

Meeting of the Board of Directors

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

AGENDA – MEETING IN PUBLIC

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

11.	-	Report from Quality Assurance Committee Chair - from the meeting on 26 November To receive assurance from Committee and recommendations from the Committee	Verbal	Mike Rymer
11.	-	Reports from Finance and Performance Chair - from the meeting on the 26 November To receive assurance from Committee and recommendations from the Committee - from the meeting on the 29 October	Verbal Enclosure	Patrick Boyle
11.	-	Reports from the Audit Committee Chair - from the meeting on the 1 October To receive assurance from Committee and recommendations from the Committee	Verbal	Lizzie Peers
12.	11.55	Board Assurance Framework To approve for publication on the website	Enclosure	Glen Palethorpe
		<u>SERVICE PRESENTATION</u>		
13.	12.00	End of Life Care (Service Presentation) To receive assurance over application of patient first processes	Presentation	Clare Williams
		<u>OUR PEOPLE</u>		
14.	12.20	National Approach to Flu Vaccinations To receive and agree any necessary actions	Enclosure	Carolyn Morrice
		<u>WELL LED & COMPLIANCE</u>		
15.	12.30	Annual Winter Plan To receive and note	Presentation (To Follow)	Jayne Black
16.	13.00	Company Secretary Report Appendices: - Learning from Deaths Report - H&S annual report To note	Enclosure	Glen Palethorpe
		<u>OTHER</u>		
17.	13.10	Any Other Business To receive and action	Verbal	Chair
18.	13.15	Questions from the public To receive and respond to questions submitted by the public	Verbal	Glen Palethorpe
19.	13.15	Date and time of next meeting: The next meeting in private of the Board of Directors is scheduled to take place on Wednesday 29 January 2020 in the Lecture Theatre 1, Euan Keats Education Centre, PRH, Haywards Heath	Verbal	Chair

Trust Board of Directors Quoracy

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

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

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

Minutes

Present:	Alan McCarthy	Non- Executive Director (Chair)
	Marianne Griffiths	Chief Executive
	Mike Rymer	Non-Executive Director
	Lizzie Peers	Non-Executive Director
	Patrick Boyle	Non-Executive Director
	Jon Furmston	Non-Executive Director
	George Findlay	Chief Medical Officer
	Karen Geoghegan	Chief Financial officer
	Pete Landstrom	Chief Delivery & Strategy Officer
	Denise Farmer	Chief Workforce & Organisational Development Officer
	Clare Williams	Interim Chief Nurse

In attendance:	Glen Palethorpe	Group Company Secretary
	Tamsin James	Board and Committee Administrator
	Helen Weatherill	HR Director
	Malcolm McKenzie	Consultant ED & Clinical Lead (Item 14)
	Renee van Der Most	Clinical Lead Organ Donation/ICU consultant (Item 15)
	Babs Harrison	Head of Inclusion (Item 16)
	Amanda Walker	Head of Nursing for Infection Prevention (Item 18)

B/09/19/1 WELCOME AND APOLOGIES Action

- 1.1 The Chair welcomed those present to the meeting. The Chair formally welcomed Jackie Cassell to the Board as Non-Executive Director from October 2019, replacing Dr Malcolm Reed.
- 1.2 Dr Malcolm Reed, although not in attendance, was thanked for his time with the Trust.
- 1.3 Apologies of absence were received from Joanne Crane, Kirstin Baker, Jayne Black, Clare Stafford & Rob Haigh
- 1.4 The Board was confirmed as quorate.

B/09/19/2 DECLARATIONS OF INTEREST

- 2.1 There were no declarations of interest.

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

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

B/09/19/4 MATTERS ARISING

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

B/09/19/5 CHIEF EXECUTIVE'S REPORT

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

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- 5.2 The Brighton Pride event was a beautiful day and Marianne expressed her gratitude at the Trust's staff involvement with PRIDE, a clear statement about the value the Trust puts on inclusion, diversity and equality. Marianne thanked all those who attended the celebration with special recognition to Nick and the team for organising the float.
- 5.3 HSJ Shortlisted the Trust for Acute or Specialist Trust of the Year: Marianne expressed her delight at being shortlisted for this prestigious award.
- 5.4 BSUH is proud to be one of 100 employers recognised by Defence Minister Ben Wallace for outstanding support for the Armed Forces community by being awarded an Employer Recognition Scheme Gold Award. This award represents the highest badge of honour available to those that employ and support those who serve, veterans, and their families. A celebration event is to be held in October.
- 5.5 The #BelongHere campaign featured 14 colleagues from across the Trust as the faces of this special campaign. It was fantastic to see the campaign on the streets of Brighton and it really helps to tell the story of the diverse, inclusive and welcome culture in the Trust, we should all be very proud.
- 5.6 Congratulations were given to Wave 6 teams from the Princess Royal Hospital who have just completed their Patient First Improvement System (PFIS) training,. Sixty teams have now completed this 4 month intensive training programme and 10 more teams have just started their PFIS journey at RSCH.
- 5.7 Staff and supporters of The Trevor Mann Baby Unit (TMBU) at The County Hospital celebrated the completion of refurbishment work and the opening of a new quiet room for families earlier this month. The improvements, which cost more than £350k, were paid for by supporters of BSUH Charity and the Early Birth Association (EBA). The changes have created a more comfortable space for parents and allows the Trust to offer them more privacy than had been possible on the main wards.
- 5.8 **Diary Highlights**
The Board was advised of some key meetings that the Executive team have attended in August & September.
- 5.9 **Looking ahead**
Marianne confirmed the Annual Staff Survey is due to launch in early October as a chance for BSUH staff to have their say. There will be a lot of activity to promote the survey to beat the 2018 59% response rate.
- 5.10 The annual Flu season is fast approaching, from October the Trust will be taking part in the national flu vaccination campaign supporting the Trust's patients, their families and staff remain healthy
- 5.11 The Board **NOTED** the report.

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

B/09/19/7 QUALITY IMPROVEMENT

- 7.1 George Findlay introduced the quality report, highlighting the key benchmarked indicators relating to Quality & Safety aligned to the organisational True North objectives.
- 7.2 The current Hospital Standardised Mortality Ratio (HSMR) for the Trust to May 19 has reduced for a further period. The in-month HSMR was 86.76. In the 12 months to May 2019 the HSMR was 90.42, just falling short of the objective to be in the Top 20 quintile of the Trust in the UK.
- 7.3 The rate of inpatient falls for the past 12 months is 3.32 falls per 1000 bed stay days; equating to 841 falls in the past year compared to 855 in the previous year. The National Falls rate is 6.63 falls per 1000 bed days.
- 7.4 Following a challenging month operationally there were 62 mixed sex accommodation breaches reported in August. Whilst a disappointing month, over the past 12 months the trend has been decreasing.
- 7.5 The rate of harm free care was 94.56% in August, 0.44% below the Trust target of 95%. The harm-free care score for the past 12 months was 94.94% against the target of 95%. Alan McCarthy emphasised the significance of this good quality performance for the Trust's patients which supported the views he had heard that patients once being seen by the Trust receive a great service and outcomes.
- 7.6 The pressure ulcer rate for the past 12 months is 1.17 incidents per 1000 bed stay days. A data cleanse and a review of the current process of reporting is in progress. A new standard operating procedure (SOP) has been written that includes specific criteria for sign off for Grade 2, 3 and 4 and a monthly validation meeting from September 2019. Following the introduction of national changes to the grading of Pressure Ulcers a Training Needs Assessment has been updated with an implementation plan of cross-wide training.
- 7.7 The current rate of Friends & Family recommended rates for August were reported for Inpatients this achieved 93.6%, in A&E this recorded 86% and for Outpatients the rate was recorded as 93.3%.
- 7.8 Mike Rymer confirmed the Quality Assurance Committee had met the day before and through its work it was able to assure the Board over the Trust's delivery of these objectives. The Committee also received information and reports in respect of learning from incidents, Safeguarding and External Visits reporting. Mike confirmed that at the conclusion of the meeting the Committee were assured over the quality of care being provided to the Trust's patients.
- 7.9 Alan McCarthy stated the Trust was performing well against the range of quality metrics and had strong plans to continue to improve.
- 7.10 The Committee **NOTED** the report.

B/07/19/8 SYSTEMS AND PARTNERSHIPS

- 8.1 Pete Landstrom updated the Board in respect of a range of performance indicators.
- 8.2 Pete informed the Board that for August the A&E performance was 82%, compared to a national average of 86.3%.
- 8.3 The Trust's 62 day cancer performance for GP referral to treatment reduced by 6.1% to 57.9% in July-19 compared to June-19. This reduction was expected as part of the recovery actions that was put in place to reduce the waiting list size and the concentration on dealing with patients waiting for the longest time. National average performance (July-19) was 77.6%.
- 8.4 The Trust's RTT Performance decreased slightly by 0.6% in August-19 to 64.8%, with the waiting list reduced by 219 patients since June-19. There were thirty four 52 week breaches in the month this was an increase of 21 on the prior month. National average performance (July-19) was 85.8%.
- 8.5 Pete confirmed that the Trust has implemented its robust plans to improve both RTT and Cancer wait times and expects this will see improvements in the reported performance in the near future.
- 8.6 The Trust's Diagnostics performance improved by 5% to 21.1% in August-19 compared to June-19. Significant improvements have been made in Non-obstetric Ultrasound. National average performance (July-19) was 3.5%.
- 8.7 Pete drew the section to a close by confirming that there have been challenges but a number of extra measures have been implemented to reduce the wait time for patients and confirmed that Cancer, Endoscopy and Diagnostics are still working hard to deliver their trajectory.
- 8.8 The Committee **NOTED** the report.

B/07/19/9 SUSTAINABILITY

- 9.1 Karen Geoghegan reported to the Board the Trust financial performance, reporting that for August, the Trust is reporting a deficit of £3.8m which is slightly better than plan.
- 9.2 At the end of M5, the Trust has delivered a deficit of £25.9m, in line with the plan, so has earned £7.97m of PSF and FRF income. In addition the Trust has also received confirmation of £0.6m of 2018/19 as a national post accounts reallocation of PSF.
- 9.3 The Trust is on trajectory to deliver an underlying deficit of £53m; which will earn an additional £25.4m of PSF and FRF funding. This will achieve the year-end deficit control total of £25.7m.
- 9.4 Karen informed the Board that the delivery of the control total will require close management of elective and non-elective activity and control of the Trust's cost base, particularly in relation to medical pay, which is a break-through objective for 2019/20.
- 9.5 The Trust's Finance and Use of Resources Risk Rating for August is 3, and the individual rating components are in line with plan.

- 9.6 The Efficiency and Transformation Programme is forecasting full delivery of the £27m requirement.
- 9.7 There is less spend to date on Capital the Trust's capital programme due to delays within the 3Ts programme. Purchases of medical equipment and estates infrastructure continues to progress as planned.
- 9.8 The Chair asked Patrick Boyle, as Chair of the Finance & Performance Committee, to provide the Board with an update from that Committee's meetings. Patrick confirmed the Committee was able to assure the Board that the Trust is performing well despite the issues highlighted within the report just presented. Both Patrick and Marianne stated they were confident of reaching the required trajectories in Cancer, Diagnostics and Endoscopy by December in line with the Trust's plan.
- 9.9 Lizzie Peers requested assurance over the long wait times and the potential impact on patients in Cancer and Diagnostics is monitored. It was confirmed efforts are in place to keep patients fully informed along their journey and the impact of any long waits is subject to detailed reviews the outcome of which has been reported to the Quality Assurance Committee.
- 9.10 The Committee **NOTED** the report.

B/09/19/10 OUR PEOPLE

- 10.1 Helen Weatherill presented the Board with an update on workforce developments and emphasised the positive outcome from the annual staff survey and the more frequent Pulse surveys and how these results are used to drive improvements based on the captured feedback from staff.
- 10.2 Helen updated the Board on the monthly pulse survey results which provides a "snap shot" of how staff are feeling in relation to the 9 key engagement questions. These questions determine the overall engagement score. The overall score this month has remained at 7.1 out of 10. The 2018 National NHS staff acute trust average was 7 out of 10 and we were slightly below this at 6.9. The best Acute Trust scored 7.6 out of 10. Our ambition is to be above average in 2019 National Staff Survey.
- 10.3 Following the increase in the 2018 staff survey score of 'care is my organisations top priority' which is now in line with the national average for Acute Trusts, the Breakthrough Objective for Our People has been changed in July 2019 to 'I would recommend the organisation as a place to work.' Focused staff input has created a developed plan of actions. The measurable goal is to increase the NHS staff survey score of 'I would recommend the Trust as a place to work' to above the National Acute Trust average score by the 2020 Staff Survey. In 2018 we were slightly below average compared to other Acute Trusts.
- 10.4 An active Trust wide Health & Well Being service was initiated in 2017, combining support/activities around physical, mental and financial wellbeing; with a comprehensive on-line interactive platform developed in the Autumn of 2017. The website continues to grow and receives an average of 260 hits per month (September 2018-2019) and 32% of these are return visitors.
- 10.5 The Trust has run the NHS Staff Survey for all Trust employees since 2016 Participation has increased from under 40% in 2016 to 59.1% in 2018. The NHS staff survey opens on 3rd October for 8 weeks until 30th November 2019. Initial results will be available between December 2019 and January 2020, with

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

- 10.6 Helen drew the Board's attention to the fact that there has been an improvement to staff turnover of rates reducing to 12.5% which is now in line with the Trust set target.
- 10.7 The Board **NOTED** the information received from the Integrated Performance Report.

B/09/19/11 REPORT FROM QUALITY ASSURANCE COMMITTEE

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

B/09/19/12 REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

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

B/09/19/13 BOARD ASSURANCE FRAMEWORK

- 13.1 Glen Palethorpe drew the Board's attention to the summary of the key strategic risks within the Board Assurance Framework (BAF) and noted that the information received through the integrated performance report and assurance reports from Committee Chair's link to the details in the BAF. The Board agreed that no changes were required to the scores.
- 13.2 The Board **APPROVED** the Board Assurance Framework.

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

- 14.1 Malcolm McKenzie presented the Board with an overview of the Urgent & Emergency Care Service at both the Royal Sussex County and Princess Royal sites. The presentation commenced with informing the Board on the areas of improvement made by the service, these being:
- 14.2 We are one of few Trusts providing Consultant Delivered Services which include 24/7 consultant cover ensuring patients are seen and reviewed at all times. This forms part of the improvements regarding timely and senior assessment/treatment, from Arrive to Triage in under 15minutes – 92% of the time; Arrival to Assessment in under 1hour – 97% of the time; Arrival to Specialist Referral – 96minutes; and Arrival to Senior Specialty review – 4hours.
- 14.3 The introduction of single clerking ensures the patient sees the most appropriate clinical senior decision maker as early in their attendance as possible, cutting the wait time by over 5hours, which has been core to development of the acute medical model and allows focus on patient best practice.

- 14.4 A successful recruitment campaign includes the expansion of consultant numbers providing 24/7 cover and a review of nursing templates fully established at both BSUH and PRH sites.
- 14.5 There has been a successful rebuild in the Princess Royal Emergency department that includes an improved resuscitation room; a dedicated ambulance handover area; an expansion of Majors trolley area for safety; while continuing to work closely with the CCG for Improved Access and Primary Care for patients in the local area.
- 14.6 There has been an improvement in ambulatory care at Royal Sussex County Hospital which includes extended opening hours to 22:30; and enhanced ambulatory handover processes.
- 14.7 Patrick Boyle asked for further information in relation to primary care engagement with the Urgent and Emergency Care pathway with Malcolm confirming there is a IC24 funded GP service at Royal Sussex from 9-11pm and an employed GP at Princess Royal from 2pm-10pm daily, there is a trial in place currently to offer extended hours at PRH, this offers the opportunity to stream patients away from unnecessary acute care.
- 14.8 Alan McCarthy questioned how Mental Health patients was impacting A&E departments, Malcolm confirmed this area was supported well at Royal Sussex County through a 24/7 liaison service; and PRH is supported by a shift based Mental Health Nurse and a dedicated psychiatric liaison suite.
- 14.9 The Board thanked Malcolm McKenzie and **NOTED** the presentation.

B/09/19/15 ANNUAL ORGAN DONATION REPORT

- 15.1 The Board welcomed Renee Van Der Most, Clinical Lead for Organ Donation and ICU consultant to present the Annual Organ Donation Activity Report and highlighted the following key points:
 - In 2018/19, 16 patients proceeded to organ donation, a slight increase from 15 the previous year. This increase is in donation after circulatory death.
 - BSUH is increasingly referring patients who meet the relevant criteria to the SNOD (Specialist Nurse in Organ Donation).
 - Improvements are being seen in Organ Donation due to increase in awareness
 - Future recruitment campaign to on-board a further 2 specialist nurses.
- 15.2 George added that the Organ Donation team work well with others in the Trust and are all committed to supporting families with the process of donation. Ideally, George would like to see the numbers of donors after circulatory death increasing. The new specialist nurse appointments will be key in aiming to increase the numbers to ensure that no potential donors are missed.
- 15.3 The Board thanked Renee for the presentation and **NOTED** the report.

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

- 16.1 Denise Farmer introduced Barbara Harris (Babs), the Trust's Head of Equality, Diversity and Inclusion, who presented the Comparative WRES Data Plan.
- 16.2 There are eight WRES Indicators and it was noted that figures for reducing

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

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

16.4 The Board **NOTED** the update.

B/09/19/17 NURSE STAFFING CAPACITY REPORT

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

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

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

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

17.5 The Board **NOTED** the Report.

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

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

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

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

who facilitate and undertake their own audits.

- 18.4 There have been changes and improvements to the team to allow ongoing infection prevention surveillance supported with daily team visits to high risk areas.
- 18.5 The Trust achieved its target for the CQUIN influenza vaccination across the Trust.
- 18.6 The Board acknowledged the complex work that the Infection Control team do and the improvements that have been made and received assurance that more robust processes are being implemented.
- 18.7 The Board thanked Amanda and **NOTED** the report.

B/09/19/19 ANY OTHER BUSINESS

- 19.1 There was no other business discussed.

B/07/19/20 QUESTIONS FROM THE PUBLIC

- 20.1 Two members of the public had previously submitted questions to the Board relating to the Community Beds Action Plan, shortage of community step down beds and complex care discharges.
- 20.2 Pete Landstrom responded by confirming that a community bed mobilisation plan has been launched in response to the overall deficit and closures in certain areas. An action plan is in place over the coming months to increase beds in Newhaven and Lindbridge.
- 20.3 Pete confirmed in relation to the complex discharges the Trust was achieving on average 25 per day, with additional support from the Red Cross it will be possible to increase the target to at least 30-40 per day. The complexity in this area needs to be streamlined by inclusion at regular CCG meetings (daily and weekly) and working with partners and reviewing winter planning and increasing bed capacity at both Newhaven and Lindbridge.

There were no further questions.

Tamsin James
Board and Committee Administrator
September 2019

Signed as a correct record of the meeting

.....Chair

.....Date

MATTERS ARISING
BSUH Board of Directors (in Public)

AGENDA ITEM: 4

Meeting	Minute Ref	Action	Person Responsible	Deadline	Status
		There were no matters arising from the BSUH Public Board Minutes.			



**Brighton and Sussex
University Hospitals**

NHS Trust

Chief Executive's Report

November 2019



Content

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- Diary highlights
- Looking ahead



Headlines

Flu campaign – Time to get your annual flu jab

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

There are many ways staff can get the jab; either by attending a drop-in clinic, requesting a roaming vaccinator to come to their departments or by contacting their local workplace vaccinator.

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



HSJ Awards: Acute or Specialist Trust of the Year Finalists

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

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

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

Headlines

Patient First Open Day

Last week we welcomed more than 50 executive and senior management team members from across Europe and the UK to a Patient First open day. Hosted at Worthing Hospital, our visitors gained an exclusive insight into the journey of both Western Sussex Hospitals and Brighton and Sussex University Hospitals, seeing how staff across the organisations have taken up the Patient First approach, striving to continuously make things better, safer and more efficient for our patients.



Clinical Improvement Scholars underway

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

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



Clinical Scientist wins BAA Audiologist of the Year

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

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



Headlines

Dementia Conference

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

The Conference was also an opportunity to launch the Trust's new Dementia strategy which was presented in the last board meeting and sets out exactly how BSUH aims to work with patients and their families to provide excellent care. The strategy aims to deliver an individualised, person-centred care approach delivered by an educated and confident workforce.



Workforce Race Equality Conference (WRES) 2019

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

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

Headlines

Long Service Awards - Thank you for your contribution!

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


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



Recognising our neighbour's success

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

Diary highlights

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

NHS Staff Survey

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

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

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



Planning for the future

After nearly three years of the management contract between Brighton & Sussex University Hospitals and Western Sussex, we have decided to further develop the relationship between the two trusts, under the leadership of a single board and executive team. This new group structure is a strategic alliance which will ensure we can do what is best for our patients and people.

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

Agenda Item:	6-10	Meeting:	Board	Meeting Date:	27/11/19
Report Title:	Integrated Performance Report				
Sponsoring Executive Director:	Marianne Griffiths, George Findlay, Peter Landstrom, Karen Geoghegan and Denise Farmer				
Author(s):	Marianne Griffiths, George Findlay, Peter Landstrom, Karen Geoghegan and Denise Farmer				
Report previously considered by and date:	Individual elements considered by relevant Board Committee				
Purpose of the report:					
Information	<input type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>		
Review and Discussion	<input checked="" type="checkbox"/>	Approval / Agreement	<input type="checkbox"/>		
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	<input type="checkbox"/>	Staff confidentiality	<input type="checkbox"/>		
Patient confidentiality	<input type="checkbox"/>	Other exceptional circumstances	<input type="checkbox"/>		
Link to Trust Strategic Themes:					
Patient Care	<input checked="" type="checkbox"/>	Sustainability	<input checked="" type="checkbox"/>		
Our People	<input checked="" type="checkbox"/>	Quality	<input checked="" type="checkbox"/>		
Systems and Partnerships	<input checked="" type="checkbox"/>				
Any implications for:					
Quality					
Financial					
Workforce					
Link to CQC Domains:					
Safe	<input checked="" type="checkbox"/>	Effective	<input checked="" type="checkbox"/>		
Caring	<input checked="" type="checkbox"/>	Responsive	<input checked="" type="checkbox"/>		
Well-led	<input checked="" type="checkbox"/>	Use of Resources	<input checked="" type="checkbox"/>		
Communication and Consultation:					
Executive Summary:					
Attached is the Trust's integrated performance report.					
Key Recommendation(s):					
To note the content and following receipt of the Committee assurance reports consider if there are areas for referral back to the Committees where enhanced assurance is required.					



Integrated Performance Report

November 2019



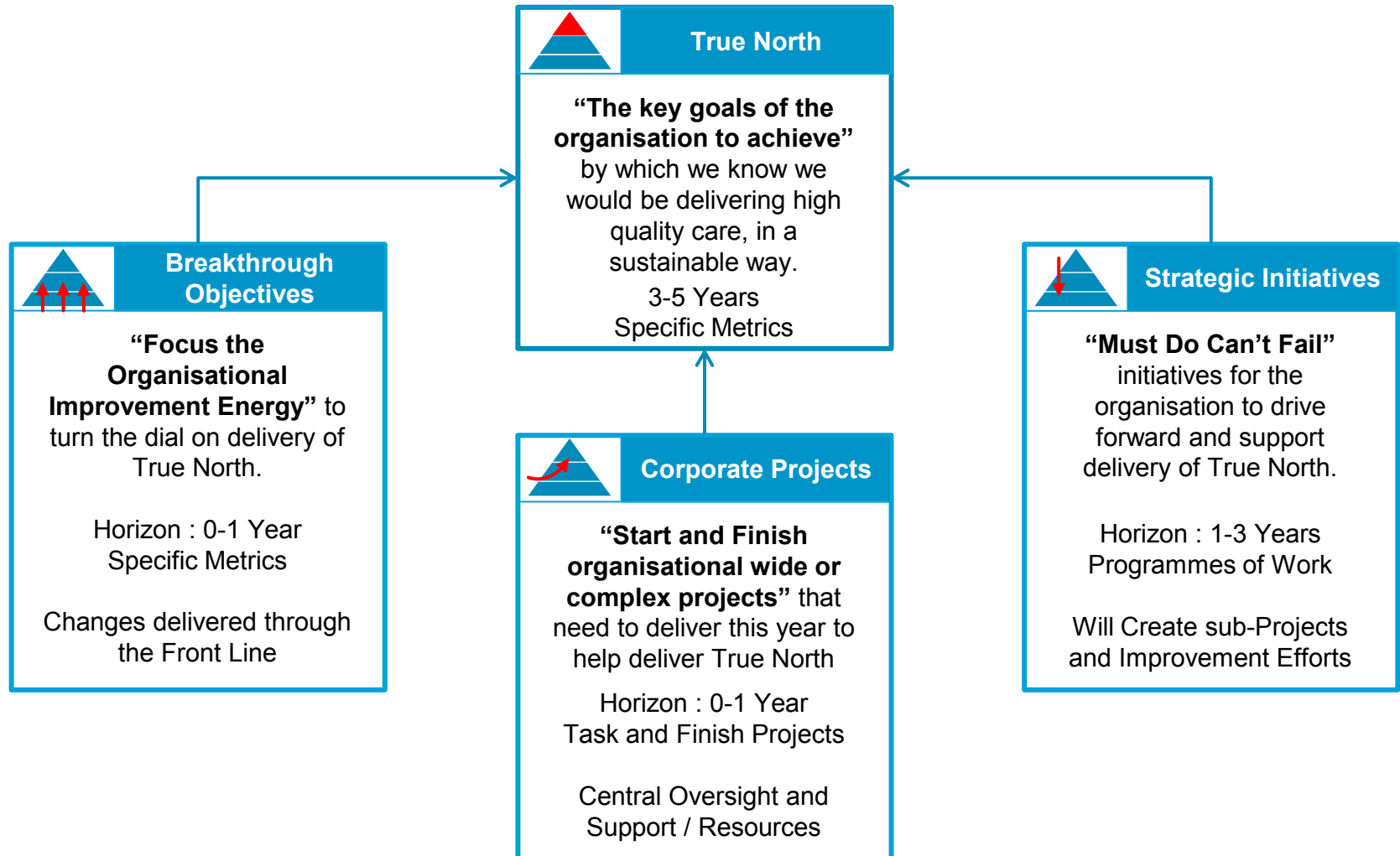
**Brighton and Sussex
University Hospitals**
NHS Trust

Contents

Structure of the report

Introduction - Patient First
Quality Improvement
Systems and Partnership
Sustainability
People

Patient First Strategy Deployment Framework



Patient First True North

Key Goals for the Organisation to achieve sustainably

Patient

Patient Satisfaction

Target: Family & Friends Recommend Rate >96%

Sustainability

Financial Management

Target: Break Even

People

Staff Engagement

Target: Engagement Score Top 20% in the Country

Quality

Preventable Mortality

Target: HSMR Top 20% in the Country

Avoidable Harm

Target: Patient Safety Thermometer 99% Harm Free Care

Systems & Partnerships

Non Elective Care

Target: A&E 95% <4hrs

Elective Care

Target: RTT 92% <18wks

Quality Performance

Quality

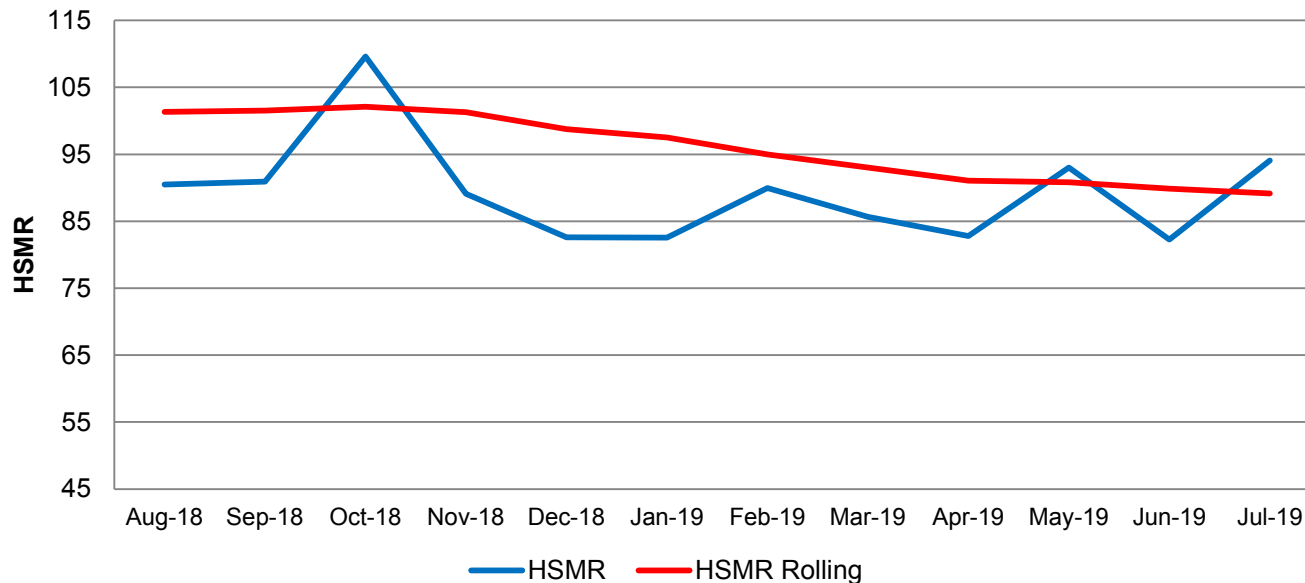
Preventable Mortality

Target: HSMR Top 20% in the Country

Avoidable Harm

Target: Patient Safety Thermometer 95% Harm Free Care

HSMR August 18 to July 19



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

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

Quality Performance

Quality

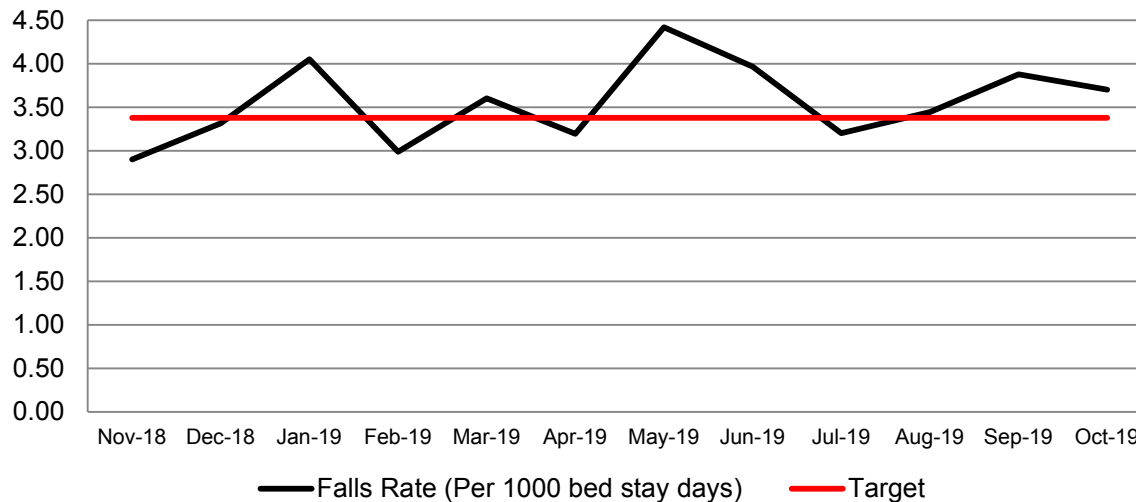
Inpatient Falls

Target: 3.38 falls per 1000 bed stay days

Pressure Ulcers

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

Inpatient falls rate per 1000 bed days



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

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

Quality Performance

Quality

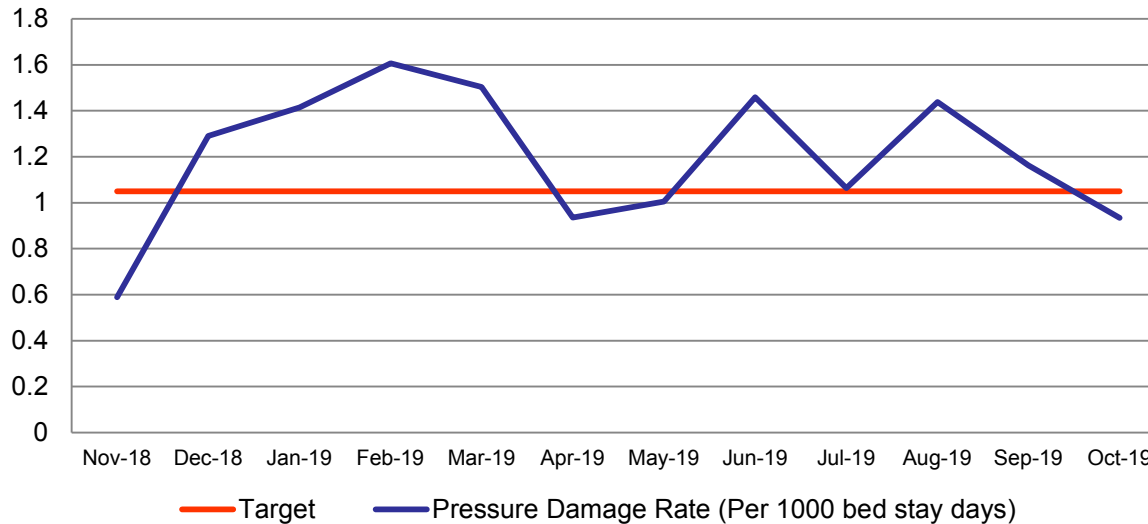
Inpatient Falls

Target: 3.38 falls per 1000 bed stay days

Pressure Ulcers

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

Pressure Ulcer rate per 1000 bed days



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

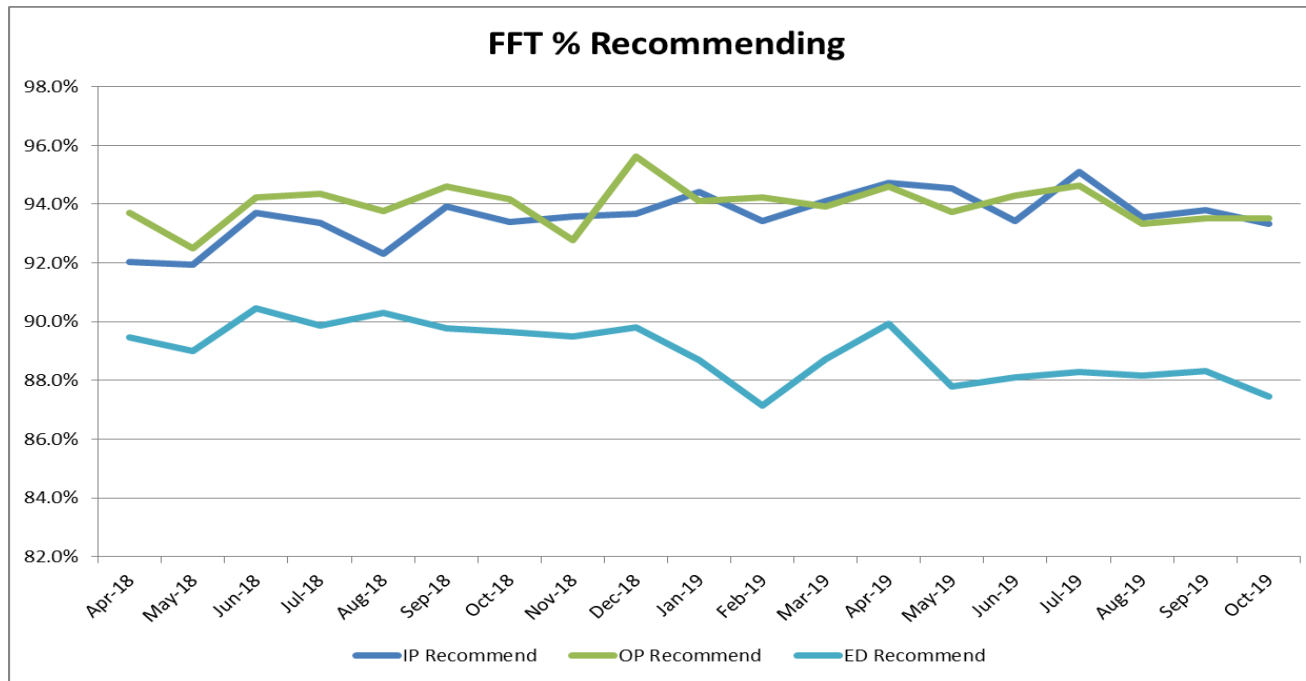
This data will form part of the quality and safety dashboard that will be presented at the Monthly Chief Nurse business meeting. This meeting will ensure ongoing monitoring, lessons learnt and action plans are completed.

Quality Performance

Quality

Friends and Family Test

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



Our current recommend rates for October 2019 are;

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

Systems and Partnerships – Summary

Systems & Partnerships

Non Elective Care

Target: A&E 95%
<4hrs

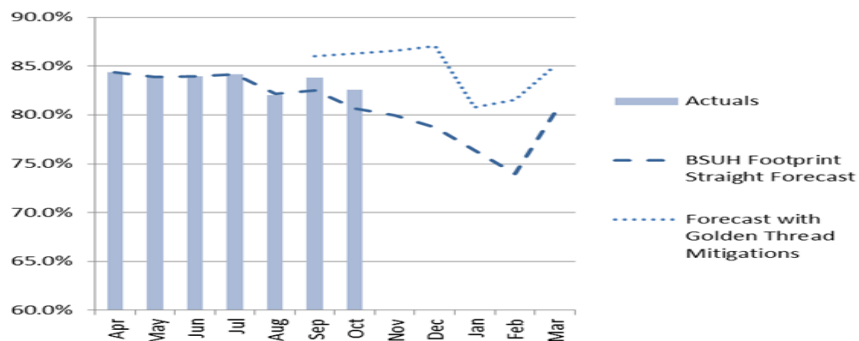
Elective Care

Target: RTT 92%
<18wks

- A&E Performance deteriorated to 82.6% (acute footprint) in October-19 compared to the national performance of 83.6%.
- 62 day cancer performance for GP referral to treatment improved by 10.4% to 73.8%% in September -19 compared to August -19. National average performance (September -19) was 76.9%.
- RTT Performance improved by 0.6% in October -19 to 67.2%. The waiting list reduced by 691 patients compared to Sept -19. There were 67 52 week breaches in the month this is an increase of 20 on the prior month. National average performance (September-19) was 84.8%.
- Diagnostics 6 week performance improved by 0.43% to 13.89% in October - 19 compared to September -19. Significant improvements have been made in Non-obstetric Ultrasound and improvements have begin for endoscopy. National average performance (September -19) was 3.8%.

Systems and Partnerships – True North Metrics

BSUH Footprint Performance Trajectory

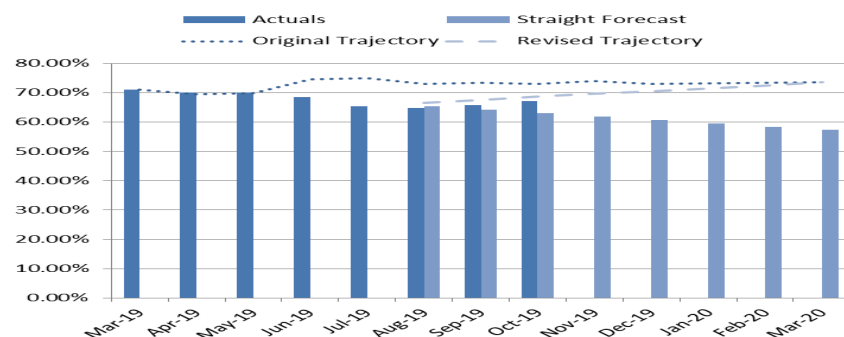


- Trust A&E Performance for Oct -19 was 82.6% including the NHSE allocated type 3.
- This is 1.2% lower than Sept - 19. The performance is behind the agreed trajectory by 3.7%.
- The trust had 3346 4 hour A&E breaches which was 469(14%) more than the same month last year.
- The trust was below the national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

Improvement Focus:

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

RTT Performance Trajectory



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

Improvement Focus:

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

Systems and Partnerships – Cancer

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

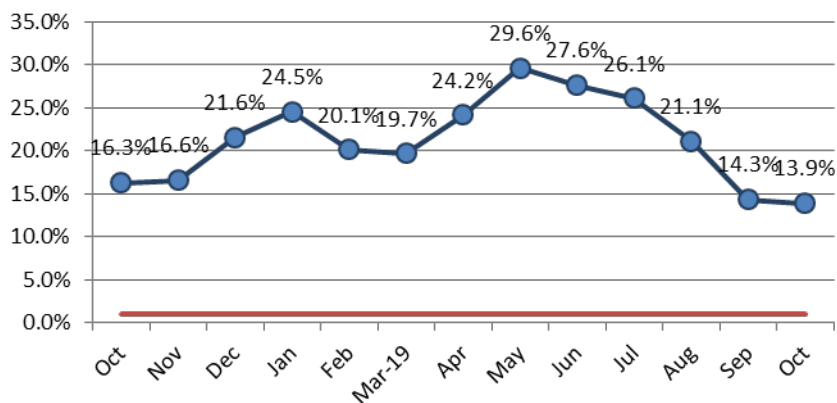
- The Trust was compliant in 6 of 8 reportable cancer metrics in September - 19.
- 2ww was compliant in September – 19
- The Trust was non-compliant against the 62 day urgent referral to treatment target of 85%, with 73.8% of patients commencing treatment within 62 days. This is a 10.3% improvement on the previous month.
- 31 patients were treated past the 62 day breach target out of a total of 120 treatments undertaken.
- Continued improvements have been made to reduce the number those waiting over 62 days for a definitive action.
- The total number of patients waiting over 104 days for a definitive action has significantly reduced and is 18 as at 13th November.

19/20 Improvement Actions:

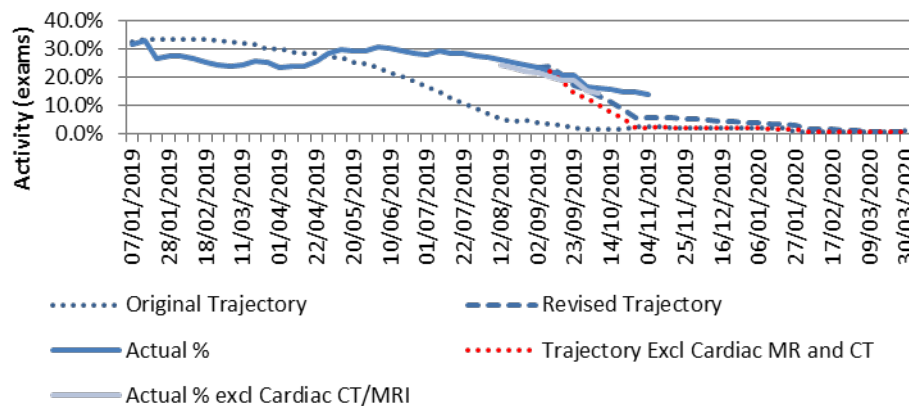
- Digestive Disease Straight to Test (STT) Pathway – expanding on the pilot delivering a straight to test pathway for 2WW colorectal referral (complete)
- Enhanced daily and weekly waiting list management
- Prostate-specific antigen (PSA) Monitoring - GP Surveillance of Patients with Prostate Cancer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

Systems and Partnerships – Diagnostics

% Performance Diagnostics by Month



Total DM01 Trajectories



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

Improvement Focus:

- The Trust have recast recovery plans by modality for imaging and endoscopic modalities which aim to reduce performance to a compliant position by March-20.
- Imaging recovery actions have delivered current performance improvement. Focus remains on reducing the wait time for cardiac CT/MRI.
- Reviewing cardiac CT protocol to become radiographer led (implementation Nov 19).
- Endoscopy recovery plan approved and mobilised including outsourcing some endoscopy activity in the short term .

Financial Performance - Summary

Sustainability

**Financial
Management**

Target: Break Even

- For October, the Trust is reporting a deficit of £3.8m which is in line with plan.
- At the end of M7, the Trust has delivered the planned deficit of £33.9m and as a result has earned £11.4m of additional income from the Provider Sustainability Fund (PSF) and Financial Recovery Fund (FRF). In addition the Trust has also received an additional £0.6m of income; part of a 2018/19 post accounts reallocation PSF.
- The Trust is on trajectory to deliver an underlying deficit of £53m; which will earn an additional £25.4m of PSF and FRF funding. This will achieve the year-end deficit control total of £25.7m.
- Delivery of the control total is challenging particularly given the impact of operational pressures; which will increase further as we move into winter. Ensuring delivery of elective and non-elective activity and control of the cost base, particularly in relation to medical pay, will require close management.

Financial Performance – Key Metrics

Finance and Use of Resources Risk Rating

A

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

At the end of October the aggregate rating is 3. Individual rating components are in line with plan apart from the agency spend rating as the ceiling has been exceeded year-to-date and is forecast to be exceeded by an estimated £1.99m.

Control Total (Surplus) / Deficit £k

G

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

The Trust deficit in Month 7, excluding PSF/FRF/MRET is in line with the plan. As a result of delivering the underlying control total the Trust has earned £2.69m of PSF/FRF/MRET in-month (£12.51m year-to-date for 2019/20). In addition, the Trust has received £0.61m of 2018/19 post accounts reallocation PSF.

Efficiency and Transformation Programme £k

A

	Plan	Actual / Forecast	Variance
Year-to-date	12,122	11,594	(528)
Year-end Forecast	27,070	27,070	0

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

Capital £k

A

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

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

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

Financial Performance – Key Metrics

Income £k R			
	Plan	Actual / Forecast	Variance
Year-to-date	(366,112)	(361,133)	(4,979)
Year-end Forecast	(634,855)	(626,072)	(8,783)
Income was below plan by £2.45m in-month giving a year-to-date adverse variance of £4.98m. Of this total, £4.56m relates to Patient Care Activities income and £0.42m to Other Operating Income.			

Agency Ceiling £k R			
	Ceiling	Actual / Forecast	Variance
Year-to-date	6,949	8,437	(1,488)
Year-end Forecast	11,783	13,769	(1,986)
Agency expenditure in October was £1.12m, exceeding the agency ceiling target by £0.15m in-month (£1.49m year-to-date). The Trust is forecasting to exceed the target at year-end by an estimated £1.99m.			

Operating Costs £k G			
	Plan	Actual / Forecast	Variance
Year-to-date	375,079	371,005	4,075
Year-end Forecast	649,701	641,242	8,459
In October, operating costs were £1.17m below plan, mainly due to non-pay inflation and a growth allocation, which have been phased in accordance with the submitted plan. Pay expenditure year-to-date is overspent by £0.93m, the key driver being medical workforce which is £2.96m above budget.			

Cash £k G			
	Plan	Actual / Forecast	Variance
Year-to-date	3,004	15,846	12,842
Year-end Forecast	3,004	3,605	601
At the end of October the consolidated cash balance was £15.8m against a plan of £3.0m. This is higher than planned following receipt of 2018/19 PSF incentive and bonus totalling £10.3m. This funding has been ring fenced to part repay high interest bearing loans in November.			

Financial Performance - Action & Recommendations

There are no actions required of the Board.

The Board is asked to note the following:














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

Our People - Improving Staff Engagement

People

Staff Engagement
Target: Top 20% Engagement Score

The monthly pulse survey provides a “snap shot” of how staff are feeling in relation to the 9 key engagement questions. These questions determine the overall engagement score. The overall score this month has remained at 7 out of 10. The 2018 National NHS staff acute trust average was 7 out of 10 and we were slightly below this at 6.9. The best Acute Trust scored 7.6 out of 10. Our ambition is to be above average in 2019 National Staff Survey.

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

Key highlights:

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

Our People - Improving Staff Engagement (continued)

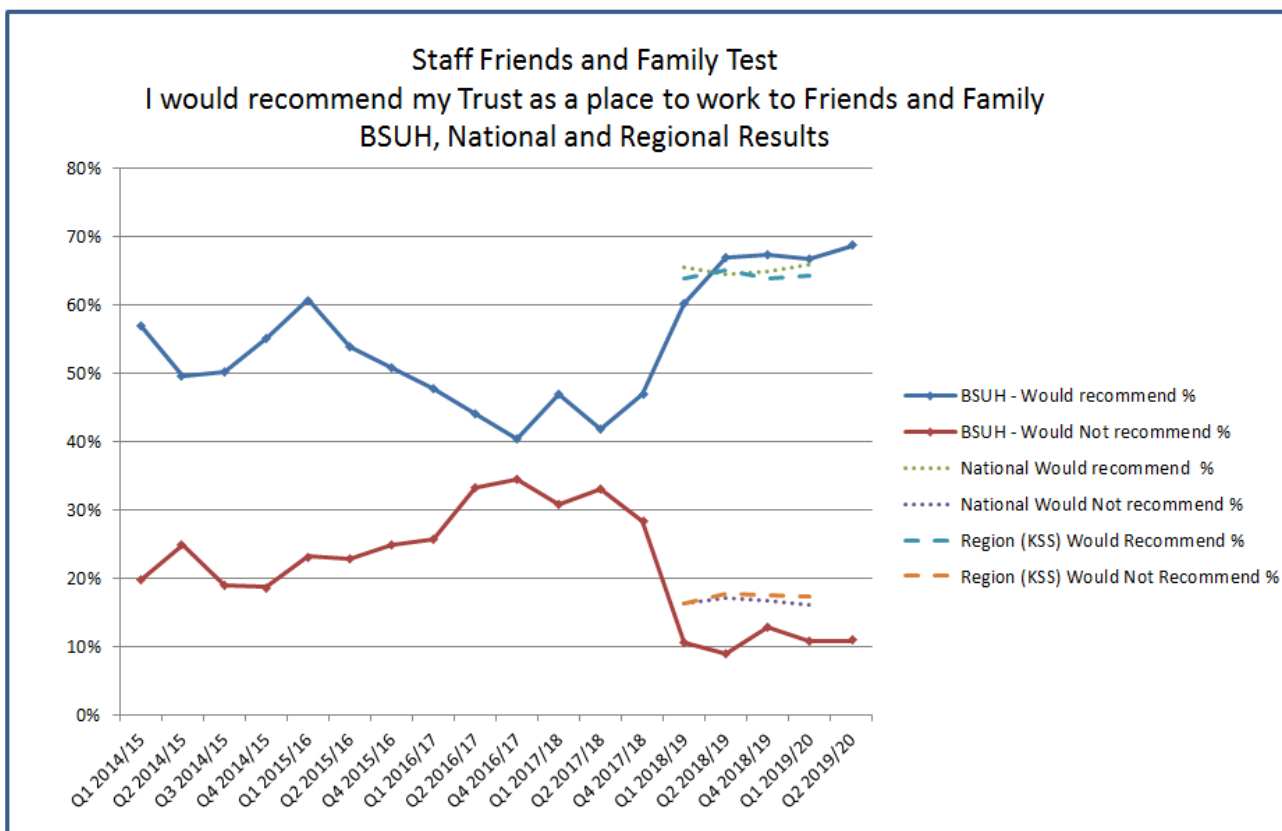
People

Staff Engagement
Target: Top 20% Engagement Score

Breakthrough Objective

Following the increase in the 2018 staff survey score of 'care is my organisations top priority' which is now in line with the national average for acute Trusts, the Breakthrough Objective for Our People changed in July 2019 to 'I would recommend the organisation as a place to work.' Focused staff input has created a developed plan of actions which is progressing against target.

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



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

Our People - Improving Staff Engagement (continued)

People

Staff Engagement
Target: Top 20% Engagement Score

2019 Staff Survey

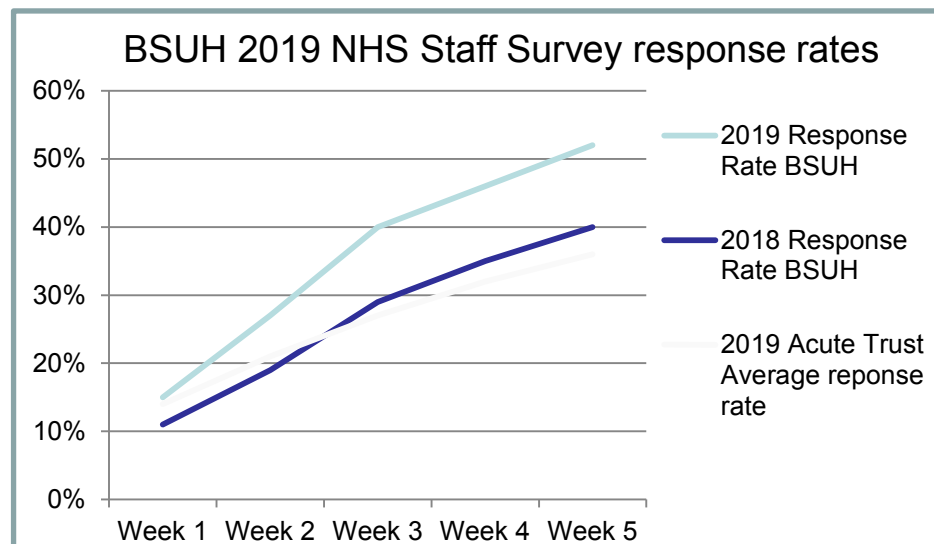
The Trust has run the NHS Staff Survey for all Trust employees since 2016 (previous only a sample of staff were surveyed). Participation has increased from under 40% in 2016 to 59.1% in 2018.

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

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

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

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



Our People

People

Staff Engagement
Target: Top 20% Engagement Score

Key Actions

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

Our People - Capacity and Capability

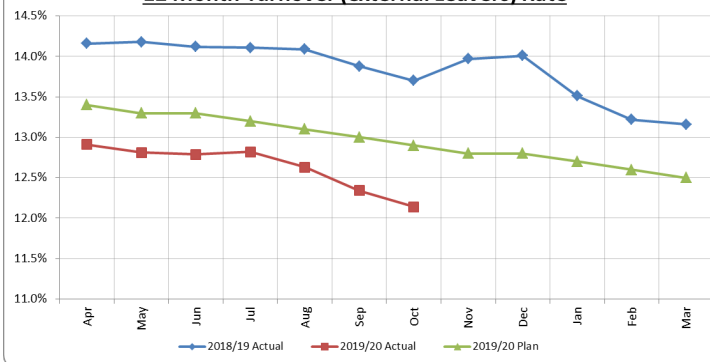
In M7, overall workforce spend was £33.35m against a plan of £33.11m, Year To Date workforce spend is overspent by £994k against a plan of £233.4m. Medical is the key driver of this YTD position with an overspend of £2.96m. The YTD position is partially mitigated by underspends in other staff groups.

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

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

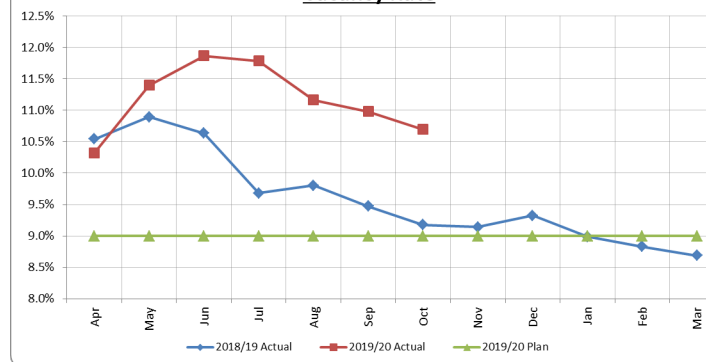
Our People – Key Metrics

12 Month Turnover (external Leavers) Rate



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

Vacancy Rate



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

• Improvement Focus:

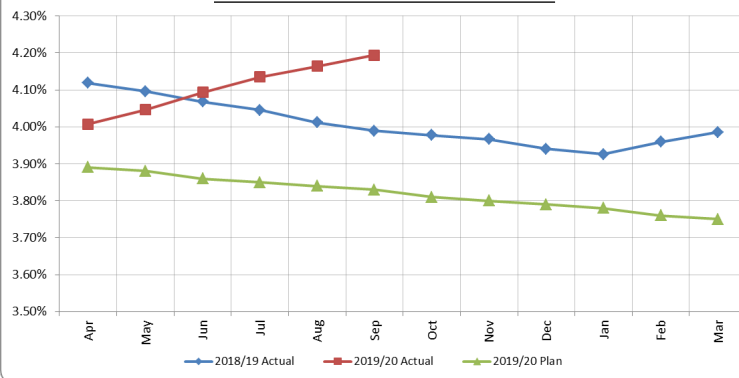
Divisions continue to review in detail their hot spot areas. Internal surveys, face to face exit interviews and engagement sessions have taken place or are planned to gather further intelligence. The output from these will be used to develop further improvement action plans. For example, the Surgery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

• Improvement Focus:

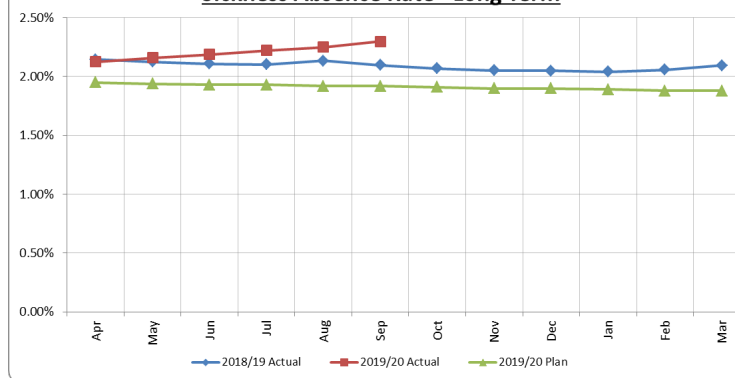
Rotas in all Clinical Divisions have been reviewed to identify opportunities to recruit a flexible nursing workforce at all levels. The Divisions continue to run rolling recruitment days to attract nursing staff. An internal transfer process is being introduced to make it easier for nurses to move from one area to another. The Surgery Division have advertised for specialist Gastrointestinal Nurses to encourage additional interest and the Medicine Division continue to look at alternative ways to attract nurses to A&E such as recruiting from the armed forces.

Our People – Key Metrics

12 Month Sickness Absence Rate



Sickness Absence Rate - Long Term



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

Improvement Focus:

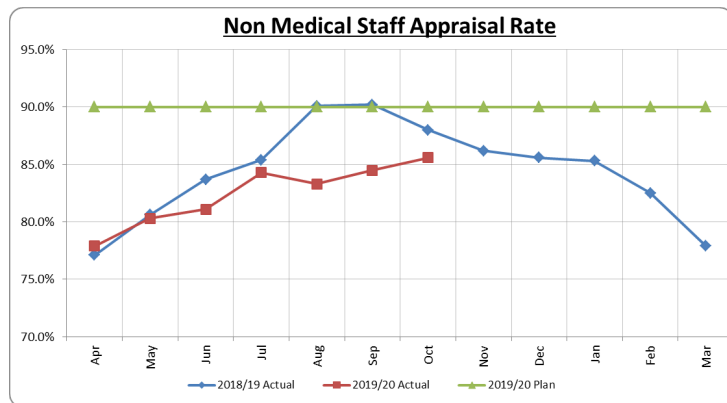
Forensic analysis of the data and hotspots is undertaken to triangulate information and reviewed monthly to understand the underlying causes of sickness by care centre and identify any actions which could be taken. Influencing factors include areas with high vacancy rates, reviews of working patterns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

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

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

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

Our People – Key Metrics

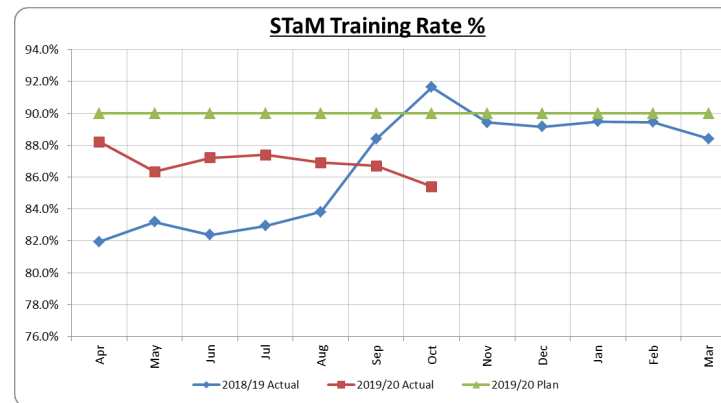


The Trust's Appraisal rate increased to 85.6% in October, the highest rate achieved since November 2018. While still below the target rate of 90% and below October 2018 when the Appraisal rate stood at 88.0%, the current rate is still the fourth best since records began

Improvement Focus - Appraisal:

The new Appraisal and Pay Progression Policies have been launched, together with an updated appraisal form and guidance. Launch sessions are being held during November and December to provide managers and staff with an overview of the changes and the link between the annual appraisal and pay progression.

Improving the quality of appraisals remains a key focus as part of the Staff Survey Engagement Action Plans developed from last year's Annual Staff Survey Results, as well as ongoing work to increase the number of appraisals completed to reach the Trust target of 90%. A targeted approach led to two Divisions (Medicine and Facilities and Estates) showing significant improvement to 89% in October (3% and 6% increases respectively).



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

Improvement Focus - STAM:

The Divisions receive detailed reports each month to identify the topics and the staff who need to be trained. Managers are responsible for checking that all training is up to date as part of the appraisal process, and for releasing staff to attend face to face sessions or given time to complete online modules where appropriate.

STAM compliance is discussed at Safety Huddles, team meetings and Divisional management meetings as well as Trust Performance Reviews with the Executive Team.

Managers are asked for detailed plans to reach the required compliance level of 90% on a monthly basis.

Agenda Item:	11.2	Meeting:	Finance and Performance Committee	Meeting Date:	29 October 2019
Report Title:	Report from Finance and Performance Committee Meeting Chair				
Sponsoring Executive Director:	Patrick Boyle, Non-Executive Director				
Author(s):	Patrick Boyle, Non-Executive Director				
Report previously considered by and date:	N/A direct report to Board				
Purpose of the report:					
Information	<input type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>		
Review and Discussion	<input type="checkbox"/>	Approval / Agreement	<input type="checkbox"/>		
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	<input type="checkbox"/>	Staff confidentiality	<input type="checkbox"/>		
Patient confidentiality	<input type="checkbox"/>	Other exceptional circumstances	<input type="checkbox"/>		
Link to Trust Strategic Themes:					
Patient Care	<input type="checkbox"/>	Sustainability	<input checked="" type="checkbox"/>		
Our People	<input type="checkbox"/>	Quality	<input type="checkbox"/>		
Systems and Partnerships	<input checked="" type="checkbox"/>				
Any implications for:					
Quality					
Financial					
Workforce					
Link to CQC Domains:					
Safe	<input type="checkbox"/>	Effective	<input checked="" type="checkbox"/>		
Caring	<input type="checkbox"/>	Responsive	<input checked="" type="checkbox"/>		
Well-led	<input checked="" type="checkbox"/>	Use of Resources	<input checked="" type="checkbox"/>		
Communication and Consultation:					
Executive Summary:					
<p>The Finance and Performance Committee met on 29 October 2019 was quorate as it was attended by three Non-Executive Directors including the Trust Chair and the following Executives, the Chief Executive, the Chief Financial Officer, the Chief Medical Officer, the Chief Nurse, the Chief Workforce & Organisational Development Officer and the Chief Operating Officer along with the attendance from the Finance Director and the Director of Human Resources.</p> <p>The Committee received its planned items and debated these reports in accordance with its cycle of business.</p>					
Key Recommendation(s):					
<p>The Board is asked to NOTE the assurances received at the meeting and that based on these the Committee did not refer any matter to any other Committee and did not refer any strategic risk to the Executives for review.</p>					

To: BSUH Private Board

Date: 29/10/19

From: Finance and Performance Committee Meeting Chair

Agenda Item: **XX**

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Finance and Performance Committee	29 October 2019	Patrick Boyle	✓	<input type="checkbox"/>
Declarations of Interest Made				
There were no declarations of interest				
Assurance received at the Committee meeting				
<ul style="list-style-type: none"> The suite of operational performance reports was RECEIVED by the Committee, which noted the Trust position against constitutional standards and discussed the trajectories in place to improve the Trust's performance. The Committee noted that the Trust was behind its planned trajectories but was on track to delivery Diagnostics and Cancer by the end of December with the exception of Cardiac CT which is on track to deliver its trajectory by March 2020. The Committee RECEIVED a detailed presentation from the Chief Operating Officer on the RTT performance plan and was ASSURED over its robustness. The Committee recognised the demand and activity delivery risks and was ASSURED that the BAF correctly records this level of risk. The Committee RECEIVED the Workforce performance report and was assured over the actions described to address the Trust's continued improvements across a range of workforce metrics. The Committee RECEIVED the financial performance reports for Month 6. The Committee was ASSURED in respect of the Trust's performance against the plan for Month 6 with the Trust recording a £4.2m deficit excluding PSF, FRF and MRET which is in line with the Trust's approved plan. The Committee agreed to continue to monitor the work being delivered to mitigate the increase in activity levels. The Committee was ASSURED over the plans supporting the delivery of the Trust's 3019/20 control total. The Committee RECEIVED the Efficiency Programme update, noting that in Month 6 the programme had slipped slightly but was on track to meet the end of year total savings of £27m and acknowledged the on-going support given to Divisions that have complex financial schemes. The Committee recognised the increase in delivery required from month 6 and was ASSURED that the BAF correctly records this level of risk. The Committee RECEIVED the Quarterly Procurement Report Trust activity for the period to the end of quarter 2, 2019/20, and were ASSURED that end of September 2019 procurement activities delivered actual cash savings of £763K. Whilst this is below the original forecast there are plans being developed to improve this position by the year end. 				
Actions taken by the Committee within its Terms of Reference				
The Committee chose not to refer any of the risks it has oversight for back to the Executives for review as the Committee was assured over the risks current scores based on the business of Committee.				

Items to come back to Committee (Items Committee keeping an eye on)	
No items were discussed to be returned to the Committee.	
Items referred to the Board or another Committee for decision or action	
Item	Referred to
The Committee referred no matters to other Board Committees and referred no matter to the Public Board.	

Agenda Item:	12	Meeting:	Board	Meeting Date:	27 Nov 2019
Report Title:	Board Assurance Framework – 2019/20 – Q3				
Sponsoring Executive Director:	Glen Palethorpe, Group Company Secretary				
Author(s):	Glen Palethorpe, Group Company Secretary				
Report previously considered by and date:	TEC –Q3 scheduled to be presented on the 3 December 2019 QAC – 26 November 2019 F&P – 26 November 2019				
Purpose of the report:					
Information	<input type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>		
Review and Discussion	<input type="checkbox"/>	Approval / Agreement	<input checked="" type="checkbox"/>		
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	<input checked="" type="checkbox"/>	Staff confidentiality	<input type="checkbox"/>		
Patient confidentiality	<input type="checkbox"/>	Other exceptional circumstances	<input type="checkbox"/>		
Link to Trust Strategic Themes:					
Patient Care	<input checked="" type="checkbox"/>	Sustainability	<input checked="" type="checkbox"/>		
Our People	<input checked="" type="checkbox"/>	Quality	<input checked="" type="checkbox"/>		
Systems and Partnerships	<input checked="" type="checkbox"/>				
Any implications for:					
Quality	Quality related strategic risks				
Financial	Finance related strategic risks				
Workforce	Workforce related strategic risks				
Link to CQC Domains:					
Safe	<input checked="" type="checkbox"/>	Effective	<input checked="" type="checkbox"/>		
Caring	<input checked="" type="checkbox"/>	Responsive	<input checked="" type="checkbox"/>		
Well-led	<input checked="" type="checkbox"/>	Use of Resources	<input checked="" type="checkbox"/>		
Communication and Consultation:					
The Board Assurance Framework has been prepared in conjunction with each of the five Chief Officers, focussing on respective strategic objectives and determining their associated strategic risks.					
Executive Summary:					
Introduction					
<p>The Trust has identified 12 strategic risks to the delivery of its objectives. The oversight of the management of these strategic risks is documented within the Board Assurance Framework. Each risk has an assigned oversight committee who review the detail of the listed assurances and their impact on the current score along with the delivery of the actions to reduce to or maintain the risk at its target score.</p> <p>For quarter 3 at 17 November there have been two changes from the Q2 assessed scores. These changes have seen risk 2.2 increase and risk 5.1 reduce to its target score.</p>					
BAF SUMMARY					
<p>The table overleaf shows by risk, their current score and their target risk score. Noting that for one risk (4.2) this continues to be scored at its target score and thus the BAF process for this risk is about securing assurance that this acceptable (target) level of risk is maintained.</p>					

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

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

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

Committee Review

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

Quality Assurance Committee

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

Finance and Performance Committee

The Committee's review of the risks to which they have allocated oversight and their receipt of assurance at their meetings across Quarter 1 Quarter 2 and the start of Quarter 3 did not identify any negative assurance that required any risk to be referred back to the Executive for review for being under stated.

The Committee however, did recognise the increase in demand as a pressure on risks 2.1, 2.2 and 5.3 in relation to the Trust's ability to flex its resources and meet it strategic and operational plans alongside the delivery of the Trust's operational targets. The Committee also recognised the need for the recovery plans to deliver the agreed performance improvement before the risk should be reduced. The Committee did refer to the Quality Assurance Committee the review of waits on the quality risks and received as stated above assurance that the long waits were not increasing the quality risks.

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

The BAF reflects an increase in the current risk score for 2.2. In respect of risk 2.2 countermeasure reports in the form of the Trust's road map to deliver the Trust's control total have been presented to Finance and Performance Committee for October and November and include information on planned mitigations and the delivery of which will be tracked within the routine reports to Finance and Performance Committee. .

Audit Committee

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

The Committee did undertake a more detailed review at its October Committee meeting of risks 3.1, 3.2 and 3.3 to complement the reviews undertaken by the Quality Assurance and Finance and Performance Committees and confirmed that the reported assurance did support the stated current risk scores.

Trust Executive Committee

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

Key Recommendation(s):

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

Appendix A

Risk Appetite Statement

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Palliative & End of Life Care

Welcome to our services

Dr Ollie Minton

Lead Clinician Palliative Medicine

Steve Bass

Lead Clinical Nurse Palliative & EOLC

Aligned to CCS Division

01

Each person is seen as an individual

I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what's possible.

02

Each person gets fair access to care

I live in a society where I get good end of life care regardless of who I am, where I live or the circumstances of my life.

03

Maximising comfort and wellbeing

My care is regularly reviewed and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible.

04

Care is coordinated

I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of the day or night.

05

All staff are prepared to care

Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care.

06

Each community is prepared to help

I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways.

Who we are:

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

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

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

Background

- The Specialist Palliative Care Team Operational Policy:

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

 - Specialist assessments and advice on the management of complex physical symptoms, psychological distress, spiritual issues, family and carer distress, social, and financial issues
 - Advice to health care staff in Brighton and Sussex University Hospitals NHS Trust
 - Formal and informal education
- We have established an integrated service model for palliative and end of life care across BSUH.

Palliative & End of Life Care 2017: GOOD

- The specialist palliative care team is not funded to provide the recommended 7 day service. This limits access to specialist advice for patients and practitioners at weekends and bank holidays.
- A business plan has been prepared for 2019/2020 as investment is required.
- We are pursuing plans to scope and develop an Enhanced Supportive Care Team to work alongside the Acute Floor.

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

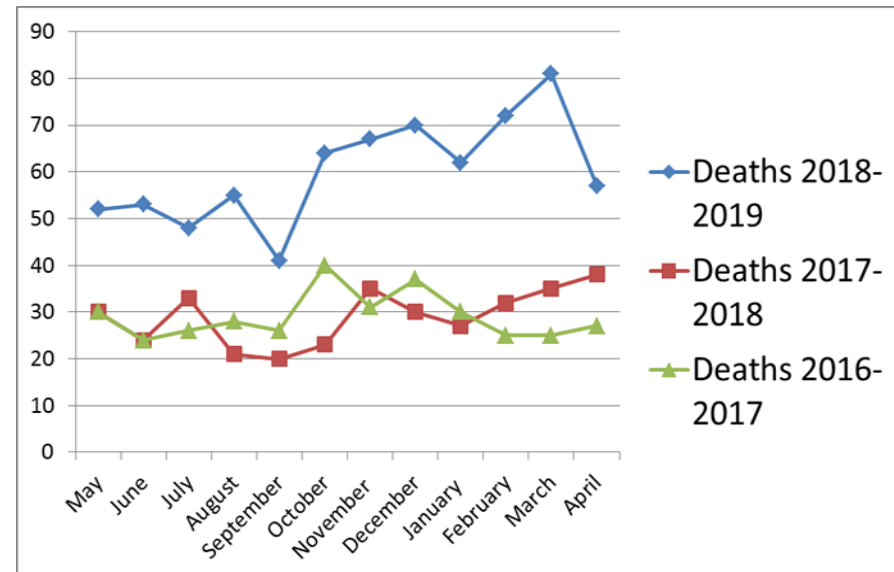
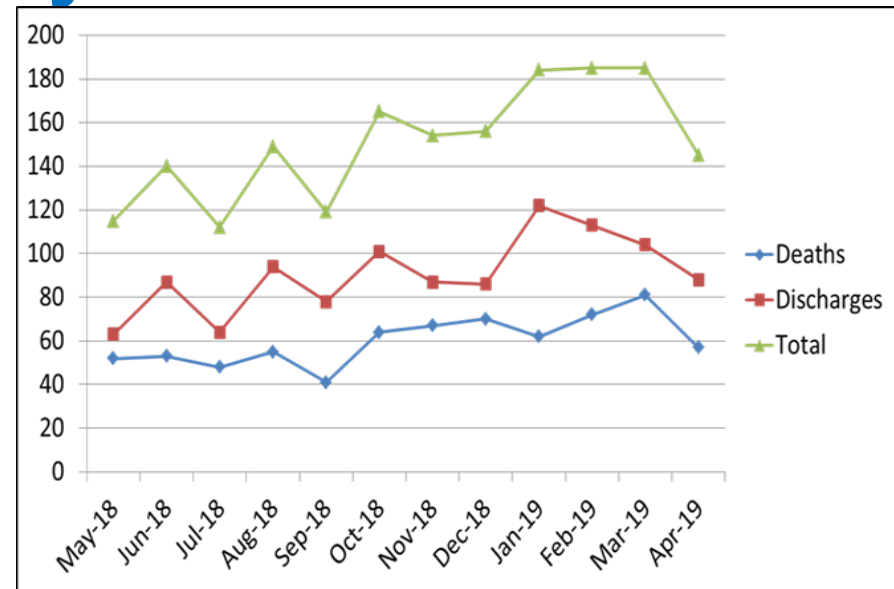
Notes

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

SPCT increased activity 2018-2019

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

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



BSUH End of Life Care Steering Group:

- Our EOLCSG now includes:
 - NED, Divisional Representation, Ward Staff, Quality and Safety team & Health Watch.
- We collaborate with the:
 - Deteriorating Patient steering Group [DPSG],
 - Trust Mortality Review Group [TMRG]
 - Dementia Steering Group

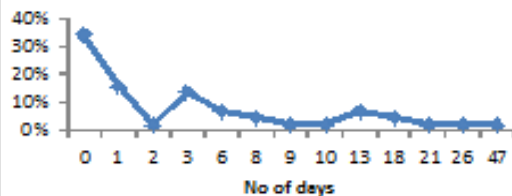
EOLC Dashboard

- We have:
 - embedded our commitment to the NHSE 6 Ambitions for EOLC into our data dashboard
 - designed our own Bereavement Survey and our planning how we use FFT
 - developed a Care of the Dying Quality Sample
 - instrumental in developing the BSUH Learning from Death Program
 - participated in the National Audit of Care at the End of Life (NACEL) and associated Carer Survey [2019 results pending]
 - Learning from complaints and datix

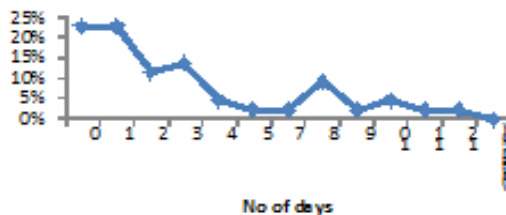
BSUH EOLC Quality Sample

Quality Sample Data August 2019–
October 2019

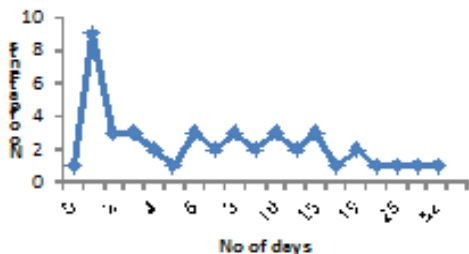
Time between admission and
recognition of dying



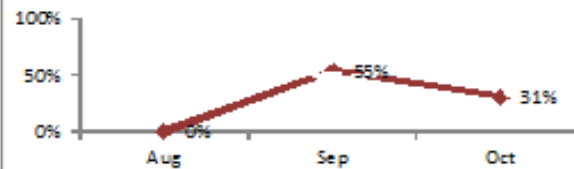
Time between recognition of
dying and date of death



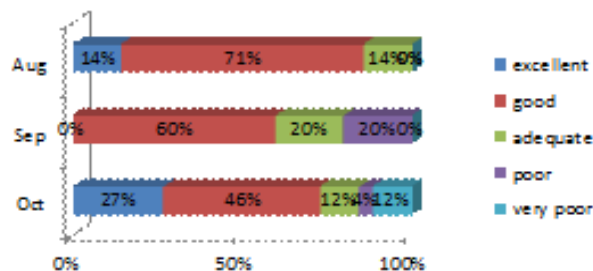
Length of Stay



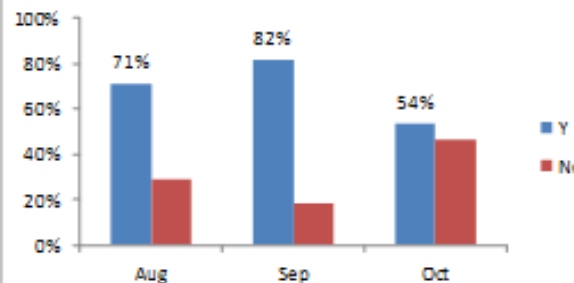
BSUH GOC Treatment Escalation Plan
used



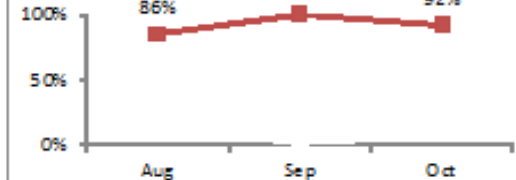
Overall score - Care of the dying person
was:



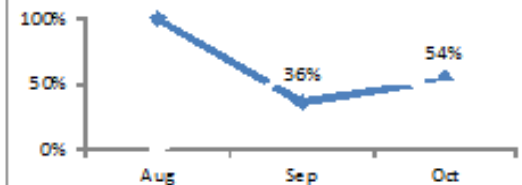
BSUH care of the dying
documentation completed?



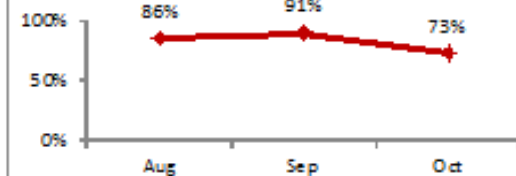
Evidence of communication of dying
with the nominated person



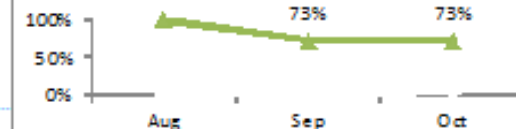
Involvement from the palliative care
team during admission



Evidence of anticipatory prescribing for
core 5 symptoms



Plan for hydration and nutrition
discussed with patient &/or nominated
person



Bereavement survey:

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

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

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

Patient name: _____
Hospital No: _____
NHS No. _____
D.O.B: _____
or affix patient ID sticker here

Brighton and Sussex
University Hospitals
NHS Trust

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

ENSURE YOU:

HAVE CONSIDERED POTENTIALLY REVERSIBLE CAUSES WHICH MAY BE APPROPRIATELY TREATED

HAVE COMMUNICATED WITH THE PATIENT AND THOSE IMPORTANT TO THEM

AIM TO INVOLVE A SENIOR DECISION MAKER (SpR/CONSULTANT)

DOCUMENT CPR STATUS AND TREATMENT ESCALATION PLAN

ASSESS SYMPTOMS AND PRESCRIBE APPROPRIATE MEDICATION

ASSESS NEED FOR CLINICALLY ASSISTED HYDRATION AND NUTRITION

CONSIDER IF DISCHARGE IS FEASIBLE IF PREFERRED PLACE OF CARE IS HOME

CONSULT 'PALLIATIVE CARE' TAB ON TRUST INTRANET FOR FURTHER GUIDANCE

THEN:

DOCTORS

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

NURSES

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

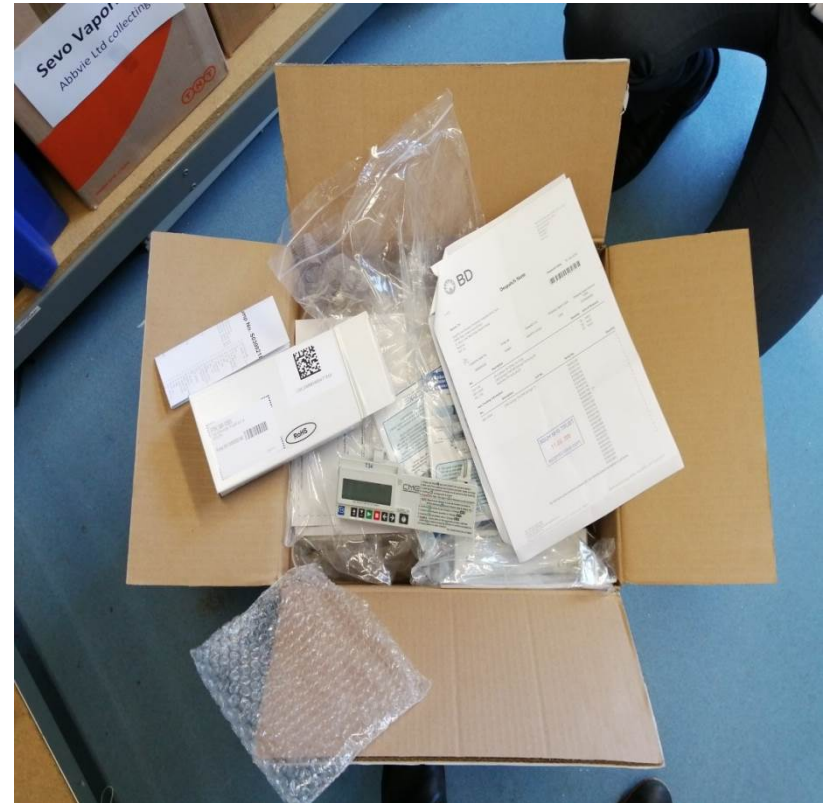
DOCTOR
NAME: _____ GRADE _____
SIGNATURE: _____ BLEEP _____
DATE: __/__/____ TIME: __:__:__

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

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

We are proud of: CME T34 Syringe Pumps

- The trust acknowledged a shortage of syringe pumps that are used to deliver medication essential to symptom management for patients in the dying phase.
- 50 new CME T34 pumps were secured
- The policy and guideline have been updated
- A training programme and competency are planned for 2019/20



We are proud of: Our work with the DPSG

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

Patient/doctor
Name: _____
DOB: _____
Hospital Number: _____

Brighton and Sussex University Hospitals NHS Trust

DO NOT PHOTOCOPY
FOR INPATIENT USE ONLY

Treatment Escalation Plan

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

Current Diagnosis:
Relevant Clinical Information and Condition / Co-Morbidities:

CEILINGS OF TREATMENT

1. Is patient for cardiopulmonary resuscitation?	Y / N
2. KIMITU (level 3) opinion if deteriorates:	Y / N
3. KIMIDU (level 2) opinion if deteriorates:	Y / N
4. KIMIV trial:	Y / N
5. KIMET call:	Y / N
6. WARD BASED LEVEL OF CARE (please select ONE of the following and update if the patient deteriorates):	
A. Active treatment within ward based setting	Y / N Date: _____
B. For trial of active treatment, but at high risk of dying during admission	Y / N Date: _____
C. Identified as dying, for end of life care with individualised care plan	Y / N Date: _____

RELEVANT INFORMATION REGARDING:

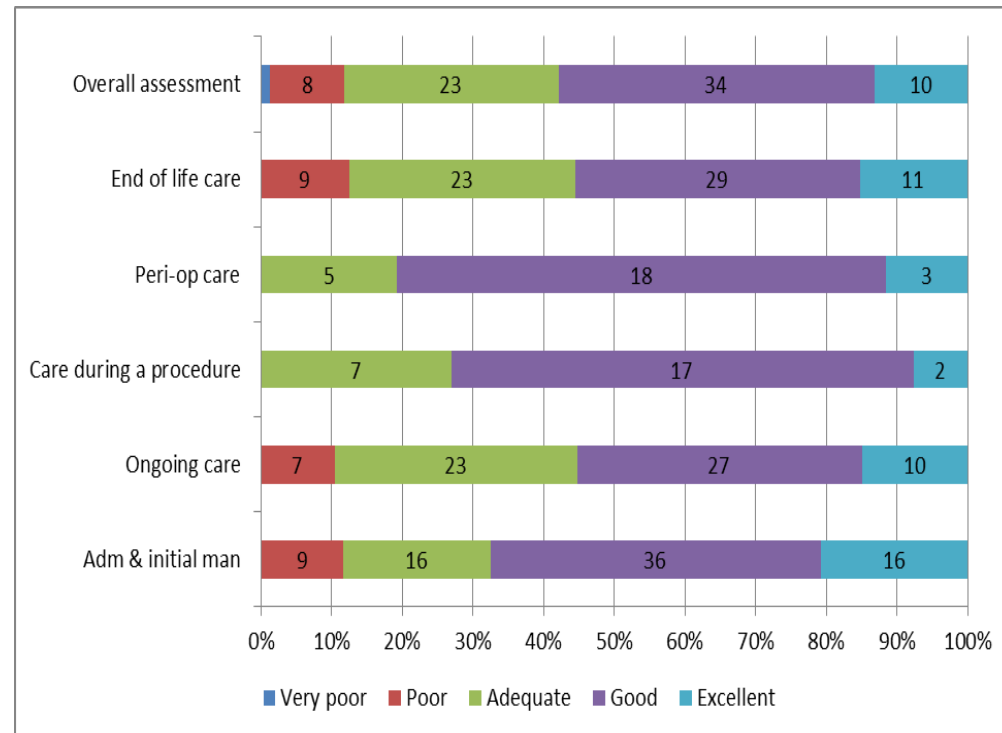
- * AGENCY CAPACITY / POLICE / ATTORNEY / ADVANCING DIRECTIONS
- * COMMUNICATION WITH PATIENT / CARERS / FAMILY / NOK

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

Junior name: _____ Grade: _____ Signature: _____ Date: _____
Consultant name: _____ Signature: _____ Date: _____
Is this an indefinite decision? Y / N OR review date: _____

We are proud of: Our work with TMRG

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



We are proud of: Integrating our training into the BSUH Education Strategy

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

“All have been well evaluated”

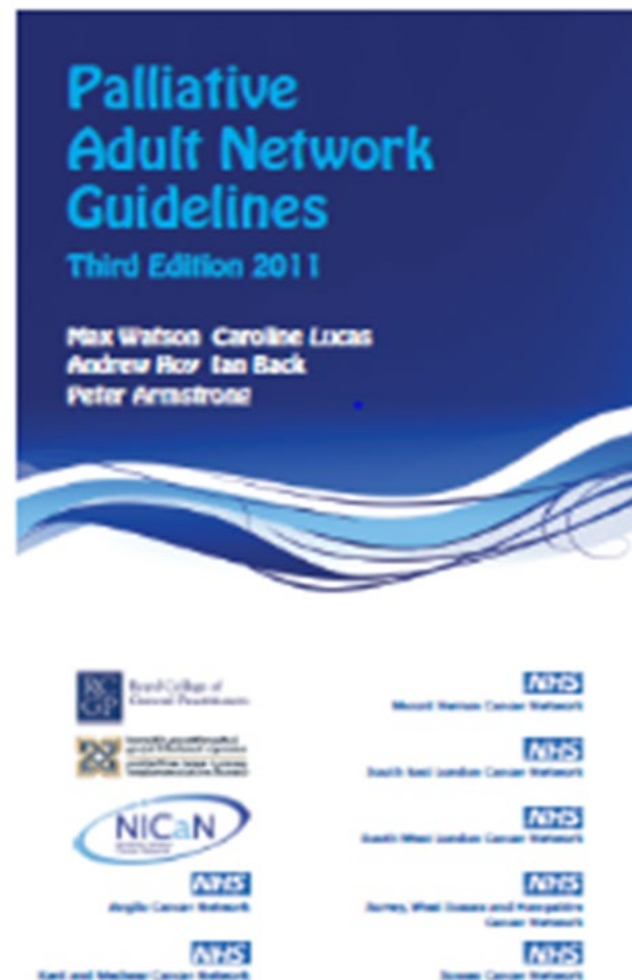
We are proud of: Our links with Brighton Medical School and Brighton University

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

“All have been well evaluated”

What are we doing: Online Resource

- Refreshing our Palliative & EOLC Infonet page: Who we are
- Developing clear guidelines on the BSUH Microguide
 - Symptom management & Prescribing information
 - Care of Dying
 - EOLC Discharge Planning
 - Advance Care Planning
 - Patient Information
- Training Opportunities
 - eELCA
 - Study Days



What we are doing: Patient Experience

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



We are challenged by:

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

Patient first: SPCT Ambition

01

Each person is seen as an individual

I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what's possible.

02

Each person gets fair access to care

I live in a society where I get good end of life care regardless of who I am, where I live or the circumstances of my life.

03

Maximising comfort and wellbeing

My care is regularly reviewed and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible.

04

Care is coordinated

I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of the day or night.

05

All staff are prepared to care

Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care.

06

Each community is prepared to help

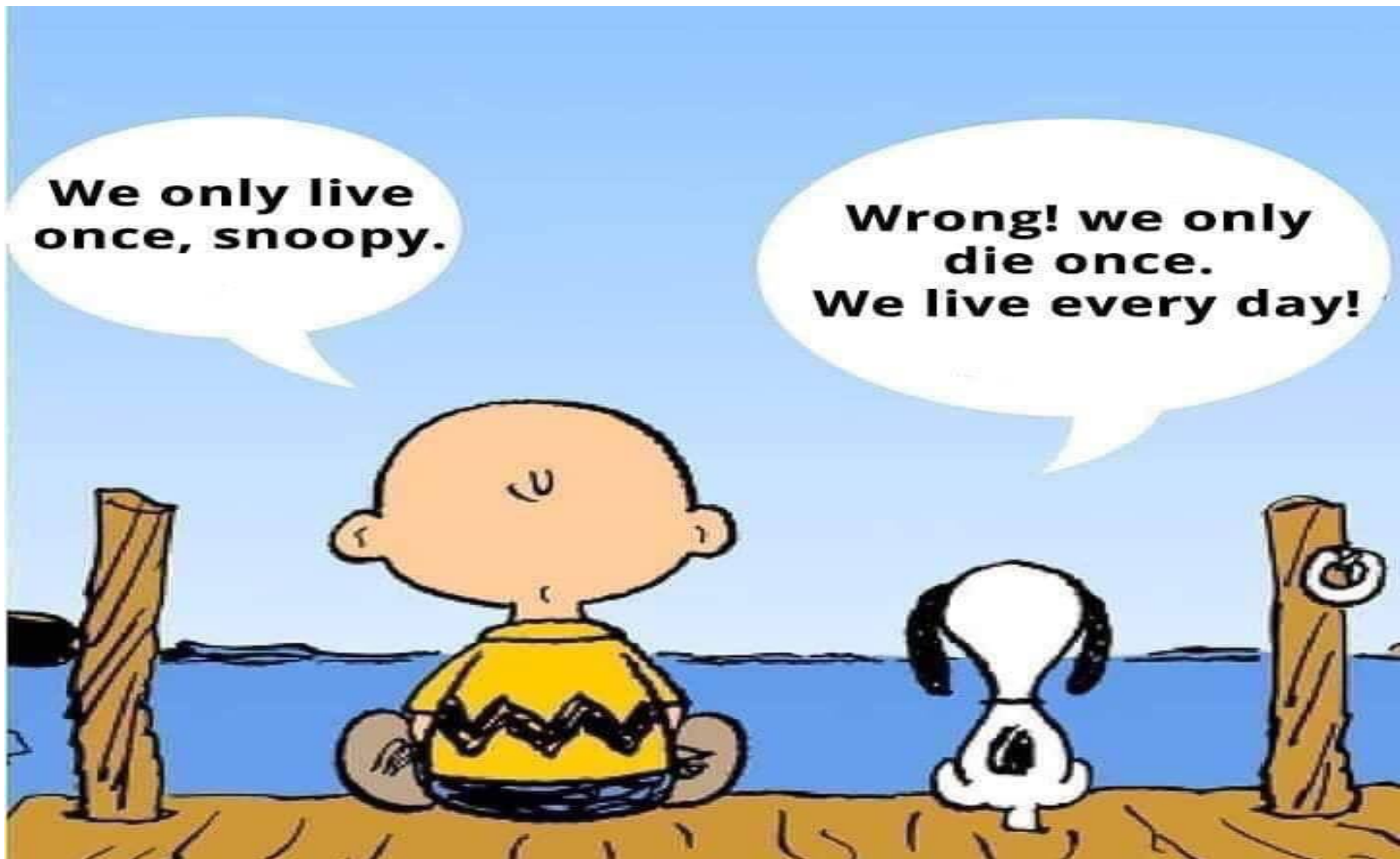
I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways.

- Earlier recognition of specialist palliative and supportive care needs for those patients living in the last year of their lives

Patient First: Our Approach

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

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



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

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

1. Introduction

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

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

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

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

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

3. Flu Vaccination campaign 2019/20

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

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

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

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

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

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

Table 1.

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

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

4. NHSE/1

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

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

7. Conclusion and Evaluation

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

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

Appendix 1 – Self – assessment

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

Agenda Item:	16	Meeting:	Board	Meeting Date:	27 Nov 19
Report Title:	Company Secretary Report				
Sponsoring Executive Director:	Glen Palethorpe, Group Company Secretary				
Author(s):	Glen Palethorpe, Group Company Secretary				
Report previously considered by and date:					
Purpose of the report:					
Information	<input type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>		
Review and Discussion	<input type="checkbox"/>	Approval / Agreement	<input checked="" type="checkbox"/>		
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	<input type="checkbox"/>	Staff confidentiality	<input type="checkbox"/>		
Patient confidentiality	<input type="checkbox"/>	Other exceptional circumstances	<input type="checkbox"/>		
Link to Trust Strategic Themes:					
Patient Care	<input checked="" type="checkbox"/>	Sustainability	<input checked="" type="checkbox"/>		
Our People	<input checked="" type="checkbox"/>	Quality	<input checked="" type="checkbox"/>		
Systems and Partnerships	<input checked="" type="checkbox"/>				
Any implications for:					
Quality					
Financial					
Workforce					
Link to CQC Domains:					
Safe	<input checked="" type="checkbox"/>	Effective	<input checked="" type="checkbox"/>		
Caring	<input checked="" type="checkbox"/>	Responsive	<input checked="" type="checkbox"/>		
Well-led	<input checked="" type="checkbox"/>	Use of Resources	<input checked="" type="checkbox"/>		
Communication and Consultation:					
Executive Summary:					
<p>This report provides the Board with a report on matters for which the Trust has complied with a NHS I or other regularly requirement. This report does not seek to duplicate matters that are subject to separate agenda items at today's board meeting.</p> <p>Learning from deaths report (attached as an appendix to this report)</p> <p>The Trust is required to receive reports on learning from deaths. The Board is reminded that the detail of this report has been scrutinised by the Quality Assurance Committee especially in respect of the Trust's processes for learning from the review of deaths. The focus continues to improve the Trust's processes. The outcome of this learning manifests itself in the Trust's mortality indices; these are tracked within the routine report to the Board as part of the Integrated Performance Report.</p> <p>Health and Safety Annual Report (attached as an appendix to this report)</p> <p>The Trust produces an Annual report on the Trust's compliance with its Health and Safety requirements. The detailed oversight of this work is delivered via the Health and Safety Committee.</p> <p>The overall conclusion for 2018/19 as supported by the Health and Safety Committee is that there has been continued improvement in H&S processes against the H&S priorities.</p>					
Key Recommendation(s):					
The Board is recommended to					

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

NOTE the 2018/19 Health and Safety Annual Report.

Agenda Item:	16.1	Meeting:	Board	Meeting Date:	27 Nov 2019
Report Title:	APPENDIX 2 - Learning from Deaths Report Q2 2019/20				
Sponsoring Executive Director:	Dr George Findlay - Chief Medical Officer, Dr Rob Haigh - Medical Director				
Author(s):	Rob Haigh – Medical Director, Della Morris - Safety & Quality Lead				
Report previously considered by and date:					
Purpose of the report:					
Information	<input checked="" type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>		
Review and Discussion	<input type="checkbox"/>	Approval / Agreement	<input type="checkbox"/>		
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	<input type="checkbox"/>	Staff confidentiality	<input type="checkbox"/>		
Patient confidentiality	<input type="checkbox"/>	Other exceptional circumstances	<input type="checkbox"/>		
Link to Trust Strategic Themes:					
Patient Care	<input checked="" type="checkbox"/>	Sustainability	<input type="checkbox"/>		
Our People	<input type="checkbox"/>	Quality	<input checked="" type="checkbox"/>		
Systems and Partnerships	<input type="checkbox"/>				
Any implications for:					
Quality	The Trust's True North Objective is for the mortality rates (HSMR) to be in the lowest 20% of Trusts.				
Financial					
Workforce	Human Resource Implications: There are training and protected time requirements for clinical staff undertaking SJR's.				
Link to CQC Domains:					
Safe	<input checked="" type="checkbox"/>	Effective	<input checked="" type="checkbox"/>		
Caring	<input checked="" type="checkbox"/>	Responsive	<input checked="" type="checkbox"/>		
Well-led	<input checked="" type="checkbox"/>	Use of Resources	<input type="checkbox"/>		
Communication and Consultation:					
Not applicable					
Executive Summary:					
This report is produced in line with National Guidance on Learning from Deaths, and provides the Trust Board with information relating to local implementation of the guidance; recent Structured Judgment Review activity; and the themes and learning that are emerging from this work.					
Key Recommendation(s):					
The Board is asked to NOTE the report.					

1. Purpose

- 1.1 Approximately 1600 deaths occur at BSUH every year. For many people death under NHS care is an inevitable outcome and they experience excellent care. However, some patients experience poor care resulting from a variety of factors. The purpose of a structured death review is to identify and learn from any problems that may have contributed to death to prevent a recurrence.
- 1.2 This paper updates the board on the implementation of the Learning from Deaths Policy at BSUH. Data is included on rates of review, mortality statistics and outcomes of reviews of mortality statistic data alerts.

2. Background

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

3. Governance

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

4. Process

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

5. SJR Training

- 5.1 The Palliative Care Team provides face-to-face training on request and has released a short training video on the IRIS system.
- 5.1.1 In addition; supportive multidisciplinary SJR sessions are held monthly, led by the Palliative Care Team.

6. Involving Families / Carers

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

7. Mortality Review Outcomes

- 7.1 A DoH recommended dashboard is used to illustrate SJR activity at BSUH (see attachment).
- 7.2 The table below shows the last 4 quarters data for BSUH (LD refers to deaths of patients with learning disabilities).

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

- 7.3 All deaths that have been recorded as 'more likely than not a result of problems in care' have been fully investigated in line with Trust policy.
- 7.4 The percentage of deaths reviewed from the most recent quarter is inevitably lower due to delays accessing patient records and allocating reviews. However, overall there has been a fall in the percentage of deaths reviewed; most of the deaths are reviewed by the Palliative Care Team, and this is reflected by the themes that are identified. The Divisional teams will be targeted to improve representation and participation in SJRs.
- 7.5 All SJRs review 6 discreet areas of care. Figure 1 shows the level of care received by patients in the last 4 quarters¹.

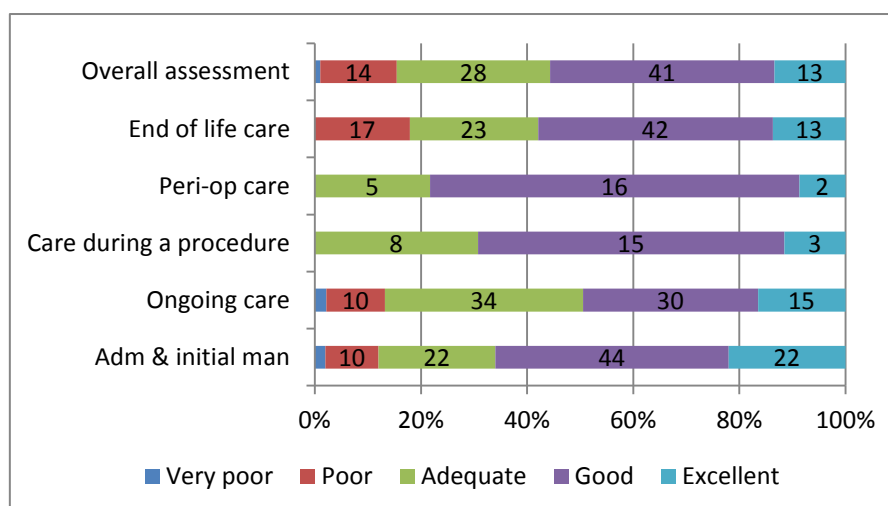


Figure 1

- 7.6 The Deteriorating Patient Steering group continues to focus on the Trust breakthrough objective 'improvement in recognition and management of deteriorating patients' by analysing the contributing factors to MET calls and sharing the learning locally to improve practice.

¹ Q3 & Q4 18/19 & Q1 & Q2 19/20

- 7.7 Following an evidence review which found no tools for reviewing the deaths of children and young people, the Paediatric Team have developed a paediatric version of the SJR. The team use the Child Death Overview Panel (CDOP) form. The CDOP focus on population level data rather than learning from individual cases. The tool is now available on PANDA and is the result of a consensus in the paediatric team. BSUH are switching to a new strategic process whereby the CDOP panel will be held in the acute trust, there will be some duplication but the SJR will inform the CDOP process.
- 7.8 The team presented learning from paediatric deaths which have been reviewed using the new tool including improved staff support for deaths on the adult ITU and poor scanning of notes.
- 7.9 The 'assessment of problems in healthcare' section of the SJR records quantitative data on the nature of the problem type and whether this resulted in harm to the patient. Figure 2 shows the number of SJRs in the last 4 quarters where a problem in care was identified as causing or probably causing harm to the patient.

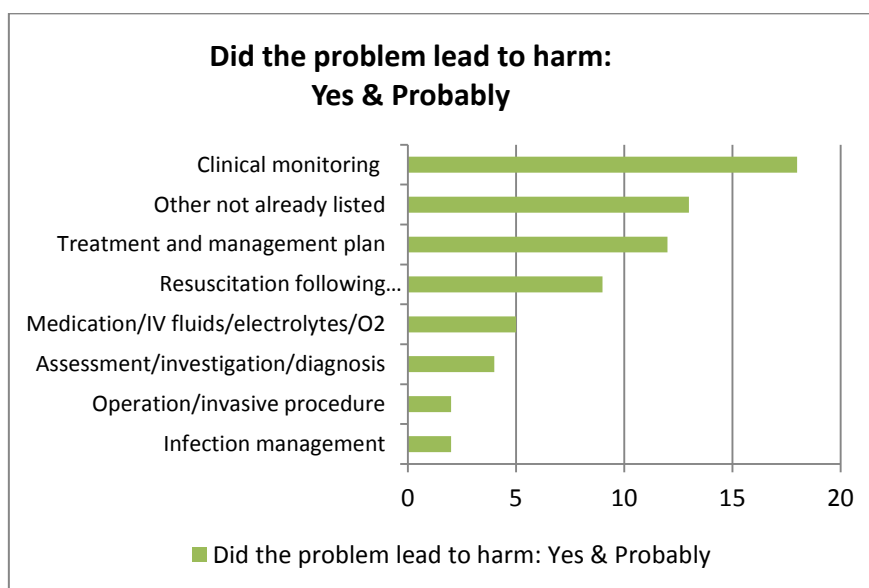


Figure 2

- 7.10 The most common 'problem' area is 'clinical monitoring' which includes 'failure to plan, to undertake or to recognise and respond to changes.
- 7.11 The further improve clinical monitoring, the trust is currently introducing Patientrack to improve hospital wide physiological surveillance of patients and thereby improve patient safety. This is integral to the Trust Patient First Strategy; improving hospital mortality rate and reducing patient harm.
- 7.12 Patientrack is live in 16 ward areas at RSCH with an ongoing roll out programme of one ward per week aiming to have all adult ward areas, paediatrics and maternity live by 16th December (on both sites). This system allows staff to view patients remotely; ward managers to view their whole ward (NEWS score and timing of observations); and NEWS auto-calculation prompts a response according to the score which the user must acknowledge mirroring the policy requirement.
- 7.13 The further improve trust awareness and understanding of the importance of appropriate, patient centred and holistic care planning, the TMRG continue to promote use of the SJR tool within PANDA and have added a third tab for use by clinical teams in their M&M meetings. This enables SJR data to be linked to M&M data –a concept which is now being piloted before roll out across the Trust.
- 7.14 The TMRG have also been recently working with the ME's to embed ME questions into PANDA, enabling junior doctors to submit data remotely saving time and allowing flexibility around this process. This work is currently been paused as a new national IT ME system is being developed centrally – but will be revisited once the national system is available.

8. SHMI² & HSMR³

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



8.2 HSMR data available is for the 12 months to July 2019. HSMR for BSUH is 89.16.⁴ The trend for in month and rolling HSMR is shown below in figure 4

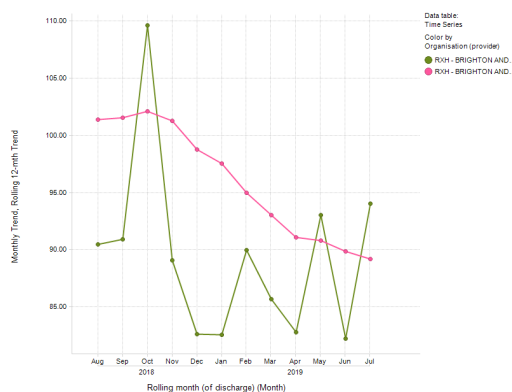
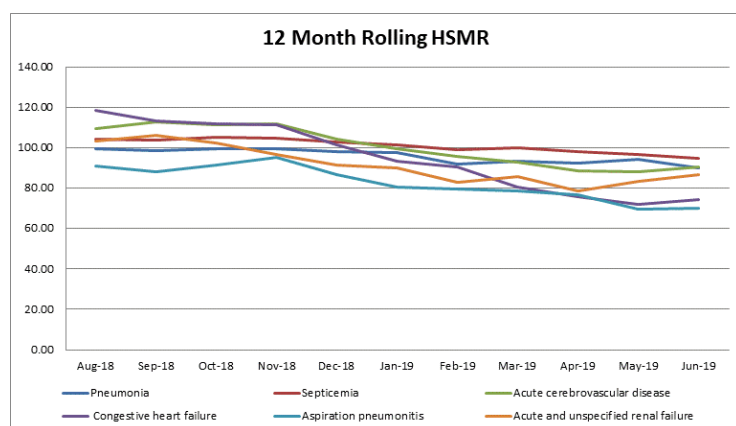


figure 4

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

8.4 Analysis of the top 6 CCS Diagnostic Groups⁵ amongst patients that die within BSUH, shows that HSMR is trending downwards for all 6 :



² SHMI is the ratio of observed to expected in-hospital deaths and deaths within 30 days of discharge for all patient diagnosis groups with limited case mix adjustment

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

⁴ National average is 100

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

9. Summary

- 9.1 In accordance with the requirements of National Guidance on Learning from Deaths, BUSH has published the specified data on deaths.
- 9.2 Overall there is a fall in the rate of deaths being reviewed, the Divisions will be targeted to improve representation and participation in SJRs
- 9.3 The Paediatric Team have developed a tool for the reviewing the deaths of children and young people.
- 9.4 Clinical monitoring remains the most commonly reported problem in care. The Trust are currently implementing Patientrak which will improve the quality of care to patients and reduce harm.
- 9.5 A mortality outlier notification regarding the National Bowel Cancer Audit is the result of a data quality error.
- 9.6 BSUH are currently in the top 20% of Trusts for HSMR.
- 9.7 Deep dive reviews conducted into mortality statistic data alerts for chronic ulcer, ventilation support, other operations on ventricle of the brain, neurostimulation and urethral catheterisation of bladder have identified no concerns in the quality and safety of care.
- 9.8 Deep dive reviews are ongoing into mortality alerts associated with complication of device; implant or graft' ; other Fractures' (SHMI > 100 i.e. above national average); primary excision of cervical intervertebral disc' ; other operations on peritoneum

10. Recommendation

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

Dr Rob Haigh

BSUH Medical Director

6.11.2019

Agenda Item:	16.2	Meeting:	Board	Meeting Date:	27 Nov 19
Report Title:	APPENDIX 2 Trust Health and Safety Committee Summary Report 2018 to 2019				
Sponsoring Executive Director:	Denise Farmer, Chief of Organisational Development and Workforce				
Author(s):	Lyn Allinson, Head of Risk Management				
Report previously considered by and date:	Trust Health and Safety Committee 22 nd October 2019 Quality Governance Steering Group – 23 rd October 2019				
Purpose of the report:					
Information	<input type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>		
Review and Discussion	<input checked="" type="checkbox"/>	Approval / Agreement	<input checked="" type="checkbox"/>		
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	<input type="checkbox"/>	Staff confidentiality	<input type="checkbox"/>		
Patient confidentiality	<input type="checkbox"/>	Other exceptional circumstances	<input type="checkbox"/>		
Link to Trust Strategic Themes:					
Patient Care	<input checked="" type="checkbox"/>	Sustainability	<input type="checkbox"/>		
Our People	<input checked="" type="checkbox"/>	Quality	<input checked="" type="checkbox"/>		
Systems and Partnerships	<input type="checkbox"/>				
Any implications for:					
Quality	Failure to manage risk, health and safety arrangements effectively compromises the safety and well-being of all patients, staff and visitors to Trust sites. Risk, Health and Safety is also a legal requirement and part of our regulatory requirements under NHS Improvement and the Care Quality Commission.				
Financial					
Workforce					
Link to CQC Domains:					
Safe	<input checked="" type="checkbox"/>	Effective	<input type="checkbox"/>		
Caring	<input checked="" type="checkbox"/>	Responsive	<input type="checkbox"/>		
Well-led	<input checked="" type="checkbox"/>	Use of Resources	<input type="checkbox"/>		
Communication and Consultation:					
To Board members.					
Executive Summary:					
This Report provides an update on the progress made by the risk management team in line with the implementation of the Trust's Health and Safety Policy Statement and other related policies and highlights the progress made in respect of the objectives for Health and Safety and Risk arrangements in the financial year 2018/19.					
Key Recommendation(s):					
The Board is asked to: <ul style="list-style-type: none"> Note the Annual report. 					

1. Introduction

- 1.1 The Trust Risk, Health and Safety Annual Report summarises the position and progress made against the Trust Health and Safety Policy, Statement of Intent and the implementation of the Risk, Health and Safety Policies and Procedures used by the Trust to minimise the risk to all.
- 1.2 The Health & Safety Policy Statement and Board Approved Statement of Intent require those responsible for health and safety within the Trust premises and for Trust activities to:
- Comply with health and safety legislation;
 - Implement health and safety arrangements through a risk-managed approach;
 - Comply with monitoring and reporting mechanisms appropriate to internal and external key stakeholders and statutory bodies;
 - Develop partnership working and consultation throughout the Trust to ensure health and safety arrangements are maintained within the Trust environment for staff, contractors, visitors and patients.
- 1.3 The Trust monitors risk, health and safety arrangements via the Trust Health and Safety Committee (bi-monthly) – the Consultation Committee which reports through Compliance Group (which in turn reports to the Trust Board via the Quality Governance Steering Group (QGSG) and Trust Executive Committee (TEC).
- 1.4 The Health and Safety Committee (H&SC) also receives reports from several other committees, steering groups and/or key pieces of work in relation to health and safety, or that cover a significant concern, which requires a specific task to enable it to be managed safely. During 2018/19 a new governance structure was introduced.

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

- Slip, Trips and Falls;
 - Safer Sharps;
 - Transport of Dangerous Goods;
 - Control of Substances Hazardous to Health (COSHH);
 - Radiation Safety;
 - Security Management including Violence and Aggression.
- 1.5 The full Health and Safety Committee annual report reviewed and agreed by BSUH Health and Safety Committee on the 22nd October 2019 includes a new format for the annual Risk, Health and Safety Compliance plan for next financial year of 2019/20. The format of the plan has utilised key Health and Safety Executive guidance, statutory requirements, risk profiling and BSUH current governance structure in its development.

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

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

2. Key Performance Indicator set for 2018/19

2.1 Summary update

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

2.2 Performance Review – current status- July 2019

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

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

BSUH Health and Safety Committee Annual Report 2018/19

4. Conclusion

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

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

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

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

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

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