Brighton and Sussex University Hospitals NHS Trust

Meeting of the Board of Directors

10:00 – 13:45 on Tuesday 2 February 2021

Virtual Meeting via Microsoft Teams

AGENDA – MEETING IN PUBLIC

1.	10.00	**Welcome and Apologies for Absence** To note	Verbal	Chair
2.	10.00	**Declarations of Interests** To note	Verbal	All
3.	10.00	**Minutes of Board Meeting held on 1 December 2020** To approve	Enclosure	Chair
4.	10.00	**Matters Arising from the Minutes** None	Enclosure	Chair
5.	10.05	**Report from Chief Executive** To receive and note overview of the Trust's activities	Presentation	Marianne Griffiths
		INTEGRATED PERFORMANCE REPORT		
6.	10.30	**Quality Improvement** To receive and agree any necessary actions	Enclosure	Carolyn Morrice Rob Haigh
		After this section the Chair of Quality Assurance Committee will be invited to provide their report included at item 10. *To receive assurance from Committee and recommendations from the Committee.*		
7.	10.50	**Systems and Partnerships** To receive and agree any necessary actions	Enclosure	Katy Jackson
8.	11.10	**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 11. *To receive assurance from Committee and recommendations from the Committee.*		
9.	11.30	**Our People** To receive and agree any necessary actions	Enclosure	Julie Bacon
		At this point the Chairs of the Committees will be invited to provide any additional assurance from the work of their committee.		
		ASSURANCE REPORTS FROM COMMITTEES		

10.	-	**Report from the Quality Assurance Chair** - **from the meeting on the 22 December 2020** To receive assurance from Committee and recommendations from the Committee	Enclosure	Mike Rymer
11.	-	**Report from Finance and Performance Chair** - **from the meetings on the 26 January 2021** To receive assurance from Committee and recommendations from the Committee	Enclosure	Patrick Boyle
12.	12.00	**Board Assurance Framework** To approve	Enclosure	Glen Palethorpe
		SUSTAINABILITY		
13.	12.10	**Emergency Planning, Resilience and Response Assurance Report** To approve	Enclosure	Katy Jackson
		QUALITY		
14.	12.30	**Vaccination Campaign Update** - Flu - Covid-19 To note	Enclosure Verbal	Carolyn Morrice Katy Jackson
15	12.50	**IPC Board Assurance Tool** To note	Enclosure	Carolyn Morrice
.		**OUR PEOPLE**		
16.	13.05	**Annual Equality Report** To approve for publication on Trust website by 2 February 2021	Enclosure	Barbara Harris
		WELL LED & COMPLIANCE		
17.	13.15	**Company Secretary Report** To note	Enclosure	Glen Palethorpe
		OTHER		
18.	13.25	**Any Other Business** To receive and action	Verbal	Chair
19.	13.35	**Questions from the public** No questions received.	Verbal	Chair
20.	13.45	**Date and time of next meeting:** The next meeting in public of the Board of Directors is scheduled to take place at **10:00** on Tuesday 30 March 2021.	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 10:00 on Tuesday 01 December 2020 in via Microsoft Teams Live.

Present:	Alan McCarthy	Non- Executive Director (Chair)
	Mike Rymer	Non-Executive Director
	Lizzie Peers	Non-Executive Director
	Joanna Crane	Non-Executive Director
	Kirstin Baker	Non-Executive Director
	Dame Marianne Griffiths	Chief Executive Officer
	Karen Geoghegan	Chief Financial Officer
	George Findlay	Deputy CEO, Chief Medical Officer
	Carolyn Morrice	Chief Nurse
	Rob Haigh	Medical Director
	Clare Stafford	Finance Director
	Ben Stevens	Director of Performance (Item 6 only)
	Julie Bacon	Strategic HR Advisor
In attendance:	Glen Palethorpe	Group Company Secretary
	Tamsin James	Board and Committee Administrator

B/12/20/1 WELCOME AND APOLOGIES **Action**

1.1 The Chair welcomed those present to the meeting.

1.2 Apologies for absence were received from Pete Landstrom, Patrick Boyle, Jayne Black, Jackie Cassell and Denise Farmer.

1.3 The Board was confirmed as quorate.

B/12/20/2 DECLARATIONS OF INTEREST

2.1 There were no declarations of interest.

B/12/20/3 MINUTES FROM THE PREVIOUS MEETING HELD ON 29 SEPTEMBER 2020

3.1 The minutes of the meeting held on 29 September 2020 were **APPROVED** as a correct record.

B/12/20/4 MATTERS ARISING

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

B/12/20/5 CHIEF EXECUTIVE'S REPORT

5.1 Dame Marianne Griffiths presented the Chief Executive's report, drawing out the key events and activities that have occurred in the last month.

5.2 Marianne began the update by sharing a huge thank you to all the Trust staff for their extraordinary support throughout the pandemic and particularly during the second surge in putting patients at the centre of all they do and ensuring they are all as safe as possible. Marianne shared that she was proud of each and every member of staff and everything that has been achieved so far and

for what the Trust and its staff continues to achieve together.

5.3 Marianne shared that the Trust is currently caring for 56 patients with Covid-19 across both RSCH and PRH, and in total the Trust has cared for 690 patients with Covid-19 so far this year.

5.4 As part of the Trust's planning response during the second surge of the pandemic, it has reintroduced the bronze workforce meetings, silver situation meetings and gold decision making meetings that worked so effectively in the early weeks and months of the pandemic. The Trust continues to adhere to the changing guidance within the realm of patient and staff PCR testing and the mass vaccination programme which will soon be launched.

5.5 Marianne stated that the Trust's goal was to restore activity to 90% by October 2020 and highlighted that the Trust's current activity compared to pre-Covid levels are being restored. Restoration rates were noted as:

- Referrals were noted at 94%;
- Outpatients 87%;
- Inpatient Elective & Day Case 84%;
- A&E: 86%
- Inpatient non-elective: 84%

5.6 Marianne went on to confirm that the Trust is focusing on patients who are in most urgent need of treatment, particularly within Cancer and Elective treatment pathways and the Trust remains committed to reducing the patient waiting list.

5.7 As the UK enters a new tiered system, the Trust remains focused on keeping its patients and staff safe. The Trust encourages staff to work from home when appropriate and noted that whilst this remains tricky for front line staff it still remains an important factor that is considered.

5.8 In relation to clinically vulnerable staff the Trust remains compliant with national guidelines in that they must remain at home and the Trust continues to work with these staff constructively and there remains enhanced support in place for all staff through the Trust's health and wellbeing programme.

5.9 Marianne highlighted that the Trust has introduced mandatory mask wearing by everyone in hospital and provides regular updates to colleagues on PPE guidance. All colleagues are regularly reminded, if they develop Covid symptoms, to stay at home and tell their manager.

5.10 Throughout the pandemic the Trust has limited patient visiting to reduce the number of people in its hospitals and continues to encourage families to use digital means to keep in touch with patients. However the Trust has used judgment and flexibility in regards to those visiting end of life care patient or those with learning disabilities.

5.11 Marianne confirmed that the Trust is also focusing on increased communication to encourage patients to come back to the hospitals for treatment. The Trust has the necessary infection prevention measures in place and utilises red and green pathways in support of patients being safe to return to hospital.

5.12 In relation to Covid testing, Marianne confirmed the Trust has been fortunate enough to be able to roll out lateral flow testing kits to its workforce in order for staff to test themselves at home twice a week, if that test provides a positive result then a subsequent PCR test at the one of the hospital based testing

pods is arranged. This should see the reduction in asymptomatic risk for the Trust.

5.13 Regarding Winter planning, the Trust is working closely with health and care system partners whilst taking into account the complexity and challenges Covid-19 poses. The Trust's key objective is to manage bed occupancy rates to ensure we can admit patients in a timely way whilst ensuring we can continue to protect our elective capacity.

5.14 In relation to supporting staff and thus our communities Marianne was pleased to report that the Trust has a team of 150 trained workplace flu vaccinators who are holding drop-in clinics and visiting wards and departments to distribute the vaccine to staff. Roaming vaccinators are also on hand to provide the flu jab to staff on shifts and in their departments. So far, the Trust has vaccinated 69% of staff against the flu, which is a great result compared to the same period in 2019. Marianne stated that it was necessary to leave 14 days between having the flu vaccine and the Covid-19 vaccine.

5.15 In October the Trust celebrated Black History Month, a nationwide celebration of the influence of black people in shaping our society. Marianne highlighted the activity and updates around cultural events in Sussex, the BAME Staff and Communities conference, and the launch of the Trust BAME staff network, SOAR, and the BAME Covid support volunteers.

5.16 Marianne went on to add that the Trust was also delighted that Renal practice educator in the Sussex Kidney Unit, Ferdinand Bravo, was awarded the South East Royal College of Nursing Black History Month Making a Difference Award for the role he has played in supporting BAME staff during Covid.

5.17 Marianne was pleased to announced that the BSUH Equality, Diversity and Inclusion team have welcomed Senior Midwife Maggie Myatt, who has joined on secondment for 12 months as the Race Equity Lead and EDI Associate

5.18 The 14 October marked Allied Health Professionals day for everyone working in one of the 14 professions represented by the group. Across the Trust it has 570 AHP's including orthoptists, physiotherapists, occupational therapists, speech and language therapists, diagnostic radiotherapists, therapeutic radiographers, dieticians and operating department practitioners. To celebrate the day, all the Trust AHPs received treats from Carolyn Morrice, Chief Nurse which were funded by the Trust Charity.

5.19 Marianne highlighted that the Trust Charity was delighted to have been chosen as the local charity partner for the 2020 Brighton Marathon which was held virtually this year. A fantastic team of supporters took part with proceeds received towards improvements for Trust patients and staff wellbeing.

Diary Highlights

5.20 The Board was advised of some key meetings that the Executive team have been involved with in October & November 2020.

5.21 Marianne was delighted to announce that the Trust Chairman, Alan McCarthy, has been awarded an MBE for his services to the NHS.

Looking Ahead

5.22 Marianne went on to comment on the WSHFT and BSUH merger and highlighted that work continues and the Trust will be seeking to merge on the 1 April 2021. The Trust's merger survey, was completed by more than 3,000 members of staff and 750 members of the public which informed much of the

work that includes the new Trust's vision and values, Patient First strategy including the Trust's organisational priorities and the survey provided valuable feedback on a possible new name. Marianne shared her thanks to everyone who took the time to share feedback and help shape the new organisation's priorities.

5.23 The Chair thanked Marianne for the update and shared his thanks to all the Trust staff for what they achieved this year and the work they continue to do over winter.

5.24 The Board **NOTED** the report.

B/12/20/6 QUALITY IMPROVEMENT

6.1 Rob Haigh introduced the Quality report, highlighting the key benchmarked indicators relating to Quality & Safety aligned to the organisational True North objectives.

6.2 The Hospital Standardised Mortality Ratio data is available up to August 2020 whereby 46 patients died in hospital against the expected number of 57 giving an in-month HSMR of 81.10. The rolling 12 month HSMR to August was 97.99. As a result of the Covid-19 pandemic, guidance received from NHS Digital is that standardised mortality tools such as HSMR and SHMI mortality models, should not be used to monitor or compare Covid-19 mortality rate and risk.

6.3 After pausing during the pandemic phase the Trust Mortality Review Group is recommencing with a strengthened emphasis on clinician led structured judgement reviews, which focus on learning and the identification of both best practice and areas for improvement.

6.4 The Trust is currently recruiting two Medical Examiner Officer (MEO) posts to support the Medical Examiners in improving the robust scrutiny of all deaths not directly referred to the coroner. The MEOs will ensure that all unexpected deaths are systematically reviewed at the Serious Incident Review Group and that Structured Judgement Reviews are allocated as appropriate.

6.5 Carolyn Morrice, Chief Nurse, informed the Board that the rate of inpatient falls for the past 12 months is 3.67 falls per 1000 bed stay days; equating to 878 falls in the past year compared to 931 in the previous year. The National Falls rate is 6.62 falls per 1000 bed days. The pressure damage rate continues to be assessed and the focus remains on this work through the development of a breakthrough objective in 2020/21.

6.6 All falls will be reviewed at the new Harm Free Care Panel and the use of Falls Preventative measures will be audited via the Perfect Ward App and triangulated with the use of the risk assessments currently being incorporated into the electronic observation system, Patientrack.

6.7 In October 2020 there were 24 incidents of hospital acquired pressure ulcers at the Trust. Over the past year the number of patients developing hospital acquired pressure ulcers has decreased, and in the past 12 months 24 hospital acquired pressure ulcer incidents have met the threshold for being declared as a Duty of Candour incident. This has resulted in an action taken by the Quality Assurance Committee to undertake a deep dive into the systems for learning form pressure damage at the Trust.

6.8 The collection of data of Friends & Family recommended rates was paused

due to the pandemic, this recommenced on the 1 October and the Trust has a True North ambition of 96% of inpatients who would recommend the Trust to their family and friends. Recent feedback received has resulted in improving environmental cleanliness in the Trust hospitals.

6.9 Carolyn updated the Board on safer staffing and began by stating how incredible all the workforce have been throughout the pandemic. The Trust, throughout the last year, has seen a persistent challenge with nursing vacancies which is currently at 12% which is set against a known national shortage. The Trust was successful in its NHS Interim People Plan bid from NHSEI in receiving funding to support an overseas recruitment campaign and the ambition for next year is to recruit up to 250 registered nurses which will make a huge difference to staff and patients.

6.10 Further positive meetings have taken place across the local Universities to increase awareness of the Trust and highlight innovative packages of learning studies to encourage both recruitment and then retention.

6.11 Carolyn highlighted what work the nursing leadership team have been undertaking to address the current qualified nursing workforce shortfalls.

6.12 Carolyn brought the Board's attention to the Trust vacancy data for October 2020 and highlighted that the HR team are progressing quicker onboarding as a priority and the benefits of that work is being monitored through the Trust's transformation group.

6.13 Joanna Crane commented that whilst the Trust is aware of the current patient waiting list and is working hard on restoration and recovery, she asked are there any further concerns to outline above those the Trust is already aware of in respect of waits.

6.14 Carolyn stated that the FFT is triangulated against both informal and formal complaints and the Trust has seen an increase. The Trust is aware it is an issue and continues to communicate effectively to its patients on why there is a delay. The Trust continues to assure its patients on the waiting list they are being actively monitored and the Trust monitors those on the list to avoid any harm; patients that are on the list are made aware of how they can escalate their care in the avoidance of harm.

6.15 Rob Haigh added that the Trust continues to monitor and manage the waiting list and this is evidenced through patient contact via telephone or virtual video calls to ascertain a level of appropriate care during their waits.

6.16 Lizzie Peers questioned whether the Trust was seeing a trend in the reasons why Nurses leave their roles in the Trust and what can the Trust do differently to encourage people to stay. Carolyn confirmed that there is a retention issue nationally in nursing and this remains something that is monitored through the community workforce transformation hubs with actions being taken to enhance retention such as flexible training offerings.

6.17 Mike Rymer questioned whether the Trust is making progress on the structured judgment reviews. Rob Haigh confirmed that over the course of the last month he has held divisional meetings hosted by Anne Middleton and Carolyn Morrice that outlines the new requirements and links with the medical examiner programme. Each Division is now working through the schedule to monitor mortality data, this will then be provided to the Quality Assurance Committee for review.

6.18 The Chair thanked both Carolyn and Rob for their update.

6.19 The Board **NOTED** the report.

B/12/20/7 SYSTEMS AND PARTNERSHIPS

7.1 Ben Stevens, Director of Performance, updated the Board in respect of a range of performance indicators and provided the Board with assurance that whilst Covid-19 had impacted the Trust, the development of plans to restore performance were being monitored through the delivery of the Trust's restoration plans.

A&E

7.2 Ben informed the Board that the Trust achieved a performance of 83.1% for October 2020, 0.5% higher than October 2019 but slightly below the national performance of 84.4%; but this was against a 14% drop in A&E attendances compared to last year and a 12.5% drop in non-elective admissions.

7.3 Ben highlighted that both hospital sites are maintaining patient flow within the red and green Covid pathways.

7.4 The Trust bed occupancy is increasing at both RSCH and PRH sites. Ben confirmed the Trust maintains its protected beds within elective and Covid pathways.

7.5 The Trust continues to work with system partners in relation to Long Length of Stay (LLOS), ensuring patients are able to be cared for at home or in the community once medically fit to leave our hospitals.

RTT

7.6 The Trust's RTT Performance position in October was at 57.8% across all specialties, a decrease of 9.4% compared to October 2019, but that this level of performance has increased by 2.8% compared to September 2020.

7.7 In relation to 52-week breaches the Trust has a prioritisation schedule in place for elective procedures through both the Trust's own pathways and the use of the independent sectors. As with other measures this delivery continues to be monitored through the Restoration and Recovery Board.

7.8 Ben confirmed that the Trust is undertaking a waiting list validation exercise to ensure no patient physical harm is attributed to the delays, the outcomes of which are overseen by Rob Haigh and reported to the Quality Assurance Committee.

CANCER

7.9 The Trust was compliant with 4 of the 8 cancer metrics in September 2020. The Trust was non-compliant against the 62-day urgent referral to treatment at 80.6%.

7.10 The backlog of patients diagnosed with cancer has increased sharply as a result of the pandemic. Whilst the Trust has maintained its delivery of very urgent treatments, there have been constraints in the overall level of treatment provision possible, particularly within diagnostic services which has contributed to this rise in waits. Plans are now in place to restore services to pre-Covid levels. This service area remains a high priority for restoration.

DIAGNOSTICS

7.11 The Trust's performance for October 2020 was 28.7%, a slight improvement

on September 2020.

7.12 The Diagnostic backlog for October 2020 stood at 2,686 patients. The number of patients waiting more than 6 weeks for diagnostics has increased by 1,592 patients since October 2019 and decreased by 177 patients compared to September 2020.

7.13 There remain challenges within Endoscopy and the insourcing of services is progressing in order to deliver the target of 100% of previous activity.

7.14 Ben confirmed that this area remains challenged but despite the second lockdown and the recent surge in Covid cases the Trust has maintained its elective restoration which is positive for our patients on their treatment pathways.

7.15 The Chair in the absence of Patrick Boyle as Chair of the Finance & Performance Committee asked Lizzie Peers to provide the Board with assurance from the previous Committee meeting.

7.16 Lizzie stated that in relation to performance the Committee held discussions on the difficulties in gaining assurance in a very fast and complex environment, however the Trust is focused on restoration and recovery and the Committee was provided with detailed performance against its constitutional targets and a more detailed dashboard against restoration plans.

7.17 Lizzie stated that the Committee was provided with assurance in relation to patient harm reviews against the patient waiting list within diagnostics, with particular focus on 64-day and 52-week reviews.

7.18 The Committee also focused on A&E performance and the positive results particular within time to triage and received assurance that patients are being triaged well.

7.19 The Chair questioned the report whereby it stated that 10% of mortality was within critical care at the Trust. Rob Haigh confirmed that the Trust has been proud of its escalation planning throughout the pandemic and has clear expectations of patient treatment and outcome plans. The critical care board are provided with a detailed assessment in critical care with basic interventions and that has had a physical impact on patient outcomes. Critical care patients do have a prolonged length of stay within ICU and the report demonstrates how much longer the length of stay is for Covid patients.

7.20 George Findlay added that the Trust offers excellent patient care and highlighted the importance of being clear with patients as to their treatment plans at the beginning of their journey. It's important to note that the Trust has excellent palliative care ensuring those patients have symptom control and good end of life care.

7.21 The Board **NOTED** the report.

B/12/20/8 SUSTAINABILITY

8.1 Karen Geoghegan reported to the Board the Trust's financial performance to the end of quarter 2, the Trust reported a breakeven position consistent with the requirement of the Phase 2 interim financial framework supported by £12.7m of additional income to address the financial impact of Covid-19.

8.2 For October 2020 to March 2021, the Trust is operating under the Phase 3

financial framework, the purpose of which is to prioritise non-Covid activity, alongside continuing its winter surge planning.

8.3 Karen stated that each ICS has been provided with a fixed funding envelope; which includes additional costs relating to operational Restoration & Recovery. The Trust is expected to breakeven which is subject to mutual agreement of other organisations within the ICS that may deliver either surplus or deficit positions.

8.4 Karen added that NHSEI has confirmed that the Cancer Drug Fund and Hepatitis C drug funding will return for the remainder of the financial year, which also includes Covid-19 test funding.

8.5 In October 2020, the Trust reported a deficit of £0.79m, which was £0.98m better than forecast.

8.6 In terms of the overall costs of Covid, year to date, the Trust has secured £14.7m for costs of the pandemic, most of that is due to the costs of the Trust's Covid response, but this funding also recognises not receiving non-NHS income recovery projections due to prolonged covid activities.

8.7 Karen confirmed the Trust currently had a healthy cash position due to the advance receipt of the M7 block payments.

8.8 Karen asked the Board to note that in response to the announcement from NHSEI earlier in the year relating to the write-off of historic loans, the transaction to write off these loans occurred in September 2020 and all the historic loans written off equated to just under £300m.

8.9 In relation to the Capital programme, the Trust was fortunate to secure additional capital plan funds to develop its Emergency Department provision at both BSUH and PRH. The Trust has also secured additional funding to support it with its critical care and endoscopy capacity.

8.10 The Trust submitted its draft financial plan to NHSEI on 18 November 2020 showing a deficit of £5.6m for the period October 2020 to March 2021. It is expected that the £3m loss of non-NHS income will be treated as an allowable overspend. Once this is factored in the forecast deficit would be circa £2.6m.

8.11 The Chair asked Lizzie Peers, to provide an update on the Finance & Performance Committee from October & November, to provide the Board with assurance from the two previous Committee meetings.

8.12 Lizzie confirmed the Committee meetings on the 27 October and 24 November, working towards its normal cycle of business, received reports covering performance and financial matters, a review of the Trust's 2020/21 efficiency programme delivery, a review of the Trust workforce update and a quarterly review of the IM&T programme.

8.13 The Committee reviewed the BAF risks for which it has oversight for and agreed these were fairly represented and asked that risk 5.2 be considered at the 3Ts Oversight and Assurance meeting.

8.14 The Chair questioned the loss of non-NHS income, Karen confirmed the Trust priority is to focus on recovering its elective activity and the reduction in the amount of patients in hospital has resulted in losses within catering and retail. In terms of private patient activity, those income streams have always been modest but it is not the Trust's focus to recover those in full; and it is thought

that those areas will be subject to an allowable overspend adjustment.

8.15 The Chair asked how the Trust is working with the independent sector and the resulting costs of this. Karen confirmed that the Trust is utilising the independent sector where possible within the System. The costs associated with that are not reflected in those costs reported to the Board today as they are accounted for separately at a national level.

8.16 The Chair thanked Karen for the update and shared his thanks to all during these challenging times.

8.17 The Board **NOTED** the report.

B/12/20/9 OUR PEOPLE

9.1 Julie Bacon presented an update on workforce developments.

9.2 Julie shared with the Board the Key highlights from the report.

9.3 In October, Turnover rate increased slightly to 11% from 10.9%. Turnover has been favourable to the 12% target for the last seven months. It is at its fourth lowest since September 2012.

9.4 The Trust's Sickness Absence rate was 4.74% in October, of which 0.10% was specifically Covid-19 related and 4.64% other Sickness Absence.

9.5 In relation to Covid-19 the Trust has a programme of risk assessments in place. Focusing on staff aged over 60s their risk assessments, their completion is now at 30%, these follow from those undertaken for BAME and vulnerable staff. Regarding lateral flow testing, the Trust has rolled out 6000 kits to staff, and a further order is awaited. The Trust will also be at the forefront of the Covid vaccination programme once launched.

9.6 The Trust's Appraisal rate was 72.6% in October. The impact of Covid-19 is challenging appraisal levels. The NHS People Plan 2020/21 includes the introduction of Health & Wellbeing Conversations for all staff and this will be integrated into the Trusts appraisals process which launches in December 2020.

9.7 Statutory and Mandatory Training compliance has dropped from 85% to 84% in October.

9.8 Julie confirmed that the annual NHS staff engagement survey ran from 28 September to 27 November, and closed with a 55% response rate, below the rate received in 2019, predominantly due to Covid and the survey only being made available online this year. Initial results are expected by February 2021.

9.9 Recruitment and vacancies remains a focus for the Trust with action being taken to improve and expedite the recruitment process particularly for the nursing and medical workforce.

9.10 The Chair invited Lizzie Peers to deliver a update on workforce matters that were presented to the Finance & Performance Committee; Lizzie confirmed the workforce update focused on managing premium spend within the medical and nursing workforce and the opportunities to tighten up governance expenditure on agency tier spend. The Committee also discussed the roll out of the health roster and it remains keen to receive further updates in terms of appraisals and Julie confirmed a more detailed piece relating to the plans to

increase appraisal rates through the health and wellbeing programme and the importance of this during this operationally difficult time would come back to a subsequent committee meeting.

9.11 Lizzie questioned Julie in regards to the over 60s risk assessments and asked for the performance targets. Julie confirmed the latest positon which is after the report was drafted is that we are awaiting 16 returns from some 400 risk assessments.

9.12 Lizzie went on to ask whether the Trust is focusing on the workforce implications in relation to the lateral flow testing kits and any subsequent positive results. Julie confirmed that 6000 kits have been distributed across the Trust which has subsequently returned 5 positive results. The access to these tests albeit not mandated remains a positive move for the staff and the results reflect the prevalence in the local area.

9.13 George Findlay added that the use of these tests is the right thing to do for the Trust and its workforce as it protects our patients and protects our staff.

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

B/12/20/10 REPORT FROM FINANCE AND PERFORMANCE CHAIR

10.1 Lizzie Peers as Chair of the Finance and Performance Committee for November 2020, asked the Board to note the update from the October and November 2020 meetings she had provided earlier in the meeting.

10.2 The Board confirmed they were **ASSURED** following the update of the report.

B/12/20/11 REPORT FROM AUDIT COMMITTEE CHAIR

11.1 Kirstin Baker as Chair of the Audit Committee, asked the Board to note the update from the October meeting.

11.2 Kirstin asked the Board to note:

- The Committee noted the Internal Audit Progress Reports and the two Audit Reports focused on Covid Governance and Budgetary Control.
- The positive assurances received from Internal Audit relating to Covid Governance.
- The LCFS 2019/20 progress report was received and the Committee was assured by the findings in the National Benchmarking report.
- The robust actions received within the Cyber Security Update and the Committee had requested an update on Data Protection from the Group IM&T Director at the January Committee meeting.
- The Committee received the External Audit Lessons Learnt paper from the last audit.

11.3 The Board **NOTED** the update and the assurances received at the Audit Committee meeting.

B/12/20/12 BOARD ASSURANCE FRAMEWORK

12.1 Glen Palethorpe drew the Board's attention to the summary of the key strategic risks within the Board Assurance Framework (BAF) and noted that the information received through the integrated performance report and assurance reports from Committee Chair's link to the details in the BAF.

12.2 Following the Finance & Performance Committee review of the BAF risks for which it has oversight for it was agreed these were fairly represented and asked that risk 5.2 should be considered at the 3Ts oversight and assurance meeting.

12.3 Glen confirmed that in relation to risk 5.2 the 3Ts Oversight & Assurance Committee confirmed progress is being made at the site and a revised programme had now been agreed with the contractor therefore it was agreed to reduce risk 5.2 to 16 as recommended

12.4 The Board **APPROVED** the Board Assurance Framework recognising that the Finance and Performance Committees had recommended the risk scores as being a fair reflection of the risks facing the Trust.

B/12/20/13 INFECTION PREVENTION & CONTROL BOARD ASSURANCE TOOL

13.1 Carolyn Morrice presented the Infection Prevention and Control Board Assurance Tool to the Board

13.2 Carolyn reminded the Board that this report is a national tool that all NHS organisations are using. The Trust report highlights ten key lines of enquiry that have been RAG rated green and amber. The prompts recorded as amber all have a full set of embedded actions against them which are in progress.

13.3 The Trust met with the CQC for a formal yet robust review of this document and they were assured over the actions taken. The Board was informed that the Trust is working with WSHFT to monitor the actions across both organisations, and maintains this tool as a live report. Which reinforces continues focus of excellence.

13.4 Carolyn highlighted that one of the live actions focuses on the nosocomial cross infection risk for the Trust and confirmed that reinforced communications to all Trust staff ensuring the wearing of the correct PPE for their situation in order to protect patients and staff.

13.5 Carolyn went on to confirm that rapid patient Covid-19 testing has increased to ensure the health status of the patient is known quickly in order to reduce any risk to their treatment pathway. Lateral flow staff testing is also key and it was previously confirmed that 6000 test kits had been distributed to Trust staff.

13.6 It was stated that Ann Gibbins is currently leading the Infection Prevention Control team at the Trust on an interim basis. Carolyn confirmed that the team are currently working with WSHFT to ensure best practice is applied and taken into the merger process and provided the Board with assurance that any risks were being monitored appropriately.

13.7 Carolyn added that the Trust has received excellent support from NHSEI and their IPC teams and Carolyn, George Findlay and Rob Haigh join National webinars to ensure mandatory training is kept up to date.

13.8 Further updates to the report would be monitored through the Quality Assurance Committee and through quarterly updates to the Trust Board.

13.9 Lizzie Peers questioned Carolyn on the top three areas of risk that were rated Amber. Carolyn confirmed firstly it was relating to staff behaviours to ensure the Trust supports IPC best practice and relentless focus on this; secondly, the environment and where the Trust can improve challenged areas with ventilation. Thirdly, is to increase lateral flow testing capacity at the Trust to

assist further with the red and green patient pathways.

13.10 George Findlay went on to add that the estate is a challenged environment for the Trust with it being aged buildings, however the Trust has escalated its capacity in other areas by utilising the Courtyard and Level 8 of the Thomas Kemp Tower as red escalation pathway treatment areas.

13.11 George also confirmed that the Trust needs to balance the risks within A&E given its red and green pathways and we remain working with the clinical teams, led by Andrew Leonard, to counter any risks within the department.

13.12 The Board thanked Carolyn for the comprehensive and detailed report.

13.13 The Committee **NOTED** the report.

B/12/20/14 COMPANY SECRETARY REPORT

14.1 Glen Palethorpe asked the Board to note the report which confirmed that the Annual General Meeting took place on the 29 September and provided the link to where the slides and video extracts used in the meeting could be found.

14.2 The Board **NOTED** the report.

B/12/20/15 ANY OTHER BUSINESS

15.1 No items were discussed.

B/12/20/16 QUESTIONS FROM THE PUBLIC

16.1 The Board received a question in advance of the Board meeting from a Mr John Gooderham who asked when the helideck at the Royal Sussex County Hospital will be operational.

16.2 Marianne Griffiths advised that the helideck structure is now complete and has been approved by the Civil Aviation Authority. The original plan was that the supporting infrastructure to make it operational such as the Trauma lift and other changes to enable its commissioning would be completed this year, however this has been delayed as a result of a number of circumstances.

16.3 The company providing the external finish around both the new and extended lift shafts unfortunately went into administration as a result of the impact of the Covid-19 pandemic. The work is therefore being completed by an alternative expert company, but this caused delay to the programme.

16.4 There are also some additional remedial works that were not originally envisaged as part of the programme (on the flues running up the side of the Thomas Kemp Tower next to the new lift shaft) that are being undertaken. The responsibility for these are part of the overall helideck contract and has to be completed prior to the handover.

16.5 Finally, the impact of the Covid-19 pandemic has obviously created delays as the number of operatives who could work in an enclosed space, like a lift car or shaft, has been appropriately reduced for reasons of safety. As with all construction projects the impacts of the pandemic, social distancing and lockdown rules have led to delays.

16.6 As a result of those impacts the current planned handover date for the helideck to the Trust is now in the spring of next year. Following that, our own helideck

commissioning works commence, and then the operational checks plus approvals from the Civil Aviation Authority can be initiated. At all points the Trust has continued to keep all of the contributors to the helideck and our commissioners updated, and all are supportive of the actions and plans in place.

B/12/20/17 ANY OTHER BUSINESS

17.1 There was no other business discussed.

B/12/20/18 DATE AND TIME OF NEXT MEETING

18.1 The next meeting in **PUBLIC** of the Board of Directors is scheduled to take place on **Tuesday 2 February 2020, at 10:00,** virtually via **Microsoft Teams Live**.

Tamsin James
Board and Committee Administrator
December 2020

Signed as a correct record of the meeting

…….Chair

…….Date

ACTIONS ARISING

Trust Board of Directors - Public

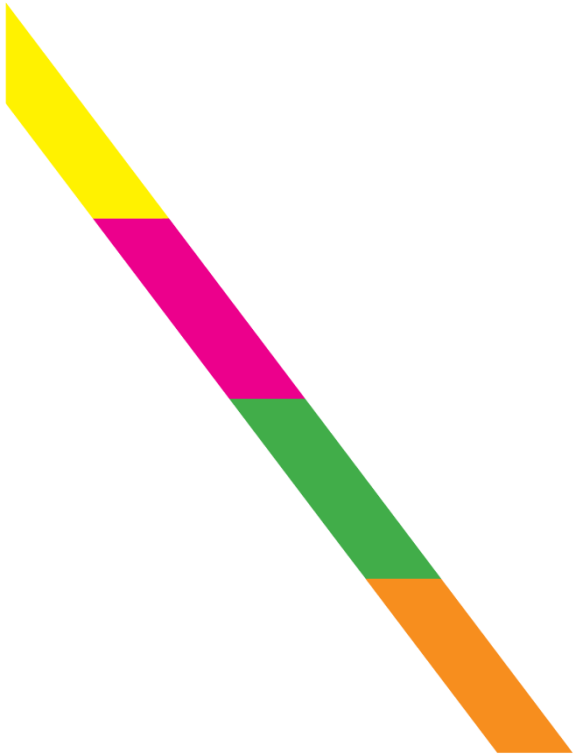
Date of meeting	Minute Reference	Minute Title	Action	Person Responsible	Deadline	Status
			There were no matters arising to note.			

NHS
Brighton and Sussex University Hospitals NHS Trust

Chief executive's report

Dame Marianne Griffiths

February 2020



Contents

Brighton and Sussex University Hospitals NHS Trust

- Headlines
- Diary highlights
- Merger update

Thank you to all our staff

Brighton and Sussex University Hospitals NHS Trust

"Thank you for all you have done throughout this extraordinary year.

You are the very best of the NHS - always putting our patients first and continually supporting and caring for one another.

I am confident that working together we will overcome all the challenges this pandemic poses."

Dame Marianne Griffiths, Chief Executive

Headlines: Covid-19 update

Brighton and Sussex University Hospitals NHS Trust

In Brighton and Hove, there were 1,152 new cases in the seven days to 19 January, which has almost halved from the peak in the seven days to 8 January.

Our hospitals remain busy with COVID-19 patients, but the number of patients has stabilised in the last few days.

We are currently caring for 224 patients across our hospitals.*

*figures from 26 January 2021.

Headlines: Vaccination launch

Brighton and Sussex University Hospitals NHS Trust

To date we have vaccinated 85% of all our staff, including 75% in high risk groups*

RSCH

- BSUH was one of 50 trusts across the country to receive the first batch of Pfizer vaccines in December.
- From finding a location for the vaccine hubs, to safe storage and training of our vaccinators, assessors and screeners, it has been challenging but momentous time.
- The first cohort to receive the vaccine at RSCH were patients over 80, priority groups of staff and colleagues in health and social care partner organisations.

Roll-out continues

- In January, PRH became one of the first hospitals to start vaccinating using the Oxford/ AstraZeneca vaccine.
- Everyone who works on our sites can now have their first dose. We are also vaccinating colleagues from health and social care partner organisations.
- In line with national guidance, second doses of both vaccines are being offered to staff 11-12 weeks after their initial dose to enable as many staff as possible to receive a first dose.

** Figures from 26 January 2021*

Headlines: Lockdown

Brighton and Sussex University Hospitals NHS Trust

Keeping staff and patients safe

Following the second national lockdown announced after Christmas, we have continued to:

- Encourage colleagues to work from home when appropriate
- Support clinically extremely vulnerable staff to stay at home
- Introduce mandatory mask wearing by everyone in our hospitals
- Limit visiting to reduce the number of people in our hospitals. Families have been encouraged to use digital means to keep in touch with patients. Our ward managers are doing their best to make compassionate decisions regarding visiting to meet the needs of our patients and their loved ones.

Headlines: Workforce Planning

Brighton and Sussex University Hospitals NHS Trust

Testing

The lateral flow testing has been in use since the end of November. Staff are continuing to test and report their results online twice a week.

We have also increased the capacity for rapid testing and can now process more than 200 tests per 24 hours across the Trust.

Winter planning

We are standing down some routine planned procedures to avoid bringing people who don't have COVID-19 into our hospital and to ensure we can support essential and urgent services.

The Workforce Hubs are working to redeploy staff where they are most needed.

We are also using independent sector capacity.

Headlines: Supporting staff

Prioritising the health and wellbeing of our staff continues to be a real focus

Brighton and Sussex University Hospitals NHS Trust

Introducing our 'Heroes' Lounge' at PRH

We are delighted to share that the new communal staff room at PRH - the 'Heroes' Lounge' opened to all staff from Tuesday 19th January. The staff room was funded by generous donations to the BSUH Charity 'Help BSUH Hospitals Covid-19' campaign. Work will now start on the new staff room at The County and we will also be improving our existing staff rooms and creating more outdoor seating facilities across both sites.

Welfare Appraisals

To ensure we are supporting staff as much as possible, we took the decision to replace traditional appraisals with a new Welfare Appraisal. This provides a forum for staff to have a structured conversation with their line manager about their experiences during these challenging times and any additional support they may need.

Shining a light on hidden disabilities

Throughout November-December we worked with the Disabled Staff Network (DSN) to celebrate Disability History Month and International Day of Persons with Disabilities. We shared stories of hidden disabilities and some of the challenges experienced by staff. We also promoted the support available within the Trust including the Health Passport launched last year, and the changes we are making to our website to ensure patients and the public can easily access communication and information.

Headlines: Mental Health

Staff in Mind

A new confidential service for staff in Sussex provided by Sussex Partnership.

Counselling service / HELP

Vivup employee assistance programme

NHS apps

Chaplains and spiritual care team

Headlines: Leadership and innovation

Brighton and Sussex University Hospitals NHS Trust

Pathology performance commended against ISO standards

We recently received good news from the Pathology department following a UKAS inspection against ISO standards by three external auditors. After rigorous scrutiny of the Haematology and Transfusion laboratories at RSCH and PRH, our processes and professionalism were highly commended.

Endoscopy nurses get up to speed on the latest tech

At BSUH we are in the unique position of having two qualified endoscopists and recently became pnly the second British hospital to run an in-house nurse training course. The training day at PRH gave nurses theoretical and practical training , using the latest technology to perform procedures that can save the need for an operation. This exciting step forward will be of real benefits to our patients.

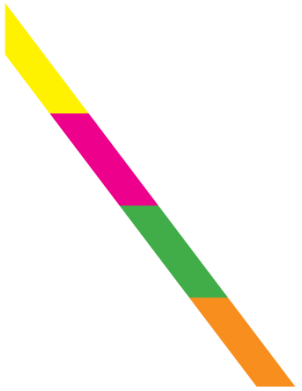
SIREN study findings shared

Public Health England (PHE) recently published the data from its SIREN study, which aims to find out more about re-infection and lasting immunity to SARS-CoV-2 in healthcare workers. It has performed regular antibody and PCR testing on 20,787 participants from 102 NHS trusts including 250 from BSUH and a further 250 from Western. A big thank you to those who are making this urgent public health priority study possible at BSUH.

Diary highlights

Brighton and Sussex University Hospitals NHS Trust

- Sussex Acute Collaborative Network – held on monthly basis
- Staff briefings
- Sussex Health & Care Partnership Executive Meeting
- South East Leadership Summit
- Covid Briefing calls with MPs
- NHSE Chief Operating Officer Amanda Pritchard visits BSUH



Merger

NHS
Western Sussex Hospitals
NHS Foundation Trust

NHS
Brighton and Sussex
University Hospitals
NHS Trust

WSHT and BSUH merger - better for everyone

The Trust Boards believe a new, single organisation will create exciting opportunities for the hospitals to grow and develop services and continue to deliver outstanding care to communities across Sussex.

BSUH and WSHT have worked closely together and shared an executive team since April 2017.

> *"To achieve together what we cannot achieve alone*

Merger – our commitments

NHS Western Sussex Hospitals NHS Foundation Trust

NHS Brighton and Sussex University Hospitals NHS Trust

Our focus is on the delivery of safe and effective care this winter and we will only change what we need to before the merger

- For example, integrating some essential processes and policies and introducing new executive structure and board committees

After merger, we will continue to invest in all services and specialties currently delivered by WSHT and BSUH

- This includes maintaining 24/7 A&E, emergency care, maternity services, tertiary, specialist and trauma services at all current locations

We are committed to Patient First, staff empowerment and the continuous improvement of all our patient services

- This is a merger of equals, bringing together the best of both trusts to achieve together what we cannot do alone

Merger progress

NHS Western Sussex Hospitals NHS Foundation Trust

NHS Brighton and Sussex University Hospitals NHS Trust

Subject to approvals, the new trust will exist from 1 April 2021.

Prior to this date, we have agreed to only change what <u>needs</u> to be changed to support the creation of the new trust. This includes:

- New regulatory registrations
- Revised Council of Governors and new membership recruitment
- Transfer and protection of staff employment terms and conditions
- New board and committee arrangements from 1 April 2021
- Executive structure in place in shadow form before April 2021

As well as:

- Financial system changes, including new single ledger
- Refresh and integration of performance and quality reporting
- Refreshed IM&T infrastructure, to enable some day one interoperability
- Integration of essential processes and policies, e.g. emergency preparedness

New **organisation**

NHS Western Sussex Hospitals NHS Foundation Trust

NHS Brighton and Sussex University Hospitals NHS Trust

Clinical operating model

- The size and scope of the new trust means a simple merger of the current divisions at WSHT with the divisions at BSUH, into a similar (but bigger) structure will not work
- An engagement and design process will run from March 2021 through to June 2021, ahead of any formal consultation and changes

Corporate operating model to be in place by April 2022

- The spine of the organisation will be the clinical operating model with services integrated, and led at appropriate divisional level
- Work is ongoing to develop the best corporate operating model and substructures that will align to new executive team portfolios
- Changes to be fully implemented by April 2022 where appropriate and possible

New organisation

Developing a new clinical strategy

- Our ambition is to embed clinical excellence and innovation at the heart of the new organisation
- The strategy will identify clinical benefits of merger and tackle long-standing issues that historically have proved too big for either trust to overcome
- The strategy will be Informed by the knowledge and expertise of our people; staff and patient feedback; and data on our services and our population
- Phase 1 of this work starts in March - creating a strategic framework to identify services with best opportunity for improvement, taking into account existing priority improvement projects and programmes

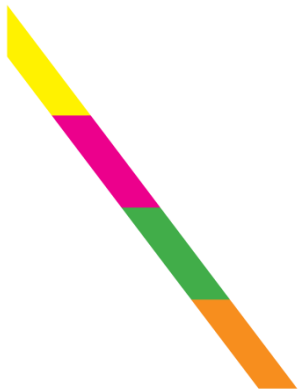
Membership recruitment

The new organisation will be a Foundation Trust supported by members and a Council of Governors. BSUH and WSHT staff, as well as existing WSHT public members, will become members of the new organisation in April.

We are now recruiting new members who represent the communities BSUH serves, i.e. Brighton and Hove, Mid Sussex and East Sussex.

NHS
Brighton and Sussex University Hospitals NHS Trust

Thank you – any questions?



Integrated Performance Report

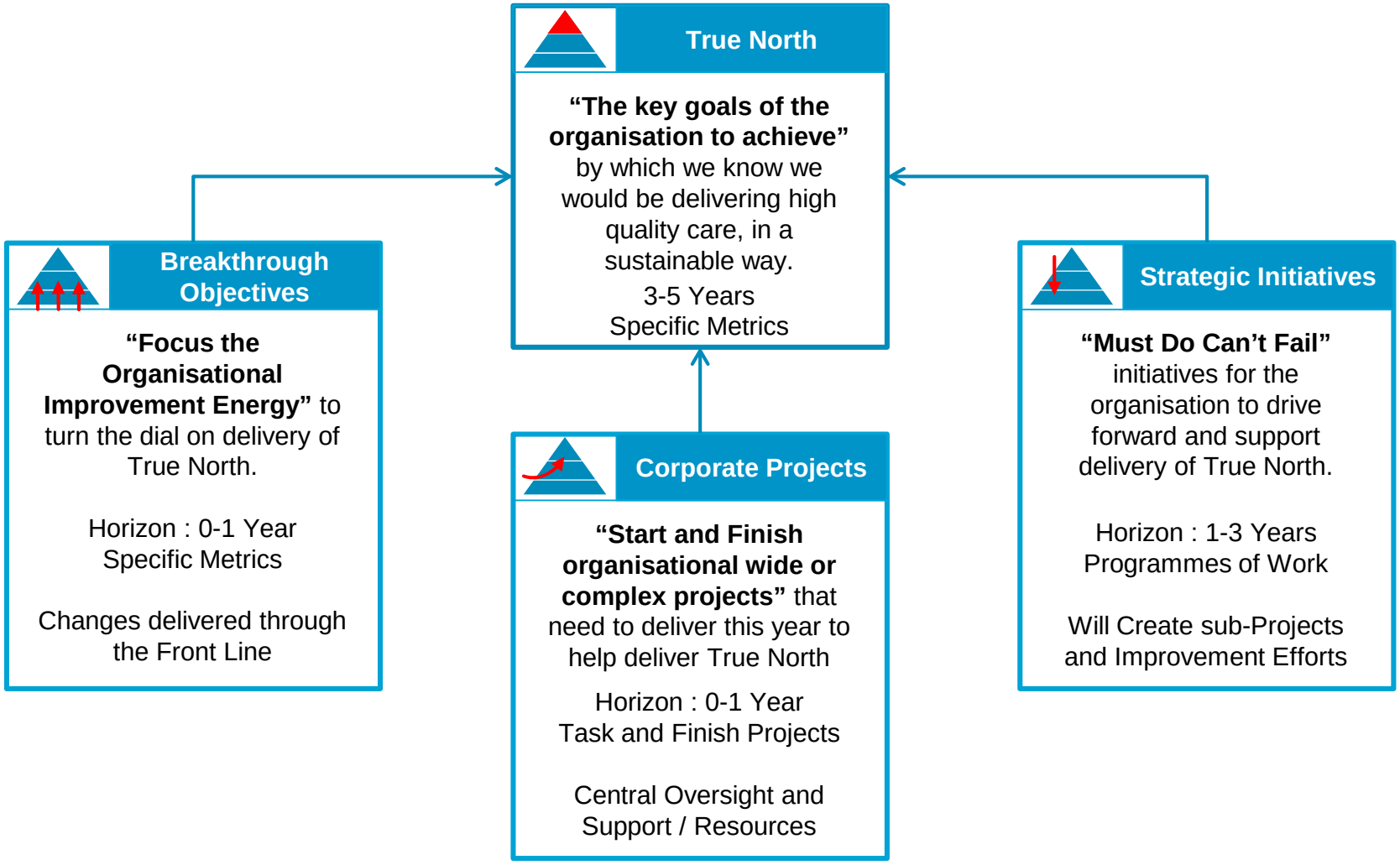
February 2021

NHS
Brighton and Sussex University Hospitals
NHS Trust

Contents

Structure of the report

Patient First Strategy Deployment Framework



Patient First True North

Key Goals for the Organisation to achieve sustainably

Patient

Patient Satisfaction

Target: Family & Friends Recommend Rate >96%

Sustainability

Financial Management

Target: Break Even

People

Staff Engagement

Target: Engagement Score Top 20% in the Country

Quality

Preventable Mortality

Target: HSMR Top 20% in the Country

Avoidable Harm

Target: Patient Safety Thermometer 95% 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

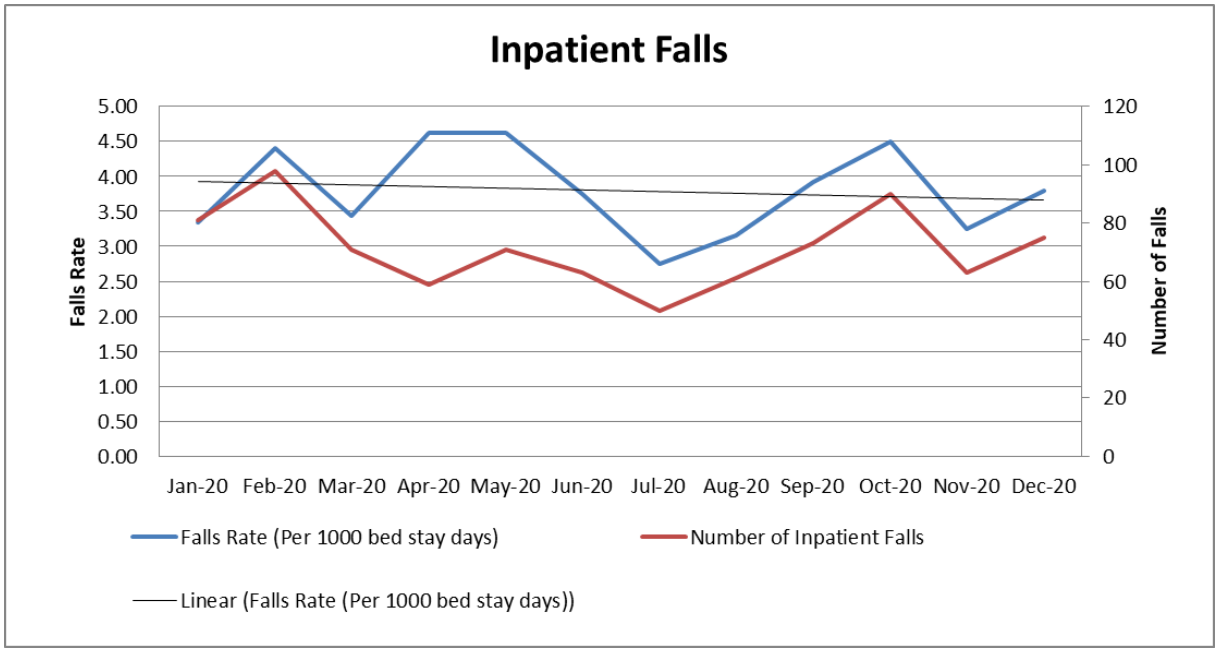
HSMR data is available up to October 2020. In October, 69 patients died in hospital against an expected number of 81 (October 2020 HSMR = 85.37; rolling 12 month HSMR to October 2020 =94.08).

As previously recorded, standard comparative mortality indicators (HSMR & SHMI) are unsuitable for monitoring or benchmarking Covid pandemic mortality. SHMI & HSMR rely on prolonged, sequential data collection and, because the Covid 19 code has been for <12 months, 'expected' mortality rates cannot be determined. HSMR is further compounded by significant changes in non Covid emergency admission volume and case-mix throughout the pandemic.

The Trust Mortality Review Group reconvened in January 2021 with a strengthened emphasis on multi disciplinary clinician led structured judgement reviews. Systems for identifying, undertaking and sharing learning from SJR processes are now in place.

To ensure that all Covid deaths at the trust promptly and thoroughly scrutinised, medical staff from the Pathology Dept have been redeployed to the bereavement service 7 days a week, so that daily completion of the MCCD and escalation for SJR or statutory external reporting (where indicated) takes place. In addition, the Trust has recently advertised for two Medical Examiner Officer (MEO) posts to support the Medical Examiners and further strengthen robust scrutiny of all hospital deaths not directly referred to the coroner.

Quality Performance



Quality

Inpatient Falls

Target: 3.38 falls per 1000 bed stay days

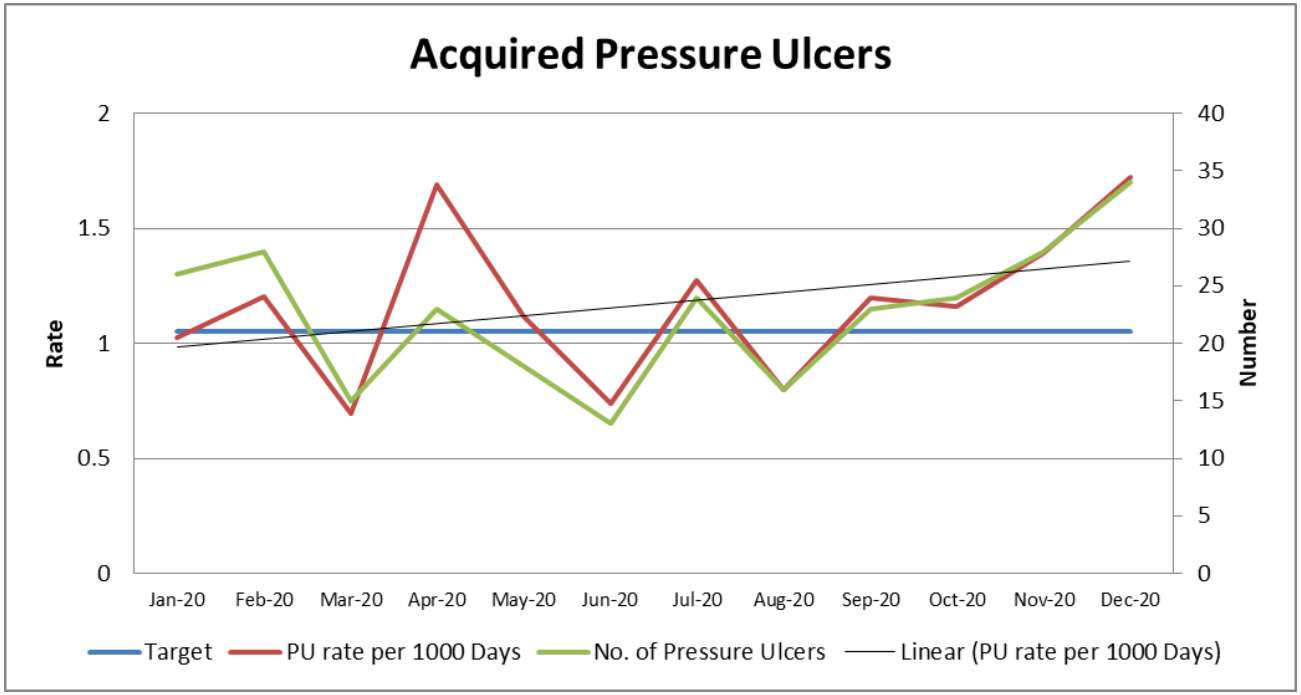
Pressure Ulcers

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

The rate of inpatient falls for the past 12 months is 3.80 falls per 1000 bed stay days; this equates to 855 falls in the past year. The National Falls rate is 6.62 falls per 1000 bed days.
In the past 12 months 26 falls have been reported as serious incidents, this compares to 23 in the previous 12 months.

All falls are reviewed at the Harm Free Care Panel and the use of Falls Preventative measures are now audited via the Perfect Ward App and triangulated with the use of the risk assessments on Patientrack.

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

In December 2020 there were 34 incidents of hospital acquired pressure ulcers with a rate of 1.72 per 1000 bed stay days. Over the past 12 months the number of patients developing hospital acquired pressure ulcers has increased. In the past 12 months 11 hospital acquired pressure ulcer incidents have met the threshold for being declared as a Duty of Candour incident.

All hospital acquired pressure ulcers are reviewed by the Harm Free Care Panel and Pressure Ulcer Preventative measures will be audited via the Perfect Ward App and triangulated with risk assessments on Patientrack.

Quality Performance

Quality

Friends and Family Test

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

Last recorded FFT rates prior to the suspension of national submission due to covid19 (February 2020) :

Inpatient 93.3% A&E 88.8% Outpatient 94.7%

NHS England has directed Trusts to recommence FFT collection and national submission from 1 December 2020 for publication in January 2021.

FFT collection recommenced across all BSUH areas on 1 October 2020 for local review:

December internal FFT recommend rates:

FFT Area	Recommend Rate
Inpatient	93.02%
Outpatient	94.05%
Emergency Department	85.06%
Maternity (birth)	93.48%

Whilst there is no overall reason for the decrease in recommend rates across all areas patient comments include concerns about social distancing and the use of PPE. These have been appropriately escalated and are being triangulated with patient feedback collated via plaudits, PALS enquires and complaints.

Performance Summary

Systems & Partnerships

Non Elective Care

Target: A&E 95% <4hrs

Elective Care

Target: RTT 92% <18wks

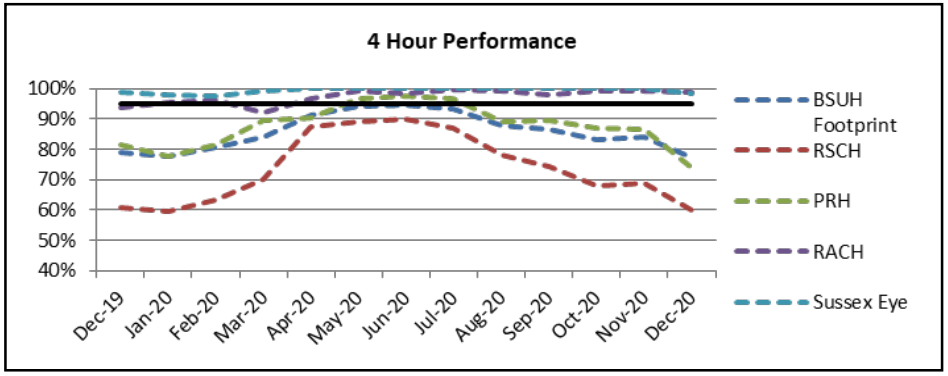
- The Trust achieved 77.2% in December 2020, 1.6% lower than December 2019. This is below the National performance of 80.3%. This was in the context of a 21.4% drop in A&E attendances compared to the same month last year and a 17.5% drop in non-elective admissions.

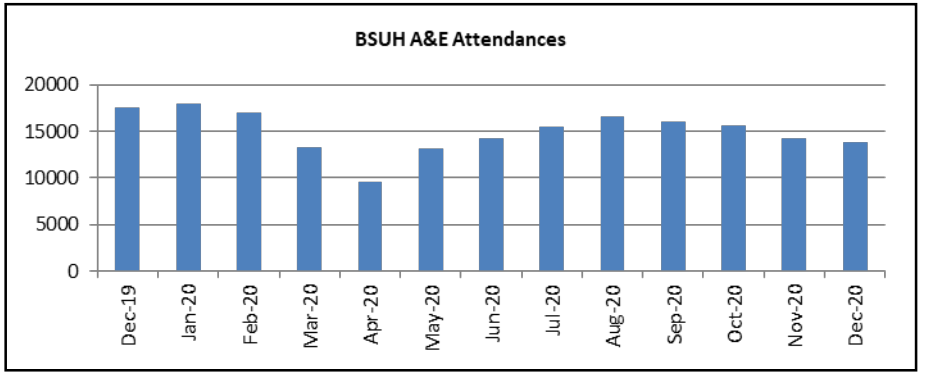
- RTT performance for December 2020 is 60.5%, a decrease of 7.6% compared to December 2019. Performance has decreased by 0.5% compared to the prior month. The total volume of patients waiting more than 52 weeks increased to 2891 which is 86 more than the phase 3 plan. The waiting list size grew to 38024 between months but remains circa 4100 below the prior year.

- The Trust was compliant against 5 of 8 reportable cancer metrics in November 2020. The Trust was compliant for 2 week wait referrals with performance of 96.4% The Trust was non compliant for 62 day treatment following urgent GP Referral with performance at 71.9%. The prospective backlog of patients waiting more than 62 days was relatively stable following significant growth.

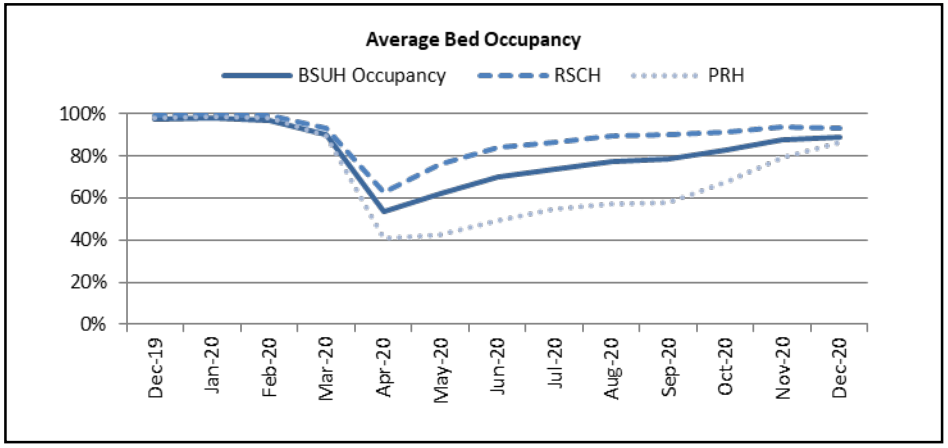
- Diagnostic performance for October 2020 is 35.9%, a 6.5% adverse movement on the prior month. Endoscopy has shown some improvement and additional capacity is expected to came on line in December.

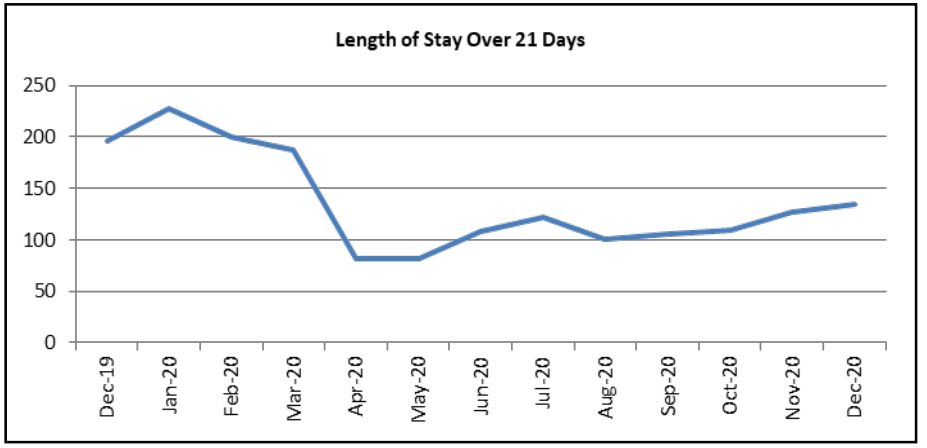
A&E



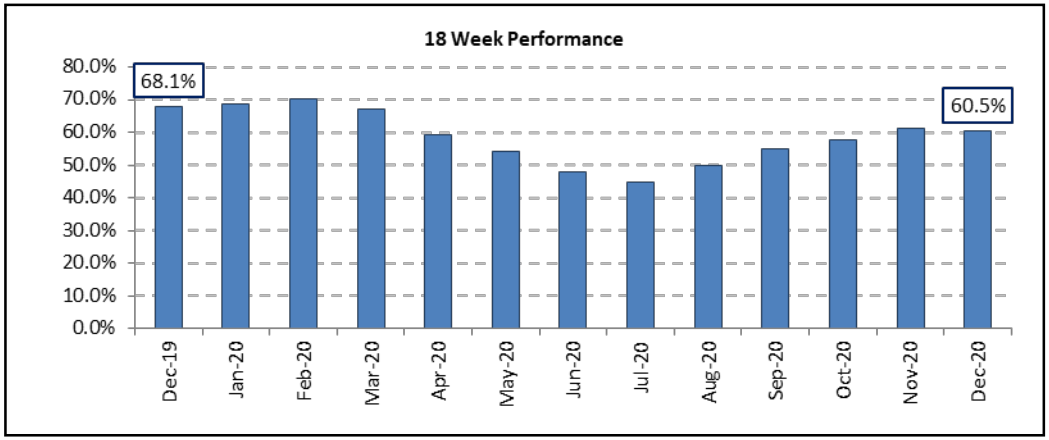


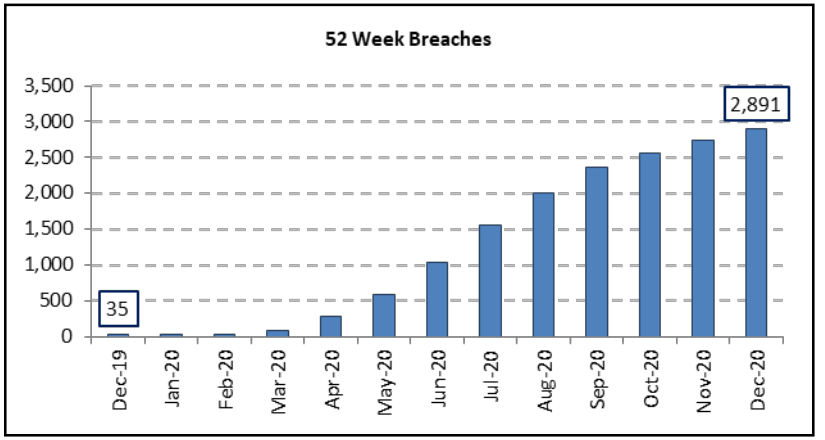
- The Trust achieved 77.2% in December 2020, 1.6% lower than December 2019 and below the National performance of 80.3%.
- A&E attendance and non elective admissions demand reduced in December 20 compared to December 19. Compared to the prior year A&E attendances dropped by 21.4% and non elective admissions dropped by 17.5%.
- Bed occupancy at both RSCH and PRH has been increasing since the low observed in April and in December was circa 89% (93.4% at RSCH).
- The number of patients with a long length of stay increased on the prior month with an average of 134 patients in hospital for more than 21 days.



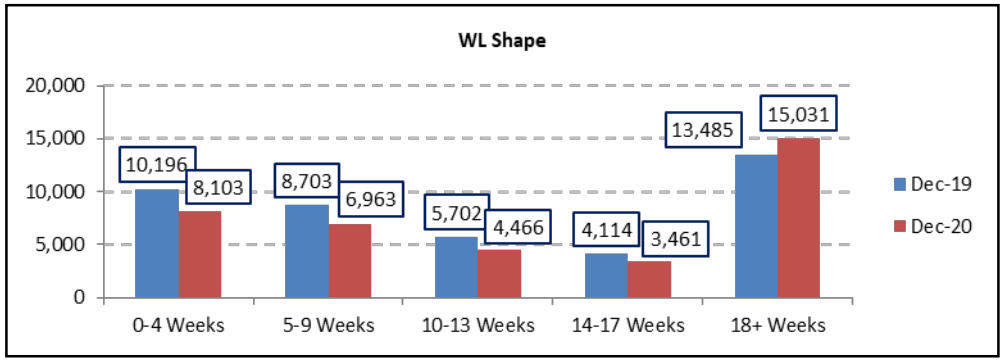


RTT



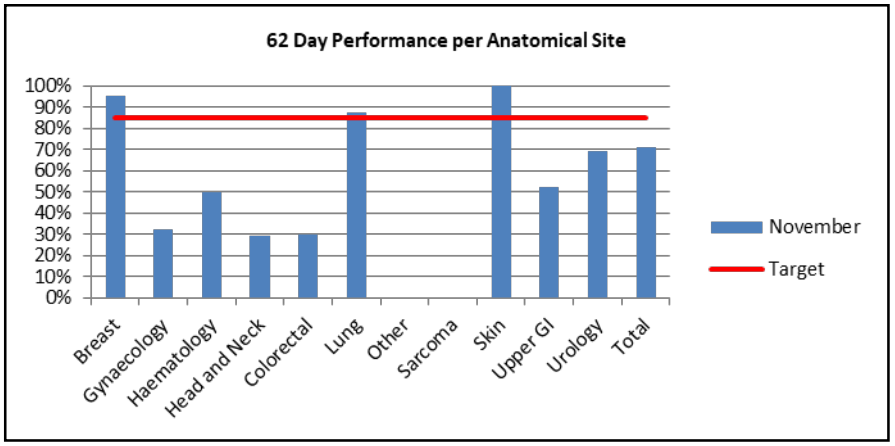


- RTT performance for December 2020 is 60.5%, a decrease of 7.6% compared to December 2019. Performance has decreased by 0.5% compared to the prior month. The total volume of patients waiting more than 52 weeks increased to 2891 which is slightly more than the phase 3 plan.
- December referral demand returned to 91% compared to the same month last year. Clock stops in December are 73.1% restored when compared with the same period last year.
- The waiting list size grew to 38,024 as demand has caught up with supply but remains circa 4,100 less than December 2019.
- Restoration plans progressed well in December but have since been impacted by the current wave of the pandemic.
- A validation of the admitted waiting list has been undertaken.

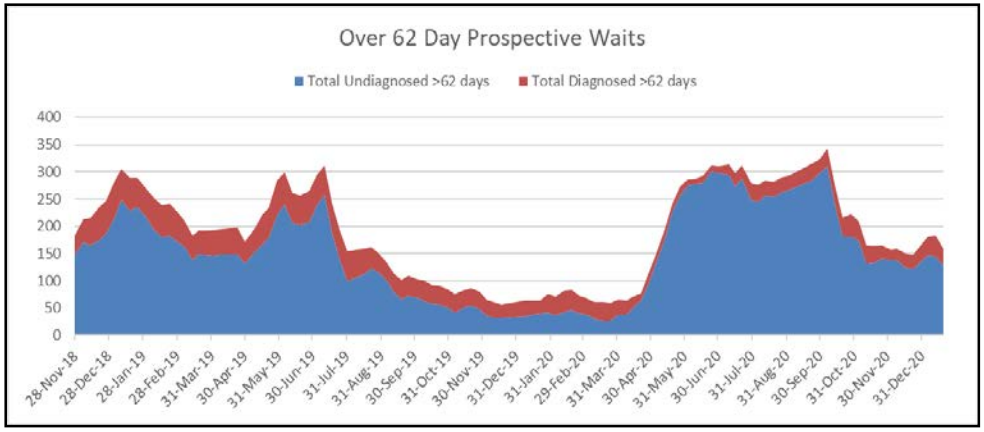


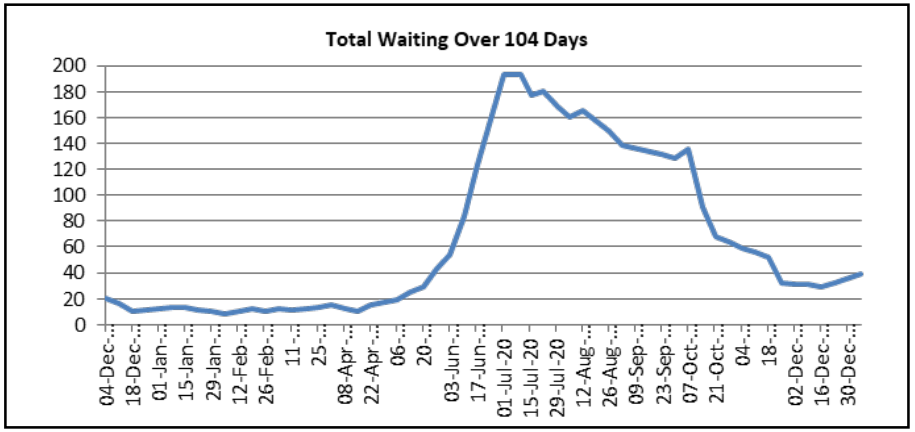
Cancer

	2020/21		
	Nov	YTD	Target
2 week GP ref to 1st OP	96.4%	90.0%	93%
2 week GP ref to 1st OP - breast symptoms	97.4%	96.0%	93%
31 day 2nd or subs trtmnt - surgery	100.0%	95.3%	94%
31 day 2nd or subs trtmnt - drug	100.0%	99.2%	94%
Cancer: 31 day second or subsequent treatment - radiotherapy	87.8%	86.0%	94%
31 day diag to trtmnt all cancers	94.1%	97.5%	96%
62 day ref to trtmnt: screening	94.4%	72.0%	90%
62 day ref to trtmnt : upgrade	90.3%	83.9%	85%
62 days urgent GP ref to trtmnt : all cancers	71.9%	78.6%	85%
28 Day Faster Diagnosis	97.0%		75%

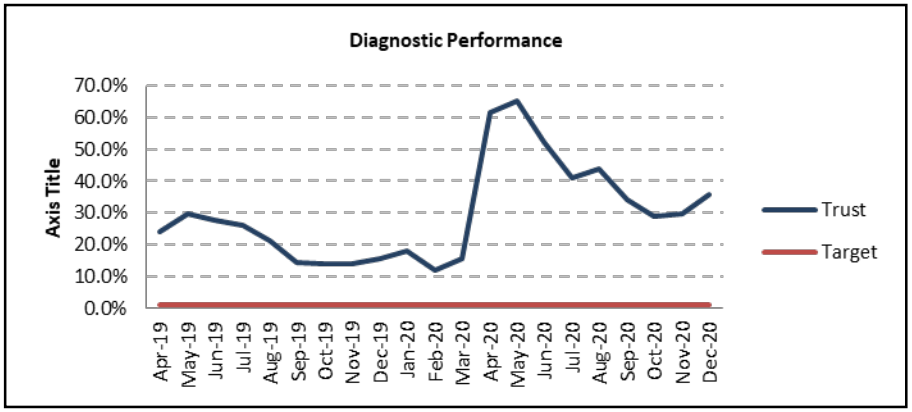


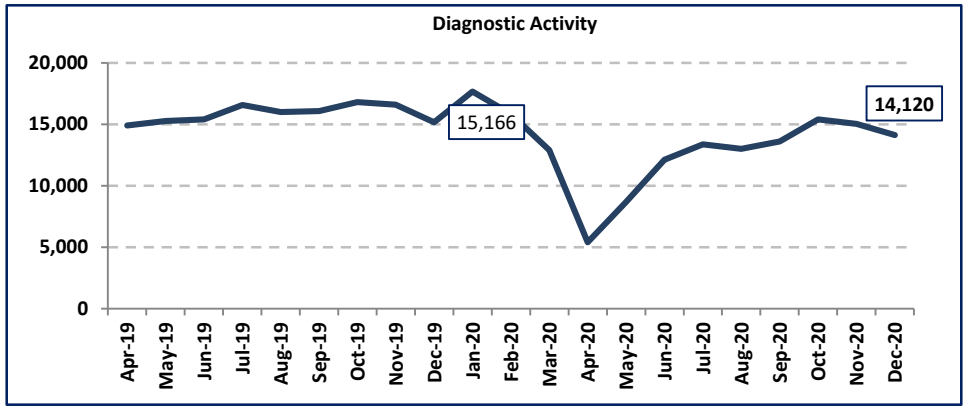
- The Trust was compliant against 5 of 8 reportable cancer metrics in November 2020.
- November performance for the 2ww standard was compliant at 96.4%. This is the highest performance of the 12 month period.
- November performance for the 62 day GP referral was non compliant at 71.9%.
- The prospective 62 day backlog grew materially during lockdown, but fell to the end of July and has remained relatively stable. The majority of over 62 day waits are in the Colorectal speciality.
- 104 day waits increased significantly as a result of the Covid impact but good progress has been made to reduce this number.



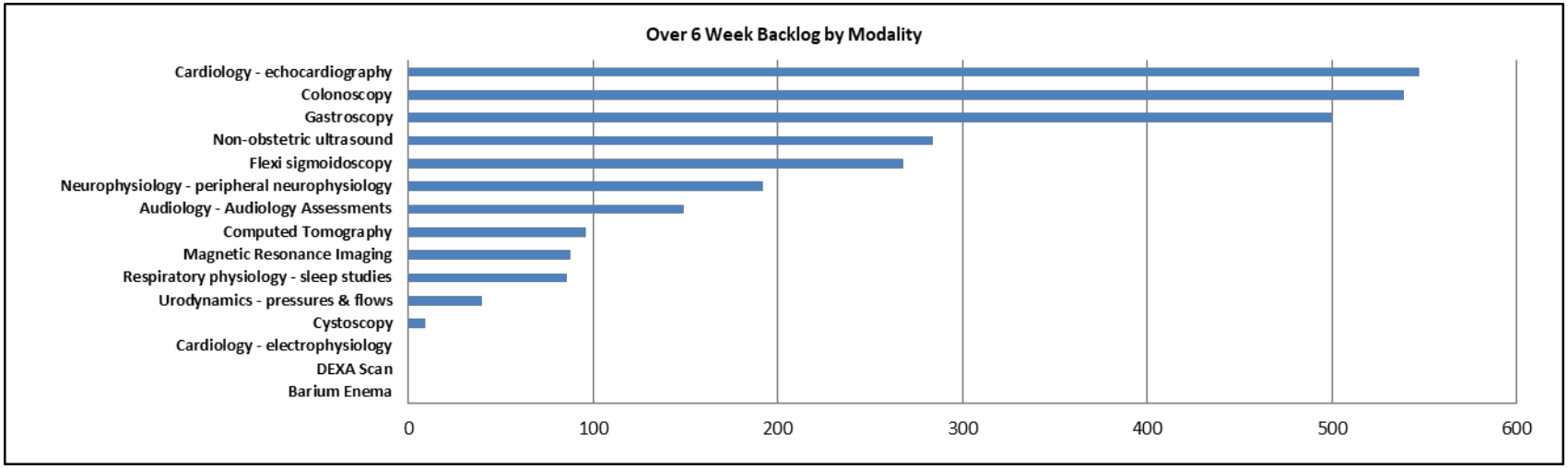


Diagnostics

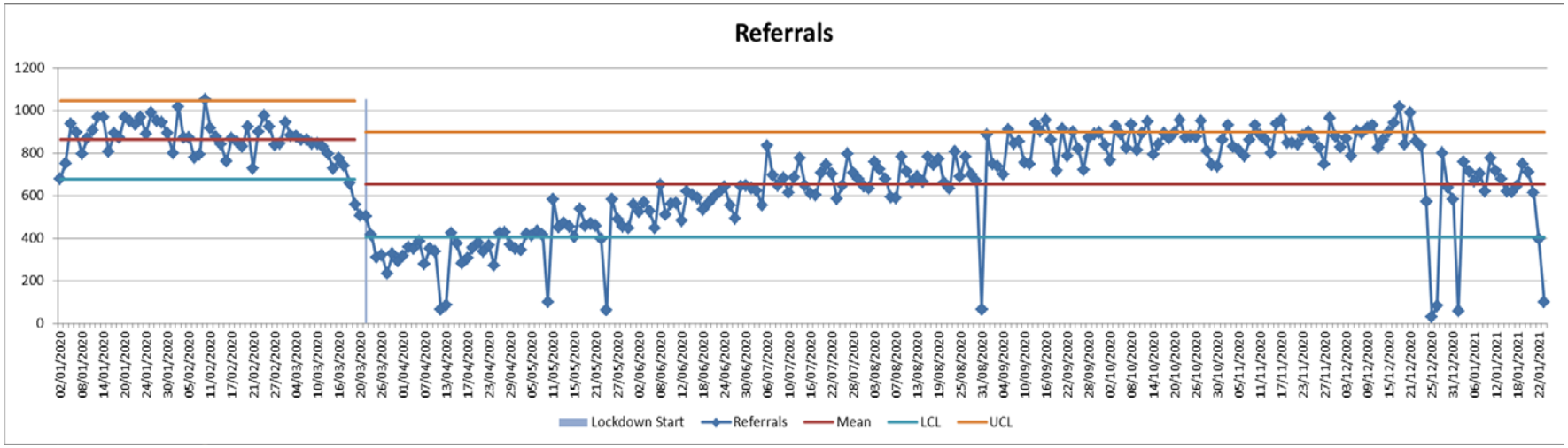




- Diagnostic performance for December 2020 is 35.9%, a 6.5% adverse variance when compared to the prior month.
- Endoscopy restoration improved by 20% compared to the prior month.
- Imaging modalities have restored to or above pre Covid levels well in CT and MRI.
- Cardiac Echocardiography has the biggest number of over 6 week waiting patients. Recovery actions are in place to support gaining an improvement in the position.



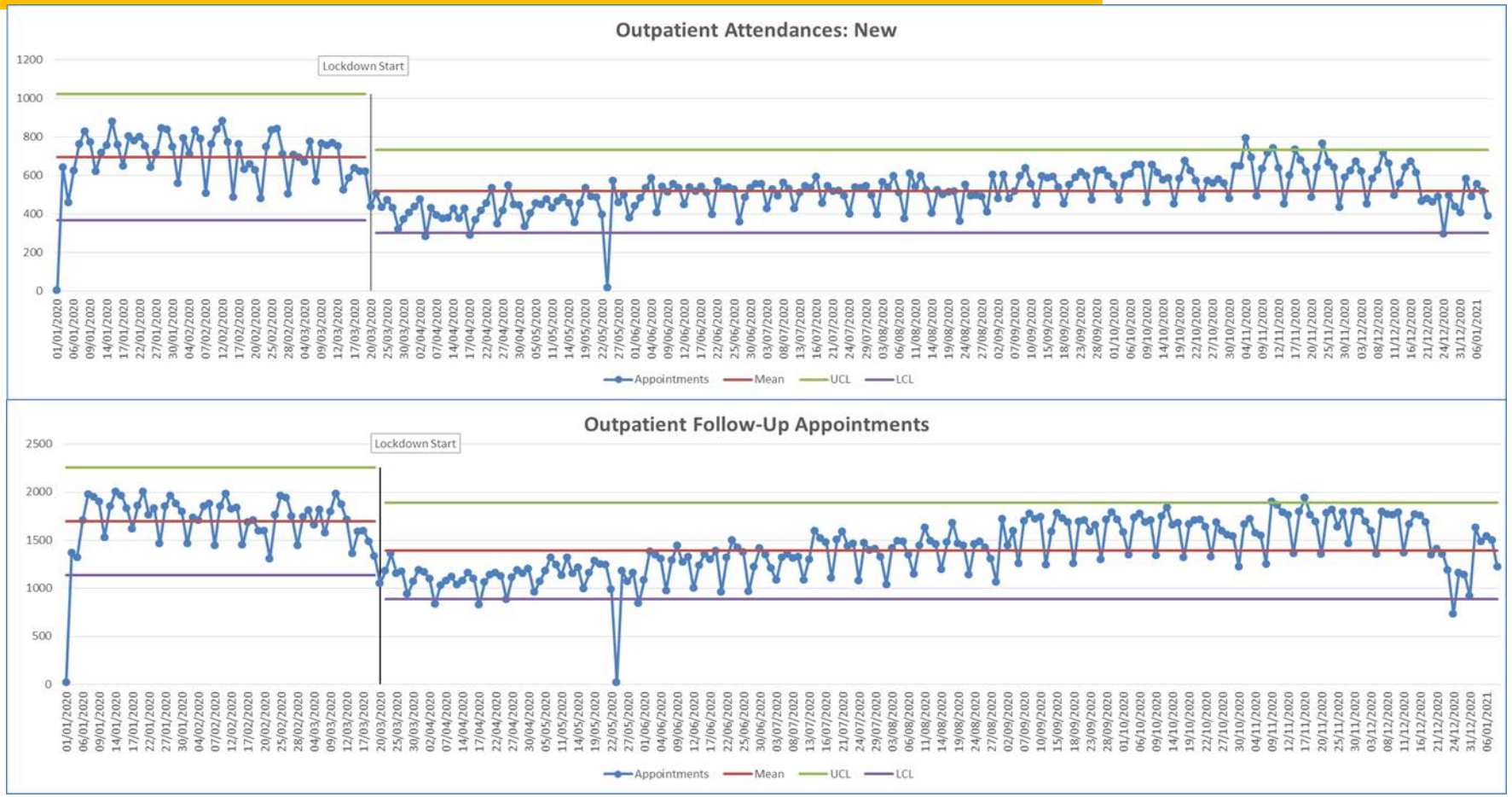
COVID-19 Annex : Elective Referrals



For December 2020:

- Elective referral demand has been restored to 108% of pre-Covid levels.

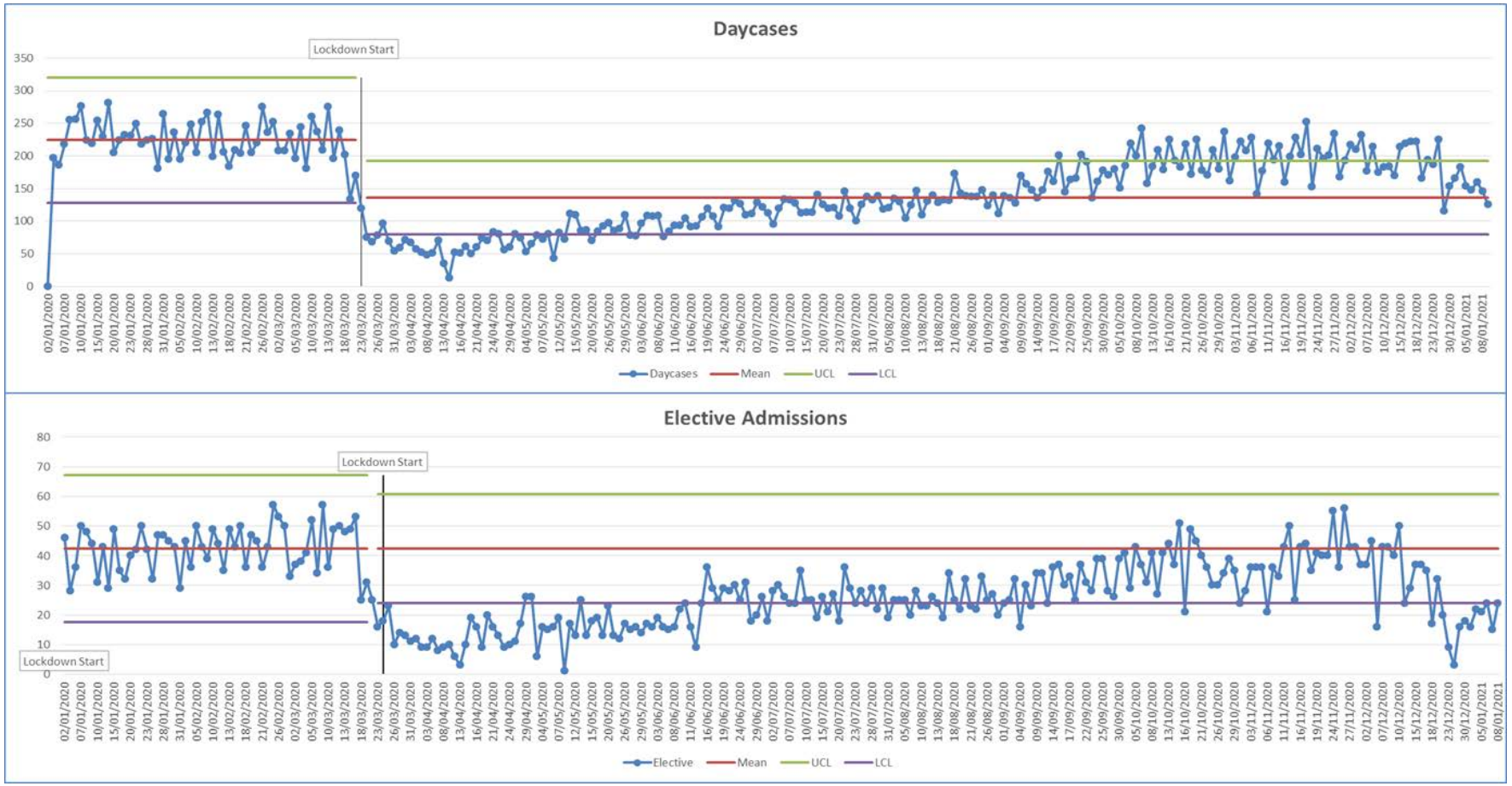
COVID-19 Outpatient Attendances



For December 2020:

- New OP activity has been restored to 89% of pre-Covid levels.
- Follow Up OP activity has been restored to 103% of pre-Covid levels.

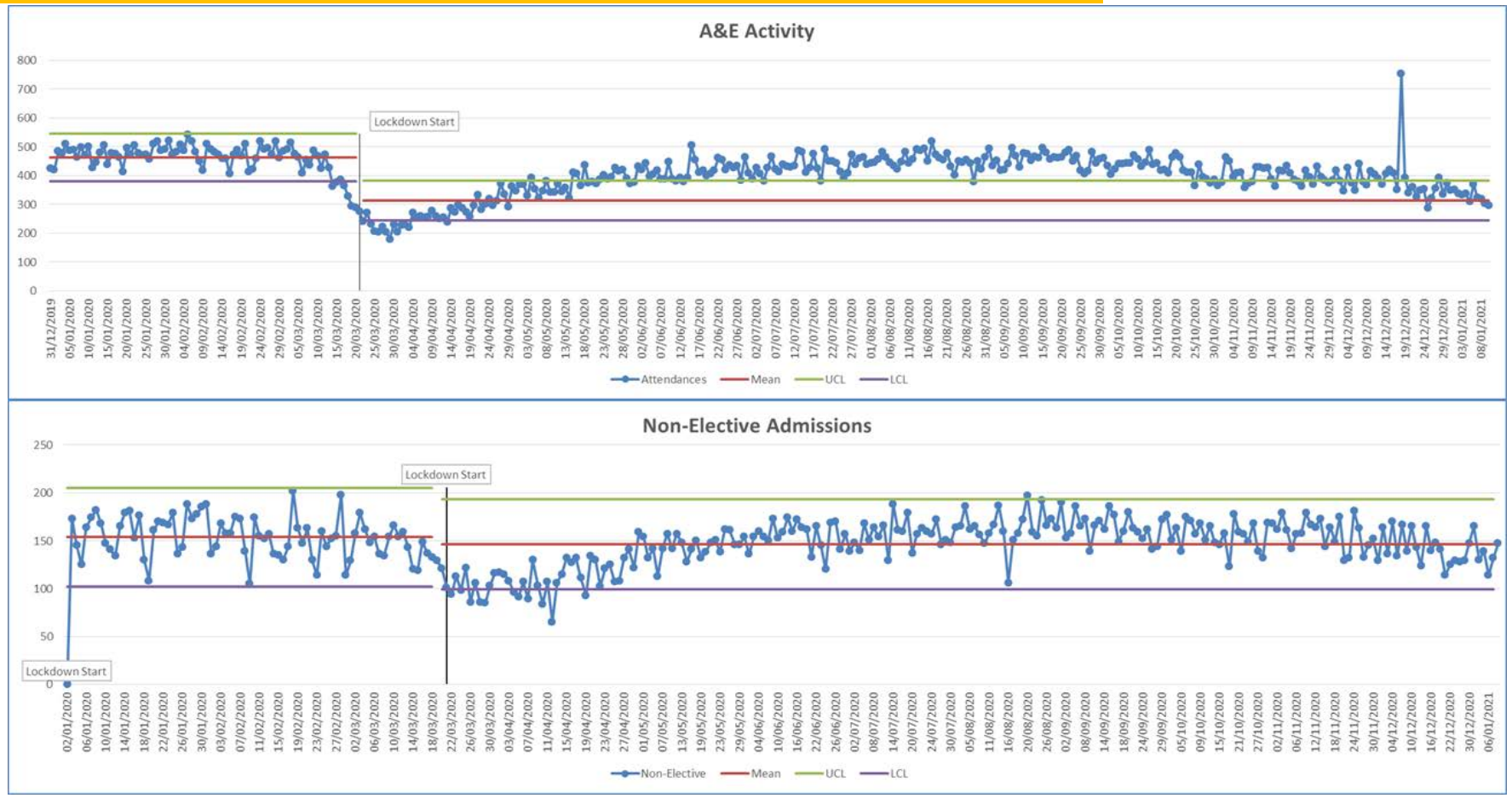
COVID-19 Elective Admissions



For December 2020:

- Day case activity has been restored to 91% of pre-Covid levels.
- Inpatient activity has been restored to 82% of pre-Covid levels.

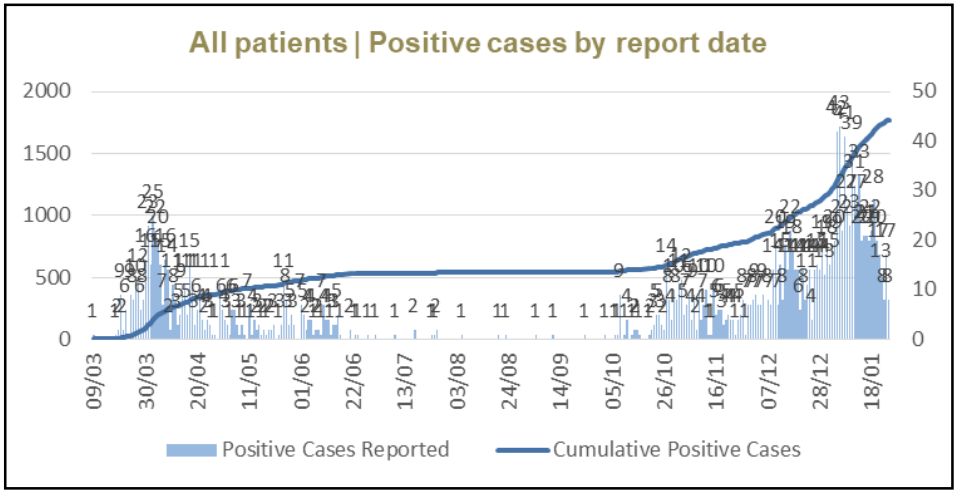
COVID-19 Emergency Demand

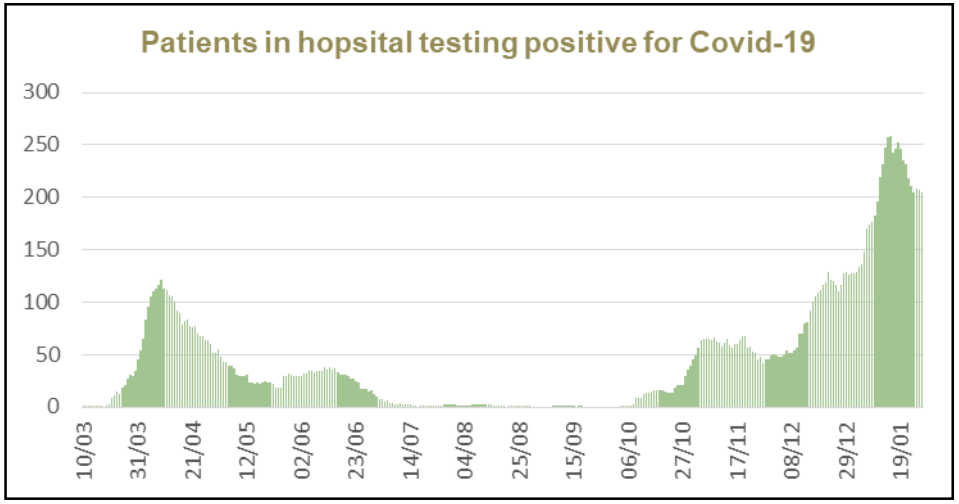


For December 2020:

- A&E attendance activity returned to 80% of pre-Covid levels.
- Non elective admission activity returned to 83% of pre-Covid levels.

COVID-19 Occupancy and Positive Testing





All confirmed Covid-19 patients					
1771	266	1143	362	16.5	17.4
Admissions for lab-confirmed Covid19	15% patients remain In hospital	65% Discharged	20% Patients Died	Average length of stay for discharges	Average length of stay for deceased

Patients admitted to Critical Care					
207	49	108	50	25.6	19.7
12% Patients go to ITU/HDU	23.7% patients remain in hospital	52.2% Discharged	24.2% Died	Average length of stay for discharges	Average length of stay for deceased

Patients staying on general wards only					
1564	217	1035	312	15.6	17.0
88% Patients stay in other wards	13.9% patients remain in hospital	66.2% Discharged	19.9% Died	Average length of stay for discharges	Average length of stay for deceased

As at 27th January 2021

Financial Performance - Summary

Sustainability

Financial Management

Target: Break Even

- The Trust has continued to operate within the interim (Phase 3) financial framework that has been in place since October; the purpose of which was to support the overarching priority to accelerate non-COVID activity, alongside continuing readiness for winter and a potential increase in COVID-19 cases.

- Each Integrated Care System (ICS) has been provided with a fixed funding envelope; including resources to meet the additional costs of COVID-19 response and recovery. Systems are expected to breakeven; subject to mutual agreement, organisations within the ICS may deliver surplus and deficit positions. The Trust submitted a revised draft financial plan to NHSE/I in November 2020 with a deficit of £5.64m. After allowable adjustments the planned performance deficit was £1.92m.

- As at the end of Q3, the Trust delivered a cumulative surplus of £1.60m against a planned deficit of £1.72m; resulting in a favourable variance of £3.32m. This is due to less cost incurred for elective activity partially offset by Covid-19 costs. The Trust is continuing to forecast a performance deficit of £1.92m at year end

Financial Performance – Key Metrics

Control Total Surplus £k — **G**

	Plan	Actual / Forecast
Year to Date	1,720	(1,600)
Year End Forecast	5,634	8,515
Year End Forecast (after allowable items)	1,915	1,915

The Trust has set a £5.64m deficit plan for M7-12. Loss of Non-NHS Income and increase in outstanding annual leave at year-end are allowable items. This reduces the performance deficit to £1.9m. The forecast deficit is increased to £8.5m to refelct increased annual leave costs. once adjusted, the forecast perofermance deficit remains at £1.9m

In Month 9, the Trust generated a £1.09m surplus position for December 2020 against a planned deficit of £0.57m.

COVID-19 £k — **G**

COVID-19 Response	(18,415)
Income Shortfall (not mitigated by under spends)	(1,548)
Top-Up and System Income recovered	(19,963)

Total COVID-19 top-up and system income of £19.96m has been included in the year to date position, which covers the additional costs of COVID-19 and lost income, which has not been mitigated by under spends due to reduced levels of activity during April to December 2020.

Cash £k — **G**

	Plan	Actual / Forecast
Year-to-date	35,331	76,239
Year-end Forecast	7,000	12,634

Under the interim financial framework, the block and top-up payments for January 2021, amounting to £50.91m, were received in December 2020.

Capital £k — **G**

	Plan	Actual / Forecast
Year-to-date	69,377	87,541
Year-end Forecast	103,951	129,856

The M09 forecast outturn is £25.9m more than the plan set in Q1. This is due to additional spend approved for 3Ts and national funding awarded; £3.7m towards winter A&E investments, £0.8m for Diagnostic Imaging, £0.8m for Critical Care Beds, £1.6m for Endoscopy capacity and £2.3m for Covid-19 capital after the plan was submitted.

Financial Performance - Plan

Sustainability

Financial Management

Target: Break Even

- NHSE/I have confirmed in principle that both the in-year movement in untaken annual leave and the loss of Non-NHS income are allowable deficits, when assessing the Trust's financial performance.
- The submitted deficit plan of £5.64m included £3.72m of allowable deficits so the deficit plan for assessing the Trust's financial performance was £1.92m.
- The Trust year-end forecast deficit, as at Month 9, has increased by £2.88m; from £5.64m to £8.52m.
- The increase in the forecast out turn is solely related to the cost of the anticipated increase in untaken annual leave, which is an allowable deficit; as such the forecast Trust financial performance deficit remains at £1.92m.
- Forecast system funded COVID expenditure has increased by £1.4m, as a result of the second wave response; financial impact of which is offset by a forecast reduction in restore and recover elective expenditure, due to reduction in elective activity levels.

Financial Performance - Action & Recommendations

There are no actions required of the Board.

The Board is asked to note the following:

- In December 2020, the Trust reported a surplus of £1.09m, which was £1.66m better than the plan. Year-to-date the Trust is reporting a surplus of £1.60m which was £3.32m better than plan.

- The Trust is forecasting to deliver the planned Trust's financial performance deficit of £1.92m; after adjusting for allowable items.

- Forecast system funded COVID expenditure has increased and is being offset by a forecast reduction in restore and recover elective expenditure.

- Detailed financial performance information has been shared with Finance and Performance Committee; who continue to provide oversight on behalf of the Board.

Our People - Staff Engagement

People

Staff Engagement
Target: Top 20% Engagement Score

NHS Staff Survey 2020 Results
These are currently embargoed until later in February 2021.

Equality, Diversity and Inclusion
The Annual Equality Report is now complete and is being be presented for internal approval and sign-off. This showcase the work that is taking place to meet our statutory and regulatory obligations.

Volunteers
The Trust has 341 registered volunteers. Volunteering activity inevitably fell during 2020 (a combination of volunteers' themselves shielding, and Covid wards being unsuitable for volunteers). The number of placed volunteers is now gradually increasing (80 volunteers currently), reflecting volunteers' roles in areas such as the vaccination clinics.

The interest in volunteering remains high. As at December 2020, BSUH had 118 people on the waiting list plus 75 new volunteers in the recruitment process. All without the need to advertise.

BSUH secured £20,000 from Health Education England to roll out the National Volunteer Certificate (NVC) between now and March 2022 through 'Assemble', the new volunteer management database (currently being implemented at BSUH, and WSH). This will help to systematise training and develop a cohort of volunteers who could transition to paid support worker roles more easily (the NVC modules have been mapped to the outcomes of the National Care Certificate and Core Skills Training Framework to provide some common underpinning knowledge).

Our People – HR Key Metrics

	Sickness %	Turnover %	Appraisal %
Trust	4.96%	10.5%	74.5%
Central Clinical Services	5.01%	12.4%	78.4%
Children & Women	4.45%	10.9%	73.7%
Medicine	5.33%	11.2%	73.9%
Specialised Services	4.33%	8.6%	67.0%
Surgery	4.88%	10.6%	73.4%
Target - 2020/21 Y/E	4.20%	12.0%	90.0%

In **December,** the Trust's **Turnover** (external leavers) reduced from 10.8% to 10.5% which remains favourable to the 12.0% Target. Turnover is at its lowest level since August 2012.

The Trust's **one month Sickness Absence** rate was 5.30% in **November**, of which 0.28% was specifically Covid-19 and 5.02% other Sickness Absence. In November 2019 that rate was 5.11%.

The **12 month Sickness Absence rate** is now 4.96%, compared to 4.37% twelve months ago.

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The Trust's (non medical) **Appraisal rate** stood at 74.5% in **December**, an improvement on the November rate of 73.3%. It is the fifth month in a row where rates have increased. However, appraisal rates remain down on both December 2019 month (86.8%) and the average across the 2019 calendar year (83%). A recovery plan is in place.

Statutory and Mandatory Training (STAM) compliance has decreased from 85% to 84%. In January BSUG paused face-to-face STAM *update* training for four week, due to the impact of the Covid surge on workforce capacity to undertake the training. This included Paediatric and Advanced Life Support and Patient Moving & Handling. This was following a full consideration of the risk.

Our People – Recruitment and Vacancies

	Vacancy %
Trust	8.7%
Central Clinical Services	7.2%
Children & Women	3.1%
Medicine	12.2%
Specialised Services	7.3%
Surgery	9.3%
Target - 2020/21 Y/E	10.0%

	Vacancy %
Medical	0.5%
Nursing - Registered	11.8%
Nursing - Unregistered	13.9%
Nursing - All	12.5%
S,T&T	8.6%
Admin & Clerical	6.1%
Ancillary Support	11.3%

In **December** the Trust's overall Vacancy Rate reduced to 8.7% from 8.8% and remained below the Trust Target of 10.0%. There are currently 755 FTE of vacancies across the Trust:

- Medical: 7 FTE
- Nursing: 459 FTE
- Scientific, Therapeutic and Technical (S,T&T): 112 FTE,
- Admin & Clerical: 100 FTE
- Ancillary Support: 77 FTE.

If staff groups are shown by Vacancy Rate rather than vacant numbers, then it shows Medical at 1%, Nursing at 13%, S,T&T (9%), Admin & Clerical (6%) and Ancillary Support (11%).

Recruitment - As at 15 Jan 2021, there were:

- 211 vacancies in the pipeline which equates to 317.63 FTE.
- 496 candidates are being processed. (167 are COVID workers, 329 are business as usual).
- 309 Medical Students have been contacted to support with work as HCA'S, out of these 132 are being processes and are in the figures above.

25 International Nurses are in the pipeline, with 17 joining BSUH during February 2021

Our People – Covid-19

Overview – The Trust closely manages its workforce situation relating to Covid-19 and continue its programme of risk assessments, staff testing and support.

Over 60's and 70's Risk Assessment – This commenced in mid-November. 82% of age 60 to 69 have been completed and 90% of over 70's.

Clinically Vulnerable – Staff previously recorded as shielding were contacted to identify their current position and to provide support and advice as required. 100% of these staff have been risk assessed. There are currently 199 individuals either working form home or not at work.

Surveillance Testing – The Trust commenced (asymptomatic) lateral flow self-testing which is used by most staff at BSUH including bank workers.

Vaccinations – BSUH is offering staff vaccination both at the Royal Sussex County Hospital and at the Princess Royal Hospital site.

Covid Absence

Under NHS guidance, staff either Self-Isolating or Shielding due to Covid-19 are recorded as Special Leave rather than Sickness Absence. In November 2020 the Absence rate of these staff was 0.16%, putting total Covid-19 related staffing absence at 0.44%. The total of all Sickness Absence plus Covid-19 related Special Leave was at 5.46%. This compares to 4.95% last month, and 10.68% at the April peak.

Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	10	Meeting:	Trust Board in Public	Meeting Date:	2 February 2021
Report Title:	Report from Quality Assurance 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	The Committee's focus was on supporting the flow of assurance on quality, safety and patient experience to the Board.
Financial	The Committee did not refer any matters to the Finance and Performance Committee.
Workforce	The Committee agreed to keep under review the BAF risks relation to staff wellbeing given the demands on the Trust.

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

Communication and Consultation:

Executive Summary:

The attached report provides the Board with information from the Quality Assurance Committee meeting on the 22 December 2020.

The Quality Assurance Committee was quorate and was attended by four Non-Executive Directors and the following Executives, Chief Medical Officer and the Chief Nurse along with the attendance from the Trust's Medical Director and Trust's Quality Governance Director.

The Committee meeting, received reports covering the suite of quality performance metrics along with an update on the Trust's approach to Ophthalmology virtual clinics, a report on the Trust's current Covid position, an update on the Trust's CNST submission which included a briefing on the Trust's response to the Ockendon Report; the Trust workforce update, an update on the Trust's External Visits Register, the Quarterly Junior Doctors Guardian of Safeworking report and the Information Governance Caldicot Update.

The Committee also considered the risks within the BAF for which it has oversight for and agreed their current scores fairly represented these risks.

Brighton and Sussex University Hospitals NHS Trust

Key Recommendation(s):

The Board is asked to:

- **NOTE** the assurances received at this meeting, in particular those relating to patient safety where treatment has been delayed and the learning and action taken as a result of incident investigations and the review of patient mortality data.

- **NOTE** the assurance provided to the Committee in regards to the implementation of Ophthalmology virtual clinics in support of addressing the workload demands on this service

- **NOTE** the assurance provided in respect of the current Covid plans in place for the Trust.

- **NOTE** the report received in regards to the CNST maternity standards submission and note the assurance received in relation to the Trust's response to the Ockendon report.

- **NOTE** the view of the Committee in respect of the BAF risks it has oversight for, in that the current scores are a fair reflection of these risks.

To: Trust Board Date: 2 February 2021

From: Quality Assurance Committee Chair

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Dates	Chair	Quorate	
			yes	no
Quality Assurance Committee	**22 December 2020**	**Mike Rymer**	✓	☐

Declarations of Interest Made

None

Actions taken by the Committee

- The Committee **RECEIVED** an update which focused on Mortality (the Crude mortality rate, HMSR and SHMI) and noted the impact Covid deaths have on these metrics, with HSMR excluding these to allow comparison for none Covid patients with those prior to the Covid pandemic The Committee was **ASSURED** over the actions taken supporting mortality performance and was **ASSURED** over the processes being developed to link the structured judgemental reviews to the Trust's Serious Incidents processes. The Committee **NOTED** the work being undertaken to increase the number of cases being reviewed which makes their outcome more meaningful.

- The Committee **RECEIVED** a report from the Chief Nurse and Trust Quality Governance Director in respect of the Patient Safety metrics, these covered pressure care, falls and incidents with the reporting including actions taken in respect of national safety alerts. The Committee was informed over the developed report for Board in respect of Serious Incidents and to report information at a thematic level to support learning.

- The Committee **RECEIVED** an update from the Trust Medical Director on the outcomes of patient reviews where the cancer treatment had been delayed by more than 64 days and the patient reviews where there had been a delay in excess of 52 weeks. The Committee was **ASSURED** over the outcome of the patient reviews where delays in treatment for cancer of over 64 days and where there had been a delay of over 52 weeks.

- The Committee **RECEIVED** an update from the Quality Governance Steering Group and stated that the Steering Group has focused on medical and nursing workforce pressures throughout the pandemic and continues to be a point of focus.

- The Committee **RECEIVED** an update from the Trust Medical Director on the Ophthalmology glaucoma services and the improvements being made to this service through workforce modernisation.

- The Committee **RECEIVED** a report in respect of the Trust's CNST Maternity Standards and agreed to receive the final submission for approval in June 2021. The Committee **NOTED** the Trust's response to the Ockendon report and the submission made indicating compliance with the key actions required of all Trusts and that the progress against all the actions will be linked to the Trust's CNST complaicne submission in June 2021.

- The Committee and **NOTED** the Trust's current Covid position and **RECEIVED** assurance over the plans in place throughout the Christmas and New Year period.

- The Committee **NOTED** the Trust's workforce headline absence data and the trajectories for improvement in this area.
- The Committee **NOTED** a report regarding the delivery of the work in respect of IG and the caldicott guardian.
- The Committee **NOTED** the Junior Doctor guardian of Safeworking report.
- The Committee **RECEIVED** and **NOTED** the Trust External Visits Register which had been subject to extensive review and was **ASSURED** over the actions being taken as a result of these visits.
- The Committee reviewed the BAF risks for which it has oversight and **AGREED** their scores were fairly represented, and **AGREED** that whilst not recommending any changes, the People risks relating to 3.3 and 3.4 need to be kept under careful consideration given the pressure on Trust services and its impact on staff wellbeing.

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

The Committee discussed the requirement to hold a Quality Assurance Committee seminar prior to 21 January 2021 to gain further assurances relating to the patient experience at the Trust.

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

Item	Referred to
There were no specific matters were referred to the Finance & Performance Committee or Board.	

Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	11.	**Meeting:**	**Trust Board**	**Meeting Date:**	**2 Feb 2021**
Report Title:	Report from Finance and Performance Committee Meeting Chair				
Sponsoring Executive Director:	Patrick Boyle, Non-Executive Director				
Author(s):	Patrick Boyle, 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	The Committee did not refer any matters to the Quality Assurance Committee.
Financial	The Committee's focus was on supporting the flow of assurance on financial and performance systems of internal control to the Board.
Workforce	Under the revised Committee governance processes workforce matters and assurance would be taken directly at the Board

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

Communication and Consultation:

Executive Summary:

There has been one Finance and Performance Committee meeting since the last Board this being on the 26 January 2021. The attached document provides an update to the Board on this meeting.

The Finance and Performance Committee was quorate and was attended by two Non-Executive Directors and the Trust Chair along with the following Executives, the Chief Executive, Deputy Chief Executive Officer, the Chief Financial Officer, Chief Operating Officer and Chief Nurse along with the attendance from the Finance Director, Director of Performance, Trust Medical Director and from the Strategic HR Advisor.

The Committee received information on key performance and financial matters along with that relating to the Trust's Efficiency programme and information on the Trust's workforce capacity and performance metrics. The Committee also considered the BAF risks for which it has allocated oversight.

Key Recommendation(s):

The Board is asked to **NOTE** the assurance provided at this meeting; and **NOTE** the view of the Committee in respect of the BAF risks it has oversight for, this being that the current scores are a fair reflection of these risks.

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board

Date: 2 February 2021

From: Finance and Performance Committee Chair

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Finance and Performance Committee	**26 January 2021**	**Patrick Boyle**	✓	☐

Declarations of Interest Made

None

Actions taken by the Committee

- The Committee **RECEIVED** a report from the Chief Operating Officer and the Director of Performance on the Trust's performance against the constitutional standards and the Trust's developed restoration and recovery plans across each of these. The Committee received information on the delivery of the established restoration plan and the Trust's delivery against the trajectory through November and into December which was then impacted by the second lock down and impact of covid patients. The Committee was updated on the work undertaken to enable the Trust to focus on managing the impact of the pandemic in December which continues into January. The Committee was updated on the work being undertaken with the independent sector to maintain activity, but with resources focusing on covid patients it is impacting on the original restoration plan, and this will see a revised plan being developed as the system and Trust moves from covid management back to restoration. The Committee discussed the risks to Trust's performance delivery whist managing the pandemic demands and **AGREED** that these challenges were reflected within the Trust's BAF with risks 5.1, 5.2 and 5.3 with risk 5.3 being the highest scored risk within the BAF.

- The Committee **RECEIVED** a report on the Trust's financial performance and noted the position for month nine under the revised national financial regime sees the Trust in an equivalent break even position. The Committee **RECEIVED** information on the robust financial governance framework applied to the covid costs and was **ASSURED** over their application. The Committee received information that the new framework will be more aligned to the underlying position, this supported the BAF risk scores for risks 2.1 and 2.2 not yet changing.

- The Committee **RECEIVED** an update Trust Finance Director on the Trust's ledger upgrade and was **ASSURED** over the project plan delivery for a combined ledger (version 11) is materially complete. The Committee **RECEIVED** an update on the progress to migrate to version 12 and that a further update on progress would be provided to the next meeting along with risk mitigations given the transfer for BSUH is close to the year end. The Committee was informed that this update supports no change in BAF risk 2.3.

- The Committee **RECEIVED** a report on the Trust's efficiency programme. The Committee was updated on the work that is progressing and the Trust is its delivery and the work being undertaken deliver and further develop the tactical schemes.

- The Committee **RECEIVED** a report on the Trust workforce capacity and performance indicators and recognised the linkage between this report and extra workforce costs through use of bank and agency staff. The Committee was updated on the key workforce KPIs including as requested by the Committee trajectories for improved appraisal compliance which sees focus being given to support corporate areas which are less impacted by the covid response, coupled with the launch of the welfare appraisal

process which is rolled out to support staff. The Committee **RECEIVED** an update that initial feedback on the welfare appraisal has been positive and was supporting staff. The Committee **RECEIVED** information in respect of the linkages between the rostering and payroll as requested at its last meeting.

- The Committee reviewed the BAF risks for which it has oversight for and **AGREED** these were fairly represented, nothing that the quarter four update to the BAF is currently underway. The Committee was informed that the risks relating to workforce wellbeing are being actively considered given the activity pressure on the Trust

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

The Committee is to receive a further update on the ledger upgrade to version 12 at its meeting in February.

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

Item	Referred to
There were no items referred to r other Committees from the meeting. The Committee recommended to the Board that the risks within the BAF for which it has oversight are fairly represented, recognising that the quarter four update was in progress.	

NHS
Brighton and Sussex University Hospitals
NHS Trust

Agenda Item:	12	**Meeting:**	Board	**Meeting Date:**	2 Feb 2021
Report Title:	**Board Assurance Framework – 2020/21 Quarter 3**				
Sponsoring Executive Director:	Glen Palethorpe, Group Company Secretary				
Author(s):	Glen Palethorpe, Group Company Secretary				
Report previously considered by and date:	The relevant risks have been considered by Quality Assurance Committee 22 December 2021 Finance and Performance Committee 26 January 2021 TEC 19 January 2021				

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 13 strategic risks which have been assessed against the Trust's risk appetite when setting their target score. The Trust's risk appetite statements are under review and in setting the target risk scores reflect the Board's view in respect of patient treatment times being aligned to their clinical priority and need rather than solely being driven by the duration of the wait.

The opening score for 2020/21, has taken into account the changing environment the Trust is operating within post Covid. There has been one risk added to the BAF for 2020/21, this is within the people section of the BAF. Risk 3.4 relates to the risk to staff wellbeing resulting from increased demands brought about by the pandemic and whilst many actions have been taken further work is being undertaken through the Trust's Refresh, Restoration and Recovery plans.

BAF Summary

The table overleaf shows by risk, their current score and their target risk score The table shows pictorially the movement in risk between the current score for Q3 and that recorded for Q2. (⟷ No change, ↑ an increase in risk and ↓ a decrease in risk)

Noting that there is one risk, risk 2.3 which is currently at its target score and therefore the BAF process for this risk is about securing assurance that this acceptable (target) level of risk is maintained.

Quarter 3 update

Risk 5.3 which is in relation to the Trust's consistent delivery of the NHS Constitutional targets remains the Trust's highest scoring current risk at 20.

Risk 5.2 has been reduced this quarter. Although the risks as a result of a second wave of COVID and winter pressures remain, the completion of the actions required give assurance about the planning and mitigating actions to minimise these if possible. As a result of this, combined with the agreement for the revised programme for 3Ts, the likelihood score of the risk has reduced to 4 although the overall risk rating remains high. It is not expected this will decrease further in the next quarter given the work being undertaken within the system and wider national NHS, in respect of COVID, and Winter pressures.

Risks 2.1, 2.2 and 5.1 remain at their previous quarter scoring 16.

The update for quarter 4 is currently taking place and through the review of all risks will consider the comments made by the Finance and Performance Committee in relation to the activity demands on the Trust and their potential to impact on the people risks, especially those linked to BAF risk 3.4, should be considered.

BAF: Strategic Objectives and Strategic Risks (Key: I = Impact L = Likelihood T = Total)	Opening risk			Risk Scores											
				Q2			Q3			Q4			Target		
	I	L	T	I	L	T	I	L	T	I	L	T	I	L	T
1. Patient ***Quality Assurance Committee***															
1.1 we are unable to deliver or demonstrate a continuous and sustained improvement in patient experience resulting in adverse reputational impact and loss of market share	3	3	**9**	3	3	**9** ↔	3	3	**9** ↔				3	2	**6**
2. Sustainability ***Finance and Performance Committee***															
2.1 We are unable to align or invest in our workforce, finance, estate and IM&T infrastructure effectively to support operational resilience, deliver our strategic and operational plans and improve care for patients	4	3	**12**	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	4	3	**12**	4	4	**16** ↑	4	4	**16** ↔				4	2	**8**

unmanaged deficit and inefficient, unaffordable and unsustainable services															
2.3 We are unable to meet high standards of financial stewardship meaning we cannot sustain compliance with our statutory financial duties	4	2	**8**	4	2	**8** ⟷	4	2	**8** ⟷				4	2	**8**
3. People ***Quality Assurance Committee and Board***															
3.1 We are unable to appropriately develop and sustain the leadership and organisational capability and capacity to lead on going performance improvement and build a high performing organisation.	4	3	**12**	4	3	**12** ⟷	4	3	**12** ⟷				4	2	**8**
3.2 We are unable to effect cultural change and involve and engage staff in a way that leads to continuous improvements in patient experience, patient outcomes, and staff morale and wellbeing	4	3	**12**	4	3	**12** ⟷	4	3	**12** ⟷				4	2	**8**
3.3 We are unable to meet our workforce requirements through the effective recruitment, development, training and retention of staff adversely impacting on patient experience and the safety, quality and sustainability of our services	4	3	**12**	4	3	**12** ⟷	4	3	**12** ⟷				4	2	**8**
3.4 We are unable to consistently meet the health, safety and wellbeing needs of our staff as we recover and restore services in line with CV-19 restrictions	4	3	**12**	4	3	**12** ⟷	4	3	**12** ⟷				4	2	**8**
4. Quality Improvement ***Quality Assurance Committee***															
4.1 We are unable to deliver and demonstrate compliance with regulatory requirements or clinical standards adversely impacting on patient safety and our registration and accreditation by	3	4	**12**	3	4	**12** ⟷	3	4	**12** ⟷				3	3	**9**

regulatory and supervisory bodies															
4.2 We are unable to deliver service improvements and improve safety, care quality and outcomes for our patients or demonstrate that our services are clinically effective	3	3	**9**	3	3	**9** ↔	3	3	**9** ↔				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	4	**16**	4	4	**16** ↔	4	4	**16** ↔				4	2	**8**
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	5	**20**	4	5	**20** ↔	4	4	**16** ↓				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, financial penalties and the Trust's reputation.	4	5	**20**	4	5	**20** ↔	4	5	**20** ↔				4	2	**8**

Board Committee review of the risks

Both the Quality Assurance Committee that met on the 22 December and the Finance and Performance Committee at its meeting on the 27 January reviewed the risks for which they have allocated lead oversight for and confirmed that they considered the current scores are fairly represented. The Finance and Performance Committee commented that given the activity demands on the Trust then the people risks especially those linked to BAF risk 3.4 should be considered as part of the quarter 4 update which is currently being undertaken.

Key Recommendation(s):

The Board is asked to consider the current risk scores in light of the assurances provided by the respective oversight committees and the assurances received directly at the Board and agree the current scores are fairly represented.

Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	13	**Meeting:**	Trust Board	**Meeting Date:**	2 February 2021
Report Title:	EPRR Yearly Report				
Sponsoring Executive Director:	Katy Jackson, Chief Operating Officer				
Author(s):	Natasza Lentner & Eleanor Coleman				
Report previously considered by and date:					
Purpose of the report:					
Information		✓	Assurance		✓
Review and Discussion		☐	Approval / Agreement		✓
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		☐	Staff confidentiality		☐
Patient confidentiality		☐	Other exceptional circumstances		☐
Link to Trust Strategic Themes:					
Patient Care		✓	Sustainability		☐
Our People		☐	Quality		✓
Systems and Partnerships		✓			
Any implications for:					
Quality					
Financial					
Workforce					
Link to CQC Domains:					
Safe		✓	Effective		✓
Caring		☐	Responsive		✓
Well-led		☐	Use of Resources		☐
Communication and Consultation:					

Executive Summary:

This paper outlines the Trust's current NHSE EPRR assurance rating and subsequent action plan and updates the board on our current emergency planning, resilience and response readiness and the further work that is required.

Key Recommendation(s):

The Board is asked to:

APPROVE the EPRR paper for publication to the Trust website.

NOTE the current EPRR Assurance rating of substantial compliance.

NOTE the gap in major incident preparedness due to a lack of nominated and trained team to take on the Clinical Lead/Major Incident Officer in a major incident or critical incident.

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board **[01.2021]**

From: Chief Operating Officer **Agenda Item: [ ]**

FOR INFORMATION

Emergency Planning, Resilience and Response (EPRR)

Yearly Annual Assurance

1. INTRODUCTION

1.1 This paper outlines our current NHSE EPRR assurance rating and subsequent action plan and updates the board on our current emergency planning, resilience and response readiness and the further work that is required.

2 NHSE EPPR ASSURANCE

2.1 Every year BSUH has to complete the NHSE EPRR assurance self-assessment.

2.2 Subsequent to our non-compliant rating in 2016 an action plan was put together and the Executive Team committed to appropriately resourcing the Resilience Team by financing a Resilience Manager post to work with the Head of Resilience. This post has now been permanently filled.

2.3 Since our non-compliance rating in 2016 we have steadily improved our assurance rating year on year, last year reporting partial compliance.

2.4 Despite also responding to the Covid19 emergency the EPRR Team have managed to continue with the standard EPRR work plan, keeping plans reviewed and up to date as per the work plan and continuing critical training. In doing so we have improved our overall assurance position. Therefore having reviewed our position this year we are satisfied that BSUH has improved compliance and is able to demonstrate substantial compliance against the assurance framework for October 2020.

3 Areas of Improvement

The Areas of improvement include the following:

- loggist training,
- on call manager and director training
- FFP3 training

All of which are now compliant. The Trust has also implemented a new system to maintain plans for Mass Casualty - patient identification standard. This is now compliant.

4 Red - Non Compliance:

Lockdown

We remain non-compliant with Lockdown although the Trust is moving forward with its plans to improve this significantly. A draft Plan has been produced by Security

Team led by the Director of Estates & Facilities / Interim Group Director of Estates and Engineering and the EPRR Team are supporting them with this.

5 **Amber - Partial compliance:**

49 & 51 Business Continuity
Despite some delay in updating service level Business Continuity Plans due to Covid19, business Impact Analyses and Action Cards have now been completed by the Medicine Division, Central Clinical Services Division, Children & Women's and Specialist Division. All of these plans have been tested with table top exercises.

The IT Service Team have also updated their plans to the new format and will be producing up to date plans for Switchboard this month.

The remaining Corporate services and Surgery Division will be updating and testing their business continuity plans as soon as Covid allows. .

This demonstrates that we made significant improvements with our business continuity planning and business impact analyses but due to Covid-19 this work has taken longer than planned and therefore remains amber.

20 Duty to maintain plans Shelter and evacuation
This plan remains in draft due to gaps in relation to patient tracking and transport, the plan to work on this this year has been delayed due to covid19 but will be completed next year.

6 Last year's assurance letter from the Regional Head of EPRR stated that there remained some concern that EPRR resources are sometimes diverted away from EPRR duties to support other activity such as surge. Given the Trust is the only Major Trauma Centre in the Kent, Surrey and Sussex patch, they agreed this should be monitored to ensure the right staff are involved in escalation management and the organisation can adequately fulfil its EPRR duties. Update for 2020: this year the Trust has managed operational escalation within the Clinical Operations team although much of this year has been overshadowed by the response to Covid-19. The appointment of a resilience manager to work within the team has greatly improved our ability to maintain some business as usual EPRR activity while responding to emergency planning incidents such as the Covid-19 response which has helped us improve our EPRR assurance rating and support the Covid-19 response.

7 We undertake to keep the Trust's EPRR position under review and ensure that we continue to give due consideration National Core Standards for EPRR with a view to being able to maintain this standard throughout the coming year.

8 **OTHER ISSUES REQUIRING ESCALTION**

8.1 We have one continued unmitigated risk. Risk Register ID 2232. No medical lead allocated to take on the Clinical Lead/Major Incident Officer role in a major incident (appendix 2). The Clinical Lead/ Major Incident Officer role is a very important role in a major incident. It is the link and liaison between all the medical teams and the Strategic and tactical commands

8.2 **Background:** For many years our Urology Consultants held the role of Clinical Lead/ Major Incident Officer in a major incident, the thought was that they would be less likely to be needed in a response role yet still had an on call rota so could easily be called in to hold the clinical role in the HICC (Control Room)

8.3 They stood down from this role in 2015 when they moved to PRH and since then we have been discussing which medical teams should take this role without finding a solution.

8.4 The medical director at the time spoke to all the directorates and agreed that each speciality with an on call role would hold the MIO role for 6-12 months. Cardiology held it first (although they weren't necessarily the right speciality to hold the role as they were not always available as they may have been in theatre). They kindly agreed to extend their term until another group could be found. The Gastro team were scheduled up next and they agreed to hold the role for a year before handing over (which took us to till March 2018) and the role has been unfilled since then.

8.5 We have tried to discuss this at a number of forums and with different medical directors over the last year but have not come up with any solutions. We have written papers with options and escalated it at a number of trust meetings.

8.6 WSHFT have a Medical Consultant in the role but BSUH felt that they Medical Cons would be busy undertaking second ward rounds and making difficult decisions about discharging patients so we didn't think this model suited us.

8.7 In December 2018 discussions took place between the Medical Director and the Stroke team who were considering volunteering for the role but after a number of discussion and taking part in a table top exercise in late 2018 to scope out the role they had to pull out due to significant staff vacancies in their team.

8.8 Currently for any emergencies our Medical Director will take on this role in an incident but this is not a sustainable long term solution and resolution is required.

9 RECOMMENDATION

The Board is asked to:

- **APPROVE** the EPRR paper for publication to the Trust website.
- **NOTE** our current EPRR Assurance rating of substantial compliance.
- **NOTE** the gap in major incident preparedness due to a lack of nominated and trained team to take on the Clinical Lead/Major Incident Officer in a major incident or critical incident.

Natasza Lentner, Head of Resilience & Eleanor Coleman, Resilience Manager [19/01/2021]

Appendix 1 Clinical Lead/Major Incident Officer (MIO) Major Incident Action Card

ACTION CARD	**NO 3 (1 OF 2)**
INCIDENT ROLE	**CLINICAL LEAD/MAJOR INCIDENT OFFICER (MIO)**
ROLE HELD BY	**NOMINATED CONSULTANT ON CALL**
LOCATION	Hospital Incident Coordination Centre (HICC)
ROLE DESCRIPTION	To act as the liaison between the clinical teams in the Trust and the Tactical Commander (On Call Manager) in the HICC. To maintain a list of the major incident patients. To act as liaison between SECAmb and the Tactical Commander. In a Mass Cass Incident to establish the network Clinical Coordinating Team This is a hands off role & is based within the HICC.

	STANDBY Notification from RSCH Switchboard	Time
1	**Proceed immediately to RSCH HICC**	
2	**Ensure HICC is set** up & that all the telephones plugged in.	
3	**Log:** Ensure you document all decisions made & actions taken	
4	**Contact ED Commander:** Establish contact with ED Commander (X4218) regarding front line resource availability – including clinical resources, capacity and equipment availability. Establish number of P1, P2 & P3 patients we can admit. Establish the current situation with the Incident from the Tactical Commander (Manager on Call)	

Triage Status

Category	Clinical Need	Location
Priority One (P1)	**Immediate**	**Resuscitation Room Zone1**
Priority Two (P2)	**Serious**	**Majors/Zone 2a/Zone 2b**
Priority Three (P3)	**Walking wounded**	**UCC/Zone 2b**

5	**Brief Strategic Commander:** With the Tactical Commander brief Strategic Commander of the details of incident & current	
6	**Has the ambulance service declared this as a Mass Casualty Incident**? If so contact the below and ask them to form the Network Clinical Advice Team (NCAT) • **Critical Care Consultant On Call (Chair)** • **Neurosurgical Consultant On Call** • **General Surgical Consultant On Call** • **Trauma & Ortho Consultant On Call** • **+/- Paediatric Surgical Consultant on call**	
7	**Liaise with** the Surgical Consultant On Call & Trauma Consultant On Call and discuss any required actions at this stage – which may include delaying the start of any long surgical cases and reviewing patients for discharge. **Inform** Pathology about need for blood products.	
8	**Contact Registrar or other colleague to attend & act as an assistant**	
9	**Liaise with the SECAmb** representative within HICC if available & the ED Consultant concerning the number & severity of incoming patients & the Trusts ability to continue to receive them. Establish which areas of ED will be utilised and what resources will be needed.	

ACTION CARD	NO 3 CONT… (2 OF 2)
INCIDENT ROLE	CLINICAL LEAD/MAJOR INCIDENT OFFICER (MIO)
ROLE HELD BY	NOMINATED CONSULTANT ON CALL

	DECLARED Notification from RSCH Switchboard	Time
10	**If the triage category "expectant" has been instigated** by the Medical Incident Advisor on scene make sure this is communicated to the ED and the triage team.	
11	**Ensure** above standby actions 1-9 have been undertaken	
12	**Maintain an accurate list of the MI patients** and their current location within the hospital. This can be done using Symphony in the HICC which can be set up using the projector available. The ED will keep a paper copy of attendees in case of an IT failure. If this system fails ask the ED Triage to call through with patient details.	
13	**Theatres:** In conjunction with the Consultant Surgeon & Anaesthetist, ensure the continued provision of clinical resources within the operating theatres by liaising between the theatres teams and the Tactical Commander.	
14	**Out Patients & Electives:** With the Tactical Lead and relevant Clinical Colleagues consider need to cancel Outpatient clinics & electives within the Trust in order to redirect resources towards Major Incident patients. Ensure any decision is communicated to all appropriate Consultants and Managers.	
15	**Assessment of Consultant's workloads:** In conjunction with the responding clinical Consultants, ensure that each Consultants work load remains workable and fair – even if this means transferring the care of patients to other medical teams, or calling in further Consultants to assist.	
16	**Relief:** If this is likely to be a prolonged incident assess the need to call in another Clinical Lead/Major Incident Officer to take over from you after 6-8 hours or when necessary.	

	STAND DOWN Decision to be taken within HICC	Time
17	**Stand down:** When the HICC team have decided that it is time to stand down the Trust this must be communicated to **all** areas within BSUH through the switchboard cascade and through the Comms team & Divisional leads. All external agencies previously notified will also need to be informed of the stand down declaration	
18	**Assess Trust position:** In conjunction with other clinical colleagues, assess the Trust position in relation to ED, Operating Theatre, recovery & ICU workload currently & for the next 6-12 hours (considering the impact of the MI patient's requirements).	
19	**Attend the** 'hot' debrief with the HICC staff immediately after the incident.	
20	**Documentation:** Complete any documentation created during the incident, and leave within the HICC cupboard.	

Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	14	Meeting:	Trust Board	Meeting Date:	2 February 2021
Report Title:	Flu Vaccination Campaign Update				
Sponsoring Executive Director:	Carolyn Morrice, Chief Nurse				
Author(s):					
Report previously considered by and date:					
Purpose of the report:					
Information		☐	Assurance		✓
Review and Discussion		☐	Approval / Agreement		☐
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		☐	Staff confidentiality		☐
Patient confidentiality		☐	Other exceptional circumstances		☐
Link to Trust Strategic Themes:					
Patient Care		✓	Sustainability		☐
Our People		✓	Quality		✓
Systems and Partnerships		☐			
Any implications for:					
Quality	Nothing to note				
Financial	Nothing to note				
Workforce	Nothing to note				
Link to CQC Domains:					
Safe		✓	Effective		☐
Caring		✓	Responsive		☐
Well-led		✓	Use of Resources		☐
Communication and Consultation:					
Communication Team actively involved in the flu Vaccination Campaign					
Executive Summary:					
The report provides the Trust Board with an update of the current Flu Vaccination campaign for 20/21 and an evaluation of the Flu Vaccination campaign for 19/20.					
Key Recommendation(s):					
The Board is asked to note					

Flu vaccination campaign 2020/21 – summary plan (and 2019/20 evaluation)

1. Introduction

The Trust undertakes an annual staff flu vaccination programme and over the last 3 years this has been set against a national CQUIN target. The 2020 flu vaccination programme launched on Monday 5th October 2020 and will run until 28th February.

For 2020 the target is for 90% of frontline staff to be vaccinated. In 2019 BSUH achieved a vaccination rate of 65% against a national target of 80%.

2. Flu vaccination campaign 2019/20 – lessons learned.

Although making an improvement of 8%, the 2019 campaign did not achieve compliance against the national target and fell short by 15%. A review following the campaign highlighted 8 key areas for focus which are summarised below.

1. Increase number of workplace vaccinators across the organisation, including non-ward areas.
2. Advance arrangements to ensure coverage for satellite areas (such as Hove Polyclinic and Brighton General Hospital), and earlier roaming plan agreed.
3. Increased support for vaccinators, including enhanced information on vaccines and flu facts (utilising the national PHE materials – leaflet - and training).
4. Focus on staff wellbeing, and alignment to the Trust's wellbeing / people objective.
5. Focussed approach with a dedicated "push".
6. Dedicated coverage for night/weekend staff, and twilight roaming required.
7. A need for drop in clinics at a variety of locations around the sites, rather than one base at each site.
8. A need for more detailed analysis to focus on "hot spot" areas of low uptake.

3. Flu Vaccination campaign 2020/21

The 2020/21 programme launched on the 5th October 2020 and took into consideration the 8 identified areas to improve from 19/20. The improvements are listed below

1. 150 local workplace vaccinators spread across RSCH/RACH/PRH/SEH, including a small team of roaming vaccinators. AHPs included and covering their own areas (e.g. imaging, physiotherapy)
2. All satellite areas have been contacted and advance arrangements in place. Roaming plan in place prior to start of campaign.
3. Flu vaccinators have received training and have access to Flu facts leaflet
4. Comms focus on link to wellbeing, and protection for staff.
5. Flu campaign focussed for 10 weeks October to December 2019, with weekly prize draw.
6. Staff have access to night, twilight and early morning vaccinators and roamers.
7. Safety and quality team are a central point for all enquiries and organising sessions on request, a robust list of drop in clinics supported by OH and PDT. All clinic dates, list of vaccinators and roamers listed on the intranet. Electronic booking system used for clinics.

8. Improved data collection and analysis processes to include % uptake by area.

The Flu Vaccinator campaign 2020/21 has been overseen by a "Flu team" led by the Deputy Chief Nurse. The "Flu team" meet fortnightly and consist of representation from nursing, communication, pharmacy, occupational health and CQUIN lead.

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

- Executive team vaccination during the first week of the campaign, with photos
- Personalised posters and communications materials using photos of BSUH staff, covering the diversity of staff roles and groups.
- FAQ for vaccinators to address concerns and provide pertinent information about the benefits of vaccination – both digital and paper copies
- Consistent posters, leaflets and messaging – using national 'protection' theme
- Social media updates, including a flu jab selfie campaign (selfie shield) and video "vox pops" from influencers and leaders
- Updated local clinic dates and times

The "Flu Team" provide weekly dashboard updates, reported to the executive team, NHSE/I and CCG. As of the 25 January the compliance is presented in table 1.

Table 1.

BSUH Flu Vaccination Campaign (as at 25 January 2020)		
Staff type	**Vaccinated (No of staff)**	**Vaccinated (%)**
Medical	850	70%
Nursing	1688	75%
Other professionally qualified	517	87%
Support to clinical staff	1437	91%
Non-clinical	1386	46%
Total (All)	5878	68%
Total (Frontline)	**4492**	**80%**

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

4. NHSE/1

In light of BSUH not achieving the national target in 19/20, the trust received a letter from NHSE/I setting out their ambition to increase uptake on the flu vaccinations across the NHS. Along with the letter, NHSE/I included a self-assessment checklist for Trusts to review and provide 'public assurance via trust boards". This self-assessment has been repeated for 20/21 (appendix 1).

5. Conclusion and Evaluation

In conclusion the success of the 20/21 Flu vaccination campaign will be reflected in the number of staff vaccinated, the campaign reflects the lesson learned from 19/20 and the trust ambition to deliver the baseline target of 90%.

Following the 20/21 campaign an After Action Review (AAR) will take place, and a survey circulated to workplace vaccinators to inform future campaigns.

Appendix 1 – Self – assessment

A	Committed Leadership	Compliance	Comments
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.		Full communication campaign sharing Trust commitment to offering the flu vaccine to all staff. Process in place for collection of 'declines' data
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers.		Stocks of quadrivalent (and Trivalent for staff aged 65+) ordered and arrived.
A3	Board receive an evaluation of the flu programme 2018/19, including data, successes, challenges and lessons learnt.		Board Paper to be presented November 2020.
A4	Agree on a board champion for flu campaign.		Deputy Chief Nurse.
A5	All board members receive flu vaccination and publicise this		Completed and publicised in social media during launch.
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives.		Flu team set up chaired by the Interim Chief Nurse (Nurse Director) consists of nursing, doctors, AHP, Occupational Health, Communications and S&Q representatives. Vaccinator team covers all divisions and receive regular communication.
A7	Flu team to meet regularly from September 2020		Weekly phone huddles in place between Clinical and project lead. Flu team meet regularly over Teams every other week.
B	**Communications Plan**	**Compliance**	**Comments**
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions		National leaflet publicised both electronically and physical copies, with further information on the info-net. Vaccinator and staff profiles also include flu facts.
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper		Drop in clinics are electronically published - roaming vaccination schedule is shared with relevant managers on a one to one basis. Also advertised via Workplace.
B3	Board and senior managers having their vaccinations to be publicised		Completed and publicised in social media, including photos and “vox-pops”
B4	Flu vaccination programme and access to vaccination on induction programmes		All Trust Inductions covered by PD team
B5	Programme to be publicised on screensavers, posters and social media		Communication campaign includes posters and social media. Screensaver in plan
B6	Weekly feedback on % uptake for directorates, teams and professional groups		Weekly update provided at staff group level to Exec/NHS E and CCG. Plan to include % update split by Division/Directorate this year.
C	**Flexible accessibility**	**Compliance**	**Notes**
C1	Peer Vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered.		150 workplace vaccinators including 20 roamers in place. Also including AHPs this year.
C2	Schedule for easy access drop in clinics agreed		All publicised on the info-net – varied times and locations
C3	Schedule for 24 hour mobile vaccinators to be agreed		Several vaccinators work nights & planned twilight/early morning/weekend sessions in place.
D	**Incentives**	**Compliance**	**Notes**

D1	Board to agree on incentives and how to publicise		Vaccinators provided with sweets and stickers for staff. Thank you lunch planned for vaccinators. Weekly prize draw for those vaccinated.
D2	Success to be celebrated weekly		Regular updates in Buzz and weekly messages and shared on workplace.

Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	15	**Meeting:**	Trust Board	**Meeting Date:**	02/01/21
Report Title:	BSUH IPC Board Assurance Framework				
Sponsoring Executive Director:	Carolyn Morrice – Chief Nurse				
Author(s):	Ann Gibbins – Interim HoN for IPC; Kimberly O'Hara – Deputy Chief Nurse; Lyn Allinson – Head of Risk Management				
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	Reducing the risks of nosocomial infection				
Financial	Additional COVID costs captured through Trust governance routes				
Workforce	Protecting our people				
Link to CQC Domains:					
Safe	✓		Effective	✓	
Caring	✓		Responsive	✓	
Well-led	✓		Use of Resources	✓	
Communication and Consultation:					

Executive Summary:

To update the Board on progress against the IPC BAF for Brighton and Sussex University Hospitals NHS Trust (BSUH). This framework provides a clear roadmap to drive best practice, identify gaps and mitigation to provide safe and effective care to our patients and protect our staff as best we can. This is a dynamic framework to reflect the rapidly changing control measures required for the current Global Pandemic we are managing.

Current position:

- 51 actions
- 45 are currently rated green
- 6 are rated amber where work is underway and further assurance required that practice is fully embedded
- No red ratings against progress
- Continual focus on learning and adapting practice against national policy
- Peer review with NHSEI IPC team on 25th February

Key Recommendation(s):

For review and discussion

The Board Assurance Framework, including progress made against mitigating actions, is monitored through the Quality Assurance Committee Monthly and the Infection Prevention and Control Committee Bi-monthly

	Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Timeline	Progress
1.	**Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users**					
	Systems and processes are in place to ensure:					
1.1 **Lead Director:** **Chief Operating Officer** **Manager: Divisional Management teams**	**Infection risk is assessed at the front door and this is documented in patient notes.**	• Signage and use of coloured footprints are used for staff and patients to follow. • Trust wide risk assessment and have complete action to ensure social distancing measures throughout the Trust or mitigation using physical barrier/plastic screens. • The COVID 19 Safe Workplace Group completed September 2020. Screens added to reception area in any reception area fitted by Estates. These are available via bamboo for review or available on T drive-Risk Assessment via risk assessors/ managers who have submitted in Excel format.	Review of how patient are assessed if self-presentation for treatment via other entrances than ED For GP or community referred admission is the process ACU is via GP discussing admission with lead Consultant and possible COVID status discussed. They will be admitted to side room if high risk. ED process followed. This needs to be added to the guidance note.	Trust guidance updated in line with the updated national PHE guidance and NHSE 17/11/20 which Updated Trust guidance approved at Clinical Advisory Group (CAG) and disseminated to clinical areas, as well as being made available on Microguide. Fluid Resistance Surgical Face Masks (FRSM) and alcohol hand sanitizer are available for patients and staff at entry points to hospitals.	31/1/2021 Review at the IPC safety Huddle and weekly CAG agree any changes.	↔
1.1.1 **Lead Director:** **Chief Operating Officer**	**Emergency department (ED's)**	• Patients are triaged on entering Emergency Department (ED) and assessed as high, exposed or low risk, as per PHE definitions	18/01/21 CAG meeting IT / IPC to add tag to Medway for Patient COVID status.	Improved capacity for rapid swab testing on arrival at ED reducing the need for a holding	31/1/2021 Review at the IPC safety Huddle and weekly CAG	↔

Manager: Divisional Management teams		• ED follows the Emergency Care Pathway for COVID-19, which includes the case definition for COVID19. Patients are then assigned to follow either a high, medium or low risk pathway. This is documented in patient notes in the ED. Note- evidence in patient notes in ED's and Guidance available on Microguide.		area until swab results known.	agree any changes.	
1.1.2 Lead Director: Chief Operating Officer **Manager: Medicine Divisional Management teams**	**Outpatient areas / elective admissions**	• OPD departments assess patients on arrival using a checklist to assess for symptoms of COVID19. • Pre testing for COVID 19 72 hours – guidance on appointment letters and information sent to patient re isolation and testing before planned admissions or treatment. detail re the	New letter discussed at CAG for patients re safety arrangements when visiting hospital.	Use of virtual clinics when assessed to reduce footfall for outpatient access. Rapid testing for clinically vulnerable patient prior to treatment e.g. Cancer, Cardiac etc. Protocol agreed and reviewed by CAG.	31/1/2020 Review at the IPC safety Huddle and weekly CAG agree any changes. Review March 2021	**New**
1.1.3 Lead Director: **Chief Operating Officer** **Manager: Clinical Director of Facilities**	**Other entrances**	Security manager reception areas for entrances and exits including RACH except ED and Outpatients receptions during high use times.	Require the details from Facilities re audit of compliance of IPC in commons areas and entrances Reception areas are managed by security. Reception areas are not managed 24/7 but relies on out of hour access security and access to the hospital.	Facilities team have responsibility for common areas and housekeeping supervisor carryout cleaning audits. Security manager reception areas for entrances and exits including RACH except ED and Outpatients receptions.	28/2/2021 Review at the IPC safety Huddle and weekly CAG agree any changes.	**New**

1.2 Lead Director: Chief Operating Officer **Manager: Silver rota**	**Patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission**	• Emergency Care Pathway for confirmed or suspected COVID-19 cases available on Microguide. • The clinical site team have records available to evidence that patients are moved from either ED or the Acute Medical Unit (AMU) and once there is a decision to admit they are allocated to the right bed. They are then only moved for clinical reasons, and moves are kept to a minimum to enhance patient experience and safety, as much as possible. • A Prioritisation isolation Tool for all types for key infections is used to enable Site Team decision making surrounding patient placement in single rooms. • Rapid testing process agreed via CAG and provided on Microguide. • POCT – guidance.	Patient is assessed as low (green) risk patient pathway. If patient then following rapid swab results for COVID is positive then should immediately be moved to side room. Due current operation pressures this can be delayed due to surge capacity exceeded.	-exposed risk patients admitted to low risk wards are assessed by a senior clinical decision maker -all staff wear a FRSM and patients/visitors wear a FRSM as tolerated / unless exempt -infection prevention and control precautions used, including adherence to hand hygiene. Weekly IPC audit on Prefect ward includes review of hand hygiene. -2 metre distancing is maintained wherever possible -On-going advice is available from the IPC Team, Infectious Diseases Department and On-Call Microbiology -Clinical site management teams meet 3 x daily to review inpatient capacity and movement. They have the	28/02/2021 Review monthly or as PHE guidance changes	↔

				current COVID status of all ward and departments. Any Positive patient or exposed are not moved without clinical assessment and will access additional advice from IPC if required. -Rapid testing currently used for pre agreed priority patient groups. Additional rapid testing is now available.		
1.3 **Lead Director:** **Chief Operating Officer** **Manager: Discharge team under Silver Rota.**	**Compliance with the national guidance around discharge or transfer of COVID-19 positive patients**	• The guidance is available on Microguide within the section called 'hospital discharge pathways and referral processes' • The discharge pathway links to national PHE / NHS guidance • Patients are tested prior to discharge to care homes and the results communicated. • Infection prevention and control discharge communication form developed, for completion prior to discharge to other care facilities, including care homes, sheltered housing and discharge home with carers. The form is being	-Assurance required about whether the IPC discharge communication form is being used when discharging to other care facilities/home with carers - sustained assurance required that patients are swabbed prior to discharge to other care facilities/home with carers – (Clinical audit of notes)	-All patients are assessed by a Consultant and normal discharge planning is in place. -The Trust is swabbing patients prior to discharge to Care Homes and is part of the discharge pathway. Guidance re the discharge of patient to community setting post 14 day positive result for COVID but prior	31 January 2021 Review 28.02.21 through community pathway	↔

		implemented via the Discharge Hub. Completed and shared verbally and then copy in notes. This is available on Microguide.	Audit to be undertaken to assess compliance with use of the IPC discharge communication form and pre-discharge swabbing to other care facilities / home with carers. Monitoring through Weekly system infection prevention meeting with council and CCG partners	90days – low risk (lateral flow test would test positive. 18/1/21 CAG agreed pathway for the transfer of the Management of patients with COVID in community with Pulse Oximeter and O2 (Hospital at Home for East Sussex)		
1.4 **Lead Director:** **Chief Nurse / Chief Medical Officer** **Manager: Head of Nursing – Quality Improvement / IPC lead /IP Consultant (Deputy DIPC)**	**Patients and staff are protected with PPE, as per the PHE national guidance**	• 'PPE for COVID-19 based on Patient Risk Category' developed in line with national PHE guidance issued August 2020 and available on Microguide • Daily/regular updates from Procurement on PPE availability, feeding into the Bronze IPC huddle, Clinical Advisory Group and Silver meetings – COVID electronic status board led by BSUH Resilience team. Updated daily. • Procurement seek advice from IPC if replacement items need to be sourced in times of low stock. • Fit testing and fit checking is undertaken in line with	November 2020 national advise that Staff require fit testing for a variety of FFP3 masks so there isn't an over reliance on one or two specific makes/models of masks, in line with national guidance. Implementing a robust system for centralised fit testing for a variety of FFP3 masks.	IPC Team provide on-going support, e.g. regular ward rounds Local procurement initiatives including Brighton university and local suppliers e.g. alcohol, visors, goggles. Mutual Aid enlisted to ensure deployment of PPE stocks if there are local shortages. Continuing informal education, trust wide communication and	Reviewed by CAG use of FFP3 and PPE in high risk areas and low risk AGP: ongoing review against guidance. 28/02/2021	↔

		national requirements and as detailed in the BSUH fit testing SOP / centralised fit testing. Information include on Info net and Microguide which includes posters and videos - Link • Web based fit testing records available of staff fit testing undertaken (Bamboo / panda) • FIT testing team to support clinical areas in fit testing staff and fit testing can be booked on IRIS by staff. • Fluid resistant surgical facemasks (FRSM) advised for everyone, staff, patients and visitors, entering the hospital (whether working in clinical or non-clinical areas). Microguide • FRSM are available for patient use (as tolerated), included in clinical pathways & included in transfer guidance. • Also details and use and PPE requirement updated on trust intranet and workplace sites to allow staff to access as well as issued on Microguide. • Procurement are keeping records of all types of PPE used in the Trust from national issue. Records held by Clinical Procurement Manager. • Separate order process for COVID stock for wards with 24hour turn around on separate email and order form Bsuh.covidstock@nhs.net		training to enforce PHE PPE guidance Availability of reusable respirators and Power-hoods, for staff who repeatedly fails fit testing for disposable FFP3 masks. Video available on info-net to instruct staff on use and care of Power-hoods		

		• Safety alerts are issued and cascaded re PPE to Divisions. Records are available on request. bsuh.cas.alerts@nhs.net All COVID CAS and updates from MHRA included into the CAG agenda every Monday. All new COVID escalated to Chief Medical Officer and Chief Nurse and discussed with specialist lead e.g. pharmacy.				
1.5 Lead Director: Chief Nurse / Chief Medical Officer **Manager: IPC and Comms**	**National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way**	• The IPC Team check national IPC guidance regularly and any changes are discussed at the IP Team huddle, Bronze IP huddles, Silver meetings and Clinical Advisory Group meetings • Updated /new guidance received via the Senior IP Nurse network and cascaded within the Trust as appropriate • Clinical advisory group discuss any new guidance and any national guidance or safety alerts issued from November 2020 there is a monthly joint CAG with WHST to agree and share guidance. Any new guidance is shared across Trusts in between these meetings. • Minutes for CAG are held and managed by Chief Medical Officer PA.		Any new guidance is discussed at the Clinical Advisory Group meetings and a Trust decision via Gold command taken on implementation to ensure consistency in rollout across BSUH and WSHFT as joint Executive team and merging in April 2021.	On-going Review 3 x weekly for CAG meeting. Review weekly IPC huddle	↔

1.6 **Lead Director:** **Chief Nurse / Chief Medical Officer** **Manager:** **IPC lead, IP consultant (Deputy DIPC),** **Lead Pharmacist,**	**Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted**	• Latest updated PHE guidance, e.g. 'COVID-19: Guidance for the remobilisation of services within health and care settings, infection prevention and control recommendations' and NHSE guidance 'Key Actions' briefing note brought to attention of Trust Management via DIPC, bronze IP, Silver (daily) and CAG(3x weekly) • Gold command meet daily and approval / notification new guidance is discussed and approved there • Clinical/ward areas have been assessed to ensure compliance with the national requirement for 2m distancing – records are held by Clinical Director for Facilities.	Not all bed spaces comply with 2m physical distancing – currently working through solutions Group chaired by the chief operating officer reviewing ventilation , environmental adaptations Barry building and patient pathways to maximise the use of the estate at PRH Changes to patient testing and movement as per 'Key Actions' briefing note currently being worked through locally and regionally	-Physical barriers assessed / installed in BSUH for patient, staff, common areas and reception areas -Patients with suspected / confirmed COVID19 currently managed in single rooms whenever possible -Trust surge plan includes details about which wards can be used to safely care for high risk COVID19 patients, e.g. wards with the best environment and infrastructure -'Key Actions' briefing note being discussed at Gold Command regarding implementation	December 2020 Review monthly via IPC Huddle or as PHE guidance changes	↔
1.7 **Lead Director:** **Chief Nurse / Chief Medical Officer** **Manager:**	**Risks are reflected in risk registers and the Board Assurance Framework where appropriate**	• There is a COVID specific risk register held a separate log that is managed through Gold command and reviewed at least once a week. Risk register is held with Gold records.	-Learning from outbreaks continues and is in line with national HSIB findings report (October2020)	-On-going surveillance of all HCAI's including COVID19, is in place for early identification and management of	Daily review. Gold currently meeting daily and CAG 3x weekly	↔

IPC		• COVID specific incidents reported on DATIX are reviewed daily by Patient Safety and Risk Management teams. There is specific cording and reporting available for COVID incidents and escalated to Serious incident review group (SIRG) which meets x2 weekly if review or appropriate manager. There is a focus on reviewing and learning from each incident report raised on DATIX and these have helped inform the risk register. • Ward Matrons use Safety and Quality Improvement Tools to ensure best practice- introduction Perfect Ward will strengthen assurance and drive best practice • Daily spread sheet of new COVID-19 cases by ward completed by IP Team. National guidance on identifying Healthcare Acquired COVID-19 cases used and outbreak meeting called if 2 cases identified on any one ward for cases that occur on 8 day or onwards • Gold approved approach to investigation outbreaks as serious incidents in line with WHST and agreed with Sussex CCG	-Learning from first COVID 19 wave is informing current approach to challenges -Continual focus on excellence IPC, PPE and staff behaviours. Supporting patients with capacity to adhere to social distancing and hand hygiene. -Currently Trust wide review of environment in terms of ventilation and bed spacing. -Outbreaks which indicate issue in common areas with use of hand hygiene and cleaning of regular touch surfaces. Embed prefect ward weekly IPC audit into all clinical areas. Root cause analysis undertaken for hospital acquired COVID19, for future learning. Lead by Assistant Director of Quality and Safety.	clusters and outbreaks of infection. Where these are identified, appropriate IPC advice is given and outbreak control meetings are held in a timely manner. -Regular IPC ward rounds for early identification of any IPC risks and appropriate advice - completion of ward managers / matron COVID19 management checklist -3 times a week IPC safety huddle including Chief Medical Officer, Chief Nurse, Deputy Chief Nurse ,Microbiology Consultant, IP consultant (deputy DIPC) -Weekly quality and safety huddle – IPC attendance -weekly system meeting with Brighton and Hove public health and		

			Any on-going risks identified included in the Trust risk register and escalated to Gold risk register. Risk register to be reviewed by IPC team and Head of Risk Manager.	Sussex CCG IPC lead - Attendance IPC network meetings and regional webinars and CN meetings to share best practice and escalate concerns.		
1.8 **Lead Director: Chief Nurse** **Manager: Deputy Chief Nurse and Head of Nursing (Division)**	**Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens**	• IPC ward rounds lead by ID team • Infectious Diseases & Microbiology team support is provided on an on-going basis • Isolation nursing for patients with known cross infection risks, in line with IP policies for non COVID-19 infections and pathogens, e.g. MRSA and Clostridium Difficile. •Programme of annual infection control audits in place. MRSA pre elective surgery screening in place and detailed in the IPC policies and procedures.	-Current IPC Team leadership gap. -Focus is primary on COVID as highest risk. Recruiting to a nurse consultant post -Reviewing the option of additional consultant PA time to strengthen expertise -Ahead of planned merger working with DIPC at WHST on new organisation IPC structure Evidence of audits once embedded via the IPC prefect ward weekly audit tool.	-Interim head of nursing appointed to provide leadership to the senior IPC nurses -On-going surveillance of healthcare associated infections to identify clusters and outbreaks at the earliest opportunity. -Picked up in daily and weekly safety huddles -ward managers / matrons to complete a weekly audit using an IPC quality improvement tool. IPC discussed as part of Divisional Governance meetings.	March 2021 Weekly review of progress or concern at IPC safety huddle.	↔**In progress**

2.	**Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections**					
	Systems and processes are in place to ensure:					
2.1 **Lead Director:** **Chief Nurse / Chief Medical Officer** **Manager: Deputy Chief Nurse, Infectious disease consultant and IPC**	**Designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas**	• The infectious diseases team manage COVID-19 positive patients in single rooms over 3 floors in the Courtyard building and other designated wards used for high risk patients • Designated specialist teams e.g. cardiology, ITU, respiratory, care for and treat COVID-19 patients elsewhere in the Trust • COVID included in IPC training on IRIS for induction and updates.	-On-going education of staff in clinical areas is needed, to ensure staff are aware of the current national guidance when caring for patients with COVID-19 (this is particularly challenging given that guidance is rapidly changing)	-IPC team provide on-going informal training IPC IRIS – updated for donning and doffing. AGP -Clinical pathways and guidance available on Microguide. -Updated guidance is discussed at the Clinical Advisory Group; all Divisions via Clinical speciality leads are represented at the CAG. Wards, managers and speciality leads use of Safety Huddles in local areas forward advice and guidance. PPE training for all staff and fit testing for all staff in red areas.	On- going Review March 2021	↔
2.2 **Lead Director: Chief Nurse** **Manager:**	**Designated cleaning teams with appropriate training in required**	• All Housekeeper staff are trained in cleaning standards for Red areas which is detailed in the Standard Operating Procedures, and	-High rate of red area cleaning required means demand is currently	14/1/21 Outsourcing funding agreed by Silver to allow the shortfall in staff in	Weekly via cleaning audit process.	↑

Clinical Director of Facilities	**techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas**	the correct usage of PPE as directed by IPC. Tristel is used in all areas. • Reviewed all facilities staff for vulnerable staff who do not clean high risk clinical areas. • Full review of training for facilities staff and training processes changed. Records are held by Facilities management team and capability assessments. • Endeavour to keep staff working in designated areas. All housekeeping teams are trained in 'red cleans' for COVID areas as required. This allow flexibility require due to number of red cleans required. Contractors / agency to support internal staff in public facing areas. • The Housekeeping team are supported and work load is managed to protect staff and support the operational management of BSUH. Issue escalated from facilities team to Silver from Bronze meeting and facilities safety huddles on a daily basis. • Clinical director for facilities now fully in post reporting to the Chief Nurse (DIPC). They meet at least weekly at safety huddle. • Ward managers and Matron have access to cleaning audit on t drive. These are	not matching capacity. -Ensure outsourced cleaning has level of training to cover public/ common areas. -Out sourced teams will allocated to public areas so release in-house housekeeping staff to allow utilisation of internal experienced staff in higher risk. -IP Team meeting with Housekeeping supervisors every 2 months to discuss issues needs to be re-established currently using weekly outbreak meetings. -On-going review of training standards for Band1 to move to Band 2 for housekeeping staff where training and competency checked. -In the process of moving all a cleaning audit to electronic	facilities which fluctuates and also additional cleaning of high risk (red) areas. Outbreak meeting weekly including Facilities representatives from both sites. This due to current Outbreak status of Trust and meeting minutes and actions. - The outbreak meeting is attended by IPC lead from CCG and PHE for additional support and guidance. Within cleaning audit which are carried out jointly with ward manager / matron and facilities compliance team. These are held on To drive: clinical Audit and reported on daily basis to clinical team by Clinical Director of Facilities. They also provide report of any outstanding	Review 8.02.2021	

		escalated to IPC committee and Weekly Quality and Safety huddles for non-compliance.		Estate request so can be cross reference with cleaning audit to ensure reported to Estates team and ensure Estates team complete action where this issue may result in failure of cleaning audit.		
2.3 **Lead Director: Chief Nurse** **Manager: Clinical Director of Facilities**	**Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance**	• Red cleans undertaken using Tristel, cleaning records available within facilities compliance team. • Ward managers and Matron have access to cleaning audit on t drive. These are escalated to IPC committee and Weekly Quality and Safety huddles for non-compliance.	Need to strengthen the terminal decontamination of isolation / cohort areas, to include office spaces in wards, as well are clinical areas On-going review of training standards for Band1 to move to Band 2 for housekeeping staff where training and competency checked. This review is currently managed within the Facilities Management team. Need route for escalation.	Tristel is used decontamination for cleaning.	Daily	↑

2.4 **Lead Director: Chief Nurse** **Manager: Clinical Director of Facilities**	**Increased frequency of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance**	• The housekeeping team provide enhanced cleaning in areas as required, including high use touch point, e.g. doors, lights and handles. • Weekly update by Chief Medical Officer highlights cleaning of all frequent touch points for staff in IPC section.	-A robust system for decontamination of high touch surfaces in all work environment s e.g. computer keyboards, multiple times a day is not in place and difficult to implement due to heavy workload, particularly in clinical areas. Issue new poster developed by Risk Management team. Regular reminders to staff re cleaning of own work areas before and after use.	-Constant reminders to staff to clean frequent touch sites multiple times a day -Reviewing recent guidance on above through CAG -Cleanliness audits , clinical director reviewing process and ensuring visibility through various governance routes – promoting local accountability Embedding weekly IPC audit via Prefect wards.	Review 26th Feb – evidence, impact and embedded in practice	↔
2.5 **Lead Director: Chief Nurse / Chief Medical Officer** **Manager: Clinical Director of Facilities**	**Linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken**	• All linen is managed via external contract. • Facilities team have regular weekly contract review meeting where non-compliances with linen are highlighted to the Trust. • All linen is rented and not owned by the Trust.	-Add infected linen audit reminder to be added to the weekly IPC audit on Prefect wards. -IPC team to check included into monthly IPC audit. -Facilities team have inadequate storage arrangement for central linen on RSCH site as in	• Linen bagging poster available and is in line with PHE guidance.	N/A	↑

			temporary unit in car park. This has been an on-going issue since 2016.			
2.6 Lead Director: Chief Financial Officer **Manager: Head of Procurement**	**Single use items are used where possible and according to Single Use Policy**	• Single use guidance included in 'decontamination policy 27.1.2017' available on Trust intranet via IPC link. • Procurement are informed of any new "red" wards or areas daily so they can ensure single use items (e.g. BP cuffs) are delivered ready for use. This is requested by Ward managers on Matman.	-Single use items not always used or not always labelled with the patient's first and last name. -Embed weekly IPC Perfect Ward audit.	-Included in IPC update training. -Ward Managers and Matrons spot check compliance. -Weekly IPC Perfect Ward audit will enable monitoring of this.	On-going Review March 2021	↔
2.7 Lead Director: Chief Nurse / Chief Operating Officer **Manager: Head of SSD / Divisional management teams**	**Reusable equipment is appropriately decontaminated in line with local and PHE and other national policy**	• Decontamination policy on trust intranet. • Programme of annual infection control audits in place • Ward managers / Matrons complete COVID management checklist via Perfect Ward audit process.	Embed weekly IPC prefect ward audit	Included in IPC update training Ward Managers and Matrons spot check compliance Weekly IPC Perfect Ward audit will enable monitoring of this	Review March 2021	↔
3.	**Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance**					
	Systems and process are in place to ensure:					
3.1 Lead Director: Chief Medical Officer / COO **Manager: DDO CCS / Chief pharmacist.**	**Arrangements around antimicrobial stewardship are maintained**	• Antimicrobial stewardship meetings being held monthly • Discussions about changing our community acquired pneumonia / hospital acquired pneumonia policy took place. A review of the literature and co-infections in COVID positive patients did not show	-Vacant position which has been appointed and waiting to start in role of Lead Antimicrobial Pharmacist. -Meetings not occurring monthly currently due to	Paper to CAG – medicine– new guidance procalcitonin, Microguide.	Reported to medicine management and IPC committee monthly	↑

		many co-infections, mirroring our experience locally. Consequently it was agreed that there was no need to change our policy • The antimicrobial pharmacist is fully involved in *Clostridium difficile* root cause analysis meetings	competing demands. Report to Medicines Management Committee - Large spike in Antibiotic use in 1st wave and 2nd wave. Currently reviewing data			
3.2 **Lead Director: Chief Nurse** **Manager: IPC lead manager**	**Mandatory reporting requirements are adhered to and boards continue to maintain oversight**	• All mandatory reporting is in place, including reporting to the Trust Board • Relevant issues discussed at Bronze, Silver and Gold Command are escalated to the Trust Board who maintain an oversight on IPC issues • IPC annual report present at Board • IPC BAF reviewed at QAC – escalation to board	Meeting schedule in place next year	Discussed at monthly IPC meeting. Medicine management weekly.	N/A	↔
4.	**Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion**					
	Systems and processes are in place to ensure:					
4.1 **Lead Director: Chief Nurse** **Manager: Assistant Director of Quality and Safety.**	**Implementation of national guidance on visiting patients in a care setting**	• Hospital visiting restricted in line with national guidance • Visiting guidance available for staff on Info net / intranet • Posters advising on restricted visiting displayed around the hospital and use of: - Social medial - Staff messaging - BSUH website - Refreshed compassionate visiting guidance approved. October 2020	Nil	Compassionate visiting only Guidance info net	N/A	↔

		at Gold command and in place - This has been approved and available on Trust info net.				
4.2 **Lead Director: Chief Nurse / Chief Operating Officer** **Manager: Matrons**	**Areas in which suspected or confirmed COVID-19 patients are being treated are clearly marked with appropriate signage and have restricted access**	• Red and green pathways marked by footprints on the floors through the Emergency Department • Signage, including pull-up banners and 'High risk area' posters available for use as and when require	Signage to the entrance to high risk wards to be improved, to make high risk areas more explicit	Existing signage currently in use - IPC check signage and ward and matron management team to check this is in place. - Part of prefect ward weekly audit -	On- going review by Prefect ward weekly IPC audit Report Bi-monthly IPC meetings	↓
4.3 **Lead Director: Chief Nurse / Chief Medical Officer** **Manager: Comms team**	**Information and guidance on COVID-19 is available on all Trust websites with easy read versions**	• All Trust information and guidance is available on the info net, workplace and Micro-guide and links also provided to PHE guidance • Link info net. • CMO weekly update and briefing. • Quick links on front page of info net Microguide.	Nil	New Guidance approved by Silver, CAG etc. and then escalated to Gold for approval. Specific links on front page of info net for COVID	Guidance updated weekly.	↔
4.4 **Lead Director: Chief Operating Officer** **Manager: Silver Rota and Site Management team**	**Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved**	• Verbal communication is provided for individual patients being handed over. • Transfer-nursing handover (SBAR) available on trust intranet, which includes a section on Infection Control issues on handover. • IPC discharge communication form developed, including COVID19 and other common	IPC discharge communication form not yet fully embedded discharges to other care facilities, e.g. care homes and discharges home with carers	Infection status is included in the discharge letter, a copy of which is sent to the patient's GP	Work in progress with the Discharge Hub to embed use of the form Review 28.02.21	↔

		cross-infection risks, e.g. MRSA. • Discharge information available on Microguide.	-Working on collaboration with CCG and public health partners on improving communication and pathways between 4 secondary and primary care.			
5.	**Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people**					
	Systems and processes are in place to ensure:					
5.1 Lead Director: Chief Operating Officer **Manager: Division Management team (Medicine and women and Children)**	**Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms to minimise the risk of cross-infection**	• The emergency department have implemented a red and green pathway for non-COVID and COVID patients to ensure patients are cohorted to minimise the risk of cross infection • Reflected in a variety of clinical pathways, e.g. emergency care. Pathways are detailed on Microguide	Nil	-clinically assessed red or green	N/A Review March 2021	↔
5.2 Lead Director: Chief Operating Officer **Manager: Silver rota / Head of Pathology / Lead Microbiology Consultant**	**Patients with suspected COVID-19 are tested promptly**	• Guidance for testing of patients with suspected COVID-19 is available on Microguide. • Non-elective patients are currently routinely screened on admission and day 5. In addition, any patient who develops symptoms of COVID-19 are tested • Point of care testing is used in admission areas, to aid a		exposed risk patients, i.e. asymptomatic but awaiting swab results, are assessed by a senior clinical decision maker before placing onto low risk pathway -Point of care testing capacity	December 2020	↓

		speedy diagnosis with booking for rapid testing and increased capacity for swab testing.		now increased at the front door, so patients COVID status is known prior to admission, making it easier to move patients onto the appropriate low, medium or high risk pathway.		
5.3 **Lead Director: Chief Operating Officer** **Manager:**	**Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested**	• Guidance is provided for managing patients who test negative but develop symptoms, available in a variety of clinical pathways on Microguide. • Appropriate segregation and prompt retesting is undertaken • Patients who test negative on admission are rescreened in line with national guidance and test results available as evidence of this	Nil	Weekly Outbreak meeting for COVID 19. 18/1/2021 Incident discussed at CAG relating to care pathway for management of the patients. Incident report and RCA carried out to learn lessons where appropriate.	On-going Review	↔
5.4 **Lead Director: Chief Operating Officer / Chief Nurse** **Manager: Divisional DDO's and Heads of Nursing**	**Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately**	• All patients attending routine appointments are assessed for symptoms of COVID19 (by asking patients relevant triage questions). If a patient answers yes to the questions, the patient is asked to go home and self-isolate, following the advice provided on Gov.uk website. Their appointment is rescheduled.		-Staff wear the appropriate personal protective equipment. -Patients are asked to wear a fluid resistant surgical mask on entering the hospital. -2 metre distancing is maintained as much as possible. -Test that the triage questions are		↔

				asked consistently in all OPD outpatient departments which was approved by CAG.		
6.	**Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection**					
	Systems and processes are in place to ensure:					
6.1 **Lead Director: Chief Nurse** **Manager: IPC and Learning and development (IRIS team)**	**All staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe**	• E-learning for IPC is available at all times via IRIS. • IPC induction / update training available via e-learning. • Training compliance is 90%. Monthly reports provided by LD department to Manager and divisional management teams. Also there is a reminders sent to staff 3month timeframe to renew training direct from IRIS	Slight drop in mandatory training figure report to H&S committee. Specific training on COVID There should be a record of training for PPE and on COVID.	• Informal ward based training delivered by ICN's and PPE safety officers. • Donning and Doffing videos are available on staff intranet in line with PHE guidance. • Electronic capture of training	Monthly review via IPC monthly meeting 05.02.2021	↔
6.2 **Lead Director: Chief Nurse** **Manager: IPC team / Head of Nursing Quality Improvement**	**All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it**	• Training and on-going support is provided by the Infection Control Team and PPE safety officers.	Nil	• Donning and Doffing videos are available on the staff intranet in line with PHE guidance • IPC IRIS training	N/A	↔

6.3 **Lead Director: Workforce** **Manager: Head of Learning and Development**	**A record of staff training is maintained**	• Training records maintained on IRIS for mandatory IPC training, including induction training and updates.	Nil	Managers can see if their reporting staff training is up to date for Statutory and Mandatory Training via report on IRIS.	N/A	↔
6.4 **Lead Director: Chief Nurse / Chief Medical Officer** **Manager: Clinical Procurement Manager, Head of Risk management**	**Appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed**	• PPE is not being reused outside of PHE guidance • CAS evidence provided to the central reporting system and Evidence held on the risk management T drive of responses from procurement and divisions as on cascade. Evidence available on request via bsuh.cas.alerts@nhs.net		COVID CAS reported weekly to CAG.	N/A	↔
6.5 **Lead Director: Chief Nurse** **Manager: Head of risk Management**	**Any incidents relating to the re-use of PPE are monitored and appropriate action taken**	• DATIX is available to report any such incidents accessible to all staff on Trust info net. • Previous incidents have been verbally discussed at the Clinical Advisory Group and appropriate action taken. Minutes available. • Any Dangerous occurrence report escalated and reported under RIDDOR. • Any specific issues escalated to manager of area, Weekly safety quality and safety huddle and SIRG if serious incident. • Additional PPE incident reviewed following escalation is that where staff react to the FRSM and unable to tolerate.	Nil	There is specific coding on DATIX to highlight COVID incidents. PPE COVID incidents reviewed daily by Risk Management Team and discussed daily team meeting / safety huddle. Reported to Silver and escalated to Divisional Quality and Safety Manager as required. 3 recent incident reports made.	N/A	↔

		Discussed at CAG and recorded individual risk assessment for COVID if there is an issue but still continues to be raised as a concern. These are reviewed by the workforce individual risk assessment group on case by case basis.		Evidence held on DATIX system and also report provided to the H&S committee on 22nd December.		
6.6 **Lead Director: Chief Nurse** **Manager: Head of Nursing – Quality improvement**	**Adherence to PHE national guidance on the use of PPE is regularly audited**	• Adherence checked by the Infection Control Team during IPC ward rounds and senior leadership teams, namely Matrons, Directorate Lead Nurses & Heads of Nursing; check and challenge in use	Promote ownership at local level to monitor and audit and providing expert advice. Embed prefect ward weekly IPC tool	Matrons issued with a quality improvement tool – COVID19 management checklist, which includes checking adherence to PPE requirements Prefect ward weekly IPC audits	N/A	↔
6.7 **Lead Director: Chief Nurse** **Manager: Deputy Chief Nurse, IPC lead, Workforce Matron**	**Staff regularly undertake hand hygiene and observe standard infection control precautions**	• Hand hygiene training incorporates the World Health Organisation's Five Moments for Hand Hygiene. • Hand hygiene audit programme in place- training. • IPC ward rounds – check and challenge. • Annual infection control audits, include hand hygiene. • Ward managers / matrons issued with an IPC quality improvement tool – COVID19 management checklist, which incorporates hand hygiene		-Matrons complete the quality assurance improvement tool: COVID19 checklist, on for audits. -check and challenge during IPC ward rounds -infection prevention link nurses trained to carry out hand hygiene audits -Monthly Peer review to provide fresh eyes and challenge by Deputy Chief		↔

				Nurse and Workforce Matron. - Weekly IPC audit.		
6.8 **Lead Director: Chief Nurse.** **Manager: Clinical Director for Facilities**	**Staff understand the requirements for uniform laundering where this is not provided for on site**	• PHE guidance regarding uniform laundering has been included in frequently asked questions for staff and is available on the intranet. • Scrubs are provided for staff in high risk areas / undertaking high risk procedures and these are laundered in the Trust off site laundry.	Staff continues to take Scrubs home to wash which is against IPC and Linen Contractor requirements. This can also lead to reduce supply available on site.	-Clinical Director for Facilities escalates to silver any issue with scrub availability. -Large amount of additional Scrubs rented from contractor following an increase in there supply March / April 2020. -Facilities laundry team monitor and report stock levels to the silver group.	N/A Review via Silver meeting daily	↑
6.9 **Lead Director: Operational Director of HR** **Manager: HR relationship managers.**	**All staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms**	• Staff regularly updated via the Trust intranet and on Weekly Chief Medical Officers all staff briefings. • Regular communications sent to staff in line with national guidance • Supported by the Ways of Working Team and Occupational Health • Records of lateral flow staff self-testing reported on Info net and guidance on self-isolation and reporting to Workforce and manager. Also how to obtain PCR retest via staff POD. Link		Regular staff testing rolled out in line with national guidance, including instructions on how to use the self-testing kits, how to interpret the results and what to do if the self-test is positive	Reported to Silver and Gold as Daily Dashboard	↔

7.	**7. Provide or secure adequate isolation facilities**					
	Systems and processes are in place to ensure:					
7.1 **Lead Director:** **Chief operating Officer /Chief Nurse** **Manager: Silver rota / Deputy Chief Nurse**	**Patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate**	• Patients are isolated in single rooms when clinically suspected or confirmed to have COVID19, or cohorted if insufficient single rooms available, based on risk assessment • Surge plans ensure the capacity for both COVID and non-COVID patients is available throughout the hospital. Surge plan reviewed daily by Silver and updated Surge continues. This is reported to Gold • Flow chart for "exposed" patients originally updated August 2020. Updated as changes required and published on Microguide. • IPC ward rounds undertaken to ensure patients are appropriately isolated. • Guidance available on staff redeployments. Link	-Exposed patients (asymptomatic, but swab result awaited) are currently placed on the low risk pathway if assessed as being low risk by a senior clinical decision maker – this potentially increases the risk of nosocomial transmission. -Additional SURGE capacity exceeded for ICU and red (high risk) areas. Part of daily management of Silver and reporting to Gold Daily. -Surge plan currently being extended and extra ICU beds and staff redeployments. -Additional areas open in nursing Adult ICU COVID positive patients in RACH level 7. Risk assessment undertaken	-Senior clinical decision maker involved with the assessment. -Exposed patient pathway followed as and when necessary which has been agreed at CAG. -Cohort of patients at day 10 positive due to low risk of transmission agreed at CAG on 12/1/2021 in extremis and approved by DIPC/HoN and Director on call out of hours -Staff wear the PPE for exposed patients to reduce the risk of cross-transmission. -Additional rapid testing commenced which will help ensure patients COVID status is known before leaving the Acute Floor.	On - going daily review as part of Surge and capacity review	↔

7.2 **Lead Director: Clinical Operating Officer / Chief Nurse** **Manager: Clinical Director of Facilities, Director of Estates, Head of**	**Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national Guidance**	• Clinical/ward areas have been assessed to ensure compliance with the national requirement for 2m distancing and the standards set out in 'Infection Control in the Built Environment' • Assessment of ventilation undertaken in a number of areas that carry out AGPs, e.g. endoscopy. Records are held by Estates team. • Review of national key actions and agreed implementation reviewed and agreed at CAG and to Gold Week from 30th November 2020	- Not all bed spaces comply with 2m physical distancing – main area of where 2m distance cannot be achieved is the Barry building. – Capital Development carried out measurement of distance between beds. Operational teams to discuss where beds can be removed but this is part of the surge plan and capacity issues in Trust. -Ventilation is suboptimal in some areas across the Trust. -Changes to patient testing and movement as per 'Key Actions' briefing note currently being worked through locally and regionally.	-Group chaired by the Chief Operating Officer reviewing ventilation, environmental adaptations Barry building and patient pathways to maximise the use of the estate at PRH. -A programme to assess and improve the ventilation in clinical areas is in place, focusing starting with priority areas lead by Estates. -Estates adding additional exaction in clinical rooms with no current extraction and CO2 testing in area of concern to see how much air exchange is occurring. Progress is review with regular meeting with IPC and Estates. Report to H&S committee 22/12/20 of Ventilation review by estates.	To be review by Gold and H&S committee and via IPC bi-monthly meetings. Feb 2021 progress update	↔

				-All clinical areas advised to de-clutter and maximise bed spacing as much as possible.		
7.3 Lead Director: Chief Nurse / Chief Operating Officer **Manager: Silver Rota, Site management team.**	**Patients with resistant / alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement**	• IPC policies for management of patients with resistant/alert organisms are available to Trust staff on the info net- IPC polices. • Included in induction and update IPC training recorded on IRIS. Learning and Development teams send monthly report sent to all line managers and staff automatically sent reminders of training due via IRIS training system) Divisional management teams to ensure all training is maintained at (90%) . • Clinical site team have records available regarding placement of patients with resistant/alert organisms. • Single room prioritisation list available and provided to the Site Team.	-Single room provision is quite limited in many areas of the Trust, including provision of single rooms with en-suite facilities. Consequently, there is often insufficient to meet demand (for IPC requirements and other clinical needs, such as end-of-life). COVID limits this provision for patient other than COVID 19 which exacerbates this risk. .	-IPC precautions are implemented at the patient bedside based on risk assessment when single rooms are unavailable – checked during IP ward rounds -Ward managers / matrons check and challenge whether the correct precautions are in place -Site team assist with correct placement of patients to help mitigate risk.	2023- New hospital (3Ts) will include 50% single room isolation facilities. Currently exploring redirooms as medium solution to increase side room capacity	↔
8.	**Secure adequate access to laboratory support as appropriate**					
	There are systems and processes in place to ensure:					
8.1 Lead Director; Chief Operating Officer	**Testing is undertaken by competent and trained individuals**	• The Microbiology Department hold UKAS accreditation and accredited for COVID testing in January 2021 which provides assurance of the high quality service they provide. The department have also	Nil	-Pathology departments have as large schedule of audit requirement which are scheduled and	In Place	↔

Manager: DDO CCS / Pathology director		applied for and received in January 2021 the accreditation for COVID-19 which was optional for all sites undertaking testing. This is recorded on their local governance system Q-pulse.		results are recorded Q-pulse. -Non-conformances are tracked via Q-pulse on CAPA module where it is assigned to individual to create action plan and complete on q-pulse. -Review any breach of deadline is reviewed at the appropriate Pathology Quality management meetings. - Full UKAS external accreditation is carried out very 2 to 3 years with interim annual satellite visits.		
8.2 Lead Director: Chief Medical Officer / Chief Operating officer **Manager: Clinical site team**	**Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance**	• Patient testing is undertaken in line with PHE / national guidance on admission and the follow days e.g.: day 0, 3,5 and 7 and every 7th day – included in clinical pathways. This will • Staff testing embedded in the testing POD. Staff records are held by Workforce and master list of positive staff is held by Occupational Health team. Link	-Undertake an audit to assess compliance with swabbing requirements currently in place. -Lateral flow self-testing for staff cannot be used for 12weeks post positive COVID PCR test as will appear positive.	-Daily list of patients who require re-swabbing circulated via the Site Team. -All front line staff have been issued with lateral flow test for twice weekly staff testing in line with national guidance –	Retrospective audit January 2021 to test system	↔

		• SOP for staff testing managed by the workforce team. • Staff lateral flow results entered on form twice weekly by staff member on Trust info net. link		self testing kits and accompanying information provide for 12 weeks and when to use the test.		
8.3 Lead Director: Chief Nurse **Manager IPC lead manager. ,**	**Screening for other potential infections takes place**	• Screening takes place as per local / national guidance / policies, e.g. MRSA • IPC policies, which includes the need for screening, are available on the Intranet • IPC ward rounds		-The IP Team visits wards based on priority (this is assessed on a daily basis) -Local ownership led by Matrons and ward managers	Reported via IPC group (bi-monthly)	↔
9	**Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections**					
	Systems and processes are in place to ensure that:					
9.1 Lead Director: Chief Nurse Manager: IPC Lead	**Staff are supported in adhering to all IPC policies, including those for other alert organisms**	• Trust induction • IPC ward rounds • IPC training • IPC policies • Local leadership/link nurses • IPC annual audit programme • IPC quality improvement tool – weekly checks	-Sustained need for vigilance and compliance -Promote local ownership through divisional and department leaders -Need to further strengthen the IPC team at BSUH and as the new merged organisation Embed IPC Prefect audit	-IPC quality improvement tool issued to ward managers / matrons for weekly checks of IP standards, encouraging local leadership of IP issues -on-going support and advice provided by the IP Team -Interim Head of Nursing appointed to provide leadership to the senior IPC nurses	April 2021	↔

				-Recruiting to a nurse consultant post -Reviewing the option of additional consultant PA time to strengthen expertise -Ahead of planned merger working with DIPC at WHST on new organisation IPC structure		
9.2 Lead Director: Chief Nurse Manager: IPC Lead / Comms team	**Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff**	• Reviewed daily by the Incident Control Room and IPC Team • Any changes are communicated at Bronze IP huddle, CAG and Silver meetings for dissemination to all clinical areas via directorate representatives, minutes of meetings available as evidence • Guidance available for all staff on Microguide.	Nil		Daily/ weekly/Monthly	↔
9.3 Lead Director: Chief Nurse Manager: Clinical Director of Facilities	**All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance**	• All waste generated from confirmed / suspected Covid-19 patients is discarded as infectious waste – waste consignment notes provide evidence of this. • Cat A waste management procedure agreed for Trust. • Trust Waste Policy and procedure in place • Included in IPC training on IRIS.	-Waste storage facilities inadequate on RSCH for main storage and some ward areas. Additional area have been allocated. Will only be resolved with completion of 3t's project.	- Waste manager within Facilities team. - Regular audit with transport of dangerous. - No conformance on waste escalated by Clinical Director of Facilities via Silver or directly to area concerned.	Daily at Facilities Safety Huddle	↑

		• Transport of Dangerous good Advisor contracted by Risk Management team supports Waste Manager on monthly visit for advice and review of waste compounds and consignment notes.	- Regular breach in waste segregation in picked up by waste management team especially in for Sharp boxes. These are managed daily. - ensure included in Prefect Ward IPC weekly Audit.			
9.4 Lead Director: Chief Financial Officer Manager: Head of procurement	**PPE stock is appropriately stored and accessible to staff who require it**	• Covid-19 PPE stock is stored in the Procurement department and dispensed to clinical areas on a daily basis, as needed • All PPE stock queries are directed to bsuh.covidstock@nhs.net • Senior ward staff check stock availability on their ward	-National / international stock shortages can impact accessibility. 18/1/21 CAG discussed expanding FFP3 use – Review impact of any change on stock levels.	-Mutual aid Careful use of PPE, taking account of whether areas are undertaking aerosol generating procedures	On-going - review Daily and reported to Silver. On Daily COVID resilience dash board	↔
10	**Have a system in place to manage the occupational health needs and obligations of staff in relation to infection**					
	Appropriate systems and processes are in place to ensure:					
10.1 Lead Director: Director of Human resource / workforce/ Chief Nurse Manager: Workforce team / Deputy Chief Nurse /	**Staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported**	• Risk assessment completed for at risk groups by managers with additional support for process provided by Occupational Health and HR WOW team via bamboo • Risk assessment updated and reissued with additional guidance particularly in relation to BAME staff. Head of Inclusion and team are fully included in this review process	Nation NHS direction 2nd vaccination will not be provide until 11 week for Pfizer as well as the Oxford vaccination.	-Vaccination programme at both Trust sites for started with providing appointments to front line staff and clinical vulnerable and high risk staff. Over 80% of staff currently received 1st vaccination.	N/A	↔

Head of Inclusion		and provide guidance as support to staff and managers. • FAQ for Vaccine and high risk staff available on Trust info net. • HR in July 2020 contacted all High risk staff risk assessment. • Wellbeing information provided on info net for all staff. • HELP service available for staff requiring additional counselling support and can provide support to all staff.		-Panel review all individual high risk assessment on weekly basis. Guidance and email address available for guidance form review group. Link		
10.2 Lead Director: Chief Nurse Manager: Head of Nursing – Quality Improvement	**Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained**	• Training provided for FFP3trainers • Portacount machines purchased by directorates for FFP3 testing • Web based fit testing records are available and can be accessed via the qualitative fit testing report	-Some records were paper based prior to electronic recording	• -All records have been uploaded electronically on via bamboo	N/A	↔
10.3 Lead Director: Director of Human resource / workforce/ Chief Nurse Manager: Workforce team / Deputy Chief Nurse	**Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing**	• Dedicated Senior Nurse contacts all 'at-risk' staff at 7 days absence, 7 days per week. Ways of Working Team (WOW) keep the database of all staff absence related to COVID • Advice for managers on info-net and staff sickness reported at Silver Command meetings link	Nil	NA	N/A	↔

10.4 Lead Director: Director of Human resource / workforce/ Chief Nurse Manager: Workforce team / Deputy Chief Nurse	**Staff that test positive have adequate information and support to aid their recovery and return to work**	• Dedicated Senior Nurse contacts all staff who test positive and offer advice and support, also supported by the Ways of Working (WOW) Team	Nil	NA	N/A	↔

Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	16	**Meeting:**	Trust Board	**Meeting Date:**	2 February 2021
Report Title:	Annual Equality Report 2020				
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 where improvements are required relate to Disability, Ethnicity and Gender and each of these areas have their own Action plans/Pay Gap Report.				
Link to CQC Domains:					
Safe	☐		Effective	☐	
Caring	☐		Responsive	☐	
Well-led	✓		Use of Resources	☐	

Communication and Consultation:

This report has been shared with the Diversity Matters Steering Group (with the recommendation for the report to be approved by TEC before being shared and agreed by Board.

Executive Summary:

The Equality Annual Report sets out how we are meeting our commitment to the Public Sector Equality Duty (PSED) in all that we do. This report highlights in some detail the work being undertaken across the organisation and demonstrates progress being made, whilst also indicating where improvements still need to be made.

The Trust's commitment to the equality agenda is evidenced in the improvements made during 2019/20 in areas such as:

- Improvements for consistent implementation of NHS Accessible Information Standard
- Improved information on protected characteristics on ESR
- Launch of SOAR (BAME Network)
- Continued improvements for meeting communication needs for our patients and service users
- Improving the risk assessment process
- Promotion of wellbeing services for our workforce

Key Recommendation(s):

This Report is submitted to the Trust Board for approval.

Brighton and Sussex University Hospitals NHS Trust

Annual Equality Report 2020

January 2021

The Inclusion Team

Contents

Introduction

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

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

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

These nine attributes are known as protected characteristics.

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

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

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

This report provides a summary of activity and a snapshot of demographical data covering 1st April 2019 to 31st March 2020 as a public sector organisation extra care is taken to monitor decisions that could unfairly affect any particular protected characteristic of staff, carers, volunteers, patients and their families.

Towards the end of 2019/20 – the COVID-19 pandemic hit the world and presented all organisations with unprecedented circumstances. As a result, there will be an impact on the delivery of some of the objectives covered within this and the next reporting periods.

Who benefits from this report?

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

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

Those who work within the Trust
Attracting, developing and retaining a diverse and reflective workforce is essential to delivering responsive and inclusive services. Having such a workforce encourages the Trust to develop and deliver services that understand the complex needs of the diverse communities it serves. National research suggests that the degree to which organisational demography is representative of community demography drives positive effects in terms of the patient experience. (Why Organisational and

Community Diversity Matter: Representativeness and the Emergence of Inclusivity and Organisational Performance, King et al., 2011).

Response to COVID-19/Coronavirus Pandemic

Towards the end of March, the impact of the global pandemic was visible and felt across the world. Within healthcare in the UK, major changes were made in the way that services were both delivered and how they were accessed.

To meet the demands from the pandemic, the Trust implemented a number of changes across the board. Some of the changes made during this period included:

- Improving risk assessment process, for both departments and individuals to enable effective judgements on the best ways to protect both our staff and services.
- Introducing a risk assessment advisory panel – an independent panel reviewing complex individual risk assessment and providing advice and solutions to issues highlighted.
- Commissioning of more SignLive British Sign Language services, allowing BSL users to communicate with hospital staff effectively (both in-person and remotely).
- Widespread use of 'virtual clinics' both telephone and video conferencing.
- Widespread use of working from home practices.
- Promotion and expansion of staff health and wellbeing services.
- Installed a bronze, silver and gold COVID-19 command centre – to take trustwide decisions on issues affecting capacity and flow in services.
- Installed a COVID-19 Workforce taskforce – to help address questions and resourcing of departments.

As national guidance and guidelines changed throughout the pandemic, the Trust worked hard to ensure that it was compliant and delivering effective services for both patients and staff.

Vision statement

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

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

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

Our patients and service users:

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

Our staff:

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

Our communities:

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

Our organisation:

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

What is the Trust doing to further the inclusion agenda?

The Trust undertakes a wide range of work, projects and activities to support the inclusion agenda to benefit patients and the workforce. Below is a summary of some of the key highlights that occurred during 2019/20.

Diversity Matters Steering Group (DMSG)
The steering group is co-chaired by the Chief Executive (Marianne Griffiths), Deputy Chief Executive/Chief Medical Officer (George Findlay) and the Director of Human Resources. The group provides a valuable forum to discuss issues that impact equality and inclusion in the Trust for both staff and patients.

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

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

There are workstreams which cover a range of activities that impact our staff – this is led by our Chief Executive, Marianne Griffiths and Deputy Chief Executive/Chief Medical Officer, George Findlay.

The workstreams are:

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

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

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

Gender Pay Gap Reporting

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

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

To see the 2019 report and action plan, please go to:

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

Due to the difficulties presented by COVID-19 during this financial year, there is no requirement to centrally report to the national reporting service during this reporting period. In the interests of ongoing transparency, the Trust decided to declare gender pay gap data for this reporting period.

NHS England Equality Standards

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

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

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

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

The Workforce Disability Equality Standard (WDES) was mandated in the NHS Standard contract in April 2018 with implementation in April 2019. The reporting period for the standard covered 2018/19. The aim of the standard is demonstrating fairness within services using standardised data available to all NHS Trusts; the standard will also highlight areas for improvement. This standardisation of data allows NHS Trusts to compare the experiences of disabled and non-disabled staff in a range of areas that impact staff. A specific working group (formed of Trust staff) has been formed to look at issues raised within the standard.

The areas that the standard looks at include:

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

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

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

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

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

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

Stonewall Workplace Equality Index

The Stonewall Workplace Equality Index (WEI) is a ranking list of British employers compiled annually by the Lesbian, Gay, Bisexual and Transgender (LGBTQ+) equality charity and training provider Stonewall. It provides a 'definitive list showcasing the best employers for Lesbian, Gay, Bi and Trans staff', through a detailed review of documentation, employer inclusion practices and staff surveys. The Index was launched in 2005. The Trust's 2019 submission (covering the period

September 2018 to September 2019) comprised nearly 30,000 words: responses to 180 questions over ten domains sections with 83 free-text answers. 155 Trust LGBTQ+ staff and Allies completed the Stonewall survey to validate the Trust submission – an increase of 47% over the 2018 survey.

Results of the 2019 WEI were announced in early 2020. In 2018, the Trust ranked 143 out of 445 entrants (top 32%). In 2019, the Trust improved its ranking to 101 out of 503 entrants (top 20%). In 2018 the absolute score was 97 out of 200; in 2019 the score was 138 – a 42% increase. This was a very significant achievement. Stonewall noted a number of positive developments (please see items in the LGBTQ+ Network section), which followed the wide engagement with LGBTQ+ staff, Allies and the wider leadership community in the Trust through the LGBTQ+ Inclusion Conference held in February 2019.

The Inclusion Team

The Trust continues to have a dedicated Inclusion team, comprised of a Head of Inclusion (key areas of responsibility include Race and WRES), Deputy Head of Inclusion (key areas of responsibility include service improvement, disability, and the Workforce Disability Equality Standard) and Inclusion Advisor (a key area of responsibility is training). This enables the organisation to benefit from their expert advice for both staff and patients.

Due Regard Assessments

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

Freedom of Information Request

The Freedom of Information Act 2000 was introduced to promote transparency within public services. The Inclusion team assists in the completion of a number of requests, mainly dealing with the use of interpretation and translation within the Trust.

Staff Conferences

BSUH did not hold any staff conference events during 2019/20.

However, the Inclusion Team supported their colleagues at Western Sussex NHS Foundation Trust with two staff conferences which focused on inclusion during 2019/20.

In February 2019 (to coincide with LGBTQ+ History Month), the Trust was invited to host Stonewall's South East Regional Awards & Networking Event. This was held at Princess Royal Hospital, with the Trust Chair Alan McCarthy and Non-Executive Director (and Inclusion Lead) Patrick Boyle welcoming Stonewall Interim CEO Paul Twocock and over 50 guests from partner and other Stonewall Diversity Champion organisations from across the Region.

The Trust LGBTQ+ Network was delighted to receive the Regional Network of the Year Award at this event, in recognition of its leadership work within the Trust and across the wider health sector and regional geography.

Staff Networks

LGBTQ+ Network

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

LGBTQ+ Network Sports, Social & Wellbeing

During 2019/20 the LGBTQ+ Network has continued to expand the number and range of social, sports and wellbeing activities for Network members, incl. Allies (i.e. those who do not identify as LGBTQ+ but share the commitment to inclusion and equality and want to show their practical support). Activities and events have included: Sunday Roast Social, Brighton Festival and Fringe Festival theatre visits, Bouldering, 10 Pin Bowling, Countryside Hike, 2nd Annual Beach Volleyball & Sunset Picnic, Film Club, Book Club, 'Knit 'n' Natter' Craft Group, Vinyasa Flow yoga, 'Couch to 5k' running challenge, Victoria & Albert Museum LGBTQ+ Tour. These activities provide opportunities for members to network and collaborate. The Network has also sought to incorporate health and wellbeing, recognising the significant health inequalities experienced by LGBTQ+ people (e.g. mental health, smoking, physical exercise, domestic abuse) and the barriers to participation that mainstream activities and venues can present (in particular for trans and non-binary people).

Prides 2019

In 2019 the Trust participated in:

- Trans Pride (July 2019) – the Trust Patient Experience Team and LGBTQ+ Network helped steward the march and then hosted a stall alongside Clinic T / Brighton & Hove Sexual Health and Contraception (SHAC) service and the Trust's Midwifery Service (hosted by the Trust's Gender Inclusion Midwives). These provided unique opportunities to engage the local trans and non-binary communities in discussing best, inclusive, equitable patient care at the Trust. The team was also pleased to have organised and staffed the Children & Families stall for the event.
- Disability Pride (July 2019) – the Trust Patient Experience Team, LGBTQ+ Network and Disabled Staff Network hosted a stall for this event. Again, this provided a unique opportunity to engage with local LGBTQ+ and non-LGBTQ+ disabled residents and visitors and to promote its inclusive approach and values.
- Brighton & Hove Pride (August 2019) – this marked the 50th Anniversary of the US Stonewall riot of 1969 when brave trans women of colour and other gender non-conforming activists stood up for their rights in what is now recognised as a watershed moment for LGBT+ equality and the establishment internationally of the Pride movement. 70+ Trust staff participated. The Trust float (donated by Laing O'Rourke) was again led by Trust CEO Dame Marianne Griffiths. In parallel, the Network ran a 'Prides at BSUH' campaign to recognise the staff who were working and continuing to care for patients, over the Pride weekend.

'Belong Here' Recruitment Campaign

In Summer 2019 the Trust ran a high-profile 'Belong Here' recruitment campaign, aimed at LGBTQ+ people and Allies and promoting the Trust's inclusive employment, volunteering and apprenticeship opportunities. Rather than use models, 14 Trust staff agreed to be featured. In addition to large images at bus stops along the Pride parade route, the campaign included Staff Stories and a bespoke recruitment home page – to provide tailored messaging, and track impact data.

LGBTQ+ Network Newsletter

The Network has continued to increase its presence on social media and outreach to LGBTQ+ staff and Allies. Between March 2019 and March 2020, it has circulated a Weekly Newsletter with a variety of Network, the local LGBTQ+ community, educational and resource updates. As at December 2020 (outside the reporting period), the Network had 640 members, with 752 Twitter followers and 378 Trust members of the BSUH LGBTQ+ Network on Facebook Workplace. The new LGBTQ+ extranet webpage also includes a wide range of resources and Staff Stories promoting inclusion at the Trust.

LGBTQ+ Educational Seminar Series

In 2019/20 the Network worked in partnership with the Trust Education & Knowledge Directorate and BSMS (Brighton & Sussex Medical School) Spectrum LGB&T Society to run a series of six educational seminars. These featured speakers from a range of partner organisations and were videoed and edited to provide a wider educational resource. Topics:

- LGBTQ+ and Mental Health (May 2019)
- LGBTQ+ and learning from the Armed Forces (July 2019)
- LGBTQ+ and Ageing (September 2019)
- How LGBTQ+ intersectionality affects care (October 2019)
- Include education curricula (November 2019)
- Trans & Non-Binary experiences of healthcare (December 2019) – this session is being developed into a further 'Trans 101' educational resource.

LGBTQ+ Mentoring Programme

In 2019/20 the Trust ran its first, year-long LGBTQ+ mentoring programme, involving 19 pairs of LGBTQ+ and Ally mentors (including CEO Dame Marianne Griffiths) and

LGBTQ+ mentees. The programme ran for 12 months from May 2019. A full evaluation report has been published. Headline results:

- What did mentees want from the programme: support for personal effectiveness (100%), personal development (100%), career progression (83%), confidence in being authentic self at work (50%), expanding own networks (50%), building self-confidence (17%).
- Although reverse mentoring was not a principal purpose, 80% of mentors reported they had developed personally/professionally as a result of the programme, 60% of mentors said their own motivation at work had increased, and 100% felt they had contributed meaningfully to the LGBTQ+ community.
- For the LGBTQ+ mentees, the experience and achievement of individual objectives was also positive overall: nearly 70% of respondents said it had been a good investment of their time; 83% of mentees said they would recommend the programme; 80% of mentors and mentees would like to see the programme run again; 100% of respondents reported satisfaction with the administration, communication and programme support.

'No Excuse for Abuse'

In Autumn 2019 the Trust Security Team launched a 'No Excuse for Abuse' campaign and worked with the LGBTQ+ Network to develop a supplementary campaign recognising the additional and particular abuse that LGBTQ+ staff, and other minority staff groups, can experience.

Trans & Non-Binary Group

During 2019/20 the LGBTQ+ Network established a subgroup for staff who are Trans or Non-Binary. This has provided additional safe space, as well as a network of staff with 'expertise through experience'. Working in close partnership with the Trust Gender Inclusion Midwives, the group has continued to influence Trust, local and national NHS clinical and employment policies to ensure inclusive, equitable care for patients/service users.

In November 2019 the Trust's Gender Inclusion Midwives were awarded the NHS Chief Midwifery Officer's Silver Award for their work in supporting pregnant people in the trans and non-binary community. This work is now being extended regionally and nationally to share best practice. This provided a very positive vision of inclusive care to close Trans Awareness Week 2019.

Role of NHS LGBTQ+ Staff Networks

During 2019/20 the LGBTQ+ Network was one of nine case study sites for a significant research study into the role and function of LGBTQ+ Staff Networks in the NHS, led by the University of York and NHS Employers.

BSUH Disabled Staff Network

In February 2019, the BSUH Disabled Staff Network (BSUH DSN) was launched. Marce Quinn leads the Network, and since then Vickie Johnson has become the Secretary to the Network. This Network provides staff with a safe space to discuss issues that are affecting them, especially those who have a disability or long term health condition or support someone who does. The Network meetings are also used as a forum to discuss ideas that could be made to improve standards for disabled staff. During the last two years, the Network has encouraged the Trust to adopt a Health Passport, and with a great deal of work by the Inclusion Team, this has now become ratified by the Trust. The Network campaigns for a better understanding for those staff covered under the Equality Act 2010 and Marce, as Lead has been able to mediate between those staff who may need support with their Managers to implement reasonable adjustments within their workplace. Marce has reached out to other Trusts and organisations, and there is now a thriving Network of workplace disability groups within the South East which is regularly growing.

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

Workforce Race Equality Working Group

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

- Recruitment
- Communication
- Education and Training

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

Workforce Disability Equality Standard Working Group

The group was established to look at the data and information from the annual WDES data; the group also helps to produce an action plan to address any areas of inequity that the data highlights. The group reports into the Diversity Matters

Steering Group, which provides oversight and governance on the delivery of the action plan.

The action plan covers three financial years and contains actions that seek to address:

- Declaration rates
- Supporting disabled staff
- Education and training

Information to support the workforce and patients

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

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

Recruitment

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

Training

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

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

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

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

Service Improvements and other initiatives

NHS Accessible Information Standard

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

The workforce has access to a range of interpretation and translation services, hospital communication books and a Learning Disabilities Liaison Team. The Inclusion team have also provided support by purchasing and distributing Sonido Personal Listening Devices to a number of wards and departments, providing hospital communication books (this provides a pictorial way of communicating) to wards and departments, and purchasing the 'Recite Me' system which has helped to improve the accessibility of the Trust's website.

Recite Me (website accessibility tool)

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

Overseas and Communication Support

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

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

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

From March 2020 the Trust went live with SignLive British Sign Language remote services. This enables virtual interpreting using video conferencing and BSL users to contact the hospital via the switchboard (and departments) by telephone (via an interpreter). During this period Sussex Interpreting Services and Vandu expanded their services to include video conferencing, which the Trust has used to facilitate patient appointments.

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

Engagement with Patient Experience

The Trust has taken a number of steps to engage with patients and their experience. The Trust has a Patient Experience and Engagement Group, a disabled patient and user group and many departments undertake their own engagement exercises.

Patient Experience and Engagement activity during 2019/20

1. The Patient Experience team quickly responded to the emerging Covid-19 pandemic and introduced several initiatives ensuring that patients were able to maintain contact with their loved ones. Plans are in place to continue these initiatives post-COVID.

2. Bringing families together – the patient safety team supplied wards with mobile telephones for those patients who do not have access to a mobile device and tablets to enable patients to facetime/skype their family and friends.

3. Hearts for the dying and the bereaved – the patient experience team has worked with the critical care and palliative care teams in this project which ensures that a handmade heart is placed with a dying patient and, once they have died, a matching heart is sent to the next of kin along with a condolence card.

4. Letters to loved ones – Relatives and friends unable to visit our hospitals can write to their loved ones via bsuh.letterstolovedones@nhs.net or by calling the PALS team who will write up the message and ensure that it is safely delivered.

5. In 2019/20 BSUH continued to extend its community network to ensure that the voices of all of our patients are routinely sought, listened to and used to inform future service planning. BSUH now has formal engagement with:

5.1. Possability People – supporting and involving disabled people, including:

5.1.1. Facilitation of focus groups with the 3T's Wayfinding Project to ensure improved accessibility and communication with differently-abled patients.

5.1.2. A Top Tip list of things to bring for an unplanned hospital admission.

5.1.3. A clear point of contact for information relating to hospital services, including pharmacy, 3T's, specialist services provided at BSUH.

5.2. Switchboard – community, support and information for LGBTQ+ people. Engagement initiated to encourage greater involvement of the LGBTQ+ community in service planning.

5.3. YMCA – Right Here - Engagement initiated to encourage greater involvement of young people in service planning.

5.4. Trans and Disability Pride - BSUH was visible at both events encouraging better communication and feedback from these groups.

5.5. Maternity Voice Partnership, Brighton and Hove and West Sussex - The patient experience team attends the quarterly meeting to provide real-time data to help explore individual concerns raised. In May 2019, feedback about a lack of pain relief during labour was discussed, and FFT data confirmed and reassured local women that no other concerns had been raised about this matter.

5.6. MENCAP Treat Me Well Campaign - The Patient experience team held the first Brighton and Hove Treat Me Well campaign, attended by patients and their representatives with colleagues from the social and voluntary sector. The focus of this group is to improve the experience of patients with a learning disability by utilising the 'my care passport'.

5.7. Healthwatch - Brighton and Hove, West Sussex and East Sussex Healthwatch are independent charities forming part of a national network of 152 local Healthwatch organisations in England. The network is overseen and supported by Healthwatch England, which provides a formal link to the Department of Health and Secretary of State for Health. Their role is to ensure that local decision-makers and health and social care services put the quality of experiences of people at the heart of their work. BSUH has several joint initiatives with Brighton and Hove Healthwatch including:

5.7.1. Hospital Care Environmental and PLACE Audits - Healthwatch (HW) undertake planned environmental inspections each month using the NHS 15-

step challenge. HW representatives also attend the Trust's formal monthly PLACE meeting and are represented on the BSUH Food Improvement Group. These initiatives allow patients and their representatives to be involved in decision making and conversations about our hospitals to help ensure that our services are always considered and viewed from a patient's perspective. Improvements made following visits include the upgrading of the public toilets within the main outpatients building; refurbishment of Bristol ward; providing adequate and compliant storage for linen and cleaning equipment; an increase in clinical storage space and a dedicated room for the multi-disciplinary team to base themselves in. Further work is currently ongoing, including new signage across the sites.

5.7.2. End of Life Care - The patient experience and End of Life Care Team invited Healthwatch to review the End of Life Care provided to our patients and their families. Whilst this review is on-going, initial feedback provided by Healthwatch has enabled us to support changes to the information provided to patients and their families to improve the communication for our patients who are approaching the end of their life.

5.8. Quality visits - As part of our culture of continuous improvement, clinical and non-clinical reviewers of all grades are invited to assess our services against CQC standards and what we know is important to service users and staff. This provides an opportunity to assess the quality of care through observation of the clinical environment and listening to the views of patients, visitors and staff. This is not intended to be a checklist, but more an opportunity to assess the quality of care through observation of the clinical environment and listening to the views of patients, visitors and staff. Reviewers are asked to consider: is the area welcoming, and does it feel safe, is care effective and of high quality, is the ward responsive and well-led. The reviews are documented and shared with the ward leadership team for learning.

5.9. Dementia - The patient experience team supported the Dementia team in the planning and publication of their strategy. This allows the Trust to embed principles of engagement and focus on the importance of patient experience from an early stage. In 2020/21 work will continue with the dementia team to support patient engagement events.

5.10. Patient Knows Best - Launched in response to feedback from patients, this offers a more flexible way to access details about appointments. The patient experience team held an engagement event to ensure that patients were made aware of the service which was attended by members of the public, Healthwatch, Clinical Commissioning Groups (CCG) and Possabilty People. Further events will be held in 2020/21 to support the wider launch of the

system.

5.11. Sussex Health and Care Partnerships - Sussex Health and Care Partnerships, including BSUH, began reviewing patient engagement across Sussex to improve learning across the Healthcare System. Through this partnership, we hope to engage with more patient groups in 2020/21 to gain further insight into the experience of our patients.

5.12. Patient Entertainment

Following feedback from patients regarding the current bedside entertainment system, the patient experience team began working with Facilities and Estates to support the procurement of a new system which will enhance the patients' experience.

5.13. 3Ts Wayfinding

In 2019/20, the patient experience team held its first 3Ts wayfinding group with patients to ensure their input is involved throughout the process. In 2020/21 there will be further groups.

<u>The Learning Disability Liaison Team (LDLT)</u>

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

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

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

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

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

Freedom to Speak Up Guardian

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

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

HELP Service – Health, Employee, Learning and Psychotherapy

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

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

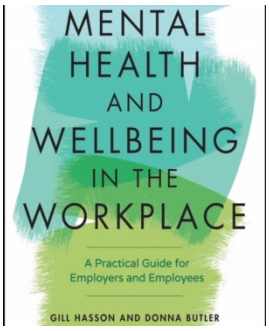
During 2019/20 the service undertook the following activities to help support staff:

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

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

- Developing Mental Health Awareness training to improve knowledge and reduce stigma. The first pilot of this training has been completed, and a second pilot is planned. This training will be available to all managers.
- The HELP Service has involvement and engagement with Workforce Disability/Race Equality Standards, Learning and Development and the LGBTQ+ Network and acts as organisational allies for these protected characteristics.,
- HELP service recruitment and expansion has diversity awareness at the forefront.
- Video logging will be going live in November 2020 to improve further understanding of mental health/wellbeing in the workplace.
- HELP are promoting equality and diversity and inclusion, in its hosting and training honorary psychotherapists from University (on placement).
- Mindfulness workshops delivered to teams within the Trust.
- The service has developed a number of resources for staff, including managing anxiety, depression, grief and trauma.
- Developed a community resource, with contact numbers, for staff who want to access BME/ BAME/ LGBTQ + and disability groups.

Donna has co-authored a book called 'Mental Health and Wellbeing in the Workplace'. The book looks at issues involving inclusion, wellbeing and mental health in the workplace. The book has case studies highlighting the importance of inclusivity.



Mental Health and Wellbeing in the Workplace has been endorsed by all national wellbeing leads. The Trust's Chief Executive, Dame Marianne Griffiths has also endorsed the book. The foreword was written by Duncan Selbie - Public Health England, Chief Executive.

<u>Occupational Health Services</u>

Occupational Health (OH) offers a range of services which are provided by qualified professionals (nurse specialists, clinic nurses, a physiotherapist and a locum consultant) including:

OCCUPATIONAL HEALTH SERVICES

- Health screening prior to or on commencement of employment
- Fitness for work assessments and advice
- Advice on workplace adjustments due to injury, illness or disability
- Advice on the applicability of the Equality Act 2010 in relation to disability
- Work-related vaccination and blood taking service
- Sharps/splash assessment
- Moving and handling training and advice
- Physiotherapy for injuries caused by or affecting work
- Ergonomic workplace assessments for staff with injury or disability
- Health surveillance including skin assessments

Inclusion

- The vaccination service is available at both RSCH (St Mary's site) and PRH
- Consultations can be arranged via phone or video
- The OH department is wheelchair accessible
- Alternative venues can be arranged on a case by case basis
- Hearing induction loop in OH department
- Correspondence can be provided in a larger font
- Interpreting services can be arranged on request
- Equality impact statements are completed for all OH policies

Data Protection

Occupational Health Services processes personal and health data in line with the Data Protection Act 2018 as per our Privacy Statement (BSUH Intranet):

https://www.bsuh.nhs.uk/wp-content/uploads/sites/5/2016/09/Occupational-health-services-privacy-notice.pdf.

The Data Protection Act 2018 allows staff to view, or to receive a copy of their records.

Confidentiality

Information held in staff OH records will only be passed to a third party with the consent of the individual. In exceptional circumstances, confidentiality can be breached by OH, e.g. if withholding of information would have a safety implication. All OH staff are bound by both BSUH Trust and a local confidentiality agreement.

Further information about Occupational Health Services is available on the Trust's info-net or by contacting Occupational Health Services directly.

Risk Assessment Advisory Panel

At the beginning of May 2020 to support our Managers to undertake Risk Assessments for staff in the following groups:

- Black, Asian and Minority Ethnic (BAME)
- Pregnant Women
- Over 70's
- Certain underlying health conditions

This was to ensure that there was a proper Trustwide undertaking of Risk Assessments and that both managers and staff understood what was required of them.

To help address the queries that inevitably came to light regarding Green – Non-COVID areas and Red – COVID Areas. We set up a Risk Assessment Advisory Panel which comprised of the following expertise:-

- HR Representatives
- Paediatric Consultant
- Medical Director
- Occupational Health
- Cardiac Consultant
- Snr Nurse COVID
- Deputy Chief Nurse
- Head of Inclusion

Expertise from other areas is called upon as is required. This group has met every week since then to advise on the more complex issues that arise as a result of staff undertaking their risk assessments.

The value to the organisation is this is a relatively consistent group that meet – thus ensuring fairness to the process for our managers and staff.

Rainbow Allies

In February 2018 the Trust launched the Rainbow Allies scheme, following a pilot at Evelina Children's Healthcare (Guy's & St Thomas' NHS FT). Of 223 Acute Trusts in England, 144 had launched the scheme by February 2020, with a further 18 planning to launch and 200 Trusts interested – a total of 73% of Trusts (plus 16 Trusts with their own local schemes). BSUH proudly participates in the NHS Rainbow Badge scheme, with its own BSUH lanyards, national NHS rainbow pins, and a bespoke LGBTQ+ Network badge featuring the Pride, Trans Pride and Allies flags. The badges are just one way to show that the Trust is an open, non-judgemental and inclusive place for people (staff and patients/service users) who identify as LGBTQ+.

Rainbow Lanyard and Pin Badges Scheme

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

The lanyards and badges also provide a subtle signifier that the wearer is a 'safe listening ear' for LGBTQ+ patients, colleagues, volunteers and students. This has been a hugely successful scheme with over 4,000 lanyards and badges being distributed around the Trust.

Uptake of patient interpretation and translation services

During 2019/20 a total of 6587 interpreting sessions happened throughout the Trust. The total cost for this was £497,617.03, and this was for 2.358 individual patients.

This can be further broken down:

BSL / Communication Support	Overseas Language (face-to-face)	Overseas Language (remote services)
£71,800.90 (641 sessions)	£423,905.63 (5,723 sessions)	£1,910.50 (223 sessions)

1,318 sessions qualified as a late cancellation, this cost the Trust £61,169.30 and this was for 934 individual patients.

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

1. Arabic (1,912 sessions)
2. British Sign Language (640 sessions)
3. Polish (441 sessions)
4. Bengali (390 sessions)
5. Farsi (344 sessions)
6. Mandarin (307 sessions)
7. Cantonese (272 sessions)
8. Portuguese (264 sessions)
9. Romanian (263 sessions)
10. Spanish and Turkish (210 sessions)

The clinical divisional spend for interpretation:

Division	Number of Sessions	Cost
Central Clinical Services	1,800	£115,962.07
Children and Women's	2,100	£154,701.41
Medicine	551	£ 48,558.30
Specialist Services	618	£ 51,038.61
Surgery	1,494	£125,336.24

There were 65 translations jobs completed in this reporting period, which cost £14,896.69.

This can be further broken down into:

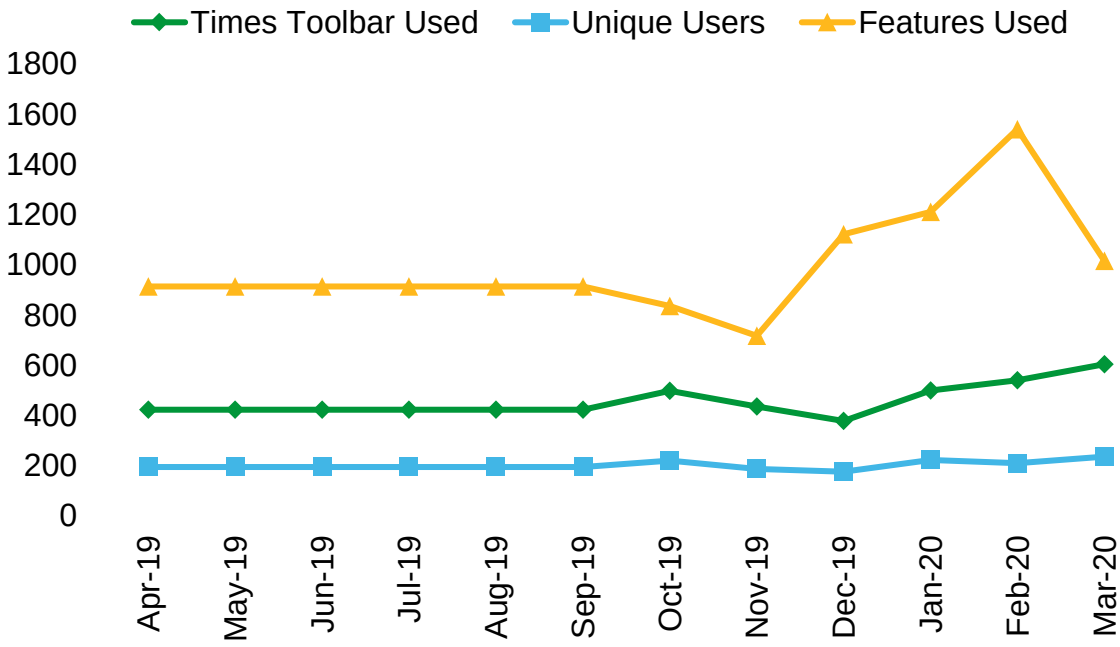
Braille and other communication support	Overseas Languages
£1,854.27 (12 requests)	£13,042.42 (53 requests)

Uptake of Recite Me website accessibility toolbar

Below is information about the use of the Recite Me web accessibility toolbar during 2019/20. Data from April to September was provided as an overall use (as opposed to broken down by month), as such an average was taken over this period to report in the charts below.

Number of users (patients and the general public using the service):

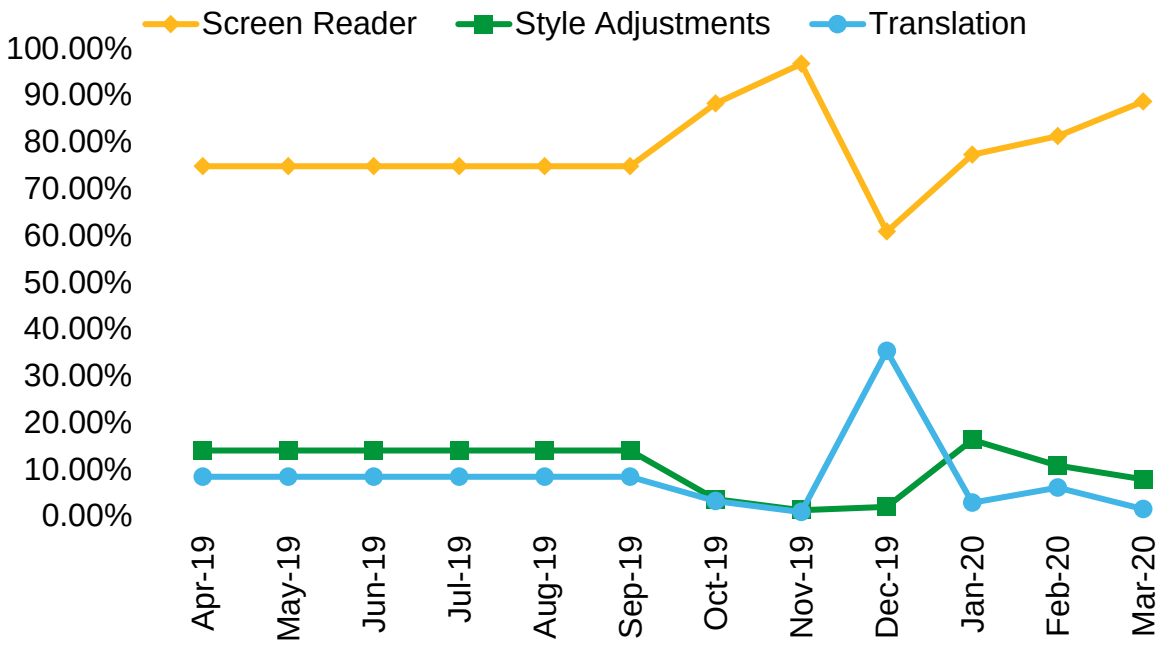
- **Times toolbar used –** refers to the number of times the toolbar has been loaded.
- **Unique users –** how many individual people have used the toolbar
- **Features used –** is in total the number of features used during the period



General use of the toolbar	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Times Toolbar Used	424	424	424	424	424	424	499	437	379	500	541	605
Unique Users	196	196	196	196	196	196	221	188	177	224	211	237
Features Used	915	915	915	915	915	915	837	718	1122	1211	1541	1017

Breakdown of features used during 2019/20:

- **Screen reader –** reads out the information on the screen in English or another language.
- **Style Adjustment –** changing the font type, font size, colour, etc.
- **Translation -** changing the text on the screen from English to a number of different languages.



Feature used	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Screen Reader	74.76%	74.76%	74.76%	74.76%	74.76%	74.76%
Style Adjustments	13.99%	13.99%	13.99%	13.99%	13.99%	13.99%
Translation	8.41%	8.41%	8.41%	8.41%	8.41%	8.41%

Feature used	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Screen Reader	88.17%	96.66%	60.78%	77.21%	81.18%	88.59%
Style Adjustments	3.58%	1.25%	1.96%	16.27%	10.77%	7.87%
Translation	3.23%	0.84%	35.29%	2.89%	6.04%	1.47%

Brighton and Sussex University Hospitals NHS Trust Equality Objectives

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

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

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

1. Aim to have the workforce's declared equality monitoring data as a minimum of 90% across the board.
    - As of March 2020 the current rates staff declaring their diversity data (including 'prefer not to say'): Age (100%), Disability (92.9%), Gender (100%), Marriage and Civil Partnership (96.4%), Race and Ethnicity (96.7%), Religion or Belief (88.7%) and Sexual Orientation (90.8%).

2. Review the disparity of experiences from the NHS Staff Survey.
    - This is currently being reviewed under the Leadership, Culture and Workforce workstream (see page 5), work is also being undertaken as part of WRES and WDES (see page 6) with respective action plans that will address the issues highlighted

3. Review recruitment and selection process and training to identify areas of practice and unconscious bias.

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

4. Engage with patients to encourage greater Trust with patient monitoring exercises.

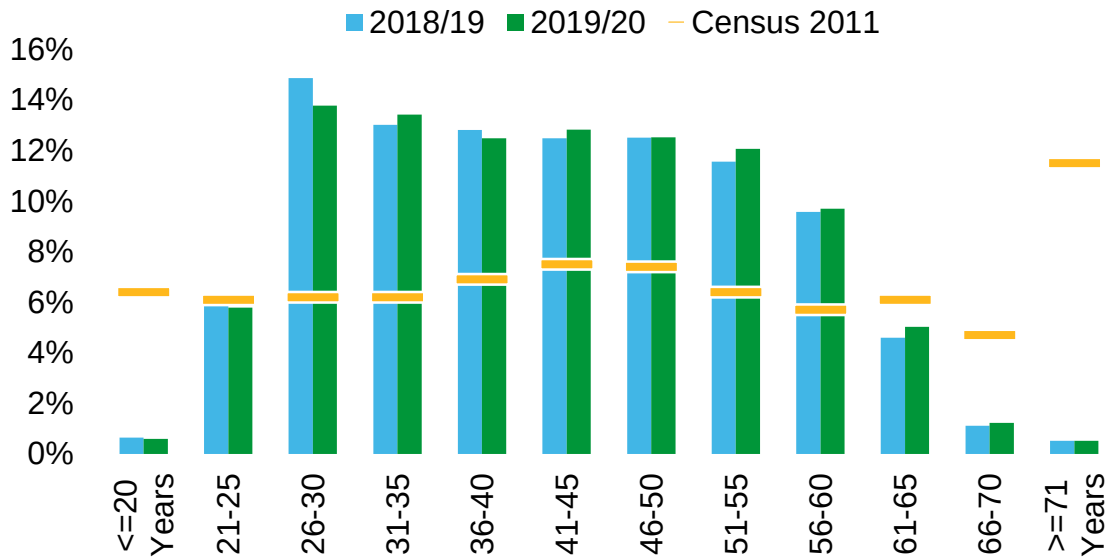
5. Adult services to receive Trans, Non-Binary and Gender Fluidity awareness.
    - It is expected that 20% of the (untrained) workforce will undergo this training per annum

Who are the Trust's Workforce?

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

	Headcount
2018/19	8,521
2019/20	8,598

Age



Age Range	<=20 Years	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	>=71 Years
2018/19	0.6%	6.3%	14.9%	13.0%	12.8%	12.5%	12.5%	11.6%	9.6%	4.6%	1.1%	0.5%
2019/20	0.6%	5.8%	13.8%	13.4%	12.5%	12.8%	12.5%	12.1%	9.7%	5.0%	1.2%	0.5%
Census 2011 (SE England)	6.4%	6.1%	6.2%	6.2%	6.9%	7.5%	7.4%	6.4%	5.7%	6.1%	4.7%	11.5%

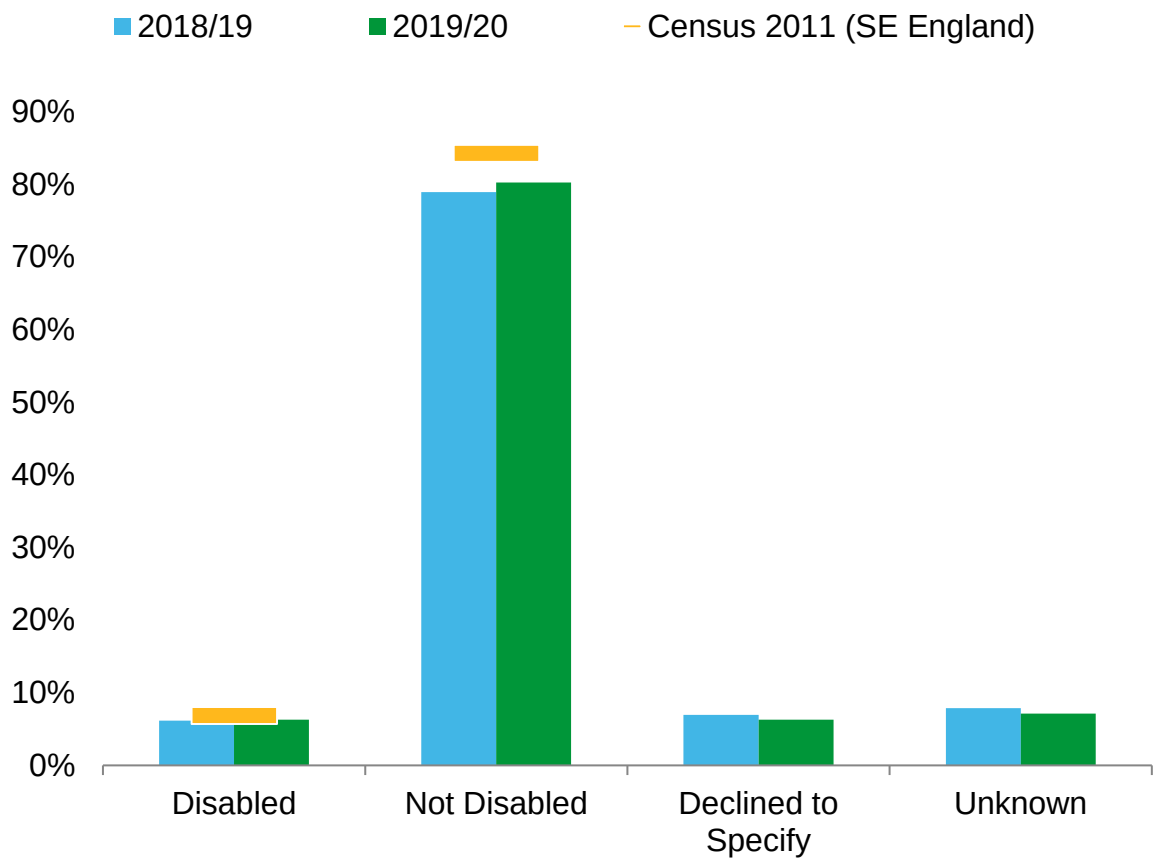
Gender Identity

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

Maternity and Pregnancy

During 2019/20 there were 500 members of staff on maternity leave.

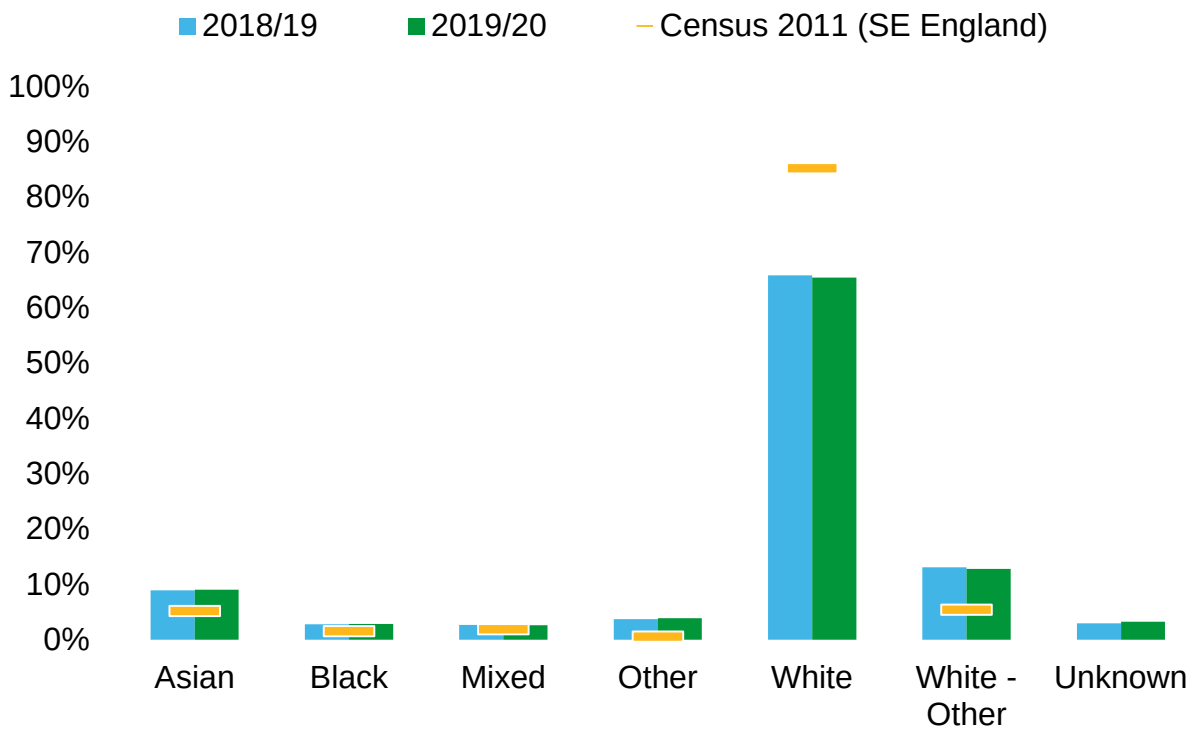
Disability



Disability Status	Disabled	Not Disabled	Declined to Specify	Unknown
2018/19	6.2%	79.0%	7.0%	7.9%
2020/20	6.3%	80.3%	6.3%	7.1%
Census 2011 (SE England)	6.9%	84.3%		

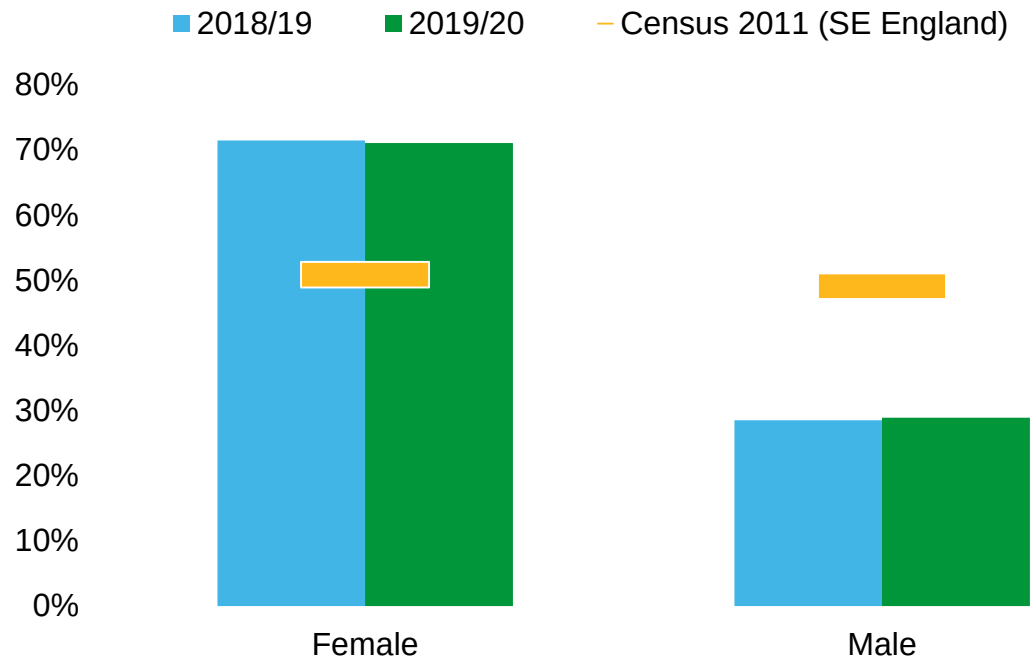
There is not a direct comparison with the Census 2011 data. Whilst it is safe to say that those who identify as having their day-to-day activities 'limited a lot' will be counted as disabled, those who identify as 'limited a little' (this is subjective) only some will be considered disabled.

Ethnicity



Ethnicity	Asian	Black	Mixed	Other	White	White - Other	Unknown
2018/19	8.9%	2.8%	2.7%	3.7%	65.8%	13.1%	3.0%
2019/20	9.1%	2.9%	2.6%	3.9%	65.5%	12.8%	3.3%
Census 2011 (SE England)	5.2%	1.6%	1.9%	0.6%	85.2%	5.4%	

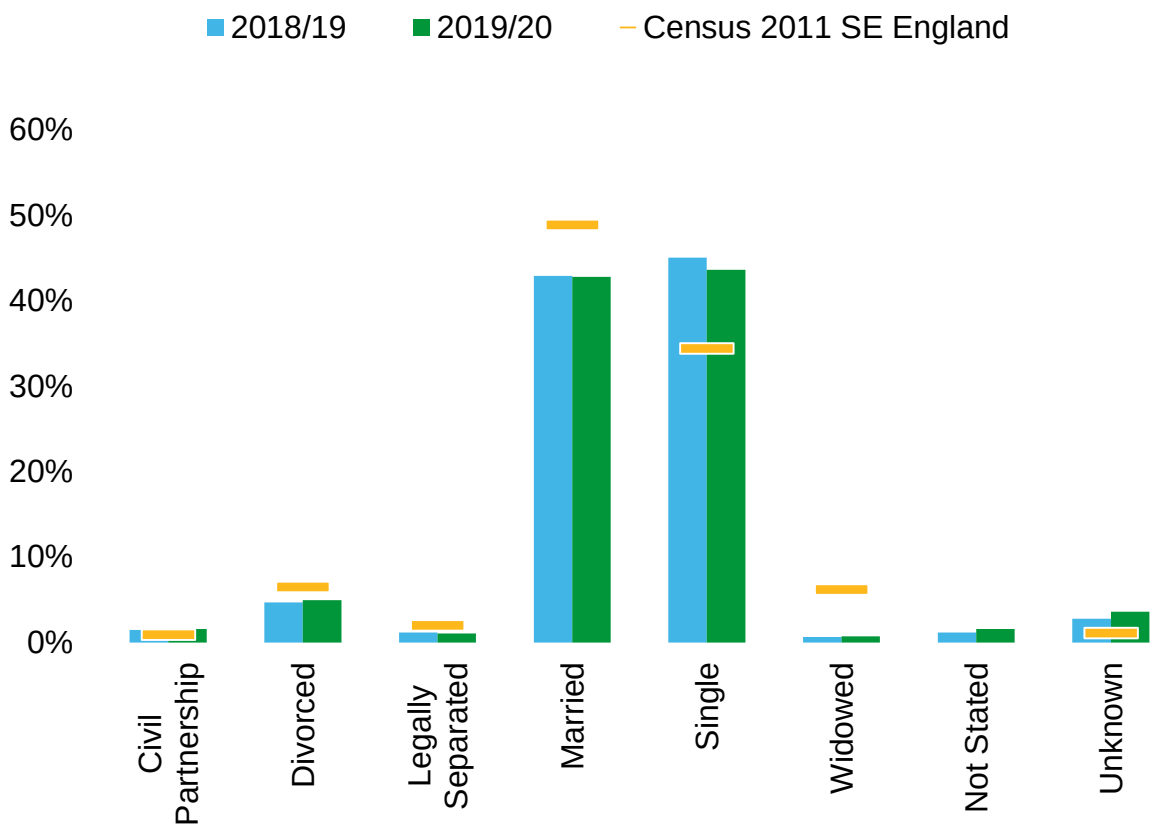
Gender



Gender	Female	Male
2018/19	71.5%	28.5%
2019/20	71.1%	28.9%
Census 2011 (SE England)	50.9%	49.1%

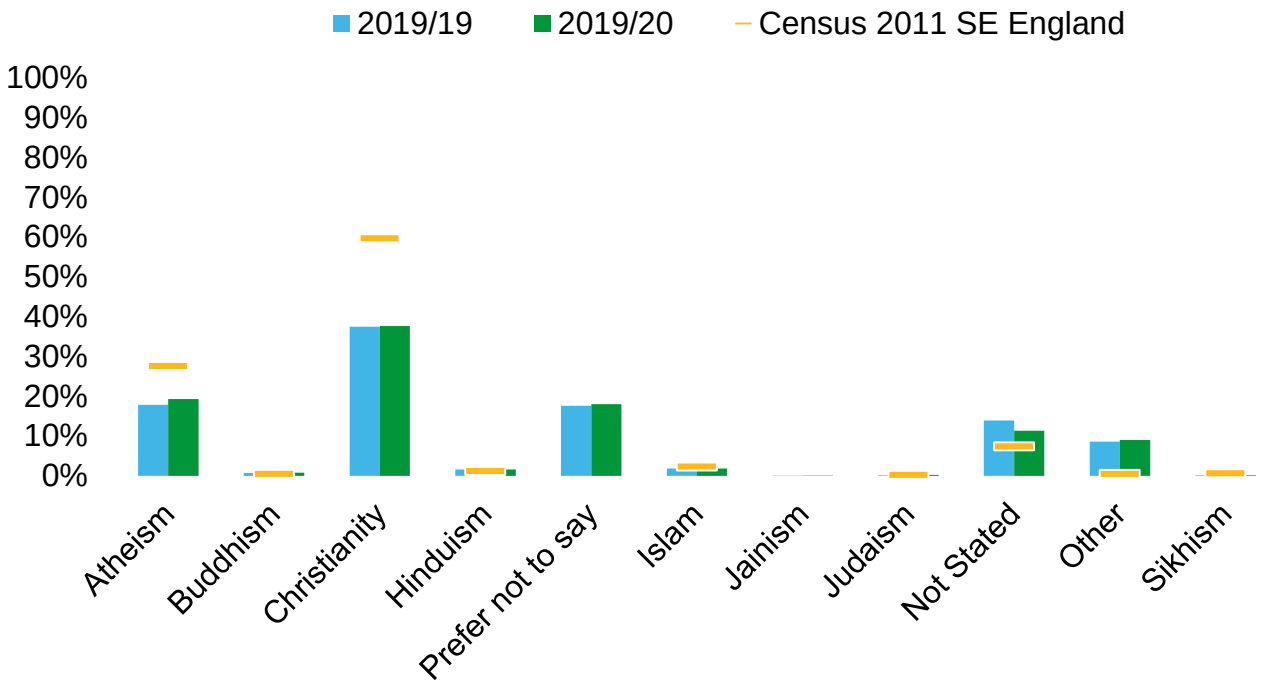
Electronic Staff Records is currently only able to record female and male genders. There is work (nationally) that is looking at expanding the recording capabilities of the Electronic Staff Records database.

Marital Status



Marital Status	Civil Partnership	Divorced	Legally Separated	Married	Single	Widowed	Not Stated	Unknown
2018/19	1.5%	4.7%	1.2%	42.9%	45.1%	0.7%	1.2%	2.8%
2019/20	1.6%	5.0%	1.1%	42.8%	43.6%	0.7%	1.6%	3.6%
Census 2011 SE England	0.9%	6.5%	2.0%	48.9%	34.4%	6.2%		1.1%

Religion or Belief



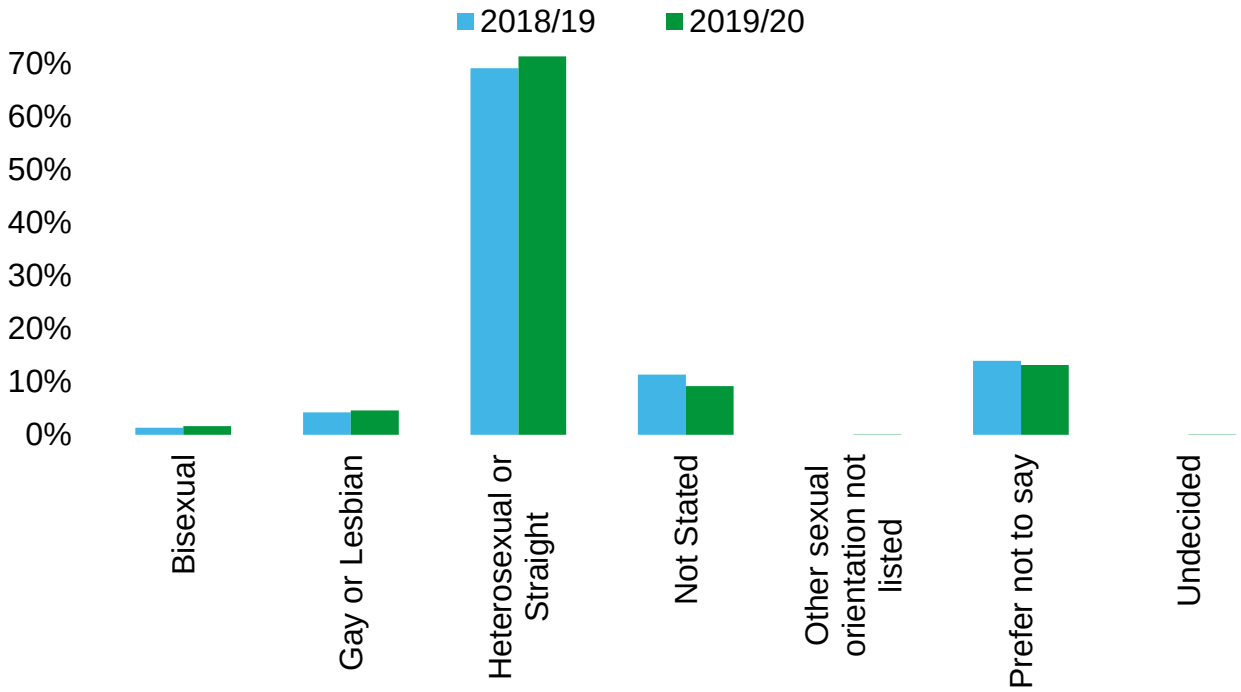
Religion or Belief	Atheism	Buddhism	Christianity	Hinduism	Prefer not to say	Islam	Jainism	Judaism
2019/19	17.8%	0.7%	37.5%	1.6%	17.6%	1.8%	0.0%	0.2%
2019/20	19.3%	0.8%	37.6%	1.6%	18.0%	1.9%	0.0%	0.2%
Census 2011 SE England	27.6%	0.5%	59.7%	1.2%		2.3%		0.2%

Religion or Belief	Jainism	Judaism	Not Stated	Other	Sikhism
2019/19	0.0%	0.2%	13.9%	8.6%	0.2%
2019/20	0.0%	0.2%	11.3%	9.0%	0.1%
Census 2011 SE England		0.2%	7.4%	0.5%	0.6%

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

Religion or Belief	Atheism	Buddhism	Christianity	Hinduism	Islam	Jainism	Judaism	Other	Sikhism
2018/19	26.1%	1.0%	54.8%	2.4%	2.7%	0.1%	0.2%	12.6%	0.2%
2019/20	27.3%	1.2%	53.2%	2.3%	2.6%	0.1%	0.3%	12.8%	0.2%
Census 2011 SE England	27.6%	0.5%	59.7%	1.2%	2.3%		0.2%	0.5%	0.6%

Sexual Orientation



Sexual Orientation	Bisexual	Gay or Lesbian	Heterosexual or Straight	Not Stated	Other sexual orientation not listed	Prefer not to say	Undecided
2018/19	1.3%	4.2%	69.1%	11.4%	0.0%	14.0%	0.0%
2019/20	1.7%	4.6%	71.3%	9.2%	0.1%	13.1%	0.1%

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

However, there are some national figures/estimates:

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

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

Sexual Orientation	Bisexual	Gay or Lesbian	Heterosexual or Straight	Other sexual orientation not listed	Undecided
2018/19	1.8%	5.7%	92.6%	0.0%	0.0%
2019/20	2.1%	5.9%	91.8%	0.1%	0.1%

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

Text highlighted in green (text in bold and underlined) indicates that there is a higher than an expected representation of that group compared to the general workforce.

Age by Pay banding

Pay Band	<=20 Years	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	>=71 Years
Band 1	**0.6%**	3.9%	5.0%	11.0%	**15.1%**	12.8%	11.6%	**14.5%**	**10.4%**	**9.8%**	**3.0%**	**2.4%**
Band 2	**2.3%**	**8.0%**	10.1%	12.9%	11.0%	10.6%	11.3%	**13.0%**	**11.4%**	**6.2%**	**1.9%**	**1.4%**
Band 3	**1.2%**	**7.0%**	11.0%	10.0%	12.1%	11.0%	10.7%	**12.5%**	**12.5%**	**9.7%**	**1.7%**	**0.8%**
Band 4	**1.1%**	4.9%	11.7%	9.7%	12.2%	8.1%	12.0%	**14.7%**	**13.1%**	**9.6%**	**2.1%**	**0.8%**
Band 5	0.0%	**10.6%**	**22.5%**	**15.2%**	10.3%	9.7%	9.9%	9.0%	8.5%	3.4%	0.6%	0.2%
Band 6	0.0%	4.3%	**14.4%**	**15.4%**	12.3%	**15.4%**	**13.9%**	11.9%	8.0%	3.3%	1.1%	0.1%
Band 7	0.0%	0.5%	6.4%	11.9%	**16.4%**	**16.7%**	**17.7%**	**14.8%**	**10.6%**	4.4%	0.6%	0.0%
Band 8a	0.0%	0.4%	3.1%	5.5%	12.1%	**18.4%**	**25.8%**	**21.5%**	8.6%	3.1%	**1.6%**	0.0%
Band 8b	0.0%	0.0%	1.8%	4.5%	**16.4%**	**14.5%**	**19.1%**	**21.8%**	**14.5%**	**6.4%**	0.9%	0.0%
Band 8c	0.0%	0.0%	0.0%	5.3%	10.5%	**18.4%**	10.5%	**28.9%**	**26.3%**	0.0%	0.0%	0.0%
Band 8d	0.0%	0.0%	0.0%	0.0%	10.5%	0.0%	**21.1%**	**21.1%**	**31.6%**	**10.5%**	0.0%	**5.3%**
Band 9	0.0%	0.0%	0.0%	7.7%	7.7%	**15.4%**	**23.1%**	**30.8%**	**15.4%**	0.0%	0.0%	0.0%
Directors	0.0%	0.0%	0.0%	7.1%	0.0%	7.1%	**57.1%**	**14.3%**	**14.3%**	0.0%	0.0%	0.0%
Local Contracts	0.0%	0.0%	0.0%	0.0%	**100.0%**	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Medical: Training Grade	0.0%	**9.0%**	**36.4%**	**30.3%**	**13.4%**	7.7%	2.5%	0.4%	0.4%	0.0%	0.0%	0.0%
Medical: Middle Grade	0.0%	0.0%	5.3%	1.8%	**14.0%**	**19.3%**	**15.8%**	**17.5%**	**19.3%**	**5.3%**	**1.8%**	0.0%
Medical: Consultant	0.0%	0.0%	0.0%	2.7%	**14.9%**	**27.5%**	**20.6%**	**16.2%**	**12.4%**	4.0%	**1.5%**	0.2%

Disability by Pay banding

Pay Band	Disabled	Not Disabled	Declined to Specify	Unknown
Band 1	**11.0%**	**85.8%**	3.3%	0.0%
Band 2	**7.7%**	**82.9%**	4.1%	5.2%
Band 3	**9.7%**	79.1%	3.7%	**7.5%**
Band 4	**7.3%**	**81.7%**	3.4%	**7.6%**
Band 5	5.7%	**84.0%**	3.4%	6.9%
Band 6	5.0%	78.6%	5.0%	**11.4%**
Band 7	5.2%	**80.9%**	4.3%	**9.7%**
Band 8a	**6.6%**	**82.8%**	3.9%	6.6%
Band 8b	**10.0%**	**81.8%**	2.7%	5.5%
Band 8c	0.0%	**89.5%**	5.3%	5.3%
Band 8d	5.3%	63.2%	**15.8%**	**15.8%**
Band 9	**15.4%**	69.2%	**7.7%**	**7.7%**
Directors	0.0%	57.1%	**42.9%**	0.0%
Local Contracts	0.0%	**100.0%**	0.0%	0.0%
Medical: Training Grade	1.3%	72.1%	**26.1%**	0.6%
Medical: Middle Grade	1.8%	59.6%	**36.8%**	1.8%
Medical: Consultant	4.7%	74.9%	**13.2%**	**7.2%**

Ethnicity by Pay banding

	Asian	Black	Mixed	Other	White	White - Other	Unknown
Band 1	8.3%	**6.8%**	**4.5%**	**4.5%**	29.4%	**40.9%**	**5.6%**
Band 2	**9.8%**	2.3%	**2.7%**	**4.4%**	62.3%	**16.1%**	2.3%
Band 3	6.7%	2.5%	2.2%	3.0%	**72.2%**	11.6%	1.8%
Band 4	3.9%	2.1%	1.9%	1.9%	**79.1%**	8.1%	2.9%
Band 5	**12.0%**	**4.1%**	1.8%	**6.4%**	56.5%	**16.0%**	3.0%
Band 6	6.5%	2.1%	2.3%	**3.9%**	**71.0%**	11.1%	3.1%
Band 7	3.6%	1.7%	2.6%	2.0%	**82.1%**	5.5%	2.6%
Band 8a	3.9%	2.7%	2.0%	1.6%	**84.4%**	2.7%	2.7%
Band 8b	2.7%	2.7%	0.0%	0.0%	**87.3%**	5.5%	1.8%
Band 8c	0.0%	2.6%	0.0%	0.0%	**89.5%**	7.9%	0.0%
Band 8d	0.0%	**5.3%**	**5.3%**	0.0%	**78.9%**	5.3%	**5.3%**
Band 9	0.0%	**7.7%**	0.0%	0.0%	**84.6%**	0.0%	**7.7%**
Directors	**14.3%**	0.0%	0.0%	0.0%	57.1%	0.0%	**28.6%**
Local Contract	0.0%	0.0%	0.0%	0.0%	**100.0%**	0.0%	0.0%
Medical: Training Grade	**14.9%**	**3.7%**	**4.5%**	**4.1%**	54.1%	10.1%	**8.5%**
Medical: Middle Grade	**24.6%**	**5.3%**	**8.8%**	**10.5%**	31.6%	**17.5%**	1.8%
Medical: Consultant	**21.4%**	2.3%	**4.0%**	2.9%	55.3%	12.0%	2.1%

Gender by Pay banding

Pay Band	Female	Male	Total
Band 1	55.2%	**44.8%**	100.0%
Band 2	68.7%	**31.3%**	100.0%
Band 3	**74.2%**	25.8%	100.0%
Band 4	**78.6%**	21.4%	100.0%
Band 5	**78.2%**	21.8%	100.0%
Band 6	**81.7%**	18.3%	100.0%
Band 7	**78.5%**	21.5%	100.0%
Band 8a	69.5%	**30.5%**	100.0%
Band 8b	65.5%	**34.5%**	100.0%
Band 8c	65.8%	**34.2%**	100.0%
Band 8d	36.8%	**63.2%**	100.0%
Band 9	38.5%	**61.5%**	100.0%
Directors	64.3%	**35.7%**	100.0%
Local Contracts	0.0%	**100.0%**	100.0%
Medical: Training Grade	54.0%	**46.0%**	100.0%
Medical: Middle Grade	45.6%	**54.4%**	100.0%
Medical: Consultant	41.2%	**58.8%**	100.0%

Marital Status by Pay banding

Pay Banding	Civil Partnership	Divorced	Legally Separated	Married	Single	Widowed	Not Stated	Unknown
Band 1	**2.1%**	**5.9%**	**1.8%**	35.9%	40.7%	**2.1%**	0.0%	**11.6%**
Band 2	**2.1%**	**6.3%**	**1.3%**	39.3%	43.4%	**1.1%**	1.4%	**5.2%**
Band 3	**1.7%**	**6.8%**	**1.2%**	42.3%	42.2%	**1.3%**	0.4%	**3.9%**
Band 4	**1.8%**	**8.8%**	**1.8%**	41.5%	41.7%	**1.0%**	0.8%	2.8%
Band 5	1.0%	4.5%	**1.2%**	34.9%	**54.1%**	0.3%	1.0%	2.9%
Band 6	**1.7%**	4.5%	**1.4%**	**44.7%**	43.4%	0.5%	1.0%	2.8%
Band 7	**1.8%**	**5.5%**	0.6%	**51.2%**	36.9%	0.4%	0.7%	2.8%
Band 8a	1.2%	**5.5%**	0.8%	**55.1%**	30.5%	**1.2%**	0.4%	**5.5%**
Band 8b	0.9%	3.6%	**2.7%**	**50.9%**	32.7%	**2.7%**	**2.7%**	**3.6%**
Band 8c	0.0%	**5.3%**	0.0%	**52.6%**	34.2%	0.0%	**2.6%**	**5.3%**
Band 8d	**5.3%**	**5.3%**	**5.3%**	**63.2%**	10.5%	0.0%	0.0%	**10.5%**
Band 9	0.0%	**15.4%**	0.0%	38.5%	38.5%	0.0%	0.0%	**7.7%**
Directors	0.0%	0.0%	0.0%	**71.4%**	28.6%	0.0%	0.0%	0.0%
Local Contracts	0.0%	0.0%	0.0%	0.0%	**100.0%**	0.0%	0.0%	0.0%
Medical: Training	1.1%	0.1%	0.1%	30.0%	**59.5%**	0.0%	**7.6%**	1.5%
Medical: Middle	0.0%	**5.3%**	0.0%	**61.4%**	24.6%	0.0%	**1.8%**	**7.0%**
Medical: Consultant	**1.7%**	1.5%	0.0%	**70.0%**	22.7%	0.4%	**2.3%**	1.5%

Religion or belief by Pay banding

Pay Band	Atheism	Buddhism	Christianity	Hinduism	Prefer not to say	Islam	Jainism	Judaism	Not Stated	Other	Sikhism
Band 1	6.8%	**1.5%**	**51.6%**	**1.8%**	**20.2%**	**6.5%**	0.0%	0.0%	0.0%	**11.6%**	0.0%
Band 2	17.4%	0.6%	**45.5%**	1.4%	12.7%	**1.9%**	0.0%	**0.4%**	7.7%	**12.5%**	0.1%
Band 3	15.9%	**1.0%**	**41.5%**	0.9%	12.8%	1.3%	0.0%	0.0%	**15.7%**	**10.5%**	**0.2%**
Band 4	17.0%	0.3%	37.3%	0.8%	15.1%	0.5%	0.0%	**0.3%**	**16.4%**	**12.3%**	0.0%
Band 5	**21.4%**	0.8%	**43.4%**	1.6%	13.4%	0.7%	**0.1%**	0.1%	11.1%	7.5%	0.0%
Band 6	**22.6%**	0.4%	36.4%	0.6%	14.2%	1.0%	0.0%	0.1%	**15.5%**	**9.0%**	**0.1%**
Band 7	**21.0%**	**1.3%**	34.5%	0.9%	15.0%	0.5%	0.0%	0.1%	**18.8%**	8.0%	0.0%
Band 8a	19.1%	0.4%	31.6%	**2.3%**	16.0%	0.8%	0.0%	0.0%	**21.1%**	8.2%	**0.4%**
Band 8b	**24.5%**	0.0%	26.4%	**2.7%**	15.5%	0.9%	0.0%	0.0%	**19.1%**	**10.9%**	0.0%
Band 8c	**28.9%**	**2.6%**	34.2%	0.0%	10.5%	0.0%	0.0%	0.0%	**15.8%**	7.9%	0.0%
Band 8d	**21.1%**	0.0%	26.3%	0.0%	10.5%	0.0%	0.0%	0.0%	**31.6%**	**10.5%**	0.0%
Band 9	7.7%	0.0%	**53.8%**	0.0%	7.7%	0.0%	0.0%	0.0%	**23.1%**	7.7%	0.0%
Directors	14.3%	0.0%	14.3%	0.0%	**71.4%**	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Local Contract	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**100.0%**	0.0%
Medical: Training	**25.2%**	**1.8%**	19.8%	**3.2%**	**36.6%**	**7.2%**	**0.1%**	**1.0%**	0.4%	4.3%	**0.4%**
Medical: Middle	12.3%	0.0%	24.6%	0.0%	**54.4%**	**5.3%**	**1.8%**	0.0%	0.0%	1.8%	0.0%
Medical: Consultant	13.4%	0.6%	26.3%	**6.9%**	**43.7%**	**2.7%**	**0.2%**	**0.4%**	0.0%	5.3%	**0.4%**

Sexual Orientation by Pay banding

Pay Band	Bisexual	Gay or Lesbian	Heterosexual or Straight	Not Stated	Other sexual orientation not listed	Prefer not to say	Undecided
Band 1	**1.8%**	2.1%	**72.7%**	0.0%	0.0%	**23.4%**	0.0%
Band 2	**1.9%**	**4.7%**	**77.2%**	7.4%	**0.2%**	8.5%	**0.2%**
Band 3	1.5%	**5.4%**	**71.8%**	**12.9%**	0.0%	8.3%	**0.1%**
Band 4	1.5%	3.6%	71.3%	**13.3%**	0.0%	10.2%	**0.2%**
Band 5	**2.6%**	4.1%	**73.5%**	**9.3%**	**0.2%**	10.4%	0.1%
Band 6	**2.0%**	**5.2%**	70.7%	**12.2%**	**0.1%**	9.7%	0.1%
Band 7	0.9%	**4.8%**	70.7%	**13.5%**	0.0%	10.2%	0.0%
Band 8a	1.2%	**6.6%**	69.1%	**16.8%**	0.0%	6.3%	0.0%
Band 8b	0.0%	4.5%	65.5%	**13.6%**	0.0%	**16.4%**	0.0%
Band 8c	0.0%	**7.9%**	71.1%	**10.5%**	0.0%	10.5%	0.0%
Band 8d	0.0%	**10.5%**	57.9%	**26.3%**	0.0%	5.3%	0.0%
Band 9	0.0%	**15.4%**	69.2%	7.7%	0.0%	7.7%	0.0%
Directors	0.0%	0.0%	50.0%	0.0%	0.0%	**50.0%**	0.0%
Local Contract	0.0%	0.0%	0.0%	0.0%	0.0%	**100.0%**	0.0%
Medical: Training	1.1%	4.5%	69.6%	0.4%	0.0%	**24.4%**	0.0%
Medical: Middle	**1.8%**	3.5%	47.4%	0.0%	0.0%	**47.4%**	0.0%
Medical: Consultant	0.8%	3.4%	58.8%	0.2%	0.0%	**36.8%**	0.0%

Quick facts about management staff (excluding medical staff)

36.4% of management staff identify as **male**, **63.6%** of management staff identify as **female**

- **6.7%** of management staff are **disabled**
- **82.2%** of management staff **do not have a disability**
- **4.7%** of management staff have **chosen not to provide** information about their disability
- We **do not know** the disability status of **6.4%** of management staff

- **0.7%** of management staff are **bisexual**
- **6.8%** of management staff are **gay or lesbian**
- **9.3%** of management staff have **chosen not to provide** information about their sexual orientation
- We **do not know** the sexual orientation of **14.6%** of management staff

88.3% of management staff are **white**, **8.3%** are **BME**

3.9% of management staff are **white (non-British)**,
84.5% of management staff are **white (British/Irish)**

2.8% of management staff are **Asian**,
3.1% of management staff are **Black**,
1.4% of management staff are **mixed**,
1.1% of management staff are from **'other' ethnic group,** and **3.4%** of management staff ethnicity is **unknown**.

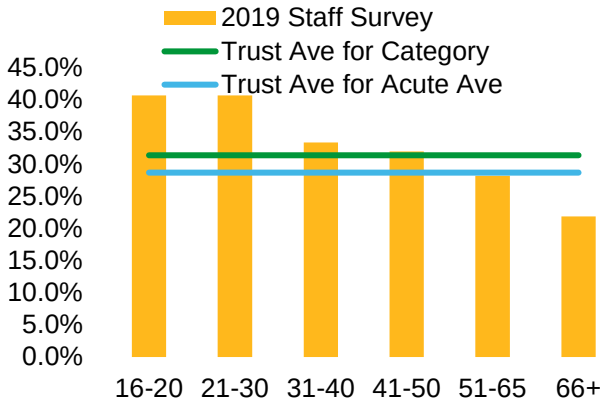
Results from the NHS Staff Survey 2019

5,051 staff completed the annual NHS Staff Survey from Brighton and Sussex University Hospitals NHS Trust – this gives the Trust an overall response rate of 62%. The average response rate for acute trusts is 47%.

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

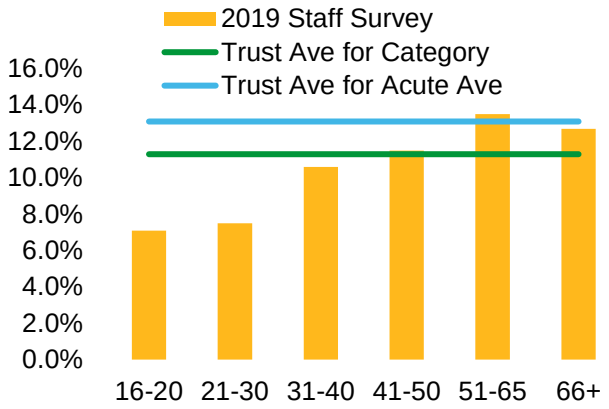
Results broken down by age:

Question 13a – Staff that have experienced abuse, bullying or harassment from patients, service users and visitors



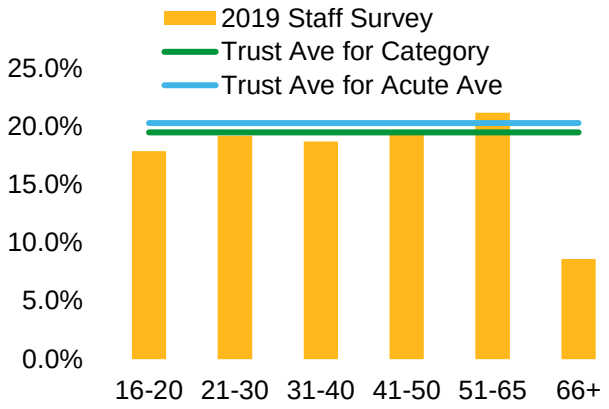
Age Band	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
16-20	40.7%	31.4%	28.7%
21-30	40.7%	31.4%	28.7%
31-40	33.4%	31.4%	28.7%
41-50	32.0%	31.4%	28.7%
51-65	28.2%	31.4%	28.7%
66+	21.9%	31.4%	28.7%

Question 13b Staff that have experienced abuse, bullying or harassment from their managers



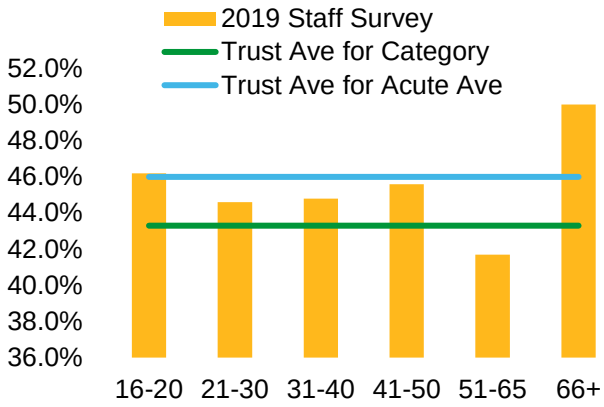
Age Band	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
16-20	7.1%	11.3%	13.1%
21-30	7.5%	11.3%	13.1%
31-40	10.6%	11.3%	13.1%
41-50	11.5%	11.3%	13.1%
51-65	13.5%	11.3%	13.1%
66+	12.7%	11.3%	13.1%

Question 13c Staff that have experienced abuse, bullying or harassment from other colleagues



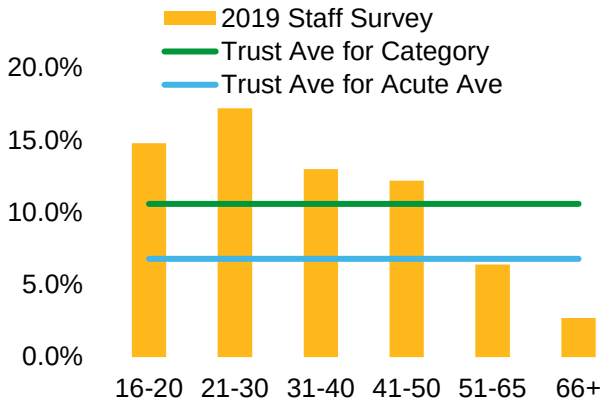
Age Band	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
16-20	17.9%	19.5%	20.3%
21-30	19.2%	19.5%	20.3%
31-40	18.7%	19.5%	20.3%
41-50	19.5%	19.5%	20.3%
51-65	21.2%	19.5%	20.3%
66+	8.6%	19.5%	20.3%

Question 13d Staff that have experienced abuse, bullying or harassment that reported, or a colleague reported the incident



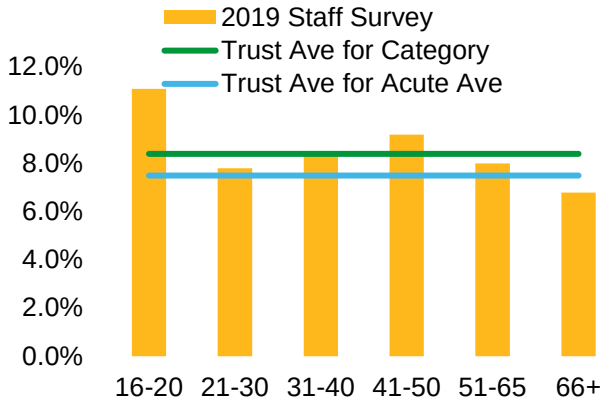
Age Band	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
16-20	46.2%	43.3%	46.0%
21-30	44.6%	43.3%	46.0%
31-40	44.8%	43.3%	46.0%
41-50	45.6%	43.3%	46.0%
51-65	41.7%	43.3%	46.0%
66+	50.0%	43.3%	46.0%

Question 15a Staff that have experienced discrimination from patients, service users and visitors



Age Band	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
16-20	14.8%	10.6%	6.8%
21-30	17.2%	10.6%	6.8%
31-40	13.0%	10.6%	6.8%
41-50	12.2%	10.6%	6.8%
51-65	6.4%	10.6%	6.8%
66+	2.7%	10.6%	6.8%

Question 15b Staff that have experienced discrimination from other staff



Age Band	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
16-20	11.1%	8.4%	7.5%
21-30	7.8%	8.4%	7.5%
31-40	8.5%	8.4%	7.5%
41-50	9.2%	8.4%	7.5%
51-65	8.0%	8.4%	7.5%
66+	6.8%	8.4%	7.5%

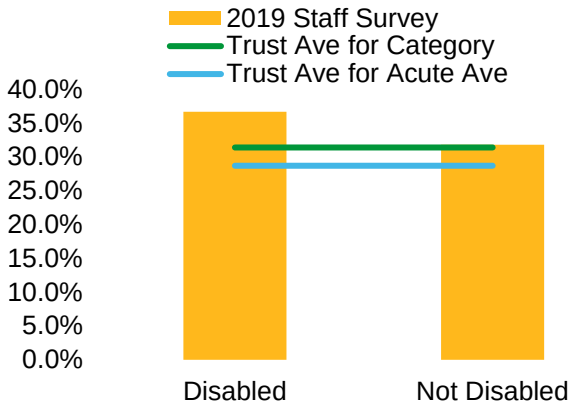
Question 15c Staff that have experienced discrimination attributing it to their age

Age Range	Age cited as being a cause	Trust Ave	Acute Ave
16-20	-	17.7%	18.9%
21-30	29.2%	17.7%	18.9%
31-40	10.7%	17.7%	18.9%
41-50	5.0%	17.7%	18.9%
51-65	24.6%	17.7%	18.9%
66+		17.7%	18.9%

Items in the Trust Average and Acute Average columns: Items are highlighted in red where the Trust score is worse than the average, items are highlighted in green where they are better than the average.

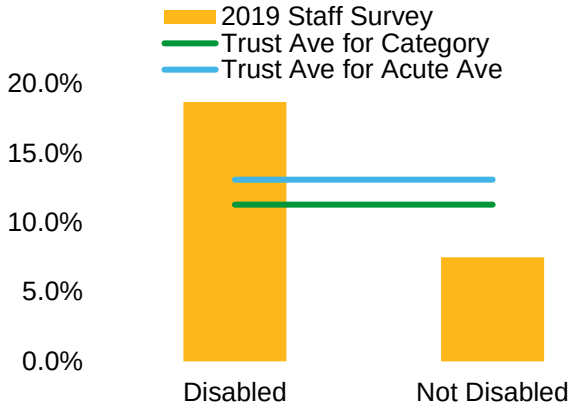
Results broken down by disability status:

Question 13a – Staff that have experienced abuse, bullying or harassment from patients, service users and visitors



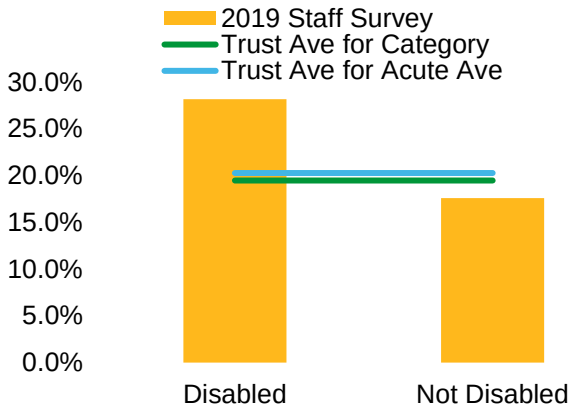
Disability	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
Disabled	36.7%	31.4%	28.7%
Not Disabled	31.8%	31.4%	28.7%

Question 13b Staff that have experienced abuse, bullying or harassment from their managers



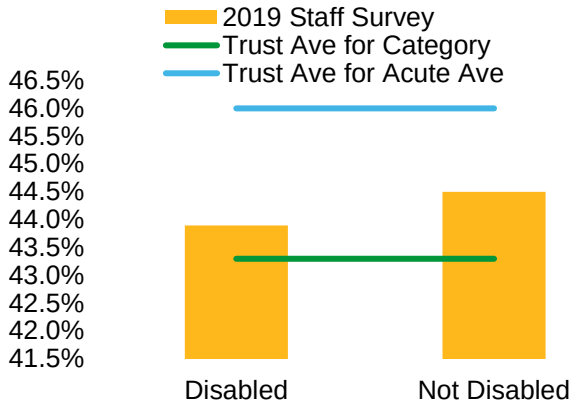
Disability	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
Disabled	18.7%	11.3%	13.1%
Not Disabled	7.5%	11.3%	13.1%

Question 13c Staff that have experienced abuse, bullying or harassment from other colleagues



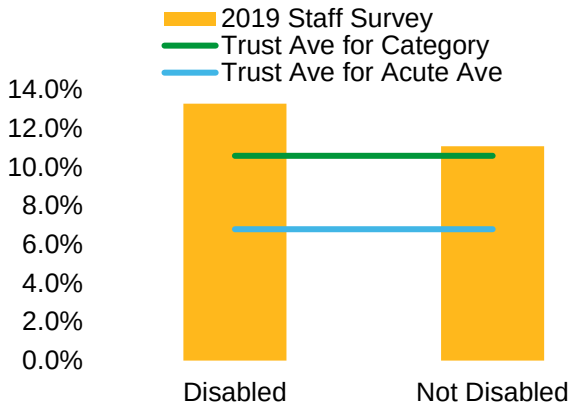
Disability	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
Disabled	28.2%	19.5%	20.3%
Not Disabled	17.6%	19.5%	20.3%

Question 13d Staff that have experienced abuse, bullying or harassment that reported, or a colleague reported the incident



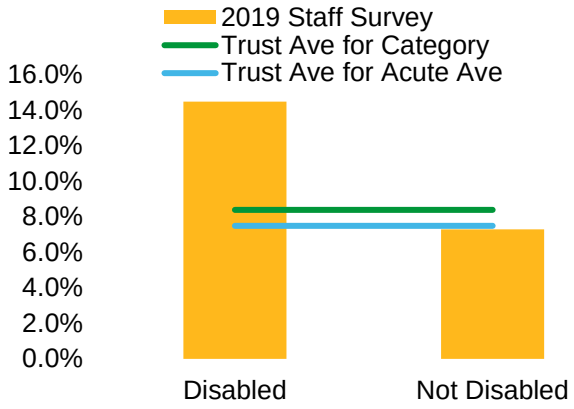
Disability	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
Disabled	43.9%	43.3%	46.0%
Not Disabled	44.5%	43.3%	46.0%

Question 15a Staff that have experienced discrimination from patients, service users and visitors



Disability	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
Disabled	13.3%	10.6%	6.8%
Not Disabled	11.1%	10.6%	6.8%

Question 15b Staff that have experienced discrimination from other staff



Disability	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
Disabled	14.5%	8.4%	7.5%
Not Disabled	7.3%	8.4%	7.5%

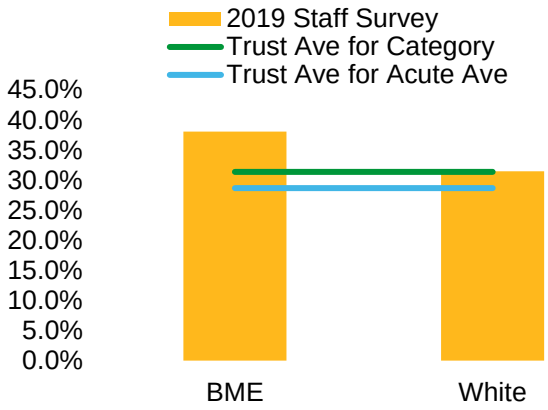
Question 15c Staff that have experienced discrimination attributing it to their disability

Disability	Disability cited as being a cause	Trust Ave	Acute Ave
Disabled	23.3%	7.4%	7.2%
Not Disabled	1.4%	7.4%	7.2%

Items in the Trust Average and Acute Average columns: Items are highlighted in red where the Trust score is worse than the average, items are highlighted in green where they are better than the average.

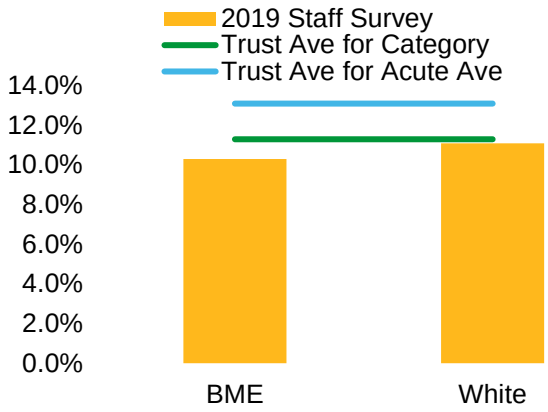
Results broken down by ethnicity:

Question 13a – Staff that have experienced abuse, bullying or harassment from patients, service users and visitors



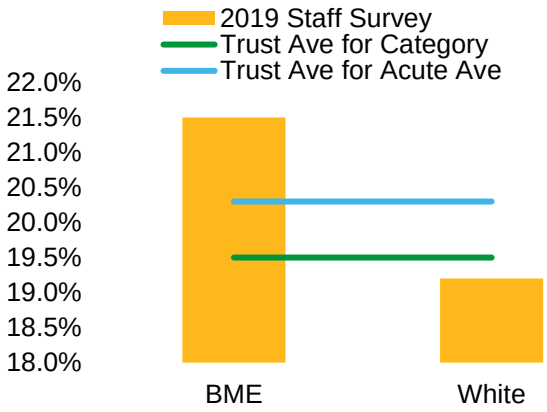
Ethnicity	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
BME	38.1%	31.4%	28.7%
White	31.5%	31.4%	28.7%

Question 13b Staff that have experienced abuse, bullying or harassment from their managers



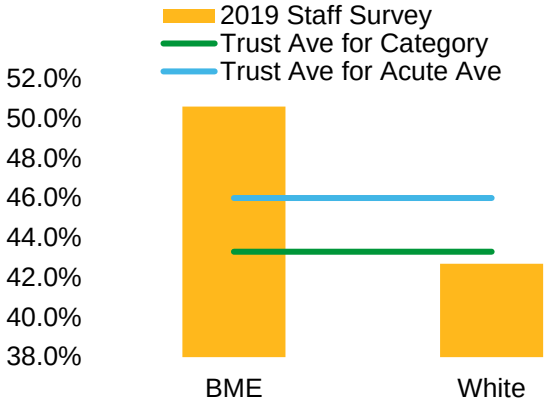
Ethnicity	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
BME	10.3%	11.3%	13.1%
White	11.1%	11.3%	13.1%

Question 13c Staff that have experienced abuse, bullying or harassment from other colleagues



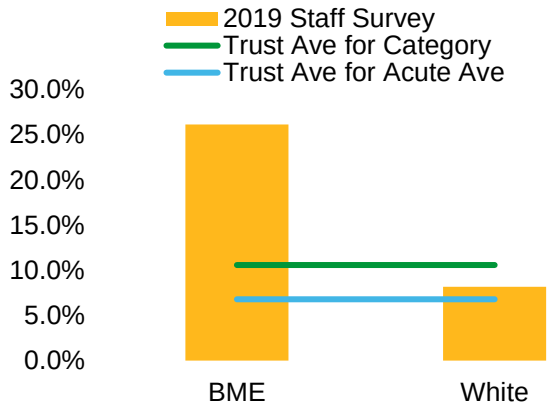
Ethnicity	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
BME	21.5%	19.5%	20.3%
White	19.2%	19.5%	20.3%

Question 13d Staff that have experienced abuse, bullying or harassment that reported, or a colleague reported the incident



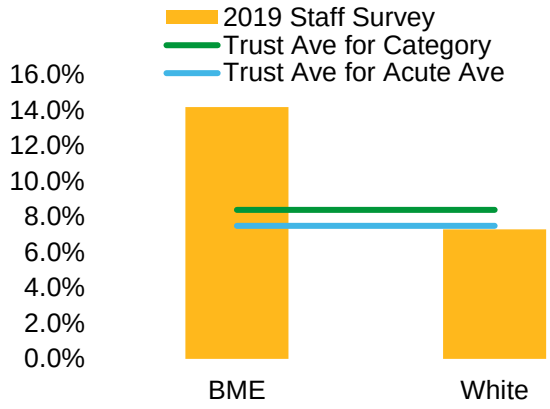
Ethnicity	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
BME	50.6%	43.3%	46.0%
White	42.7%	43.3%	46.0%

Question 15a Staff that have experienced discrimination from patients, service users and visitors



Ethnicity	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
BME	26.2%	10.6%	6.8%
White	8.2%	10.6%	6.8%

Question 15b Staff that have experienced discrimination from other staff



Ethnicity	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
BME	14.2%	8.4%	7.5%
White	7.3%	8.4%	7.5%

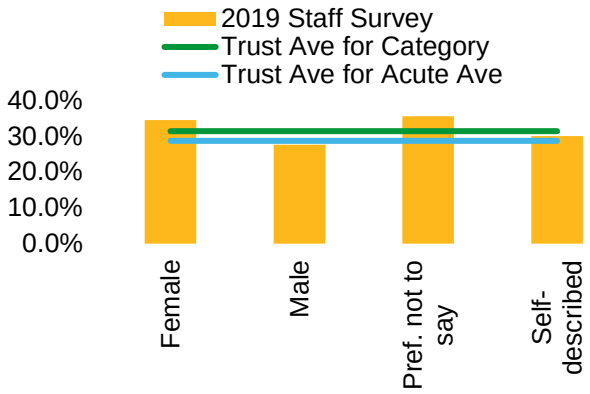
Question 15c Staff that have experienced discrimination attributing it to their ethnicity

Ethnicity	Ethnicity cited as being a cause	Trust Ave	Acute Ave
BME	87.3%	48.4%	45.5%
White	30.6%	48.4%	45.5%

Items in the Trust Average and Acute Average columns: Items are highlighted in red where the Trust score is worse than the average, items are highlighted in green where they are better than the average.

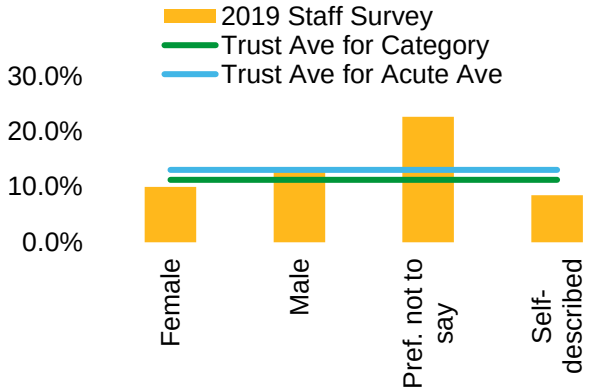
Results broken down by gender:

Question 13a – Staff that have experienced abuse, bullying or harassment from patients, service users and visitors



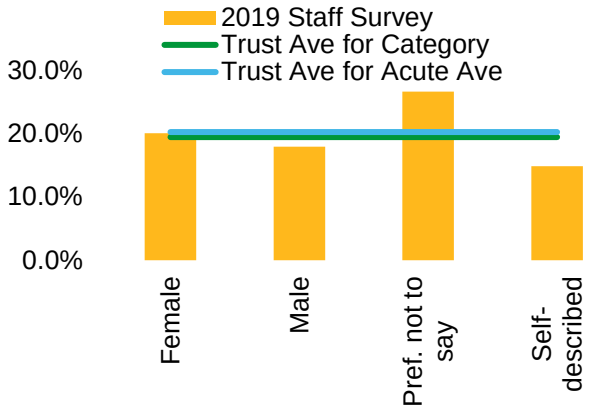
Gender	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
Female	34.5%	31.4%	28.7%
Male	27.6%	31.4%	28.7%
Pref. not to say	35.6%	31.4%	28.7%
Self-described	30.0%	31.4%	28.7%

Question 13b Staff that have experienced abuse, bullying or harassment from their managers



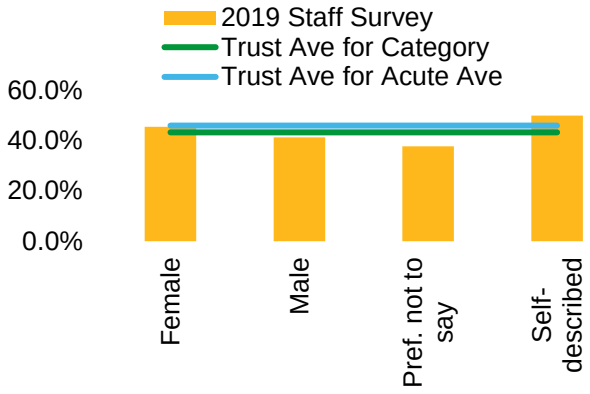
Gender	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
Female	10.0%	11.3%	13.1%
Male	13.3%	11.3%	13.1%
Pref. not to say	22.7%	11.3%	13.1%
Self-described	8.5%	11.3%	13.1%

Question 13c Staff that have experienced abuse, bullying or harassment from other colleagues



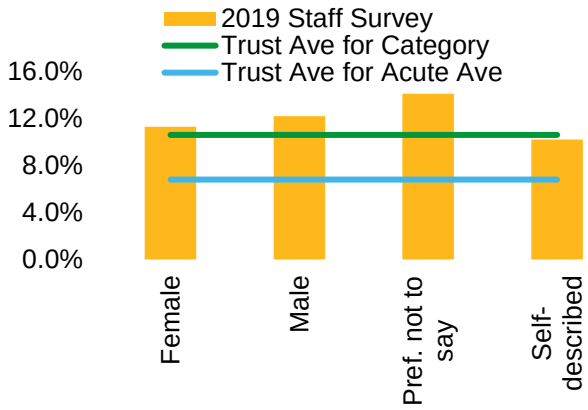
Gender	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
Female	20.1%	19.5%	20.3%
Male	18.0%	19.5%	20.3%
Pref. not to say	26.7%	19.5%	20.3%
Self-described	14.9%	19.5%	20.3%

Question 13d Staff that have experienced abuse, bullying or harassment that reported, or a colleague reported the incident



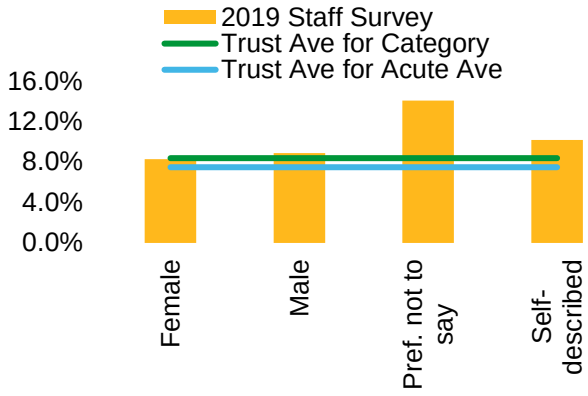
Gender	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
Female	45.5%	43.3%	46.0%
Male	41.3%	43.3%	46.0%
Pref. not to say	37.8%	43.3%	46.0%
Self-described	50.0%	43.3%	46.0%

Question 15a Staff that have experienced discrimination from patients, service users and visitors



Gender	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
Female	11.3%	10.6%	6.8%
Male	12.2%	10.6%	6.8%
Pref. not to say	14.1%	10.6%	6.8%
Self-described	10.2%	10.6%	6.8%

Question 15b Staff that have experienced discrimination from other staff



Gender	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
Female	8.3%	8.4%	7.5%
Male	8.9%	8.4%	7.5%
Pref. not to say	14.1%	8.4%	7.5%
Self-described	10.2%	8.4%	7.5%

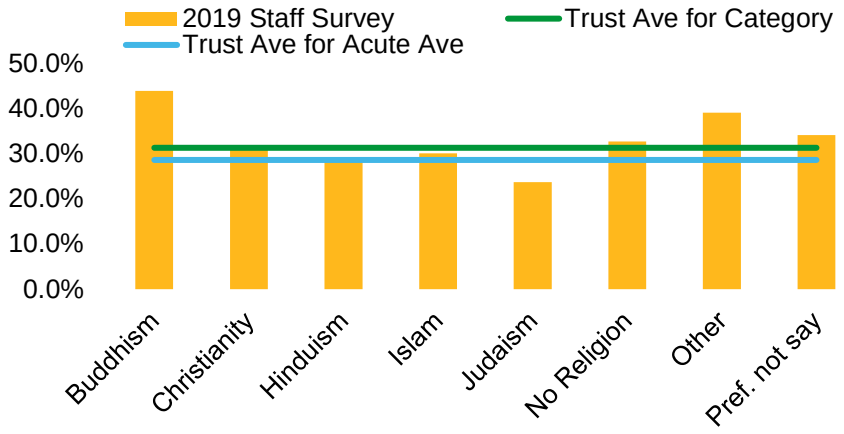
Question 15c Staff that have experienced discrimination attributing it to their ethnicity

Gender	Gender cited as being a cause	Trust Ave	Acute Ave
Female	25.6%	24.5%	19.6%
Male	18.1%	24.5%	19.6%
Pref. Not Say	38.9%	24.5%	19.6%
Self-describe	-	24.5%	19.6%

Items in the Trust Average and Acute Average columns: Items are highlighted in red where the Trust score is worse than the average, items are highlighted in green where they are better than the average.

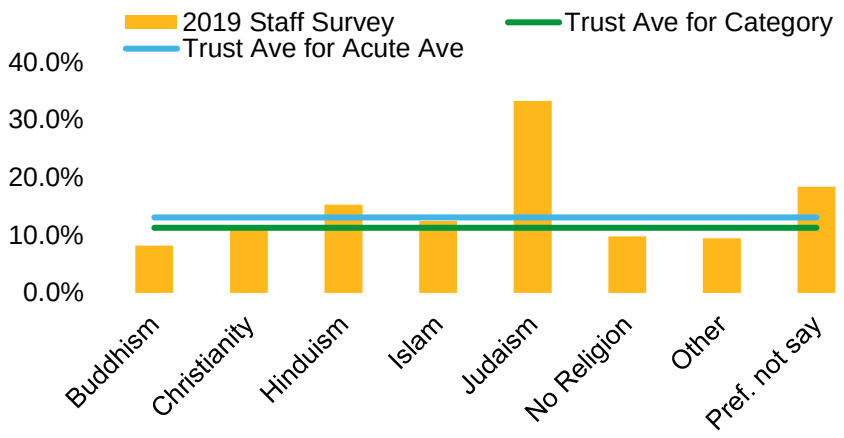
Results broken down by religion or belief:

Question 13a – Staff that have experienced abuse, bullying or harassment from patients, service users and visitors



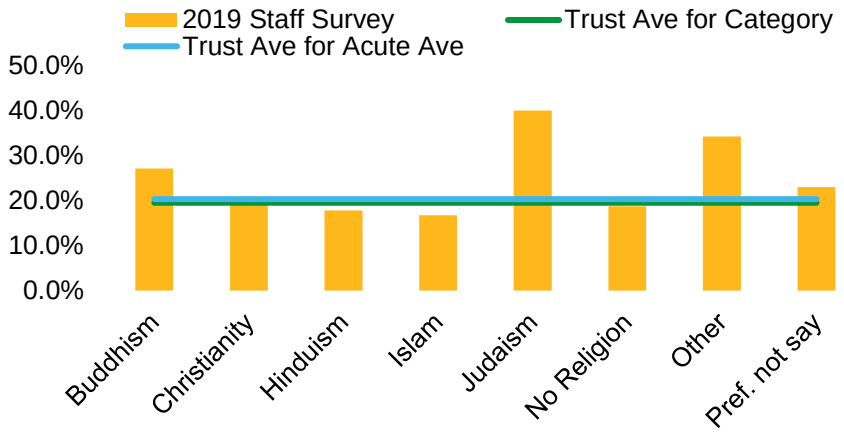
Religion or Belief	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
Buddhism	44.0%	31.4%	28.7%
Christianity	32.0%	31.4%	28.7%
Hinduism	28.8%	31.4%	28.7%
Islam	30.2%	31.4%	28.7%
Judaism	23.8%	31.4%	28.7%
No Religion	32.8%	31.4%	28.7%
Other	39.2%	31.4%	28.7%
Pref. not say	34.2%	31.4%	28.7%

Question 13b Staff that have experienced abuse, bullying or harassment from their managers



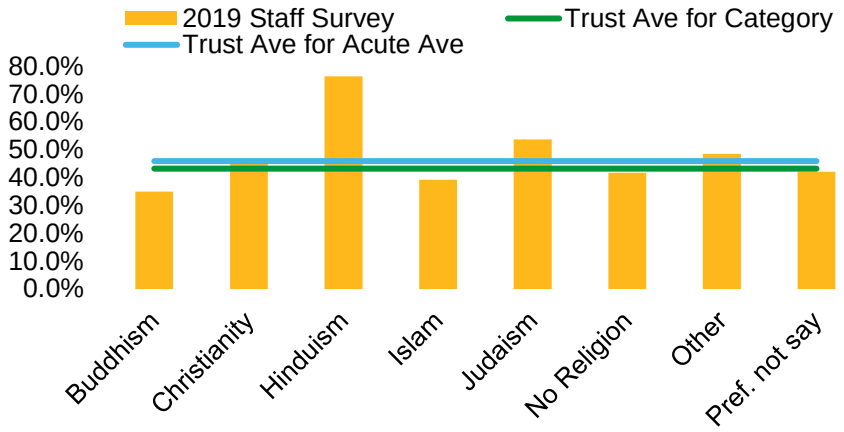
Religion or Belief	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
Buddhism	8.2%	11.3%	13.1%
Christianity	11.1%	11.3%	13.1%
Hinduism	15.3%	11.3%	13.1%
Islam	12.5%	11.3%	13.1%
Judaism	33.3%	11.3%	13.1%
No Religion	9.8%	11.3%	13.1%
Other	9.5%	11.3%	13.1%
Pref. not say	18.4%	11.3%	13.1%

Question 13c Staff that have experienced abuse, bullying or harassment from other colleagues



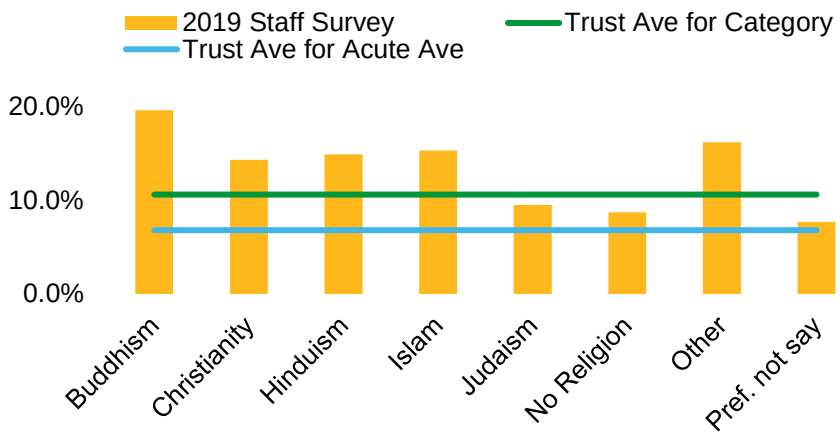
Religion or Belief	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
Buddhism	27.1%	19.5%	20.3%
Christianity	19.5%	19.5%	20.3%
Hinduism	17.8%	19.5%	20.3%
Islam	16.7%	19.5%	20.3%
Judaism	40.0%	19.5%	20.3%
No Religion	18.7%	19.5%	20.3%
Other	34.2%	19.5%	20.3%
Pref. not say	23.0%	19.5%	20.3%

Question 13d Staff that have experienced abuse, bullying or harassment that reported, or a colleague reported the incident



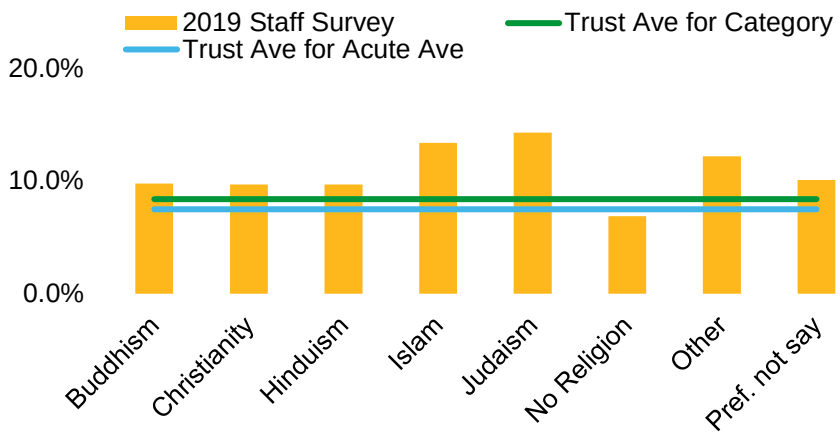
Religion or Belief	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
Buddhism	35.0%	43.3%	46.0%
Christianity	46.3%	43.3%	46.0%
Hinduism	76.5%	43.3%	46.0%
Islam	39.3%	43.3%	46.0%
Judaism	53.8%	43.3%	46.0%
No Religion	41.8%	43.3%	46.0%
Other	48.6%	43.3%	46.0%
Pref. not say	42.2%	43.3%	46.0%

Question 15a Staff that have experienced discrimination from patients, service users and visitors


2019 Staff Survey
Trust Ave for Category
Trust Ave for Acute Ave
20.0%
10.0%
0.0%
Buddhism
Christianity
Hinduism
Islam
Judaism
No Religion
Other
Pref. not say

Religion or Belief	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
Buddhism	19.6%	10.6%	6.8%
Christianity	14.3%	10.6%	6.8%
Hinduism	14.9%	10.6%	6.8%
Islam	15.3%	10.6%	6.8%
Judaism	9.5%	10.6%	6.8%
No Religion	8.7%	10.6%	6.8%
Other	16.2%	10.6%	6.8%
Pref. not say	7.7%	10.6%	6.8%

Question 15b Staff that have experienced discrimination from other staff



Religion or Belief	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
Buddhism	9.8%	8.4%	7.5%
Christianity	9.7%	8.4%	7.5%
Hinduism	9.7%	8.4%	7.5%
Islam	13.4%	8.4%	7.5%
Judaism	14.3%	8.4%	7.5%
No Religion	6.9%	8.4%	7.5%
Other	12.2%	8.4%	7.5%
Pref. not say	10.1%	8.4%	7.5%

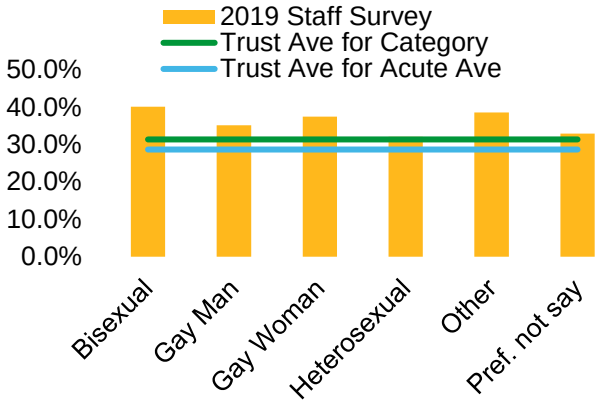
Question 15c Staff that have experienced discrimination attributing it to their ethnicity

Religion or Belief	Religion or belief cited as being a cause	Trust Ave	Acute Ave
Buddhism	8.3%	2.9%	3.8%
Christianity	2.3%	2.9%	3.8%
Hinduism	9.1%	2.9%	3.8%
Islam	22.2%	2.9%	3.8%
Judaism	-	2.9%	3.8%
No religion	0.7%	2.9%	3.8%
Other	-	2.9%	3.8%
Pref. not say	9.5%	2.9%	3.8%

Items in the Trust Average and Acute Average columns: Items are highlighted in red where the Trust score is worse than the average, items are highlighted in green where they are better than the average.

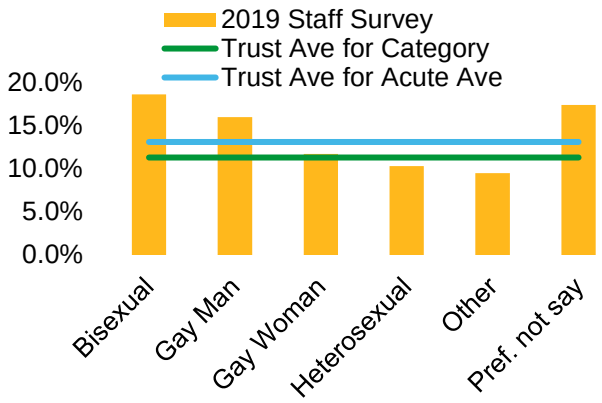
Results broken down by sexual orientation:

Question 13a – Staff that have experienced abuse, bullying or harassment from patients, service users and visitors



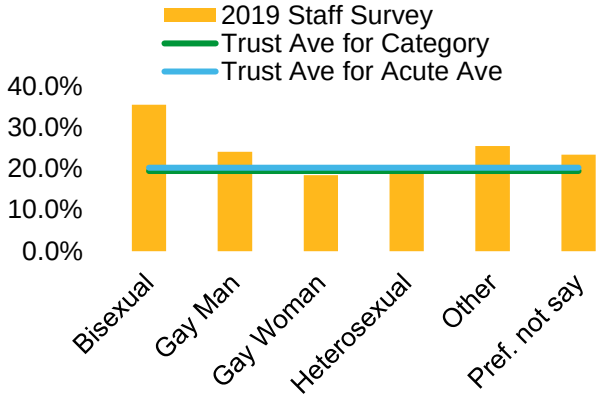
Sexual Orientation	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
Bisexual	40.2%	31.4%	28.7%
Gay Man	35.2%	31.4%	28.7%
Gay Woman	37.5%	31.4%	28.7%
Heterosexual	32.1%	31.4%	28.7%
Other	38.6%	31.4%	28.7%
Pref. not say	33.0%	31.4%	28.7%

Question 13b Staff that have experienced abuse, bullying or harassment from their managers



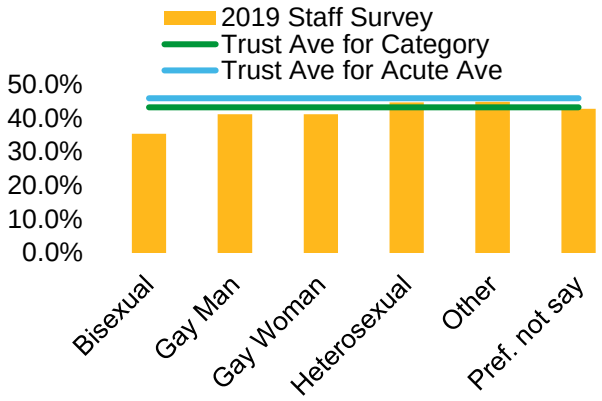
Sexual Orientation	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
Bisexual	18.6%	11.3%	13.1%
Gay Man	16.0%	11.3%	13.1%
Gay Woman	11.7%	11.3%	13.1%
Heterosexual	10.3%	11.3%	13.1%
Other	9.5%	11.3%	13.1%
Pref. not say	17.4%	11.3%	13.1%

Question 13c Staff that have experienced abuse, bullying or harassment from other colleagues



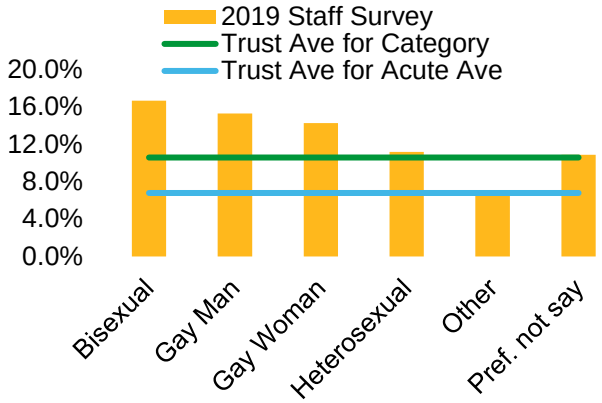
Sexual Orientation	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
Bisexual	35.6%	19.5%	20.3%
Gay Man	24.2%	19.5%	20.3%
Gay Woman	18.5%	19.5%	20.3%
Heterosexual	18.9%	19.5%	20.3%
Other	25.6%	19.5%	20.3%
Pref. not say	23.5%	19.5%	20.3%

Question 13d Staff that have experienced abuse, bullying or harassment that reported, or a colleague reported the incident



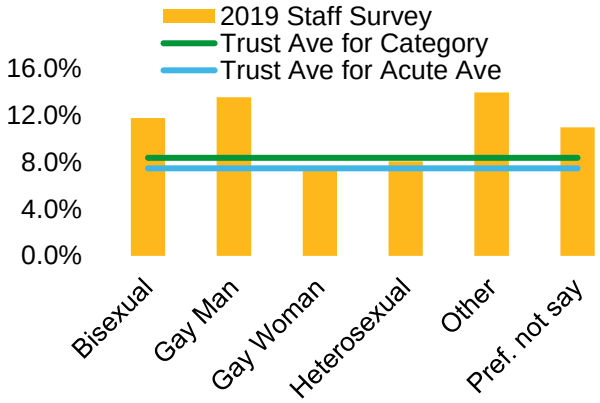
Sexual Orientation	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
Bisexual	35.4%	43.3%	46.0%
Gay Man	41.2%	43.3%	46.0%
Gay Woman	41.2%	43.3%	46.0%
Heterosexual	44.8%	43.3%	46.0%
Other	45.0%	43.3%	46.0%
Pref. not say	42.9%	43.3%	46.0%

Question 15a Staff that have experienced discrimination from patients, service users and visitors



Sexual Orientation	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
Bisexual	16.7%	10.6%	6.8%
Gay Man	15.3%	10.6%	6.8%
Gay Woman	14.3%	10.6%	6.8%
Heterosexual	11.2%	10.6%	6.8%
Other	7.0%	10.6%	6.8%
Pref. not say	10.9%	10.6%	6.8%

Question 15b Staff that have experienced discrimination from other staff



Sexual Orientation	2019 Staff Survey	Trust Ave for Category	Trust Ave for Acute Ave
Bisexual	11.8%	8.4%	7.5%
Gay Man	13.6%	8.4%	7.5%
Gay Woman	7.6%	8.4%	7.5%
Heterosexual	8.1%	8.4%	7.5%
Other	14.0%	8.4%	7.5%
Pref. not say	11.0%	8.4%	7.5%

Question 15c Staff that have experienced discrimination attributing it to their ethnicity

Sexual Orientation	Sexual Orientation cited as being a cause	Trust Ave	Acute Ave
Bisexual	9.5%	6.5%	3.8%
Gay Man	64.1%	6.5%	3.8%
Gay Woman	42.9%	6.5%	3.8%
Heterosexual	1.4%	6.5%	3.8%
Other	-	6.5%	3.8%
Pref. not say	5.4%	6.5%	3.8%

Items in the Trust Average and Acute Average columns: Items are highlighted in red where the Trust score is worse than the average, items are highlighted in green where they are better than the average.

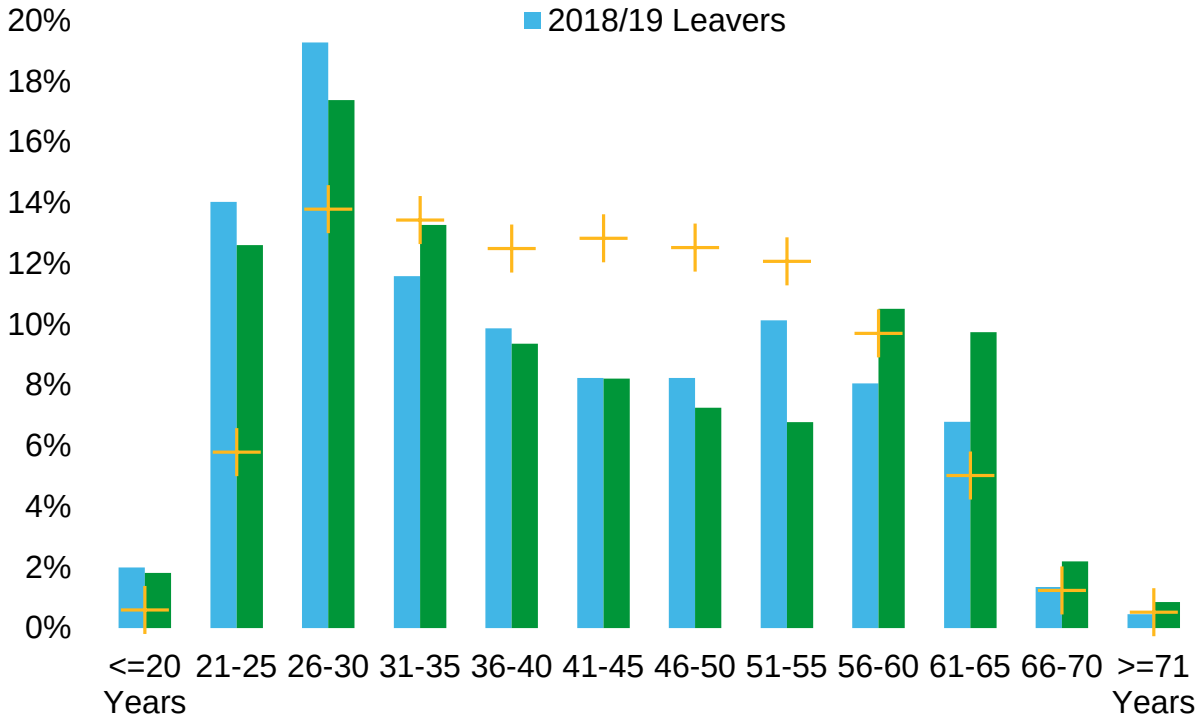
The Trust also uses opportunities to collect information from staff outside of the NHS Staff Survey. This data is collected when staff complete their statutory and mandatory training and provides information which gives a 'real-time temperature gauge' of staff experiences.

Due to the pandemic, all reporting for this method collection has been paused. This sadly means we are unable to provide data or information for this report.

Information about staff that have left the Trust during 2019/20

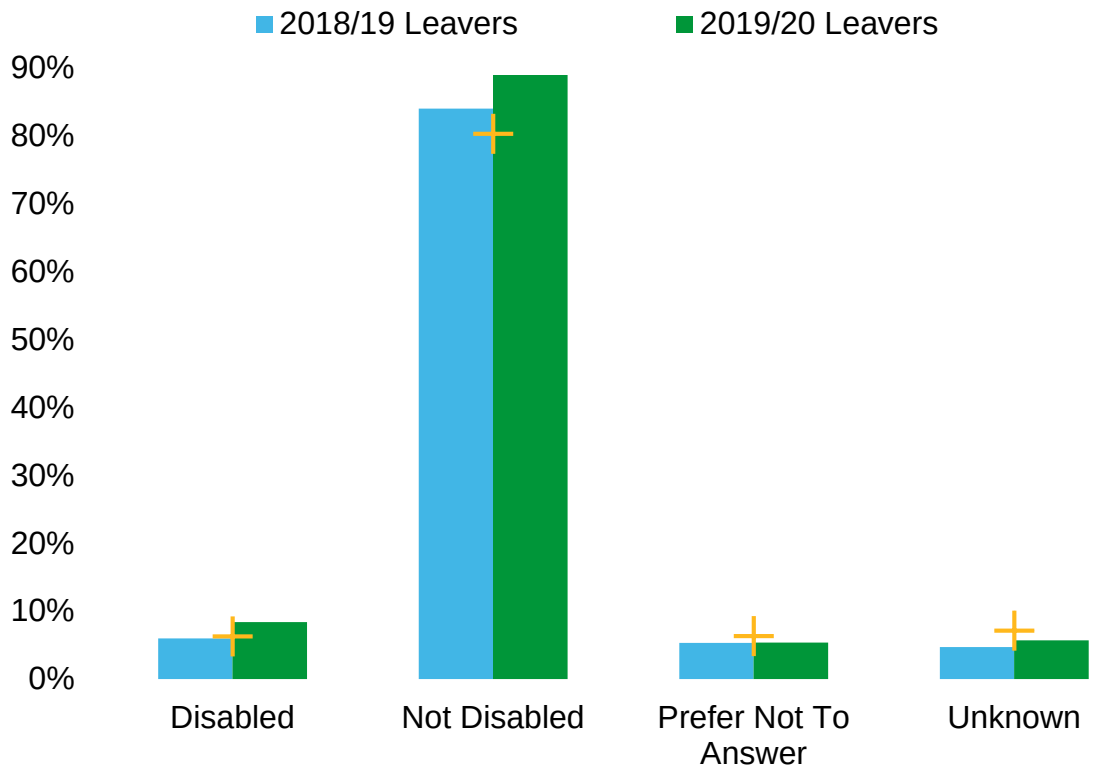
During the reporting period, a total of 1,047 staff left the Trust, due to the pandemic exit interviews and surveys were paused and therefore, information from this process is not available.

Leavers by age



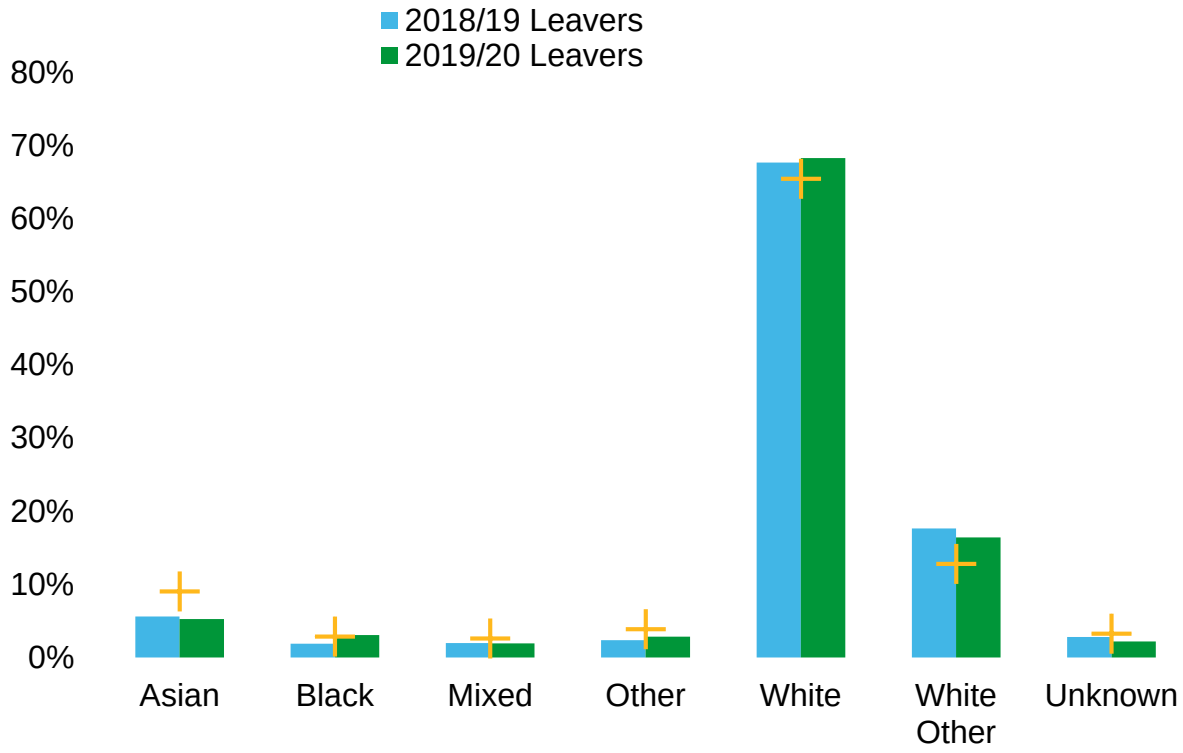
Age Band	<=20 Years	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	>=71 Years
2018/19 Leavers	2.0%	14.0%	19.3%	11.6%	9.9%	8.2%	8.2%	10.1%	8.1%	6.8%	1.4%	0.5%
2019/20 Leavers	1.8%	12.6%	17.4%	13.3%	9.4%	8.2%	7.3%	6.8%	10.5%	9.7%	2.2%	0.9%
2020 Workforce Representation	0.6%	5.8%	13.8%	13.4%	12.5%	12.8%	12.5%	12.1%	9.7%	5.0%	1.2%	0.5%

Leavers by disability



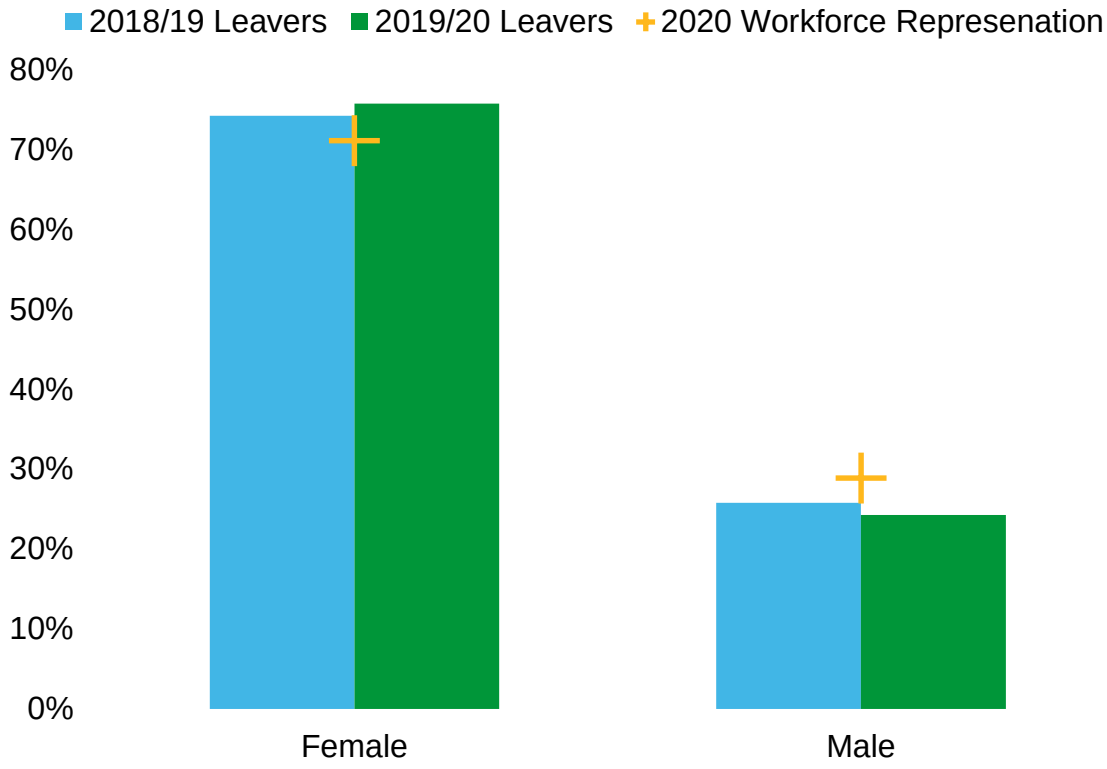
Disability	Disabled	Not Disabled	Prefer Not To Answer	Unknown
2018/19 Leavers	6.0%	84.0%	5.3%	4.7%
2019/20 Leavers	8.4%	88.9%	5.4%	5.7%
2020 Workforce Representation	6.3%	80.3%	6.3%	7.1%

Leavers by ethnicity



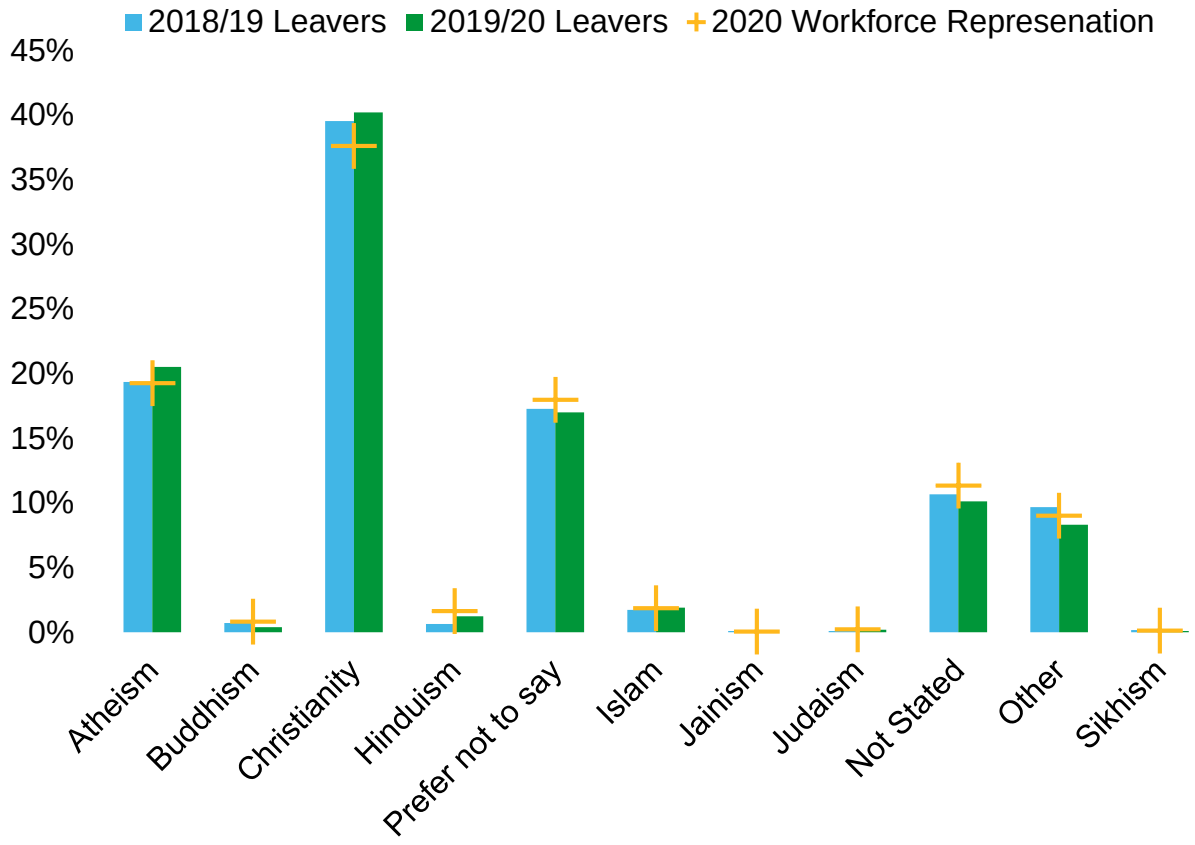
	Asian	Black	Mixed	Other	White	White Other	Unknown
2018/19 Leavers	5.6%	1.9%	2.0%	2.4%	67.7%	17.6%	2.8%
2019/20 Leavers	5.3%	3.1%	1.9%	2.9%	68.3%	16.4%	2.2%
2020 Workforce Representation	9.1%	2.9%	2.6%	3.9%	65.5%	12.8%	3.3%

Leavers by gender



	Female	Male
2018/19 Leavers	74.2%	25.8%
2019/20 Leavers	75.7%	24.3%
2020 Workforce Representation	71.1%	28.9%

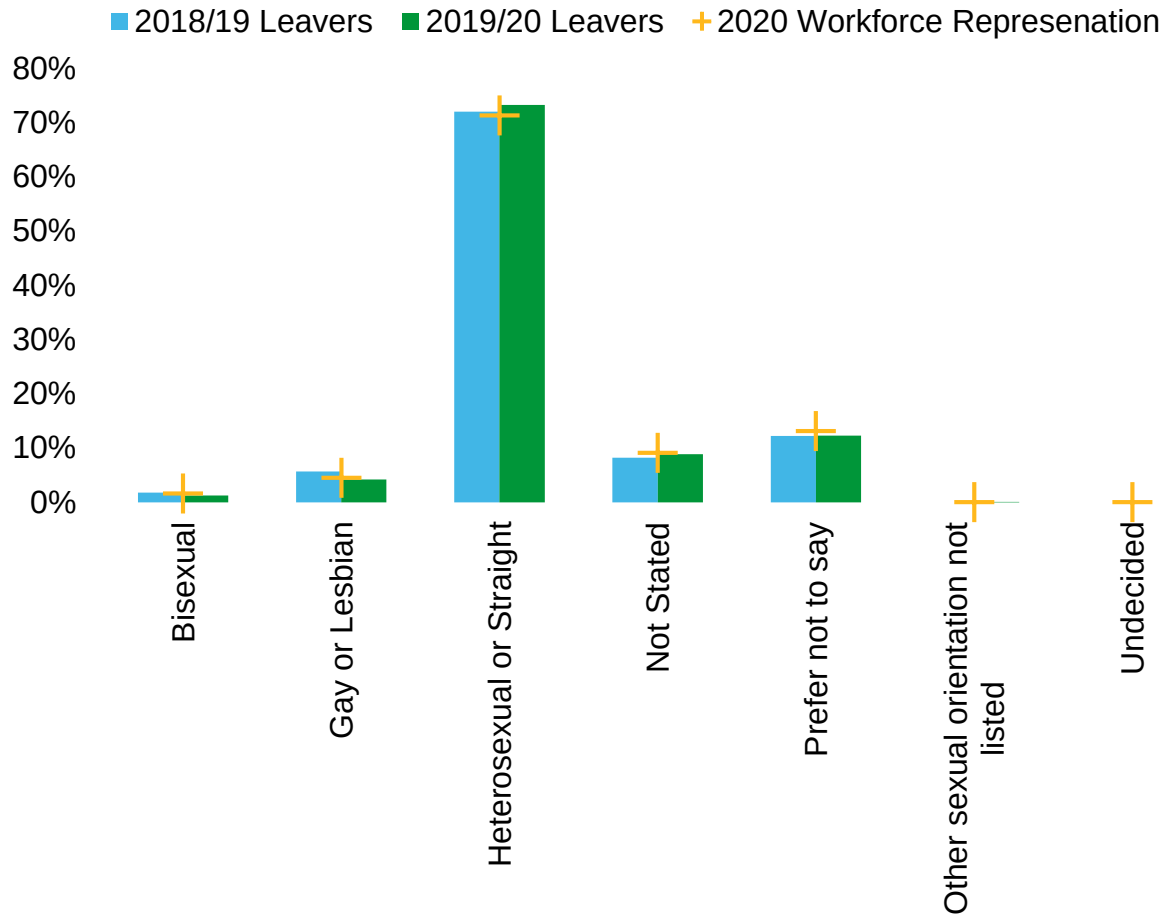
Leavers by religion or belief



	Atheism	Buddhism	Christianity	Hinduism	Prefer not to say	Islam	Jainism
2018/19 Leavers	19.4%	0.7%	39.5%	0.6%	17.3%	1.7%	0.1%
2019/20 Leavers	20.5%	0.4%	40.2%	1.2%	17.0%	1.9%	0.0%
2020 Workforce Representation	19.3%	0.8%	37.6%	1.6%	18.0%	1.9%	0.0%

	Judaism	Not Stated	Other	Sikhism
2018/19 Leavers	0.1%	10.7%	9.7%	0.2%
2019/20 Leavers	0.2%	10.1%	8.3%	0.1%
2020 Workforce Representation	0.2%	11.3%	9.0%	0.1%

Leavers by sexual orientation



Sexual Orientation	Bisexual	Gay or Lesbian	Heterosexual or Straight	Not Stated	Prefer not to say	Other sexual orientation not listed	Undecided
2018/19 Leavers	1.8%	5.7%	72.0%	8.2%	12.2%	0.0%	
2019/20 Leavers	1.2%	4.2%	73.3%	8.9%	12.3%	0.1%	
2020 Workforce Representation	1.7%	4.6%	71.3%	9.2%	13.1%	0.1%	0.1%

The Trust's recruitment processes data

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

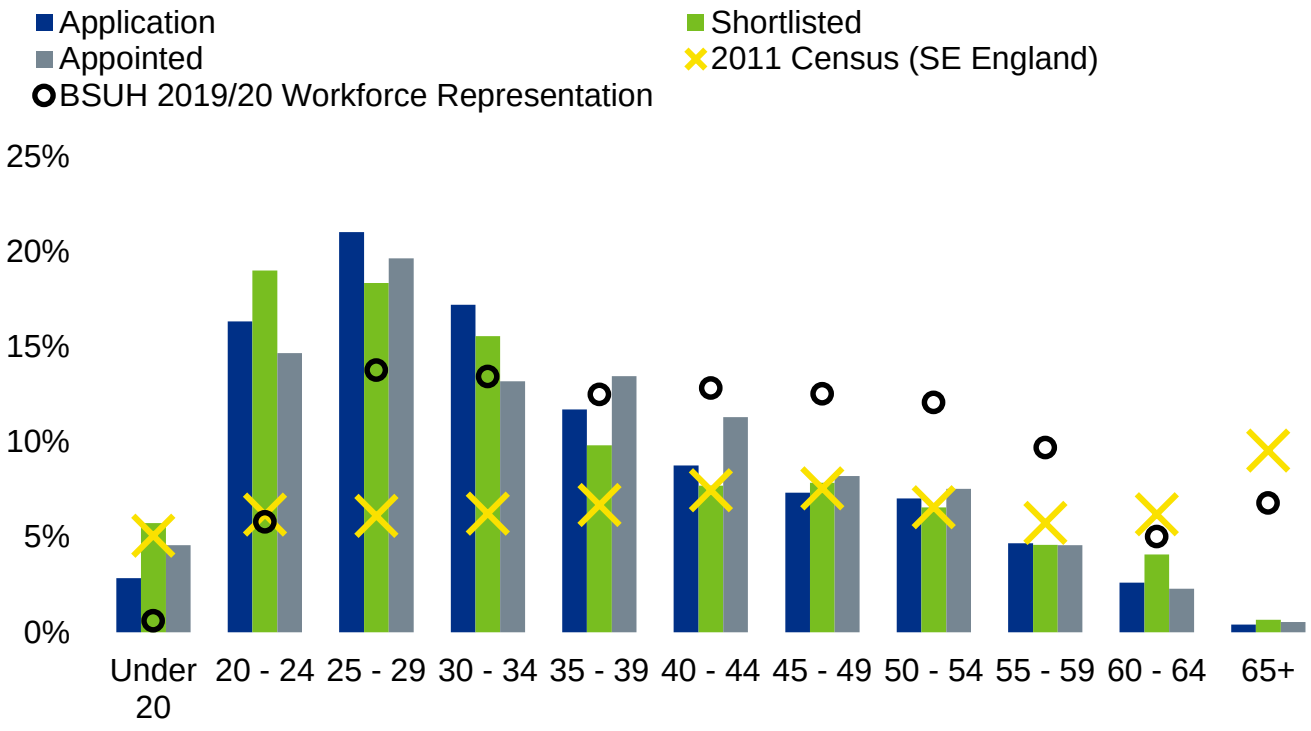
Given that the Trust is open to recruitment from applicants internationally, it would be unrealistic to expect the demographic of applicants to exactly mirror the profile of the 2011 Census. This could have an impact on the representation of applicants through all three stages of recruitment.

During 2019/20 in general recruitment: there were:
Applications received: 19,131
Applicants Shortlisted: 610
Applicants Appointed: 743

During 2019/20 in medical recruitment: there were:
Applications received: 1,665
Applicants Shortlisted: 802
Applicants Appointed: 78

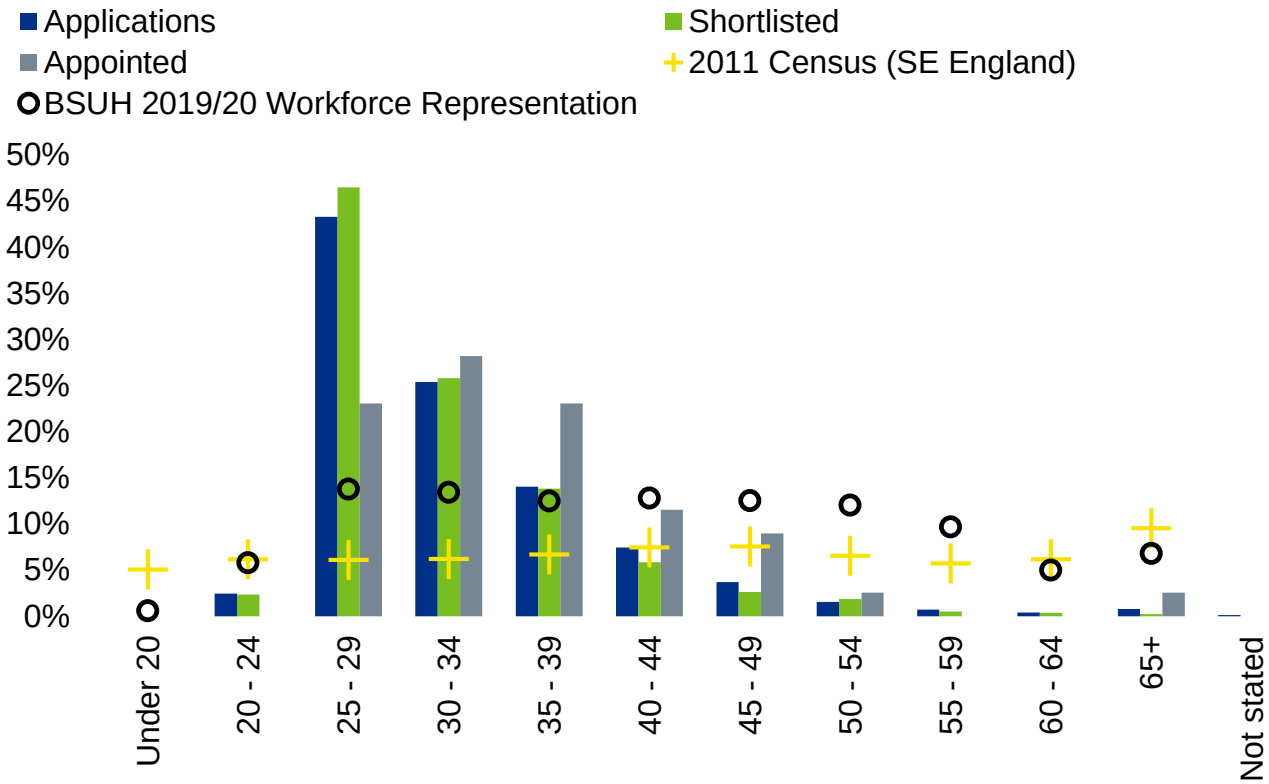
By age

Age: General recruitment – excluding medical posts



Age Band	Application	Shortlisted	Appointed	2011 Census (SE England)	BSUH 2019/20 Workforce Representation
Under 20	2.8%	5.7%	4.6%	5.1%	0.6%
20 - 24	16.3%	19.0%	14.7%	6.2%	5.8%
25 - 29	21.0%	18.4%	19.7%	6.1%	13.8%
30 - 34	17.2%	15.6%	13.2%	6.2%	13.4%
35 - 39	11.7%	9.8%	13.5%	6.7%	12.5%
40 - 44	8.8%	7.7%	11.3%	7.5%	12.8%
45 - 49	7.3%	7.9%	8.2%	7.6%	12.5%
50 - 54	7.0%	6.6%	7.5%	6.6%	12.1%
55 - 59	4.7%	4.6%	4.6%	5.7%	9.7%
60 - 64	2.6%	4.1%	2.3%	6.2%	5.0%
65+	0.4%	0.7%	0.5%	9.6%	6.8%
Not stated	0.0%	0.0%	0.0%		

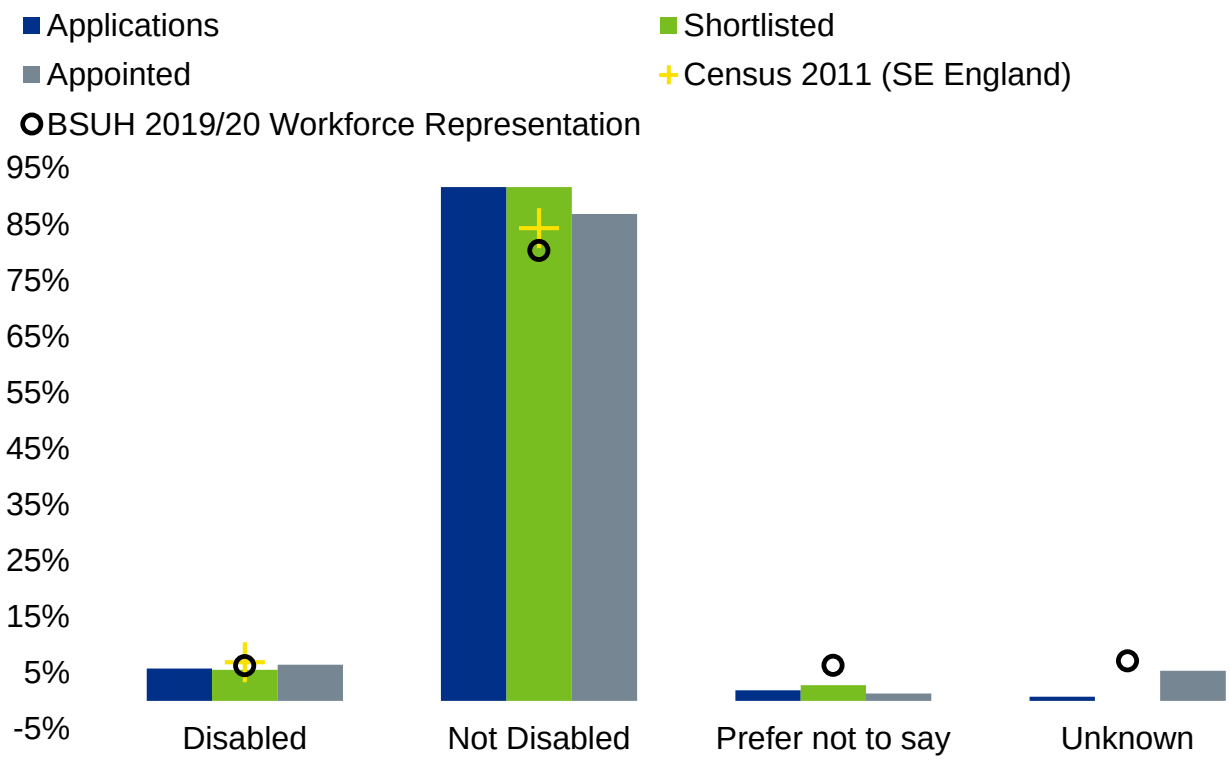
Age: Medical recruitment only



Age Band	Applications	Shortlisted	Appointed	2011 Census (SE England)	BSUH 2019/20 Workforce Representation
Under 20	0.0%	0.0%	0.0%	5.1%	0.6%
20 - 24	2.5%	2.4%	0.0%	6.2%	5.8%
25 - 29	43.3%	46.5%	23.1%	6.1%	13.8%
30 - 34	25.4%	25.8%	28.2%	6.2%	13.4%
35 - 39	14.1%	13.8%	23.1%	6.7%	12.5%
40 - 44	7.4%	5.9%	11.5%	7.5%	12.8%
45 - 49	3.7%	2.6%	9.0%	7.6%	12.5%
50 - 54	1.6%	1.9%	2.6%	6.6%	12.1%
55 - 59	0.7%	0.5%	0.0%	5.7%	9.7%
60 - 64	0.4%	0.4%	0.0%	6.2%	5.0%
65+	0.8%	0.2%	2.6%	9.6%	6.8%
Not stated	0.1%	0.0%	0.0%		

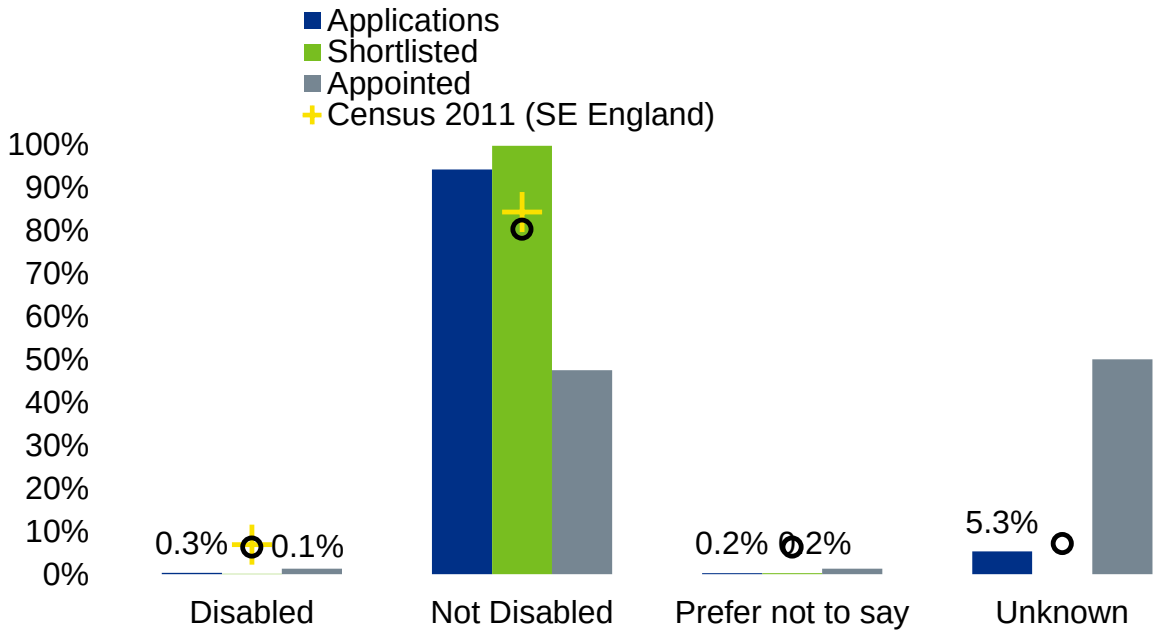
By disability

Disability: General recruitment – excluding medical posts



Disability	Applications	Shortlisted	Appointed	Census 2011 (SE England)	BSUH 2019/20 Workforce Representation
Disabled	5.8%	5.6%	6.5%	6.9%	6.3%
Not Disabled	91.6%	91.6%	86.8%	84.3%	80.3%
Prefer not to say	1.9%	2.8%	1.3%		6.3%
Unknown	0.8%	0.0%	5.4%		7.1%

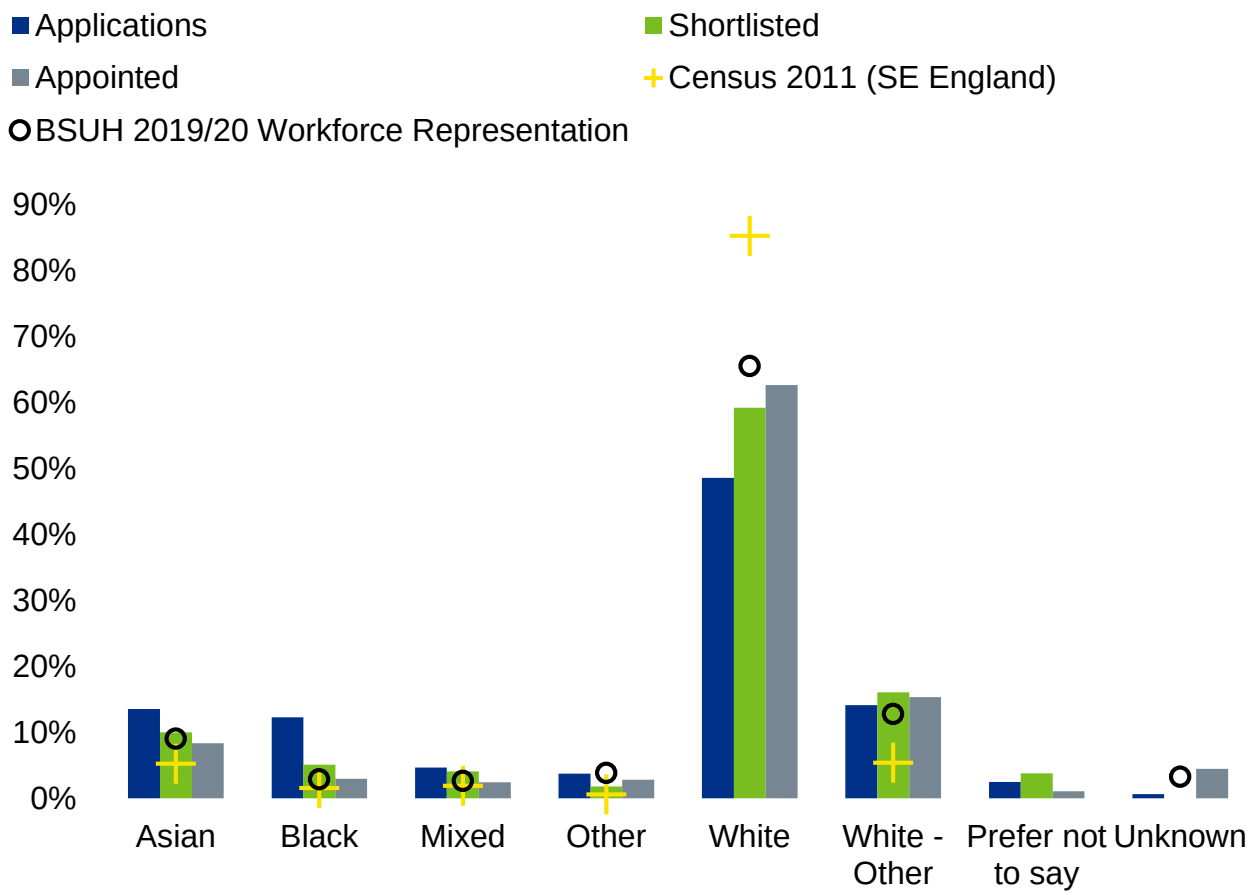
Disability: Medical recruitment only



Disability	Applications	Shortlisted	Appointed	Census 2011 (SE England)	BSUH 2019/20 Workforce Representation
Disabled	0.3%	0.1%	1.3%	6.9%	6.3%
Not Disabled	94.2%	99.6%	47.4%	84.3%	80.3%
Prefer not to say	0.2%	0.2%	1.3%		6.3%
Unknown	5.3%	0.0%	50.0%		7.1%

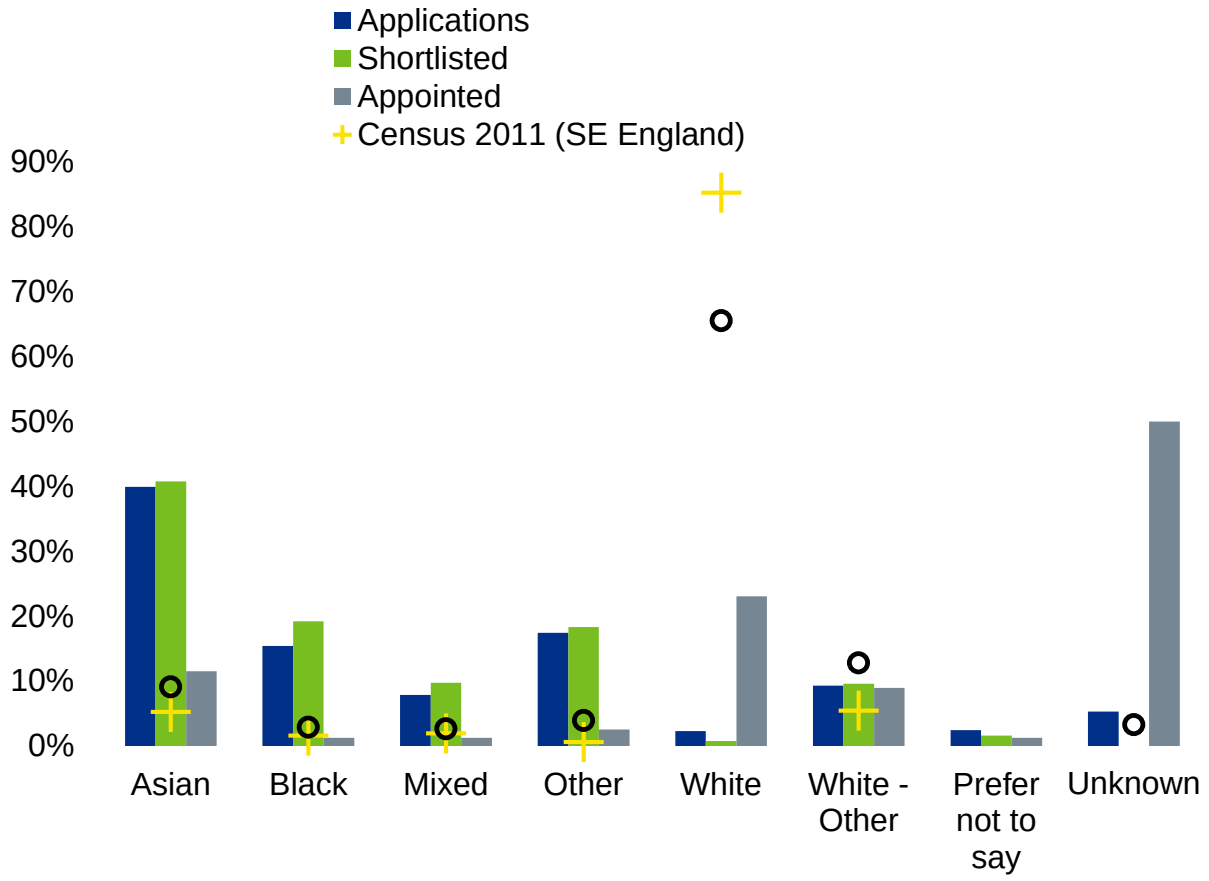
By ethnicity

Ethnicity: General recruitment – excluding medical posts



Ethnicity	Applications	Shortlisted	Appointed	Census 2011 (SE England)	BSUH 2019/20 Workforce Representation
Asian	13.5%	10.0%	8.3%	5.2%	9.1%
Black	12.3%	5.1%	3.0%	1.6%	2.9%
Mixed	4.6%	4.1%	2.4%	1.9%	2.6%
Other	3.8%	1.8%	2.8%	0.6%	3.9%
White	48.6%	59.2%	62.6%	85.2%	65.5%
White - Other	14.1%	16.1%	15.3%	5.4%	12.8%
Prefer not to say	2.5%	3.8%	1.1%		
Unknown	0.6%	0.0%	4.4%		3.3%

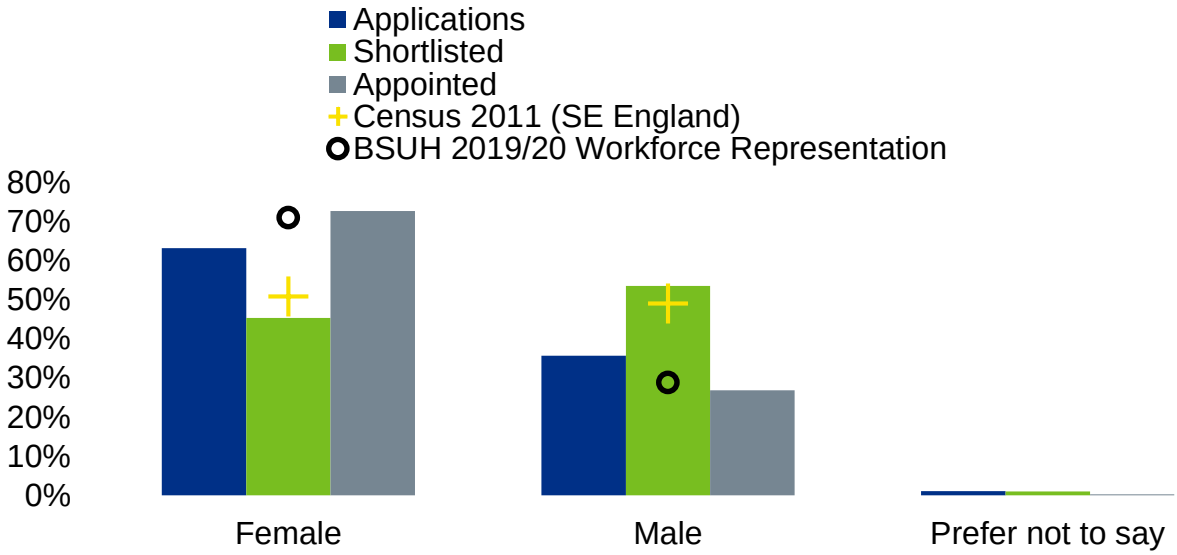
Ethnicity: Medical recruitment only



Ethnicity	Applications	Shortlisted	Appointed	Census 2011 (SE England)	BSUH 2019/20 Workforce Representation
Asian	39.9%	40.8%	11.5%	5.2%	9.1%
Black	15.4%	19.2%	1.3%	1.6%	2.9%
Mixed	7.9%	9.7%	1.3%	1.9%	2.6%
Other	17.4%	18.3%	2.6%	0.6%	3.9%
White	2.3%	0.7%	23.1%	85.2%	65.5%
White - Other	9.3%	9.6%	9.0%	5.4%	12.8%
Prefer not to say	2.5%	1.6%	1.3%		
Unknown	5.3%	0.0%	50.0%		3.3%
Grand Total	100.0%	100.0%	100.0%		

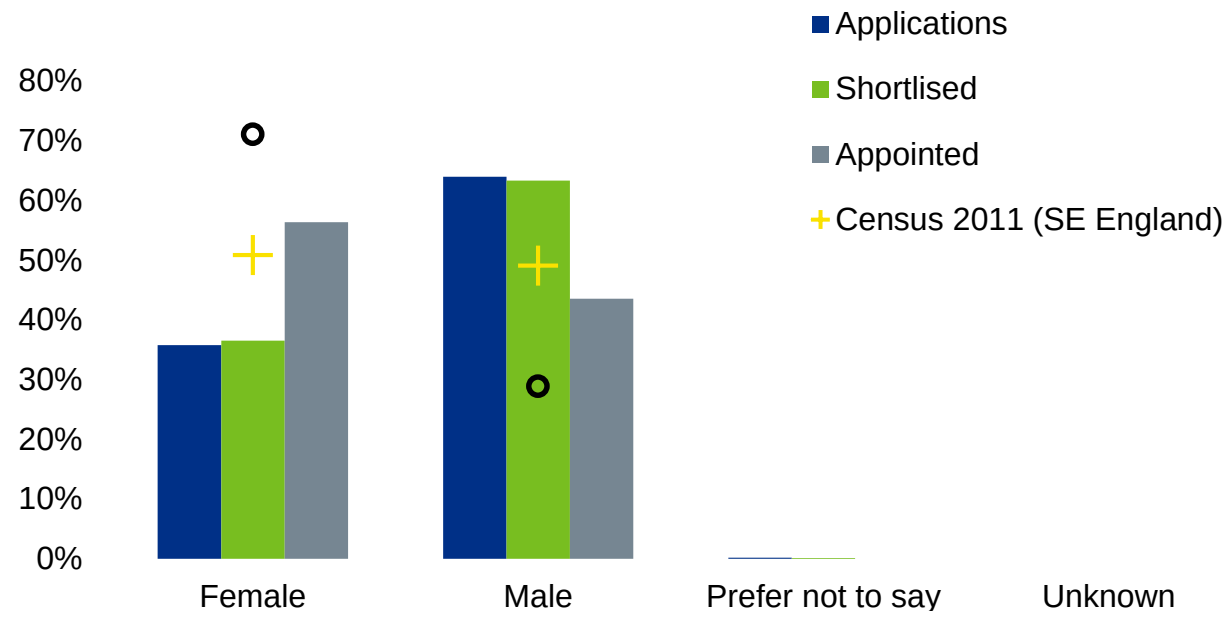
By gender

Gender: General recruitment – excluding medical posts



Gender	Applications	Shortlisted	Appointed	Census 2011 (SE England)	BSUH 2019/20 Workforce Representation
Female	63.2%	45.4%	72.8%	50.9%	71.1%
Male	35.7%	53.6%	26.9%	49.1%	28.9%
Prefer not to say	1.0%	1.0%	0.3%		
Unknown	0.0%	0.0%	0.0%		

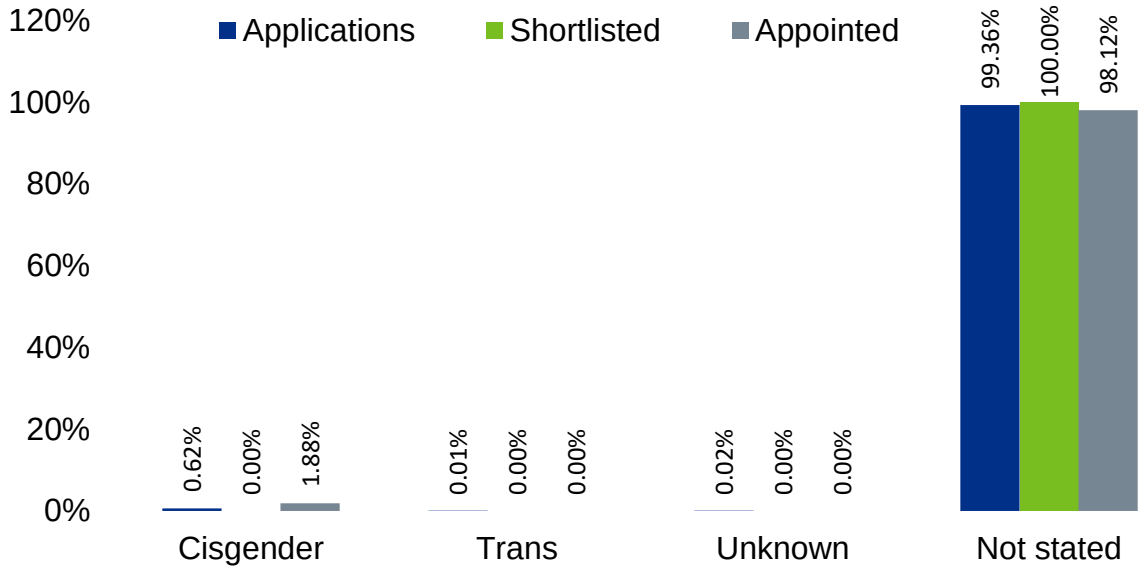
Gender: Medical recruitment only



Gender	Applications	Shortlisted	Appointed	Census 2011 (SE England)	BSUH 2019/20 Workforce Representation
Female	35.8%	36.5%	56.4%	50.9%	71.1%
Male	64.0%	63.3%	43.6%	49.1%	28.9%
Prefer not to say	0.2%	0.1%	0.0%		
Unknown	0.0%	0.0%	0.0%		

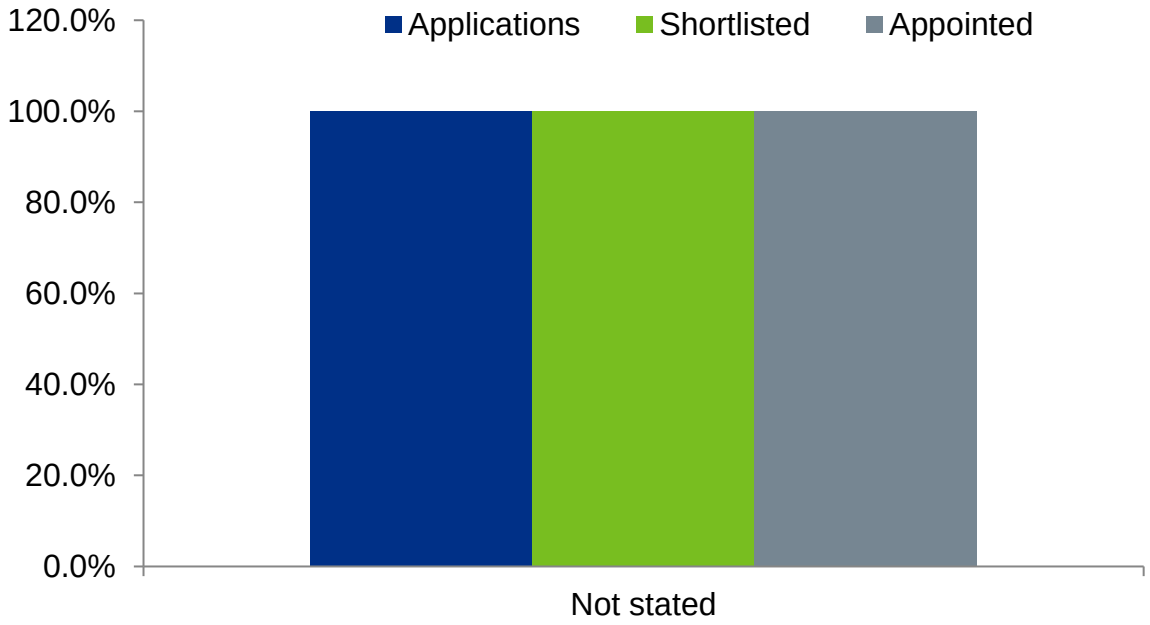
By gender identity

Gender Identity: General recruitment – excluding medical posts



Gender Identity	Applications	Shortlisted	Appointed
Cisgender	0.62%	0.00%	1.88%
Trans	0.01%	0.00%	0.00%
Unknown	0.02%	0.00%	0.00%
Not stated	99.36%	100.00%	98.12%

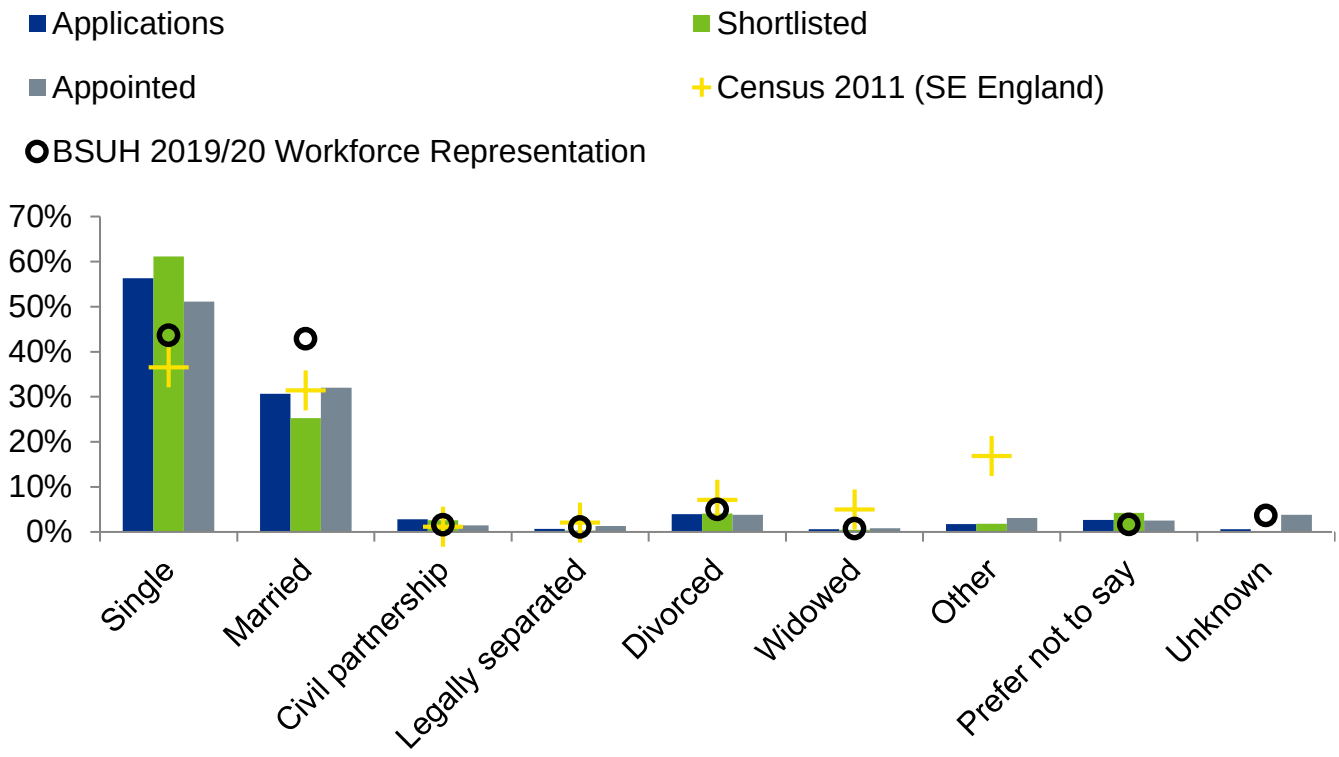
Gender Identity: Medical recruitment only



Transgender	Applications	Shortlisted	Appointed
Not stated	100.0%	100.0%	100.0%

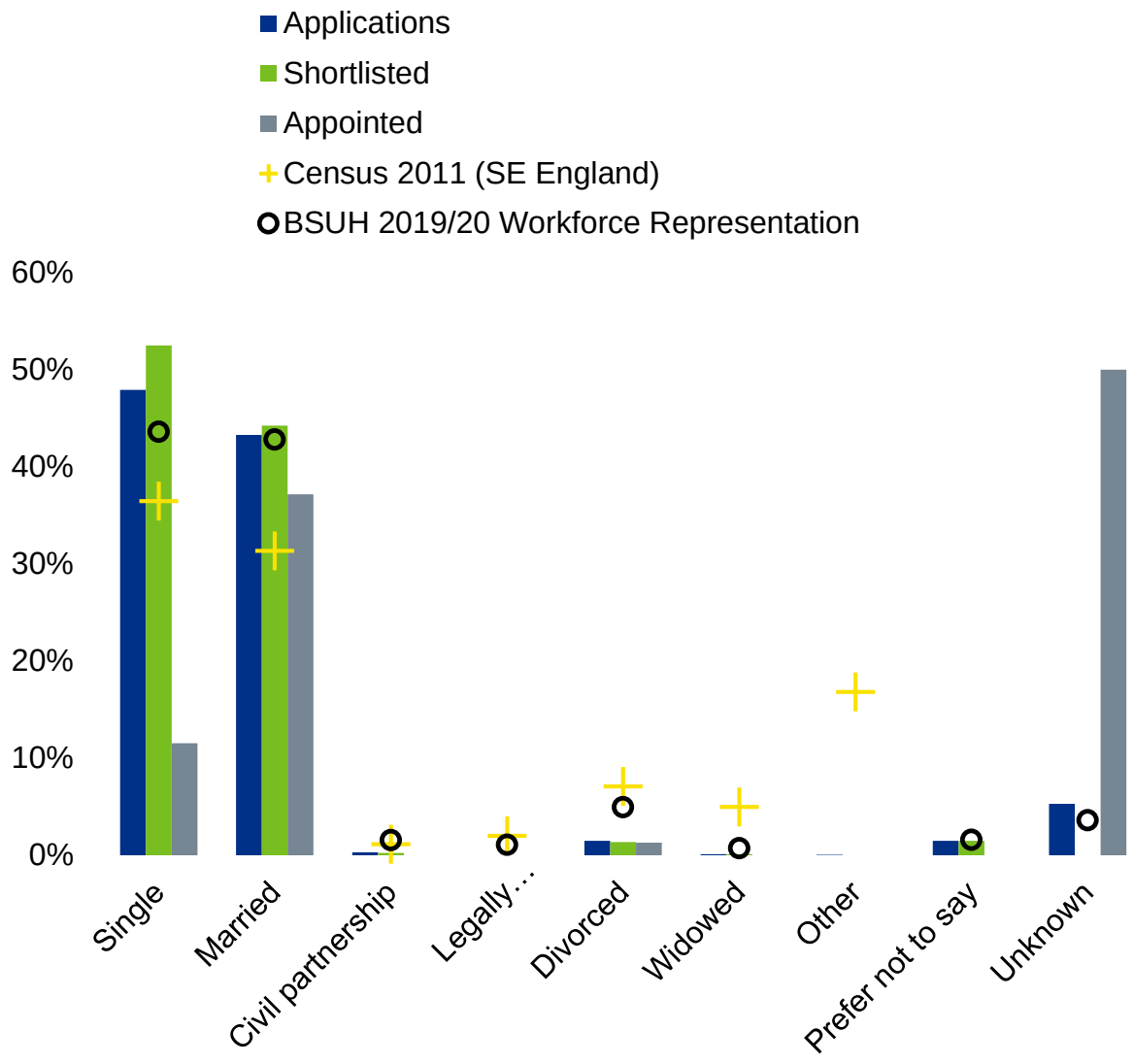
By marital status

Marital status: General recruitment – excluding medical posts



Marital Status	Applications	Shortlisted	Appointed	Census 2011 (SE England)	BSUH 2019/20 Workforce Representation
Single	56.3%	61.1%	51.1%	36.5%	43.6%
Married	30.6%	25.2%	32.0%	31.4%	42.8%
Civil partnership	2.8%	2.6%	1.5%	1.2%	1.6%
Legally separated	0.6%	0.3%	1.3%	2.0%	1.1%
Divorced	4.0%	4.1%	3.8%	7.1%	5.0%
Widowed	0.6%	0.5%	0.8%	5.0%	0.7%
Other	1.7%	1.8%	3.1%	16.8%	
Prefer not to say	2.7%	4.3%	2.6%		1.6%
Unknown	0.6%	0.0%	3.8%		3.6%

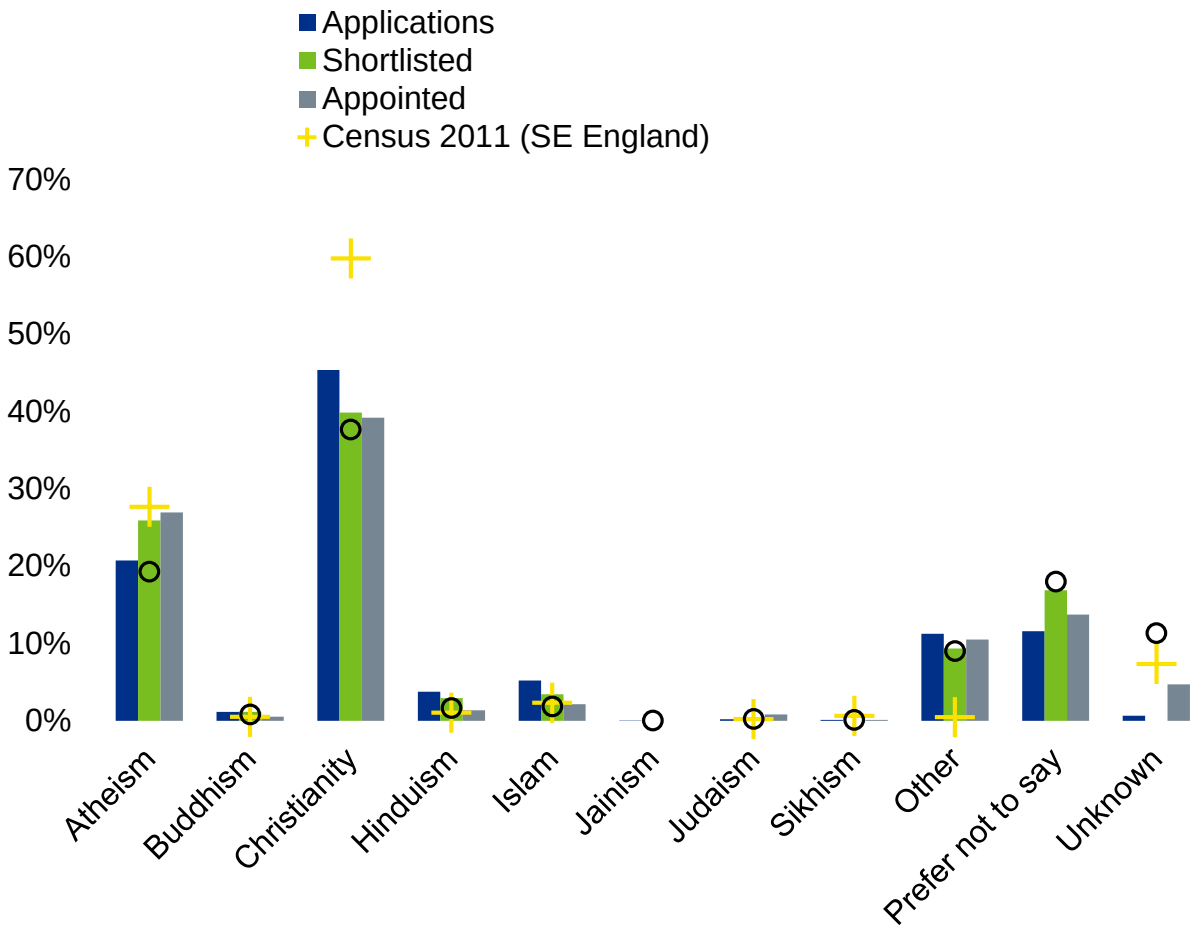
Marital status: Medical recruitment only



Marital Status	Applications	Shortlisted	Appointed	Census 2011 (SE England)	BSUH 2019/20 Workforce Representation
Single	47.9%	52.5%	11.5%	36.5%	43.6%
Married	43.3%	44.3%	37.2%	31.4%	42.8%
Civil partnership	0.3%	0.2%	0.0%	1.2%	1.6%
Legally separated	0.0%	0.0%	0.0%	2.0%	1.1%
Divorced	1.5%	1.4%	1.3%	7.1%	5.0%
Widowed	0.1%	0.1%	0.0%	5.0%	0.7%
Other	0.1%	0.0%	0.0%	16.8%	
Prefer not to say	1.5%	1.5%	0.0%		1.6%
Unknown	5.3%	0.0%	50.0%		3.6%

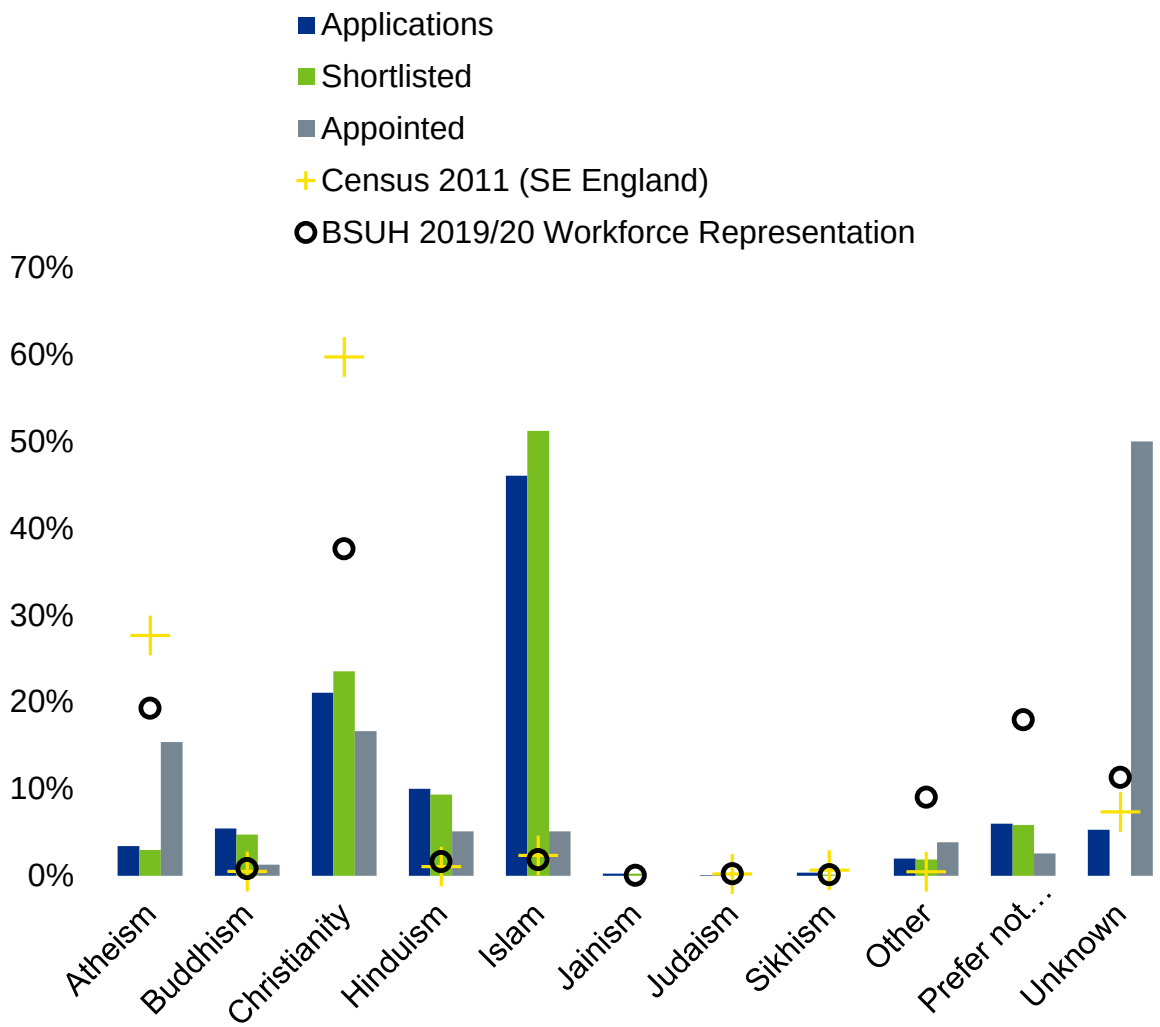
By religion or belief

Religion or belief: General recruitment – excluding medical posts



Religion or Belief	Applications	Shortlisted	Appointed	Census 2011 (SE England)	BSUH 2019/20 Workforce Representation
Atheism	20.7%	25.9%	26.9%	27.7%	19.3%
Buddhism	1.1%	1.1%	0.5%	0.5%	0.8%
Christianity	45.3%	39.8%	39.2%	59.8%	37.6%
Hinduism	3.8%	3.0%	1.3%	1.1%	1.6%
Islam	5.2%	3.4%	2.2%	2.3%	1.9%
Jainism	0.0%	0.0%	0.0%		0.0%
Judaism	0.2%	0.5%	0.8%	0.2%	0.2%
Sikhism	0.1%	0.0%	0.1%	0.6%	0.1%
Other	11.3%	9.3%	10.5%	0.5%	9.0%
Prefer not to say	11.6%	16.9%	13.7%		18.0%
Unknown	0.7%	0.0%	4.7%	7.4%	11.3%

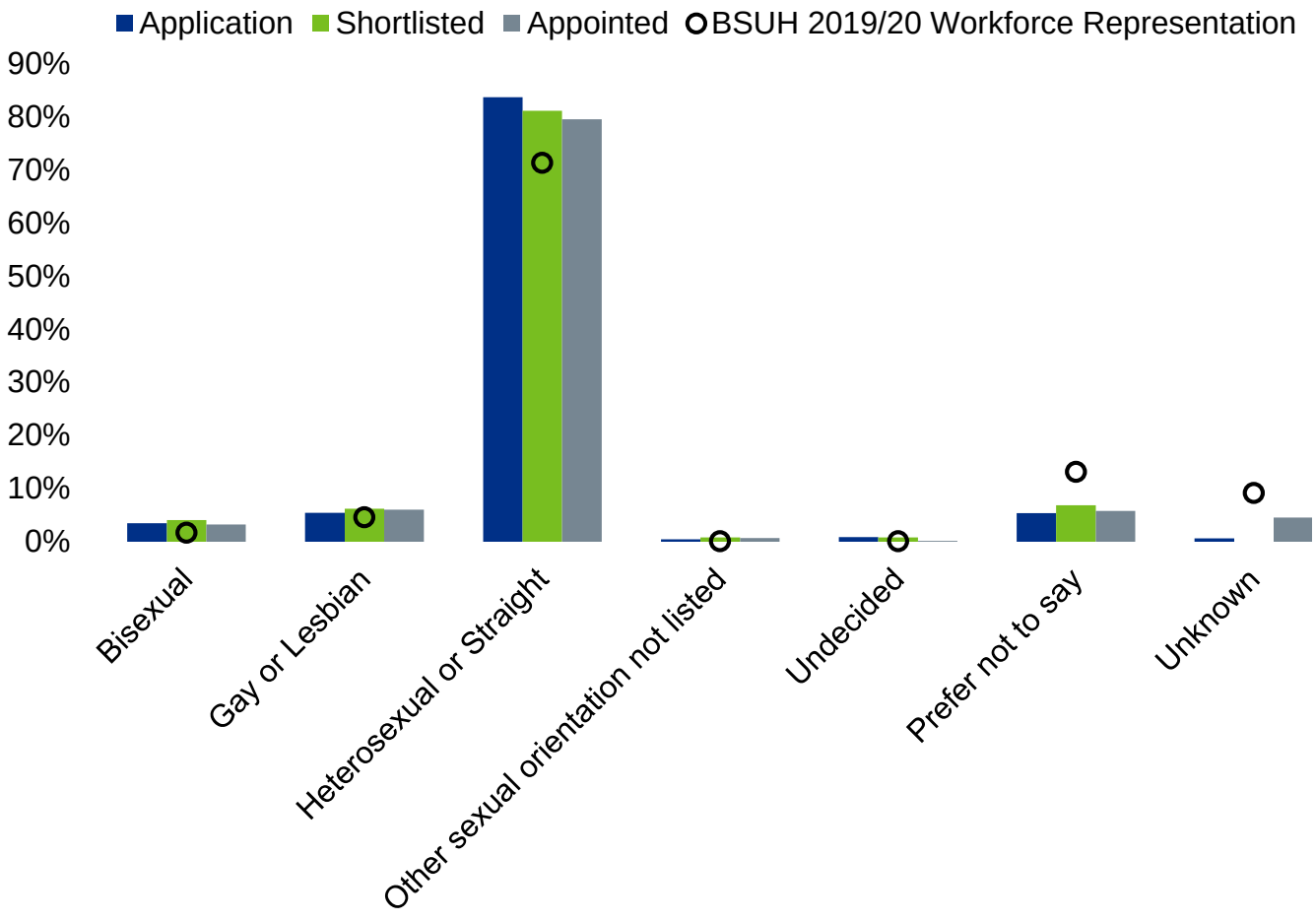
Religion or belief: Medical recruitment only



Religion of belief	Applications	Shortlisted	Appointed	Census 2011 (SE England)	BSUH 2019/20 Workforce Representation
Atheism	3.4%	3.0%	15.4%	27.7%	19.3%
Buddhism	5.5%	4.7%	1.3%	0.5%	0.8%
Christianity	21.1%	23.6%	16.7%	59.8%	37.6%
Hinduism	10.0%	9.4%	5.1%	1.1%	1.6%
Islam	46.1%	51.2%	5.1%	2.3%	1.9%
Jainism	0.2%	0.2%	0.0%		0.0%
Judaism	0.1%	0.0%	0.0%	0.2%	0.2%
Sikhism	0.4%	0.1%	0.0%	0.6%	0.1%
Other	2.0%	1.9%	3.8%	0.5%	9.0%
Prefer not to say	6.0%	5.9%	2.6%		18.0%
Unknown	5.3%	0.0%	50.0%	7.4%	11.3%

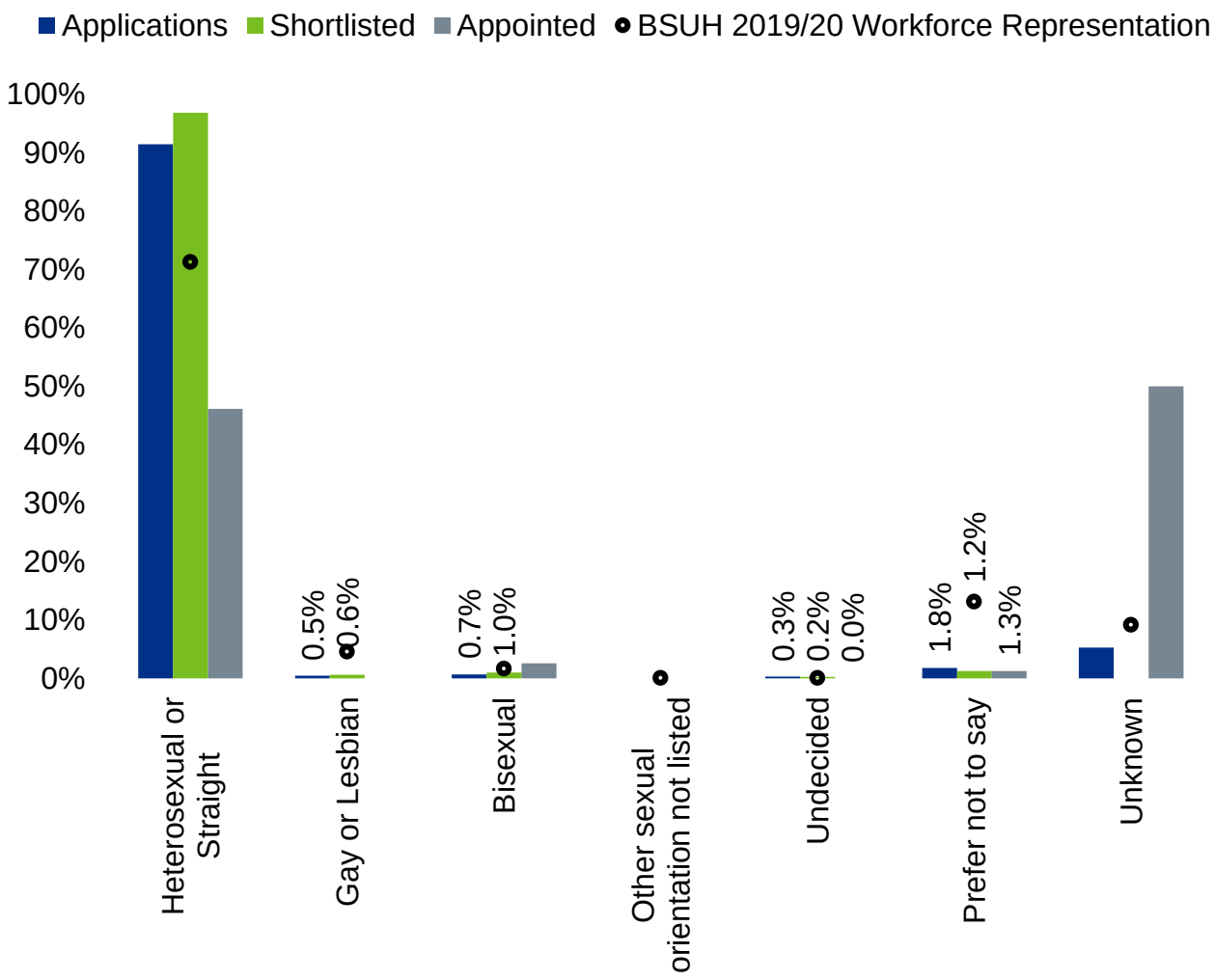
By sexual orientation

Sexual orientation: General recruitment – excluding medical posts



Sexual Orientation	Application	Shortlisted	Appointed	BSUH 2019/20 Workforce Representation
Bisexual	3.5%	4.1%	3.2%	1.7%
Gay or Lesbian	5.5%	6.2%	6.1%	4.6%
Heterosexual or Straight	83.7%	81.1%	79.5%	71.3%
Other sexual orientation not listed	0.4%	0.8%	0.7%	0.1%
Undecided	0.9%	0.8%	0.1%	0.1%
Prefer not to say	5.4%	6.9%	5.8%	13.1%
Unknown	0.7%	0.0%	4.6%	9.2%

Sexual orientation: Medical recruitment only



Sexual Orientation	Applications	Shortlisted	Appointed	BSUH 2019/20 Workforce Representation
Heterosexual or Straight	91.5%	96.9%	46.2%	71.3%
Gay or Lesbian	0.5%	0.6%	0.0%	4.6%
Bisexual	0.7%	1.0%	2.6%	1.7%
Other sexual orientation not listed	0.0%	0.0%	0.0%	0.1%
Undecided	0.3%	0.2%	0.0%	0.1%
Prefer not to say	1.8%	1.2%	1.3%	13.1%
Unknown	5.3%	0.0%	50.0%	9.2%

The Trust's employment policies and practices data

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

During 2019/20 there were:

- 20 Capability cases (underlying health reason)
- 23 Capability cases (no underlying health reason)
- 16 Harassment cases
- 4 Grievances
- 34 Disciplinary cases
- 28 Dismissals
    - of which 20 dismissals related to sickness

The items that have been highlighted in green and bold text, show groups where their representation Is greater than their representation in the workforce.

Breakdown of cases by age

Age Band	Capability (UHR)	Capability (Non-UHR)	Harassment	Grievance	Disciplinary	Dismissal (All)	Dismissal (Sickness Only)	Workforce Representation
16 - 20	0.0%	0.0%	0.0%	0.0%	**2.9%**	0.0%	0.0%	0.6%
21 - 25	**10.0%**	**8.7%**	0.0%	0.0%	**5.9%**	**7.1%**	**10.0%**	5.8%
26 - 30	**15.0%**	**17.4%**	12.5%	0.0%	2.9%	**14.3%**	**15.0%**	13.8%
31 - 35	10.0%	8.7%	0.0%	0.0%	**20.6%**	3.6%	10.0%	13.4%
36 - 40	5.0%	4.3%	0.0%	0.0%	**14.7%**	7.1%	5.0%	12.5%
41 - 45	10.0%	8.7%	12.5%	0.0%	2.9%	10.7%	10.0%	12.8%
46 - 50	0.0%	13.0%	6.3%	**100.0%**	17.6%	7.1%	0.0%	12.5%
51 - 55	**30.0%**	**26.1%**	**25.0%**	0.0%	**14.7%**	**25.0%**	**30.0%**	12.1%
56 - 60	**10.0%**	0.0%	**18.8%**	0.0%	8.8%	**10.7%**	**10.0%**	9.7%
61 - 65	5.0%	**13.0%**	**18.8%**	0.0%	**5.9%**	**10.7%**	5.0%	5.0%
66 - 70	**5.0%**	0.0%	**6.3%**	0.0%	**2.9%**	**3.6%**	**5.0%**	1.2%
71 - 75	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%

Breakdown of cases by disability status

Disability Status	Capability (UHR)	Capability (Non-UHR)	Harassment	Grievance	Disciplinary	Dismissal (All)	Dismissal (Sickness Only)	Workforce Representation
Disabled	25.0%	13.0%	12.5%	0.0%	17.6%	10.7%	25.0%	6.3%
Not Declared	10.0%	4.3%	18.8%	25.0%	20.6%	14.3%	10.0%	6.3%
Not Disabled	50.0%	82.6%	62.5%	75.0%	58.8%	57.1%	50.0%	80.3%
Undefined	15.0%	0.0%	6.3%	0.0%	0.0%	14.3%	15.0%	7.1%
Other					2.9%	3.6%		

Breakdown of cases by ethnicity

Ethnicity	Capability (UHR)	Capability (Non-UHR)	Harassment	Grievance	Disciplinary	Dismissal (All)	Dismissal (Sickness Only)	Workforce Representation
Asian	10.0%	8.7%	0.0%	0.0%	0.0%	0.0%	0.0%	9.1%
Black	0.0%	13.0%	12.5%	50.0%	0.0%	3.6%	0.0%	2.9%
Mixed	5.0%	0.0%	0.0%	0.0%	5.9%	7.1%	10.0%	2.6%
Other	10.0%	4.3%	0.0%	25.0%	8.8%	14.3%	20.0%	3.9%
White	60.0%	73.9%	87.5%	0.0%	64.7%	60.7%	60.0%	65.5%
White - Other	15.0%	0.0%	0.0%	25.0%	8.8%	10.7%	10.0%	12.8%
Unknown	0.0%	0.0%	0.0%	0.0%	11.8%	3.6%	0.0%	3.3%

Breakdown of cases by gender

Gender	Capability (UHR)	Capability (Non-UHR)	Harassment	Grievance	Disciplinary	Dismissal (All)	Dismissal (Sickness Only)	Workforce Representation
Female	90.0%	65.2%	75.0%	25.0%	61.8%	82.1%	90.0%	71.1%
Male	10.0%	34.8%	25.0%	75.0%	38.2%	17.9%	10.0%	28.9%

Breakdown of cases by marital status

Marital Status	Capability (UHR)	Capability (Non-UHR)	Harassment	Grievance	Disciplinary	Dismissal (All)	Dismissal (Sickness Only)	Workforce Representation
Civil Partnership	0.0%	0.0%	0.0%	**25.0%**	**2.9%**	0.0%	0.0%	**1.6%**
Divorced	0.0%	**8.7%**	**25.0%**	0.0%	2.9%	0.0%	0.0%	**5.0%**
Legally Separated	**5.0%**	**17.4%**	**6.3%**	**50.0%**	**2.9%**	**7.1%**	**5.0%**	**1.1%**
Married	25.0%	21.7%	**50.0%**	0.0%	**55.9%**	28.6%	25.0%	**42.8%**
Not Disclosed	**10.0%**	**4.3%**	**6.3%**	**25.0%**	**2.9%**	**10.7%**	**10.0%**	**1.6%**
Single	**50.0%**	**47.8%**	12.5%	0.0%	32.4%	**53.6%**	**50.0%**	**43.6%**
Widowed	**10.0%**	0.0%	0.0%	0.0%	0.0%	0.0%	**10.0%**	**0.7%**
Unknown	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**3.6%**

Breakdown of cases by religion or belief

Religion or Belief	Capability (UHR)	Capability (Non-UHR)	Harassment	Grievance	Disciplinary	Dismissal (All)	Dismissal (Sickness Only)	Workforce Representation
Atheism	**20.0%**	**21.7%**	6.3%	0.0%	11.8%	17.9%	**20.0%**	19.3%
Buddhism	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.8%
Christianity	**40.0%**	**56.5%**	**68.8%**	**100.0%**	**38.2%**	35.7%	**40.0%**	37.6%
Hinduism	**5.0%**	0.0%	0.0%	0.0%	**5.9%**	**7.1%**	**5.0%**	1.6%
Islam	0.0%	0.0%	0.0%	0.0%	**2.9%**	0.0%	0.0%	1.9%
Jainism	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Judaism	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%
Not Disclosed	**25.0%**	4.3%	12.5%	0.0%	**23.5%**	**28.6%**	**25.0%**	18.0%
Sikhism	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
Other	**10.0%**	**13.0%**	**12.5%**	0.0%	**17.6%**	**10.7%**	**10.0%**	9.0%
Undefined	0.0%	4.3%	0.0%	0.0%	0.0%	0.0%	0.0%	11.3%

Breakdown of cases by sexual orientation

Sexual Orientation	Capability (UHR)	Capability (Non-UHR)	Harassment	Grievance	Disciplinary	Dismissal (All)	Dismissal (Sickness Only)	Workforce Representation
Bisexual	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**1.7%**
Gay or lesbian	**10.0%**	**8.7%**	0.0%	0.0%	2.9%	**10.7%**	**15.0%**	**4.6%**
Heterosexual	**85.0%**	**78.3%**	**93.8%**	**100.0%**	**73.5%**	**78.6%**	**85.0%**	**71.3%**
Not Disclosed	**5.0%**	**8.7%**	**6.3%**	0.0%	**23.5%**	**10.7%**	0.0%	**13.1%**
Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.1%**
Undefined	0.0%	**4.3%**	0.0%	0.0%	0.0%	0.0%	0.0%	**9.2%**
Undecided	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.1%**

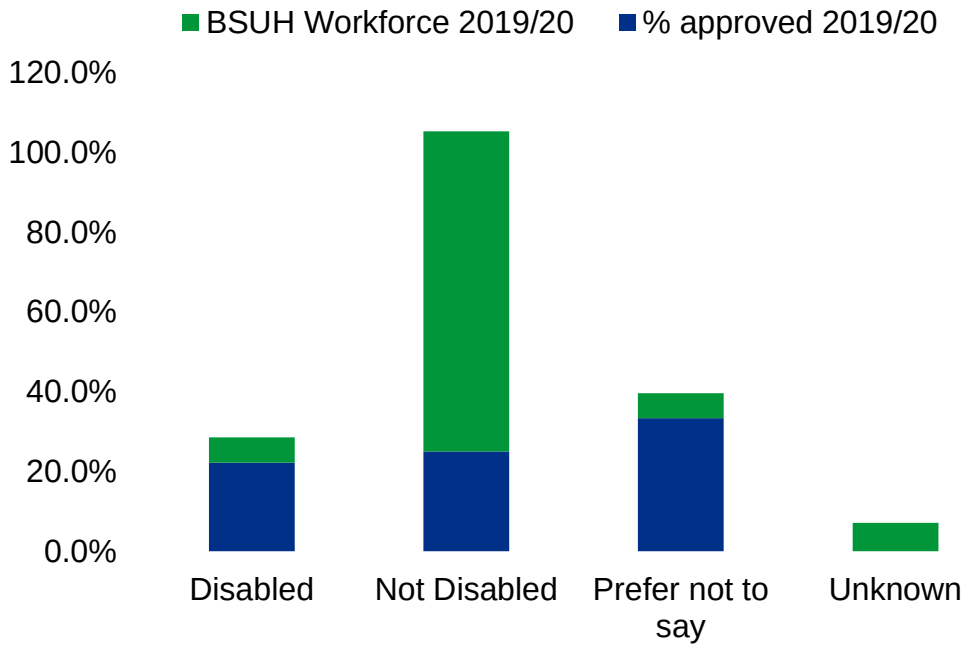
Training and development opportunities

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

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

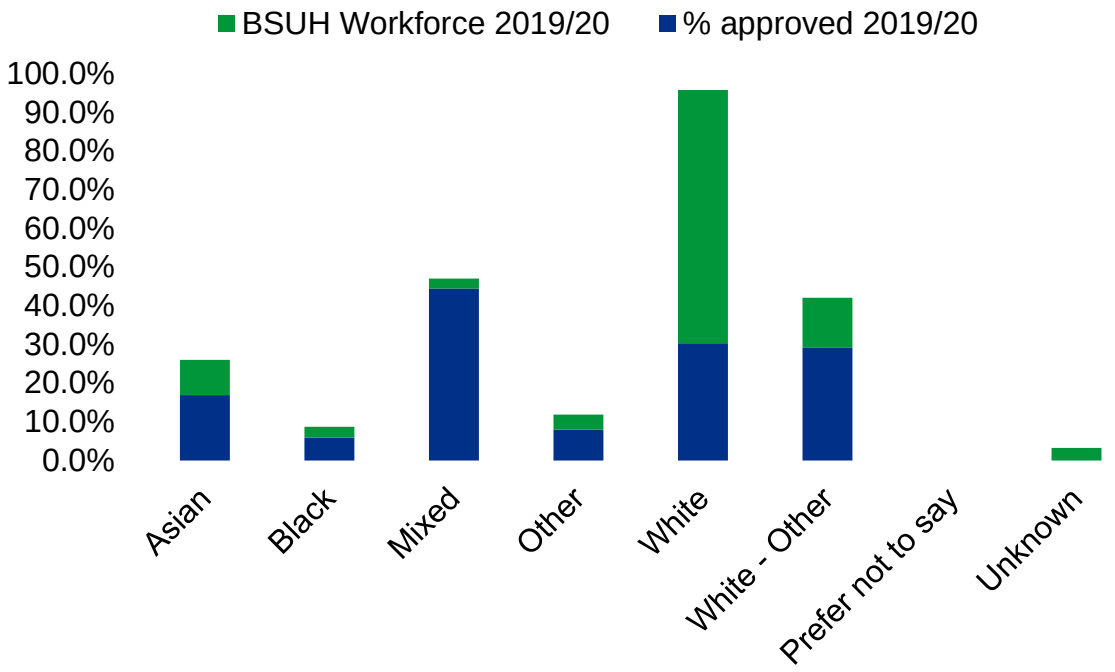
During 2019/19, 474 applications were received, and 325 were approved.

Disability



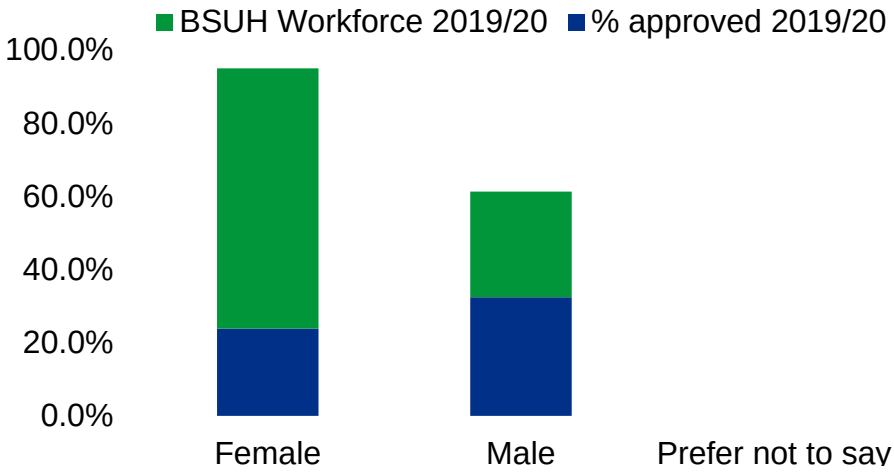
Disability	Number of applicants	Number of approved	% approved 2019/20	BSUH Workforce 2019/20
Disabled	18	4	22.2%	6.3%
Not Disabled	447	112	25.1%	80.3%
Prefer not to say	9	3	33.3%	6.3%
Unknown				7.1%

Ethnicity



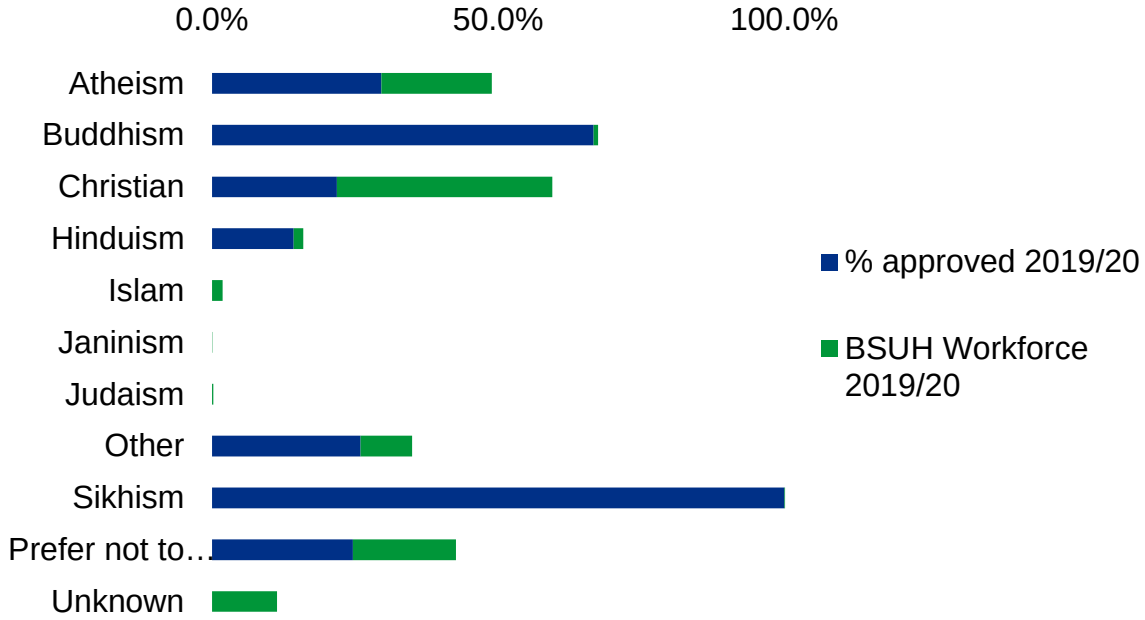
Ethnicity	Number of applicants	Number of approved	% approved 2019/20	BSUH Workforce 2019/20
Asian	65	11	16.9%	9.1%
Black	17	1	5.9%	2.9%
Mixed	9	4	44.4%	2.6%
Other	25	2	8.0%	3.9%
White	307	93	30.3%	65.5%
White - Other	41	12	29.3%	12.8%
Prefer not to say	10	202	-	
Unknown	0	200	-	3.3%

Gender



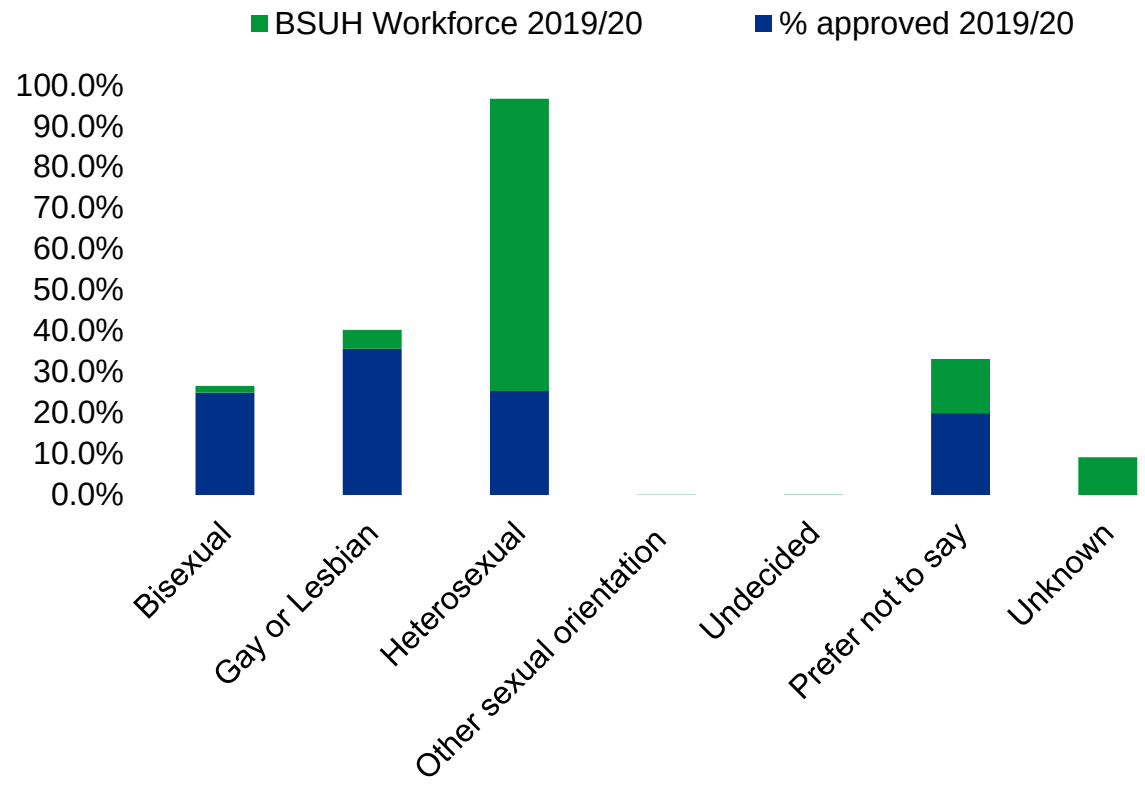
Gender	Number of applicants	Number of approved	% approved 2019/20	BSUH Workforce 2019/20
Female	402	96	23.9%	71.1%
Male	71	23	32.4%	28.9%
Prefer not to say	1	0	0%	

Religion or Belief



Religion or belief	Number of applicants	Number of approved	% approved 2019/20	BSUH Workforce 2019/20
Atheism	125	37	29.6%	19.3%
Buddhism	3	2	66.7%	0.8%
Christian	211	46	21.8%	37.6%
Hinduism	7	1	14.3%	1.6%
Islam	3	0	0.0%	1.9%
Jainism				0.0%
Judaism				0.2%
Other	54	14	25.9%	9.0%
Sikhism	2	2	100.0%	0.1%
Prefer not to say	69	17	24.6%	18.0%
Unknown				11.3%

Sexual Orientation



Sexual orientation	Number of applicants	Number of approved	% approved 2019/20	BSUH Workforce 2019/20
Bisexual	4	1	25.0%	1.7%
Gay or Lesbian	14	5	35.7%	4.6%
Heterosexual	406	103	25.4%	71.3%
Other sexual orientation				0.1%
Undecided				0.1%
Prefer not to say	50	10	20.0%	13.1%
Unknown	0	200		9.2%

What does the data tell us about our staff?

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

When the term 'expected' is used, it refers to the comparison of a dataset (e.g. pay bands, employee relations, etc.) to Trust workforce representation. E.g. 'lower than expected' would mean lower than Trust workforce representation for that group, the converse is true for higher than expected.

Age

Workforce representation (including pay bands) – the Trust's workforce representation does not follow the pattern of the Census data. Representation from ages 26-55 is relatively stable. From ages <20-25 representation increases, whilst 56 onwards representation decreases.

Within Agenda for Change (AfC) bands 1-4, there is a high representation of staff under 20 and 51-71, in AfC bands 5-7, there is a high representation of staff aged 21-35 (bands 5-6) and 41-55 (bands 6-7), in bands 8a-9 there is a high representation of 36-60. Medical trainees have the highest representation of staff aged 21-40, and middle and consultant grade have a high representation of staff aged 36-70.

Results from the staff survey – staff aged 16-30 are most likely to experience abuse, bullying or harassment from patients, service users and visitors, however, those aged 66+ are least likely to experience this.

Staff aged 51+ are most likely to experience abuse, bullying or harassment from their manager, those aged 16-30 are least likely to experience this.

Staff aged 41-65 are most likely to experience abuse, bullying or harassment from other colleagues, those aged 66+ are least likely to experience this.

Staff aged 66+ are most likely to report incidents of abuse, bullying or harassment.

Staff aged 16-30 are most likely to experience discrimination from patients, service users and visitors, those aged 51+ are least likely to experience this.

Staff aged 16-20 are most likely to experience discrimination from staff, those aged 66+ are least likely to experience this.

Staff in age groups 16-20 and 51-65 are most likely to have experienced discrimination because of their age.

Leavers – there is a higher than expected number of staff aged 16-30 and 56+ leaving the organisation during 2019/20.

Recruitment – General recruitment – the pattern of candidates in the recruitment processes appear to better correlate with the workforce representation than Census data. When looking at the candidate's age profile, those aged 25-34 have a higher representation than expected; most other age groups appear to have a lower representation. When comparing from shortlisting to appointment stages it would appear candidates aged 20-24, 30-34 and 60-64 seem to be disadvantaged by the process. Conversely, those aged 35-44 seem to benefit from the recruitment process.

Medical recruitment - the pattern of those in the 2019/20 recruitment processes, do not appear to correlate with either the workforce representation or the Census data. Generally, candidates aged 25-39 and 45+ appear to be well represented in the Trust's recruitment processes. It appears that when moving from the application to shortlisting stages, those aged 65+ appear to be disadvantaged by the recruitment process. When moving from shortlisting to appointment stage those aged <20-24 and 60+ appear to be disadvantaged. However those aged 35-54 and 65+ appear to benefit from the recruitment processes, while 20-29 and 55-59 appear to be disadvantaged.

Employee relations data

- Capability (underlying health reasons) – staff aged 21-30, 51-60, 66-70 are overrepresented in this process.
- Capability (non-UHR) – staff aged 21-30, 51-55 and 61-65 are overrepresented in these processes.
- Harassment – staff aged 51-70 are overrepresented in this process.
- Grievances – staff aged 46-50 are overrepresented in this process.
- Disciplinary – staff aged 16-25, 31-40, 51-60 and 61-70 are overrepresented in this process.
- Dismissals - staff aged 21-30 and 51-70 are overrepresented in this process. When specifically looking at dismissals relating to sickness, staff aged 21-30, 51-60 and 66-70 are overrepresented in this process.

Disability

Workforce representation (including pay bands) – because of the way disability is recorded on the Census (i.e. day-to-day activities limited a lot or little); it is not

possible to draw an accurate comparison against the Trust's workforce data – this applies to all comparative data. However, when we single out the category 'day-to-day activity limited a lot' from the Census data, the workforce data closely follows the pattern highlighted in the Census data.

Disabled staff have a lower than expected representation in all medical grades. Disabled staff have a good representation in most Agenda for Change bands; however, this group has a fair representation in bands 5-7 and 8d and no representation at director level. However, there is a high proportion of staff at director level and all medical grades that have declined to declare their disability status.

Results from the staff survey – disabled staff when compared to non-disabled staff are 1.15 times more likely to experience abuse, bullying or harassment from patients, 2.5 times more likes to experience abuse, bullying or harassment from their manager, 1.6 times more likely to experience abuse, bullying or harassment from other colleagues. Disabled staff are only slightly less likely than non-disabled staff to report incidents of abuse, bullying or harassment.

Disabled staff, when compared to non-disabled staff are 1.2 times more likely to experience discrimination from patients, nearly twice as likely to have experienced discrimination from staff. Nearly a quarter of disabled staff that experienced discrimination attributed it to their disabled.

Leavers – overall there is a higher than expected rate of disabled staff that have left the organisation during 2019-20.

Recruitment – General recruitment – The representation of disabled candidates at application and shortlisting stages are a little lower than both workforce representation and Census data. However, at appointment stages, the representation of disabled candidates is generally in line with both workforce representation and Census data. When comparing from shortlisting to appointment stages, disabled candidates appear to benefit from the recruitment processes. The Trust also operates a guaranteed interview scheme, and a proportionate number of disabled candidates progress from application to shortlisting stages.

Medical recruitment – disabled candidates are underrepresented in recruitment processes when comparing to workforce representation and Census data. It would appear that disabled candidates appear to be disadvantaged when progressing from application to shortlisting stages. However, from shortlisting to appointment stages, disabled candidates appear to benefit.

Employee relations data – disabled staff, are overrepresented in nearly all employee relations processes, excluding grievances.

Access to training – *a higher proportion of disabled staff compared to the representation of disabled staff in the workforce have been accepted for non-mandatory or CPD training.*

Ethnicity

Workforce representation (including pay bands) – for all minority ethnic groups there is a greater representation in the Trust's workforce than the Census data. As a result, there is a lower representation of white employees in the Trust's workforce than the Census data. It should be noted that the pattern of representation is generally in line with national NHS workforce data.

Staff in minority groups are generally well represented in medical grades. The majority of the minority groups have poor representation in senior management bands.

Asian staff have a lower than expected representation in most Agenda for Change (AfC) band except bands 2 and 5, as well as directors (non-executive).

Black staff have a fair representation across all AfC bands. However, they have a higher than expected representation in AfC bands 1, 5, 8d and 9.

Mixed ethnicity staff have a fair representation from AfC bands 1-8a and 8d; there is a higher than expected representation in bands 1, 2 and 8d.

Staff classified as an 'other' ethnicity have a higher than expected representation in bands 1, 2, 5 and 6 and a fair to low representation in bands 3, 4, 7 and 8a – there is no representation past band 8a.

Staff in the White-Other ethnicity, have a good representation across most AfC bands; however, there is a higher representation than expected in bands 1, 2 and 5.

White staff have a fair to good representation across all AfC bands but have a lower representation in medical grades.

A proportion of directors (non-executive) level have elected to share their ethnicity on their Electronic Staff Record.

Results from the staff survey – BME staff are 1.2 times more likely (when compared to white staff) to experience abuse, bullying or harassment from patients, service users and visitors, 1.1 times more likely to experience abuse, bullying or harassment from their manager and 1.1 times more likely to experience abuse, bullying or harassment from other colleagues. BME staff are 1.2 times more likely to report incidents of abuse, bullying or harassment than white staff.

BME staff are 3.2 times more likely (when compared to white staff) to experience discrimination from patients, nearly twice more likely to experience discrimination from staff. Nearly 88% of BME staff that experience discrimination attributed it to their ethnicity.

Leavers – all minority groups that left during 2019/20 is lower than expected, white staff that left during this period is slightly higher than expected.

Recruitment – General recruitment – all minority groups have a good representation when comparing to the Census data, however, white and 'other' ethnicity groups have a lower than expected representation at some stages when comparing to workforce representation data. Generally, candidates from ethnic minority groups have a high or equal representation to workforce representation. White candidates when comparing from application to shortlisting stages. Asian, Black and Mixed ethnicities appear to be disadvantaged while white and white-other groups appear to benefit. When comparing from shortlisting to appointment stages, black and mixed candidates appear to be disadvantaged and white, and 'other' ethnicity groups appear to benefit.

Medical recruitment – when comparing the application and shortlisting, there is a high representation of minority groups; however, white and white-other groups are underrepresented in all stages when looking at workforce representation and Census data. However, at appointment stages (comparing to both workforce representation and Census data) there appears to be a lower than an expected representation of most minority groups, except Asian and 'other' (Census data, only) ethnicity groups. When comparing application to shortlisting stages, back and mixed candidates appear to benefit, but white candidates appear to be disadvantaged. When comparing shortlisting to appointment stages, most minority groups except white-other appear to be disadvantaged by the recruitment processes, whilst white candidates appear to benefit.

Employee relations data

- Asian staff are overrepresented in Capability (underlying health reasons) processes.
- Black staff are overrepresented in Capability (non-UHR), harassment, grievance and dismissal processes.
- Mixed ethnicity staff are overrepresented in Capability (UHR), disciplinary and dismissal process.
- 'Other' ethnic group staff are overrepresentation in almost all (except harassment) processes.
- White staff are overrepresented in Capability (non-UHR) and harassment processes.
- White-Other staff are overrepresented in Capability (UHR) and grievance procedures.

Access to training – all minority groups are accepted for non-mandatory or CPD training in a greater proportion than the workforce representation, white staff have a disproportionately low acceptance rate for training. It should be noted that a high proportion of staff that undertook this type of training ethnicity is unknown.

Gender

Workforce representation (including pay bands) - the Trust's workforce does not follow the pattern in the Census data, i.e. a greater proportion of women to men. However, this is in line with national NHS workforce data.

Staff that identify as female have a higher representation than expected in Agenda for Change (AfC) bands 3-7. All other AfC bans there are lower representations than expected, especially from bands 8b onward. There are more female directors (non-executive) than male, and staff that identify as female have a lower than expected in medical grades. The opposite is true for staff that identify as male, have a higher representation than expected in bands 1, 2, 8a-9, directors and all medical grades.

Results from the Staff Survey – staff that identify as female compared to men are 1.3 times more likely to experience abuse, bullying or harassment from patients, service users and visitors and 1.2 times more likely than staff that prefer to self-describe their gender. Staff that identify as male are 1.3 times more likely than females and 1.6 times more likely than staff that prefer to self-describe their gender to experience abuse, bullying or harassment from their manager. Staff that identify as female are 1.1 times more than male and 1.4 times more than staff that prefer to self-describe their gender to experience abuse, bullying or harassment from colleagues. Staff who prefer to self-describe their gender are 1.1 times more likely than female staff and 1.2 times more likely than male staff to report incidents of abuse, bullying or harassment.

Staff that identify as male are 1.1 times more likely than female staff and 1.2 times more likely than staff that prefer to self-describe their gender to experience discrimination from patients. Staff that prefer to self-describe their gender are 1.2 times more likely than male and female staff to experience discrimination from staff. Over 25% of staff that identify as female that experienced discrimination attributed it to their gender.

Leavers There was a higher than expected amount of staff that identified as female who left the Trust during 2019/20; the opposite is true for staff that identified as male.

Recruitment – General recruitment – when comparing against Census data, the shortlisting stage would generally align, whilst comparing to workforce representation data the appointment stage aligns. When comparing the application to shortlisting stages, female candidates appear to be disadvantaged, whilst male candidates

appear to benefit. The pattern reverses when comparing shortlisting to appointment stages.

Medical recruitment – when looking at workforce representation and Census data, both male and female candidates do not correlate. Both male and female candidates broadly move from application to shortlisting stages proportionally. Whilst in shortlisting to appointment stages, female candidates appear to benefit, while male candidates appear to be disadvantaged.

Employee relations data

- Staff that identify as female are overrepresented in Capability (underlying health reasons), harassment and dismissal processes.
- Staff that identify as make are overrepresented in capability (non-UHR), grievance and disciplinary processes.

Access to training – staff that identify as female have a disproportionately low acceptance rate for non-mandatory or CPD training. This is opposite for staff that identify as male.

Gender Identity

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

Recruitment – General recruitment – There is no Census or workforce representation data to compare to. It would appear that Trans candidates have not progressed passed application stage. However, given that nearly 99.4% of applicants did not complete their Gender Identity information, it is not possible to draw and accurate picture for this group.

Medical recruitment – no candidates completed their Gender Identity information, so it is not possible to draw any conclusion about the fairness of the recruitment processes.

Marriage and Civil Partnership

Workforce representation (including pay bands) – There are more staff in a civil partnership in the Trust's workforce compared to the Census data. However, there are slightly less married staff in the Trust's workforce compared to the Census data.

Staff in civil partnerships have a higher than expected representation in Agenda for Change bands 1-8a, 8d and medical consultants. In all other bands and medical grades, staff in civil partnerships have a lower than expected representation.

Staff that are married have a higher representation than expected in bands 7-8d, directors and medical middle and consultant grades. All other bands and medical grades, staff that are married have a lower than expected representation.

Recruitment – General recruitment – when comparing against Census data except for shortlisting stage (lower than expected representation), married candidates correlate. Whilst candidates in a civil partnership have a higher than expected representation in all stages. When comparing against the workforce representation data, married candidates are underrepresented in recruitment processes, whilst candidates in civil partnerships are overrepresented in application and shortlisting stages, but in line at appointment stag. Married applicants appear to be disadvantaged moving from application to shortlisting stages; candidates in a civil partnership are at about an equal level. While in shortlisting to appointment stages, married candidates appear to benefit, whilst candidate in a civil partnership appear to be disadvantaged.

Medical recruitment – generally, married candidates are broadly represented in line with workforce representation, but overrepresented when comparing to the Census data. Candidates in a civil partnership representation are much lower than workforce representation and Census data. Married candidates appear to be slightly disadvantaged when moving from shortlisting to appointment stages, while candidates appear to be disadvantaged by all stages of recruitment.

Employee relations data

- Staff in a civil partnership are overrepresented in grievance and disciplinary procedures.
- Married staff are overrepresented in harassment and disciplinary procedures.

Pregnancy and Maternity

Workforce representation (including pay bands) – due to limitations within Electronic Staff Records, there is no way to accurately extract data about the staff

that are either pregnant or on maternity leave. However, during the reporting period, 500 staff was on maternity leave.

Religion or Belief

Workforce representation (including pay bands) – for most of the minority of religion or belief groups, the Trust's workforce is roughly in line with the pattern in the Census data; the only exception to this is for staff that are Sikhs or 'other religion' where there is a higher proportion in the Trust's workforce. However, there are fewer atheists and Christians in the Trust's workforce than compared to the Census data. It should be noted that a high proportion of Trust staff (18%) opted not to share their religion or belief on their Electronic Staff Record.

Atheists – have a high representation in Agenda for Change (AfC) bands 5-8d, directors and medical trainees.

- Buddhists – have a fair to good representation in bands 1-3, 5, 7, 8c and medical trainees and consultants.
- Christians – have a mainly good representation in all AfC bands and a lower than expected representation in medical grades.
- Hindus – have a good representation in bands 1, 2, 5, 8a-b and medical trainee and consultant posts.
- Muslims – have a higher than expected representation in AfC bands 1, 2 and al medical grades.
- Jains – have a good representation in AfC band 5 and all medical-grade, however no other representation across any other band or medical grade.
- Jewish staff – have a good representation in AfC bands 1, 2 and medical trainees and consultant posts. Jewish staff also have a fair representation in 5-7, however no other representation across any other band or medical grade.
- Other religion or belief – have a fair to good representation in most AfC bands (1-8d), but fairly low representation in medical grades.
- Sikhs – have a good representation in AfC bands 2, 3, 6, 8a and medical trainee and consultants.

It is worth noting that in medical grades and director level (non-executive) there is a high proportion of staff that have elected not to declare their religion or belief status on their Electronic Staff Record.

Results from the Staff Survey.- Buddhists and those from 'other' religions are most likely to experience abuse, bullying or harassment from patients, Jewish staff are least likely to experience this. Jewish staff are most likely to experience abuse, bullying or harassment from their manager, Buddhist staff are least likely to experience this. Buddhist, Jewish and staff from 'other' religions are most likely to

experience abuse, bullying or harassment from other colleagues; Muslim staff are least likely to experience this. Hindu and Jewish staff are most likely to report incidents of abuse, bullying or harassment, Buddhist and Muslim staff are the least likely to report such incidents.

Staff that are either Buddhist or from 'other' religion are most likely to experience discrimination from patients, whilst Jewish staff are least likely to experience this. Muslim, Jewish and staff from 'other' religions are most likely to experience discrimination from staff; those without a religion are least likely to experience this. Over 20% of Muslim staff that experienced discrimination cited their religion or beliefs as the cause.

Leavers – only atheist and Christian staff left the Trust at a higher rate than expected, all other groups either left in line or below the expected rate during 2019/20.

Recruitment – General recruitment – when comparing to the Census data most groups demonstrate a higher than expected representation (except Christians, Sikhs and Atheists – to a small degree). When comparing against workforce representation, broadly, most groups have a higher than expected representation in recruitment processes (Sikh candidates is about level). When reviewing progression from appointment to shortlisting stages, Atheist and Jewish candidates appear to benefit, whilst most other groups experience a disadvantage. When looking at the progression from shortlisting to appointment stages, Buddhist, Hindu and Muslim candidates appear to suffer a disadvantage whilst Jewish and Sikh candidates appear to benefit.

Medical recruitment – Overall, the representation in recruitment does not correlate with either Census or workforce representation data. When comparing progress through application to shortlisting stages, Atheists, Buddhist Jewish and Sikh candidates appear to experience a disadvantage. When comparing from shortlisting to appointment stages, the majority of groups experience some degree of disadvantage – except Atheist and 'other' religion or belief groups, appear to benefit from the recruitment processes.

Employee relations data

- Buddhist, Jain, Jewish and Sikh staff are not overrepresented in any employee relations processes.
- Atheist staff are overrepresented in capability and dismissal (sickness) procedures.
- Christian staff are overrepresented in almost all (except dismissal) procedures.
- Hindu staff are overrepresented in capability (underlying health reasons), disciplinary and dismissals procedures.
- Muslim staff are overrepresented in disciplinary processes.

- Staff in ‘other’ religion or belief groups are overrepresented in almost all (except grievance) procedures.

Access to training – Most groups approved at a higher rate than their workforce representation, except for Christian staff (lower) and Muslim staff where no applications were approved.

Sexual Orientation

Workforce representation (including pay bands) - there is no Census data to compare the Trust’s workforce representation data to. However, in the Trust’s workforce, the representation is greater than national NHS data and estimates of lesbian, bisexual and gay people in the UK from the Office for National Statistics. It is worth noting that a high proportion of staff have opted not to share their sexual orientation on their Electronic Staff Record.

Bisexual staff have a fair to good representation in Agenda for Change (AfC) Bands 1-6 and medical middle grade. However, staff that are bisexual have a lower than expected representation in AfC bands 7, 8a and medical trainee and consultant posts.

Gay men and women have overall a good representation across most AfC bands, and there is particularly good representation in senior manager grades (excluding directors level). In medical grades, there is good representation in consultant level, but lower than expected representation in middle and trainee levels.

Heterosexual staff have a good representation in AfC bands 1-8a and 8c, but slightly lower than expected in 8b, 9d and 9. In medical grades, there is fair representation for trainees and relatively low representation in middle and consultant grades.

Staff with ‘other’ sexual orientation are only represented in AfC bands 2,5 and 6; however, this group has a good representation in these bands.

Staff with an undecided sexual orientation are only represented in AfC bands 2-6; however, this group has a good representation in these bands.

Results from the Staff Survey – minority groups are more likely than heterosexual staff to experience abuse, bullying or harassment from patients. Lesbian, Gay and Bisexual staff are more likely than heterosexual staff to experience abuse, bullying or harassment from their managers. Bisexual, Gay and ‘other’ sexual orientations are most likely to experience abuse, bullying or harassment from other colleagues. Lesbian, Gay and Bisexual staff are least likely to report incidents of abuse, bullying or harassment.

Lesbian, Gay and Bisexual staff are most likely to experience discrimination from patients. Gay, Bisexual and staff from 'other' sexual orientations are most likely to experience discrimination from staff. A disproportionately high number of Lesbian and Gay staff attributes the discrimination they have experienced to their sexual orientation.

Leavers – broadly, all groups that have declared their sexual orientation are leaving in proportion to the workforce representation.

Recruitment – General recruitment – all minority groups have a higher than expected representation in recruitment processes when comparing against workforce representation data (there is no Census data to compare to). When looking at the progression from applicants to shortlisting stages, Lesbian, Gay, and Bisexual candidates benefit. When comparing progression from shortlisting to appointment stages, only Bisexual and undecided candidates appear to experience disadvantage.

Medical recruitment – when comparing against workforce representation data (no Census data to compare to), overall Lesbian, Gay and Bisexual (except at appointment) are underrepresented. From application to shortlisting stages, Lesbian, Gay, and Bisexual candidates appear to benefit, when comparing from shortlisting to appointment stages on Bisexual candidates appear to benefit from the recruitment processes.

Employee relations data

- Heterosexual staff are overrepresented in all employee relations procedures.
- Lesbian and Gay staff are overrepresented in capability and dismissal procedures.
- Bisexual, staff that are undecided and staff with 'other' sexual orientation are not overrepresented in any employee relation procedures.

Access to training – Lesbian, Gay and Bisexual staff are accepted at a higher rate for non-mandatory or CPD training than their workforce representation. Heterosexual staff are accepted at a much lower rate than their workforce representation.

Observations from the Corporate LGBTQ+ Lead

LGB+ Staff Employed

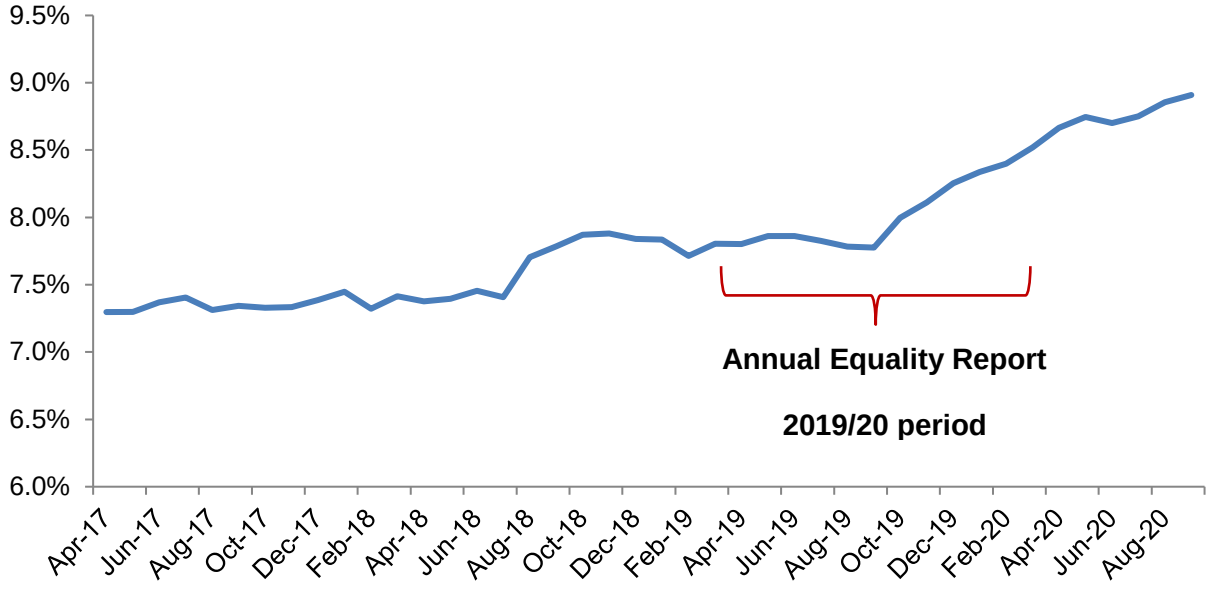
As at end March 2020, the Trust employed 8.5% Lesbian, Gay, Bi and Other/Undefined staff by Whole Time Equivalent, based on Electronic Staff Record (ESR) data. This figure is adjusted to reflect the increase in the proportion of staff willing to share their Protected Characteristics data and represents a significant increase in LGB+ staff from 7.8% in March 2019. (The proportion of staff who 'prefer

not to say' on Sexuality has fallen 17.0% in April 2018 to 13.7% in October 2020). The national NHS ESR does not currently record trans history (gender identity), and this figure, therefore, under-represents the Trust's LGBTQ+ workforce.

Among staff on the Agenda for Change pay scale at Band 8a and above (a proxy for the most senior staff, by pay band), the Trust employed 8.5% LGB+ staff in March 2019, rising to 9.9% in March 2020.

Analysis of longer-term ESR data since shows a broadly level % LGB+ staff from October 2012 to October 2016 (at c. 7.0%) but then a noticeable set of step increases to 8.9% in October 2020 (outside the reporting period for this report) following each Summer's Prides season. Analysis suggests a positive direct and cumulative effect from the Trust and LGBTQ+ Network's active participation in community events such as Pride, Trans Pride and Disability Pride, as well as direct recruitment campaigns.

BSUH % Lesbian, Gay, Bisexual, Other of defined & disclosed
Source: BSUH ESR (October 2020 extract)

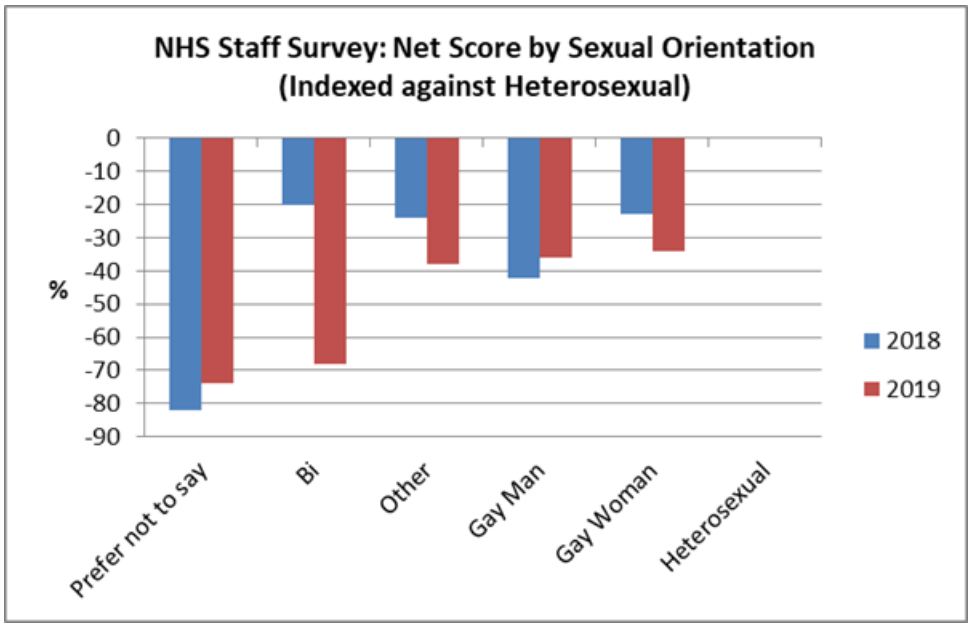


Working with NHS Digital to benchmark data identified that the Trust employs nearly three times as many LGB+ staff as the average for NHS Acute Trusts in England (2.5%) and for all NHS Trusts and CCGs (Clinical Commissioning Groups) in England (2.7%). This reflects both local demographics and the higher proportion of LGBTQ+ residents in Brighton & Hove in particular, but also the Trust's work to promote itself as an 'inclusion employer of choice'.

NHS Staff Survey 2018 and 2019

The increase in LGB+ staff (recognising that trans and non-binary identities are not currently recorded by the NHS ESR) and Stonewall WEI 2019 result and ranking represent positive progress towards the Trust's ambition for equality and inclusion. However, analysis of the 2018 and 2019 NHS Staff Survey by Sexuality show that the workplace experience of LGB+ staff continues to be poorer across almost all domains of the survey than heterosexual (straight) colleagues. This also reflects the national picture, in which LGB+ staff scores are on average poorer than for Heterosexual staff across 10 of the 11 domains.

While quantitative data will encompass a wide range of staff lived experiences, the results do identify the considerable distance still to go to ensure that all LGBTQ+ staff have at least as positive a workplace experience as Heterosexual and cisgender colleagues. The proposed merger with Western Sussex Hospitals NHS FT in April 2021 (outside this reporting period) presents a significant opportunity to integrate LGBTQ+ Staff Networks and refresh members' priorities.



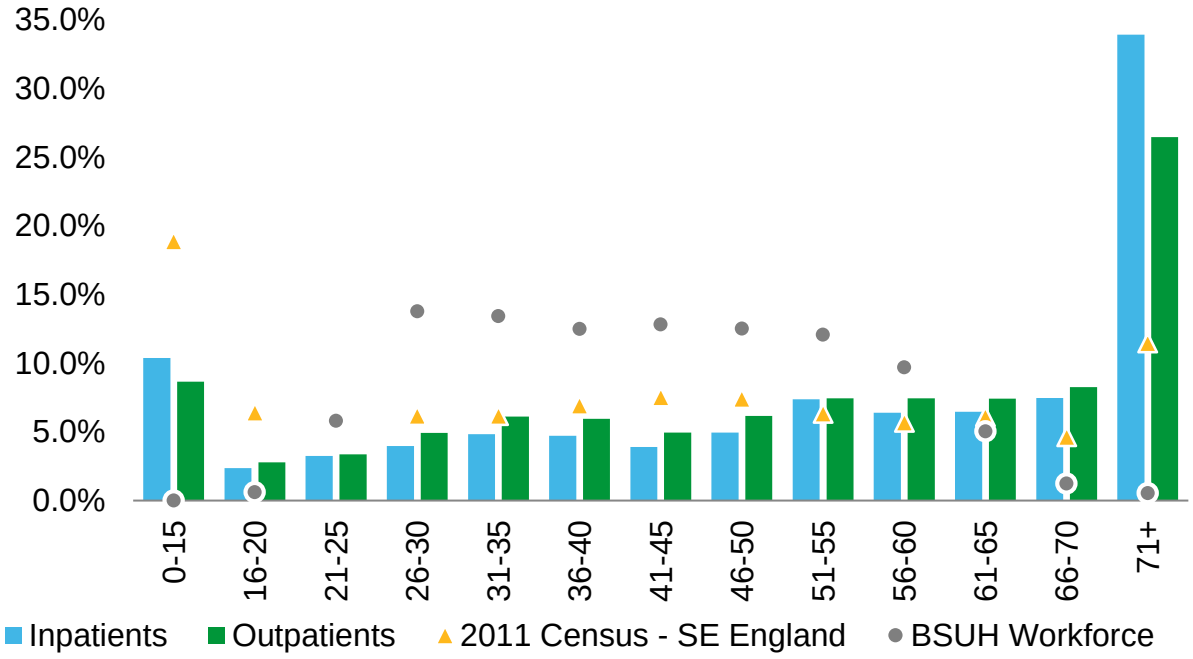
Who are the Trust's patients?

During 2019/20 the Trust saw over 750,000 patients attending its services, which included:

- 158,311 inpatient admissions
- 603,175 outpatient appointments

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

Age



	Inpatients	Outpatients	2011 Census - SE England	BSUH Workforce
0-15	10.4%	8.7%	18.90%	-
16-20	2.4%	2.8%	6.43%	0.6%
21-25	3.3%	3.4%	6.13%	5.8%
26-30	4.0%	4.9%	6.18%	13.8%
31-35	4.8%	6.1%	6.18%	13.4%
36-40	4.7%	6.0%	6.94%	12.5%
41-45	3.9%	5.0%	7.53%	12.8%
46-50	5.0%	6.2%	7.43%	12.5%
51-55	7.4%	7.4%	6.35%	12.1%
56-60	6.4%	7.4%	5.69%	9.7%
61-65	6.5%	7.4%	6.11%	5.0%
66-70	7.5%	8.3%	4.66%	1.2%
71+	33.9%	26.5%	11.47%	0.5%

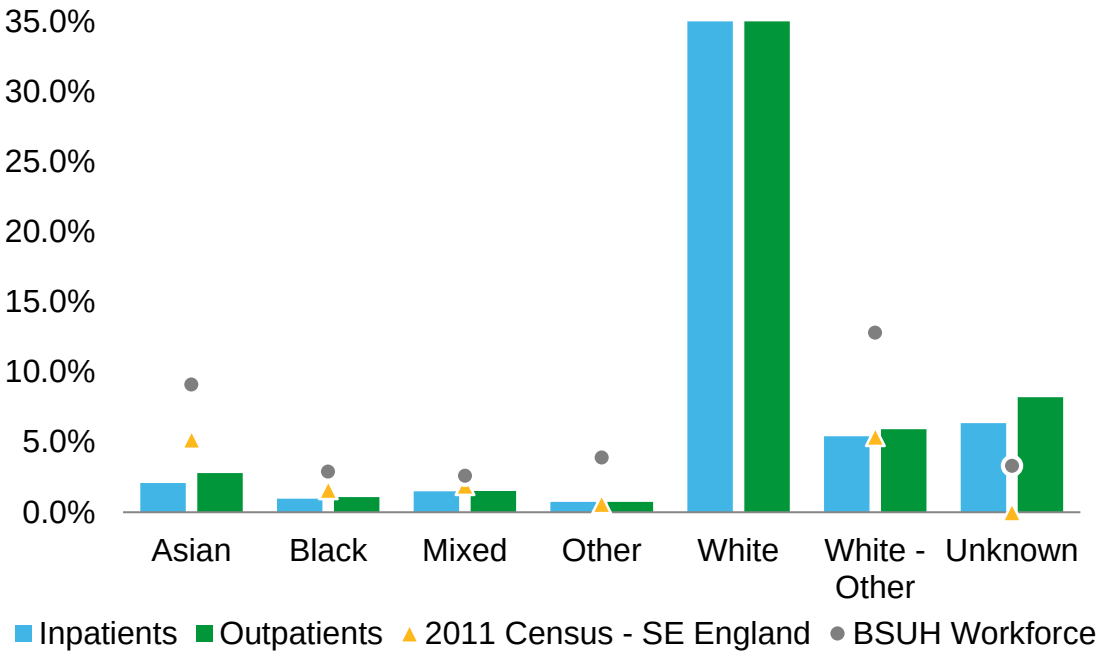
The census data acts as a good indicator for both inpatient and outpatient attendance. However, from age 56 onwards, there is a higher representation in attendances. This is to be expected given the likelihood of developing long term health conditions later in life and comorbidity.

Workforce – there is generally a greater rate of representation of staff than patients from 21-60; however, this dramatically decreases after 61 years of age.

Disability

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

Ethnic Background

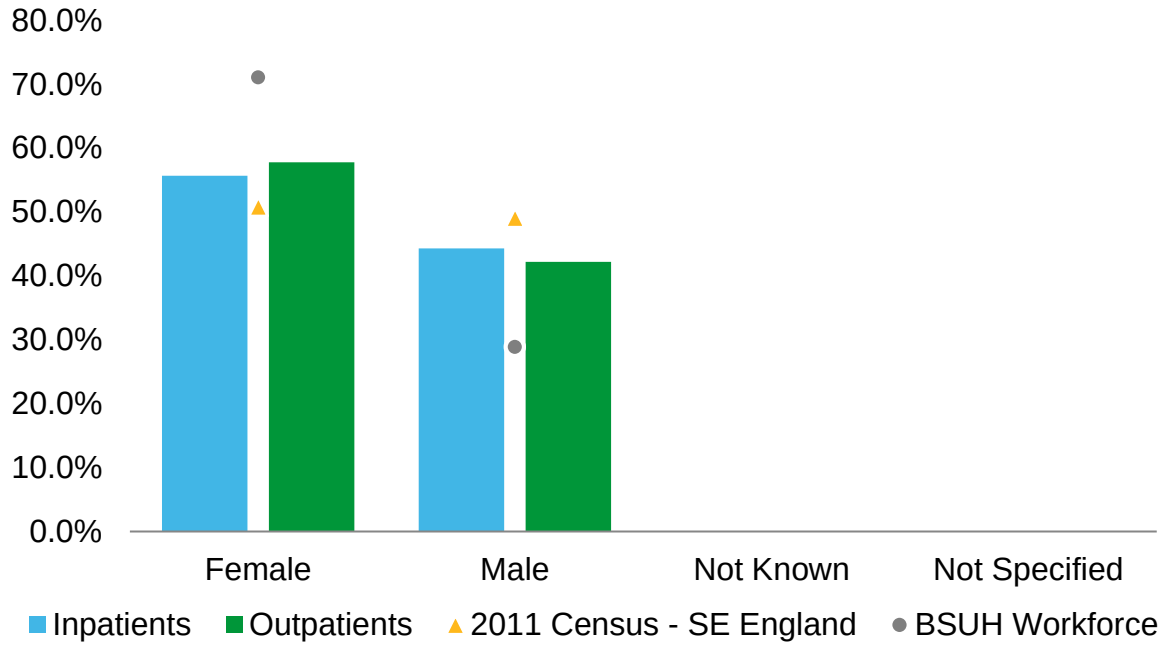


	Inpatients	Outpatients	2011 Census - SE England	BSUH Workforce
Asian	2.1%	2.8%	5.20%	9.1%
Black	1.0%	1.1%	1.60%	2.9%
Mixed	1.5%	1.5%	1.90%	2.6%
Other	0.7%	0.7%	0.60%	3.9%
White	82.9%	79.7%	85.20%	65.5%
White - Other	5.4%	5.9%	5.40%	12.8%
Unknown	6.4%	8.2%	0.00%	3.3%

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

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

Gender



	Inpatients	Outpatients	2011 Census - SE England	BSUH Workforce
Female	55.7%	57.8%	50.90%	71.1%
Male	44.3%	42.2%	49.10%	28.9%
Not Known		0.0%		
Not Specified	0.0%	0.0%		

Proportionally more women than men attend the Trust as patients and service users. Given a margin of 5-6%, it is roughly in line with the census data.

Workforce – there is a much higher proportion of female staff when compared to patients, the opposite is true about male staff, in relation to patients that are attending Trust hospital services.

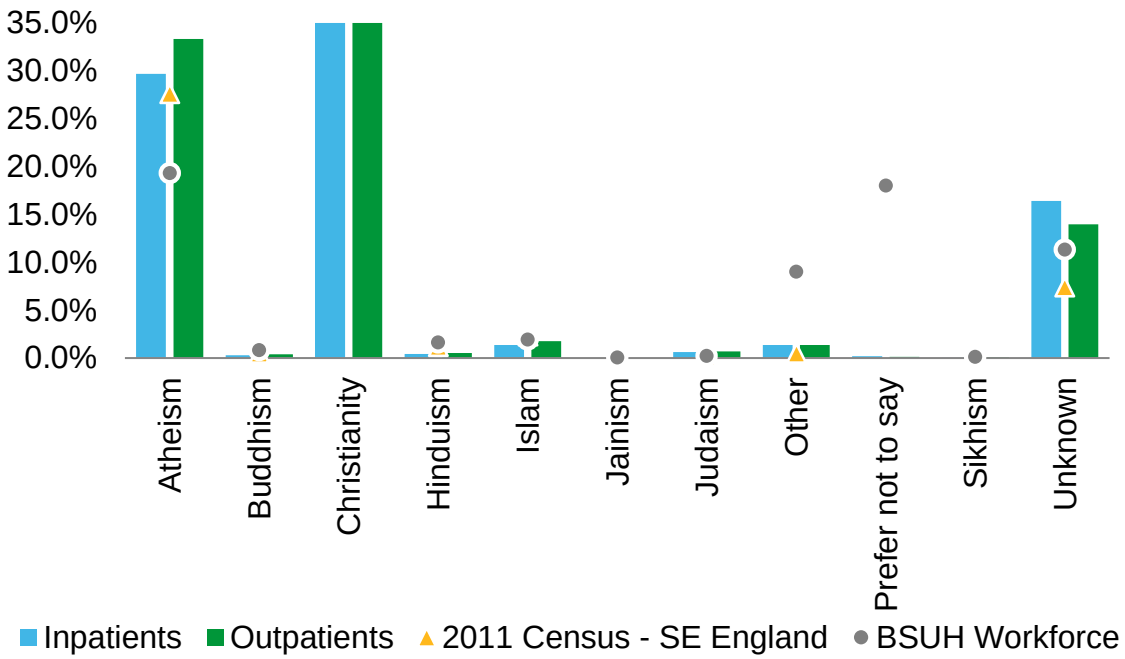
Marriage and Civil Partnership

	Inpatients	Outpatients	2011 Census - SE England	BSUH Workforce
Divorced/Dissolved Civil Partnership	5.8%	5.1%	6.5%	5.0%
Married/Civil Partner	40.1%	43.6%	49.8%	44.4%
Prefer not to say	2.7%	1.3%	-	1.6%
Separated	0.9%	0.8%	2.0%	1.1%
Single	35.3%	34.3%	34.4%	43.6%
Unknown	8.0%	10.3%	1.1%	3.6%
Widowed/Surviving Civil Partner	7.2%	4.6%	6.2%	0.7%

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

Workforce – in all categories (except divorced/dissolved civil partnership and widowed/surviving civil partner) there is a greater representation of staff compared to patients and service users. Married and Civil partner data for patients and data are similar.

Religion or Belief



	Inpatients	Outpatients	2011 Census - SE England	BSUH Workforce
Atheism	29.7%	33.3%	27.6%	19.3%
Buddhism	0.3%	0.4%	0.5%	0.8%
Christianity	49.6%	47.8%	59.7%	37.6%
Hinduism	0.4%	0.5%	1.2%	1.6%
Islam	1.4%	1.8%	2.3%	1.9%
Jainism				0.0%
Judaism	0.6%	0.7%	0.2%	0.2%
Other	1.4%	1.3%	0.5%	9.0%
Prefer not to say	0.2%	0.1%		18.0%
Sikhism	0.0%	0.1%	0.6%	0.1%
Unknown	16.4%	14.0%	7.4%	11.3%

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

Workforce – in relation to Buddhist, Hindu, Other and those who have selected 'prefer not to say' there is a greater representation of staff compared to patients and service users. For most other groups, there is a lower representation; however, in general data for Muslim and Sikh patients roughly correlates with the workforce data.

Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	17.	**Meeting:**	Board of Directors	**Meeting Date:**	2 Feb 2021
Report Title:	**Company Secretary Report**				
Sponsoring Executive Director:			Glen Palethorpe, Group Company Secretary		
Author(s):			Glen Palethorpe, Group Company Secretary		
Report previously considered by and date:					
Purpose of the report:					
Information			✓	Assurance	✓
Review and Discussion			☐	Approval / Agreement	☐
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality			☐	Staff confidentiality	☐
Patient confidentiality			☐	Other exceptional circumstances	☐
Link to Trust Strategic Themes:					
Patient Care			✓	Sustainability	✓
Our People			✓	Quality	✓
Systems and Partnerships			✓		
Any implications for:					
Quality					
Financial					
Workforce					
Link to CQC Domains:					
Safe			☐	Effective	☐
Caring			☐	Responsive	☐
Well-led			✓	Use of Resources	☐
Communication and Consultation:					

Executive Summary:

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

Learning from Deaths report Q3– Appendix 1

The Trust is required to receive reports on learning from deaths. The Board is reminded that the detail of this report is scrutinised by the Quality Assurance Committee especially in respect of the Trust's processes for learning from the review of deaths. The focus for learning is to improve the Trust's processes. The outcome of this learning manifests itself in the Trust's mortality indices; these are tracked within the routine report to the Board as part of the Integrated Performance Report.

Membership Recruitment

As part of the merger, work is being undertaken to promote that the enlarged Trust will be a Foundation Trust, and therefore there is an opportunity for members of the public to become members of the Trust. The Trust is specifically looking for members who live in Brighton and Hove, Mid and East Sussex linked to the area of our enlarged Trust.

There are an array of membership benefits, these include receiving information about the Trust, its plans and its achievements, engagement through periodic surveys on shaping services, the opportunity to stand for election to our Council of Governors and members also qualify for the NHS

discount scheme. We have also found that the public consider becoming members as a way to show their support for the NHS.

We have promoted our simple on line membership application form on our website, social media, through neighbouring FT newsletters (as you can be a member of more than one Foundation Trust), through the local friends of our hospitals and through the local chamber of commerce. We will be placing local newspaper adverts shortly to extend the message.

Becoming a member is simple and free and anyone over the age of 16 can join. Our on line application form can be found at https://secure.membra.co.uk/WesternSussexApplicationForm/.

Key Recommendation(s):

The Board is recommended to

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

NOTE the membership recruitment activity.

Appendix 1

Agenda Item:	17.	**Meeting:**	BSUH Trust Board	**Meeting Date:**	2 February 2021
Report Title:	Learning from Deaths Report Q3 (October, November, December) 2020/21				
Sponsoring Executive Director:	Rob Haigh - Medical Director				
Author(s):	Anne Middleton, Associate Director of Quality, Jane Carmody, Head of Patient Safety, Experience and Engagement				
Report previously considered by and date:					
Purpose of the report:					
Information	✓		Assurance	✓	
Review and Discussion	☐		Approval / Agreement	☐	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	☐		Staff confidentiality	☐	
Patient confidentiality	☐		Other exceptional circumstances	☐	
Link to Trust Strategic Themes:					
Patient Care	✓		Sustainability	☐	
Our People	☐		Quality	✓	
Systems and Partnerships	☐				
Any implications for:					
Quality	The Trust's True North Objective is for the mortality rates (HSMR) to be in the lowest 20% of Trusts.				
Financial					
Workforce	Human Resource Implications: There are training and protected time requirements for clinical staff undertaking SJR's.				
Link to CQC Domains:					
Safe	☐		Effective	☐	
Caring	☐		Responsive	☐	
Well-led	☐		Use of Resources	☐	
Communication and Consultation:					
Not applicable					
Executive Summary:					
This report is produced in line with National Guidance on Learning from Deaths, and provides the Trust Board with information relating to local implementation of the guidance; recent Structured Judgment Review activity; and the themes and learning that are emerging from this work.					
Key Recommendation(s):					
The Board is asked to NOTE the report.					

1. Purpose

1.1 Approximately 1600 deaths occur at BSUH every year. For many people death under NHS care is an inevitable outcome and they experience excellent care. However, some patients experience poor care resulting from a variety of factors. The purpose of a structured death review is to identify and learn from any problems that may have contributed to a death to prevent a recurrence.

1.2 This paper updates the board on the implementation of the Learning from Deaths Policy at BSUH. Data is included on rates of review, mortality statistics and outcomes of reviews of mortality statistic data alerts.

2. Background

2.1 The CQC report 'Learning, Candour and Accountability' published in December 2016 outlines the importance of mortality review as a source of learning and improvement. In March 2017, the National Quality Board published guidance for Trusts on mortality review processes and Learning from Deaths.

2.2 BSUH's Learning from Deaths Policy was ratified in 2017 and data has been collected quarterly since Q1 17/18 using the National Learning from Deaths Dashboard.

3. Governance

3.1. The BSUH Medical Director is the Board Lead with responsibility for delivering the Learning from Deaths Agenda.

3.2. The Medical Director chairs the Trust Mortality Review Group (TMRG) ensuring the committee appropriately discharges its functions, including the implementation of the Learning from Deaths Policy.

3.3. The TMRG reports to the Patient Safety Group (PSG) which escalates on an exception basis to the Quality Assurance Committee (QAC).

4. Process

4.1. Deaths requiring review are identified and triangulated via the Serious Incident Review Group (SIRG), Complaints Department, Medical Examiners (ME), Medico-legal Department, Learning Disabilities Team, or in response to risk adjusted mortality statistics.

4.2. The Trust's mortality review processes have been revised and an SJR electronic form within PANDA (the Trust's electronic patient information system) is now used for data collection and analysis. PANDA is also used to alert the Divisional Quality and Safety Managers (DQSM) to those cases requiring a Structured Judgment Review (SJR). The DQSM allocates each case to a trained reviewer (multidisciplinary) to complete an SJR and share the findings for learning. All consultants have access to submit and review SJRs on PANDA.

4.3. Any deaths identified as potentially resulting from failures in care are recorded on the DATIX patient safety incident reporting system and reviewed at SIRG where they are considered for Serious Incident (SI) investigation.

4.4. Deaths of all known patients with Learning Disabilities (LD) are referred to the Learning Disabilities Mortality Review (LeDeR) Programme for independent care pathway review but also undergo local SJR, to ensure timely scrutiny and learning.

5. SJR Training

5.1. The Palliative Care Team has produced a short training video on the IRIS system and the provision of bespoke training for staff teams is currently being explored.

6. Involving Families / Carers

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

6.2. The ME service has recently advertised two Medical Examiner Officer (MEO) posts, to support the ME process across both sites. Additional medical resource has also been provided to support the ME team during the current Covid surge.

7. Mortality Review Outcomes

7.1. Structured Judgement Review (SJR) Programme

The unreliability of usual benchmarked mortality analysis resulting from the Covid pandemic emphasises the importance of SJR (see also 8.2, 8.3)

7.2. The objective of the review method is to look for strengths and weaknesses in the care given, to provide information about what can be learnt about the hospital systems where care goes well, and to identify any issues in care.

7.3. In the 12 months to the end of December 2020 15 SJRs were undertaken; this equates to an SJR rate of 1%. Of these, 12 were completed in Q2 and Q3 following actions taken to improve SJR performance (e.g. the introduction of standardised specialty Mortality and Morbidity Meetings).

7.4. An additional four historical SJRs were undertaken during this timeframe as noted in the recommended best practice dashboard used to illustrate SJR activity.

7.5. **Table 1:** Showing the last two quarters SJR data for BSUH (LD refers to deaths of patients with learning disabilities).

	Q2 20/21	**Q3 20/21**	**Total**
*Total Inpatient Deaths	288	415	703
Total number of SJRs undertaken for adult inpatient deaths in Quarter	7	5	12
Following investigation adult inpatient deaths found to be more likely than not a result of problems in care	0	0	0
Known LD Deaths	0	0	0
Total known LD deaths in quarter reviewed using SJR	0	0	0
LD deaths more likely than not a result of problems in care	0	0	0
Total % of all deaths in Quarter SJR	**1.7%**	**1.2%**	**1.7%**

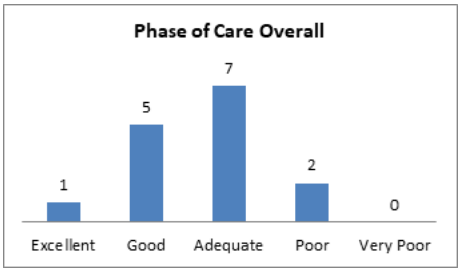
*including inpatient elective, non-elective and paediatric

7.6. The ‘assessment of problems in healthcare’ section of the SJR records quantitative data on the nature of the problem type and whether this resulted in harm to the patient. All adult deaths that have been recorded as ‘more likely than not a result of problems in care’ have been fully investigated in line with Trust Serious Incident policy. There were two serious incident investigations following adult patient death ongoing in Q3 2020/21.

7.7. **Table 2**: Serious Incident investigations commenced Q3 2020/21

Datix no	date reported and STEIS No	description	Division	Target completion date
211786	20/11/2020 2020/22155	Missed follow up of aortic aneurysm leading to a patient's death	Medicine	17/02/2021
212188	27/11/2020 2020/22740	COVID 19 Cluster Outbreak	Medicine	24/02/2021

7.8. **Figure 1** shows the overall assessment of the level of care received by patients in the last four quarters[1].



7.9. The LeDeR programme commenced in 2015 to support the review of deaths in people with learning difficulties and take forward lessons learned from the reviews, to make improvements to service provision. The LeDeR programme collates and shares anonymised information about the deaths of people with learning disabilities so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements.

7.10. Due to the second wave of the covid pandemic only two of 10 historical LeDeR cases requiring SJR have been completed to date. The Trust is committed to quickly completing SJRs for the outstanding eight cases.

7.11. The Trust has received the LeDeR review for one of the completed SJRs which found that *'care fell short of expected good practice and this significantly impacted on the person's wellbeing and/or had the potential to contribute to the cause of death'.* The findings mainly focused on limitations in community care. However, the report also outlined *'limited evidence of end of life care (EoLC) planning despite a long stay in hospital'.* The report did reference that the SJR had raised concerns in regard to the last episode of hospital care, including EoLC medication and the lack of medical review at this time. The Trust SJR considered that EoLC could have been improved.

7.12. The action plan addresses pain assessment and continuity of hospital follow up for people with a learning disability. The report will be presented at the EoLC Steering group to ensure joint learning between acute and community providers.

7.13. Trust Mortality Review Group

The TMRG resumed in January 2021 with representation including divisional Chiefs of Service, DQSMs, the central Quality and Safety team, Medico-legal Services, Medical Examiners, Palliative care, End of Life Care and RTT Performance teams. Clinical and nursing job planning is also being undertaken to ensure a multidisciplinary SJR programme and attendance at TMRG.

7.14. Serious Incident Review Group (SIRG)

The Terms of Reference of SIRG have been revised to widen the remit of the group to include the review all unexpected deaths reported in the Trust and to increase its frequency. SIRG is currently

[1] Q4 19/20, Q1, Q2, Q3 20/21

held twice weekly with a plan for this to be extended to three meetings a week once Covid pressures diminish.

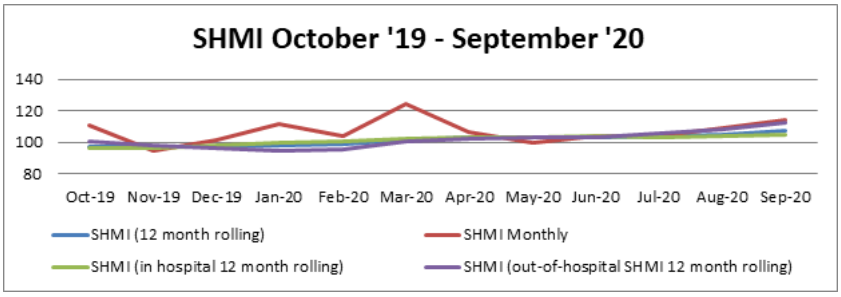
8. Summary Hospital-Level Mortality Indicator (SHMI)

8.1. To the end of September 2020, the 12 month rolling SHMI was 107.14 In-hospital SHMI was104.69 and out of hospital 112.59.

8.2. Current guidance from NHS Digital and HEDs (Healthcare Evaluation Data) is that standardised mortality tools including HSMR and SHMI should not be used to monitor Covid-19 mortality rates because they are not designed to model pandemic activity. Each rely on prolonged data collection to model the effects of case-mix on death.

8.3. Since February 2020, SHMI and HSMR have also been influenced by the significant changes in volume and case-mix of non-Covid patients admitted to hospital.

Figure 2: In-month SHMI October 2019 to September 2020 (latest available data - Covid deaths not included)



8.4. Figure 2 demonstrates that over the last 12 months, the rolling SHMI has increased slightly. However, this needs to be interpreted with caution due to the caveats above.

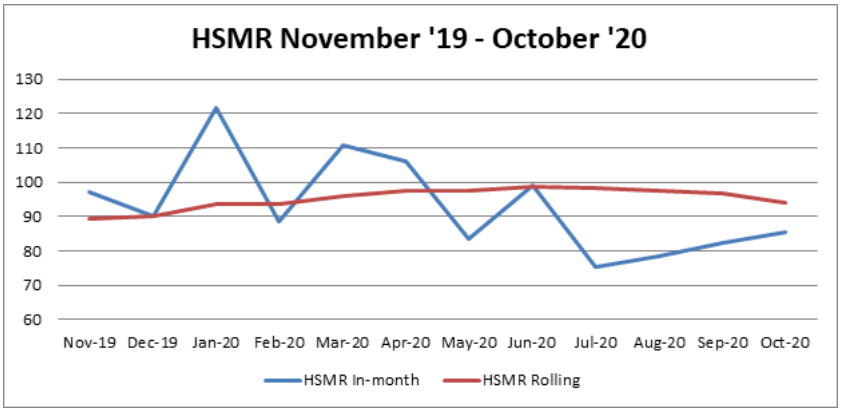
9. HSMR

9.1. HSMR is based on 56 diagnosis groups which normally contribute to 80% of in-hospital deaths in England. Covid-19 is automatically excluded from the analysis. The volume and case-mix of non-Covid patients admitted to hospital will also impact on the Trust's HSMR. Table 4 shows that the current in-month trend for the Trust's HSMR is downwards, whilst the rolling 12-month trend is upwards. This is accounted for by a higher seasonal HSMR recorded between September 2019 and March 2020. The most recent HSMR data is from October 2020 when the 12 month rolling HSMR was 94.08 (1075 observed deaths against an expected number of 1142).

9.2. **Table 4**: In-Month and 12 month rolling HSMR

Month of Discharge	HSMR In-month	HSMR Rolling
Nov-19	97.29	89.38
Dec-19	89.95	90.12
Jan-20	121.54	93.63
Feb-20	88.54	93.53
Mar-20	110.79	95.77
Apr-20	105.98	97.55
May-20	83.31	97.4
Jun-20	99.21	98.8
Jul-20	75.12	98.24
Aug-20	78.42	97.31
Sep-20	82.31	96.57
Oct-20	85.37	94.08

9.3. **Figure 3**: In-month and 12 month rolling HSMR November 2019 to October 2020



9.4. BSUH is currently ranked 28th out of 131 Trusts for HSMR.

9.5. A detailed report reviewing BSUH SHMI and HSMR data was presented at the December 2020 Quality Assurance Committee.

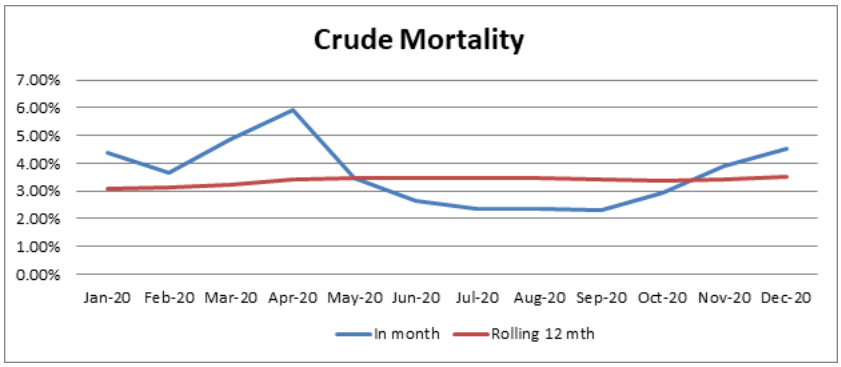
10. Crude Trust Mortality – Non-Elective

10.1. The crude mortality rate looks at the number of deaths of non-elective patients that occur in a hospital in any given month or year versus the number of people admitted for care in the same time period.

10.2. Table 5: Crude mortality data Q4 (19/20) Q1, Q2 and Q3 (20/21)

Month	Number of deaths	Total Discharges	Mortality Rate (In Month)	Mortality Rate (Rolling 12)
Jan-19	179	4097	4.37%	3.07%
Feb-19	131	3574	3.67%	3.12%
Mar-19	164	3364	4.88%	3.24%
Apr-20	149	2521	5.9%	3.43%
May-20	116	3334	3.5%	3.46%
Jun-20	95	3579	2.7%	3.49%
Jul-20	87	3705	2.3%	3.48%
Aug-20	93	3950	2.4%	3.46%
Sep-20	90	3929	2.3%	3.44%
Oct-20	116	3754	2.9%	3.38%
Nov-20	139	3579	3.88%	3.43%
Dec-20	151	3339	4.52%	3.52%

10.3. Figure 4: Trust in-month crude mortality rate for non-elective admissions.



10.4. In accordance with the requirements of National Guidance on Learning from Deaths, BSUH have published the specified data on deaths.

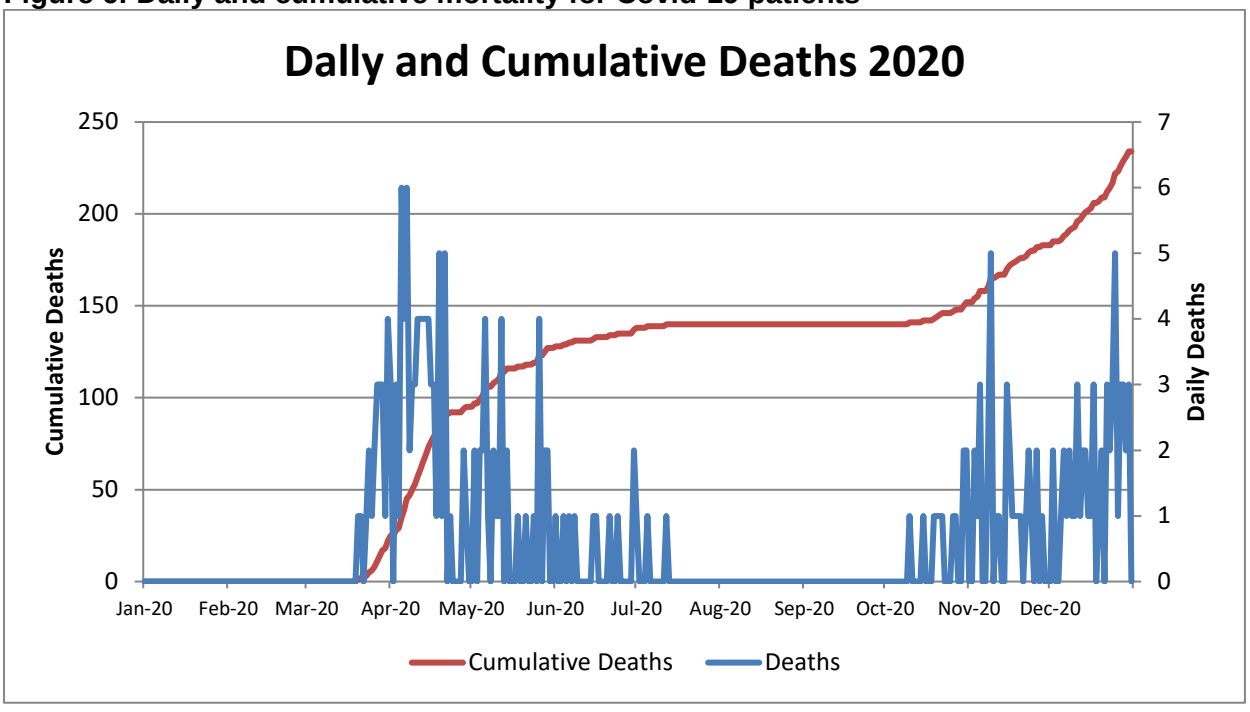
11. Covid Mortality – Wave 1 and Wave 2

11.1. The final section of this report contains a brief review of Covid mortality during the first wave and second waves of the Covid-19 pandemic, with the caveat that direct comparisons must be interpreted with caution because the second wave is ongoing and because significant numbers of patients admitted during wave 2 remain in hospital.

11.2 Figure 6 plots the daily and cumulative number of deaths for Covid-19 patients, illustrating that the first death occurred on the 19th March; the final death in wave 1 was on the 12th July. In total 140 patients died in the intervening 114 days. The steep red plot in Figure 6 highlights how rapidly the number of deaths rose during the first wave, 60% of these deaths (n=73) occurring within 31 days.

11.3 The first death in the second wave occurred on the 10th October with a further 24 patients dying in the subsequent 31 days. In total 94 patients have died in the second wav to date.

Figure 6: Daily and cumulative mortality for Covid-19 patients



11.2 Table 6 illustrates that the difference in mortality by gender has shifted between the first and second wave. In the first wave male patients accounted for 66% of the deaths, in wave 2 to date this figure has dropped to 58%. The average age in both waves is identical at 82.1 years.

11.3 Table 6: Proportion of male and female patients who died during the first and second Covid-19 wave

Gender	Female	Male
First Wave	33.6%	66.4%
Second Wave	42.6%	57.5%

Summary

- 1547 patients died in BSUH during 2020. Of these 234 (15%) died within 28 days of having a positive swab for Covid-19
- The annual number of deaths in 2020 was lower than the previous five years with 53 fewer deaths in 2020 compared to 2019
- The number of deaths in March and April were higher than predicted and the crude mortality rate was also high in these months
- Deaths in July and October were lower than predicted
- The proportion of male deaths as a result of Covid-19 is statistically significantly higher (63% overall)
- 65% of the Covid-19 deaths occurred in patients aged 80 or above, this compares to 55% of the non Covid-19 deaths
- In total 140 patients died in the first wave of Covid-19; 94 patients have died during wave 2 to date