Brighton and Sussex University Hospitals NHS Trust

Meeting of the Board of Directors

10:00 – 13:00 on Tuesday 29 September 2020

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 4 August 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.	10.25	**Introduction from Chief Executive** To receive and note overview of the Trust's activities	Enclosure	Marianne Griffiths
7.	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 11. To receive assurance from Committee and recommendations from the Committee		
8.	10.50	**Systems and Partnerships** To receive and agree any necessary actions	Enclosure	Jayne Black
9.	11.05	**Sustainability** To receive and agree any necessary actions	Enclosure	Karen Geoghegan
		After these two sections the Chair of Finance and Performance Committee will be invited to provide their report included at item 12. To receive assurance from Committee and recommendations from the Committee.		
10.	11.20	**Our People** To receive and agree any necessary actions	Enclosure	Denise Farmer

		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		
11.	-	**Report from Quality Assurance Committee** - **from the meetings on the 22 September*:*** To receive assurance from Committee and recommendations from the Committee	Enclosure	Mike Rymer
12.	-	**Report from Finance and Performance Chair** - **from the meetings on the 25 August & 22 September** To receive assurance from Committee and recommendations from the Committee	Enclosure	Lizzie Peers
13.	11.40	**Board Assurance Framework** To approve	Enclosure	Glen Palethorpe
		SERVICE PRESENTATIONS		
14.	11.50	**Annual Organ Donation** To receive assurance over application of patient first processes	Presentation	Alex Harrison
		QUALITY		
15.	12.05	**Annual Infection Prevention Control Report** To approve for publication on Trust website	Enclosure	Carolyn Morrice
		WELL LED & COMPLIANCE		
16. 16.1	12.35	**Company Secretary Report** To note **Charitable Funds Committee Terms of Reference** To approve	Enclosures	Glen Palethorpe
		OTHER		
17.	12.45	**Any Other Business** To receive and action		
18.	12.50	**Questions from the public** None Received	Verbal	Chair
19.	13.00	**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 1 December	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 4 August 2020 in via Microsoft Teams Live.

Present:	Alan McCarthy	Non- Executive Director (Chair)
	Mike Rymer	Non-Executive Director
	Lizzie Peers	Non-Executive Director
	Patrick Boyle	Non-Executive Director
	Joanna Crane	Non-Executive Director
	Jackie Cassell	Non-Executive Director
	Dame Marianne Griffiths	Chief Executive Officer (from Item 6)
	Pete Landstrom	Chief Delivery & Strategy Officer
	Jayne Black	Chief Operating Officer
	Carolyn Morrice	Chief Nurse
	Denise Farmer	Chief Workforce & Organisational Development Director
	Clare Stafford	Finance Director
	Rob Haigh	Medical Director
In attendance:	Glen Palethorpe	Group Company Secretary
	Tamsin James	Board and Committee Administrator
	Caroline Owens	Freedom to Speak Up Guardian (Item 17 only)

B/08/20/1 WELCOME AND APOLOGIES **Action**

1.1 The Chair welcomed those present to the meeting and apologised for the slightly later start than advertised due to technical issues.

1.2 Apologies of absence were received from George Findlay, Karen Geoghegan Kirstin Baker and Robert Cairney.

1.3 The Board was confirmed as quorate.

B/08/20/2 DECLARATIONS OF INTEREST

2.1 There were no declarations of interest.

B/08/20/3 MINUTES FROM THE PREVIOUS MEETING HELD ON 23 JANUARY 2020

3.1 The minutes of the meeting held on 23 January were included for information purposes only following their approval at private board in April 2020.

3.2 Carolyn Morrice commented that she had been noted as an apology at the 23 January meeting and asked for this to be rectified after confirming her attendance.

3.3 With that amendment noted the Board **RECONFIRMED** the minutes of the 23 January 2020 as a correct record.

B/08/20/4 MATTERS ARISING

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

B/08/20/5 INTEGRATED PERFORMANCE REPORT

5.1 Due to Marianne Griffiths experiencing technical difficulties and unable to join the meeting at this point, Pete Landstrom presented the Board with an introduction to the report, which provided the structure for the integrated performance report and provided information on the activity being undertaken by the Trust and how this links to the Trust's True North Objectives.

B/08/20/6 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 current Hospital Standardised Mortality Ratio (HSMR) for the Trust in the 12 months to March 2020 was 95.54, it was confirmed that BSUH remains ranked within the top 30% of Trusts for HSMR.

6.3 Rob asked the Board to note that to date the Trust's Covid-19 mortality rate was 166 patients, whilst three patients remain in hospital with Covid-19 and none in ICU. The Trust has had no further deaths or Covid-19 admissions in this period.

6.4 Carolyn Morrice, Chief Nurse, informed the Board that the rate of inpatient falls for the past 12 months is 3.73 falls per 1000 bed stay days; equating to 931 falls in the past year compared to 909 in the previous year. The National Falls rate is 6.62 falls per 1000 bed days. Whilst the Trust is below the national target, focus remains on reducing those further throughout 2020/21, which will continue to be monitored through the Quality Assurance Committee.

6.5 The pressure damage rate continues to be assessed and the focus remains on the breakthrough objectives in 2020/21.

6.6 The current data of Friends & Family recommended rates was not available given a pause in the recording of this data due to the Covid-19 pandemic. Carolyn asked the Board to note further data was available within the Annual Patient Experience Report, and that A&E recommended rates were above the national average despite recent pressures. The team continues to align the quality performance report with True North objectives and a further update would be provided later this year once the final drafts from both BSUH and WSHFT had been reviewed.

6.7 Carolyn asked the Board to note the infection prevention data and highlighted that the single case of MRSA in June 2020 was deemed unavoidable and was pleased to note that the patient had recovered well.

6.8 Carolyn raised awareness that two BSUH wards (Vallance and Bailey) were confirmed to have had a Covid-19 outbreak, whereby patients tested positive on or after day 15 of their admission, the patients had recovered well. It was confirmed there had been no further hospital acquired cases on either ward since 26 May 2020.

6.9 In relation to Adult Safeguarding, Carolyn asked the Board to note that there had been a slight increase in safeguarding alerts within the Trust due to vulnerable people within our society, whilst there has been no significant harm there is significant focus on complex community discharges which remains a breakthrough objective for 2020/21.

6.10 Regarding Children's Safeguarding there is a general anticipation of a potential

surge in September given the ending of school holidays and both BSUH and WSHFT are closely aligned in reviewing their preparedness for any upturn in activity.

6.11 Carolyn closed the report by highlighting that the Trust's CQC Action plan is progressing & continues to be monitored through the Safeguarding committee.

6.12 Alan McCarthy asked the Chair of the Quality Assurance Committee to present the update from the Committee. Mike Rymer confirmed the Quality Assurance Committee had met on the 23 June and 28 July 2020 and through its work it was able to assure the Board over the Trust's delivery of these objectives.

6.13 In June 2020, the Committee, under the revised Committee governance arrangements, focused on key quality matters, including Mortality, Serious Incidents, Patient delay reviews and Infection Prevention and Control.

6.14 In July 2020, the Committee, working towards its normal cycle of business, received reports covering quality performance, the patient experience annual report, the annual adults and children's safeguarding reports, an update from ITU, the Guardian of Safeworking Annual report and a report on the outcome and actions being taken in respect of a Invited Service Review into Neurosurgery. The Committee also received the Annual Workforce Race Equality Standard report and the Annual Workforce Disability Equality Standard report. The Committee also considered the risks within the BAF for which it has oversight for and agreed their current scores fairly represented these risks.

6.15 Mike confirmed that at the conclusion of the meeting the Committee was assured over the quality of care being provided to the Trust's patients.

6.16 Lizzie Peers questioned the FFT data surrounding the new ways of working particularly relating to virtual clinics and hard to reach groups, and the Trust's mechanisms for overseeing that services quality.

6.17 Carolyn answered Lizzie's question by highlighting the Trust's requirement to restore services in a different way and that the Trust recognised it can continually improve our services with the use of technology. In response to this a strategy is in progress to approach and shape this area and increase the Trust's level of communication to our patients on these options. This area will be managed through the Refresh, Recovery and Restore board and through reporting to Quality Assurance Committee will provide assurance on the quality of news ways of working.

6.18 Lizzie went on to raise a question relating to the adult safeguarding readmission themes vs the discharge themes. Carolyn stated that the triangulation of themes were not as joined up as they could be and assured the Board that the Quality Assurance Committee will oversee this as the Trust develops its integrated quality report.

6.19 Alan McCarthy stated the Trust was performing well against the range of quality metrics and had strong plans to continue to improve against a backdrop of significant Covid-19 pressures.

6.20 The Board **NOTED** the report.

B/08/20/7 SYSTEMS AND PARTNERSHIPS

7.1 Jayne Black 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 that the development of plans to restore performance were being monitored through the Trusts restoration plans.

A&E

7.2 Jayne informed the Board that the Trust achieved a performance of 92.4% for June, 10.5% higher than June 2019; but this was against a 21.6% drop in A&E attendances compared to last year and a 18% drop in non-elective admissions.

7.3 The Trust bed occupancy has decreased dramatically at both RSCH and PRH sites largely due to the Trust's continuance in following national guidance and creating a robust discharge model to create the necessary capacity to increase critical care capacity at the height of the pandemic but was also aided by the reductions in attendances and admissions into the hospital. .

RTT

7.4 The Trust's RTT Performance position in June was at 48% across all specialties, a decrease of 20.8% since June 2019.

7.5 In relation to 52-weak breaches the Trust was on track, prior to Covid, to reach zero breaches by the end of March 2020. However, Covid has had a material impact on this and has resulted in circa 1039 patients breaching the 52-week wait to date. The Trust has a prioritisation schedule in place for elective procedures through both the Trust pathways and the use of the independent sectors and this delivery continues to be monitored through the Refresh, Restore, and Recover Board.

7.6 Jayne confirmed that the Trust reviews 52-week breaches to ensure no patient physical harm is attributed to the delays, the outcomes of which are reported to the Quality Assurance Committee.

CANCER

7.7 The Trust was compliant with 6 of the 8 cancer metrics in June 2020. The Trust was non-compliant against the 62-day urgent referral to treatment at 84.6%, the Trust commenced treatment for 84 62 day patients in June 2020.

7.8 The backlog of patients diagnosed with cancer has increased sharply as a result of Covid-19. 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 being developed to restore services as much as is possible to pre-Covid levels. This service area remains a high priority for restoration.

DIAGNOSTICS

7.9 Jayne confirmed the Trust has robust PTL in place and has significantly improved the overall performance recovery to achieve target at the end of May 2020, whilst recognising challenges in particular within Endoscopy.

7.10 The Trust's performance for June 2020 was 52.3%, a 13% improvement on May's performance at 65.3% but continues to remain significantly challenged.

7.11 Lizzie Peers raised a question regarding how well the system has worked together, and what are the Trust's actions as Winter approaches. Jayne confirmed the pathways put in place throughout Covid will continue, and with the support of Sussex community and social care how these will deliver. Jayne commented that the developed discharge hub will also continue. Jayne stated that the winter plans are due to be approved in September 2020 and will

involve a high end objective to ensure patients pathways are used in an effective and efficient manner as we head in to Winter, which would also allow to the Trust to better prepare for a possible second wave of Covid-19.

7.12 Pete Landstrom echoed Jayne's response and stated that the Trust's preparation for Winter is to not only respond to the increase in demand but ensure that the Trust's Covid surge plans are executed robustly should we see a spike in cases throughout the period.

7.13 Pete announced that communication was received from the government on Friday 31 July, which focuses on recognised precautions all Trusts have to maintain; whilst clinics and theatres are more challenged than previously, the Trusts Refresh, Restore and Recover plans will oversee this.

7.14 Pete also highlighted the Trust's relationship with the Sussex Acute Collaborative network, which focuses on a Sussex wide demand & capacity model to focus on flow to become successfully embedded into the community pathways.

7.15 The Board **NOTED** the report.

B/08/20/8 SUSTAINABILITY

8.1 Clare Stafford reported to the Board the Trust's financial performance, whilst reminding the Board of the NSHEI announcement in March 2020 that operational planning for 2020/21 would be suspended and interim financial arrangements would be put in place for April – July 2020. The purpose of which was to simplify contracting and negotiations to allow focus on Covid readiness and response.

8.2 Clare stated that all Trusts are being provided with a guaranteed level of income from April to July 2020, in the form of block payments. All providers are able to claim additional costs to reflect incremental costs due to Covid-19.

8.3 In summary, Clare stated that the Trust is reporting a breakeven position at the end of June, in line with NHSEI supported financial framework.

8.4 The Trust has incurred £5.7m of incremental costs to date due to the impact of Covid, which was entirely expected due to bulk purchases of testing kits and increased nursing and medical staffing requirements.

8.5 Other income streams have reduced by £4.6m during the same period, the impact of which has been partially mitigated through underspend on operating expenditure, resulting from lower levels of activity.

8.6 To date, Capital expenditure is £23.4m broadly in line with expectations, it was noted that £730k of expenditure relates to Covid capital expenditure, which is a separate stream of income expected once approvals have been received from NSHEI.

8.7 Clare confirmed the Trust currently had a healthy cash position due to the advance receipt of the M4 block payments.

8.8 It was noted that the Trust's Covid expenditure, whilst broadly in line with all expectations, remains subject to significant scrutiny and challenge by Internal Audit, who will be supplying a report to be presented at the next Audit Committee.

8.10 Regarding the reforms to NHS Cash and Capital Regimes, Clare confirmed there is a new Public Dividend Capital (PDC) issued to repay over £13bn of NHS historic debt, effectively writing it off. This has resulted in positive arrangements for the Trust, ensuring a much healthier position.

8.11 In relation to Capital spending, Clare confirmed the government announced an additional £600m of capital to address high and significant risk critical infrastructure and estates backlog maintenance, of which £18.5m was allocated to the Sussex ICS. Clare announced that through the Trust's collaborative discussions with the Sussex ICS, the Trust was successful in negotiating a £6m allocation from that fund.

8.12 To finalise Clare asked the Board to note that confirmation had been received from NHSEI that the current financial arrangements would be extended to September 2020, and any changes from October 2020 would be shared via the Finance & Performance Committee who will continue to provide oversight to the Board.

8.13 The Chair asked Patrick Boyle, as Chair of the Finance & Performance Committee, to provide the Board with assurance from the two previous Committee meetings.

8.14 Patrick confirmed the Committee meetings on the 23 June, under the revised Committee governance arrangements, focused on key performance and financial matters, including the approval of the Trust's revised capital plan and the approval of a number of schemes from the Trust's capital programme.

8.15 The Finance and Performance Committee met on 28 July 2020, working towards its normal cycle of business received reports covering performance and financial matters, a review of the Trust's 2019/20 efficiency programme delivery and any lessons for the 2020/21 programme.

8.16 The Board **NOTED** the report.

B/08/20/9 OUR PEOPLE

9.1 Denise Farmer presented the Board with an update on workforce developments.

9.2 The Trust has developed the staff Health & Wellbeing programme throughout the pandemic to support staff in a number of ways from psychological support, provision of food and hydration to staff working longer shifts and has been working on improving staff rest areas and offering activities to support staff general physical wellbeing. This workstream is supported by the BSUH Charity who work to align the allocation of donations from the Community and NHSEI to support staff welfare.

9.3 Denise highlighted the Trust's focus on its Equality & Diversity agenda, particularly in respect of the Black, Asian, Minority Ethnic (BAME) workforce, ensuring the correct level of support in the most appropriate way. Denise was pleased to state that 100% of risk assessments had been completed within the BAME workforce.

9.4 Denise highlighted there had been a surge of interest in working for the NHS including an increase in voluntary services recruitment, since the pandemic.

9.5 Denise drew the Board's attention to the following key metrics:

- STAM, whilst levels have been maintained, further improvement work

will continue through the Refresh, Restore & Recovery plans.
- Appraisals, focus will continue on this through the new people plan.
- Sickness, non-Covid related absence has reduced over recent months; Covid absence continues to be monitored separately.

9.6 Lizzie Peers thanked Denise for the update and asked how the Trust is monitoring mental health absence in relation to Covid-19. Denise confirmed the Trust monitors mental health & wellbeing at individual and team levels and support is provided through the Trust's well developed psychological support service.

9.7 Jackie Cassell questioned whether necessity items would be being supported by the BSUH Charity in the long term, Denise confirmed that through the kind public donations, NHS Charities Together funds and those funds the Trust is able to bid on, it will not only ensure those comfort items for staff, but enable the Trust to focus on wider improvements to support staff welfare.

9.8 The Chair questioned the level of apprenticeships available at the Trust and levy vs actual spend in this area. Denise confirmed this workstream would be subject to further focus at BSUH and an update would be provided once complete.

9.9 The Chair asked how the Trust was supporting staff who had been shielding throughout the pandemic, Denise confirmed that all shielding staff are subject to a risk assessment prior to returning to work. Denise assured the Board that a detailed report would be presented at the next Board meeting in September.

9.10 The Board offered their thanks to all staff in what has been an extraordinarily challenging time.

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

B/08/20/10 CHIEF EXECUTIVE'S REPORT

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

10.2 Marianne recognised that the Covid-19 pandemic has dominated public lives since January 2020 and that the Trust had to respond to its critical care requirements rapidly by instigating the Trust's critical incident plans whilst following national guidance throughout. The creation of red and green pathways across all sites mitigated clinical risk. Assurance was provided to the Board that the Trust was never restricted on its critical care capacity at BSUH or PRH.

10.3 Marianne highlighted the redeployment of staff resource, including the Trust's clinical retraining programmes throughout the pandemic and shared her thanks to all members of staff for their resilience in such a testing period.

10.4 Marianne noted that 72% of patients admitted with Covid-19 to date were discharged safely to their homes, but sadly 166 patients have passed away which has been deeply distressing for all involved. Marianne went on to thank Trust staff for their courage and bravery throughout the pandemic and the Board they are very proud of and grateful to all involved.

10.5 Marianne highlighted the BBC South-East news feature that showcased the work of the Trust's critical care team, which demonstrated the brilliance of our

staff, and thanked all involved.

10.6 Other headlines include:

- The leadership and innovation triumphs within clinical research leadership
- Brighton pharmacists working alongside colleagues in Zambia to enhance infection prevention
- Cardmedic has received outstanding reviews and continues to make a difference in 120 countries
- Mannequins to deliver safe handling training have been launched across the Trust.
- Supporting staff and communities through the Trust Health and Wellbeing Programme continues
- Celebrating Trust staff through International Nurses Day in May and charity support for wellbeing.

10.7 Marianne went on to comment on the WSHFT and BSUH proposed merger and highlighted that work continues to progress the workstreams involved to develop a full business case for national approval, and should this progress be made the Trust will be in a position to merge on the 1 April 2021.

Diary Highlights

10.8 The Board was advised of some key meetings that the Executive team have been involved with in June and July 2020.

Looking ahead

10.9 Marianne focused on the restoration of Trust services and confirmed that work is underway to restore Trust services with assistance from the Sussex Acute Collaborative network to gather resource both regionally and nationally to restore services safely that have been affected by the pandemic.

10.10 Patrick Boyle questioned how the Trust locks in innovation given it is very much part of the recovery programme, to reduce the backlog. Marianne confirmed the divisional clinical teams focus on innovation and the Trust nurtures that approach to move forward.

10.11 Jayne Black added that particularly relating to Covid innovations through divisional leadership feedback, the drive to progress with initiatives is recognised and is supporting these being locked into future delivery.

10.12 Relating to restoration of patient care both Rob Haigh and Carolyn Morrice highlighted the wonderful innovations made, particularly within the workforce hub which remain in place.

10.13 The Chair thanked Marianne for the update.

10.14 The Board **NOTED** the report.

B/08/20/11 REPORT FROM QUALITY ASSURANCE COMMITTEE

11.1 Mike Rymer, Quality Assurance Committee Chair asked the Board to note the update from the June and July 2020 meetings he had provided earlier in the meeting along with the attached reports for the Board's information.

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

B/08/20/12 REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

12.1 Patrick Boyle, Chair of the Finance and Performance Committee asked the Board to note the update from the June and July 2020 meetings he had provided earlier in the meeting.

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

B/08/20/13 REPORT FROM AUDIT COMMITTEE (INCLUDING ANNUAL REPORT)

13.1 In the absence of Kirstin Baker, due to technical issues, the Board asked Lizzie Peers a member of the Audit Committee to provide the report from that Committee's meeting.

13.2 Lizzie asked the Board to note:

- The Committee approved the local counter fraud specialist 2019/20 annual report.
- The revised plan from Internal Audit incorporating the Refresh, Restore, Recover processes
- The External Audit Letter and there were no changes to the opinions presented to the Board when approving the annual report and accounts. The Committee noted that the scheduled review of the external audit for 2019/20 would be reported to the next meeting.
- The Audit Committee Annual Report which summarised the work of the Audit Committee over the last year.

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

B/08/20/14 BOARD ASSURANCE FRAMEWORK

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

14.2 The Board was informed that the Trust's highest scoring risks were within the area of Systems & Partnerships which corresponded to the updates received at Board within the Integrated Performance Report and the commentary provided by the Finance and Performance Committee.

14.3 The Board was informed that a separate BAF risk had been added relating to staff wellbeing to ensure focus on this area was maintained. The Board was reminded that again within the Integrated Performance Report and the update from the Chief Executive information on the actions being taken in relation to all the people risks had been provided.

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

B/08/20/15 FREEDOM TO SPEAK UP ANNUAL REPORT 2019/20

15.1 The Board welcomed Caroline Owens the Trust's Freedom to Speak to Up Guardian to present the 2019/20 Annual Report.

15.2 Caroline assured the Board that throughout 2019/20 the role and

encouragement to use the service has consistently been promoted through Trust training programmes and communications. This has resulted in year on year improvement in respect of staff engagement with the process which also helps underpin the Trust's Patient First improvement work.

15.3 Going forward Caroline highlighted that through feedback groups and knowledge sharing with colleagues from other Trusts, it was noted that throughout the pandemic, civility amongst staff has increased resulting in increased confidence levels that issues are resolved effectively.

15.4 The Board thanked Caroline for the update and wished her all the best for the future as she retires from the Trust in August 2020.

15.5 The Board **APPROVED** the annual report.

B/01/20/16 ANNUAL MEDICAL APPRAISAL & REVALIDATION REPORT

16.1 Rob Haigh, Trust Medical Director, updated the Board on the year-end position with regard to medical appraisal and revalidation and asked the Board to approve the NHS England statement of compliance.

16.2 Rob stated that NHS England cancelled the Annual Organisation Audit for 2019-20, however it was noted that the appraisal rate of 93% was sustained throughout 2019-20.

16.3 In relation to the 2020-21 medical appraisal cycle and in line with NHSE guidance, medical appraisal was suspended on 1st April due to Covid-19 – this will resume for the Trust on 15th September.

16.4 The Board **APPROVED** the report and the signing of the required statement.

B/08/20/17 COMPANY SECRETARIAL REPORT

17.1 Glen Palethorpe asked the Board to note that the Trust's 2019/20 Provider License Self-Declarations, the 2019/20 Annual Report and Accounts and the the 2019/20 Quality Account have all been placed on the BSUH website.

17.2 The Board is asked to note that the Annual General Meeting has been set for the 29 September 2020 after the next public board meeting.

17.3 The Board **NOTED** the reports.

B/08/20/18 QUESTIONS FROM THE PUBLIC

18.1 A member of the public submitted two questions to the Board relating to the Sussex Eye Hospital, and whether WSHFT current restaurants, patient feeding & catering services, portering & cleaning services all provided were all provided in-house and not outsourced.

18.2 In relation to the first question, Dame Marianne Griffiths confirmed that there were no discussions or plans in place regarding the reallocation of Sussex Eye Hospital.

18.3 Clare Stafford covered the second question and stated that the Trust is not seeking to change delivery of the in-house cleaning, laundry or catering services provided by WSHFT, and it should be noted that WSHFT is proud of its high satisfaction scores in these areas.

18.4 With regard to patient catering, Clare stated this is delivered in house and prepared by the central processing unit recently opened by the Health Minister and Prue Leith.

18.5 In relation to external food outlets, these were confirmed to be delivered through charity partners and trusted suppliers.

18.6 The site Engineering is all self-delivered and there are no aspirations to change this.

18.7 There were no further questions.

B/01/20/19 ANNUAL WORKFORCE RACE EQUALITY SURVEY
ANNUAL WORKFORCE DISABILITY EQUALITY SURVEY

19.1 Due to technical difficulties Babs Harris, the Trust's Head of Equality, Diversity and Inclusion was unable to join the Board, therefore the WRES and WDES updates were delivered by Denise Farmer & The Chair.

19.2 The Chair asked the Board to note that the WRES and WDES reports were reviewed in detail at Quality Assurance Committee and highlighted that the purpose of this report is to demonstrate the Trust's understanding of its staff and patients, fulfilling regulatory requirements and to enable staff, patients and service users to see the Trusts commitment to the Inclusion agenda, including focusing on internal projects and activities within BSUH through Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).

19.3 The Board thanked the team for the huge amount of effort put in to the Annual Equality work and emphasised the importance of prioritising the Trust's profile in this area.

19.4 The Board **APPROVED** the Annual Workforce Equality Survey and the Annual Workforce Disability Quality Survey.

B/08/20/20 ANY OTHER BUSINESS

20.1 There was no other business discussed.

B/08/20/21 DATE AND TIME OF NEXT MEETING

The next meeting in **PUBLIC** of the Board of Directors is scheduled to take place on **Tuesday 29 September 2020, at 10:00,** virtually via **Microsoft Teams Live**.

Tamsin James
Board and Committee Administrator
August 2020

Signed as a correct record of the meeting

……Chair

……Date

ACTIONS ARISING

Public Board

Date of meeting	Minute Reference	Minute Title	Action	Person Responsible	Deadline	Status
			There are no matters arising			

Brighton and Sussex University Hospitals NHS Trust

Chief Executive's Report

Dame Marianne Griffiths
September 2020

Content

- Headlines
- Diary highlights
- Looking ahead

Thank you to all our staff

“It’s been an unprecedented year. Covid-19 dominates everything we do, influences every decision we make and has placed extraordinary demands on every area of our hospitals.

“I want to thank you to each and every one of our staff for the way in which they have pulled together in these exceptional times.

“I am proud of all we have achieved so far and continue to achieve together.”

Dame Marianne Griffiths, Chief Executive

Headlines: COVID-19

There has been a significant rise in positive Covid test results in many areas of the country over recent weeks but current numbers of positive patients in our hospitals remains very low.

At its peak in April we were caring for 114 COVID patients. We currently have no Covid patients in our hospitals.

Ahead of a possible second surge work is underway to restore all services, with priority areas already seeing and treating patients.

Headlines: COVID-19

Our goal is to restore activity to more than 90% of last year's activity by October.

*Activity compared to pre-COVID levels was:

Referrals: 92%
Outpatients: 82%
Day case: 59%
Inpatient elective: 67%
A&E: 94%
Inpatient non-elective: 100%

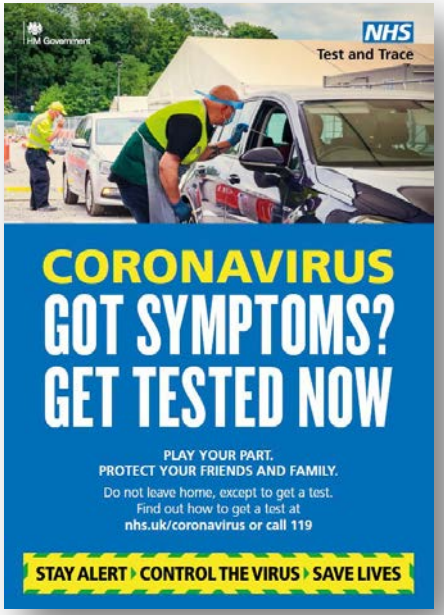
Headlines: COVID-19

- **The right thing to do is put those in most urgent need of treatment first**
- If we ask to see patients it is both important and safe for them to come into hospital
- We have necessary infection prevention measures in place that unfortunately limit the number of people we can see and treat
- We are sorry people are waiting longer but we’re doing everything we can to see as many as soon as possible

Headlines: COVID-19

Testing

We have introduced additional covid testing capacity for elective patients and for symptomatic staff or anyone in their household if this results in the staff member having to isolate.



Winter planning

Work is already underway on our winter planning and we are working collaboratively across the system with all our health and care partners. This year our winter plans must take into account the additional complexity and challenge posed by Covid.

We have a number of key objectives which include:

- Maintaining patient and staff safety
- Managing increased levels of demand/red and green areas for covid and non-covid patients
- Making sure our bed occupancy rates are at a level which ensures we can admit patients from A&E in a timely way
- Protecting elective work

Headlines: COVID-19

Additional A&E funding

BSUH has been allocated £3.7m to improve A&E facilities and invest in new measures to protect patients and staff from Covid-19 ahead of winter. The trust is one of 117 trusts to receive additional funding. Plans are currently being developed for Princess Royal and The County which will look at infection control, social distancing and an increase in capacity. The funds will also support the delivery of an Urgent Treatment Centre service alongside A&E from October, in line with the new national model for the delivery of integrated urgent care.

Investing in our staff thanks to charity support

In March this year the BSUH Charity set up a fundraising campaign dedicated to staff welfare, with more than £350k received from direct donations as well as the central NHS Charities Together fund. In June we shared a wellbeing survey with staff to ask how they would like us to use the donations. The overwhelming feedback was for investment in staff rest areas, followed by training, and more psychological support. As a result we will be investing the money in improvements which will support staff health and wellbeing.

Highlights include creating two large communal staff rooms, more outdoor seating facilities, the refreshment of 142 departmental staff rooms, enhancing our HELP service to support mental wellbeing as well as our in-house physiotherapist telephone service to ensure staff have early intervention for musculoskeletal issues.

Headlines: COVID-19 response cont…

Finally home after 109 days in hospital

A patient who received lifesaving treatment for Covid-19 at The County hospital finally went home after 109 days in Intensive Care and is now fundraising for the Trust. Lin Bloor was taken to hospital in Surrey by ambulance in March after showing symptoms of coronavirus. After testing positive Lin was admitted and transferred to the Intensive Care Unit in Brighton where she received lifesaving care during the height of the pandemic. While in hospital, Lin and her husband Glyn, took part in a short interview via video call with BBC South East health reporter Mark Norman.

Putting the birthing person at the centre of our care during a pandemic

BSUH Maternity team have embraced social media to educate, reassure, support and inform service users and their families. During restrictions, like many other departments, they have had to reduce a lot of face to face contact and cancel all antenatal classes, which are an essential part of clinical care. So instead the team have been filming mini-antenatal education clips and increasing their online presence to prepare and support pregnant women. A recent video on home birthing has had 1.3K views to date. The team are now planning virtual antenatal classes and intend to keep growing their online resources.

Headlines: Leadership and innovation

Leadership, teamwork and innovation have triumphed during this difficult time. Here are just a few examples.

Getting discharge right and improving flow

Since COVID-19, the way we manage discharges has changed thanks to the creation of the newly formed Integrated Discharge Hub. Made of a multidisciplinary team of nurses, doctors, discharge and flow coordinators, therapists, social care, community care workers and more, the team work closely with wards, patients, families and system partners to ensure our patients are discharged in a timely and safe manner. This is reducing the length of stay for patients who are medically ready for discharge and is helping to improve flow across the hospitals.

Pictured: Pamela Heafield, Trust wide pathways and ward intensive support lead

Using technology to improve patient safety

Patientrack, an electronic observations and warning system, has been used widely at BSUH since January and is now embedded in nearly all wards. It is used to capture bedside observations and patient assessments digitally and alerts clinicians to deteriorating patients who require immediate medical intervention. The system has delivered significant benefits to patient care and operational management, and has also seen a reduction in Medical Emergency Team (MET) calls – down 15% compared to 12 months ago. New upgrades this month will bring further technological enhancements to patient care.

Headlines: Supporting staff and communities

Our colleagues continue to tell the story of the our diverse, inclusive and welcoming culture.

Welcome to our junior doctors and newly qualified nurses!

Over 250 foundation and year one doctors have chosen to start their medical careers with BSUH and were welcomed at a socially distanced induction day in Brighton. Welcoming them were colleagues from across the trust who took part to help them feel ready to start their roles. Meanwhile, 31 student nurses who worked with us throughout the peak of COVID-19 have also now joined the BSUH team as Newly Qualified Nurses.

BSUH BAME Network launch

We are pleased to have launched a new Network for BAME staff. The idea stemmed from feedback I received at the workshops I ran last year focussed on improving race equality within our organisation. The network will provide a forum for BAME staff to discuss issues that are impacting on them and to provide support to each other. The first network meeting was held last week and I am delighted that Yvonne Coghill, who until recently was the Director of Workforce Race equality Standard at NHSE, will chair the new network.

BSUH Digital Pride

BSUH was Proud to take part in Brighton Pride last year and although it didn't quite look the same this year, we celebrated online with the launch of the BSUH Digital Pride video. The video celebrated our diverse workforce, recognised the struggles of LGBTQ+ people throughout history and talked about what it means to be proud at work.

Headlines: Supporting staff and communities

Health Passports now available for staff

We introduced the Health Passport this summer enabling anyone with a long-term health conditions to have and record meaningful conversations about health and adjustments with their managers or supervisors. The idea stemmed from conversations with the Trust's Disabled Staff Network and Workforce Disability Equality Standard Working Group.

Shining a light on Organ Donation and our physios

This month we celebrated Organ Donation (OD) Week, shining a light on the recent law change and the importance of registering your donation decision. The team of BSUH specialist OD nurses ran a number of awareness raising activities, from live Q&As on Workplace to answer staff questions, to attending ICU huddles and sharing the powerful stories of BSUH organ donors both internally and externally. Meanwhile, we marked World Physiotherapy Day and shared physio profiles as well as facts about the 178 physios across our sites and the diverse areas they support.

Headlines: BSUH and WSHT merger

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The name of the new trust

NHSE&I sets out a number of principles and an approval process which must be followed when choosing a name and we must take all these into account. We have started conversations with our key partners to outline possible options within this guidance and next week we will share a shortlist with staff and our communities so they can give us their views on the new name.

Deliver outstanding care, grow our clinical expertise, bring together the very best of both organisations

Diary highlights

- MP meeting: merger and restoration of services
- Sussex Acute Collaborative Network
- BSUH and WSHT Sussex CCG CEO and Chairs meeting
- Sussex Health and Care Partnership Executive meetings
- Health Oversight and Scrutiny Committee

Looking ahead

Protecting our staff and patients from flu

The annual flu season is fast approaching and our staff flu vaccination campaign launches next week. Frontline NHS healthcare workers are more at risk of being exposed to, and therefore of spreading the flu virus, so vaccination is a vital part of infection control. The flu vaccination helps to stop the spread of flu to colleagues and their families, as well as protecting vulnerable patients who are at increased risk of complications. We have a team of 150 trained workplace vaccinators within the Trust who will be holding drop-in clinics and visiting wards and departments to distribute the vaccine to staff. Roaming vaccinators will also be on hand to provide the jab to staff on shifts and in their departments.

Staff survey

The Annual NHS staff survey launched yesterday and is an opportunity for all BSUH staff to have their say. It is a completely anonymous survey, conducted by an external company, and enable staff to provide valuable feedback on issues that matter most to them, including: quality of care, health and wellbeing, equality and diversity, appraisals and the workplace environment. This has been an unprecedented time and this year the survey includes a new section called ‘The Covid-19 pandemic’ to help us better understand the experiences of staff.

Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	6-10	**Meeting:**	Board	**Meeting Date:**	29/09/20
Report Title:	**Integrated Performance Report**				
Sponsoring Executive Director:	Dame Marianne Griffiths, Carolyn Morrice, Jayne Black, Karen Geoghegan, & Denise Farmer				
Author(s):	Dame Marianne Griffiths, Carolyn Morrice, Jayne Black, Karen Geoghegan, & Denise Farmer				
Report previously considered by and date:	Individual elements considered by relevant Board Committee				
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:					
Attached is the Trust's integrated performance report for September 2020.					
Key Recommendation(s):					
To note the content and following receipt of the Committee assurance reports consider if there are areas for referral back to the Committees where enhanced assurance is required.					

Integrated Performance Report

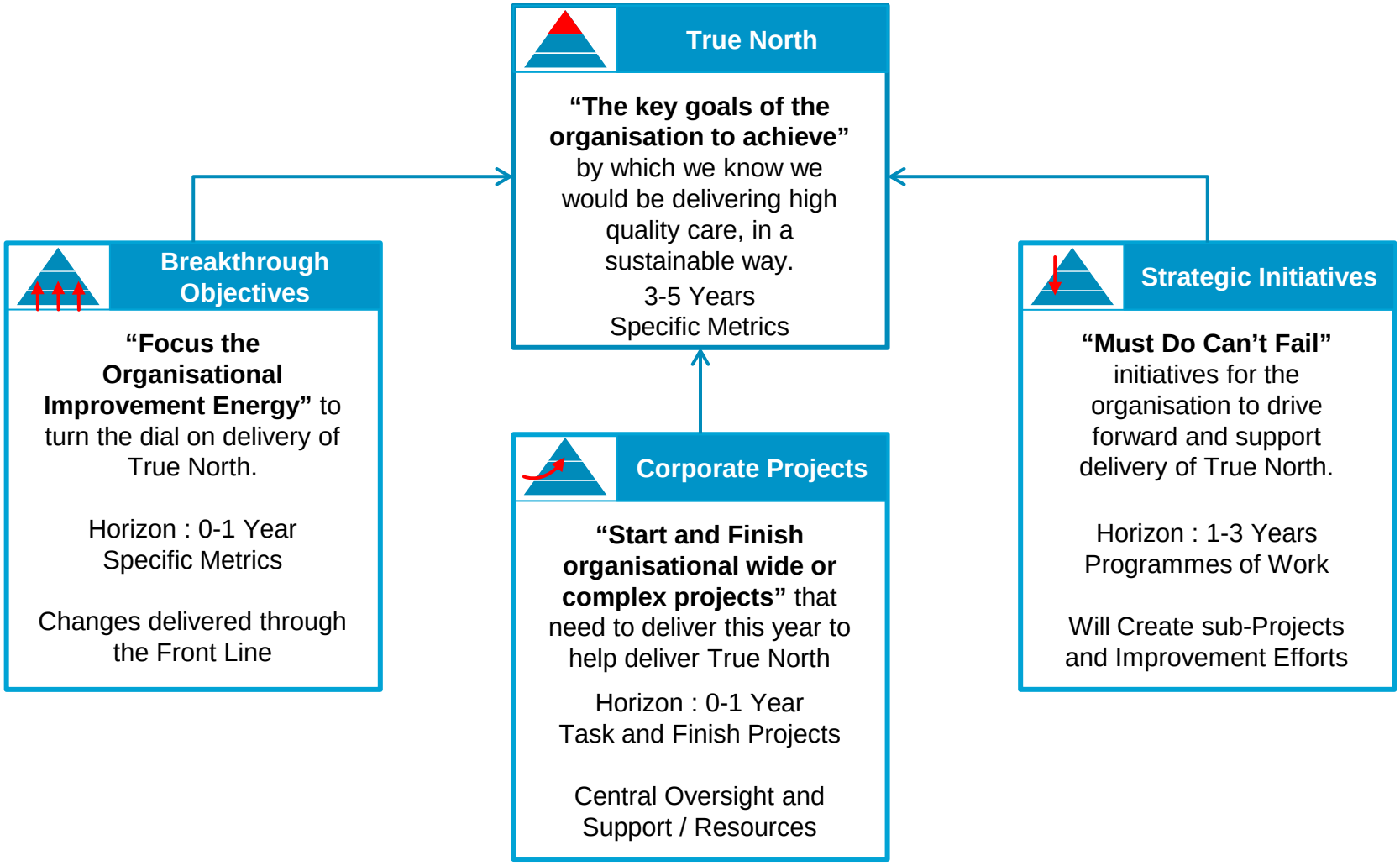
September 2020

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 May 2020; in may, 58 patients died in hospital against the expected number of 70. In month HSMR is 83.33; and the rolling 12 month HSMR to May 97.19 – placing BSUH in the top 33% nationally in terms of in-hospital mortality.

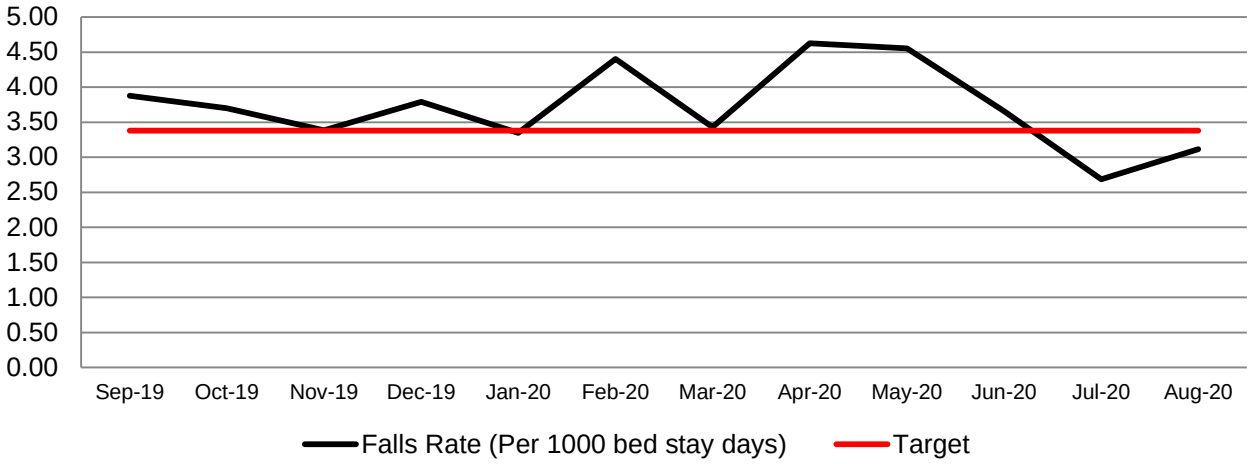
However, current national guidance states that the usual, comparative mortality indicators (HSMR & SHMI) are not suitable for monitoring CoVid 19 mortality rates, because these risk adjusted monitoring systems are not designed to benchmark pandemic mortality. SHMI & HSMR rely on prolonged, sequential data collection and as the CoVid 19 code has only been in place since March, ‘expected’ mortality rates cannot be determined

This is further compounded by the significant changes in volume and case-mix of non CoVid patients emergency admissions during the pandemic so far.

After pausing during the pandemic phase I, 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 good practice and areas for improvement

Quality Performance

Inpatient falls rate per 1000 bed days



Quality

Inpatient Falls

Target: 3.38 falls per 1000 bed stay days

Pressure Ulcers

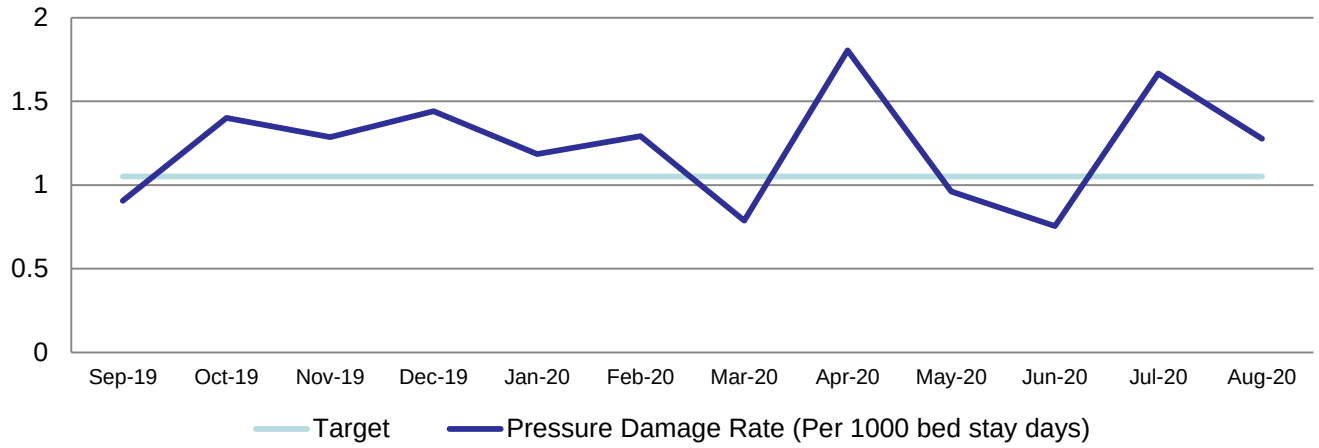
Target: 1.05 rate of acquired pressure ulcers per 1000 bed stay days

The rate of inpatient falls for the past 12 months is 3.68 falls per 1000 bed stay days; this equates to 892 falls in the past year compared to 912 in the previous 12 months. The National Falls rate is 6.62 falls per 1000 bed days. Over past 12 months the number of falls reported each month has dropped significantly (p-value 0.003). However, this reduction is primarily driven by the reduction in inpatient activity due to Covid 19 as the falls rate per 1000 bed stay days is 3.7 which is higher than 12 months ago.

In the past 12 months 25 falls have been reported as serious incidents .This compares to 18 in previous 12 months. Each fall has a factfinder completed and themes and trends have been identified. A Harm Free Care Group is being set up by the Associate Director for Quality to progress identified actions as a result of thee reviews .

Quality Performance

Acquired Pressure Ulcer rate per 1000 bed days



In August 2020 there were 209 Datix incidents were submitted in relation to pressure ulcers. . Over the past 12 months the number of patients developing pressure damage has decreased. The majority (67%) of these patients presented at A&E with a pressure ulcer acquired outside of hospital
Between June and August 2020 five acquired pressure ulcers have been treated as Duty of Candour incidents.
The Associate Director for Quality has initiated a multi disciplinary arm Free Care Group to review each pressure ulcer, make recommendations and monitor improvement

Quality

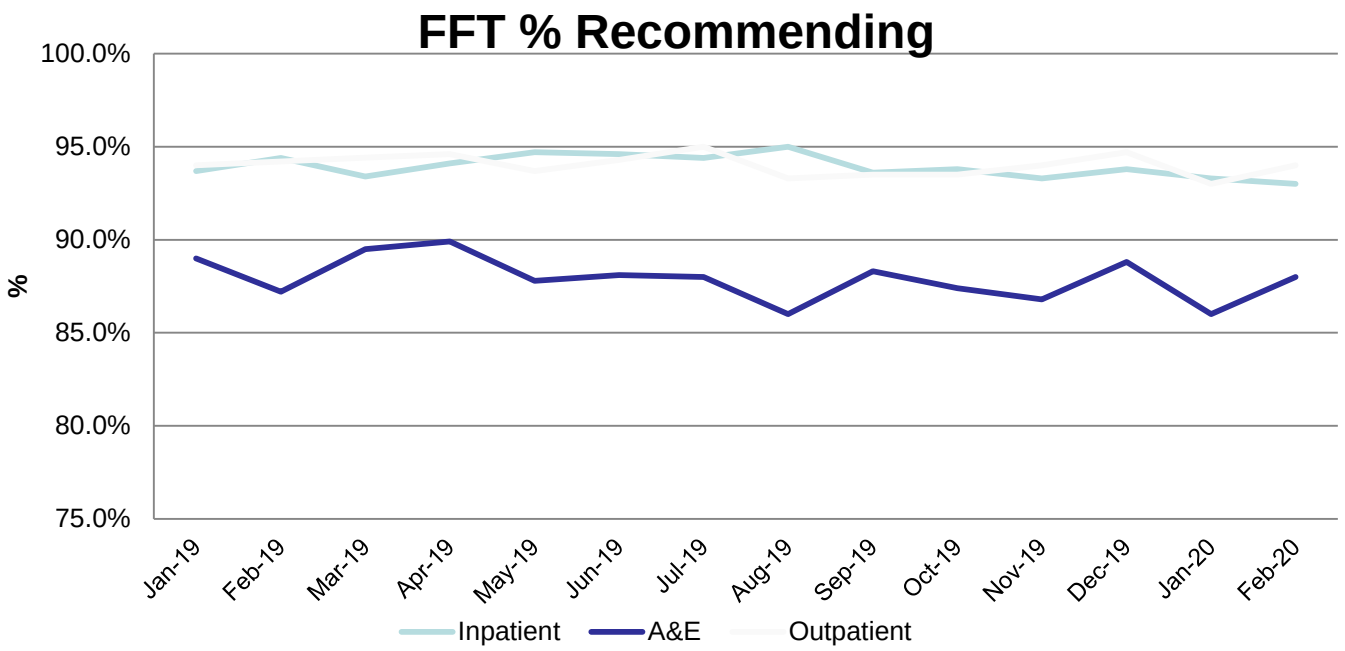
Inpatient Falls

Target: 3.38 falls per 1000 bed stay days

Pressure Ulcers

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

Quality Performance



Quality

Friends and Family Test

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

Our current recommended rates for Feb are:

Inpatient	93.3%
A&E	88.8%
Outpatient	94.7%

FFT has not been collected since February 2020 due to COVID-19. Collection of FFT recommences on October 1st. Patient feedback is also collated through triangulating plaudits, PALS enquires and complaints along with Patient Survey data

Performance Summary

Systems & Partnerships

Non Elective Care

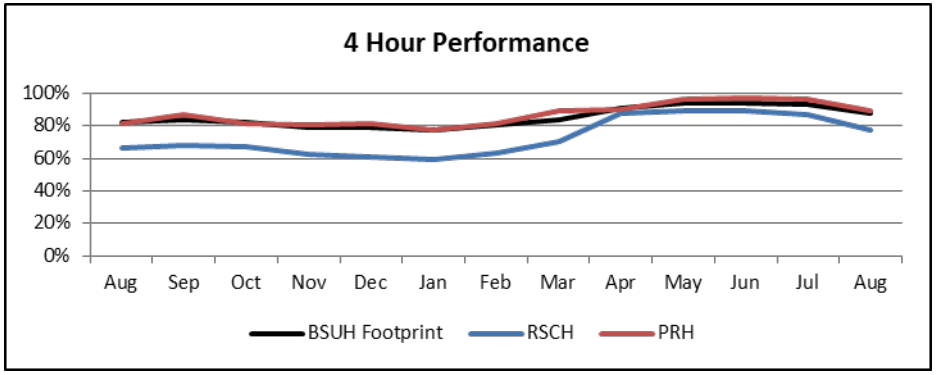
Target: A&E 95% <4hrs

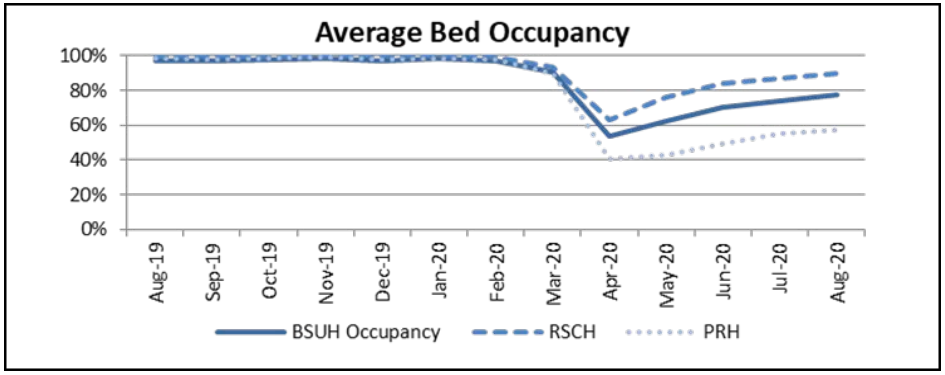
Elective Care

Target: RTT 92% <18wks

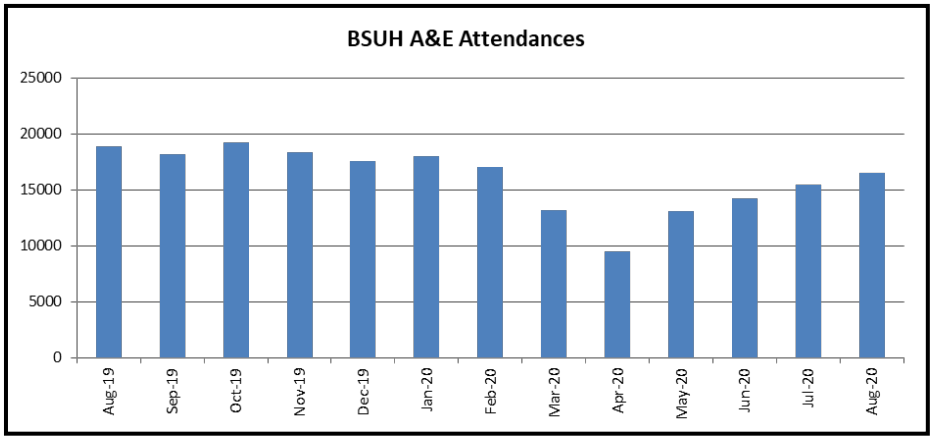
- The Trust achieved 87.8% in August 2020, 5.8% higher than August 2019. This is below the National performance of 89.3%.
- This was in the context of a 12.5% drop in A&E attendances compared to the same month last year and a 8.6% drop in non-elective admissions.
- RTT performance for August 2020 is 49.8%, a decrease of 15% compared to August 19. Performance has increased by 5% compared to the prior month. The total volume of patients waiting more than 52 weeks increased to 1999. The waiting list size grew marginally between months but remains circa 10,000 below the prior year.
- The Trust was compliant against 3 of 8 reportable cancer metrics in July 2020. The Trust was non compliant for 62 day treatment following urgent GP Referral with performance at 81.5%. The prospective backlog of patients waiting more than 62 days reduced by circa 50 in July following significant growth.
- Diagnostic performance for August 2020 is 49.3%, a 5% deterioration on the prior month. Endoscopy remains one of the most challenged modalities in terms of restoration plans and progress.

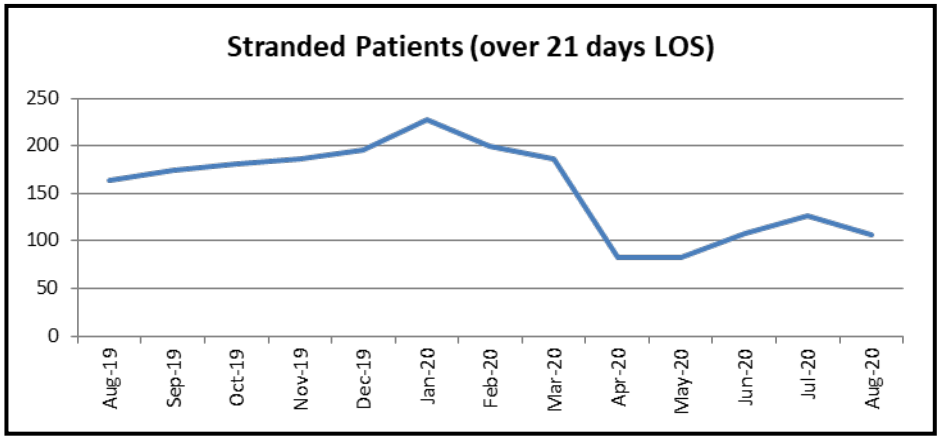
A&E



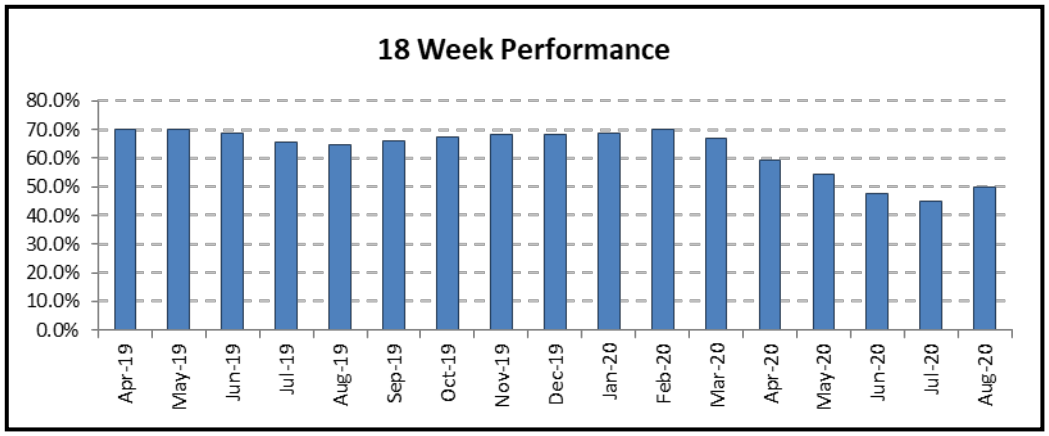


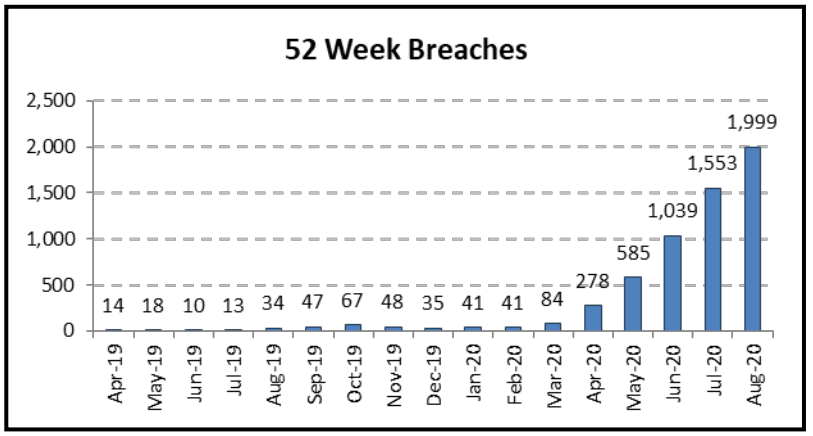
- The Trust achieved 87.8% in August 2020, 5.8% higher than August 2019 but below the National performance of 89.3%.
- This was in the context of a 12.5% drop in A&E attendances compared to the same month last year and a 8.6% drop in non-elective admissions.
- Bed occupancy at both RSCH and PRH has been increasing since the low observed in April and in August was 77.4% (89.8% at RSCH).
- The number of patients with a long length of stay dropped but has remained circa 100 patients.
- Following the early reductions on A&E attendance and non elective admissions demand is increasing once more. August restoration figures demonstrate that A&E attendances returned to 91% of pre-Covid levels and non elective admissions to 102% of pre-Covid levels. This is in line with bed occupancy increases as detailed above.



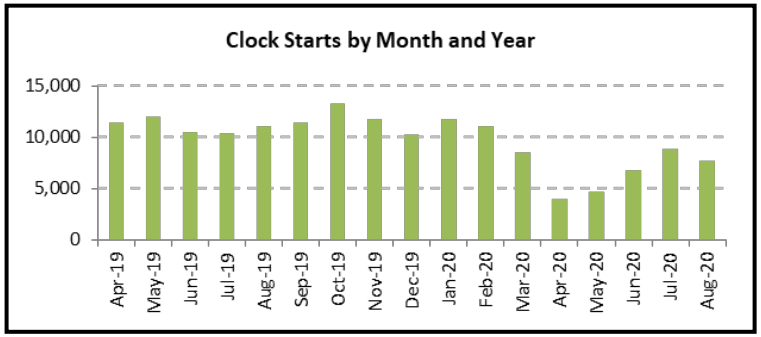


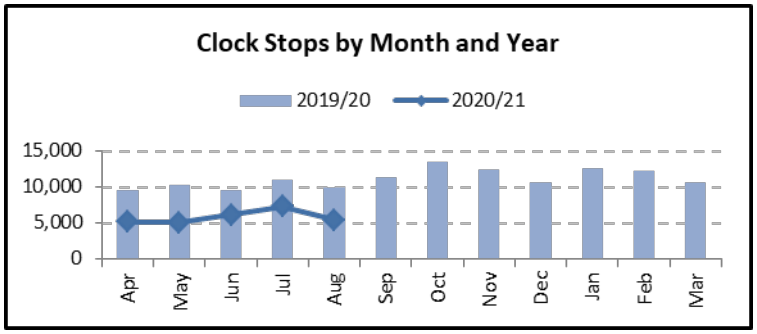
RTT





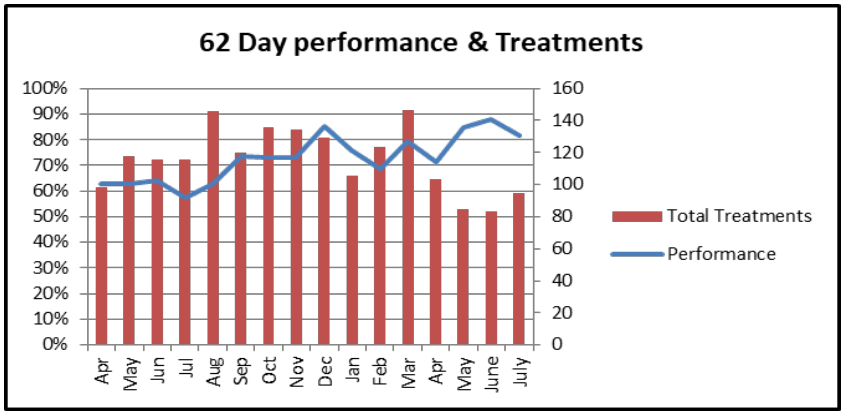
- RTT performance for August 2020 is 49.8%, a decrease of 15% compared to August 2019. Performance has increased by 5% compared to the prior month. The total volume of patients waiting more than 52 weeks increased to 1999.
- August referral demand returned to 84% of pre-Covid levels. Clock stops in August are 54.9% restored when compared with the same period last year.
- The waiting list size grew marginally between months as demand has caught up with supply but remains circa 10,000 less than August 2019.
- The Trust is focussing on restoration with the aim to meet phase 3 restoration targets, with particular focus around outpatient and theatre restoration and productivity, with support from the Independent Sector where possible.
- There continue to be monthly harm panel reviews but also weekly reviews of >52s to see if any patients have moved priority.



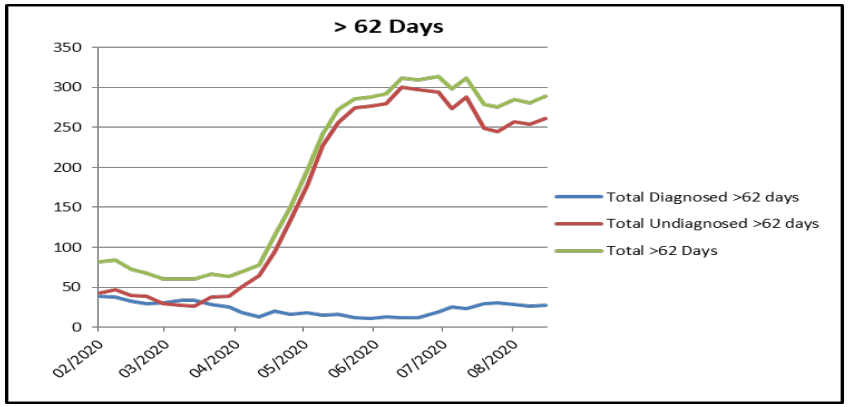


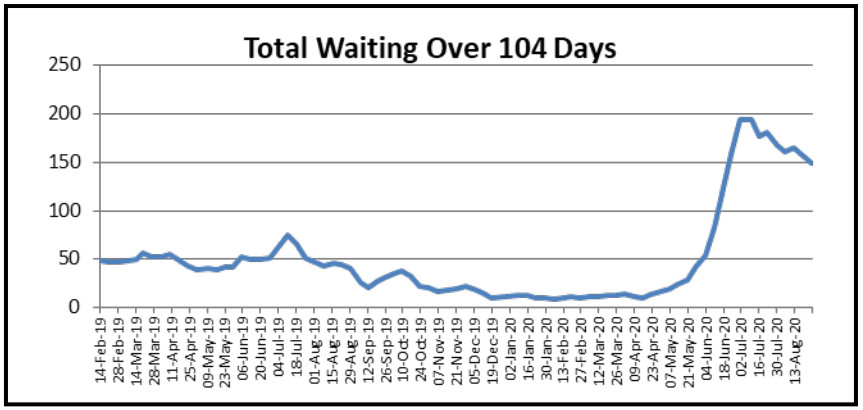
Cancer

Metric	2020/21 July	YTD 20/21	Target
2 week GP ref to 1st OP	85.9%	87.6%	93%
2 week GP ref to 1st OP - breast	98.9%	95.8%	93%
31 day 2nd or subs trtmnt - surgery	91.4%	95.3%	94%
31 day 2nd or subs trtmnt - drug	100.0%	98.8%	98%
31 day 2nd or subs trtmnt - radiotherapy	83.5%	90.8%	94%
31 day diagnosis to trtmnt all cancers	98.8%	99.4%	96%
62 day ref to trtmnt screening	0.0%	61.1%	90%
62 day ref to trtmnt upgrade	93.5%	88.4%	85%
62 days urgent GP ref to trtmnt all cancers	81.5%	81.0%	85%

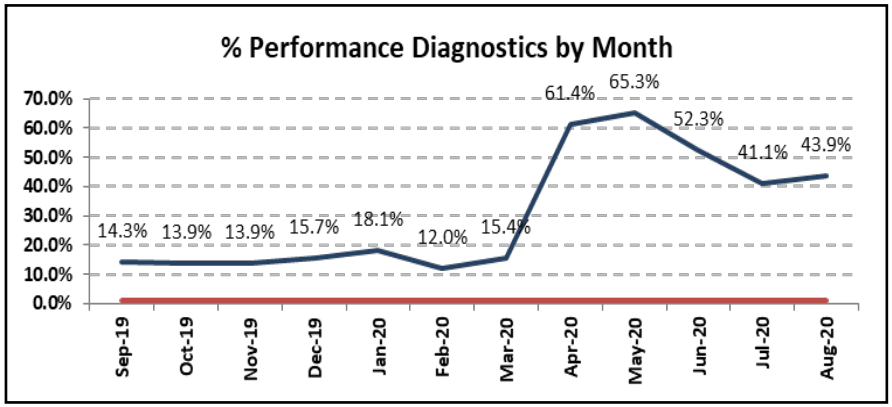


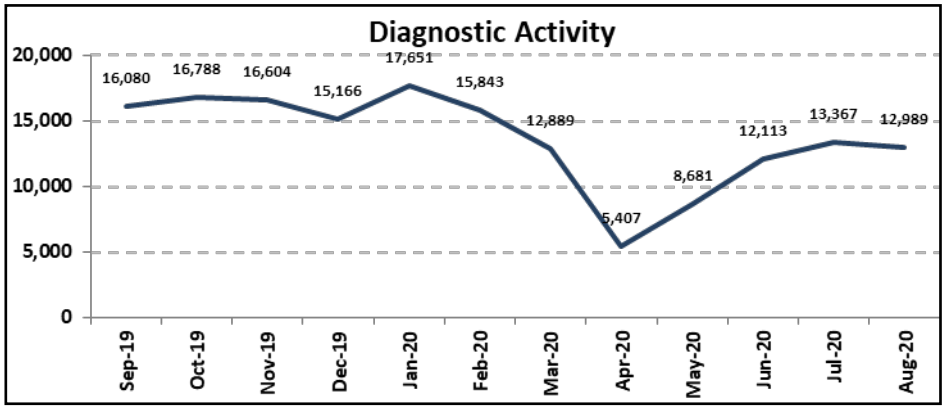
- The Trust was compliant against 3 of 8 reportable cancer metrics in July 2020.
- July Performance for the 2ww standard was non compliant at 85.9%.
- July performance for the 62 day GP referral was non compliant at 81.5%.
- The prospective 62 day backlog grew materially during lockdown, but fell to the end of July and has remained static during August. 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 have begin to reduce.
- Work to recover the performance is underway with particular focus for colorectal anatomical sites via FIT programme and scaling up restoration activities internally, augmented by IS support.



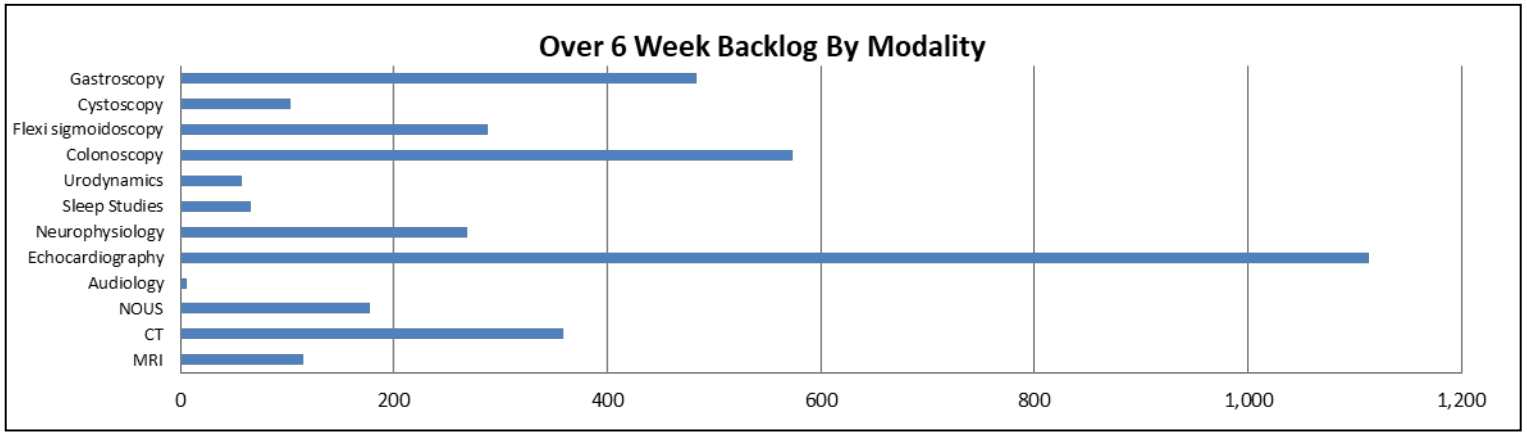


Diagnostics

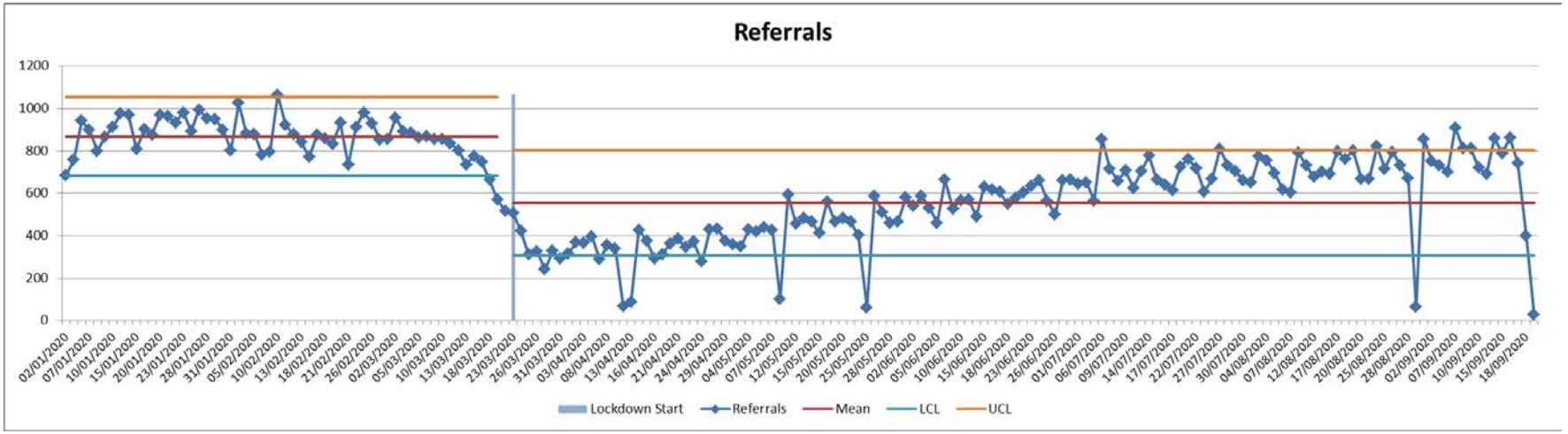




- Diagnostic performance for August 2020 is 49.3%, a 5% deterioration on the prior month.
- Challenges remain across a number of modalities . Restoration plans are in progress to deliver an improved position.
- As per the national picture restoration plans remain the most challenged in Endoscopy with further solutions being identified including the use of the independent sector and in source options.
- Imaging modalities have restoration plans in place to restore to 100% of pre-covid levels in CT and NOUS and 92% for MRI.



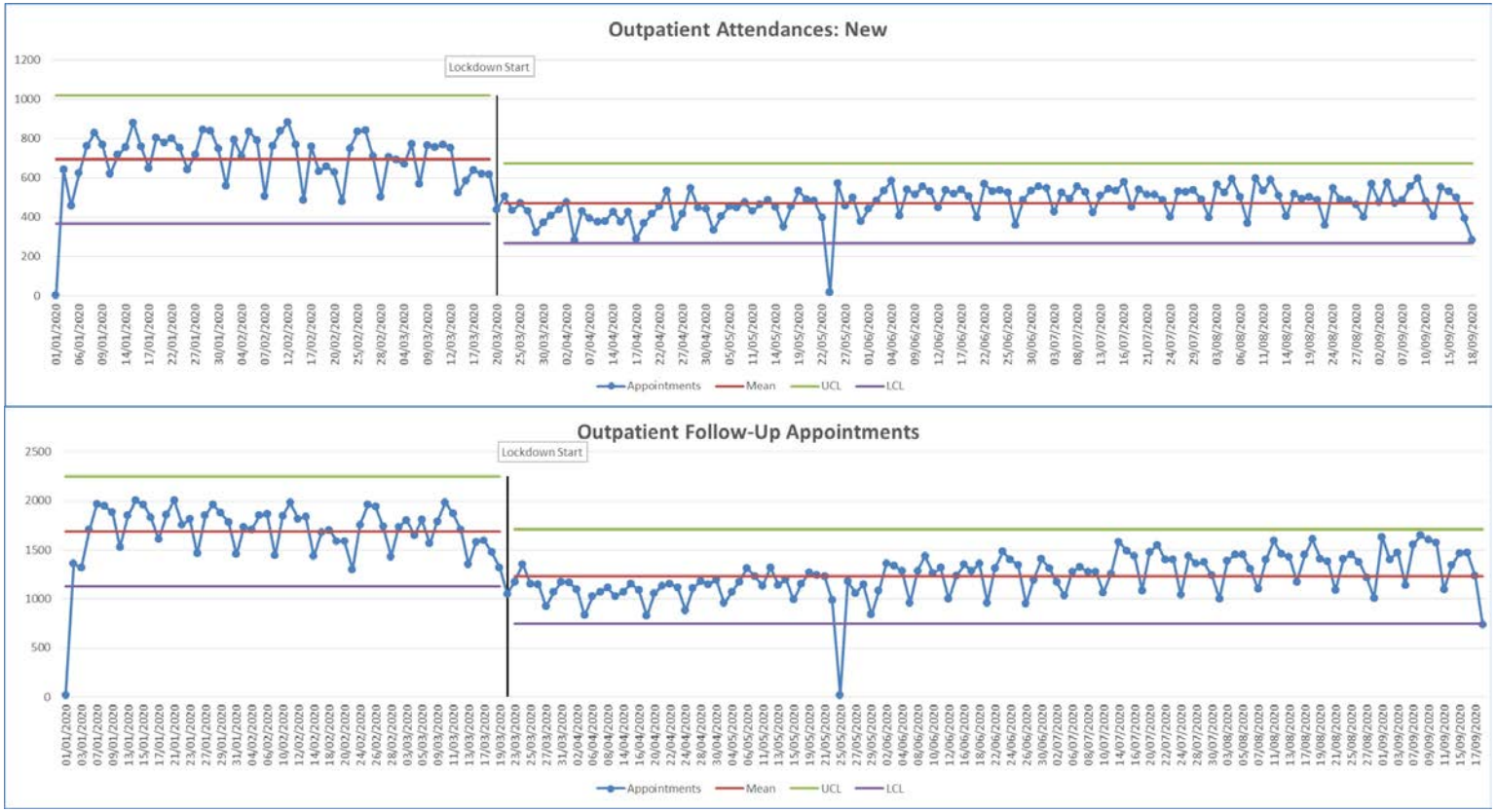
COVID-19 Annex : Elective Referrals



For August 2020:

- Elective referral demand returned to 84% of pre-Covid levels.

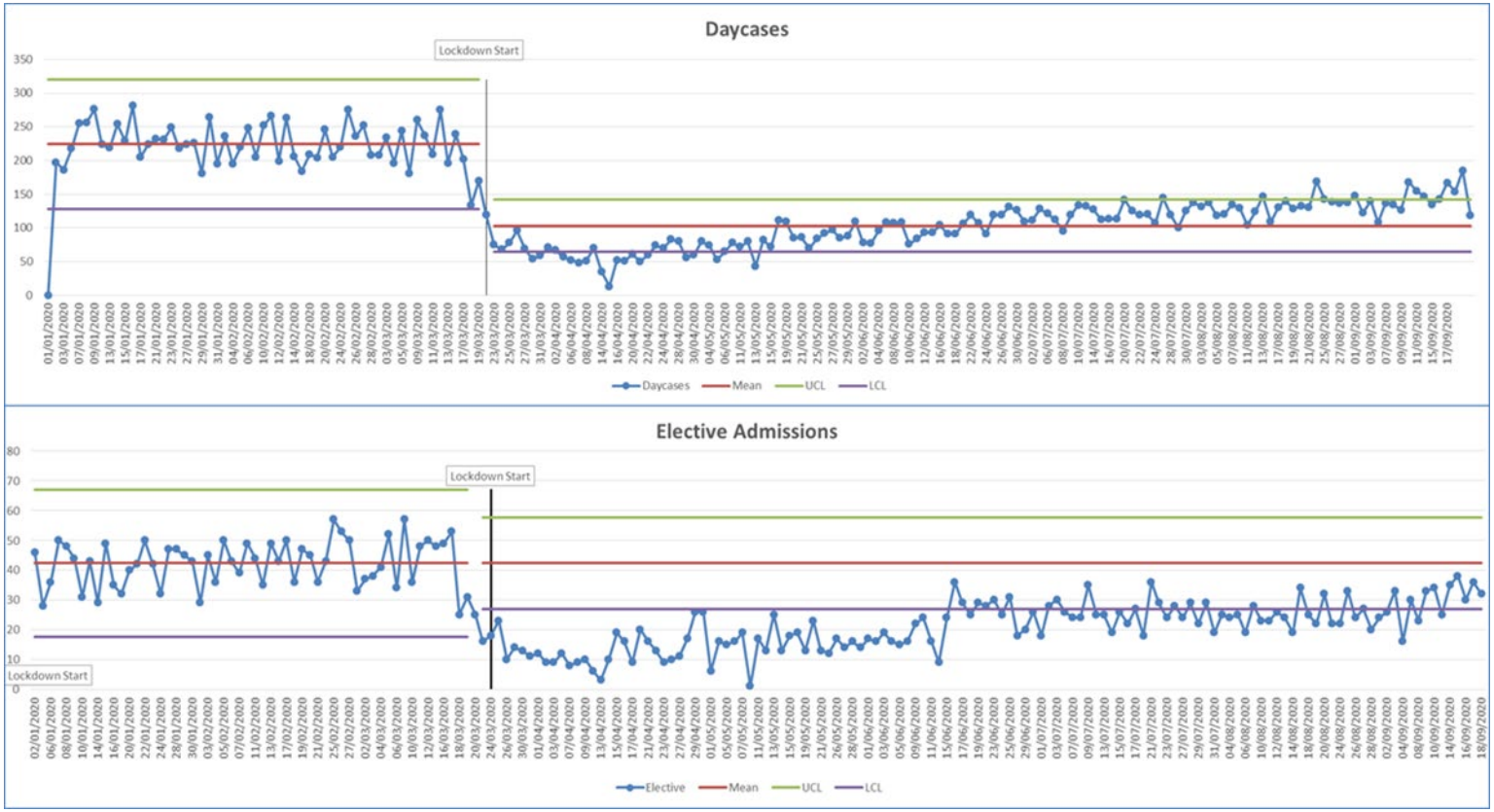
COVID-19 Outpatient Attendances



For August 2020:

- New OP activity has been restored to 68% of pre-Covid levels.
- Follow Up OP activity has been restored to 78% of pre-Covid levels.

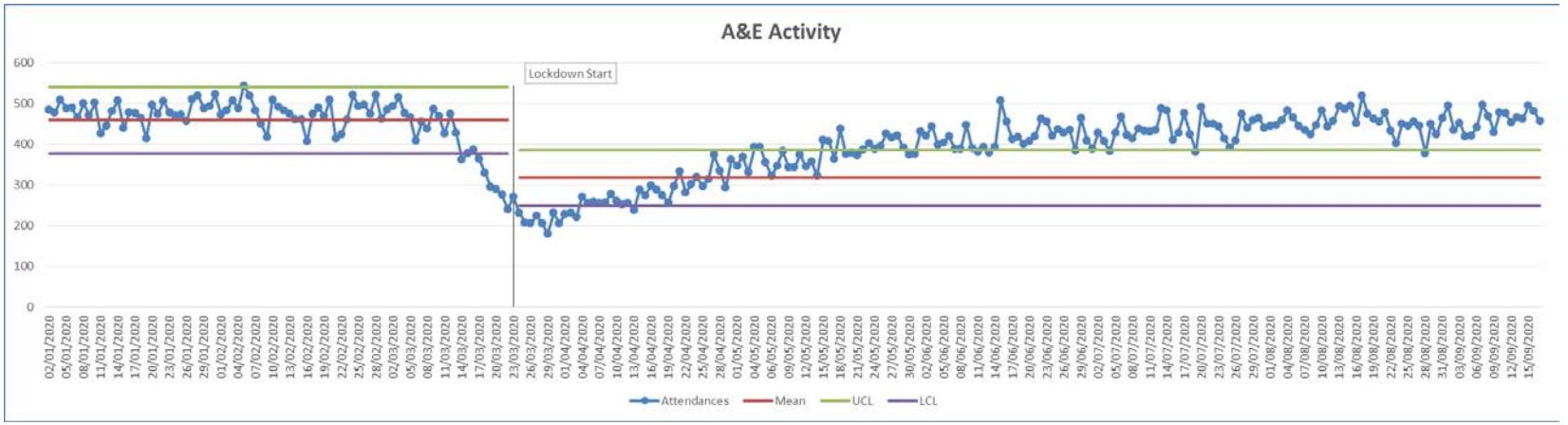
COVID-19 Elective Admissions

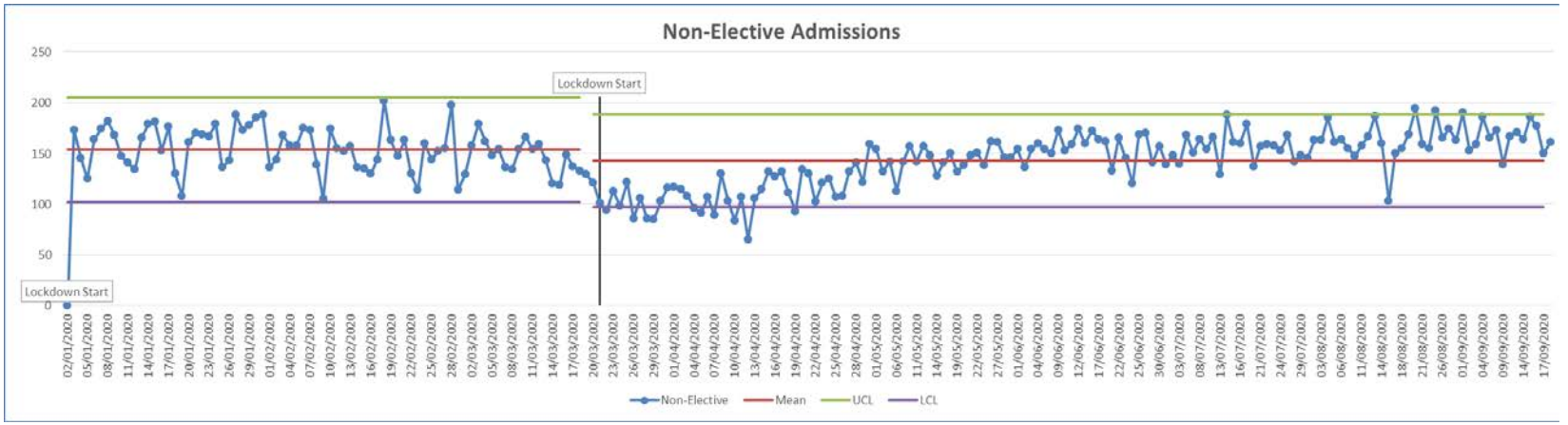


For August 2020:

- Day case activity has been restored to 54% of pre-Covid levels.
- Inpatient activity has been restored to 58% of pre-Covid levels.

COVID-19 Emergency Demand

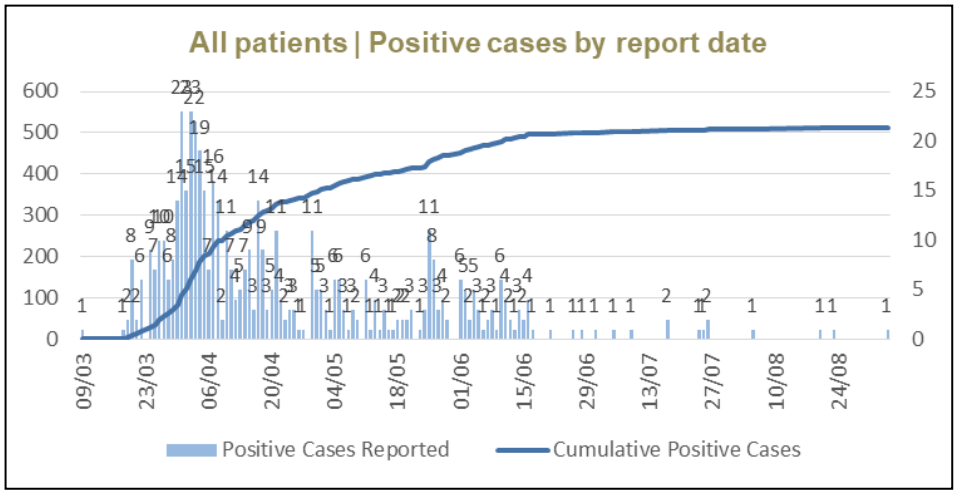


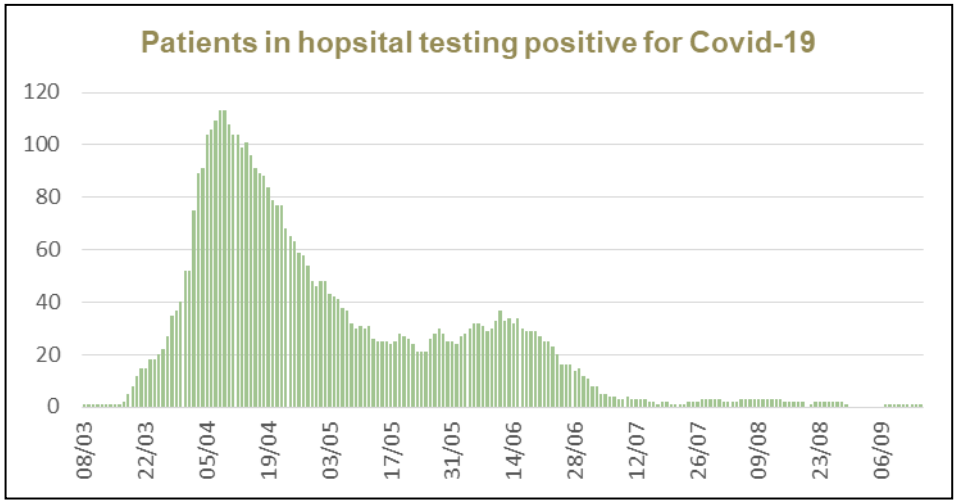


For August 2020:

- A&E attendance activity returned to 91% of pre-Covid levels.
- Non elective admission activity returned to 102% of pre-Covid levels.

COVID-19 Occupancy and Positive Testing





All confirmed Covid-19 patients					
513	5	369	139	18.4	17.7
Admissions for lab-confirmed Covid19	1% patients remain In hospital	72% Discharged	27% Patients Died	Average length of stay for discharges	Average length of stay for deceased

Patients admitted to Critical Care					
57	5	37	15	22.6	24.3
11% Patients go to ITU/HDU	8.8% patients remain in hospital	64.9% Discharged	26.3% Died	Average length of stay for discharges	Average length of stay for deceased

Patients staying on general wards only					
456	0	332	124	18.0	16.9
89% Patients stay in other wards	0.0% patients remain in hospital	72.8% Discharged	27.2% Died	Average length of stay for discharges	Average length of stay for deceased

Financial Performance - Summary

Sustainability

Financial Management

Target: Break Even

- The Trust has continued to operate within an interim financial framework that has been in place since April. The purpose of the financial framework has been to remove routine burdens and allow NHS organisations to devote maximum operational effort to COVID readiness and response.

- The Trust continues to report a breakeven position, which remains in line with the financial framework guidance issued from NHSE/I for the interim period.

- Additional income of £8.1m has been included within the position to reflect the genuine and reasonable additional marginal costs incurred as a result of COVID-19 and to recompense for any associated reduction in other income streams.

- A new Funding Framework comes into place on 1st Oct 2020. The Trust will be operating within a funding envelope and additional costs relating to COVID-19 will become prospective and at an Integrated Care System (ICS) level rather than retrospective and organisational.

Financial Performance – Key Metrics

Control Total Surplus £k — G

	Plan	Actual / Forecast
Year to Date	0	0
Year End Forecast	0	0

The Trust continues to report a breakeven position at the end of August in line with the financial framework guidance issued from NHSE/I. The position includes £8.1m of income from NHSE/I as part of the monthly true-up process to ensure that all organisations report a break-even position. Further analysis of the position is provided in the COVID-19 summary.

COVID-19 £k — G

	Full Cost	Marginal
COVID-19 Response	(10,065)	(4,108)
Shortfall Other Income		(4,036)
True-Up Income		(8,144)

Total True-up income of £8.1m has been included in the year to date position, of which £4m reflects the shortfall on planned commercial and non-contract income to the end of August. A further £4.1m of income has also been included to reflect the marginal costs of the Trusts COVID-19 response. The full COVID-19 response cost of £10.1m incurred to date continues to be partially offset by underlying expenditure budget underspends resulting from reduced elective activity.

Cash £k — G

	Plan	Actual / Forecast
Year-to-date	3,605	49,268
Year-end Forecast	8,000	8,000

Cash is £45.7m ahead of plan at the end of August. Under the interim financial framework, the block and top-up payments for September, amounting to £47.5m, were received in August which has accounted for the significant movement in the cash balance.

Capital £k — G

	Plan	Actual / Forecast
Year-to-date	37,913	38,849
Year-end Forecast	103,951	107,651

The forecast position is £3.7m above the plan reflecting the notified capital funding for the Urgent and Emergency Care Programme (£3.7m). The Trust is still awaiting feedback from NHSE/I on a £2.4m COVID-19 capital return that was submitted in August but would anticipate that this expenditure will be funded via an additional PDC allocation.

Sustainability – Funding Arrangements M7 -12 (20/21)

- On the 16th September, revised guidance and Funding envelopes were been made available to each Integrated Care System (ICS) for the period from October 2020 to March 2021

- The priority for each Trust and ICS is accelerating activity for non-COVID care in line with the Phase 3 goals, alongside continuing readiness for winter and a potential increase in COVID-19 cases.

- An elective incentive scheme is being introduced with levels of performance being set and planned performance below these targets will trigger a reduction in funding at a marginal rate. Performance in excess of these targets will trigger additional funding at a marginal & semi-fixed rate.

- System funding envelopes are based on the expectation, that organisations will return non-NHS income to the levels seen in 2019/20, and organisations should make all reasonable efforts to do so as quickly as possible.

Financial Performance - Action & Recommendations

There are no actions required of the Board.

The Board is asked to note the following:

- The financial framework in relation to the financial arrangements from the 1st October has been published and will require further analysis and triangulation with submitted finance and activity plans.

- NHSE/I have held a series of national webinars and regional meetings to provide further clarity and receive feedback on the proposed funding mechanisms.

- Any changes to the financial framework, and the impact thereof, will be shared with the Finance and Performance Committee; who will continue to provide oversight on behalf of the Board.

- Plans to restore and recover elective activity have been implemented and performance against activity trajectories are reviewed by the Group Executive at both the Refresh, Restore and Recovery Delivery Board and at individual Divisional meetings.

Our People - Improving Staff Engagement

People

Staff Engagement
Target: Top 20% Engagement Score

- **Staff Health & Wellbeing**

The Trust has committed considerable charitable funds to support staff H&W – predominantly to create better spaces for Trust staff to take their breaks and time out to deal with challenging work demands, and to provide enhanced psychological support for staff .

The priorities have been agreed with staff and allocations overseen by a multi disciplinary group of staff chaired by the Chief Nurse.

The delivery of these projects will be reported back to the Charitable Funds Committee via the established approvals group.

- **NHS Staff Survey 2020**

The annual NHS Staff Survey administered for the Trust by Quality Health will run from 28 September until the 27th November 2020.
Timelines for results have yet to be confirmed but initial Trust results are expected between January/February 2021, with National Results issued February/March 2021.

- **Recruitment**

We are proactively recruiting staff and have:

- 204 vacancies in the pipeline which equates to 350.10 FTE.
- 246 candidates in process. Out of the 246 candidates, 8 are COVID workers 238 are considered business as usual.
- 265 candidates have moved through the on-boarding process between the period of 14th August 2020 to 14th September 2020.

The HR team are supporting nursing leaders with an Internal transfer process for Band 5 Nurses and targeted recruitment for Bank vacancies to support reducing the Agency spend.

Our People

People

Staff Engagement
Target: Top 20% Engagement Score

- **Equality, Diversity and Inclusion**

Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data has been forwarded to relevant NHS departments and are available on our external website.

Work is now being planned on how to address some of the discrepancies in outcome for our BME (WRES) or Disabled (WDES) staff.

BSUH is launching it's new BAME Network - they have agreed to name it SOAR which stands for **S**afe space, **O**pportunities , equity and empowerment - also a platform to **A**mplify voices, **R**edress the balance. We will take the opportunity to consolidate the work being done on this agenda and provide a more detailed update to the Board at a future meeting.

Our COVID-19 BAME Volunteers are engaging with colleagues and the issues they are highlighting will be brought to our Diversity Matters Steering Group.

Initial work is taking place to start the process of drafting our Equality Annual Report and we will be working with our colleagues at WSHFT again this year.

STATUTORY AND MANDATORY training compliance

Overall compliance has remained at 85% during the pause in face-to-face STAM training. Some face-to-face STAM training has resumed but there remains a decline in compliance for e-learning subjects which have no attendance restrictions and may be accessed from both work & home; in particular Information Governance which is 11% below it's target of 95%. (all other subjects have a 90% compliance)

Our People – HR Key Metrics

	Vacancy %	Sickness %	Turnover %	Appraisal %
Trust	8.6%	4.90%	10.7%	70.6%
Central Clinical Services	7.9%	5.00%	12.8%	74.2%
Children & Women	2.4%	4.42%	9.4%	79.1%
Medicine	11.1%	5.16%	12.2%	62.6%
Specialised Services	8.3%	4.36%	9.4%	63.3%
Surgery	10.5%	4.71%	9.6%	76.6%
Target - 2020/21 Y/E	10.0%	4.20%	12.0%	90.0%

Turnover - In August the Trust's Turnover (external leavers) rate reduced to 10.7%, the lowest level seen across the past eight years. Turnover is also favourable to the 12.0% Target set within the 2020/21 Operational Plan. Turnover rates continue to be largely favourable to Target across the Clinical Divisions, with the exception of Central Clinical Services (12.8%), where Turnover rates are higher due to the greater number of Scientific, Therapeutic & Technical staff working within the Division.

Vacancies - In August the Trust's overall Vacancy Rate stood at 8.6%, and favourable to the Trust Target of 10.0%. There are currently 742 FTE of vacancies across the Trust, and drilling down by staff group shows 22 FTE of Medical vacancies, 412 Nursing, S,T&T at 116, Admin & Clerical at 118 and Ancillary Support at 74. If staff groups are shown by Vacancy Rate rather than vacant numbers, then it shows Medical at 2%, Nursing at 11%, S,T&T (9%), Admin & Clerical (7%) and Ancillary Support (11%).

Appraisal - In August the Trust's (non medical) Appraisal Rate stood at 70.6%, slightly up on last month (70.4%) but down from 83.3% in August 19. The impact of operational pressures is still being felt upon appraisal levels, and this was the fifth month in a row where the rate has been in the low seventies range, compared to an average of 84% in the twelve months beforehand.

Sickness - The Trust's one month Sickness Absence rate was 4.48% in July, of which 0.18% was specifically COVID-19 and 4.30% other Sickness Absence. In July 2019 the one month Sickness Absence rate was 4.35%, so the Trust rate has slightly reduced year on year if COVID-19 is excluded. The 12 month Sickness Absence rate is now 4.90%, compared to 4.14% twelve months ago.

Under NHS guidance, staff either Self-Isolating or Shielding due to COVID-19 are recorded as Special Leave rather than Sickness Absence. In July 20 the Absence rate of these staff was 0.25%, putting total COVID-19 related absence at 0.43% (0.18% Sickness + 0.25% Special Leave), and the total of all Sickness Absence plus COVID-19 related Special Leave at 4.73% (4.48% Sickness + 0.25% Special Leave). The all absence rate of 4.73% compares to 6.17% last month, and 10.61% at the April peak.

NHS People Plan

- **We are the NHS: action for us all** – published 28 July 2020
- Focuses on how we must look after each other and foster a culture of inclusion and belonging, as well as action to grow and train our workforce, and work together differently to deliver patient care.
- The plan is focused primarily on the immediate term (2020-21) with an intention for the principles to create longer lasting change.
- Includes ‘Our People Promise,’ which sets out ambitions for what people working in the NHS say about it by 2024.
- Sets out commitments for NHSE/I, HEE and local employers that focus on:

  Looking after our people – with quality health and wellbeing support for everyone

  Belonging in the NHS – with a particular focus on the discrimination that some staff face

  New ways of working – capturing innovation, much of it led by our NHS people

  Growing for the future – how we recruit, train and keep our people, and welcome back colleagues who want to return

NHS People Plan

- Our NHS People Promise is central to the plan both in the next nine months and in the longer term. It has been developed to help embed a consistent and enduring offer to all staff in the NHS. From 2021 the annual NHS Staff Survey will be redesigned to align with Our People Promise.

- Each local system is asked to develop a local People Plan in response to the national plan, to be reviewed by regional and system level People Boards. We contributed to the Sussex plan which has been submitted and is awaiting feedback.
- Employers are encouraged to devise their own local People Plan and we are in the process of doing so.
- Metrics will be developed by September 2020 with the intention to track progress in line with the NHS Oversight Framework.
- Nationally, an independent review of HR/OD capability and capacity to deliver the NHS People Plan has been commissioned.
- A second plan is expected later in the year.

Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	11	**Meeting:**	**Trust Board in Public**	**Meeting Date:**	**29 Sept 2020**
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	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:

The attached report provides the Board with information from the Quality Assurance Committee meeting on the 22 September 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 the Trust's 2019/20 Infection Prevention and Control annual report and a report on Covid research activity.

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

Key Recommendation(s):

The Board is asked to:

- **NOTE** the assurance provided in respect of the patient safety where treatment has been

delayed and the learning and action taken as a result of incident investigations.

- **NOTE** the assurance provided in relation to the reviews over 52 week elective and 64 day cancer delays.

- **NOTE** that the Committee recommends to the Board for their information the Infection Prevention and Control 2019/20 Annual 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: 29 September 2020

From: Quality Assurance Committee Chair

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Dates	Chair	Quorate	
			yes	no
Quality Assurance Committee	**22 September 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 on the developing prospective harm reviews processes and **NOTED** the actions being taken by the Trust working with Sussex wide providers to develop the prospective process.

- 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 chair informing the Committee the actions being taken to reinstate this meeting with the support of the newly appointed Quality Governance Director. There was nothing the QGSG chair wished to raise outside the items on the agenda.

- The Committee **RECEIVED** a report in respect of undertaking a maternity peer review with WSHFT and agreed to receive the outcome of this work along with plans for the services to continue to enhance their closer working relationships.

- The Committee **RECEIVED** the Trust's annual report in respect of Infection Prevention & Control. The Committee **NOTED** the performance of the team, recognising the positive impact the team had. The report also included how the team will be working across 2020/21 to improve performance across the Trust to enhance the IP&C performance for the Trust. Based on the review at the meeting the

Committee **RECOMMENDED** this be shared with the Board for information and assurance.

- The Committee **RECEIVED** and **NOTED** the level of research activity being undertaken by the Trust linked to Covid and the outcomes of this research work would come back to the Committee through the normal reporting next year.

- The Committee reviewed the BAF risks for which it has oversight and **AGREED** their scores were fairly represented.

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

The Committee agreed it would receive back information from the Maternity peer review with WSHFT.

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.	No matters were required referral to the Finance and Performance Committee
The Committee recommended to the Board for their information the Trust's 2019/20 Annual Infection Prevention & Control Report	Board for information
The Committee recommended to the Board that the risks within the BAF for which it has oversight are fairly represented.	Board as part its approval of the BAF

Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	12.	Meeting:	Trust Board in Public	Meeting Date:	29 Sept 2020
Report Title:	Report from Finance and Performance Committee Meeting Chair				
Sponsoring Executive Director:	Lizzie Peers, Non-Executive Director				
Author(s):	Patrick Boyle, Non-Executive Director and Lizzie Peers, 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 have been two Finance and Performance Committee meetings since the last Board these being on the 25 August and the 22 September. The attached document provides an update to the Board on these two meetings.

The Finance and Performance Committee met on the 25 August 2020 was quorate and was attended by three Non-Executive Directors and the following Executives: the Chief Executive Officer, the Chief Financial Officer, and the Chief Nurse, with the Finance Director in attendance.

The Finance and Performance Committee also met on 22 September. It was quorate and was attended by three Non-Executive Directors, and the following Executives: the Deputy Chief Executive / Chief Medical Officer, the Chief Financial Officer, and the Chief Delivery and Strategy Officer along with the attendance from the Trust HR Director, Director of Efficiency and Delivery and Director of Capital and Estates, with Lizzie Peers taking the Chair for this meeting

At both meetings the Committee meeting, received information on key performance and financial matters along with that relating to the Trust's Efficiency programme. At the September meeting the Committee also received information on the Trust's capital programme and workforce capacity and

performance metrics.

Key Recommendation(s):

The Board is asked to

NOTE the assurance provided in respect of the Trust's performance plans and the established restoration plans and their supporting actions.

NOTE the assurance provided in relation to the delivery against the revised financial framework between April – August 2020.

NOTE the assurance provided in respect of the Trust's Efficiency Programme.

NOTE the assurance provided in respect of the Trust's workforce capacity and performance metrics.

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 noting that two risks, risk 2.1 and 2.2 have increased in Quarter 2.

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board

Date: September 2020

From: Finance and Performance Committee Chair

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Finance and Performance Committee	**25 August 2020**	**Patrick Boyle**	✓	☐
	22 September 2020	**Lizzie Peers (chair for this meeting)**	✓	☐

Declarations of Interest Made

None

Actions taken by the Committee

- The Committee **RECEIVED** at both meetings a report from the Managing Director/Chief Medical Officer on the Trust's performance and the impact of Covid-19 on the established improvement plans. The Committee was updated on the work being undertaken in respect of the development of the performance plans, within the national refresh, restore and recover framework and the Committee noted the challenges and constraints the Trust was seeking to work through within the developing plan. The Committee at its August meeting had a detailed discussion on the Stage three restoration of services communication received from NHSEI, including NHSEI's ambition to restore activity by October 2020 and the challenges facing the Trust and the wider system. Within the meeting in September the Committee held further discussions about the Trust's developed restoration plans and was **ASSURED** over the level of detail that had been applied to the performance planning and the submission made on 21 September 2020. The Committee discussed the risks to performance and managing expected winter demands and recognised these challenges are reflected within the Trust's BAF with risks 5.1, 5.2 and 5.3 with risks 5.2 and 5.3 being the highest scored risks within the BAF.

- The Committee **RECEIVED** a report on the Trust's financial performance and noted the position for month four at the August meeting and month five at the September meeting under the revised national financial regime. The Committee in the August meeting was **ASSURED** over the processes underway in relation to the stage three planning guidance received from NSHEI, and the confirmation that the Trust/ICS has been asked to submit expenditure forecasts based on activity projections. The Committee was informed that the MSK partnership block arrangements will be replaced with payment activity from M5. The Committee in the September meeting **RECEIVED** information in relation to the revised financial framework guidance and discussed the risks this may bring noting that detailed work to understand the implications of the framework changes remains underway. The Committee recognised that whilst the Trust has achieved its financial duties to break even the changes to the financial framework do represent an increase to risks 2.1 and 2.2 whilst the changes are being understood and challenging the service costs to deliver the restoration demands.

- The Committee at both meetings **RECEIVED** a report on the Trust's efficiency programme, its delivery and the work being undertaken deliver and further develop the tactical schemes. The Committee received information on the processes being applied to develop the more complex schemes and the processes being applied to assure the identified benefits. The Committee was **ASSURED** over the efficiency programme development and the work being undertaken to support the divisions in determining the scheme benefits.

- The Committee at its September meeting **RECEIVED** a report on the Trust workforce capacity and

performance indicators and recognised the linkage between this report and increased workforce costs through use of bank and agency staff and the pressure on the Trust's divisional budgets as referenced within the Month 5 financial report, with work to be done to better understand premia staff usage.

- The Committee **RECEIVED** at its September meeting a report on the Trust's capital programme. The Committee was **ASSURED** over the programme's performance with both the operational and strategic capital plan being ahead of spend forecasts but the year-end forecasting remaining within 102% of its allocation an improvement from earlier months. The Committee recognised the extra external funds being allocated to the Trust and the pressure this places on the Trust to deliver the schemes by the year end, with a risk of slippage.

- The Committee reviewed the BAF risks for which it has oversight for and **AGREED** these were fairly represented with the increase in risks 2.1 and 2.2 and the others remain at their quarter 1 scores.

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

The performance reports will incorporate delivery information against the restoration plan trajectories and track medically fit for discharge levels as this is key to sustained delivery.

The Committee will receive more detail on the revised financial framework.

The Committee will receive information on the work being done in respect of health rostering and the management of staff deployment through the routine workforce reports to the Committee.

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

Item	Referred to
The Committee recommended to the Board that the risks within the BAF for which it has oversight are fairly represented.	
The Committee referred to the Quality Assurance Committee a request to understand the drivers supporting the level of current sickness and how they impact on risk BAF risk 3.4 and staff wellbeing. The Committee also recognised that QAC will continue to review the quality impact of the continued performance demands on the Trust.	

NHS
Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	13	**Meeting:**	Board	**Meeting Date:**	29 Sept 2020
Report Title:	**Board Assurance Framework – 2020/21 Quarter 2**				
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 September 2020 Finance and Performance Committee 22 September 2020				

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 Q2 and that recorded for Q1. (⟷ 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.

Within Quarter 2, two risks have seen an increase within their current score, these are risks 2.1 and 2.2 which have increased due to the financial regime for Q3 and Q4 changing but as this revised framework has only just been issued and its impact has yet to be confirmed it presents increasing uncertainty and financial risk for the remaining part of the year.

Along with the risks 2.1 and 2.2 risks 5.1, 5.2 and 5.3 remain the Trust's highest scores with risks 5.2 and 5.3 both scoring 20.

Risk 5.1 which remains at the Q1 score with actions still to deliver; this is mainly related to the ongoing capacity and flow pressures within the B&H system relating to social care, and an emerging Mental Health increase in demand. Delivery of these actions will be reported to Finance and Performance Committee.

Risk 5.2 which remains at the score of Q1 last year reflecting the known delay to Stage 1 of 3Ts construction coupled with the potential further impact of COVID. This has the potential to impact the Trust's medium term strategic intentions. For this risk there are a series of actions in place which are being monitored by the 3Ts Oversight and Assurance Committee of the Board.

Risk 5.3 is in relation to the Trust's consistent delivery of the NHS Constitutional targets, which like all NHS providers; have been impacted following implementation of the national requirements to cease certain activities during the pandemic. As with a number of the BAF risks, the plans to mitigate this risk will be delivered through Trust's Refresh, Recovery and Restoration plans.

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	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	2	**8**

2.2 We cannot deliver ongoing efficiencies and flex our resources in an agile way resulting in an increasing or unmanaged deficit and inefficient, unaffordable and unsustainable services	4	3	**12**	4	4	**16** ↑							4	2	**8**
2.3 We are unable to meet high standards of financial stewardship meaning we cannot sustain compliance with our statutory financial duties	4	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	2	**8**
3.2 We are unable to effect cultural change and involve and engage staff in a way that leads to continuous improvements in patient experience, patient outcomes, and staff morale and wellbeing	4	3	**12**	4	3	**12** ↔							4	2	**8**
3.3 We are unable to meet our workforce requirements through the effective recruitment, development, training and retention of staff adversely impacting on patient experience and the safety, quality and sustainability of our services	4	3	**12**	4	3	**12** ↔							4	2	**8**
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	2	**8**
4. Quality Improvement ***Quality Assurance Committee***															
4.1 We are unable to deliver and demonstrate compliance with	3	4	**12**	3	4	**12** ↔							3	3	**9**

regulatory requirements or clinical standards adversely impacting on patient safety and our registration and accreditation by 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	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	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	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	2	**8**

Board Committee review of the risks

The Quality Assurance and Finance and Performance Committees at their respective meetings on the 22 September reviewed the risks for which they have allocated lead oversight for. Both Committees confirmed that they considered the current scores are fairly represented.

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:	14	**Meeting:**	Trust Board in Public	**Meeting Date:**	29/09/20
Report Title:	Annual Organ Donation				
Sponsoring Executive Director:			Dr George Findlay, Deputy CEO, BSUH Managing Director, Chief Medical Officer		
Author(s):			Alex Harrison, Clinical Lead for Organ Donation		
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:					
Annual Organ Donation Presentation for 20/21					
Key Recommendation(s):					
For the Board to NOTE.					

NHS
Brighton and Sussex University Hospitals NHS Trust

Organ Donation

Alex Harrison
Clinical lead for organ donation
29th September 2020

BSUH Activity

Brighton and Sussex University Hospitals NHS Trust

- Analysis *via* NHSBT potential donor audit
- Impact of COVID-19
- 2020-21 Activity
- Future challenges

NHSBT potential donor

Brighton and Sussex University Hospitals NHS Trust

- Summary report as circulated
- Quality indicators according to NHSBT best practice
- Bottom line = proceeding donors

NHSBT potential donor

Brighton and Sussex University Hospitals NHS Trust

- Lower “referral” rate than NHSBT would wish, but true ‘*missed referrals*’ are few and far between
- Brain stem testing rate less than 100%
- SNOD presence less than 100%
- Consent rates consistently superior to UK average (with or without SNOD present)

BSUH activity

Brighton and Sussex University Hospitals NHS Trust

- 24 consented solid organ donors 2019-20
- 17 actual donors
  - 9 DBD ; 8 DCD
- 31 life-saving transplants
  - 20 Kidney
  - 9 Liver
  - 2 Lung

COVID activity

Brighton and Sussex University Hospitals NHS Trust

- Reduction in Transplant activity nationally
  - Recipient risk from immunosuppression
  - Loss of ICU space in tertiary centres
  - Reduction in SNOD availability
- Now returning towards pre-pandemic levels
  - Likely to reduce again with 2nd wave

COVID activity

Brighton and Sussex University Hospitals NHS Trust

  - 3 donors during March
- April 2020 to August 2020 (inclusive)
- 8 Consented donors (of which 7 proceeding)
- 18 Organs transplanted
  - 12 Kidney
  - 3 Liver
  - 1 Lung
  - 2 Heart

2020-21 activity

Brighton and Sussex University Hospitals NHS Trust

- Organ donation week
  - National media campaign
  - Trust comms
  - Q&A on Workplace
- 4 SNOD in post
- Appointment of assistant CLOD (0.5 PA)

- Deemed consent (Max & Keira's law)

Future challenges

Brighton and Sussex University Hospitals NHS Trust

- Family approach and consent in COVID-era
- Improvement in “referral rates”
- Space for SNODs now and in 3Ts
- Implementation of Deemed Consent
- Service of Thanksgiving for donor families

- DCD heart retrieval

- Memorial to Donors in 3T building

Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	15	**Meeting:**	Trust Board in Public	**Meeting Date:**	29/9/20
Report Title:	**Annual Report Infection Prevention and Control 2019-2020**				
Sponsoring Executive Director:	Carolyn Morrice, Chief Nurse				
Author(s):	Kimberley O'Hara, Deputy Chief Nurse				
Report previously considered by and date:					
Purpose of the report:					
Information	✓		Assurance	☐	
Review and Discussion	☐		Approval / Agreement	✓	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	☐		Staff confidentiality	☐	
Patient confidentiality	☐		Other exceptional circumstances	☐	
Link to Trust Strategic Themes:					
Patient Care	☐		Sustainability	☐	
Our People	☐		Quality	☐	
Systems and Partnerships	☐				
Any implications for:					
Quality					
Financial					
Workforce					
Link to CQC Domains:					
Safe	☐		Effective	☐	
Caring	☐		Responsive	☐	
Well-led	☐		Use of Resources	☐	
Communication and Consultation:					

Executive Summary:

All Trusts have a legal obligation to comply with the Health and Social Care Act (2008) –Code of Practice for the Prevention and Control of Healthcare Associated Infections (DH 2015). A requirement of this Act is for the Board of Directors to receive an annual report from the Director of Infection Prevention and Control (DIPC). This report provides an overview of the infection prevention and control activity at the Royal Sussex County NHS Trust from April 1st 2019 to March 31st 2020. The annual report provides a summary of the infection prevention and control activity over the year 2019-2020 and performance against Healthcare Associated Infection (HCAI) reduction objectives for Brighton and Sussex University Hospital Trust.

Key Recommendation(s):

For Trust Board to APPROVE.

Brighton and Sussex University Hospitals NHS Trust

Annual Report Infection Prevention and Control 2019-2020

Contents

1. Executive summary

All Trusts have a legal obligation to comply with the Health and Social Care Act (2008) –Code of Practice for the Prevention and Control of Healthcare Associated Infections (DH 2015). A requirement of this Act is for the Board of Directors to receive an annual report from the Director of Infection Prevention and Control (DIPC). This report provides an overview of the infection prevention and control activity at the Royal Sussex County NHS Trust from April 1st 2019 to March 31st 2020. The annual report provides a summary of the infection prevention and control activity over the year 2019-2020 and performance against Healthcare Associated Infection (HCAI) reduction objectives for Brighton and Sussex University Hospital Trust.

The Chief Nurse is the accountable Board member for Infection Prevention and Control and undertakes the role of the Director of Infection Prevention and Control.

The infection prevention teams overarching strategy for 2019-20 was to avoid preventable healthcare associated infections (HCAIs). To achieve this, the objectives were:

- To focus on getting the basics right (i.e. hand hygiene, isolation, cleaning, polices and guidelines)
- Learning from Root Cause Analysis to improve patient safety
- Recruiting to the team (while supporting team members development and education).

During 2019-2020 the Trust met key standards and regulatory requirements for Infection Prevention and Control:

- The Trust met the objective reduction set for *Clostridiodes difficile* Infections (CDI)
- Only one outbreak of norovirus, which was well contained and occurred for a short period only
- Mitigation and monitoring continued to control *Pseudomonas aueriginosa* and *Legionella* in water

Healthcare Associated Infection Reduction Performance for 2019-2020:

There were 6 “Trust apportioned” MRSA bacteraemia cases in 2019-2020

The objective for *Clostridiodes difficile* Infection was 76 cases and this target was achieved.

There were 28 cases of Meticillin sensitive Staphylococcus aureus blood stream infections.

For the year 2019-2020 the IP Team delivered a multi-disciplinary education and training programme

Hand hygiene compliance with the World Health Organisation “5 moments for hand hygiene” is monitored monthly by departments who facilitate and undertake their own audits. Results are uploaded by departments onto a web based system. The infection prevention nurse team carry out a rolling programme of ward and department audits and these are reported at the infection prevention and control meeting, at senior staff meetings (such as Nursing Midwifery and Allied Health Professional Board) and in email updates. Hand hygiene performance is reported and monitored at the Divisional clinical governance meetings.

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

Pseudomonas and *Legionella* in water continues to be monitored and managed and the Infection Prevention Team attend the Waters Safety Group, which reports to the Infection Prevention and Control Committee

Key Challenges and risks include:

- The COVID-19 Pandemic. On February 6, a British businessman in Brighton was diagnosed.
- MRSA bacteraemia cases related to IV lines
- Hand Hygiene compliance with the "5 moments for hand hygiene". Although audits have demonstrated improvement, the Trust average is below 90%
- Attendance of key clinical staff at the Water Safety, Ventilation and Decontamination Groups has been low.

2. The Infection Prevention and Control team

2.1 The Infection Prevention and Control Committee (IPCC)

The IPCC meets every 2 months and reports to the Patient Safety Committee. It is chaired by the Director of Infection Prevention and Control or the Deputy Director of Infection Prevention and Control. In the first quarter of 2020 all Trust meetings were cancelled (to ensure social distancing during the COVID-19 pandemic). This was replaced by daily silver and gold meetings. From July 2020 the committee used Microsoft Teams for meetings online.

2.2 Infection Prevention and Control reporting framework

The Annual Report from the Director of Infection Prevention and Control (DIPC) for 2018-2019 was presented to the Trust Board September 2019

Infection Prevention and Control reported to the BSUH Quality Assurance Committee monthly

2.3 Antimicrobial Stewardship

Antimicrobial Stewardship is an overarching system of strategies to improve the use of antibiotics to benefit patient outcomes from infection, and it remains an integral part in the Trust achieving its Clostridium difficile infections targets. Continued reduction in overall antimicrobial consumption and particularly broad-spectrum penicillin and carbapenem prescribing is a priority in slowing the emergence of antimicrobial resistance.

The approach within in the Trust is both proactive e.g. comprehensive antimicrobial prescribing guidelines harmonised across primary and secondary care, utilisation of a local health economy joint formulary and reactive e.g. antimicrobial stewardship ward-rounds by infection doctors and pharmacists, audit and feedback.

Antimicrobial stewardship is recognised as being a critical component of Clostridium difficile infection control.

2.3.1 Key achievements around antimicrobial stewardship

Achievements for 2019/20 include;

- Appointment of a Lead Pharmacist for Antimicrobial Stewardship and Clinical Infection from January 2020 and the introduction of a rotational advanced clinical practitioner pharmacist in infectious diseases and Antimicrobial Stewardship.
- Reestablishment of joint antimicrobial stewardship ward-rounds by infection doctors and pharmacists within acute medicine at RSCH.
- Successful completion of the Royal Pharmaceutical Society AMS course by an advanced clinical practitioner pharmacist.
- Planning for the role out of electronic prescribing across the Trust starting August 2020 and liaising with the EPMA team as to how a 72 hour review of antimicrobials will be managed.
- Implementation of continuous antibiotic infusions using elastomeric pumps within OPAT
- Review of local GUM Primary Care Antimicrobial guidelines in collaboration with the CCG

In 2019 the Brighton-Lusaka Pharmacist Link was awarded a Commonwealth Partnerships for Antimicrobial Stewardship Scheme (CwPAMS) grant to improve AMS and infection prevention and control at University Teaching Hospitals, Lusaka, Zambia (UTH). A further grant from the Tropical Health Education Trust (THET) has enabled countrywide dissemination of capability to manufacture locally, WHO alcohol handrub.

In June 2019, the link hosted a three-day conference in Zambia for government level stakeholders plus pharmacists, physicians, nurses and allied healthcare professionals from UTH. This included workshops covering subjects such as global and local antimicrobial resistance patterns, behaviour change, global point prevalence survey training, use of defined daily doses to monitor antimicrobial consumption, infection prevention and control strategies such as handwashing and bare below the elbow initiatives and 'train the trainer' methodology.

A reciprocal visit to BSUH in November 2019 allowed opportunity for first-hand experience of AMS ward-rounds, infectious diseases clinical pharmacy services including OPAT, mandatory infection control education provided to all healthcare staff and inter-professional learning.

2.3.2 Publications by BSUH staff: antimicrobial stewardship and IPC:

J Antimicrob Chemother 2019 Nov 1;74(11):3362-3370. Intervention planning for Antibiotic Review Kit (ARK): a digital and behavioural intervention to safely review and reduce antibiotic prescriptions in acute and general medicine. (Author – Martin Llewelyn. Contributors – Samantha Lippett, Vikesh Gudka, Catherine Sargent, Daniel Agranoff, Sally Curtis, Elizabeth Cross, Jasmin Islam, Sacha Pires, Will Hamilton)

BMC Infect Dis 2020 Feb 3;20(1):102. The impact of diagnostic microbiology on de-escalation of antimicrobial therapy in hospitalised adults. (Authors – Martin Llewelyn, Samantha Lippett, Vikesh Gudka, William Hamilton, Sacha Pires, Elizabeth Cross)

Commonwealth Pharmacist Partnership develops antimicrobial stewardship and infection control in Zambia. FIP World Congress 2020. (Anja St. Clair Jones, Fiona Rees, Samantha Lippett)

Pharmaceutical Journal 2020 April 27th. Infection prevention and enhancing antimicrobial stewardship. (Anja St. Clair Jones, Fiona Rees)

2.3.3 Key goals around antimicrobial stewardship

Our key goals for 2020/21 include:

- To publish paediatric antimicrobial guidelines on Microguide App.
- Addition of novel antimicrobials (e.g. ceftazolone/tazobactam, ceftazidime/avibactam and ceftaroline) to the Joint Formulary to treat infections caused by multi-drug resistant organisms
- To continue to respond to the Covid-19 pandemic in terms of participation in clinical trials and the availability of novel treatments.
- To audit the use of antimicrobials in Covid positive patients. To learn from this and to assess guidelines on how to manage these patients in future.
- Extend the breadth of anti-fungal prescribing guidelines to support appropriate stewardship and reduce financial risk to Trust from inappropriate use of high-cost anti-fungals
- Publish guidelines for extended B-lactam infusions in critical care units to realise mortality benefit
- Increase use of procalcitonin tests to reduce antimicrobial consumption for respiratory infections after it has been introduced for Covid-19 patients.
- Extend antimicrobial stewardship ward rounds to wards identified by audit that are prescribing outside published guidelines.
- Introduce pharmacist led antimicrobial stewardship ward rounds on medical wards.

2.4 IPC advice and on call service

A continuous advice service is provided by the IPC Team/Infection Control Doctor (and out of hours by the on call Microbiologist). The Head of Nursing for Infection Prevention provides advice out of hours during outbreaks.

2.5 IPC Staff Establishment

The team establishment is as below and see appendix 3 (Please note the comments in parentheses to confirm alterations to set establishment)

Band 3 Infection Prevention Support Worker = 1WTE

Band 6 Infection Prevention Practitioner= 3WTE (NB 1 post holder returned from long term sickness 2/2/2020, a 2nd post holder began maternity leave on March 9th 2020)

Band 7 Infection Prevention Nurse = 1WTE

Band 8a Infection Prevention Matron = 1 WTE (NB post holder returned from long term sickness on Dec 16th 2019)

Band 8b Infection Prevention Lead Nurse = 1WTE (NB post from March 16th 2020)

Band 8d Infection Prevention Head of Nursing = 1WTE (NB post from June 2019)

Infection Control Doctor/Deputy DIPC = There is currently 2PA of Infection Prevention Doctor time. Currently support is provided by Infectious Diseases Consultant.

The Infection Prevention Team provides a daily service Monday-Friday 7.30pm – 5.30pm (these times have been extended since the previous year). Out of hours service is provided by the on call Medical Microbiologist. The Infection Prevention Head of Nursing provides support out of normal working hours as required (eg for norovirus outbreaks, and during COVID-19 pandemic).

The Infection Prevention Committee reports to the Quality Assurance Committee (QAC) and to the Trust Board directly via the DIPC.

Additional on-going Infection Prevention surveillance and support continues across the Trust with daily team visits to ward areas. Part of this daily visit is to complete a daily review of single rooms within the Trust and to ensure bed utilisation is prioritised. This has proved challenging during 2019-2020 due to staff vacancies, long term sickness, and the COVID-19 Pandemic resulting in the team prioritising visits to high risk areas.

The Infection prevention Team attends a large number of senior meetings to ensure key messages are communicated. They have also worked with the Trust Communication Team to provide posters and news updates for staff and visitors.

The Infection Prevention Team works with Procurement, Suppliers, Facilities and Estates Teams to ensure new equipment purchased, new works commissioned and new processes are managed and Infection risks are minimised in order to protect staff, patients and visitors to the Trust.

2.6 Infection Prevention Budget Allocation 2019-2020

The Infection Control Budget for Pay was £477,555 and for Non-pay was £10,388

3. Summary of Infection Prevention Audit and Surveillance programme

3.1 Mandatory Reporting via the Healthcare Data Capture System

Formal root cause analysis meetings take place for any case of MRSA bacteraemia or Clostridium diffilce (HOHA or COHA). A Trust wide audit programme is also in place with a focus on ensuring best practice to reduce Healthcare Associated Infections.

Public Health England (PHE) monitors the numbers of certain infections that occur in healthcare settings through routine surveillance programmes, and advises on how to prevent and control infection in establishments such as hospitals, care homes and schools. Public Health England's Data Capture System (DCS) provides an integrated data reporting and analysis system for the mandatory surveillance of *Staphylococcus aureus*, *Escherichia coli*, *Klebsiella* spp., *Pseudomonas aeruginosa* bacteraemia and *Clostridioides difficile* infections.

3.2 Meticillin Resistant Staphylococcus aureus bacteraemia Summary for 2019-2020:

Cases are apportioned to the Trust if the blood culture specimen date is on, or after, the third day of admission. There is no formal objective set.

There were 6 "Trust apportioned" cases in 2019-2020. Comparatively, there were only 2 cases in 2018-19.

Table 1: Summary of MRSA bacteraemia Post Infection reviews 2019-2020:

Month	Root Cause	Comments
April 2019	IV device infection	Agreed avoidable
July 2019	Not clinically significant and patient did not require treatment for the blood culture result	Blood culture sample documentation was complete but agreed likely contaminant.
September 2019	IV device infection in a child with complex underlying medical needs who required long term IV feeding, Had extensive areas of broken and ulcerated skin, and was MRSA colonised on transfer from Southampton	Agreed unavoidable
November 2019	Ongoing infection on same child as above	
February 2020	Antibiotics prescribed did not cover MRSA	Agreed lapse in care
March 2020	Vascath infection in patient requiring IV therapy due to underlying medical condition	Agreed unavoidable

There were 4 “non-Trust Apportioned” cases. This was a 33% reduction from 2018-19 where there had been 6 cases.

Table2: Comparison of MRSA positive blood cultures reported via DCS 2019-2020 and 2018-2019

Hospital cases		Community cases		Total cases	
2029–20	2018-19	2019-20	2018-20	2019–20	2018-20
6	2	4	6	10	8

3.3 *Clostridiodes difficile* Infection (Patients aged > 2 years)

Cases attributable to the Trust include:

-All hospital onset cases identified in the hospital three or more days after admission (day of admission being Day 1) – HOHA.

-All community-onset cases identified in the community (or within two days of admission) when the patients has been an inpatients in this Trust in the previous 28 days – COHA.

Summary of 2019-2020:
The objective was 76 cases and this target was achieved.

In 2019-2020 there were 17 lapses in care: 12 were due to antibiotics prescribing that did not comply with Trust guidelines, 3 were cross infection and 2 were due to delay in stool samples.

There was 1 outbreak on L8 Tower in May (i.e. 2 cases tested positive on the same ward in 28 day period that both proved to be the same ribotype (020).

There was a Period of increased incidence (PII) on Balcombe ward in November and a PII on Haemato-Oncology in January 2020

Formal meetings were held to consider how these could have been avoided, and actions agreed with clear timeframes for completion and ownership confirmed

Table 3a: Attribution of *Clostridiodes difficile* cases reported via the PHE Data Capture System 2019-2020

	HOHA	COHA	COIA	COCA	Total cases	HOHA +COHA
C.difficile	56	20	15	64	155	76

Table 3b: Attribution of Cdiff cases 2018 – 2019 (NB the 4 definitions for attribution were confirmed for the following year onward)

	Hospital	Community	Total
C.difficile	47	97	144

The following actions to reduce Cdiff infections were developed as learning from Root Cause Analysis:

- The ARK antibiotic training package was made available on the Trust info-net to enable prescribers to access the information easily. This was publicised by a competition during European Antibiotic Awareness week.
- The Antibiotic Pharmacist post was successfully recruited to and the new candidate was in post in 2020 and Antibiotic subcommittee reconvened.
- The programme of Hand hygiene audits was changed from the previous year so that the audits completed by ward staff were benchmarked against audits completed by the Infection Prevention team. These were fed back in a graphical format to allow data to be presented at Divisional Governance Meetings
- The IP Team meet monthly with Housekeeping Supervisors to discuss areas of concern.
- The Trust Stool chart updated to include Department of Health (DoH) guidelines that state type 5, 6 and 7 stool should be sent without delay if diarrhoea of an infectious cause is suspected.

3.4 Meticillin sensitive S. aureus bacteraemia

Cases are apportioned to the Trust if the blood culture specimen date is on, or after, the third day of admission. There is no formal objective set.

In 2019-2020 there were 28 “Trust apportioned” cases. This is a 16% increase from the previous year, where 24 were reported.

In 2019-2020 there were 73 “non-Trust apportioned” cases. This is a 10% increase from the previous year, where 66 were reported.

Formal root cause analysis meetings are not held for these cases, they are, however, discussed at weekly Micro hand over meetings.

3.5 Gram negative Blood Stream infection

E Coli Blood Cultures

Cases are apportioned to the Trust if the blood culture specimen date is on, or after, the third day of admission.

14% of cases are “Trust apportioned” while the remainder are “non-Trust apportioned”.

In 2019-2020 there were 40 “Trust apportioned” cases. This is a 2.5% decrease from the previous year, where 41 were reported.

In 2019-2020 there were 247 “non-Trust apportioned” cases. This is a 7% increase from the previous year, where 230 were reported.

Formal root cause analysis meetings are not held for these cases, they are, however, discussed at weekly Micro hand over meetings.

Analysis of the root cause of EColi blood stream infections has demonstrated:

Urinary = 55% (12% of these patients had a urinary catheter)
Hepatobiliary = 20%
Gastrointestinal = 7%
Skin/soft tissue = 7%
Respiratory = 4%
Others = bone and joint (<1%) or unknown (6%)

As 86% of cases are “non-Trust apportioned” learning was fed back at Sussex System meetings to ensure Community and Care Home colleagues were involved in planning, with the shared aim of reducing infections across the Healthcare economy.

***Pseudomonas aeruginosa* Blood cultures**

Cases are apportioned to the Trust if the blood culture specimen date is on, or after, the third day of admission.

In 2019-2020 there were 15 “Trust apportioned” cases. This is a 50% increase from the previous year, where 10 were reported.

In 2019-2020 there were 24 “non-Trust apportioned” cases. This is a 7.5% decrease from the previous year, where 26 were reported.

Root cause analysis is undertaken by the Infection Prevention Team and cases are assessed against water test results. This confirmed that there was no link to water outlets.

***Klebsiella spp* Blood cultures**

Cases are apportioned to the Trust if the blood culture specimen date is on, or after, the third day of admission.

In 2019-2020 there were 29 "Trust apportioned" cases. This is a 21% increase from the previous year, where 24 were reported.

In 2019-2020 there were 53 "non-Trust apportioned" cases. This is a 22.3% increase from the previous year, where 41 were reported.

Table 4: 2019 to 2020 Healthcare Data Capture System Organism totals

	Hospital cases	Community cases	Total cases
MRSA	6	4	10
MSSA	28	73	101
Ecoli	40	247	287
Pseudomonas	15	24	39
Klebsiella	29	41	70

Table 4: 2019 to 2020 DCS Organism totals comparison with 2018 to 2019

	Hospital cases	Community cases	Total cases
	2018–19 2019-20 (%+/-)	2018–19 2019-20 (%+/-)	2018–19 2019-20 (%+/-)
MRSA	2 6 (+200%)	6 4 (-33%)	8 10 (+25%)
MSSA	24 28 (+16%)	66 73 (+10%)	90 101 (+12%)
Ecoli	41 40 (-2.5%)	230 247 (+7%)	271 287 (+6%)
Pseudomonas	10 15 (+50%)	26 24 (-7.5%)	36 39 (+8%)
Klebsiella	24 29 (+21%)	53 41 (22.5%)	77 70 (-9%)

3.6 Mandatory Surgical Site Infection Surveillance (SSIS)

The Trust participates in the mandatory Public Health England Surveillance of surgical site infections (SSI's) in orthopaedic surgery. A minimum of one from a total of four surveillance periods per year is required. For 2019 to 2020 the Trust submitted data for Total Knee Replacement surgery for Quarter 3 (July to September) of 2019.

The infection rate for this quarter was 0%. PHE informed the Trust that following review of the Trust data they had found that among participating hospitals, incidence of surgical site infection (inpatient

and readmission) was above the national 90th percentile with an overall infection rate of 0.9% when the previous 3 surveillance periods were factored in. A response providing assurances was sent to PHE from Mr Majid Chowdhry (Lead for Elective Surgery) on behalf of the Trust.

The surveillance will be carried out for all 4 quarters in 2020 -2021 to enable more detailed and effective analysis of infection rates.

3.7 Vancomycin Resistant Enterococci (VRE)

In 2019-20 there were a total of 48 VRE cases, 37 of which were collected on / after the 3rd day of admission.

These cases represent a range of sample types – Blood cultures 7, Body fluid 5, ETT 1, Faecal 3, Respiratory fluid 1, Sputum 2, Tissue 10, Urine 16, Wound swab 3.

No VRE outbreaks were identified in 2019-20.

3.8 COVID-19

On 31 December 2019, the World Health Organization (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan, Hubei Province, China. A novel coronavirus (SARS coronavirus-2 (SARS-CoV-2)) was subsequently identified from patient samples.

This Trust was one of the first to be impacted in the UK when on February 6, a British businessman in Brighton was diagnosed with the virus after catching it in Singapore. The so-called 'super spreader' was later linked to 11 other cases, five of which were in the UK.

Actions were taken in short timeframes in response to the challenge of COVOID-19 with key actions listed below:

- Feb 9 – Assessment "POD" up and running so that patients and staff could be tested. This was a valuable part of the Track and Trace planning.
- Feb 14– The patient Pathway was in place for patients screened in ED or POD. This specified use of Courtyard if an ED attender required hospital admission. Contact tracing was undertaken for each patient and staff were contact by the local Health Protection Unit.
- Feb 24– Screening in place for all ITU admissions
- March 2– Level 4 incident declared in UK. The Trust had an incident coordination centre in place. Segregation of "COVID" and "Non COVID" attenders was in place in ED and Crit Care capacity was reviewed to assess the required threefold increase in current ITU bed capacity
- March 13– "Delay" phase declared. This indicated that cases were now not only related to travel. Guidelines stated that Personal Protective Equipment (PPE) was to be worn for any suspected or confirmed patient
- March 20 – non essential work was cancelled with staff working from home if possible. All meetings were held remotely
- March 23 - "Red and Green" pathways reviewed in ED

The Trust faced an unprecedented challenge in the face of the global pandemic, which at the peak of the first wave (April 11th) was 116 COVID-19 positive in-patients across both hospital and in patient ward off site at Newhaven .

Having adequate supplies of the correct and suitable Personal Protective Equipment (PPE) demanded much of the Procurement and Infection Prevention Team resource. Stock levels were monitored during daily "Bronze" and "Sliver" command meetings.

National Stock issues necessitated use of the National Pandemic Stock and as these were different items to those previously used at this Trust, a rolling programme of training and fit testing was required. From April the Trust PPE Safety Team was in place to support this.

This included ensuring a robust process of FFP3 mask fit testing was in place, and was maintained.

NHS England and NHS Improvement issued guidance on 19 May 2020 regarding interim data collection for hospital onset COVID-19. This included definitions to confirm if COVID-19 should be considered to be acquired in hospital. This has been used to assess all in-patients with COVID-19 in the Trust from that date. Two wards were confirmed as having fulfilled the criteria for a COVID-19 outbreak (NB it was noted that Trust policy to screen all inpatients had come into place at the end of May and so some patients were asymptomatic at the time of screening).

Bailey Ward

- 24/5/2020 1x patient on this ward who fulfilled the criteria for "Hospital onset definite" COVID
- 25/5/2020 1 x patient confirmed as "hospital onset definite" COVID
- 27/5/2020 1 x patient ward "Hospital onset probable" COVID

Valance Ward

- 25/5/2020 Two patients in Vallance ward were confirmed COVID-positive with the sample taken >14days after admission ("hospital onset definite").
- 26/5/2020 One additional patient confirmed as "hospital onset definite"

Outbreak meetings were held and actions agreed and there were no further cases as a result. Documentation using the national IIMARCH form was completed and sent to the local HPU, CCG and NHSE/I.

3.9 Hand Hygiene

Hand cleaning is the single most effective means to reduce the spread of any infection. It is the cornerstone of the Infection Prevention programme.

Hand hygiene compliance with the World Health Organisation "5 moments for hand hygiene" is monitored monthly by departments who facilitate and undertake their own audits. Results are uploaded by departments onto a web based system. The Infection Prevention Nurse Team carry out a rolling programme of ward and department audits and these are reported at the Infection Prevention and Control Meeting, at senior staff meetings (such as Nursing Midwifery and Allied Health Professional Board) and in email updates. Hand Hygiene performance is reported and monitored by the Divisional clinical governance meetings

Table 5a: Trust wide Hand Hygiene scores by quarter 2019-2020 (NB these are the audits completed by the Infection Prevention Team. The programme commenced in July 2019)

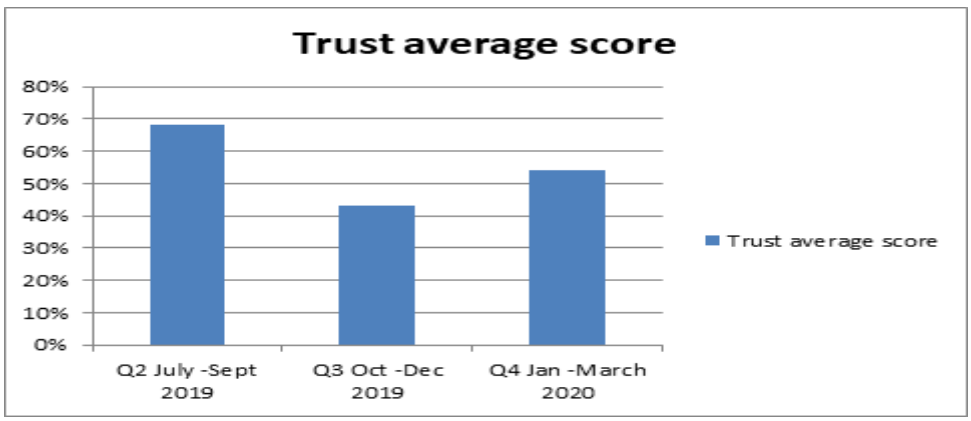
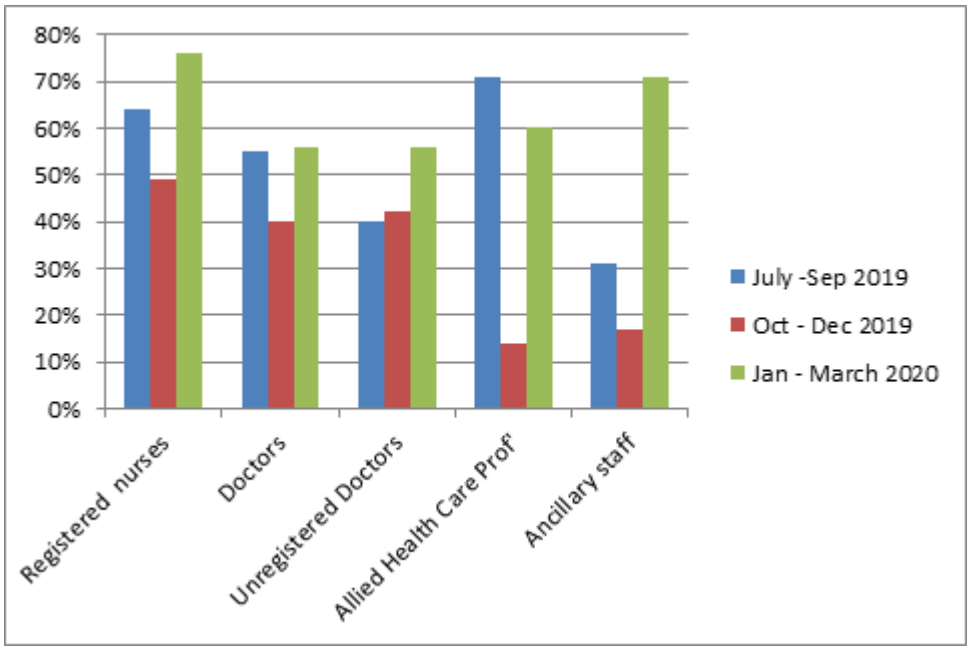


Table 5b: Trust wide hand hygiene scores by staff group 2019-2020) (NB these are the audits completed by the Infection Prevention Team. The programme commenced in July 2019)



Actions to improve hand hygiene at the Trust:

- The Infection Prevention Team complete a rolling programme of hand hygiene audits Trust wide. These are the audit scores that are reported to the Infection Control Committee and Trust Board.
- Audits are unannounced and take place over a number of days to ensure they are a true reflection of the ward performance.
- Matrons and Ward Managers are invited to take part in audits for educational purposes and to allow rapid feedback to their teams.
- Results are fed back in a graphical format broken down by staff group, and by each of the "5 moments" to allow feedback at Governance Committees etc. Results are sent to senior ward staff and also to housekeeping supervisors and managers of allied health professionals
- Audit results are discussed in MRSA and Cdiff Root Cause Analysis meetings
- Spot check audits are completed 3 monthly to ensure hand sanitiser is available at "the point of patient care" (ie at each bed, trolley and examination room
- A Trust wide hand cleaning technique week was held in 2019 to check staff used the correct technique (they were given feed back on how to improve their technique), to ensure staff are Bare Below the Elbows, and also to check for dermatitis and skin issue

Hand Sanitiser Availability "Spot Checks"

These are carried out quarterly by the Infection Prevention Nurses. The spot checks are to ensure hand sanitiser is available at the "Point of Patient Care" (i.e. there is one for every bed and cot, trolley space or examination room)

The results are sent out to Heads of Nursing, Matrons, Ward Managers and IP Link Nurses and are as below:

June 2019= 93%

October 2019 = 89%
Jan 2019 = 87%

In order to improve the scores ward staff were asked to include sanitiser checks as part of their morning huddle. The Infection Prevention Team also checked them during their ward rounds and prompted staff to replace ones that were noted to be missing.

Commode Cleanliness Audits

These are carried out by the Infection Prevention Nurses. Clean commodes are an essential part of preventing the spread of faecal-oral infection such as C.diff, as well as demonstrating to patients that the Trust has high standards of hygiene.

The audits also include potties and bed pans and the results are sent out to Heads of Nursing, Matrons, Ward Managers and IP Link Nurses and are as below:

October 2019 = 60%
January 2020 = 66%

It was noted during the audits that a number of commodes were difficult to clean and so an easier to clean model was identified for staff to order.

4. Additional aspects of the Infection Prevention programme of work

4.1 Norovirus Outbreaks

The number of outbreaks related to diarrhoea and vomiting was greatly reduced in 2019-2020 when compared to the previous year.

RSCH Chichester Ward was closed on 05/10/2019 until 14/10/2019 with confirmed norovirus

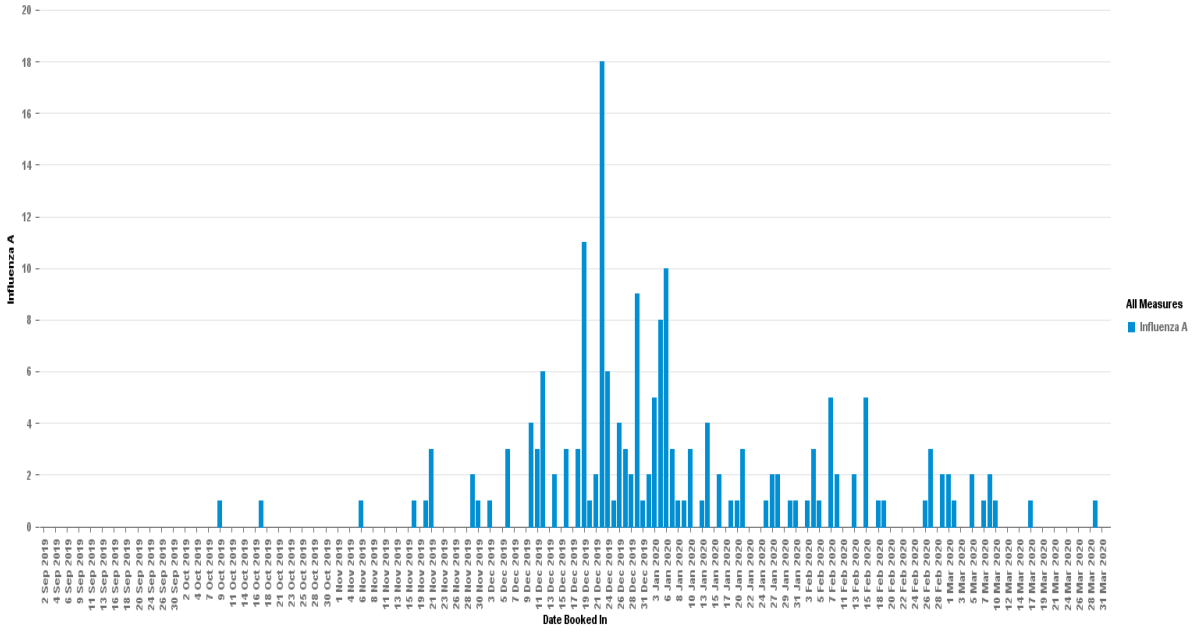
RSCH AAU was closed on 20/10/2019 until 22/10/2019 with suspected norovirus.

4.2 Influenza 2019-2020

The Southern hemisphere had experienced a difficult winter with a larger than expected number of influenza cases. This expected increase did not appear in the UK and there was no impact on bed usage or clinical work due to influenza

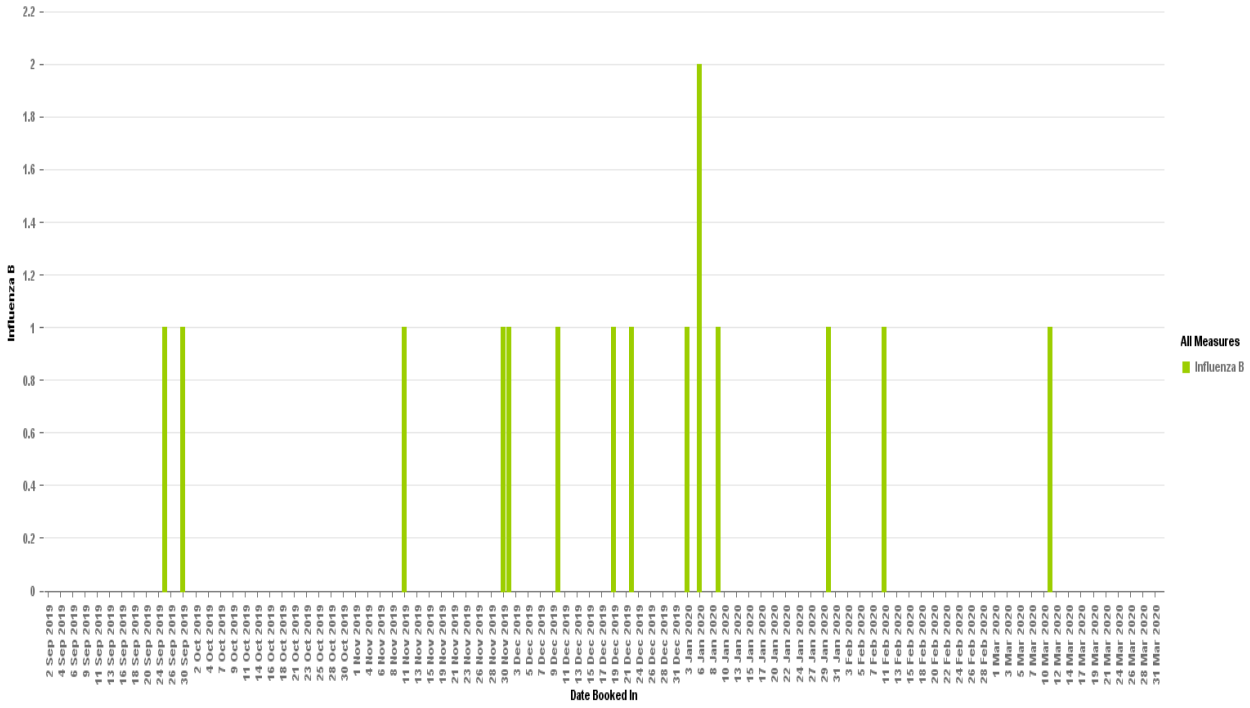
4.3 Influenza A cases

Total 175 results



Influenza B

Total 14 results



The flu vaccination campaign saw an increase in staff who were vaccinated this year. The Occupational Health Team, Practice Development Team and trained Peer Vaccinators provided set clinics, attended clinical areas and training sessions in order to enable staff to access 'flu jabs'. Roaming vaccinators were also available across both hospital sites, off site wards and outpatient areas both during normal working hours, and at weekends and evenings.

Table 6a: 2019-2020 flu season: Staff vaccinated by number and percentage

BSUH Flu Vaccination Campaign (correct as at 27/01/2020)		
Staff type	Vaccinated (Number of staff)	Vaccinated (%)
Medical	789	66%
Nursing	1487	65%
Other professionally qualified	392	66%
Support to clinical staff	995	64%
Non-clinical	883	35%
Total (All)	4546	56%
Total (Frontline)	3663	65

Table 6b: 2019-2020 flu season: Staff vaccinated by Directorate

	Vaccinated	No of staff	%
Medicine	856	1108	77
Surgery	732	1132	65
W&C	540	767	70
Specialist	625	1126	56
CSS	682	1025	67
Other	228	494	46
	3663	5652	65

To improve vaccination uptake in 2020-2021 season it is planned to include Allied Health Professionals as peer vaccinators, and to use incentives such as prizes.

4.4 Hepatitis B case in BSUH Renal Unit

This case was confirmed November 2019 and the formal meeting held agreed that there was no breach in processes, as this was not a case of cross-infection. This was an occult HBV case and the Virology Consultant stressed that this was a low risk event.

There were general lessons that were agreed during the meeting such as the need for administrative support during this time of challenge

Good practice was identified such as Consultants quickly identifying patients who required vaccination so that the Renal ward nurses were able to promptly vaccinate those who required it.

Senior staff were able to contact units where patients had dialysis on holiday and those units whose patients had holiday dialysis at BSUH.

A requirement for a robust process for cleaning of dialysis machines (confirmed in writing by manufacturer) was identified, although this was not a case of cross infection.

4.5 Decontamination

The Infection Prevention team have been involved in giving decontamination advice throughout the Trust, and attending the decontamination committee meetings. Peter Brown, Head of Decontamination is the lead for decontamination in the Trust and the IPT works closely with the decontamination committee to ensure all policies and procedures are being adhered to.

The Sterile Services Departments (SSD) are fully compliant with the Medical Devices Directive 93/42/EEC annex V (sterility only) and has an auditable ISO 13485:2016 Quality Management System; for Medical Devices.

The Endoscope Decontamination Units (EDU) are also working within ISO 13485:2016 and are JAG registered for bowel cancer screening. Audits of SSD's and EDU's are carried out on a regular basis by an external notified body on behalf of the MHRA.

The SSD at RSCH has recently had a new Reverse Osmosis water treatment system installed and commissioned.

Key priorities for decontamination for 2020/21 include:
· New Automated Endoscope Reprocessing machines at both sites
· Replacement Reverse Osmosis System at PRH
· Centralising RACH Endoscope Decontamination
· Conducting Decontamination Audits throughout the Trust

4.6 Estates and Soft Facility Management (Soft FM) Service

The cleaning of all Trust premises is provided through a combination of in house services and service level agreements with neighbouring Trusts. All of the services are managed and monitored by the corporate Facilities & Engineering team. The cleaning services provided are invaluable to maintain and promote an appropriate level of cleanliness across the Trust in an ever changing environment.
The Trust also directly manages the patient catering, retail catering, porter, security and help desk teams across the main two hospital sites.

In addition to our directly managed in house services, the department manages the waste management and linen & laundry contracts and works closely with the service providers to work more efficiently and make service improvements.

4.6.1 Cleaning Capacity
At the Royal Sussex County Hospital, the ward based catering hosts moved from the management of the housekeeping team to under the management of the patient catering team and the housekeepers ceased assisting with the food and beverage service allowing them more time to focus on cleaning. This programme was completed in March 2020 and has a significant positive impact on the cleaning throughout the hospital and there has been a great improvement in the consistency of recruitment and rota fill although staff sickness remains an issue.

Dedicated HR support and training has continued to be provided to improve sickness management within the service.

4.6.2 Quality Measurements

There are a number of internal and external quality measures in place that relate to cleanliness, patient food and healthcare waste disposal:

- Environmental Health inspection
- In house monitoring
- Infection control audits
- Internal Food Safety audits
- HACCP
- National Specifications for Cleanliness in the NHS
- Patient environment assessments (PLACE)
- Dietician advice and direction
- Waste Management audits
- Independent Swab Testing
- Independent Allergen Swab Testing

Policies

- Cleaning policy
- Linen Handling & Laundry policy
- Food Hygiene policy
- Waste Management policy
- Pest Control policy
- Food Allergen Management Policy (to be ratified)

4.6.3 National Specification for Cleanliness

The National Specification for Cleanliness 2007 monitoring criteria are used across the Trust. Soft FM and a team of independent Monitoring Officers support the monitoring of cleaning standards.
Work had to be made to improve the Synbiotix monitoring tool which the monitoring team use to audit the cleaning within the Trust and there were some issues with the system which has since then been worked on from January 2020 to rectify any issues (which have now been resolved).

4.6.4 Patient Led Assessment of the Care Environment (PLACE)

External PLACE assessments were completed during Q2 19.
The purpose of PLACE is to provide a non-technical view of the quality of non-clinical services provided to in-patients and other hospital users across all qualifying hospitals. It is based on a visual assessment, not relying on the application of any technical or scientific tools. It is therefore a fundamental component of the process that assessors will need to exercise a degree of judgement, particularly when required to agree the score to allocate for a particular aspect of the assessment.
Each PLACE visit generates a score in the 6 separate domains of Ward Cleanliness, Food & hydration, Condition and Appearance, Privacy & Dignity, Dementia, and Disability. An Action Plan which sets out how the organisation expects to improve their services before the next assessment is also required and has been undertaken per site.

Separate assessments are carried out in respect of the Royal Sussex County Hospital main site, the Royal Alexandra Hospital for Children, the Sussex Eye Hospital, the Princess Royal Hospital main site, the Sussex Orthopaedic Treatment Centre and Newhaven Downs Community Hospital/Polyclinic.

The individual results are shown below:

Royal Sussex County Hospital 98.17%
Royal Alexandra Hospital for Children 96.54%
Sussex Eye Hospital 100%
Newhaven Polyclinic 100%
Sussex Orthopaedic Treatment Centre 100%
Princess Royal Hospital 98.9%
Any immediate areas of concern are fed back to the ward/site at the time of the assessment.

4.6.5 Patient Catering Services

Patient Catering is provided in-house in both the Royal Sussex County and Princess Royal Hospitals. 2019 saw the Royal Sussex County service upgraded to a 5* Hygiene rating by the local authority Environmental Health service. The Princess Royal Hospital current holds a 5* hygiene rating which is the maximum achievable score. The accreditation recognises improvements made to the Trust's food safety system which ensures that our patients are served with safe healthy meals and complies with current and future legislation, national guidance and best practice in the areas of Food Safety.

The Food Improvement Group which commenced in August 2017 has the purpose of which is to oversee from a strategic perspective all aspects of the food and nutrition services provided to patients and staff throughout BSUH. There is operational representation within the group to ensure that national recommendations (e.g. NICE guidance) are fully implemented throughout the Trust. Issues relating to national, regional and local policies are discussed and ratified. Existing systems are discussed and reviewed to ensure, monitor and improve the quality of nutritional care to patients. The group ensures that all stakeholders are advised of proposed changes that may impact on their service in a timely manner.

In April 2019 the Trust changed the external cook freeze supplier from Tillery Valley to Apetito after a very comprehensive procurement programme. The change of supplier has resulted in very positive feedback from the wards and has been seen as a success.

4.6.6 Transfer of Host Staff to Patient Catering

As mentioned above the Ward Hosts at the Royal Sussex County Hospital have historically been managed by the Housekeeping team and not Patient Catering as is the case at the Princess Royal Hospital. This created inconsistencies between the main sites and a reduced level of support for the hosts. Concerns were also raised in relation to clarity of roles and in particular housekeeping staff moving between cleaning tasks and food service tasks. In order to address this anomaly a major implementation project was completed in March 2020 with all ward hosts transferring from Housekeeping to Patient Catering.

Under the management of the Patient Catering team hosts are fully supported and will undertake comprehensive refresher training in regeneration and food service processes. In addition all Host staff will be required to successfully complete the L2 Award in Food Safety.

The host team will be a dedicated workforce and will not be required to undertake cleaning duties other than within designated catering areas.

4.6.7 Training

Throughout the 2019/20 year, in-house managed teams undertook internal training in manual handling, fire, health & safety, infection prevention (non-clinical), hand hygiene, and safeguarding children.

In addition a number of managers and supervisors undertook externally sourced 'IOSH managing safely' health and safety training.

All Facilities staff are registered on the IRIS workforce training system and have completed the Trust's e-learning packages or face to face sessions. This contributes towards core and essential training.

Patient Catering staff have also completed CIEH accredited L2 Foundation Certificate and L3 Intermediate Certificates in Food Safety in line with the requirements of our Food Hygiene policy.
The Infection Prevention & Control team also provide training and guidance on standard infection control precautions such as hand hygiene and new protocols on terminal cleaning to Soft FM staff.

4.6.8 Estates Management Service

The Engineering Department are responsible for the infrastructure that the Trust relies on. They are not only involved with the building themselves and the systems that keep them running, but are also involved in the planning and commissioning of new buildings and facilities, redeveloping existing premises or the disposal and demolition of redundant resources.

The Engineering Department continues to work closely with the IP Team in improving the practices of maintenance and monitoring on both the ventilation and water systems.

There is now a sustainable programme in place for the annual verification of all critical ventilation areas, with specialist ventilation. The programme is overseen by the Ventilation Steering Group. Previous verification reports have been reviewed by IPT and the Engineering Department.

Water safety is managed though the Water Safety Management Group who meet monthly. There is also a newly formed Water Safety Operational Group who manage the monitoring results and associated remedial action. Currently the group meet fortnightly, IPT attend both groups. All systems continue to be tested and monitored and reported on in liaison with IPT. The meetings ensure all results and issues can be acted on in a timely manner and escalated as required.

4.6.9 Water Management

The trust uses in excess of 250,000m3 of water during the course of a normal year, which is provided by the local water authority. The water systems and functions on site range from the provision of potable water supplies, tank water supplies and specialist 'treated' water supplies providing for process plant and medical equipment.

The Trust has appointed a specialist to act as the Authorising Engineer (water) to give expert advice and support with all aspects of water hygiene. The Authorising Engineer produces an annual report, the draft 19/20 version was received by the Water Safety Management Group.

The Trust monitoring and sampling arrangements are contracted out to a 3rd party and are conducted at frequencies prescribed in the Service Level Agreement with the contractor and recorded on a web based portal (Zeta Safe) for auditing purposes.

The water samples are processed at a UKCAS accredited Laboratory which is part of the Environmental Microbiology Unit at PRH.

In addition to the monitoring contract the Trust also uses chemical dosing to the water systems, chlorine dioxide (CL02) on the RSCH site and Sliver/Copper (Ag/Cu) on the PRH site. The dosing units and residual chemical reading are managed by a 3rd party contractor and monitored by the Water Safety Operational Group.

4.7 Serious incidents

The Serious Incident (SI) Framework describes the process and procedures to help ensure serious incidents are identified correctly, investigated thoroughly and to ensure learning ensures these are not repeated.
During 2019-2020 the Trust reported one SI in response to the Cdiff outbreak on L8 Tower in May. Two patients tested positive on the same ward in 28 day period that both proved to be the same

ribotype (020). Both patients were informed of this, both had only mild symptoms and both recovered and were discharged home.

4.8 Complaints

There have been no complaints with Infection Prevention as the primary issue during 2019-2020.

4.9 Tuberculosis (TB)

There has been no TB outbreak in 2019-2020. As an action from the TB outbreak in the previous year, an IP Team member attends TB Team meetings to discuss new cases and to ensure safe patient placement within the Trust.

4.10 Training and Education

All staff in the Trust must receive a Trust induction (including volunteers) as a requirement under Trust registration (Department of Health 2015). They must also receive an update that reflects national competencies as outlined by Skills for Health (2017), General Medical Council (2015) and Nursing and Midwifery Council (2010). The IP Team has delivered an education and training programme providing face to face sessions for clinical, non-clinical, volunteers and students.
Training is also available via e-learning, and this was used during the COVID-19 pandemic (when all meetings and teaching sessions were mandated to be held remotely).

The IP Team have also facilitated FFP3 fit test “train the trainer” sessions and Infection Prevention Link Nurse study days.

4.11 Safety Thermometer

The IP Team validate the clinical catheter associated urine infection (CA_UTI) data for the Trust.

Appendix 1:

Infection Prevention and Control Committee Terms of Reference

<table>
<tr><td>Title:</td><td>Infection Prevention Operational Group (Monthly)</td></tr>
<tr><td>Date approved and approving body:</td><td>Ratified at the 30th August 2019 meeting of the Infection Prevention and Committee (IPCC)</td></tr>
<tr><td>Constitution and establishment:</td><td>The IPCC has been constituted under the authority of the Board. The IPCC reports to the Patient Safety Group, which in turn reports to the Quality Governance Steering Group which reports directly to the Trust Executive Committee (TEC).</td></tr>
<tr><td>Accountability:</td><td>The IPCC is accountable to the Patient Safety Group, which is accountable to the TEC, a sub-group of the Board.</td></tr>
<tr><td>Purpose:</td><td>1. Focus on progress against the Corporate Healthcare Associated Infection reduction action plan

2. Ensure that the Infection Prevention (IP) annual program is disseminated to the Divisions and actions monitored through the various Governance meetings

3. Monitor infection prevention standards against the Trust infection prevention key performance indicators</td></tr>
<tr><td>Membership:</td><td>
<table>
<tr><td>Director of Infection Prevention and Control (DIPC)</td><td></td></tr>
<tr><td>Infection Control Doctor (Deputy DIPC) and Head of Nursing for Infection Prevention</td><td>Chair</td></tr>
<tr><td>Nurse Director for Workforce and Education</td><td>Deputy Chair</td></tr>
<tr><td>Directorate Lead Nurses</td><td></td></tr>
<tr><td>Infection Prevention Nurse</td><td></td></tr>
<tr><td>Facilities and Engineering</td><td></td></tr>
<tr><td>IP Lead Consultant in ICU</td><td></td></tr>
<tr><td>Decontamination Operational Lead</td><td></td></tr>
<tr><td>Antimicrobial Pharmacist</td><td></td></tr>
<tr><td>Sepsis Clinical Nurse Specialist</td><td></td></tr>
<tr><td>Risk Management Safer Sharps</td><td></td></tr>
<tr><td>Heads of Nursing/Matrons</td><td></td></tr>
</table>

Meeting papers will be sent to the CCDC and CCG Leads for NHS Brighton and Hove CCG, NHS Hastings and Rother CCG and PHE. The Chair of the Group may also extend invitations to other personnel with relevant skills, experience or expertise as necessary to deal with the business on the agenda. Such personnel will be in attendances only</td></tr>
<tr><td>Communication:</td><td>A notice of each meeting, including an agenda and supporting papers, will be available for each member of the IPCC one week prior to the date of the</td></tr>
</table>

	meeting. Additional agenda items should be submitted to the Chair at least two weeks prior to the date of the meeting. A forward planner for the group will be made available, and reviewed annually.
Quorum:	A quorum of members must be present for the meeting to proceed, and should consist of: • Infection Control Doctor (Deputy DIPC) or a Consultant Microbiologist • Infection Prevention Head of Nursing • A nursing representative from at least three Divisions • Facilities and Engineering representative Deputies will count towards the quorum.
Frequency of meetings:	Meetings of the group will be held every 2 months. Extraordinary meetings may also be scheduled to expedite action in respect of any urgent issues arising in the interim period.
Agenda and notes/action points:	The Committee shall be supported administratively by the Infection Prevention Team/Administrator. In this respect, support will include: • The agreement of the agenda with the Chair, collation of relevant papers, taking and disseminating the minutes, and keeping a record of matters arising and issues to be carried forward • Ensuring the TOR's are reviewed on an annual basis • Ensuring that the group reviews the effectiveness of its reporting sub-groups on an annual basis in terms of evaluating their role in continuing to monitor and further improve clinical outcomes and effectiveness
Attendance at meetings:	Members are expected to attend all meetings. Members unable to attend **must** send a deputy who is briefed and who will count towards the quorum. If a member sends a deputy for any three meetings within a year, the Chair should discuss the member's ability to remain part of the group. One representative from each division must be in attendance at the meeting of the group.
Duties:	In particular the Group will: 1. Provide assurance that the environment within the Trust is safe for patients, visitors and staff in terms of infection prevention 2. Provide assurance that all appropriate measures are being taken to assist the Trust with achievement of national and local infection prevention and control targets/trajectories 3. Escalate any concerns, together with recommendations for action, to the relevant stakeholder. In the event of exceptional occurrences raised, this group escalated them according to the Trusts escalation

	policy 4. Monitor by exception Trust delivery plans to deliver targeted reduction and sustainable improvement of HCAI's and cleanliness 5. Provide assurance that infection prevention strategy and performance is being delivered at the point of care 6. Provide assurance that infection prevention strategy and performance is being delivered across Facilities and Engineering 7. Discuss and endorse a plan for the management of outbreaks in the Trust and to monitor its implementation and outcomes 8. Implement the annual infection prevention audit program and disseminate the information to ensure its implementation 9. Ensure compliance with antimicrobial stewardship arrangements and monitor antimicrobial consumption 10. Ensure compliance with Standards for Cleanliness, and monitoring cleaning scores 11. Ensure compliance with relevant infection prevention principles, i.e. hand hygiene etc 12. Review and monitor action plans following increased incidences, outbreaks and serious incidents in relation to infection prevention
Sub-groups:	There are no sub-groups to this meeting
Reporting responsibilities:	A summary report of the IPCC meeting should be submitted as an agenda item for information to the Trust's Patient Safety Group, advising the group with regards to achievements, exceptions themes and trends associated with infection prevention (control) management and compliance.
Review:	Terms of Reference ratified August 2019 and are due for review in August 2020.

ppendix 2: Infection control Trust action plan for year 2020-21

The table below is the 'Code of Practice' for all providers of healthcare and adult social care on the prevention of infections under The Health and Social Care Act 2008. This sets out the 10 criteria against which a registered provider will be judged on how it complies with the registration requirements related to infection prevention. The Trust action plan and work programmes link to these ten criteria.

Compliance criteria	What the registered provided will need to demonstrate
1	Systems 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 that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
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.
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.
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.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Programme of work	Goal	Lead	Time frame	Progress to date	Hygiene code
Infection Prevention and Control Team (IPC Team)					
Review IPC Team structure and establishment, including number of PA's for IPC Lead Doctor	To establish an adequately resourced IPC team across the Trust (including Western Sussex Hospitals), to create an IPC service fit for the future	-Lead Doctor IPC -Lead Nurse IPC -DIPC	September 2020		6
Assess the training needs of the IPC Team, including the need to undertake formal IPC qualifications	To ensure the IPC Team are highly skilled and knowledgeable in order to provide an appropriate and responsive service	IPC Lead Nurse	September 2020		6
Audits					
Carry out hand hygiene audits in wards / departments, and support divisions with improving compliance as and when required	To improve hand hygiene compliance	IPC Team: audit, feedback, support Matrons / Lead Nurses / Heads of Nursing: ongoing monitoring and challenging of poor practice to improve compliance	Ongoing		1, 6, 9, 10
Carry out annual audits in wards / departments to assess and improve compliance against IPC standards pertinent to the environment and clinical practice	To improve compliance against national IPC standards in relation to the environment and clinical practice	IPC Team: audit, feedback, support Matrons / Lead Nurses / Heads of Nursing: action audit findings	Ongoing		1, 6, 9, 10

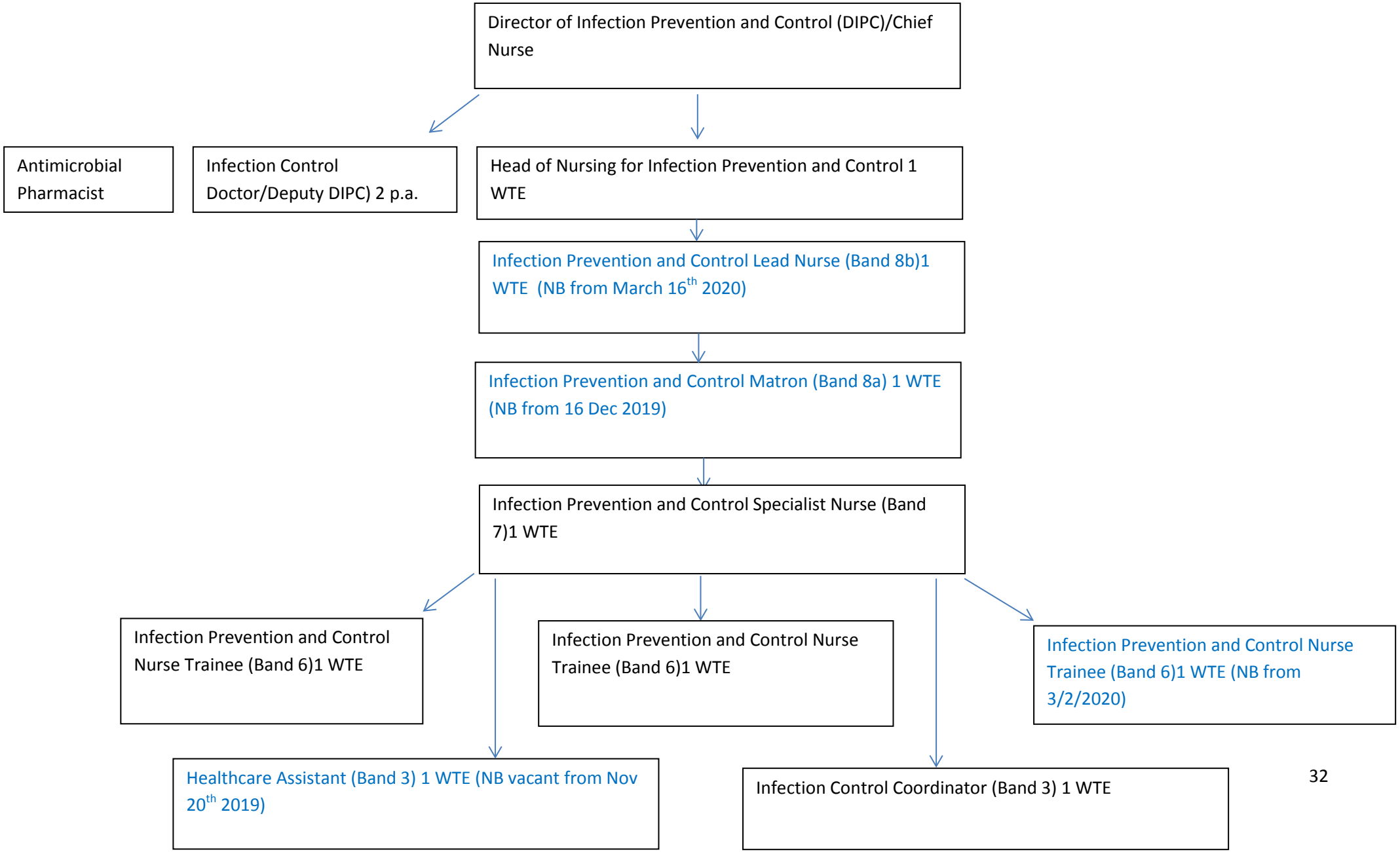
Programme of work	Goal	Lead	Time frame	Progress to date	Hygiene code
Carry out audit of compliance against Trust IPC policies, e.g. isolation audit, MRSA screening compliance, and the antimicrobial prescribing policy	To assess and improve compliance where necessary, so patients receive the best possible IPC care	IPC Team: audit IPC policies, feedback, support Pharmacy / Microbiology: audit antimicrobial prescribing policy, feedback, support Matrons / Lead Nurses / Heads of Nursing: action audit findings	March 2021		1, 6, 9, 10
Training					
Provide a programme of IPC training, including on induction of new staff and update training for current staff	To provide staff with the relevant knowledge / skills, for implementation of high standards of IPC practice in clinical care and prevention of healthcare associated infections	IPC Team	Ongoing		1, 6, 9
Review training packages to ensure training reflects current national IPC guidance	As above	IPC Team	August 2020		1, 6, 9
Monitor and feedback training compliance by ward / directorate to the IPC Committee	As above	Matrons / Lead Nurses / Heads of Nursing	Ongoing		1, 6, 9

Programme of work	Goal	Lead	Time frame	Progress to date	Hygiene code
Surveillance and monitoring for clusters / outbreaks of infection					
Surveillance of alert organisms, including MRSA bacteraemias and *Clostridium difficile,* and where these occur to undertake timely root cause analysis	To achieve the Trust trajectories for MRSA bacteraemias and Clostridium difficile and where cases occur, to learn from the RCA process to improve clinical practice and prevent further occurrence	IPC Team: carry out surveillance, feedback and support Matrons / Lead Nurses / Heads of Nursing / Relevant Clinician: lead on RCA's, disseminate findings / learning and implement any agreed actions	Ongoing		1, 5, 9
Surveillance of surgical site infection through participation in the national surveillance programme administered by Public Health England	To help minimise surgical site infection	IPC Team: carry out surveillance, feedback and support Surgical team / Matrons / Lead Nurses / Heads of Nursing: use surveillance feedback to review clinical practice and ensure care is delivered in line with the SSI care bundle	Ongoing		1, 5, 9
Monitoring for clusters or outbreaks of infection, e.g. Norovirus	Early identification and appropriate management to minimise cluster / outbreak spread	IPC Team: monitoring, expert advice and support Outbreak control team, including senior management: implement outbreak control measures, including closure of affected areas as agreed	Ongoing		1, 2, 5, 6, 7, 9

Programme of work	Goal	Lead	Time frame	Progress to date	Hygiene code
COVID-19					
Embed IPC precautions for COVID-19 into routine clinical care	To minimise the risk of cross-transmission and to maintain the safety of patients, staff and visitors	IPC Team: expert advice, training and ongoing support Senior staff in wards / departments: implement precautions, monitor and challenge poor practice	March 2021		1, 2, 4, 5, 6, 9, 10
Monitor for clusters and outbreaks of COVID-19	Early identification and appropriate management in line with national guidance	IPC Team	Ongoing		1, 2, 4, 5, 6, 9, 10
Refurbishments and new builds					
Review of refurbishment projects	To ensure refurbishment projects comply with national guidance / standards for IPC	IPC Team in collaboration with Estates / Projects Team	Ongoing		2, 7
IPC input into the 3T's new build hospital	To ensure the 3T's new build hospital complies with national guidance / standards for IPC	IPC Team in collaboration with the 3T's Projects Team	Ongoing		2, 7
Microbiology					
Explore options and secure funding for replacing ICT Track (a bespoke microbiology results system for the IPC Team), as it not provided on a sustainable IT platform	To receive microbiology results in real time, via a sustainable system	IPC Team in collaboration with Microbiology	March 2021		8

Programme of work	Goal	Lead	Time frame	Progress to date	Hygiene code
IPC policies					
Review and update IPC policies	To implement IPC policies in line with national guidance and best practice, to prevent healthcare associated infections	IPC Team	March 2021		1, 2, 4, 5, 6, 9, 10

Appendix 3: Infection Prevention and Control Arrangements 2019-2020



Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	16.	**Meeting:**	Board of Directors	**Meeting Date:**	29 Sept 2020
Report Title:	**Company Secretary Report**				
Sponsoring Executive Director:			Glen Palethorpe, Group Company Secretary		
Author(s):			Glen Palethorpe, Group Company Secretary		
Report previously considered by and date:					
Purpose of the report:					
Information		✓	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:					

Charitable Funds Committee terms of reference

The Board of Trustees agreed to the Chief Nurse becoming the executive sponsor for the Charity. The Committee's terms of reference (included as an appendix to this report) have been adjusted to reflect this (highlighted changes in yellow).

Board Approval of use of Charitable Funds donations

A paper was sent to the Board acting as Trustees for the Charitable Funds seeking their approval for committing funds donated for staff welfare, which included monies from NHS Charities together. The Board through email approved the use of the donated funds based on the recommendation of the established reference groups and the approval group chaired by the Chief Nurse. The approval was for £237,874 to enhance and create better spaces for Trust staff to take their breaks and to have places across our sites to take time out when dealing with challenging work demands, £62,212 to provide enhanced psychological support for staff and £8,700 on MSK support. The delivery of these projects will be reported back to the Charitable Funds Committee via the established approvals group.

Annual General Meeting

The Annual General Meeting is to take place after the Board meeting on the 29 September. This meeting will be undertaken using MS teams further information and the link can be found on our

website should this link BSUH Public AGM Link not take you to the meeting.

Key Recommendation(s):

The Board is asked to **APPROVE** the revised Terms of Reference for the Charitable Funds Committee

The Board is asked to **RATIFY** its decision in respect of the commitment of donated staff wellbeing finds.

BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST

CHARITABLE FUNDS COMMITTEE

TERMS OF REFERENCE

1.00 PURPOSE

1.01 The purpose of the Charitable Funds Committee is to monitor progress and performance against the strategic direction of the Charitable Trust's fundraising activity as approved by the Board of Trustees; to approve and monitor expenditure of charitable funds in line with specified priority requirements; and to monitor the management of the Charity's investment portfolio ensuring that the Charity at all times adheres to Charity Law and to best practice in governance and fundraising.

The Trustee of the Charity is the Board of Directors of the Trust acting as Corporate Trustee.

2.00 MEMBERSHIP AND ATTENDANCE AT MEETINGS

2.01 The membership of the Committee shall be:

- Chair: a nominated non-executive Director
- Two further nominated non-executive Directors
- Chief Nurse – nominated executive sponsor for the Charity
- Trust Director of Finance

2.02 The Trust Chair shall propose which non-executive Directors will be most suitable for nomination as Chair and members of the Committee. The Board of Directors shall approve the appointment of the Committee Chair and members, based on the Chair's recommendations.

2.03 Those normally in attendance at the Committee meetings shall be:

- Charity Director
- Assistant Director of Finance (with responsibility for the Charity)
- Charity Fund-Raising Manager

Any member of the Board of Directors shall have the right to be in attendance at any meeting of the Committee by prior agreement with the Chair.

2.04 The Chief Nurse may exceptionally send a deputy to the meeting but the deputy will not have voting rights at the meeting. Those who are in attendance may exceptionally send a deputy to the meeting.

2.05 Other Trust managers and clinicians may be invited to attend for particular items on the Agenda that relate to areas of risk or operation for which they are responsible.

2.06 The Company Secretary or their nominee shall act as Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

3.00 ROLE AND RESPONSIBILITIES

AUTHORITY

3.01 The Committee shall have the delegated authority to act on behalf of the Board of Directors in accordance with the Constitution of the Charity and the Standing Orders, Standing Financial Instructions, and Scheme of Reservation and Delegation of the Trust. The limit of such delegated authority is restricted to the areas outlined in the Duties of the Committee and subject to the rules on reporting, both as defined below.

3.02 The Committee is empowered to investigate any activity within its Terms of Reference, and to seek any information it requires from staff, who are required to co-operate with the Committee in the conduct of its enquiries.

3.03 The Committee is authorised by the Board of Directors to obtain independent legal and professional advice and to secure the attendance of external personnel with relevant experience and expertise, should it consider this necessary. All such advice should be arranged in consultation with the Company Secretary.

DUTIES

Governance, Legalities & Financial Statements

3.04 To ensure compliance by the Charity with Charity Law and NHS guidance on charitable funds.

3.05 To ensure that the Charity regularly benchmarks the governance arrangements and fundraising activity of its Charitable Funds against best practice and implements any lessons learned.

3.06 To advise the Board of Directors on any significant issues or variations from good practice, and to keep the Board informed of any developments.

3.07 To recommend to the Board of Directors approval of the annual financial accounts and annual report, prior to their submission to the Charity Commission.

Fundraising Strategy and Activity

3.08 To propose the strategic direction of the Charitable Trust's fundraising activity to the Board for approval.

3.09 To approve investment plans and programmes.

3.10 To monitor progress and performance against the strategic direction of the Charity's fundraising activity and to approve changes in strategy and any action to be taken in-year.

3.11 To receive regular reports on the fundraising activity carried out at the Trust and the income generated.

3.12 To keep under review all fundraising literature developed and circulated by the Trust and all information provided to the public through literature and websites.

Investments

3.13 To appoint external investment managers and monitor their investment performance.

3.14 To inform the external investment managers of the Trustees short and long-term financial goals for the charity.

3.15 To review details of the charitable funds investment portfolio quarterly and to take action where necessary to ensure that returns are maximised.

3.16 To ensure that charitable funds are invested to maximise return but on a secure and ethical basis as far as is possible.

3.17 To update investment policies annually, for approval by the Board, and by agreement the appropriate value of any reserves held by the Charity to ensure these are sufficient to support on-going operations of the Charity and deliver the approved strategy.

Expenditure

3.18 To monitor adherence to an expenditure policy for the management of the donated funds of the Charity, policy to be determined by the Trustees.

3.19 To approve the expenditure of charitable funds for amounts in excess of £10,000.

3.20 To prepare detailed guidance on the correct use of charitable funds, and the process for considering requests for funds, directly in relation to the NHS statutory duty.

3.21 To ensure gifted income is used in accordance with the Trust's Standing Financial Instructions and any purpose that may be specified by the donor.

3.22 To set levels of delegated spending authority for fund advisors, senior managers, the Charitable Funds Committee, and the Board.

3.23 To monitor income and expenditure against budgets and activity against funds.

3.24 To review expenditure projections, based on projected income together with bids approved but not yet spent.

3.25 To ensure that the Trust develops and maintains an up-to-date list of priority requirements, e.g. equipment, environmental requirements, that could be funded by charitable donations.

Risk Management

3.26 To ensure that the Charitable Trust has in place appropriate arrangements to manage the risks associated with its operations, particularly fundraising and expenditure.

3.27 To ensure that Trustees are advised at least annually, or as required, on any risk management issues associated with the operation of fundraising and to advise on any implications for the Trustee role.

REPORTING AND RELATIONSHIPS

3.28 The Committee shall be accountable to the Board of Directors.

3.29 The Committee shall make an annual report to the Board of Directors to demonstrate the Committee's discharge of its duties and to confirm the fitness for purpose of the Charity's assurance framework, risk management, and governance processes.

3.30 The Committee shall make recommendations to the Board of Directors concerning any issues that require decision or resolution by the Board of Directors.

3.31 The Committee shall report to the Audit Committee as appropriate on any matters requiring action or decision-making by that Committee.

3.32 The Committee shall review its own performance, constitution and terms of reference at least every two years to ensure it is operating at maximum effectiveness. Any proposed changes to the terms of reference should be agreed by the Board of Trustees.

SUB COMMITTEES

3.33 The Committee may establish a sub-committee for a specific purpose. For example an Investment sub-committee or a Fundraising/ Appeal Committee for a particular project.

4.00 CONDUCT OF BUSINESS

4.01 The Committee shall conduct its business in accordance with the Standing Orders and Scheme of Reservation and Delegation of the Trust.

4.02 The Committee shall be deemed quorate if there are at least two non-executive Directors present. A quorate meeting shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.

4.03 The Committee shall meet not less than four times in each financial year.

4.04 At the discretion of the Chair of the Committee business may exceptionally be transacted through a teleconference provided all parties are able to hear all other parties and where an agenda has been issued in advance, or through the signing by every member of a written resolution sent in advance to members and recorded in the minutes of the next formal meeting.

4.05 Agendas and briefing papers should be prepared and circulated in sufficient time for Committee Members to give them due consideration.

4.06 Minutes of Committee meetings should be formally recorded and distributed to Committee Members within 10 working days of the meetings. Subject to the approval of the Chair, the Minutes will be submitted to the Trust Board (noting that they will be received in the capacity of Corporate Trustee) at its next meeting and may be presented by the Committee Chair. The Committee Chair will draw to the attention of the Board of Trustees any issues that require disclosure to the full Board, or require executive action.

5.00 STATUS OF THESE TERMS OF REFERENCE

Approved by the Board: September 2020 *(reflecting change in executive sponsor for the Charity)*

Next Review March 2021