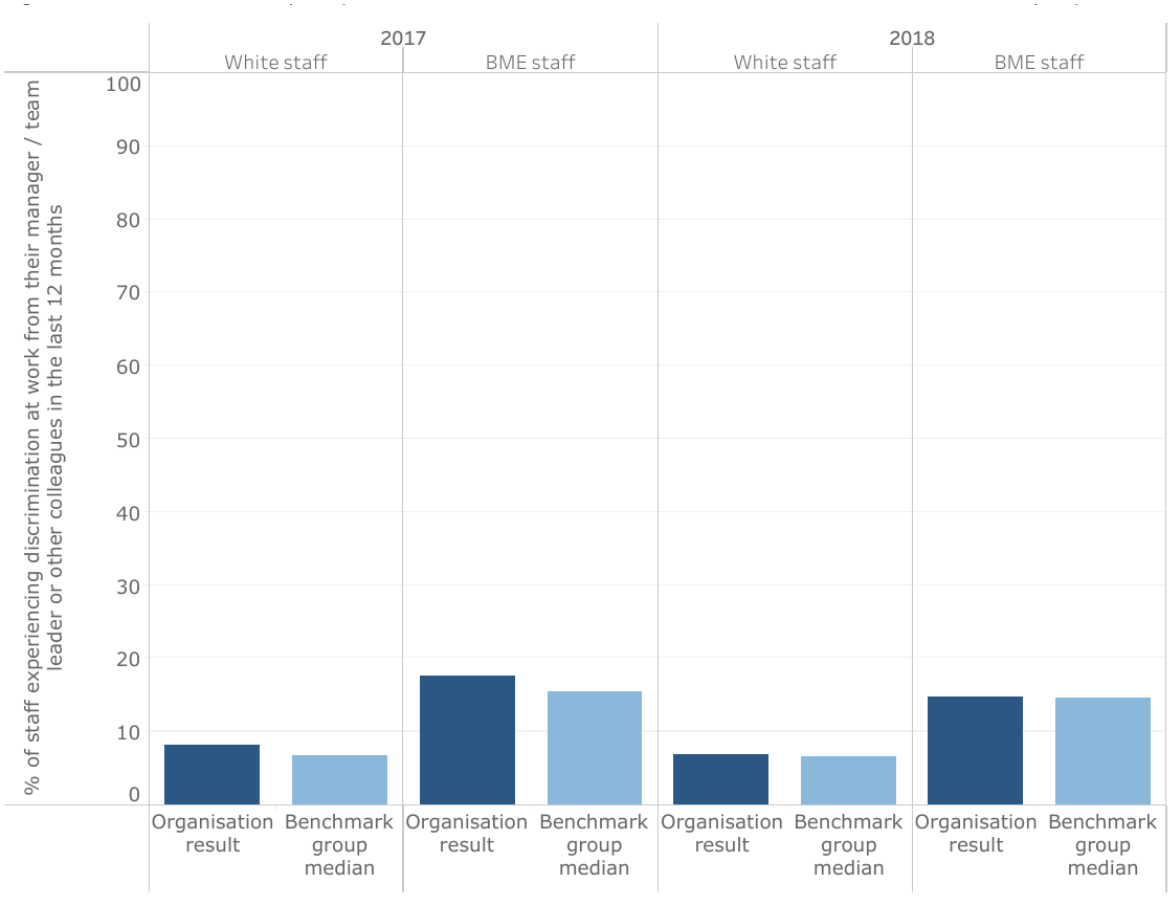
Staff Survey	White Staff		BME Staff	
	BSUH staff	Acute Average	BSUH staff	Acute Average
2017	85.3%	86.6%	71.5%	75.0%
2018	87.6%	86.5%	72.3%	72.3%



There has been an increase of BME staff believing that the trust provides equal opportunities for career progression or promotion from the 2017 to the 2018 NHS Staff Survey. This is now in line for the national average for this group in acute trusts. The same can be said for the experiences of white staff at the trust.

Indicator 8 - In the last 12 months have you personally experienced discrimination at work from your Manager/team leader or other colleagues? Q15(b) from the Staff Survey

Staff Survey	White Staff		BME Staff	
	BSUH staff	Acute Average	BSUH staff	Acute Average
2017	8.2%	6.7%	17.6%	15.5%
2018	6.9%	6.6%	14.8%	14.6%



For both BME and white staff, we can see that there has been a reduction in staff which have experienced discrimination at work from their managers, team leader or other colleagues from the 2017 and 2018 NHS Staff Surveys. Again for both groups these are roughly in line of the national average for the respective groups in acute trusts.

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

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

	Overall Workforce		Voting Board Membership		
	Number in workforce	% in workforce	Number on board	% of board	% Difference
White Staff	6729	78.9%	12	80.0%	**1.1%**
BME Staff	1552	18.2%	1	6.7%	**-11.5%**
Unknown	247	2.9%	2	13.3%	**10.4%**
Total	8528	100.0%	15	100.0%	

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

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

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

a. Any issues of completeness of data
This report is based on information presented to the Trust's Board in 2019.

b. Any matters relating to the reliability of comparisons with previous years
None .

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

Brighton and Sussex University Hospitals NHS Trust

ONE	**Issue: BME applicants appear to be less successful through our recruitment processes than White applicants**						
	What is already in place? Shortlisting through TRAC requires rationale for shortlisting. Interview assessment sheets require scoring. At least 2 people required to shortlist.						
	Actions required	**Outcome**	**WRES indicators**	**Theme(s)**	**Lead**	**Timescale**	**Progress notes**
1.1	All Band 7 and above posts to have diverse interview panels.	Better BME representation throughout the higher bands within BSUH.	2, 7	Recruitment & Training	Abbi Denyer	Oct-19	First cohort of trained staff to undertake interviews early Jan 2020. These interview panels will where possible include the diversity that represents BSUH
1.2	Values Based Recruitment to be implemented,	To achieve a fair and equitable recruitment process.	1, 2, 7	Recruitment & Selection	Abbi Denyer	Mar-19	Initial use of diversity flashcards has been succesful. Now being rolled out for wider usage
1.3	Monitor, review and publish the recruitment monitoring data.	To achieve a fair and equitable recruitment process and ensure no blockages in any areas.	2, 7	Recruitment & Training	Abbi Denyer	Jun-19	Continues to be published annually via our Workforce Race Equality Standard (since 2015). 1.1 and 1.2 are outcomes of this action. HR are now providing more detailed reports that are looking at why there are the differences we are seeing in our WRES data
1.4	Offer BME staff career development support and interview skills training.	To develop training opportunities for BME staff to aid their career development.	4,7	Education & Training	Abbi Denyer/Babs Harris	Sep-19	Liaising with Learning and Development to provide in-house support. We will also look at the resources that BAPIO has to offer and incorporate these where appropriate
1.5	Recruitment images to be representative of population.	To actively encourage a greater diversity of applicants.	2, 7	Recruitment & Training	Abbi Denyer/Neil Hopkins	Completed	The Comms Lead for this is now Tasha Gardner. In all promotional and team engagements, we are ensuring a greater diversity of our workforce are represented.
TWO	**Issue: Staff from BME groups appear more likely to be subject to formal processes than White staff**						
	What is already in place? HR spreadsheet records all formal processes and this is recorded also on ESR						
	Actions required	**Outcome**	**WRES indicators**	**Theme(s)**	**Lead**	**Timescale**	**Progress notes**
2.1	Ensure that Trust policies are equally applied to all staff.	Fairness in the application of all policies regardless of race.	3, 8	Communication & Training	Babs Harris	Jul-19	Met with Company Secretary in April 2019 and will share updated materials in June 2019 with WRES Working Group and DMSG before presenting to TEC and going live. A formal process of presenting to DMSG and Quality Assurance will take place on a 6 monthly basis
2.2	Ensure that those staff in leadership roles throughout the organisation are equipped to understand the complexities of race equality.	Greater understanding and knowledge of the impact of race discrimination. Reduction in racial discrimination cases.	3, 6, 8	Communuication, Appraisal & Education	Abbi Denyer/Kali Varadarajan/Babs Harris	Oct-19	First cohort to undertake this will be Jan 2020. Allowing sufficient time for commissioning/procurement etc.
THREE	**Issue: Throught the staff survey BME staff report higher levels of bullying, harassment or abuse from colleagues/managers than White staff**						
	What is already in place? Freedom to Speak Up Guardian, HELP Service, Working Together Effectively						
	Actions required	**Outcome**	**WRES indicators**	**Theme(s)**	**Lead**	**Timescale**	**Progress notes**
3.1	Initiate conversations in training and include equalities discrimination and bullying concerns within the remit of the Freedom to Speak Up Guardian.	Internal material to be developed. Staff better understand the role of the Freedom to Speak Up Guardian.	5, 6	Communication, Education & Training	Babs Harris/Caroline Owens	Completed	FTSUG has now a slot on Induction and continues to be at many Trust training events.
3.2	Highlight what our zero tolerance approach is.	Education through posters, online learning, messages from senior leaders.	5	Training	Babs Harris/Kali Varadarajan	Sep-19	Draft to WRES Working Group before wider dissemination to staff before presenting to DMSG. This will ensure the widest possible support from our staff
FOUR	**Issue: A higher percentage of BME staff report experiencing discrimination at work in the last 12 months**						
	What is already in place? Equality, Diversity and Inclusion Policy; Equality and Diversity session at Corporate Induction and as part of Mandatory training programme. Due Regard within workforce policies.						
	Actions required	**Outcome**	**WRES indicators**	**Theme(s)**	**Lead**	**Timescale**	**Progress notes**
4.1	Roll out the 'No Bystanders' film. (Re-named "What you permit you promote"	An organisational understanding of the impact discrimination can have.	8	Education & Training	Tasha Gardner/Babs Harris	Aug/Sept 2019	Working with WRES Working Group to produce, to showcase throughout the organisation in time for Black History Month
4.2	Update the Violence and Aggression Policy.	Current policy will be updated to ensure relevant to current issues.	5	Training & Communication	Abbi Denyer	Completed	This policy has been updated and approved by TEC. Recommendations foolowed and equipment purchased and training undertaken.
4.3	Look into unconscious bias or cultural intelligence awareness training/education.	A greater understanding of what can lead to unintentional misunderstandings in teams/departments.	All excluding 9	Education, Training & Communication	Babs Harris/Kali Varadarajan	Oct-19	This is part of the suite of services that will be commissioned to support 1.1 and 2.2

Agenda Item:	17	**Meeting :**	Trust Board	**Meeting Date:**	25th September 2019
Report Title:	**Safe Staffing – 6 month report**				
Sponsoring Executive Director:	Clare Williams – Interim Chief Nurse				
Author(s):	Clare Williams – Interim Chief Nurse Emma Symes – Workforce Matron				
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	safe staffing level for nursing are evidenced as having an impact on quality and safety of patient care
Financial	Achieving workforce KPIs will support the financial plan
Workforce	Recruitment and retention of suitably qualified staff is an essential for sustaining high quality care

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

Communication and Consultation:

Executive Summary:
This report incorporates key national, regional and local staffing indicators providing assurance for the Board and highlighting issues of concern.

Key Recommendation(s):
The Board is asked to NOTE the report.

Report to the Board of Directors

Nurse Staffing and Capacity Levels

September 2019

1. Introduction

The purpose of this report is to present to the board a review of ward nurse staffing levels as directed by the National Quality Board (NQB). The NQB has stipulated that; 'Boards must take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability'. Within their recommendations it states that every six months, as required by the NHS England *Hard Truths* report (2013), the board of directors should receive and discuss at a public board meeting a report on staffing capacity and capability.

2. Vacancies

The nursing workforce is currently overstretched and struggling to cope with service demand therefore, negatively impacting upon staff morale, retention and the standard of patient care provided (House of Commons, 2018). The NHS Five Year Forward View identified the importance of improving recruitment and retention (Department of Health, 2017) and the NHS Long Term Plan incorporates a focus on workforce including plans for training and recruitment and making the NHS a better place to work. At present, more nurses are leaving the professional register than joining it (House of Commons, 2018). The third annual NHS workforce trends report *'A critical moment: NHS staffing trends, retention and attrition'* published by the Health Foundation confirms an 'ongoing deterioration' for some staff groups with there being more than 41,000 vacant registered nursing positions in the NHS in England, equating to more than 1 in 10 posts currently vacant. The House of Commons Health Committee second report on The nursing workforce 2017-19 states only 33,000 vacancies are being filled by temporary staffing (bank and agency nurses.) These vacancy rates differ by nursing speciality as well as by geographical area whilst Health Education England (HEE) highlight that nurses nearing retirement as well as NQNs are the most likely to leave the profession. Nursing turnover continues to increase year on year, from 12.3% in 2012-13 to 15% in 2016-17, whilst evidence shows that these nursing shortages are negatively affecting the safety and quality of patient care (House of Commons, 2018). Furthermore, since the student bursary was removed in 2016 the number of people applying for nursing degrees in England has decreased by 29%.

- At Brighton and Sussex University Hospitals NHS Trust (BSUH) the rolling 12 month turnover (% FTE) of registered nurses, as of July 2019, is 11.7%. 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%.)
- As of July 2019 there are 307 WTE Band 5 vacancies across the Trust and 135 WTE Band 2 vacancies. However, our budgeted establishments saw an increase in HCA posts from 1028 WTE (April 2019) to 1092 WTE (June

2019.) The departments with the highest HCA vacancies have robust recruitment plans in place. The rolling 12 month turnover for this staff group remains high at 17.2% and work is underway to reduce this and improve HCA resilience. The increase in HCA vacancies may also be due to the introduction of more robust, rigorous, standardised numeracy and literacy testing at recruitment events. However, testing is in line with the National Skills for Health tests and the process is ensuring the appointment of a high calibre of HCAs who are able to step onto any of our developmental career pathways in the Trust which in turn should positively influence the likelihood of us retaining these staff members.

- To address high HCA turnover a Band 3 pilot was introduced with the aim of these new Band 3 posts being to improve retention and reduce sickness by providing leadership to Band 2s and providing a career pathway for unregistered nurses. The pilot consisted of 35 (headcount) Band 3s being recruited internally to 17 wards. When reviewed in August 2019, the turnover rate for Band 3 staff was much lower than the overall HCA turnover indicating it is a good way to retain unqualified nursing staff. Band 3 staff appeared to have a positive impact on ward level HCA retention suggesting it is a good way to improve Band 2 retention and although there was no impact found to Trust wide HCA performance data it suggests that the cohort of 35 staff was too small to impact at this level.

3. Staffing

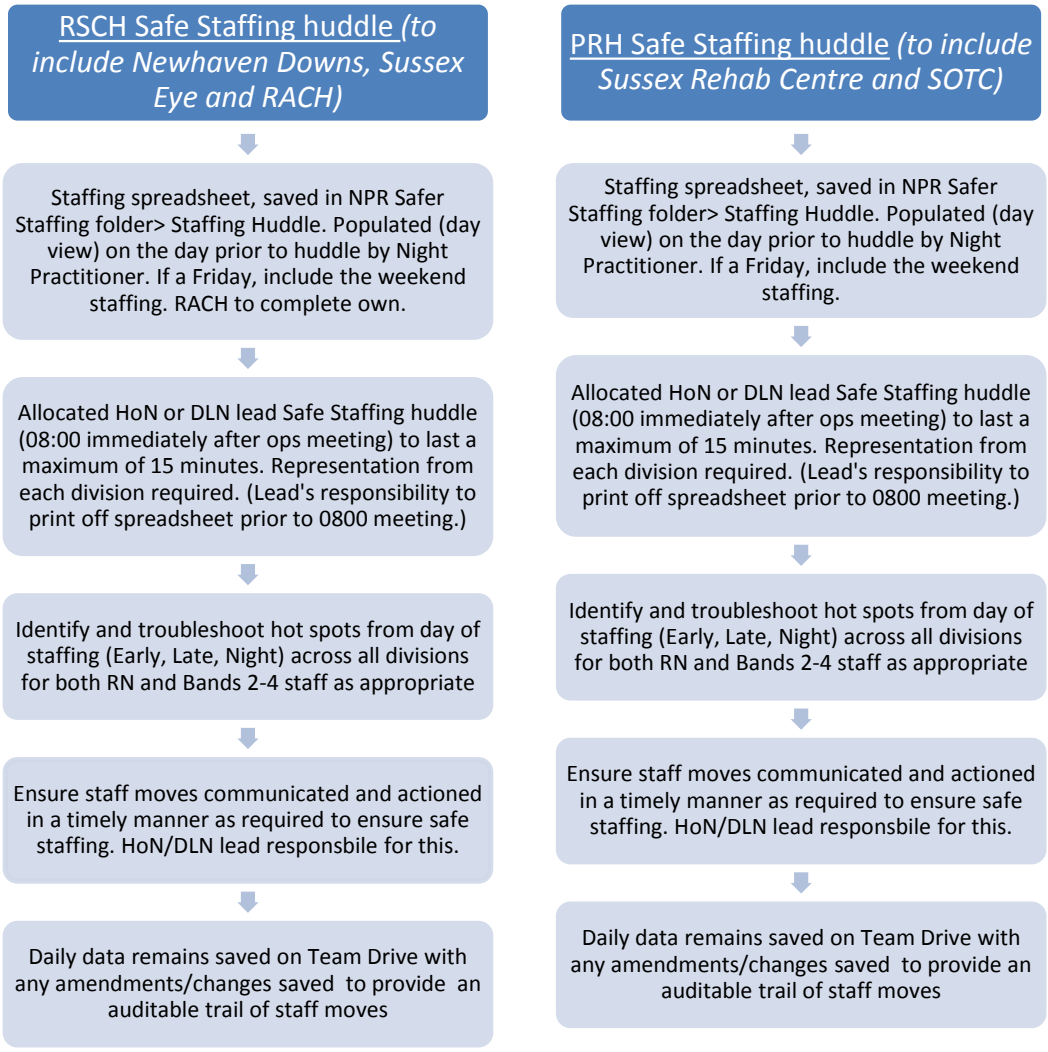
Due to the Trust's current vacancy factor it is of paramount importance that shortfalls in staffing are proactively managed. All Trusts must ensure NQBs 2018 guidance is formally embedded in their safe staffing guidance, which states:

- That the workforce consists of sufficient, suitably qualified, competent and experienced staff to meet care and treatment needs safely and effectively.
- That there is a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service to keep them safe at all times.
- When deciding on staffing Trusts must use an approach that reflects current legislation and guidance where it is available.

In July 2019 the Trust implemented a daily Safe Staffing Huddle. Shortfalls in staffing are discussed daily at this huddle which is led by an allocated Head of Nursing/Directorate Lead Nurse. The Standard Operating Procedure (SOP) is presented in Table 1.

If required staff are moved to accommodate extra capacity staffing and areas that need additional support. Bank and agency staff are used as required to ensure the nurse to patient ratio remains within acceptable levels. Heads of Nursing, Directorate Lead Nurses, Matrons and the Practice Educators have also worked clinically on the wards as needed.

Table 1: SOP for Safe Staffing Huddles



(See Appendix 1 for example of master template)

3.1 Temporary staffing:

We are actively working on reducing the agency spend in nursing (particularly in the Surgical, Medical and Specialist divisions where our highest usage areas sit) via various enablers. We ceased using non-framework, high-cost agencies at RSCH at the end of February 2018 and across the whole Trust in May 2018 and are currently looking at stakeholder relationship management with our current Tier 1 and 2 agencies.

3.2 Sickness:

The Heads of Nursing monitor overtime and sickness, following the *BSUH Health and Wellbeing Policy* with HR support and in many areas there are driver metrics (in line with the Trust's Patient First Improvement System) with the support of HR and ER to manage absences.

- Sickness amongst RNs has ranged from 3.89% to 4.90% over the last year.
- The rate for HCAs over this period of time remains unacceptably high, currently sitting at 6.16% as of June 2019.

3.3 eRostering:

October 2019 will see the introduction of HealthRoster (Allocate) as part of a Trust wide e-rostering implementation project across all staff groups. Workforce costs in BSUH are circa £365m per annum including £20m of bank and agency spend (nursing and medics in 2017/18) which makes it 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 that has been agreed is to roll out one workforce system, Allocate, across the Trust to manage rotas, absence management, job planning and temporary staffing.

E-rostering was identified as a key component in the Lord Carter Review (2015) to support workforce efficiency. Whilst in 2007 NHS Employers recommended implementation of e-Rostering to improve workforce productivity. For nursing and midwifery at BSUH (who already use an e-rostering system) this new software provides additional functionality not currently available e.g. SafeCare tool for an overview of patient acuity and dependency at ward level for better/safe operational decision making and access to rotas off site using web based service and/or an app on smart phones. Other benefits including more efficient utilisation of substantive staff hours, reduction in use of temporary staff and compliance with 6 week sign off and Trust target headroom values are predicted.

With the introduction of Allocate Healthroster our current e-rostering policy will be updated to ensure ongoing robust management of rotas and monitoring against agreed KPIs. These KPIs are reported weekly with the Heads of Nursing and shared at the monthly Nursing Workforce Efficiency Delivery Group.

3.4 Red flags:

The Safer Staffing Alliance states there is evidence that care is compromised when there are more than 8 patients (beds) to 1 registered nurse. In order to be compliant with NHS Improvement's Workforce Safeguards, as of June 2019 we now have an updated Red Flag procedure for nursing within the Trust. The purpose of a Red Flag being raised is to identify those times where either essential nursing care has not been delivered, or where there is a risk that the quality of patient care may be impacted. If departments do not have enough nurses on duty with the right skills to safely meet the needs of the unit they raise a Red Flag (Appendix 2.) Table 2 highlights the Red Flags raised over the last 2 months.

Table 2: Red Flags raised

		June	**July**
Consequences of Lack of Staffing (Note one	**No of ward with reporting lack of nursing staff (Red Flag)**	**35**	**50**
	A shortfall >8hrs or 25% in RN time	8	18
	Less than 2x RNs present on a ward	5	4
	Unplanned omission in providing patient medications	5	5
	Delay of more than 30 minutes in providing pain relief	7	17
	Vital signs not assessed or recorded as in care plan	7	4

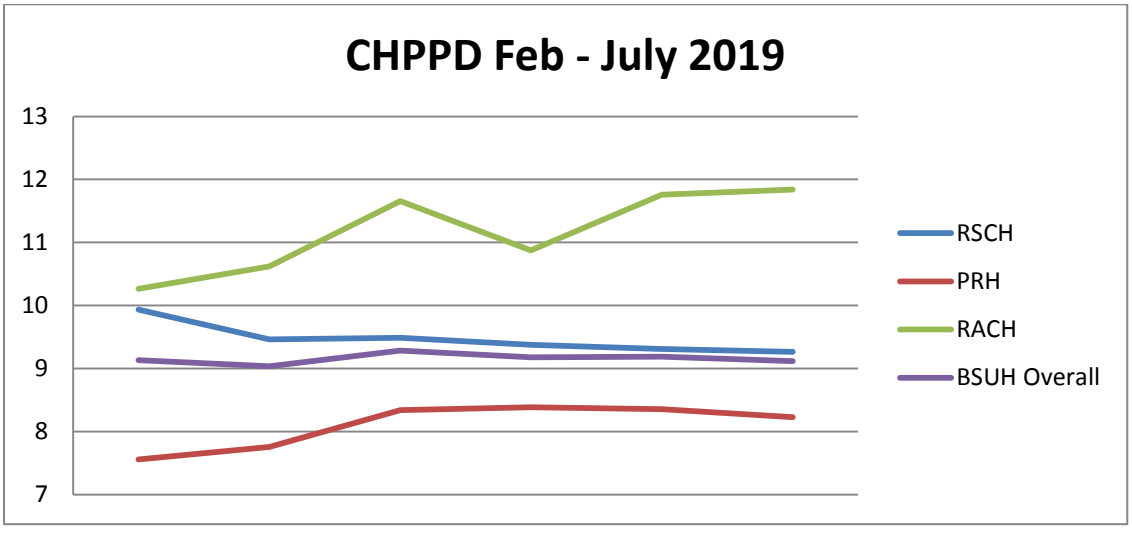
incident report can generate multiply consequences)	Delay or omission of regular checks on patients	14	23
	Pain risk assessments not done	6	3
	Patient needs such as toileting, hydration not met	8	12
	Unable to make sure needed items are within reach	9	10
	Pressure risk assessments not done	8	7

4. Care Hours per Patient Day (CHPPD)

In Lord Carter's final report, '*Operational Productivity and performance in English acute hospitals: Unwarranted variations'*, better planning of staff resources is crucial to improving quality of care, staff productivity and financial control. The report recommended that all trusts start recording Care Hours Per Patient Day (CHPPD) – a single, consistent metric of nursing and healthcare support workers deployment on inpatient wards and units. This metric enables trusts to have the right staff mix in the right place at the right time, delivering the right care for patients. From 1 May 2016, all trusts were requested to submit monthly CHPPD data to NHSi so that they can start to build a national picture of how nursing staff are deployed. From October 2019 the planned and actual hours by ward for Allied Health Professionals and Nursing Associates will also be reported. The data for the last 6 months if presented in Table 3.

Table 3: CHPPD for the last 6 months

	Feb	Mar	Apr	May	Jun	Jul
BSUH Trust overall	9.13	9.03	9.29	9.18	9.19	9.12
Royal Sussex County Hospital overall	9.93	9.46	9.49	9.37	9.31	9.27
Princess Royal Hospital overall	7.55	7.76	8.34	8.38	8.35	8.23
Royal Alexandra Children's Hospital overall	10.26	10.62	11.66	10.88	11.76	11.84



BSUH hours will be higher than some other Trusts as there are two adult ICUs, a cardiac ICU, Children's HDU and neonatal Level 3 (ICU) all areas where staffing is one to one/ one to two care.

5. Nursing Templates

Calculating staffing requirements is dependent upon a number of factors, including the acuity and dependency of patients. The last acuity staffing review of adult inpatient wards was undertaken in June 2019 using the Shelford Group Model and whilst the review is complete further work is being undertaken to compare findings with previous audits, with a subsequent data collection planned for October 2019.

Paediatric inpatient areas in the RACH are using the Safer Care Nursing Care Tool (Children's & Young People's) for the month of September 2019 (as a trial period of data collection which includes ensuring compliance with A&D training requirements and peer reviews in line with the NHSi Developing Workforce Safeguards guidelines.) The Trust's neonatal intensive care units are also currently undertaking preparatory work prior to using the tool in their departments.

5.1 Developing Workforce Safeguards:

In line with NHSi's Developing Workforce Safeguards (October 2018), the Nursing Workforce Safeguards Trust policy is currently being written to ensure compliance. This will provide assurance that the Trust's workforce decisions will promote patient safety and comply with the Care Quality Commission's (CQC) fundamental standards, NHSi's Use of Resources assessment and the board's statutory duties.

5.2 Establishment reviews:

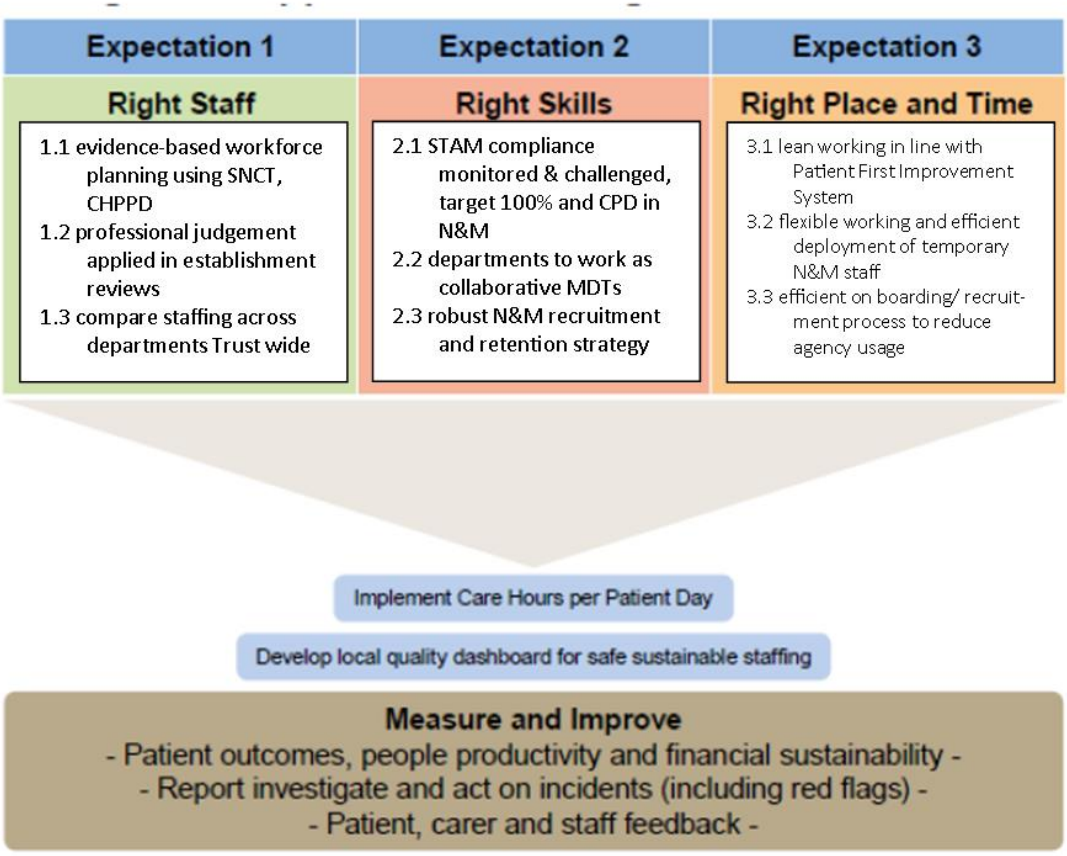
Establishment reviews should be undertaken annually (using evidence-based tools, professional judgement and outcomes) and must also include a mid-year review (see Appendix 3 for annual review process.) The next establishment reviews are planned for December 2019, will follow the Trust Ward Workforce Review template (Appendix 4) and will also take account of:

- Patient acuity and dependency using an evidence-based tool (Safer Nursing Care Tool by the Shelford Group)
- activity levels and seasonal variation in demand
- service developments and service changes
- staff supply and experience issues
- where temporary staff have been required above the set planned establishment
- patient and staff outcome measures

All stakeholders should be sighted on all recommendations to maintain or change establishments. Stakeholders should understand the rationale behind such recommendations and their anticipated impact. This will occur in nursing establishment reviews, led by the Chief Nurse/Nurse Director with the department's Directorate Lead Nurse, Matron and/or Ward Leader alongside HR and Finance and should be documented. The first review happened in January 2019 (as per Appendix 3.)

NQB's (2018) guidance states that the Trust must meet three expectations: deploying the right staff with the right skills at the right place and time. This triangulated approach to staffing decisions is outlined in Table 4.

Table 4: Approach to staff decisions



5.3 Staffing data in each inpatient area:

The Trust displays information about the number of nurses, midwifes and care staff present and the number planned, in each clinical area, on each shift. The format of the presentation has been reviewed by service users and some changes made to ensure it is useful for service users. This data is also published on the BSUH external website, in a visible, clear and accurate format for the public (see Appendix 5 for staffing ward board example.)

5.4 Introduction of Band 4 roles:

The Trust's workforce plan will include a comprehensive Quality Impact Assessment (QIA) where there is any workforce transformation or redesign including a change in skill mix and/or the introduction of new roles. Any redesign or introduction of new roles (including but not limited to nursing associates and advanced clinical practitioners) would be considered a service change and must have a full QIA.

The Trust has recruited twice a year (in February and September) for Trainee Nursing Associates (TNA) onto the 2 year Foundation Degree in health science and social care. TNA and Assistant Practitioner (AP) numbers at BSUH from September 2017 are presented in Table 5. Although numbers have been relatively small the plan is to increase TNA

numbers cohort by cohort recruiting from our own pool of "qualification ready" HCAs, looking at potential numbers of 30 per cohort. We are also building a team to support the TNAs going forward who require significant pastoral care and clinical support.

To enable this recruitment to grow from the Trust's internal pool of HCAs the Practice Development Team are providing career development packages and a clear pathway supported by a "readiness" programme which supports HCAs through the qualifications, clinical experience and values and behaviours required to apply to be a TNA.

Table 5: AP/TNA numbers since September 2019

TNA or AP	Start Date	End Date	No. staff started	No. of staff expected to complete	Reason not completed
AP	Sep-17	Sep-19	19	17	1 left BSUH / 1 Maternity leave
AP	Sep-18	Sep-20	2	2	ongoing
AP	Sep-19	Sep-21	3	3	ongoing
TNA	Feb-18	Feb-20	4	3	1 personal reasons
TNA	Sep-18	Sep-20	9	7	1 Maternity leave, 1 finish date extended
TNA	Feb-19	Feb-21	10	11	ongoing
TNA	Sep-19	Sep-21	8	8	ongoing

5. Recruitment

RN vacancies remain at a high level despite rigorous recruitment effort. Registered nurse workforce capacity across the local region and nationally remains a challenge to all health providers. Whilst there is a continued effort for both national and international recruitment, much of the activity in the Trust focusses on retention and *'grow your own',* this recognises that the supply of RNs is currently challenged.

BSUH RN vacancies from February 2019 – July 2019 are presented below in Table 6:

Table 6: RN Vacancies – last 6 months

	Feb	Mar	Apr	May	Jun	Jul
#	265	258	322	329	289	307
%	10.3	10.0	12.3	12.5	11.3	12.0

Recruitment projects at BSUH include:

- 12 month rolling standardised recruitment dates (including bank, with 3-4 dates each month booked covering both sites) supported by HRES for streamlined on boarding and good candidate experience
- New Trust Recruitment video released (currently has had 778 views on YouTube, as of August 2019)
- In March 2019 the Trust headlined the Nursing Times recruitment event in Brighton and received high praise from the Nursing Times Careers Live team about the Trust's approach to the event. The 87 nurses the team met on the day were contacted by the nursing leads of their areas of interest to discuss job opportunities within the Trust. There were also 9 individuals interviewed and appointed on the day (8x RNs and 1x HCA who was also a student nurse.)
- Nationally there is an increased reliance on bank staff (driven by NHSi requirements to reduce expenditure on agency and an increased demand for fully flexible working) so as a Trust we have a rolling Bank Nurse advert out to capture as many applicants as possible. To bolster and strengthen the skill set of our existing temporary nursing workforce and reduce reliance on agency we have also recruited, to date, 2 registered mental health nurses, as mental health was identified in the Five Year Forward View and The NHS Long Term Plan as a priority. Further work around RMN usage is ongoing.
- HCA recruitment is currently open to all, so that people are recruited based on their aptitude rather than solely on previous experience, after passing Literacy and Numeracy testing and being successful in a values based interview (the care certificate and focussed support is given to those without experience by our Bands 2-4 practice development team.)
- The 12 month preceptorship programme for newly qualified nurses – consisting of 10 mandatory days of education, has been an excellent recruitment tool. Plus the extended preceptorship programme of a Year 2 and Year 3 aims to retain these NQNs and assist them with career progression and personal development within the Trust.
- Rotational programmes are established now across multiple divisions including acute pathways for both sites, using high vacancy areas. This will enable nurses to gain a breadth of experience across specialities.
- 40 Filipino nurses were recruited in the last overseas campaign, 35 have been deployed to date. A further business case is being developed for consideration for future international recruitment.
- Monthly OSCE Support Sessions are being held to assist our internationally educated nurses currently working in Band 2-4 roles to help them develop their skills in order to prepare for OSCE. These dates, along with online resources, are available on IRIS for easy accessibility. A scoping exercise was undertaken and identified 78 internal Band 2-4 staff who may be suitable for progression, of which:
    - 12 are currently accessing face-to-face OSCE support sessions led by the PD Team
    - 8 are in Band 4 roles and 3 in Band 3 roles and are being supported and developed in their departments and may be suitable for further progression to become RNs or NAs
    - 13 are either on the waiting list or are currently a learner on Maths and English

- Improving pre-registration (pre-reg) student experience; continues to include in-house simulation and training dates, with a plan to recruit these students when they qualify, we have recruited 2 nurse Clinical Educators to support our adult pre-reg students and retention remains consistent at 60% of our Brighton students being employed at BSUH post qualification and a further 11% in the local STP catchment. 14% have decided to take their first job closer to home or in the military once their training was completed. The remaining 15% opting to take a break before commencing employment as a registered nurse. There has been a signification improvement in the retention of child branch students upon qualification with 81% retention and 19% deciding to take employment closer to home.
- In 2018 we increased our University intake for taking pre-reg students by going into both formal and informal contract with 3 Universities (The University of Portsmouth, University of Southampton and University of Surrey.) In 2019 to increase further and mitigating the diminishing numbers being recruited by our universities we are in conversation with University of West London, Kingston and the Open University. In an attempt to reduce our student nurse attrition we are running bi annual final year student nurse recruitment events for both internal and external pre-registration nurses. In line with the pledge in the NHS Long Term Plan, NHS England and NHS Improvement have confirmed that there will be 5,764 new clinical placements (a 25% increase) for pre-reg nursing students.
- Bespoke recruitment campaigns for areas with high vacancy factors have been running successfully through the use of social media promotion as well as open days/showcase events. This has been reported via metrics from the hits and reach on social media as well as the headcount of 'drop ins' at each open day. The NHS workforce trends report state that staffing trends vary across work areas therefore, it is important that our recruitment drives are targeted and tailored appropriately to the bespoke needs of each service/department and focus on showcasing their unique selling points.

Other actions that have been taken to support the nursing and midwifery workforce include;

- As part of the Trust Operational Plan for 19/20 the Trust has developed the 4Rs Workforce Strategy (Resource optimisation, Retention, Recruitment and Risk management.)
- Retire and return policy has been agreed – to encourage experienced nurses to extend their careers. This links in with the BSUH Buddy scheme (corporate mentoring) in which more experienced nurses can be paired with a newly qualified nurse to act as a critical friend to share knowledge and to assist with addressing the Complexity Experience Gap (Nursing Advisory Board)
- Agency line bookings for areas most challenged, this also supports the withdrawal from the more expensive agencies.
- Internal transfer for nursing staff is commencing in October 2019 to ease the movement of staff within the Trust and encourage retention whilst also reducing recruitment processes. This will support Band 5 Nurses in planning and forecasting their career pathway through sideways transfer(s), allowing them to develop a wealth of clinical skills and knowledge whilst enhancing their career pathway and professional goals. This

internal process will reduce duplication for all parties involved in the recruitment process by replacing the current process with a more streamlined one.

- The introduction of new routes into nursing including Nursing Associates (4 cohorts of Trainee TNAs have now been recruited to the Trust, the first of which will qualify as Band 4 registered NAs in 2020.) There are currently 31 TNAs employed in the workforce across the 4 cohorts. Initial expressions of interest have commenced for the 5th cohort due to commence their studies in March 2020. The focus of existing cohorts has been to grow our own workforce; a paper is being prepared for the Trust Executive Committee to widen the scope to directly recruit to TNA apprenticeships.
- The Trust apprenticeship pay strategy is being finalised and will be presented at Trust board, once sign off has been obtained all health care assistants recruited without experience or qualification will be recruited to apprenticeship positions. As part of the apprenticeship they will complete the care certificate, numeracy and literacy level 2 qualifications in preparation for further study.
- The allocation of CPD funding has been altered to ensure parity and transparency across divisions, the Heads of Nursing have allocated funding based on their training needs analyses within their divisions to ensure we have appropriately skilled and trained staff where we need them. However, the NHS workforce trends report explains that there is a continued lack of investment in ongoing training and development across the NHS. This is repeatedly cited as a reason for leaving in our Trust exit data for both HCAs and RNs.
- Partnership working has commenced with the University of West London to deliver cost effective in-house modules aimed at upskilling the existing workforce utilising the expertise of senior staff to provide accredited training for our staff.

Clinical areas with vacancies over 25% (as of July 2019) have been reviewed with their quality metrics in conjunction with the Divisional leads. These wards are listed below and bespoke recruitment campaigns are in place, which has resulted in AAU forecasting that they will be fully, recruited meeting their budgeted RN establishment as of February 2020.

- AAU (RSCH) 41.1%

This is a significant reduction compared to the clinical areas which had this level of vacancy in January 2019:

- Balcombe (PRH)
- Hurstpierpoint (PRH)
- Newick (PRH)
- Twineham (PRH)
- Vallance (RSCH)

6. Retention

The February 2019 NHS workforce trends report states that improving staff retention is a priority, there has been no improvement in the NHS over the past year and insufficient attention has been given to the retention of our existing nursing workforce. The NHS Long Term Plan relies on the existing NHS workforce in order to make progress and be an enabler of its objectives however, with the current workforce shortages this is going to be a challenge particularly as more nurses now leave the professional register than join it.

The Trust's current nursing retention resources were shared as a bundle in the NHSi and NHS England's provider bulletin and are publicly available on the NHSi website at the following link: https://improvement.nhs.uk/resources/extended-preceptorship-programme/

The Trust was involved in NHSi's Nursing Retention Support Programme (Cohort 3), as an outcome of this the Trust N&M Retention strategy was developed which includes various targeted initiatives:

Health and wellbeing:

- Wellbeing programme (4 week programme taken to the ward/departments)

Career progression:

- Career pathways for nursing at BSUH
- Rotational programmes for Band 5 nurses
- Internal transfer for Band 5 nurses
- Bi annual Final Year Student Recruitment events
- Time to Talk (career conversations) with Workforce Matron
- Preceptorship and Extended Preceptorship (Years 2 and 3)
- Podcast series showcasing NQN support/rotational programmes
- BSUH Broadcast (IRIS site with all current resources/communications)
- Career events (with key note speakers from the Trust)
- Quarterly Band 5 forums
- BSUH Buddy (corporate mentoring)

Supporting new starters:

- Standardised local induction process (orientation)
- A5 information welcome packs for all nursing and midwifery new starters (inserts include wellbeing and benefits, social side, Ambassador's welcome, uniform expectations/infographic and information about Patient First, our hospitals and Temporary Staffing)
- Welcome packages for all nursing and midwifery new starters (including BSUH branded pocket notebook, A4 folder, reusable plastic water bottle and bag)

HCA-specific initiatives:

- Bands 2-4 conference
- Inspirational HCA Career Events
- Career Roadshows/Communication Hit Squad
- Itchy Feet Conversations
- Quarterly Bands 2-4 forums
- Care Certificate training programme and robust support from Bands 2-4 team
- Band 3 Pilot (in areas with high HCA turnover)

The House of Commons (2018) support the work on retention led by NHS Improvement and NHS Employers as well as recommending increasing opportunities for high quality continuing professional development and flexible working and career pathways.

7. Summary and next steps

This report provides information on all wards and departments at BSUH. The Interim Chief Nurse is satisfied that nurse and midwifery staffing in all areas meet safe staffing requirements.

- Recruitment of nursing and midwifery staff is essential and will need to continue at pace, locally, nationally and internationally.
- Although the supply of nurses and midwives is limited, focussed activity in the Trust will be on retaining staff and improving resilience, increasing our student numbers and how we develop our own people to become skilled registered practitioners through apprenticeship routes such as the Assistant Practitioner and Nursing Associate roles.

8. Related documents

https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/353/353.pdf

https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

https://www.hee.nhs.uk/sites/default/files/documents/Nurses%20leaving%20practice%20-%20Literature%20Review.pdf

https://improvement.nhs.uk/documents/5940/20190903_UPDATED_Nursing_Midwifery_E-Rostering_Guidance_September_2019.pdf

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

https://improvement.nhs.uk/documents/3320/Developing_workforce_safeguards.pdf

http://shelfordgroup.org/library/documents/130719_Shelford_Safer_Nursing_FINAL.pdf

https://quicktech.imperialinnovations.co.uk/i/Surveys_Questionnaires/SNCT_CandYP.html?item=SNCT_CandYP

https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf

Appendix 1 BSUH Safe Staffing Huddle example spreadsheet template

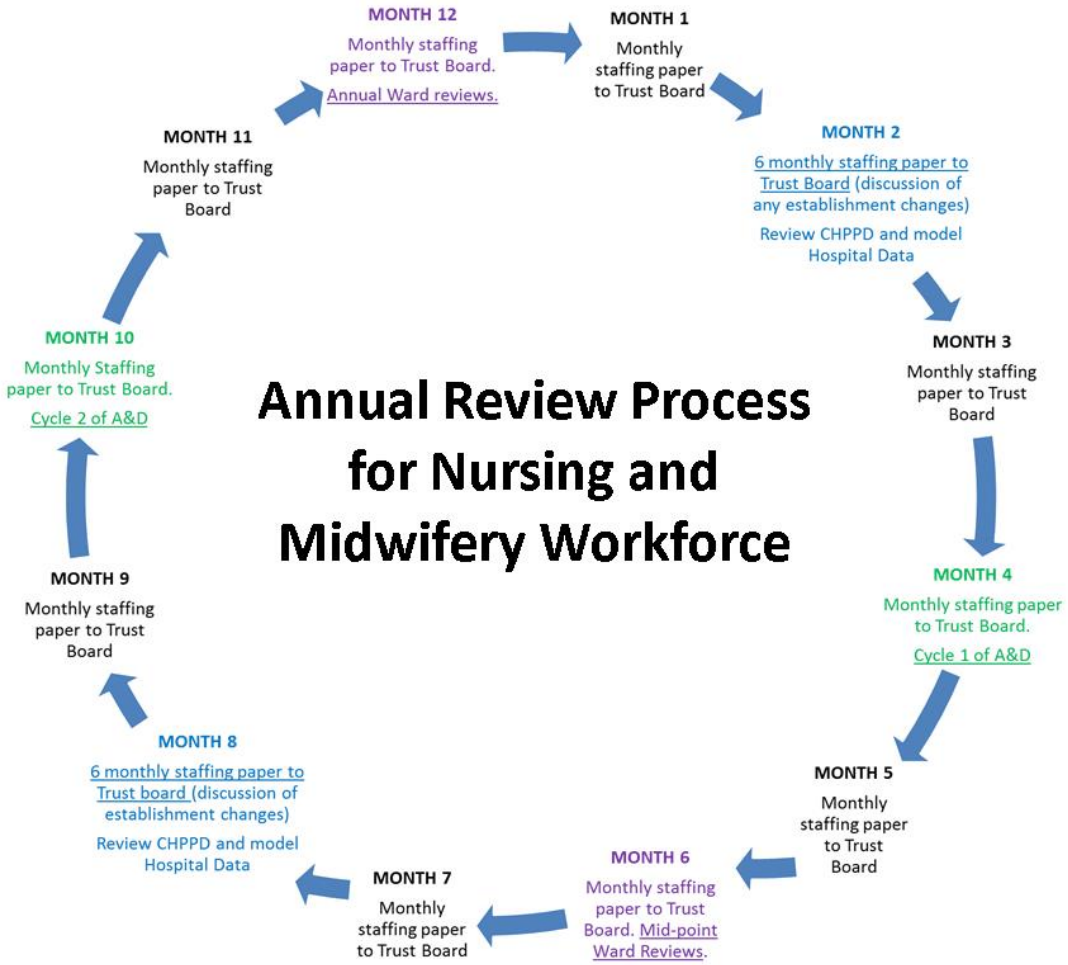
[Insert date here]

	RN						B4						HCA									Supernumerary Staff (Y/N)			Comments /Actions
Dept	NIC		Late		Night		Early		Late		Night		Early			Late			Night			Early	Late	Night	
	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	1:1	Plan	Actual	1:1	Plan	Actual	1:1	NIC	NIC	NIC	
			7		6								3			3			2						
			1		0		1		1		0		1			1			0						
			7		7								1			1			1						
			4		3								3			3			2						
			4		3		1		1		1		5			5			2						
			5		5								4			4			2						
			2		2		1		1		1		4			4			3						
			4		3								4			4			3						
			3		2		1		1		0		2			2			2						
			4		2		1		1		1		2			2			2						
	6		6		4		1		1		1		6			6			6						
	3		3		2								1			1			1						

Appendix 2 BSUH Red Flag Procedure (updated June 2019)

In order to be compliant with the new NHSi Workforce Safeguards see below our updated Red Flag procedure for nursing within the Trust. The purpose of a Red Flag being raised is to identify those times where either essential nursing care has not been delivered, or where there is a risk that the quality of patient care may be impacted. **If you do not have enough nurses on duty with the right skills to safely meet the needs of your ward/unit today – raise a Red Flag.**

Appendix 3: BSUH Annual Review Process for Nursing and Midwifery Workforce



Annual Review Process for Nursing and Midwifery Workforce 19/20:

September 2019	•6 monthly Staffinfg paper to Trust Board - discussion of any establishment changes , Cycle 2 of A&D, CHPPD and Model Hospital Data. •Monthly Unify (CHPPD) return
October	•Cycle 3 Acuity & Dependency •Monthly Unify (CHPPD) return
November	•Monthly Unify (CHPPD) return
December	• Annual Ward Establishment Reviews •Monthly Unify (CHPPD) return
January 2020	•Monthly Unify (CHPPD) return
February	•Monthly Unify (CHPPD) return
March	•6 monthly Staffinfg paper to Trust Board - discussion of any establishment changes , Cycle 2 of A&D, CHPPD and Model Hospital Data. •Monthly Unify (CHPPD) return
April	• Cycle 1 Acuity & Dependency •Monthly Unify (CHPPD) return
May	•Monthly Unify (CHPPD) return
June	•Mid -Point Ward Reviews •Monthly Unify (CHPPD) return
July	•Monthly Unify (CHPPD) return
August	•Monthly Unify (CHPPD) return

Appendix 4 Ward Workforce Review

Ward		No. Beds		Financial Review			
Site				Budget YTD	Actual YTD	Variance YTD	££ overspend RN/HCA for the last 2 years
Ward Manager							
Matron							
Divisional Lead Nurse/Senior Matron							
Head of Nursing							

Workforce Data

RN to Patient ratio	Registered WTE (band 5-7)	Non-Registered WTE	Total Establishment	Uplift	Supervisory status of Ward Manager	Number of Vacancies	% Turnover (12month rolling)	% Sickness	Agency usage

Quality Data -18/19

No. of SIs	FFT recommended	FFT Response Rate	Falls – all moderate	No. of PU ward acquired	No. of Complaints

Training posts

Number of NA in training with qualification date.	Number of DA in training with qualification date.	Number of NA or DA or 19/20
		Internal or external

Acuity & Dependency (CHPPD)

Planned	Actual	Suggested

Workforce questions

Question	Response
What are you most proud of?	
What is your biggest challenge?	
Tell me about your staffing?	
Do you professionally feel the department WTE/Skill mix meets the needs of the patients?	
What measure are in place for agency exit plan	

Proposed Establishment changes based on the data above (workforce changes will need a QIA)

Appendix 5: BSUH Ward Staffing Board

Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	18	**Meeting:**	Trust Board	**Meeting Date:**	25/09/19
Report Title:	Annual Infection Prevention report 2018 - 2019				
Sponsoring Executive Director:			Clare Williams, Interim Chief Nurse		
Author(s):			Clare Williams, Interim Chief Nurse		
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	Team Resource				
Link to CQC Domains:					
Safe			✓	Effective	☐
Caring			✓	Responsive	✓
Well-led			✓	Use of Resources	☐
Communication and Consultation:					
Senior colleagues within the team					
Executive Summary:					

The report provides the annual infection prevention data for 2018/2019 providing assurance to the board on Health Care associated Infection (HCAI) and the trust remains compliant with Health and Social Care Act 2018

The report will be supported by a presented highlighting the contents for 18/19 but a clear focus on the programme of work for 19/20.

Key Recommendation(s):

The Committee is asked to note the report and approve

NHS
Brighton and Sussex University Hospitals
NHS Trust

Brighton & Sussex University Hospitals Infection Prevention Annual Report 2018/2019

1.0 Executive Summary

1.1 This is the report of the Director of Infection Prevention and Control (DIPC) and summarises the work undertaken in the organisation for the period 1 April 2018 to 31 March 2019.

1.2 There were two Trust cases of MRSA blood stream infection (BSI) against a trajectory of zero.

1.3 There were 47 cases of Trust apportioned *Clostridium difficile* infection (CDI) during this period against an objective of no more than 45 cases. Of these there 12 were deemed to have lapses in care by the executive led RCA panel. The main issues included delays in sampling, delays with source isolation and antimicrobial stewardship.

1.4 A Trust action plan for CDI was formulated, incorporating the associated learning opportunities, which was agreed at the Strategic Infection Prevention Committee (SIPC).

1.5 There were 23 cases of MSSA BSI during this period.

1.6 Gram negative organisms including Carbapenemase producing Enterobacteriaceae (CPE) are not increasing dramatically, however there is increased concern and vigilance due to outbreaks in the other healthcare facilities.

1.6 For the year 2018-19 the IPT has delivered a multi-disciplinary education and training program.

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

1.8 The Trust continues with the mandatory Public Health England orthopaedic surgical site surveillance and works closely with the Surgical Division on this and with feedback and dissemination of results.

1.9 *Pseudomonas* and Legionella in water continues to be monitored and managed and the Infection Prevention Team (IPT) has a good working relationship with the Facilities and Engineering staff.

2.0 Introduction

The purpose of the report is to reassure the patients, public, staff and Board of Directors, Governors that the system of Health Care Associated Infection (HCAI) management meets its obligations with regards to patient safety and clinical governance. It is also to reassure that best practice is followed as identified in the Hygiene Code and Care Quality Commission underpinning national and local guidance and provide assurance that the trust remains compliant with the Health and Social Care Act 2008: code if practice on the prevention and control of infections and related guidance (Department of Health 2015).

2.1 Infection Prevention Team and Governance Structure

2.1.1 The Director of Infection Prevention and Control (DIPC) is the Chief Nurse and the direct management of the team is via the Nurse Director for Workforce and Education.

The Infection Prevention Team (IPT) comprises (Appendix 1):

- 1 WTE Band 8C (Deputy Director of Infection and Control)
- 1 WTE Band 8a
- 2 WTE Band 7
- 2 WTE Band 6
- 2 WTE Band 5
- 1 WTE Band 4
- 1 WTE Band 3
- 1 WTE Band 2

2.1.2 The IPT provides a daily service Monday – Friday 08.00 – 17.00hrs, with out of hours service provided by the On-call Microbiologist.

2.1.3 There is approximately 2 PA of Infection Prevention Doctor (IPD) times, at present time support is provided by Consultant Infectious Diseases.

2.1.4 The Strategic Infection Prevention Committee (SIPC) meetings every quarter and is chaired by the DIPC (Appendix 2).

2.1.5 The Trust Infection Prevention Committee (TIPC) meets monthly for three in every quarter and is chaired, by the Nurse Director for Workforce and Education (Appendix 3).

2.1.6 The SIPC reports Quality Governance Steering group and to the Trust Board via the DIPC (Appendix 4).

2.1.7 Additional on-going infection prevention surveillance and support continues across the Trust, with daily team visits to high risk areas, this has been exceptionally challenging during 2018-19 due to staffing changes, long term sickness, winter pressure and control and declare of outbreaks.

2.1.8 The IPT continues to do a daily review of single rooms within the Trust, this work supports not only the Clinical Site Management Team but also the Clinical Teams with the best options for bed utilisation.

2.1.9 The IPT has communicated key messages via a number of media including attending senior meetings, posters, Trust news bulletins.

2.1.10 The IPT continues to work collaboratively with suppliers, Procurement, Facilities and Engineering teams to ensure that infection risks is considered and managed when commissioning works, new equipment or processes.

3.0 Summary of Infection Prevention performance 2018-19

3.1 Meticillin Resistance *Staphylococcus aureus* blood stream infection (BSI)

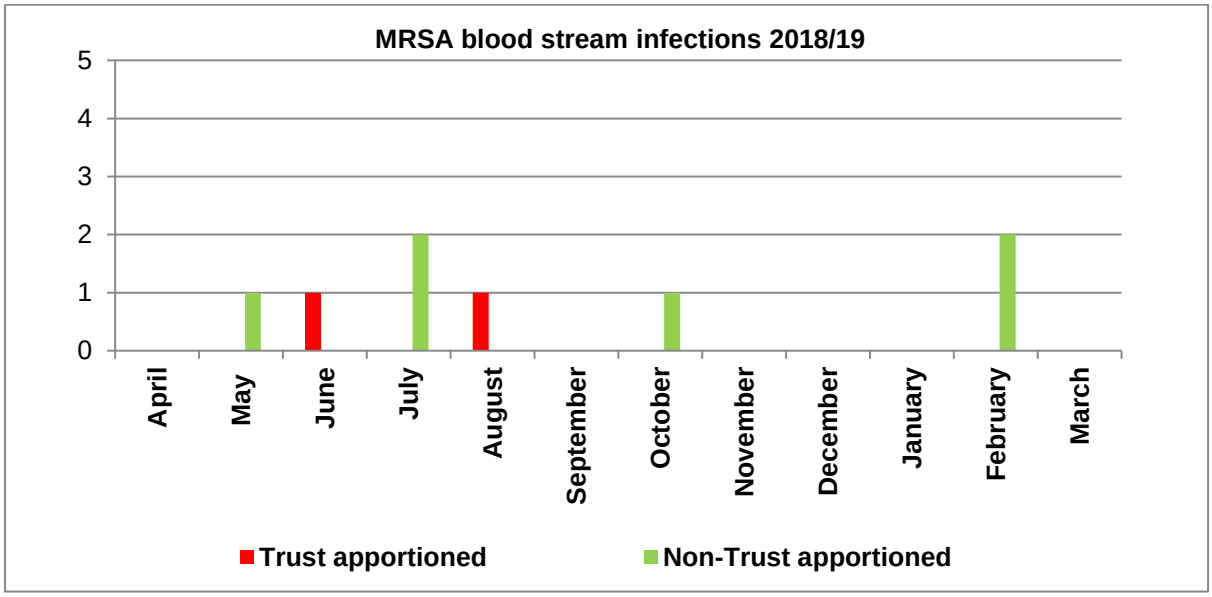
3.1.1 There were two cases of Trust apportioned Meticillin resistance *Staphylococcus aureus* (MRSA) blood stream infections (BSI) against a set objective of zero (Chart 1). There was a post infection review (PIR) held for each case.

3.1.1 There were six cases of Community apportioned MRSA BSI (Chart 1).

3.1.2 As mandated by Public Health England at that time, a post infection review (PIR) was undertaken for both cases. One case was transferred from overseas with venous access already established; MRSA positive on admission, and had a septic knee. Most probable source was the venous access. No lapses of care were identified. The second case, most probable source was connected to the individual drug recreation.

3.1.3 Education, training and support is ongoing with the aim to reduce infections associated with intravascular devices. The Infection Prevention Team (IPT) has provided training to 7436 members of staff.

Chart 1: Trust and Non-Trust apportioned MRSA BSI against a set objective of zero cases.



3.2 *Clostridioides (Clostridium) difficile* Infection (CDI)

3.2.1 There were 47 Trust apportioned cases of CDI against an objective of 45 (Chart 2).

3.2.2 There were 217 community apportioned cases during the same period, totalling 264 cases across the healthcare economy (Chart 3).

3.2.3 All Trust apportioned CDI cases had a root cause analysis (RCA) with sign off by the Clinical Commissioning Group (CCG) in line with NHSi guidance (2018). The CDI action plan for 2019/20 utilises learning from the RCA process and is monitored by the Trust Infection Prevention Committee (TIPC) to ensure representative Trust-wide involvement with shared learning.

3.2.3 All in-patients with CDI are followed up by the IPT. The IP team also undertook 164 CDI specific audits.

3.2.3 A CDI reduction action plan was developed and implemented, focusing on the previous year's lapses in care, with a multi-disciplinary approach, exploring the trends and potential learning opportunities to minimise risk to CDI. This was action plan was agreed at SIPC.

3.2.4 There were five periods of increased incidents (PIIs) declared, samples were forwarded to the PHE reference laboratory for ribotyping, which confirmed outbreak in three PPI's, there was insufficient sample to process in one PPI.

Table 1: Demonstrates the ribotyping for each declared PPI, and if these incidents remained a PPI or if they were escalated to an outbreak situation.

Area	Date	Ribotype	Status
Courtyard Building L8	May	078	Outbreak
		078	
Newhaven	July	002	PII
		014	
ITU	September	Insufficient	Inconclusive
		018	
Pyecombe	October	002	Outbreak
		002	
Ardingly	December	002	Outbreak
		002	
		002	

Chart 2: Trust apportioned *Clostridioides (Clostridium) difficile* infection against a set objective of <45 cases.

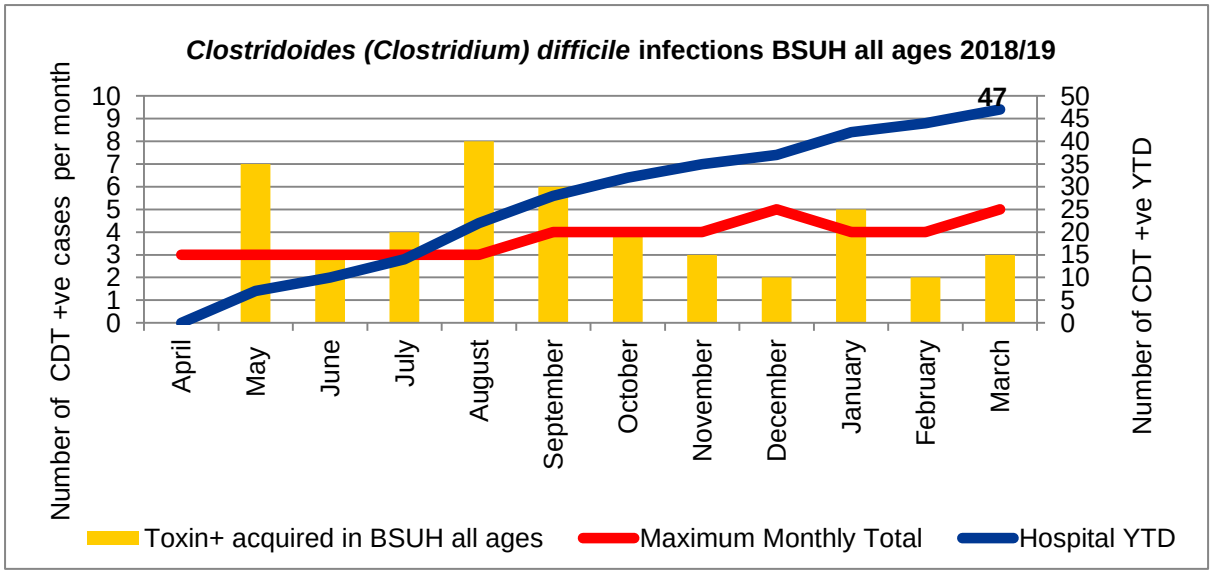
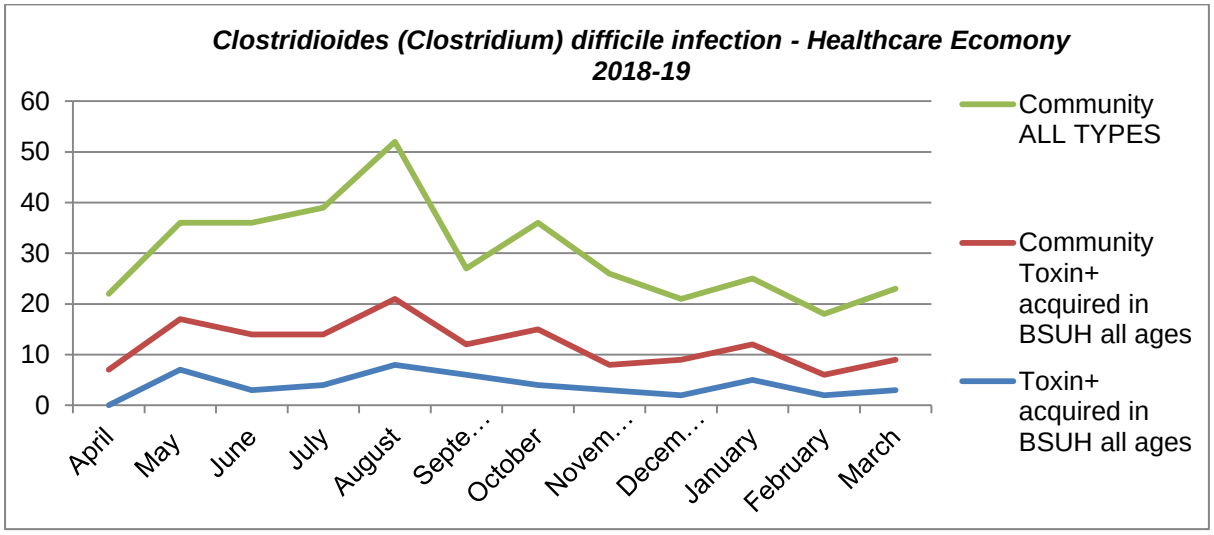


Chart 3: Health economy *Clostridioides (Clostridium) difficile* infection burden, including Trust apportioned, Non-Trust apportioned, GP and others.

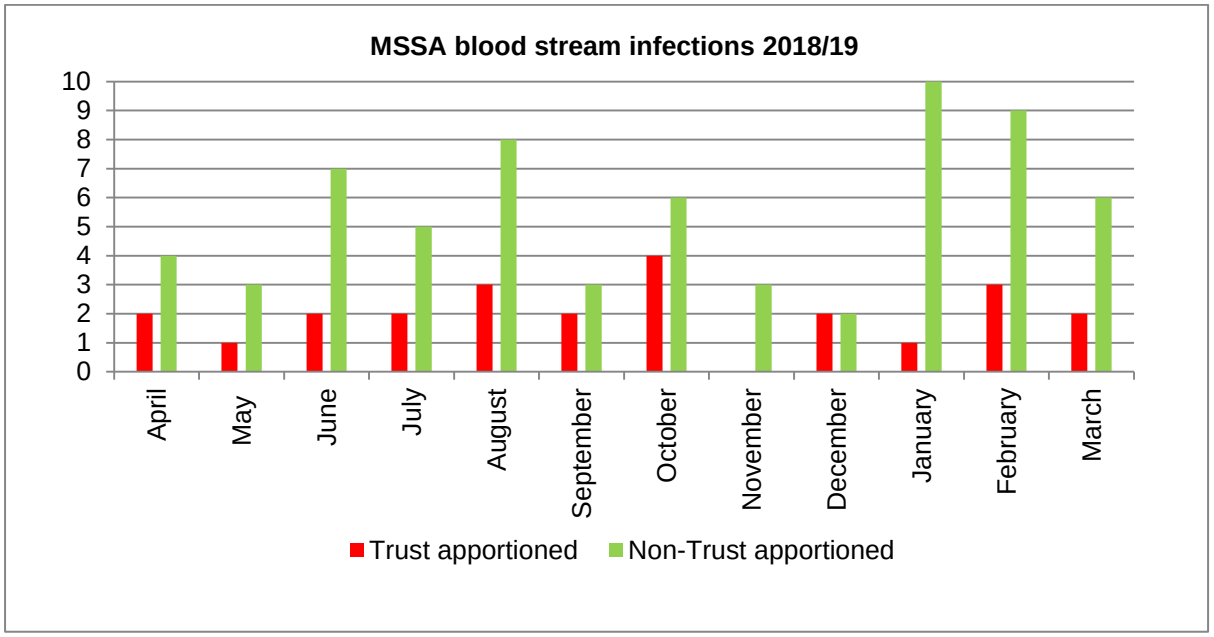


3.3 Meticillin sensitive *Staphylococcus aureus* (MSSA) blood stream infection

3.3.1 There is currently no nationally set objective for *Staphylococcus aureus* blood stream infection. The Trust reported 23 Trust apportioned cases (Chart 4).

3.3.2 The Trust reported 67 Community apportioned cases during 2017-18 (Chart 4).

Chart 4: Trust and Non-Trust apportioned MSSA BSI, no set reduction objective.



3.4 Gram negative blood stream infection

3.4.1 The Secretary of State for Health has launched an important ambition to reduce healthcare associated Gram-negative bloodstream infections by 50% by 2021 and reduce inappropriate antimicrobial prescribing by 50% by 2021.

3.4.2 Clinical commissioning groups (CCGs) are leading on achieving the Quality Premium (from April 2017, for two years). It has been acknowledged that this objective is more challenging than previous objectives as the probable causes are multi-faceted and interrelated.

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

3.4.4 Multi-resistant Gram negative organisms are also becoming an increasing problem, to date we have not seen any blood stream infections caused by Carbapenemase producing Enterobacteriaceae (CPE), although we are seeing positive sample screening results.

3.4.5 Patients who have received inpatient care aboard or outside our immediate region should be source isolated on admission and CPE screening carried out, this process will be emphasis during 2019-20.

***3.5 Escherichia coli* blood stream infections**

3.5.1 There were 41 *Escherichia coli (E. coli)* BSI Trust apportioned cases (Chart 5)

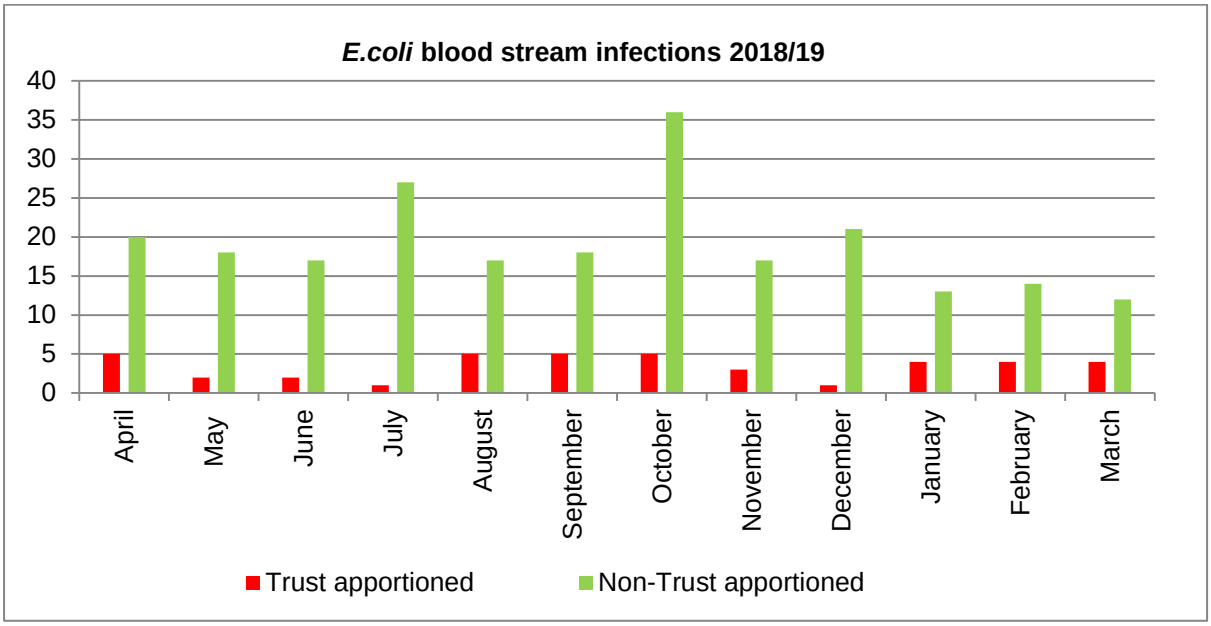
3.5.2 There were 230 *E. coli* BSI Community apportioned cases (Chart 5)

3.5.3 During 2018-19 there were 271 *E. coli* BSI across the healthcare economy.

3.5.4 The aim was to reduce *E. coli* BSIs by 10% across the healthcare economy; this was achieved with a 13.14% reduction.

3.5.5 Trust internal 10% reduction; this was achieved with a 35.93% reduction.

Chart 5: Trust and Non-Trust apportioned *E. coli* BSI, against a 10% reduction objective.



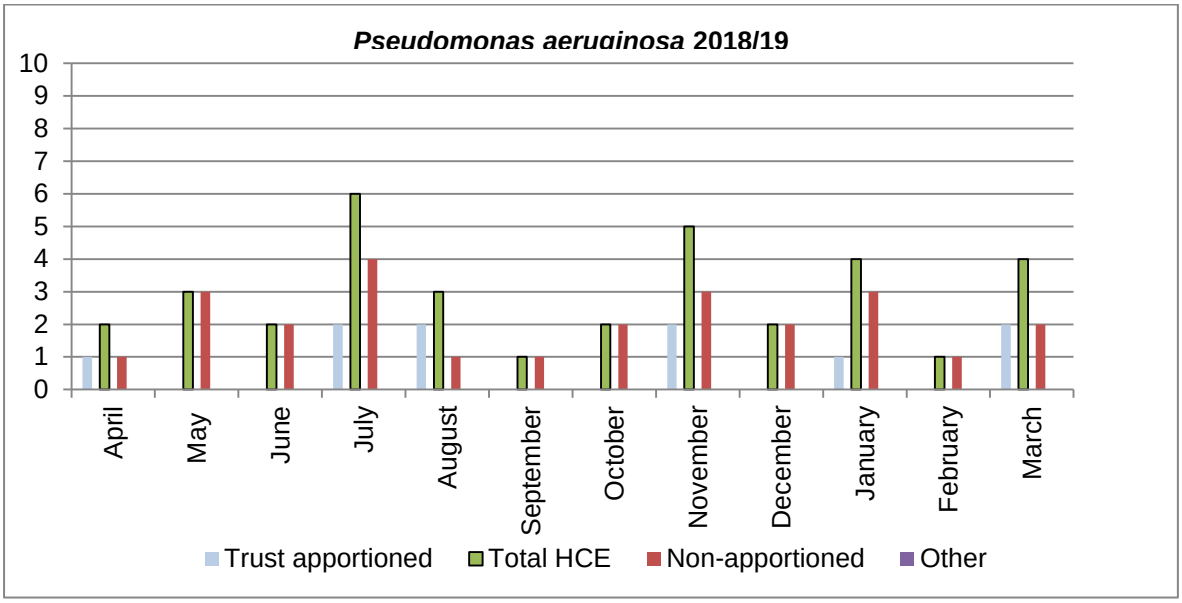
3.6 *Pseudomonas aeruginosa* blood stream infection

3.6.1 There were 10 *Pseudomonas aeruginosa* BSI Trust apportioned cases (Chart 6).

3.6.2 There were 25 *Pseudomonas aeruginosa* BSI Community apportioned cases (Chart 6).

3.6.3 This was an 11% increase to previous year.

Chart 6: *Pseudomonas aeruginosa* BSI across the healthcare economy.



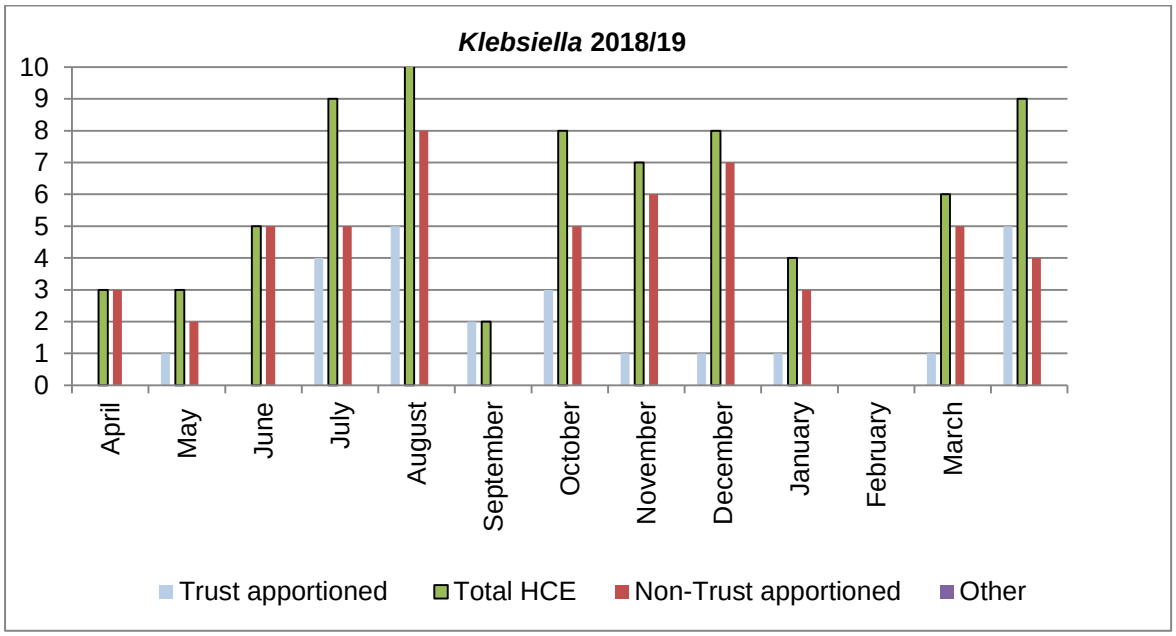
3.7 *Klebsiella* spp blood stream infection

3.7.1 There were 24 *Klebsiella* BSI Trust apportioned cases (Chart 7).

3.7.2 There were 53 *Klebsiella* spp BSI Community apportioned cases (Chart 7).

3.7.3 This is a 45.83% increase.

Chart 7: *Klebsiella* spp. BSI across the healthcare economy.



3.8 Surgical Site Infection Surveillance

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

3.8.2 The Trust submitted data for Total Knee Replacement (TKR) surgery for Quarter 1, 2 and 3 (April-December 2018).

3.8.3 Due to reduced resources within the IPT Quarter 4 (January-March 2019) TKR surveillance was not undertaken (Table 1).

Table 2: Number of operations with rates of surgical site infection by selected period (Jul-Sep 2018) and the last 4 periods for which data are available (Jul-Sep 2018, Apr-Jun 2018, Jan-Mar 2018, Oct-Dec 2016).

Operations & surgical site infections		Your hospital	
		Selected period	Last 4 periods
Operations	Total no.	73	403
	No. with PQ given	0	0
	% PQ completed	0.0%	0.0%
Surgical Site Infection	No. inpatient/readmission	0	4
	% infected	0.0%	1.0%
	No. post-discharge confirmed	1	1
	% infected	1.4%	0.2%
	No. patient reported	0	0
	% infected	0.0%	0.0%
	All SSI	1	5
	% infected	1.4%	1.2%

3.9 Surveillance of influenza

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

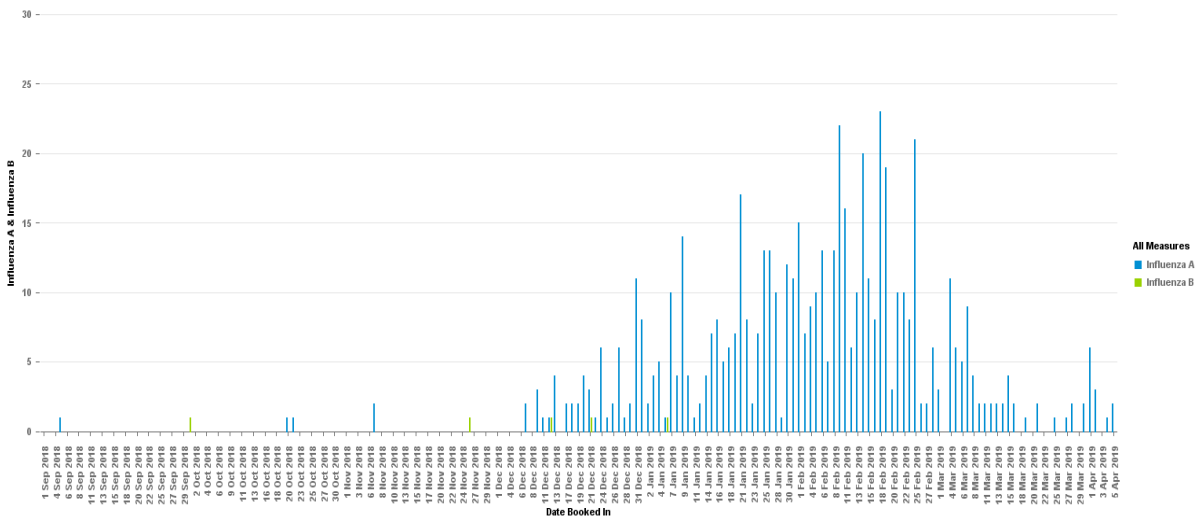
3.9.2 The Trust reports all positive cases identified in the Microbiological Laboratory to the national database.

3.9.3 There were 5 positive Influenza B across the Healthcare Economy reported (Chart 8).

3.9.4 There were 577 positive Influenza A across the Healthcare Economy reported; (Chart 8).

3.9.5 As expected influenza activity increased during January and February 2019, with influenza A viruses accounting for the majority of influenza detection, this reflected the national picture. There was not a significant impact on clinical operations, with very few bed closures due to influenza.

Chart 8: Combined positive Influenza A and Influenza B cases reported, across the healthcare economy.



3.10 Serious incident reporting

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

3.10.2 During the period 2018/19 the Trust reported no incidents within this framework.

3.11. Tuberculosis outbreak

3.11.1 February 2018 the IPT were notified of a positive Tuberculosis (TB) case, the case had been symptomatic since August 2017, it was establish that this case was linked to two further TB cases (Beijing strain).

3.11.2 An outbreak was declared, control measures and contact tracing implemented and a serious incident investigation was undertaken.

3.11.3 Extensive screening was undertaken for social, household and healthcare professionals. Latent TB was identified in a number of cases and appropriate treatment provided by the TB Team; it is not possible to say with certainty that the latent TB was a direct result of being a contact of the positive cases.

3.11.4 Although it is not possible to prevent TB entering a healthcare facility, measures have been implemented to reduce this risk, including the TB pathway.

3.11.5 Specific wards which have single room capacity have been identified on both sites, were suspected or known cases will be admitted.

3.11.6 No further active cases of TB linked to this outbreak were identified; the outbreak was closed April 2019.

3.12 Viral diarrhoea outbreaks

3.12.1 There were 17 bay/ward closures due to gastroenteritis during 2018-19 (Table 2).

3.12.2 The use of standard infection control precautions with the addition of transmission-based precautions were implemented in line with the Trust policy and national guidance on the management of viral diarrhoeal outbreaks. All outbreaks were extremely well managed and resolved quickly, causing no operational impacts – a big improvement on the previous year.

3.12.3 Management of gastroenteritis is a challenge with current estate, especially the Barry building with lower ratios of single rooms. However, this will be mitigated when a new building of the hospital opens in 2020.

Table 3: Clinical areas involved in viral outbreaks, the number of patients and staff affected as well as the number of bed lost days (shaded areas confirmed Norovirus by microbiological testing)

Ward Name	Date outbreak started	Date Ward/ Bay Closed	Date Ward/ Bay Opened	No. Patients Affected	Total number of bed days lost	No Staff Affected
Sussex House Nursery	17/04/2018			11	n/a	2
Level 8 Tower (Bay 3)	22/05/2018	25/05/2018	27/05/2018	4	0	0
Chichester (Bay)	26/07/2018	27/07/2018	28/07/2018	3	3	0
Twineham (Bay 5)	08/07/2018	09/07/2018	11/07/2018	3	5	0
Level 8 Tower (Bay 2)	12/08/2018	12/08/2018	15/08/2018	3	0	0

AAU (Bay A)	11/10/2018	11/10/2018	16/10/2018	5	2	1
Vallance Ward	03/11/2018	04/11/2018	09/11/2018	12	2	1
Level 8 A East	18/11/2018	19/11/2018	27/11/2018	8	8	2
Hurstpierpoint / Poynings	08/11/2018	08/11/2018	16/11/2018	12	3	4
Hurstpierpoint / Poynings	29/11/2018	30/11/2018	10/11/2018	12	6	3
Ardingly Ward (Bay 5)	14/12/2018	14/12/2018	21/12/2018	7	3	1
Clayton Ward (Bay 2)	01/01/2019	01/01/2019	09/01/2019	6	7	2
Ardingly Ward (Bay 6)	09/02/2019	10/02/2019	? 12/02/2019	5	3	0
AAU (Bay D)	16/02/2019	16/02/2019	19/02/2019	3	0	0
Poynings (Bay 5)	24/02/2019	26/02/2019	04/03/2019	3	0	0
Poynings /HPP Ward	27/02/2019	27/02/2019	04/03/2019	9	13	2
Level 8 Tower bay 3	23/03/2019	25/03/2019	27/03/2019	3	0	0

3.13 Contact tracing

3.13.1 Is the process of identification of individuals who may have come into contact with an infected person and subsequent collection of further information about these contacts .

3.13.2 Contact tracing was undertaken for tuberculosis, measles, pertussis, chickenpox and invasive Group A *Streptococcus.*

3.14 Training and Education

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

3.14.2 For the year 2018-19 the IPT has delivered a multi-disciplinary education and training program, which has also incorporated volunteers, students, and patients.

3.14.3 The IPT has provided 94 face to face sessions for clinical mandatory / induction training, which was attended by 4739 members of staff.

3.14.4 The IPT has provided 97 face to face sessions for non-clinical mandatory / induction training, which was attended by 2530 members of staff.

3.14.5 Infection prevention mandatory training for clinical and non-clinical is also available via eLearning, 167 members of staff accessed these

3.14.6 In January 2019 the IPT implemented a Fit Test Operator training course, for staff undertaking Fit Testing for FFP 3 respiratory, a total of 48 members of staff have received this training.

3.14.7 The IPT have provided four Infection Prevention Link study days during the year, a total of 97 members of staff attended.

3.14.8 The IPT has managed to sustain educational activity throughout the year.

3.15 Infection prevention compliance – hand hygiene

3.15.1 The emphasis on carrying out hand hygiene at the 'point of care' through the '5 moments' is well implemented within the Trust.

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

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

3.16 Infection prevention compliance - audits

3.16.1 Trust annual IP audit programme is followed, with individual wards IP Links and the IPT undertaking clinical infection prevention audits.

3.16.2 There have been significant examples of good practice observed during the reviews, with the majority of clinical and non-clinical staff adhering to Trust policy.

3.16.3 Some findings addressed have included: poor adherence to the WHO '5 moments', bare below the elbow, inappropriate use of PPE and poor decontamination of nursing/medical equipment. All audits have prompted action and resolution.

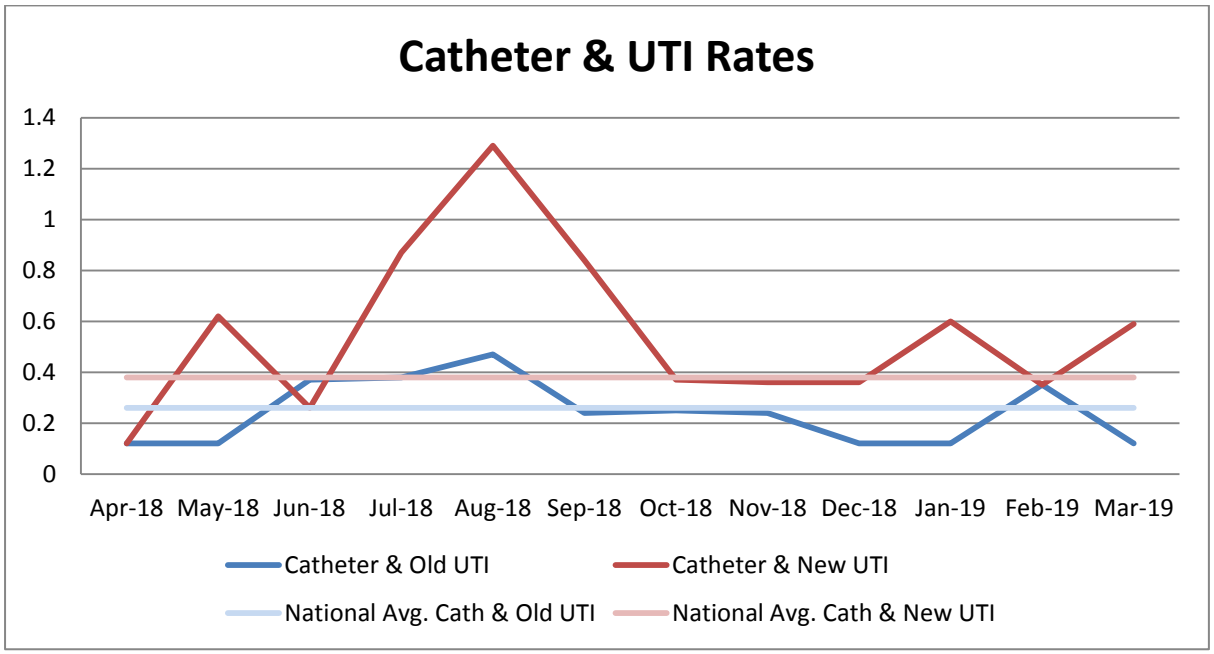
3.16.4 The IPT undertook 164 CDI specific audits, these can help or change practice within the clinical environment. These have been utilise to investigate any highlighted concerns and are a useful tool to re-audit after a poor audit outcome. Deficits highlighted by the audits. Feedback, training and best practice advice is given to staff during the review.

3.16.5 Some findings addressed have included: poor adherence to correct waste steam, incorrect source isolation signage displayed, inappropriate and incorrect use of FFP3 respirator.

3.17 Safety thermometer audit

3.17.1 The main urinary catheter audits are undertaken as part of the monthly Safety Thermometer data, collection and provide reassurance regarding documentation and standards of catheter care. Whilst this is no longer part of a CQUIN, the IPT validate the clinical Catheter associated urine tract infection (CA-UTI) data for the Royal Sussex County Hospital. The data for Safety Thermometer data versus the national data is presented in Chart 9.

Chart 9: National data v BSUH data



3.18 Technical cleaning audit

3.18.1 In addition to the routine cleaning schedule ward single rooms and bays are deep cleaned (now referred to as a Red clean) when a patient who poses an infection risk has been moved from a bed space or is discharged or following an outbreak, these is undertaken prior to another patient being allocated that bed space. An annual deep clean programme has been implemented. These are both audited routinely by Soft Facilities and by the IPT during outbreaks.

3.19 Antimicrobial Stewardship

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

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

3.19.3 The Antimicrobial Stewardship Committee meet monthly and reports to the monthly TIPC with assurance every three months to the SIPC chaired by the Director of Infection Prevention and Control (DIPC).

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

3.19.5 The pharmacy department undertake specific antimicrobial audits and the wards based metrics have been revised to include antimicrobial prescribing related audits.

3.19.6 The National Antimicrobial Resistance and Sepsis CQUIN for 2017-19 is an opportunity to further the Antimicrobial Stewardship agenda and contribute to better patient outcomes (Appendix 3).

3.20 Engineering

3.20.1 The IPT continued to support and provide advice to numerous schemes to improve the practices of maintenance a monitoring both the ventilation and water systems.

3.20.2 The 2018-19 programs in place for annual verification of critical ventilation areas have been completed and a number of remedial actions completed. The program is overseen and reports reviewed by the Ventilation Group.

3.20.3 The 2019-20 program commenced at the beginning of May 2019, the programme of verifications is to be extended to all critical vent systems (previously focussed on Theatres only).

3.20.4 The Trust uses in excess of 250.000m^3 of water during the course of a normal year, which is provided the local water authority. The water systems and functions on site range from the provision of portable water supplies, tank water supplies and specialist 'treated' water supplies providing for process plant and medical equipment.

3.20.5 Water safety is managed through the Water Safety Group (WSG), which meets on a monthly basis, and is chaired by an Estates manager with representatives from IP and contractor services attending the meetings. Appendix 2 shows the governance arrangements.

3.20.6 All systems continue to be tested, monitored and reported on in liaison with the IPT. The remedial works have been acted on quickly from notification, with excellent communication and cooperation with the end users.

3.20.7 The annual review from the Authorising Engineer (AE(W)), identified a number of shortcoming particularly in relation to on-going testing regimes and practices.

3.20.8 The WSG has taken forward actions and have spent a significant proportion of its time in managing the on-going testing programme and remedial actions as well as looking to update procedures. A new HTM compliant testing regime has been approved by the WSG for implementation across the Trust.

3.20.9 Key deliverables include in-situ disinfection systems which are routinely used with the Trust to resolve 'hot spot' issues, use of new technologies to improve flushing processes and practices and to confirm the performance of associated distribution systems, a number of domestic circulation pumps have been replaced to enhance system performance.

3.20.10 Princess Royal Hospital site has migrated to thermal disinfection as the primary means to manage water borne pathogens.

3.20.11 A dynamic daily flushing report is generated and actioned for all underutilised outlets where the new monitoring technology has been implemented.

3.20.12 There is currently an on-going programme of updating the water risk assessments this is aiming to be complete before the end of July 2019.

3.20.13 Daily safety huddles have been implemented this includes safety related issues associated with water the distribution systems.

3.20.14 All known dead legs identified and logged within the FSI system have been removed from the Trust water distribution systems.

3.21 Facilities

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

3.21.2 Cleaning of all Trust premises is provided through a combination of in-house services and service level agreements with neighbouring Trusts, which are managed and monitored by the Trust Facilities and Engineering team.

3.21.3 Directly manages the patient catering, retail catering, porter, security and help desk teams across the main two hospital sites.

3.21.4 The Waste Management, Linen and Laundry contracts have recently been retendered.

3.21.5 Soft FM and a team of independent Monitoring Officers support the monitoring cleaning standards, with the plan to roll out Synbiotix monitoring tool in Quarter 3 of 2018-19.

3.21.6 Periodic deep clean programme was re-launched via the publication of a Standard Work Instruction, outlining the collaborative approach required for timely, effective and efficient periodic deep cleaning.

3.21.7 A dedicated team of housekeeping staff have been recruited and trained to deliver the periodic deep clean programme and to operate specialist equipment as required.

3.21.8 External PLACE assessment were completed during Quarter 1.

3.21.9 Patient catering is provided in-house, the Royal Sussex County service was upgraded to a 4* Hygiene rating by the local authority Environmental Health service. Princess Royal Hospital holds a 5* rating, which is the maximum achievable score.

3.21.10 External consultants were appointed to conduct independent audits and provide an objective measure of whether food safety standards were being met by the Trust.

3.21.11 Overall food safety and hygiene standards were found to be good with appropriate management controls in place, in particular it was noted that HACCP based food safety management system has been developed and a structured staff training plan was in place.

3.22 Decontamination

3.22.1 The IPT attend the monthly decontamination group that reports to the monthly TIPC.

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

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

3.22.4 The Endoscope Decontamination Units (EDU) are also working within ISO 13485:2012 and are JAG registered for bowel screening.

3.22.5 Audits of SSD's and EDU's are carried out on a regular basis by an external notified body on behalf of the MHRA. The SSD also had an unannounced audit by the notified body, which is a requirement (within a 3 year period).

3.22.5 The SSD at RSCH has recently installed and commissioned a new Reverse Osmosis (Water treatment) Plant, serving the washer disinfectors within SSD and EDU, as well as the steam generators, which ensures clean steam for sterilisation.

Appendix 1: Infection Prevention Team Structure

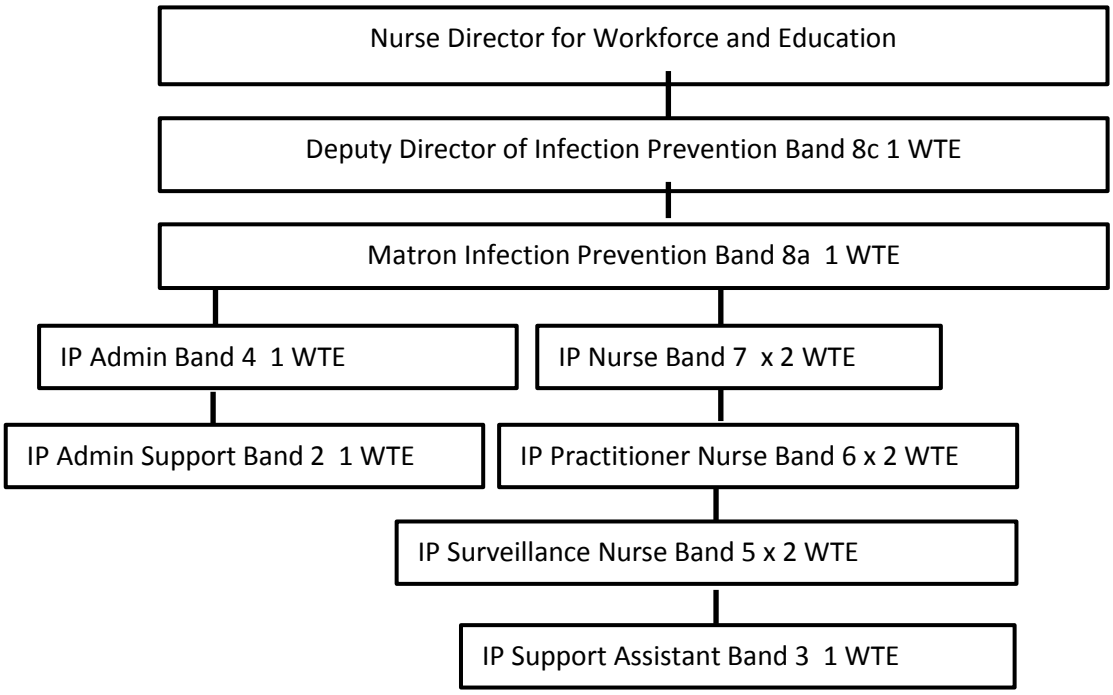
The infection prevention service is delivered and facilitated by a specialist infection prevention team, which works collaboratively with Trust staff and the Director of Infection Prevention and Control (DIPC), as well as strong working links with the Trust senior nurse managers, facilities and engineering. The DIPC reports directly to the Chief Executive for matters relating to infection prevention.

The Trust is in the process of building a new wing to the hospital that requires consistent input from the IP team from the point it was conceived up until the day it has patients in it. Therefore the current structure is dynamic and likely to change dependant on Trust activity and availability of expertise. The following flowchart (Appendix 1) details the current structure of the IP services and the governance structure (Appendix 4) details how the IP team interfaces at multiple levels within the Trust.

- The IPT reports directly to the Nurse Director Workforce and Education, who reports directly to the DIPC, who is the directly accountable to the Chief Executive and has an overarching responsibility for the strategy, policies, implementation and performance relating to infection prevention. The DIPC attends the Trust Board and chairs the SIPC
- The IPT is responsible for ensuring that a coordinated programme of work is agreed at committee and implemented annually
- The microbiology and virology laboratory services are provided on-site
- The core infection prevention service includes an infection control advisory service, proactive infection prevention work and education and training throughout the organisation. It also undertakes audit, policy formulation and advice, surveillance and epidemiology, outbreak and control management. A significant aspect of their work is advising on planning
- An advisory service is operated daily by the Infection Prevention Team and out of hours via the on-call Microbiologist Team
- There is a daily brief to review clinical information and service responses
- The TIPC is a multidisciplinary Trust committee which meets monthly, and is chaired by a Director.
- Every third month is the SIPC. This is a multidisciplinary Trust committee, which ensures that there are effective systems in place to reduce the risk of infection and where infection does occur to minimise its impact on patients, visitors and staff. The committee reports to the monthly Patient Safety Group.
- The IPT work closely with the CCG and PHE and other stakeholders

- The IP Link Representatives/Nurses meet every quarter for training updates, and infection prevention news

IP Structure 18/19



Appendix 2: Terms of Reference Strategic Infection Prevention Committee

Title:	**Strategic Infection Prevention Committee (Quarterly)**
Date approved and approving body:	Reviewed at the 31st August 2018 meeting of the Strategic Infection Prevention Committee (SIPC) and ratified by the Quality Governance Steering Group (QGSC) on XXXX 2018. These Terms of Reference (TOR) have been developed in line with the other quality assurance groups, reporting to the QGSG.
Constitution and establishment:	The SIPC has been constituted under the authority of the Board reporting to the Quality Assurance Group (QAG). Patient Safety Group, which in turn reports directly to the QGSC and Trust Executive Committee (TEC).
Accountability:	The SIPC is accountable to the QAG Patient Safety Group, which is accountable to the QGSG, which is accountable to the TEC, a sub-group of the Board.
Purpose:	1. Maintain an overview of infection prevention priorities within the Trust, and to link this into the clinical governance and risk management processes 2. Strengthening the performance management of Healthcare Associated Infections (HCAI's) and cleanliness across the whole Trust 3. To provide assurance to the Board of Directors that policy, process and operational delivery of infection prevention results in improved patient outcomes 4. Making recommendations, as appropriate on infection prevention matters to the Board of Directors 5. To assess and identify risks within infection prevention portfolio and escalate this as appropriate 6. To ensure that infection prevention issues are appropriately managed within the Trust

Membership:

Chief Nurse/Director of Infection Prevention and Control	Chair	Nicola Ranger
Medical Director	Deputy Chair	Rob Haigh
Consultant Microbiologist	Member	Dr Sally Curtis
Consultant Microbiologist	Member	Dr Sunil Sharma
Directorate Lead Nurse for Surgery	Member	Jim Valentine
Directorate Lead Nurse for Medicine	Member	Ann Gibbins
Infection Prevention Doctor	Member	Dr Catherin Sargent
Nurse Director	Member	Caroline Davies
Occupational Health	Member	Jane Kemp
Occupational Health	Member	Sarah Zahopoulos
Antimicrobial Pharmacist	Member	Samantha Lippett
Antimicrobial Pharmacist	Member	Vikesh Gudka
Associate Director of Engineering Assurance	Member	TBC
Associate Director of Quality	Member	Elma Still

Consultant ITU	Member	Dr Claire Philips	
Consultant Lead for Surgery	Member	TBC	
Consultant Lead for Children	Member	TBC	
Consultant Lead for Specialist	Member	TBC	
Consultant Lead for Medicine	Member	TBC	
Consultant Lead for Women	Member	TBC	
Decontamination Operational Lead	Member	Peter Brown	
Deputy Director of Infection Prevention (DDIPC)/Nurse Consultant	Member		
Director of Facilities and Engineering	Member	Philip Holmes	
Directorate Lead Nurse for Specialist	Member	Kimberly O'Hara	
Directorate Lead Nurse for Children	Member	Lorraine Tinker	
Directorate Lead Nurse for Women	Member	Amanda Clifton	
Emergency Resilience Lead	Member	McGovern, Jane	
Emergency Resilience Manager	Member	Lentner, Natasza	
Head of Professions, CCS division	Member	Saffron Mawby	
Head of Risk and Health and Safety	Member	Lyn Allison	
Infection Prevention Matron	Member	Martin Still	
Infection Prevention Nurse	Member	Andrew Davies	
Infection Prevention Nurse	Member	Edwina Montecillo	
Infectious Diseases	Member	Dr Joanne Peters	
Infectious Diseases	Member	Dr Martin Llewelyn	
Lead Nurse for IV/OPAT	Member	Geraldine O'Sullivan	
Lead Nurse for Sepsis	Member	Johanna Kelly	
Lead Nurse for Urology	Member	Sally Goodman	
Non-Executive Director	Member	TBC	
Nurse Director for Workforce and Education	Member	Clare Williams	
Pathology Lead	Member	Dr Mohammed Osman Hassan Ibrahim	
Representative from CCG	Member	Amy Ellison	
Representative from Public Health England	Member	Rachel Cloke	

	Representative from Public Health England	Member	Tracy Wood
	Risk Management	Member	Dominic Desouza-Campbell
		Member	Simon Maurice
		Member	Sarah Doffman
		Member	Naomi Eglington
		Member	Marco Maccario
		Member	Ryan Watkins
		Member	Carly Knell
		Member	Dominic Clarke
		Member	Lisa Leonard
		Member	Amanda Hallums
		Member	Jonathan Richenberg
		Member	Ian Wilson
		Member	Holly Kitching

In exceptional circumstances, and subject to the approval of the Chair in advance of the meeting:

- If the Chief Nurse and the Nurse Director are not available, the Chief Nurse can nominate a member of the committee to deputies as Chair for the specific meeting

The Chair of the Committee may also extend invitations to other personnel with relevant skills, experience or expertise as necessary to deal with the business on the agenda. Such personnel will be in attendances only

Communication:	A notice of each meeting, including an agenda and supporting papers, will be available for each member of the SIPC one week prior to the date of the meeting. Additional agenda items should be submitted to the Chair at least two weeks prior to the date of the meeting. A forward planner for the group will be made available, and reviewed annually.
Quorum:	A quorum of members must be present for the meeting to proceed, and should consist of: • Chief Nurse/DIPCC (Chair) / Medical Director (Deputy chair) • An Executive Director • Infection Prevention Doctor/Consultant Microbiologist/Infectious Disease Consultant • DDIPC/Matron for Infection Prevention • Pharmacy representative or a Consultant Microbiologist who can report on antimicrobial prescribing • Consultant Lead from at least three Division • Head of Nurses from at least three Divisions • A nursing representative from at least three Divisions • Facilities and Engineering representative Deputies will count towards the quorum.

Frequency of meetings:	Meetings of the group will be held quarterly (May, August, November and February). Extraordinary meetings may also be scheduled to expedite action in respect of any urgent issues arising in the interim period.
Agenda and notes/action points:	The Group shall be supported administratively by the Infection Prevention Team/Administrator. In this respect, support will include: • The agreement of the agenda with the Chair, collation of relevant papers, taking and disseminating the minutes, and keeping a record of matters arising and issues to be carried forward • Ensuring the TOR's are reviewed on an annual basis • Ensuring that the group reviews the effectiveness of its reporting sub-groups on an annual basis in terms of evaluating their role in continuing to monitor and further improve clinical outcomes and effectiveness
Attendance at meetings:	Members are expected to attend all meetings of the SIPC. Members unable to attend **must** send a deputy who is briefed and who will count towards the quorum. If a member sends a deputy for any three meetings within a year, the Chair should discuss the member's ability to remain part of the group. One representative from each division must be in attendance at the meeting of the group.
Duties:	In particular the Committee will provide assurance, raise concerns (if appropriate) and make recommendations to the Board of Directors in respect of: 1. Advise the Chief Executive Officer (CEO) and the Trust Board on all aspect of infection prevention 2. Provide assurance that the environment within the Trust is safe for patients, visitors and staff in terms of infection prevention 3. Deliver a robust assurance program that holds Division's to account and provide feedback to the Board of Directors 4. Provide assurance that all appropriate measures are being taken to assist the Trust with achievement of national and local infection prevention and control targets/trajectories 5. Escalate any concerns, together with recommendations for action, to the relevant stakeholder. In the event of exceptional occurrences raised, this group escalated them according to the Trusts escalation policy 6. Quarterly DIPC report to the Trust Board, and annual report 7. Monitoring exceptions in the annual infection prevention program of work. Agree the previous years, and endorse the new year program of work 8. Monitor by exception Trust delivery plans to deliver targeted reduction and sustainable improvement of HCAI's and cleanliness 9. Review and monitor Trust HCAI's Key Performance Indicators (KPI's) and compliance data 10. Receive reports from the Trust Infection Prevention Committee (TIPC), including Trust surveillance and compliance, to ensure any themes/trends, non-compliance are identified and resolved. All appropriate advice, guidance or support is offered 11. Receiving information about national strategy and discuss how this will impact on the Trust and be operationalised 12. Derive assurance that infection prevention strategy and performance is being delivered at the point of care, receive and discuss reports on infection prevention issues from the Heads of Nursing (per Divisions) 13. Derive assurance that infection prevention strategy and performance is being delivered across Facilities and Engineering, receive and discuss reports on infection prevention issues from the Director/Deputy Director of Facilities and Engineering 14. Monitor the Corporate Risk Register (CRR) and ensure that risks that could impact on the ability of the Trust to achieve its key objectives are identified and escalated to the

	QGSG for inclusion on the Board Assurance Framework (BAF). 15. Support compliance with reviewing and updating policies, guidelines, standard operating procedures when due for renewal, and to escalate to the TSE any issues identified with ensuring all policies are current and up to date. To recommend the approval of relevant policies in line with policy authorisation delegation 16. Discuss and endorse a plan for the management of outbreaks in the Trust and to monitor its implementation and outcomes 17. Discuss and advice on the most effective use of resources available for implementation of the infection prevention program of work and for contingency requirement 18. Ensure the IPT and all involved in Capital Planning and sign off all capital schemes 19. Approve its sub-groups' Terms of Reference and membership, and oversee the work of those sub-groups, receiving exception reports from them, evaluate the role of the sub-groups in continuing to monitor and improve risk management and compliance. To be assured of the on-going usefulness and role of any sub-group, with the aim of minimising the number of separate groups regularly meeting and their added value 20. Work co-operatively with Public Health England (PHE) and the CCG to achieve reduction across the whole healthcare economy through support of initiatives on antimicrobial prescribing, management of patients in the community and joint performance reviews of patients diagnosed with MRSA blood stream infections
Sub-groups:	The following groups are sub- groups of the SIPC, which will maintain oversight of their activities through the receipt of a report, in line with the annual cycle of business for the group: • Decontamination Group • Water Safety Group • Antimicrobial Stewardship • Trust Infection Prevention Committee
Reporting responsibilities:	A summary report of the SIPC meeting should be submitted as an agenda item for information to the Trust's QAG Patient Safety Group, advising the group with regards to achievements, exceptions themes and trends associated with infection prevention (control) management and compliance. **The group Chair will produce an annual report to the Trust Board (Code of Practice requirement). In compiling this, the Chair should have reviewed the effectiveness of their reporting sub-groups in terms of** evaluating their role in continuing to monitor and further improve infection prevention management and compliance, and **providing the QAG Patient Safety Group with delivery of the annual cycle of business.**
Review:	Terms of Reference are due for review in September 2019.

Appendix 3: Terms of Reference for Trust Infection Prevention Committee

Title:	**Infection Prevention Operational Group (Monthly)**
Date approved and approving body:	Reviewed at the 31st August 2018 meeting of the Trust Infection Prevention Committee (TIPC) and ratified by the Quality Governance Steering Group (QGSC) on XXXX 2018. These Terms of Reference (TOR) have been developed in line with the other quality assurance groups, reporting to the QGSG.
Constitution and establishment:	The TIPC has been constituted under the authority of the Board reporting to the Strategic Infection Prevention Committee (SIPC) which in turns reports directly to the Quality Assurance Group (QAG) Patient Safety Group, which in turn reports directly to the QGSC and Trust Executive Committee (TEC).
Accountability:	The TIPC is accountable to the IPC, which is accountable to the QAG Patient Safety Group, which is accountable to the QGSG, which is accountable to the TEC, a sub-group of the Board.
Purpose:	7. Focus on progress against the Corporate Healthcare Associated Infection action plan 8. Ensure that the Infection Prevention (IP) annual program is disseminated to the Divisions and actions monitored through the various Governance meetings 9. Monitor infection prevention standards against the Trust infection prevention key performance indicators
Membership:	

Deputy Director of Infection Prevention (DDIPC)/Nurse Consultant	Chair	
Nurse Director for Workforce and Education	Deputy Chair	Clare Williams
Directorate Lead Nurse	Member	Amanda Clifton
Infection Prevention Nurse	Member	Andrew Davies
Directorate Lead Nurse	Member	Angela Jenkinson
Directorate Lead Nurse	Member	Angela Myerson
Nurse Director	Member	Caroline Davies
Facilities and Engineering	Member	Christina Connolly
Directorate Lead Nurse	Member	Cristina Osorio
Infection Prevention Doctor	Member	Dr Catherin Sargent
IP Lead Consultant in ICU	Member	Dr Claire Phillips
Infection Prevention Nurse	Member	Edwina Montecillo
Directorate Lead Nurse	Member	Holly Kitching
Facilities and Engineering	Member	Huw Wooldridge
Directorate Lead Nurse	Member	Joseph Threlfall

	Directorate Lead Nurse	Member	Josephine Kerr
	Facilities and Engineering	Member	Karon Goodman
	Directorate Lead Nurse	Member	Leigh Harvey
	Directorate Lead Nurse	Member	Margaret Flynn
	Infection Prevention Matron	Member	Martin Still
	Facilities and Engineering	Member	Louise Clark
	Decontamination Operational Lead	Member	Peter Brown
	Antimicrobial Pharmacist	Member	Samantha Lippett
	Facilities and Engineering	Member	Terece Walters
	Deputy Director of Facilities and Estates	Member	William Haynes
	Sepsis Clinical Nurse Specialist	Member	Johanna Kelly
	Risk Management Safer Sharps	Member	Dominic Desouza-Campbell
	Matron	Member	Natalie Pearson

In exceptional circumstances, and subject to the approval of the Chair in advance of the meeting:

- If the DDPIC and the Nurse Director for Workforce and Education are not available, the DDIPC will nominate a member of the group to deputies as Chair for the specific meeting

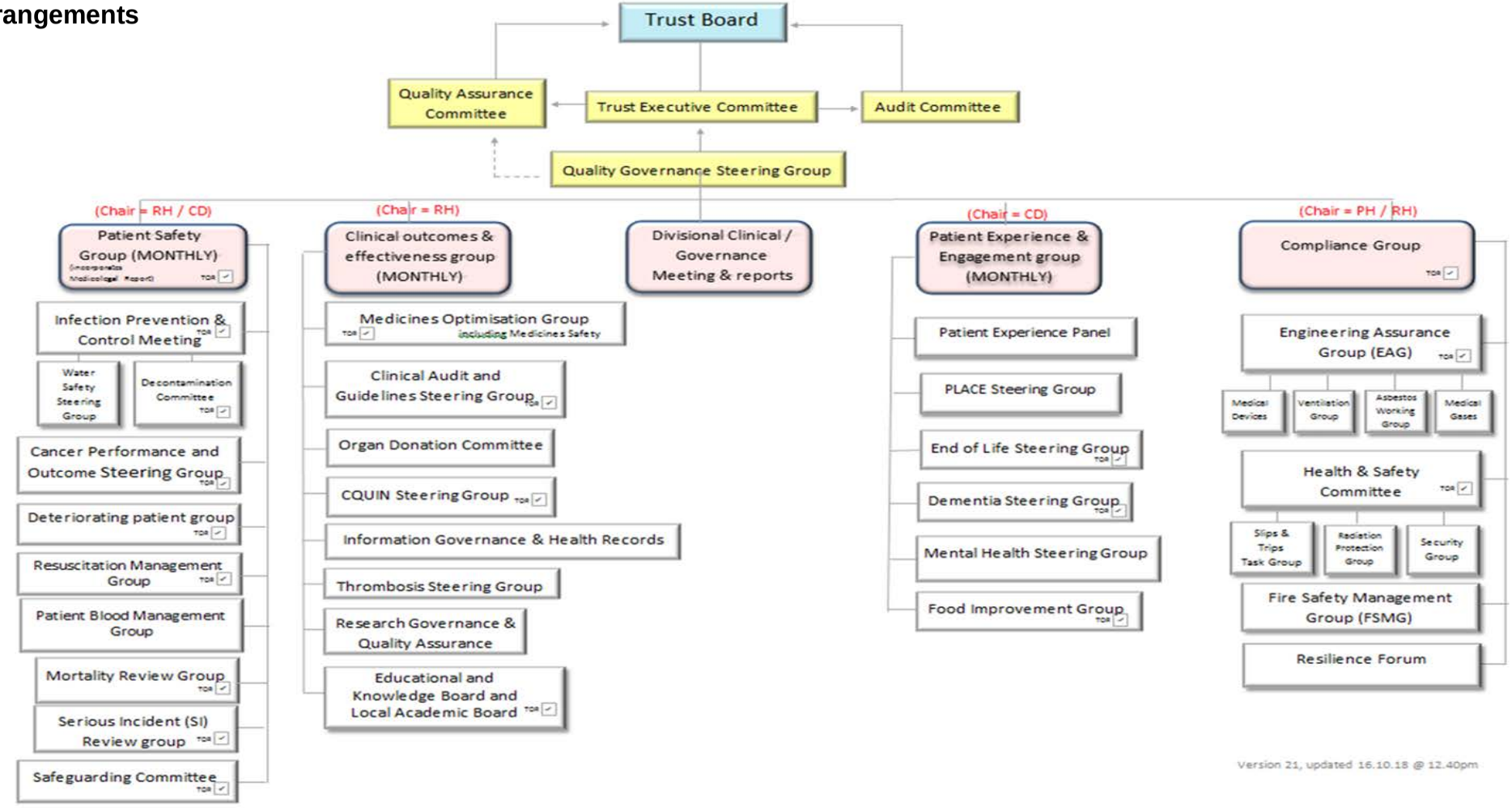
The Chair of the Group may also extend invitations to other personnel with relevant skills, experience or expertise as necessary to deal with the business on the agenda. Such personnel will be in attendances only

Communication:	A notice of each meeting, including an agenda and supporting papers, will be available for each member of the TIPC one week prior to the date of the meeting. Additional agenda items should be submitted to the Chair at least two weeks prior to the date of the meeting. A forward planner for the group will be made available, and reviewed annually.
Quorum:	A quorum of members must be present for the meeting to proceed, and should consist of: • DDIPC (Chair) / Nurse Director Workforce and Education (Deputy chair) • Infection Prevention Matron/Nurse • Pharmacy representative or a Consultant Microbiologist who can report on antimicrobial prescribing • DLN representative from at least three Divisions • A nursing representative from at least three Divisions • Facilities and Engineering representative Deputies will count towards the quorum.

Frequency of meetings:	Meetings of the group will be held monthly – last Friday of the month 10.00 – 12.00hrs. **Note:** Last Friday of the month for May, August, November and February, will be the Infection Prevention Committee, therefore there will be no Infection Prevention Operational Meeting for this particular months. Extraordinary meetings may also be scheduled to expedite action in respect of any urgent issues arising in the interim period.
Agenda and notes/action points:	The Committee shall be supported administratively by the Infection Prevention Team/Administrator. In this respect, support will include: • The agreement of the agenda with the Chair, collation of relevant papers, taking and disseminating the minutes, and keeping a record of matters arising and issues to be carried forward • Ensuring the TOR's are reviewed on an annual basis • Ensuring that the group reviews the effectiveness of its reporting sub-groups on an annual basis in terms of evaluating their role in continuing to monitor and further improve clinical outcomes and effectiveness
Attendance at meetings:	Members are expected to attend all meetings of the TIPC. Members unable to attend **must** send a deputy who is briefed and who will count towards the quorum. If a member sends a deputy for any three meetings within a year, the Chair should discuss the member's ability to remain part of the group. One representative from each division must be in attendance at the meeting of the group.
Duties:	In particular the Group will: Provide assurance that the environment within the Trust is safe for patients, visitors and staff in terms of infection prevention 21. Provide assurance that all appropriate measures are being taken to assist the Trust with achievement of national and local infection prevention and control targets/trajectories 22. Escalate any concerns, together with recommendations for action, to the relevant stakeholder. In the event of exceptional occurrences raised, this group escalated them according to the Trusts escalation policy 23. Monitor by exception Trust delivery plans to deliver targeted reduction and sustainable improvement of HCAI's and cleanliness 24. Provide assurance that infection prevention strategy and performance is being delivered at the point of care 25. Provide assurance that infection prevention strategy and performance is being delivered across Facilities and Engineering 26. Discuss and endorse a plan for the management of outbreaks in the Trust and to monitor its implementation and outcomes 27. Implement the annual infection prevention audit program and disseminate the information to ensure its implementation 28. Ensure compliance with antimicrobial stewardship arrangements and monitor antimicrobial consumption 29. Ensure compliance with National Cleaning Standards, and monitoring cleaning scores 30. Ensure compliance with relevant infection prevention principles, i.e. hand hygiene etc

	31. Review and monitor action plans following increased incidences, outbreaks and serious incidents in relation to infection prevention
Sub-groups:	There are no sub-groups to this meeting
Reporting responsibilities:	A summary report of the TIPC meeting should be submitted as an agenda item for information to the Trust's IPC, advising the group with regards to achievements, exceptions themes and trends associated with infection prevention (control) management and compliance.
Review:	Terms of Reference are due for review in September 2019.

Appendix 4: Infection Prevention governance arrangements



Appendix 5: National CQUIN

2018-19 pre WHO

National CQUIN 2017/18: Reducing the Impact of Serious Infections
Indicator 2d – Reduction in antibiotic consumption (DDDs per 1000 admissions inc. daycase)

Target NOT met
Target achieved

Monthly progress

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Total Antibiotics	6849	6769	6469	6241	6559	6376	6754	6695	7619	7520	8673	7927
Performance against target	19%	18%	12%	8%	14%	11%	17%	16%	32%	31%	51%	38%
Carbapenems	57	74	117	99	105	109	95	108	70	84	100	80
Performance against target	-28.5%	-7.4%	45.9%	23.7%	30.7%	35.7%	18.3%	34.3%	-13.3%	4.4%	24.5%	-0.4%
Access group of AWaRe category	55.07%	51.60%	50.91%	47.91%	49.94%	48.77%	50.07%	49.49%	51.51%	57.31%	55.55%	52.46%
Performance against target	1.48%	-1.99%	-2.68%	-5.68%	-3.65%	-4.82%	-3.52%	-4.10%	-2.08%	3.72%	1.96%	-1.13%

Rolling progress

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Total Antibiotics	6849	6808	6695	6577	6573	6542	6571	6586	6683	6761	6909	6983
Performance against target	19%	18%	16%	14%	14%	14%	14%	14%	16%	17%	20%	21%
Carbapenems	57	66	83	87	91	94	94	96	93	92	93	92
Performance against target	-29%	-18%	3%	8%	13%	17%	17%	20%	16%	15%	16%	15%
Access group of AWaRe category	55.0%	53.0%	53.0%	51.0%	51.0%	51.0%	51.0%	51.0%	51.0%	51%	52%	52%
Performance against target	1.4%	-0.6%	-0.6%	-2.6%	-2.6%	-2.6%	-2.6%	-2.6%	-2.6%	-2.6%	-1.6%	-1.6%

2018-19 post WHO

National CQUIN 2017/18: Reducing the Impact of Serious Infections
Indicator 2d – Reduction in antibiotic consumption (DDDs per 1000 admissions inc. daycase)

Target NOT met
Target achieved

Monthly progress

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Total Antibiotics												
Performance against target	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%

Rolling progress

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Total Antibiotics												
Performance against target	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%

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Infection Prevention Team 2019-20

The Infection Prevention Team aim is to avoid preventable healthcare associated infections (HCAIs). To achieve this in 2019-20 the team will be:

- Focussing on getting the basics right (i.e. hand hygiene, isolation, cleaning, policies and guidelines) and learning from Root Cause Analysis to improve patient safety.
- Work to recruit to the team and support their development/education will support this.

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Changes to Infection Prevention Team

- DIPC
- DDIPC/Infection Control Doctor
- Head of Nursing for Infection Prevention
- Band 8a
- Band 7
- Band 6 x2
- Band 3x2
- Currently recruiting Antimicrobial Pharmacist

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New for 2019-20

- A more clinical focus/ward rounds
- Hand Hygiene audits
- Changes to IPCC
- Working together with CCG colleagues

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Clostridioides difficile (previously *Clostridium difficile*)

The way cases are apportioned has changed from April 2019. Acute provider objectives are now set using these two categories:

- Hospital onset healthcare associated: cases that are detected in the hospital two or more days after admission
- Community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.
- The Objective for 2019-20 =76 cases (rate 25.9 per 100 000 bed days)

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E.Coli Bacteraemia

- In 2016, the Department of Health and Social Care set an ambition for England to halve the number of healthcare associated Gram Negative Blood Stream Infections (GNBSI) by March 2021.
- Recognising this is a complex challenge with more than 50% of infections occurring in people outside of hospital settings, the date for achievement of this goal has been revised to March 2024 with a 25% reduction by March 2021.