Brighton and Sussex University Hospitals NHS Trust

Meeting of the Board of Directors

10:30 to 13:30 on Wednesday 24th July 2019
Trust Headquarters, Royal Sussex County Hospital, Brighton BN2 5BE

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 29 May 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	George Findlay
		INTEGRATED PERFORMANCE REPORT		
6.	10:50	**Introduction from Chief Executive** To receive and note overview of the Trust's activities	Enclosure	George Findlay
7.	10:55	**Quality Improvement** To receive and agree any necessary actions	Enclosure	George Findlay
8.	11:05	**Systems and Partnerships** To receive and agree any necessary actions	Enclosure	Jayne Black
9.	11:15	**Sustainability** To receive and agree any necessary actions	Enclosure	Clare Stafford
10.	11:25	**Our People** To receive and agree any necessary actions	Enclosure	Helen Weatherill
		ASSURANCE REPORTS FROM COMMITTEES		
11.	11:35	**Report from Quality Assurance Committee Chair** To receive assurance from Committee and recommendations from the Committee	Verbal	Mike Rymer
12.	11:40	**Report from Finance and Performance Chair** To receive assurance from Committee and recommendations from the Committee	Enclosure	Patrick Boyle
13.	11:45	**Report from Audit Committee Chair *including Annual Report*** To receive assurance from Committee and recommendations from the Committee	Enclosure	Lizzie Peers
14.	11:50	**Board Assurance Framework** To approve for publication on the website	Enclosure	Glen Palethorpe

		SERVICE PRESENTATION		
15.	12:00	**Critical Care Service Presentation** To receive assurance over application of patient first processes	Presentation on the day	Specialist Services Division
		OUR PEOPLE		
16.	12:15	**Workforce Disability Equality Standard** To endorse planned actions	Enclosure	Helen Weatherill
		QUALITY		
17.	12:30	**Annual Adult and Children's Safeguarding Presentation**** To receive activity information for 2018/19	Presentation	Clare Williams
18.	12:40	**CNST Maternity Standards** To approve	Enclosure	Clare Williams/ Carly Knell
19.	12:50	**Dementia Strategy** To approve	Enclosure	Clare Williams
		WELL LED & COMPLIANCE		
20.	13:00	**Annual Medical Appraisal and Revalidation Report** To approve	Enclosure	George Findlay
21.	13:10	**Company Secretary Report** To note and agree any necessary actions	Enclosure	Glen Palethorpe
		OTHER		
23.	13:20	**Any Other Business** To receive and action	Verbal	Chair
24.	13:25	**Questions from the public** To receive and respond to questions submitted by the public	Verbal	Glen Palethorpe
25.	13:30	**Date and time of next meeting:** The next meeting in private of the Board of Directors is scheduled to take place at **10:00** on **25th September 2019** in the **Euan Keat Education Centre, Princess Royal Hospital, Haywards Heath** **To resolve to move to into private session** *The Board now needs to move to a private session due to the confidential nature of the business to be transacted*	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

**hard copies of these reports are available by emailing tanya.humphrys@wsht.nhs.uk

Brighton and Sussex University Hospitals NHS Trust

Minutes

Minutes of the Board of Directors (Public) meeting held at 9.30am on Wednesday 29th May 2019 in the Meeting Room, Level 6, Trust Headquarters, Royal Sussex County Hospital, Eastern Road, Brighton

Present:	Alan McCarthy	Non-Executive Director (Chair)
	Kirstin Baker	Non-Executive Director
	Joanna Crane	Non-Executive Director
	Malcolm Reed	Non-Executive Director
	Mike Rymer	Non-Executive Director
	Martin Sinclair	Non-Executive Director
	Patrick Boyle	Non-Executive Advisor
	Dame Marianne Griffiths	Chief Executive
	Denise Farmer	Chief Workforce and Organisational Development Officer
	George Findlay	Chief Medical Officer (Item 6 onwards)
	Karen Geoghegan	Chief Financial Officer
	Pete Landstrom	Chief Delivery and Strategy Officer
	Nicola Ranger	Chief Nursing and Patient Safety Officer
In attendance:	Glen Palethorpe	Interim Group Company Secretary
	Francesca Carroll	Board and Committee Administrator
	Tasha Gardner	Head of Communications

B/05/19/1 WELCOME AND APOLOGIES **Action**

1.1 The Chair welcomed those present to the meeting.

1.2 Apologies for absence were received from Lizzie Peers, Professor Malcolm Reed and Jon Furmston.

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

B/05/19/2 DECLARATIONS OF INTEREST

2.1 There were no declarations of interest.

B/05/19/3 MINUTES FROM THE PREVIOUS MEETING

3.1 The minutes of the meeting held on 27 March 2019 were approved as a correct record.

B/05/19/4 MATTERS ARISING

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

B/05/19/5 CHIEF EXECUTIVE'S REPORT

5.1 Dame Marianne Griffiths highlighted the activity undertaken by the Trust since the last Board meeting.

Celebrations

5.2 Staff were gifted with reusable cups at 'thank you' events across the Trust,

which were organised by the Trust Ambassadors as a way of recognising the hard work of staff over the winter period in addition to the improved CQC's 'Outstanding' rating for care and 'Good' overall rating which brought the Trust out of quality special measures.

5.3 The Patient First Improvement System continues to be rolled out, equipping staff to improve the delivery of excellent care. Marianne anticipated that the system will be fully implemented across the Trust by 2020.

5.4 A team of volunteers, lead by Dr Rob Galloway, worked closely with St Johns Ambulance to treat over 350 patients at the Brighton Marathon. Many of which would have otherwise attended the Trust's A&E department to receive their treatment.

5.5 The week of the 13 May saw the Trust celebrate both International Nurses Day and ODP Day, in which staff were recognised for their hard work.

5.6 The HELP Service, which was started by one of the Trust's A&E Nurses, celebrated it's 10th birthday.

5.7 A first for the Trust, saw the launch of the LGBTQ+ mentoring scheme in April which is aligned with the organisation's True North objectives and is expected to be extremely beneficial to those involved.

5.8 The Board has approved funding on £4.6m to improve Endoscopy Services at the Trust, which will significantly improve the quality of care provided and improve waiting times for our patients. The Trust also recently had a JAG accreditation visit and the inspection team were very complimentary about the teams they met.

Diary Highlights

5.9 Marianne informed the Board that she and other staff across the organisation have met with partners and stakeholders, including both CCG and Acute partners, who have each reported on the good work of the Trust. Marianne added that from a recent STP meeting, it was confirmed that a priority for the STP is to maximise the return on investment with the 3T's Hospital Redevelopment.

5.10 The Trust recently held a Lean academic conference which saw 50 attendees from other organisations who heard and discussed BSUH's improvement journey, the conference received really good feedback.

Looking Ahead

5.11 On 4th July, the Trust will hold its annual Staff "STAR Awards", which is used as an opportunity to recognise staff for their work and dedication. These also provide an excellent opportunity to improve staff engagement and to allow time for staff to celebrate what they do for our patients at BSUH.

5.12 It was a great achievement in 2018 for the Trust to enter Stonewall's list of LGBTQ+ friendly employers. Although this was a great achievement, the Trust is aiming to improve this ranking the year and, with the support of the BSUH LGBTQ+ network, the trust will be in as position to submit it's application by September.

5.13 The Board **NOTED** the Chief Executive's Report.

[George Findlay joined the meeting]

B/05/19/6 2019/20 OPERATIONAL PLAN

6.1 Oliver Phillips introduced the Operational Plan, which was submitted to NHSI at the start of April and has received positive feedback since.

6.2 The Operational Plan provides a summary of how the BSUH intends to build on its foundations and improve services across the Trust; captures the Trust's strategic initiatives and sets out how the established True North objectives, supported by breakthrough objectives are to be delivered.

6.3 Before handing over to the Executive Leads, Oliver highlighted that the plan was created from both bottom up as well as top down strategic direction, this was achieved through engagement from the Clinical Service Divisions and the Executive Team.

6.4 **Activity and Finance**
Karen Geoghegan explained that through the application of strong financial stewardship, along with other tactical initiatives, the Trust came out from financial special measures in 2018/29 having delivered the control totals in both 2017/18 and 2018/19 seeing a reduced deficit for the Trust. Karen acknowledged the development of a robust and achievable Efficiency Programme as a significant contributing factor to the Trust being able to deliver the control total in each of the last two years.

6.5 Supported by assessments conducted by the CQC and internal analysis, the Trust has created it's medium term financial plan which aligns with the wider objectives of the Trust over the coming years.

Constitutional Standards

6.6 Jayne Black explained that in response to a deterioration in A&E performance, the Trust has agreed trajectories and implemented more robust monitoring of the 4 hour performance target.

6.7 Cancer performance is measured against 9 key metrics, which the Trust aims to sustain meeting across this year.

6.8 Jayne confirmed the priorities of the Trust for 2019/20 and explained that the organisation has implemented recovery plans to align with the Constitutional Standards, the delivery of which are a priority for 2019/20.

Quality

6.9 George Findlay recognised the a key element of this plan was the delivery on not only the 'must dos' of which there were not many but the 'should dos' from the CQC's last inspection. The Trust focus on continuous improvement was reflected by their being only 2 'must dos' in the latest inspection when compared to the 64 made at the previous inspection. A key area for improvement is the reduction in mixed sex breaches, which are expected to be significantly reduced when Stage 1 of the 3Ts hospital redevelopment is operational.

6.10 George highlighted to the Board the importance of acknowledging the link between quality of care provided to patients and overall levels of staff engagement, which is monitored by the annual Staff Survey and captured through smaller exercises throughout the year.

6.11 The Patient First Strategy remains a focus for the Trust and the progress made in developing this strategy was positively noted at the more recent CQC visit.

Workforce

6.12 Denise Farmer recognised the pressures staff faced at the start point in 2017/18 and explained that significant progress has been made with further work continuing.

6.13 In depth analysis of the Staff Survey results that were initially shared with the Board in March showed that BSUH has the most improved staff engagement score of any acute Trust in the country.

6.14 Denise explained that additional resources have been invested into both the recruitment process and into the induction for newly recruited staff to ensure they feel welcomed and supported at the Trust.

6.15 There are a number of programmes to optimise and develop the workforce and Denise drew the Board's attention in particular to the Leadership Development Programme, which has received positive feedback.

INTEGRATED PERFORMANCE REPORT

B/05/19/7 INTRO FROM CHIEF EXECUTIVE

7.1 Dame Marianne Griffiths introduced the integrated report and drew the Board's attention to the Patient First framework on page 3 reminding the Board this underpins everything the Trust does.

B/05/19/8 QUALITY PERFORMANCE

8.1 George Findlay advised the Board that some of the HSMR data within the circulated report was incorrect, however, the version presented onscreen was correct and will be circulated after the meeting.

8.2 The Hospital Standardised Mortality Ratios (HSMR) was 94.11, compared to 99.11 in the previous rolling 12 month period, suggesting a downward trend. George explained that the Trust had 115 deaths in the period, against an expected 135. George added as will be discussed later in the meeting all deaths are taken as opportunities to learn.

8.3 The Trust's rolling 12 month rate of inpatient falls was 3.32, this was against the Trust's own target of 3.38, both are significantly lower than the national average of 6.62. This is evidence of the positive outcome from the previous breakthrough objective delivery in this area.

8.4 The rate of patients with pressure ulcers was above target, however, George explained there had been a higher rate of patients presenting to hospital with existing pressure ulcers but there had been a reduction in patients who had developed pressure ulcers as inpatients.

8.5 George noted the Trust's above national average response rates in respect of the Friends and Family test, which is particularly positive within A&E which has faced significant pressures over the past months. The FFT results are used to provide insight to wards to drive improvement and weekly huddles have been set up, for any trends to be identified and resolved.

8.6 As the HSMR rates place BSUH in the top percentile of organisations, Joanna Crane asked what further improvements the Trust could implement. George informed the Board that BSUH will be moving to a different benchmarking system which will enable the Trust to measure itself against a larger pool of organisations which is hoped with give a richer data set to drive further

improvement.

B/05/19/9 ORGANISATIONAL WORKFORCE AND DEVELOPMENT

9.1 Denise Framer informed the Board that Staff Friends and Family Test, which has been running quarterly at BSUH for the past 5 years, received the best responses since it was started, which were attributed to the Patient First work.

9.2 To improve staff wellbeing, the Workforce team are undertaking work to look at how to further support staff with their mental health and well being and also how to communications with staff can be further improved.

9.3 The implementation of the E-Rostering system which was approved by Board will be a key enabler for the required improvements to both capacity and capability across the Trust's workforce.

9.4 Work is underway with the Divisions to improve the completion rates for appraisals, which has been identified as lower than expected as it's monitored as a key performance indicator with each Division.

9.5 Staff turnover is the lowest is has been for some time but work continues on recruitment and retention. In response, Alan asked if there was any link between an improved CQC rating and retention of staff, to which Denise suggested it was more related to staff's ability to be empowered to carry out their duties effectively, but an improved CQC rating would provide staff with a sense of pride.

B/05/19/10 FINANCIAL PERFORMANCE REPORT

10.1 Karen Geoghegan provided the Board with an update of the financial performance of the Trust, which for the month is posting a deficit of £6.73m, this figure doesn't not include additional funds from the Provider Sustainability Fund (PSF), Provider Recovery Fund (PRF) or Marginal Rate Emergency Threshold (MRET).

10.2 The Trust's performance is in line with plan to deliver an underlying deficit of £53.0m and is working hard to meet all performance targets as if met, Trust will be able to receive further funding which will reduce its deficit to some £25.7m. Karen highlighted to the Board that the additional funds available are based on the Trust's financial performance rather than as in prior years a combination of both financial and operational performance of the organisation.

10.3 Karen talked the Board through the key metrics for detailing the Trust's financial performance and noted the on-going work and focus on reducing the medical pay bill as this is a breakthrough objective for the organisation.

10.4 The Aligned Incentive Contract (AIC) and the CCG Contract have not been signed yet but Karen anticipated they should be finalised soon.

B/05/19/11 OPERATIONAL PERFORMANCE

11.1 Jayne Black highlighted the key points from the Operational Performance element of the report. Taking the Board through each key target.

Cancer Performance

11.2 In March, there was a 12.7% improvement in the number of patients commencing treatment within 62 days when compared to those commencing treatment in February. Although a steady improvement, Jayne recognised

further work and actions are required to improve the cancer pathways, which is a breakthrough objective for 2019/20.

11.3 Underperformance in cancer is strongly linked to capacity issues and delays within diagnostics, which, in itself is a key driver and a separate diagnostics plan has been implemented as a result.

A&E Performance

11.4 The Board were informed of the most recent A&E performance figures and Jayne acknowledged that there is still a significant amount of work required to improve flow through the department to meet the 4 hour wait target. Jayne reminded the Board that BSUH continues to see an increase of patients attending A&E which keeps a constant pressure on the system.

11.5 In terms of improvements to patient flow, the Trust is aiming to reach the national target, which would require a reduction of stranded patients by 40%.

Referral to Treatment (RTT)

11.6 A real focus has been put on the number of patients who have waited over 52 weeks, of which there were 14 in April recognising the target is to have no patients waiting over 52 weeks.

Endoscopy

11.7 Jayne acknowledged that there are still some gaps in workforce capacity within this area, which puts further strain on the department but additional measures have been implemented whilst the recruitment process is ongoing. Jayne gave assurance that the organisation is working closely with NHSI to overcome the identified challenges.

11.8 Marianne reiterated to the Board that meeting the constitutional targets is a breakthrough objective for this year and the Trust is aiming to achieve all of the cancer targets by the end of the financial year.

11.9 Mike Rymer referred to the staffing issues in imaging and highlighted to the Board that a lack of sonographers is a issue across the country and not local to the Trust.

11.10 Martin Sinclair asked what measures were in place to tackle the challenges within Diagnostics to improve performance. Jayne responded that whilst there had been a slight reduction in April she assured Martin that measures are in place and a more proactive management approach had been adopted to secure improvement.

11.11 Marianne commented that it is recognised that there does need to be an improvement to the flow throughout the hospital, however, further work is underway with community providers to improve flow across the system.

11.12 The Board **NOTED** the Integrated Performance Report.

B/05/19/12 REPORT FROM QUALITY ASSURANCE COMMITTEE CHAIR

12.1 Mike Rymer, the Chair of the Quality Assurance Committee, provided the Board with a verbal update on the key points from the meeting that was held the previous day:

- The Committee received a detailed updated on performance of quality measures across the Trust.
- The Committee received assurance on site specific HSMR cases.

- The Committee had previously discussed the way in which the sub-groups feed into the Committee, and as a result, the Committee now receives a regular report from the Quality Governance Steering Group, which provides a conduit for the flow of assurance to the Committee from within the Trust.
- The Committee considered the Quality Impact Assessments and was assured over the risk mitigation and was able to confirm that high risk projects are not put forward as the process challenges these before they get to Committee.
- The Committee received workforce quality indicators and was assured over the actions being taken to manage quality

12.2 The Committee received assurance via the Trust's Internal Auditors in respect of their review and positive opinion on effectiveness of the established Quality Monitoring Groups within the Trust. There were some opportunities for improvement and the Committee requested a log of the group's activity to be presented to the Committee in 6 months.

12.3 The Committee heard from Andrew Harvey, Data Protection and Information Governance lead for the Trust in respect of information governance in general and specifically about the lessons learn and improvements made across last year.

12.4 Mike informed the Board that the Committee reviewed the Infection Prevention and Control draft annual report and advised that a new infection control lead is due to join the Trust in June and the Committee have asked for them to attend the Committee and present an update on the issues and the final annual report for the year.

12.5 The Committee approved the 7 Day Services Board Assurance Framework (BAF) which will be submitted to NHSI.

12.6 It was agreed by the Committee that it would be insightful to receive a report on the update of action taken within Maternity in respect of the CNST incentive scheme prior to its submission, which has been arranged.

12.7 The Board **NOTED** the update.

B/05/19/13 REPORT FROM FINANCE AND PERFORMANCE COMMITTEE CHAIR

13.1 Patrick Boyle, the Chair of the Finance and Performance Committee provided the Board with highlights from the Finance and Performance Committee meeting held on 30 April, which were enclosed and also provided a verbal update on the Committee meeting held the day before the Board met.

13.2 Patrick reiterated Karen's earlier point regarding the Trust's success in delivering the 2018/19 Control Total and recognised this had not been without challenges but wished to congratulate everyone involved in delivery. Patrick also reminded the Board of the achievements of the Efficiency Programme in 2018/19.

13.3 Patrick reminded the Board that the Committee now receives regular reports on Operational Performance too, the format of which has received positive feedback. The broader focus of the Committee is working well and is allowing the Committee to strengthen the level of assurance it can provide to the Board.

13.4 Patrick informed the Board that the Committee is monitoring closely the outcome of actions being taken to improve the Trust's operational performance

and will receive by exception more detailed reports if needed across the year.

13.5 The Board **NOTED** the update.

B/05/19/14 REPORT FROM AUDIT COMMITTEE CHAIR

14.1 Martin Sinclair, the Audit Committee Chair, provided the Board with an update from the Audit Committee meeting held on 10 April and the Annual Accounts meeting which convened on 23 May.

14.2 The Local Counter Fraud Specialist (LCFS) reports were received by the Committee in April and the Committee felt assured that Phillip Major, LCFS, was informed and mitigating identified fraud risks well.

14.3 The Committee received reports from the Trust's internal auditors and provided positive assurance over the systems of internal control reviewed.

14.4 The Board noted that the annual accounts were reviewed by the Audit Committee on 23rd May, prior to being submitted to NHSI.

14.5 The Board thanked Martin, who will be retiring from his role as a Non-Executive Director at the Trust at the end of June.

14.6 The Board **NOTED** the update.

B/05/19/15 MATERNITY SERVICE PRESENTATION

15.1 Carly Knell and Dr Ryan Watkins presented the Board with an update on Maternity Services at BSUH.

15.2 Carly provided a detailed overview of what the Maternity services do at the Trust, followed by the achievements of the Directorate.

15.3 Homebirth rates are significantly higher in the area, averaging 9.1%, compared to a national average of 2.3%.reminding the Board that the Trust has won awards for the homebirth services it provides to residents in the area.

15.4 Maternity Services at the hospital have created a bespoke training programme for new staff and the retention rate is good resulting in the department not using agency staff.

15.5 The Maternity department has seen a year on year reduction in serious incidents, this has been supported by the application of the sound local framework which is in place to review these and importantly share learning and make improvements to reduce reoccurrences.

15.6 In 2018/19 the Trust met, and exceeded, the compliance criteria set out by the National CNST Premium Incentive scheme, which led to a premium reduction and a further extra reduction for exceeding the minimum set criteria by NHS Resolution, not all maternity services where able to meet the required standards. Carly confirmed that Maternity is on track to achieve full compliance again in 2019/20.

15.7 On the 8th March, the Maternity team held an impactful event called 'Whose Shoes' which was well attended by maternity staff, other hospital staff and provoked thoughtful discussions by identifying different experiences for small but impactful service improvements.

15.8 Ryan acknowledged the successes of the BSUH maternity services but recognised that the department does face further challenges, these include:

- Limited access to sufficient theatre room with maternity only having access to one full theatre at present.
- Record systems needs to be improved and updated to better record patient information.
- Aim to reduce length of stay for patients
- There have been challenges in sourcing Registrar tier Junior Doctors, this has been mitigated through using Doctors from overseas who are enrolled in a programme recognised through the Royal College of Obstetricians.
- Will aim for a 1:26 ratio of patient care to improve patient care, which is being developed through a business case.

15.9 BSUH is working closely with Kings College Hospital London to provide and improve services across the maternity system.

15.10 George praised the presentation and informed the Board that there is a real focus on improving outcomes in maternity, evidenced by more developed management and engagement with expectant mother, which reduce both the risk of complications and the number of women requiring C-sections.

15.11 Marianne asked the presenter what is the most important thing to improve patient experience and Carly suggested it was multifactorial and recognised the importance of reviewing the feedback from what was discussed at the 'Whose Shoes' event.

15.12 The Board discussed effective communication and building relationships between staff and patients and between the team themselves and how this all impacts positively on the culture at the hospital.

15.13 The Board **NOTED** the presentation.

B/05/19/16 LEARNING FROM DEATHS QUARTERLY UPDATE

16.1 George Findlay provided the Board with an update on the Learning from Deaths processes applied within the Trust.

16.2 George reminded the Board that each year approximately 1600 people reach the end of their life at BSUH; the Trust has a process that gives thorough consideration as to how these patients have been cared for and treated at the end of their life.

16.3 George advised that the CQC is reviewing its national guidance regarding how Trust's should implement their guidance but George provided assurance that the Trust is compliant with the CQC's national guidance and this report provides that assurance to the Board. George reminded the Board that the Trust also seeks out any national learning and wraps that into it's communications regarding learning from deaths.

16.4 Referring to section 7 of the report, which details that 470 patients died at the Trust, 30 of those deaths met the criteria of a detailed Structured Judgement review. The outcome of the reviews showed that of the 30, none were determined to be potentially avoidable.

16.5 There were 4 patients who died and are being looked at separately under a separate process as they involved patients with a Disability. These cases follow a wider multi-disciplinary review process but due to capacity challenges

within the wider team the Trust is conducting its own review to accelerate the opportunity to learn but will share its review with the wider review as it progresses.

16.6 George drew the Board's attention to section 7.14 which demonstrates there is a high level of 'excellent' or 'good' feedback on the quality of care received, with very few areas were care was thought to be poor. An area the Trust intends to focus on is a review of patients who have died after a cardiac arrest call, to see if there is any learning from this co-hort of patients even though nothing significant has been identified from their individual review.

16.7 George informed the Board that the Trust is actively recruiting additional respiratory specialist consultants, which will assist with the management of patients who present with respiratory issues.

16.8 George confirmed there are a number of steps taken by the Divisions to learn from deaths and these result in improvements to the quality of care. This process provides confidence that the Learning from Deaths Programme is embedded into the organisation. The Trust has established and supports an independent examiner who discusses the individual cases with the families.

16.8 Mike Rymer commented positively of the Trust's involvement with palliative and end of life care. George replied that further work is required to recognise when end of life care is needed and to equip our staff to handle those situations appropriately with everyone involved.

16.9 The Board **NOTED** the update.

B/05/19/17 ANNUAL PROVIDER LICENCE SELF CERTIFICATION

17.1 Glen Palethorpe informed the Board that the Trust is required to make annual self-certifications, which will be published on the website. Glen also explained that the necessary assurances were included in the annual report.

17.2 The Board **APPROVED** the Licence Self-Certifications and **AGREED** to these being published to the Trust's website.

B/05/19/18 ANY OTHER BUSINESS

18.1 There was no other business raised.

B/05/19/19 QUESTIONS FROM THE PUBLIC

19.1 A member of the public had submitted multiple questions in relation to the provision of private beds at the hospital.

19.2 Karen Geoghegan answered by providing a summary response explaining that Trust does not have dedicated private beds for patients and that a more detailed response to each individual question would be provided after the meeting.

19.3 **ACTION:** Glen Palethorpe to provide the response formulated to the member of the public who submitted the questions

19.4 On the subject of sustainability, a member of the public submitted multiple questions to the Board, prior to the meeting.

19.5 Karen responded by confirming that the Trust is exploring a number of

avenues to increase it's environmental sustainability commitment and information on this is included within the Trust's Annual Report which will be publicised in July. Karen confirmed that a more detailed response regarding what has been achieved and what is planned has been formulated against each question raised and this will be provided post meeting.

19.6 **ACTION:** Glen Palethorpe to provide the response formulated to the member of the public who submitted the questions.

19.7 The final question received referred to the section of Marianne's update whereby she advised the Board that a replacement to Endoscopy equipment had been approved by the Board. The member of the public asked for further details around the fleet replacement and when the decision had been made. As the level of detail sought was not readily available to the Board, they agreed it would be provided post-meeting.

19.8 **ACTION:** Glen Palethorpe to provide the response formulated to the member of the public who submitted the questions.

Francesca Carroll
Board and Committee Administrator
May 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
25th July 2018	PB07/18/6.8	**Quality Report:** Dementia Strategy to be provided to Board in October.	Nicola Ranger	October 2018	*Strategy is still in development and scheduled to come to Board in March after review by QAC.* *Update 11/2/19 – strategy was not ready in time for QAC on 13/2/19. Next QAC in May then will come to Board.* *On agenda for July QAC and Board.*
29th May 2019	B/05/19/19.3 and 19.5	**Questions from the public:** Glen Palethorpe to provide members of the public with full responses to their questions.	Glen Palethorpe	July 2019	Complete – responses have been sent to members of the public.

Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	5	**Meeting:**	Trust Board	**Meeting Date:**	24 July 19
Report Title:	Chief Executive Report				
Sponsoring Executive Director:	Dame Marianne Griffiths, Chief Executive				
Author(s):	Jonathan Keeble, Director of Communications & Engagement				
Report previously considered by and date:	N/A				
Purpose of the report:					
Information	✓		Assurance	☐	
Review and Discussion	☐		Approval / Agreement	☐	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	☐		Staff confidentiality	☐	
Patient confidentiality	☐		Other exceptional circumstances	☐	
Link to Trust Strategic Themes:					
Patient Care	✓		Sustainability	✓	
Our People	✓		Quality	✓	
Systems and Partnerships	☐				
Any implications for:					
Quality					
Financial					
Workforce					
Link to CQC Domains:					
Safe	☐		Effective	☐	
Caring	✓		Responsive	☐	
Well-led	✓		Use of Resources	☐	
Communication and Consultation:					
Executive Summary:					
This report provides an overview for the Trust's activities for the months of June and July.					
Key Recommendation(s):					
The Board is asked to NOTE this report.					

Brighton and Sussex University Hospitals NHS Trust

Chief Executive's Report

July 2019

Content

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

Celebrations

Topping out gives view of hospital's future

The 'topping out' ceremony of stage one of the 3Ts took place last month, marking the completion of the building's framework.
Alan McCarthy and I were joined by representatives of the trust, Laing O'Rourke, Brighton and Hove City Council and partner healthcare organisations. Dolores Glover, who has worked in the Trust for more than 40 years, placed a ceremonial piece of yew wood into the concrete.

With the main framework for the building complete, the focus of the construction programme will be on making the building weather proof, while the complex internal fit out programme will continue for the next 18 months.

The ceremony was also featured on BBC South East News. A bird's eye view is available on our You Tube channel

Neonatal services recognised in HSJ Patient Safety Awards

Congratulations to TMBU who were finalists in the HSJ Patient Safety Awards in the Innovation of the year category.

Their entry 'making the neonatal unit safer in 5 minutes' recognised the work done to implement a multifaceted programme based on human factors. The programme is based around 'safety pauses' which are five minute multidisciplinary, hot-team debriefs immediately after any emergency or procedure. They focus on safety, team behaviours and identifying latent risks in the environment.

Celebrations

Praise for BSUH culture change

The National Guardian's Office has shared the results of its case review into Brighton and Sussex University Hospitals and has praised the Trust for the progress it has made in improving its speaking up processes, practices and culture. In recognising that there is still work to do, it has made six recommendations for how we can continue to improve.

The case review involved a series of focus group sessions in January, which were open to all staff. The inspectors interviewed 78 BSUH colleagues, the majority of whom felt the working culture across the Trust has improved since the new Trust leadership has been in place. It also identified Patient First as providing a framework for people to speak up about and resolve issues collectively

Cardiac procedure milestone

Surgeons at the Royal Sussex County Hospital have carried out more than 1000 TAVI operations since their first a decade ago.

The procedure is performed instead of open-heart surgery, where surgeons reach the heart by cutting a hole in the groin and inserting a new valve from there. This makes it ideal for older, frail patients or people with lung disease, previous surgery or liver disease who would be high risk for open surgery.

About 20 hospitals in the UK perform TAVI procedures and BSUH has the lowest documented mortality according to the national database NICOR.

Celebrations

Fond farewells

We bid a fond farewell to Chief Nurse Nicola Ranger and Nurse Director Caroline Davies in June. Nicola has joined Kings College Hospital as their Director of Nursing .

Caroline retired after 21 years at the trust and a nursing career that began at Guys and St Thomas' and included work on cardiac and orthopaedic wards and in practice development. Caroline also volunteered on the AIDS helpline in Brighton in the 1980s.

Looking ahead Carolyn Morrice will be joining us later in the year as our new Chief Nurse. She has extensive experience as a nurse leader and has held the role of Chief Nurse at Buckinghamshire Healthcare NHS Trust for the last five years.

BSUH celebrates Armed Forces Week

Brighton and Sussex University Hospitals Trust played its role in celebrating Armed Forces Week including our own reserves on Wednesday 26 June. Reservists play an essential role, helping protect our nation's security at home and overseas.

Although in its infancy the Armed Forces Network, led by Lieutenant Colonel Alex Saunders QARANC, Head of Resuscitation & Simulation Services, is a collaboration of BSUH's Armed Forces community. It includes, regulars, reserves, cadet adult volunteers, veterans, service families and the bereaved.

Diary highlights

- Meetings with partner organisations
- Sustainability and Transformation Partnership
- Acute Network
- East Sussex Women of the Year
- NHS Providers Quality Conference
- NHS Confederation Annual Conference
- BSUH Cancer Board
- Institute for Healthcare Improvement (Brighton chapter)
- Topping Out ceremony 3Ts
- NHSI/E executive team visit to Royal Sussex County
- STAR awards

Looking ahead

Progress on our Stonewall Workplace Equality Index commitment
The Board will remember our commitment to becoming a Stonewall Top 100 Employer in this financial year.

Since our last meeting, we have made substantial progress. An exciting programme of LGBTQ+ education seminars is now underway in partnership with BSMS. Key HR policies are being reviewed to ensure that they are fully inclusive. We are also building brand new LGBTQ+ webpages to share important information and staff stories – including one on our Chairman's lifelong support for equality and inclusion.

We have nearly 50 projects underway to help us continually improve the experience of working here for our LGBTQ+ staff. There is still a lot to do in the next 45 days, but I am confident that we will make the best submission possible on 6th September.

Proudly part of Pride
This month, we have played a part at Disability Pride and Trans Pride – supporting the event teams as well as being stand holders. On 3rd August, we will also be celebrating at Brighton Pride with a float in the parade.

I have been delighted to see how Disability Pride and Trans Pride have grown. They are now regionally important events offering supportive, celebratory atmospheres which the whole community benefits from.

We are committed to an open, diverse, equal and fair culture here at BSUH. Playing our part in Pride events is an important way to celebrate this with our LGBTQ+ staff, patients and their allies throughout the trust.

Integrated Performance Report

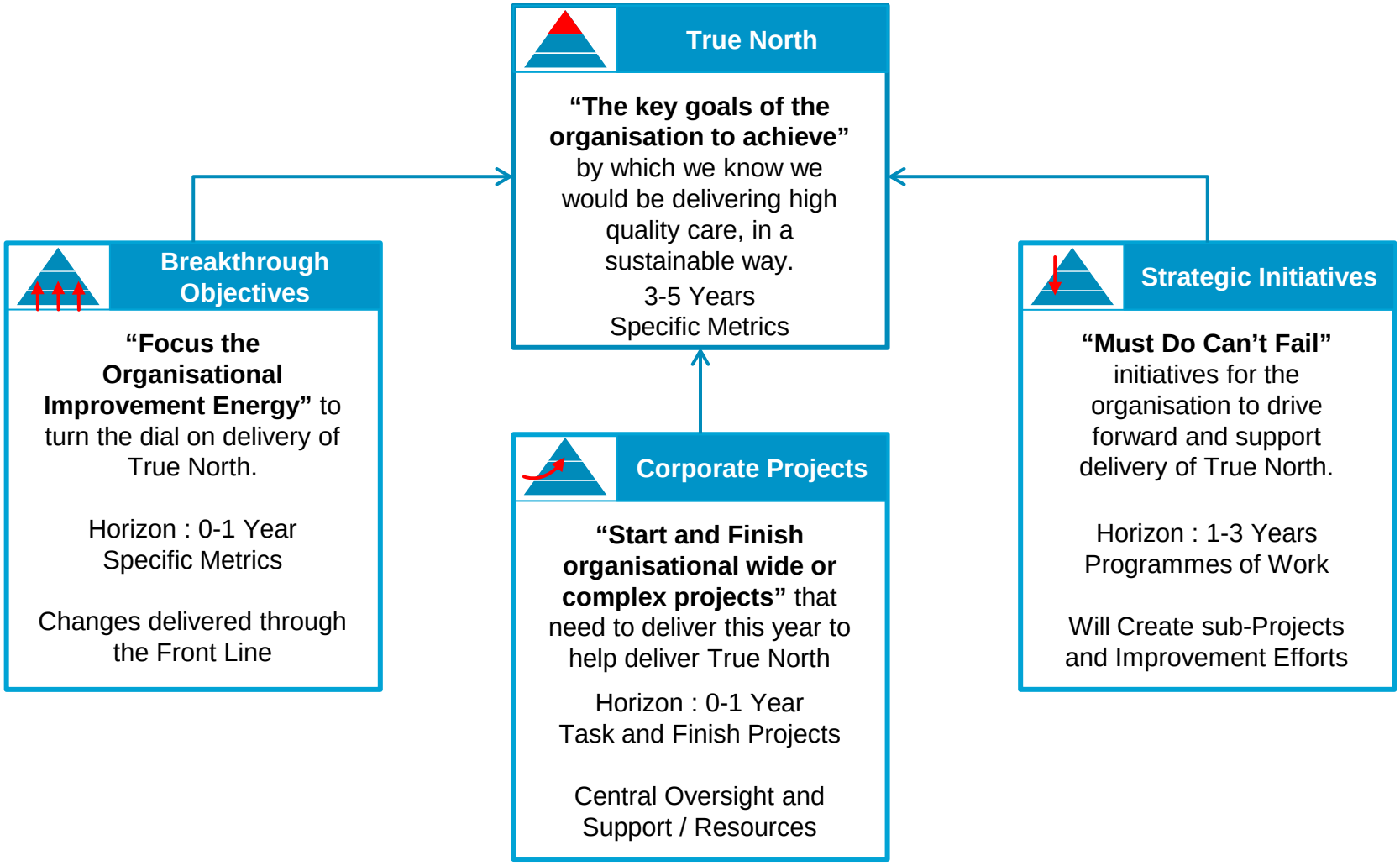
July 2019

Brighton and Sussex University Hospitals NHS Trust

Contents

Structure of the report

Patient First Strategy Deployment Framework



Patient First True North

Key Goals for the Organisation to achieve sustainably

Patient

Patient Satisfaction

Target: Family & Friends Recommend Rate >96%

Sustainability

Financial Management

Target: Break Even

People

Staff Engagement

Target: Engagement Score Top 20% in the Country

Quality

Preventable Mortality

Target: HSMR Top 20% in the Country

Avoidable Harm

Target: Patient Safety Thermometer 99% Harm Free Care

Systems & Partnerships

Non Elective Care

Target: A&E 95% <4hrs

Elective Care

Target: RTT 92% <18wks

Quality Performance

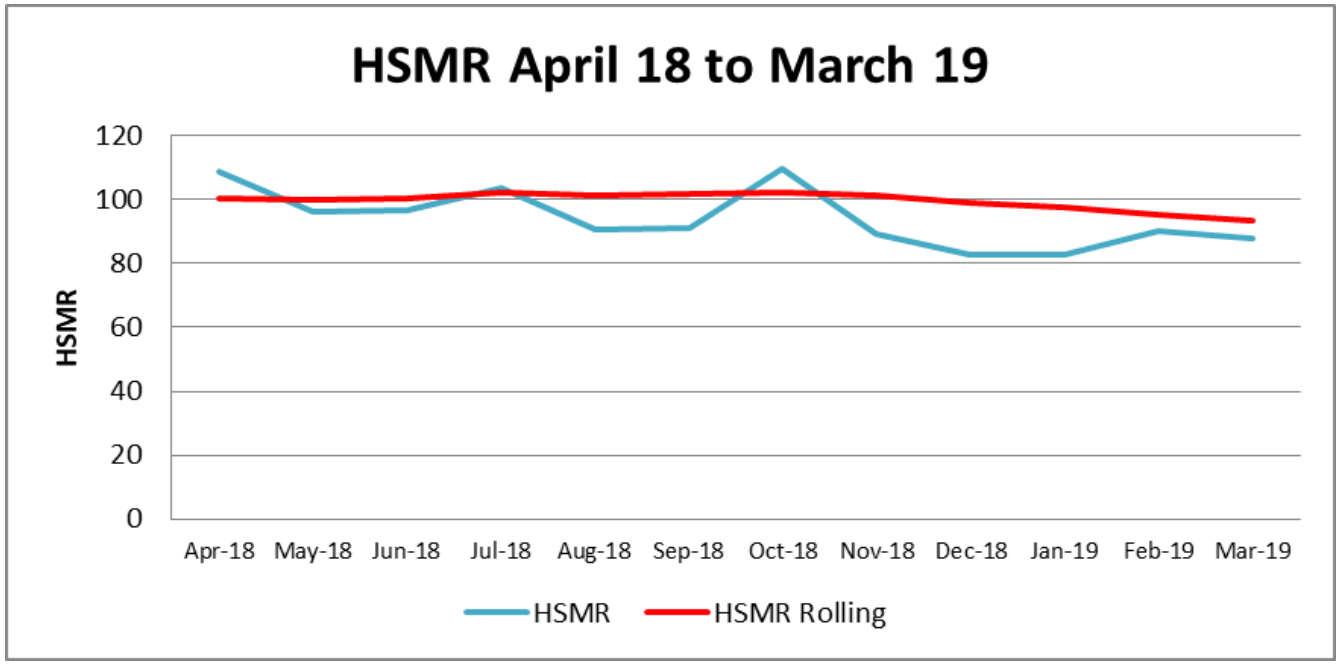
Quality

Preventable Mortality

Target: HSMR Top 20% in the Country

Avoidable Harm

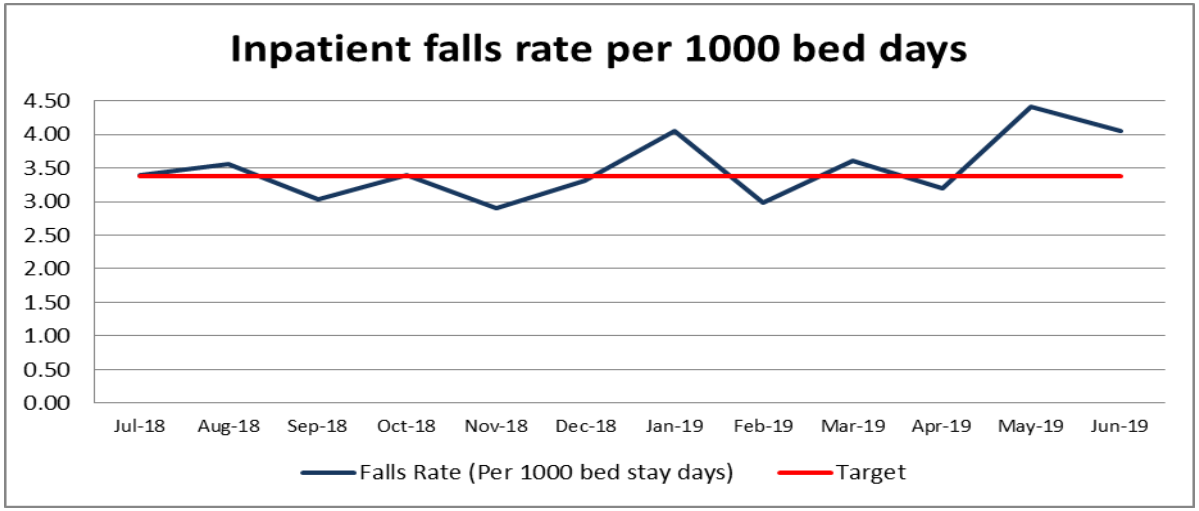
Target: Patient Safety Thermometer 95% Harm Free Care



HSMR data is now available up until March 19. The rolling 12 month mortality rate continues on a downward trend, with the in-month HSMR at March being 87.64.

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

Quality Performance



Quality

Inpatient Falls

Target: 3.38 falls per 1000 bed stay days

Pressure Ulcers

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

The rate of inpatient falls for the past 12 months is 3.32 falls per 1000 bed stay days; in May the falls rate was 4.42 per 1000 bed stay days, and in June was 4.05 per 1000 bed stay days. The National Falls rate is 6.63 falls per 1000 bed days.

The Patient Safety Team has sent every inpatient area a detailed report of the falls on their ward for the past 12 months; this includes information to reinforce learning from past investigations.

The Head of Nursing in Quality Improvement is currently reviewing the data. A task and finish group is being setup and review and implement a programme of actions and SOP.

Quality Performance

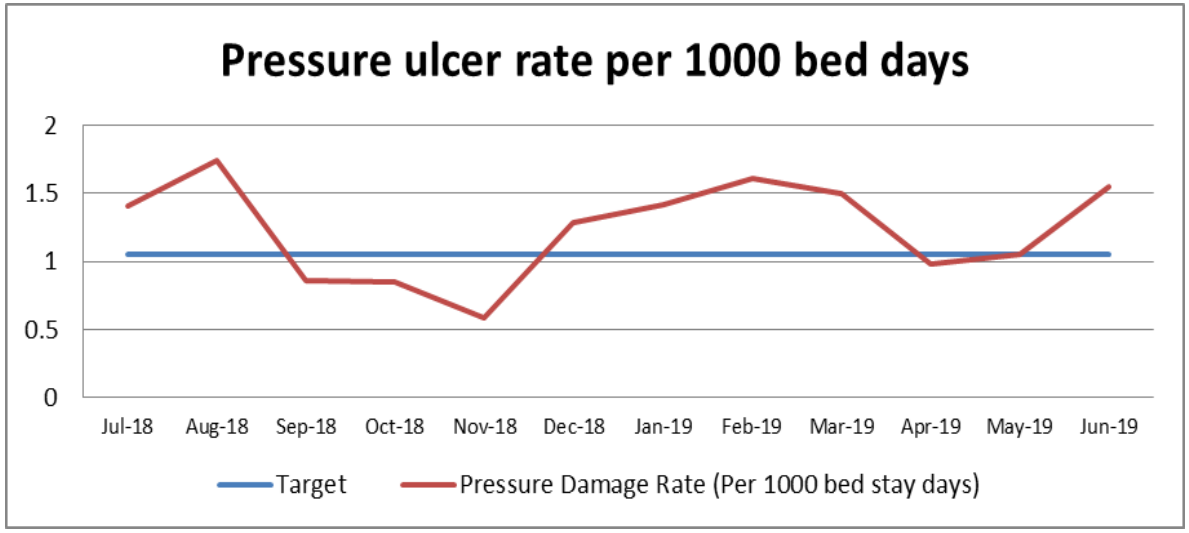
Quality

Inpatient Falls

Target: 3.38 falls per 1000 bed stay days

Pressure Ulcers

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



The rate of pressure ulcers per 1000 bed stays days for the three months to June 2019 was 1.19; this compares to a rate of 1.20 for the equivalent period 2018/2019.

In March NHS Improvement published guidance for local reporting on implementing the pressure ulcer framework and reporting to the National Reporting and Learning System (NRLS): The advice instructs organisations to report pressure ulcers to the NRLS whether they developed during care provided by the Trust or were present on admission. They should always be reported with the accurate degree of harm, whichever group they belong to. The guidance acknowledges that this will cause a shift in the Trusts incident grading profile

The Head of Nursing for Quality Improvement is currently undertaking a data cleanse and a review of the current process of reporting is underway with new SOP's being written ready for implementation. Work has commenced with SCFT to explore working together and the reporting of pressure ulcers.

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

Quality Performance

Quality

Friends and Family Test

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

	Percentage recommending BSUH June 19	Response Rate June 19
Inpatient care	93.4%	23.4%
A&E	88.1%	18.9%
Maternity	95.5%	N/A
Outpatient	94.3%	N/A

In June the Inpatient FFT was 93.4%, whilst a reduction from the rate reported in April this is an improvement since the prior year.

The Emergency Department FFT is 88.1% and whilst a reduction from the rate reported in April, the national average has never exceeded 86%, the national average response rate is 12% and BSUH's rate is 18.9%

Maternity and Outpatients have been reported separately for the first time to allow closer monitoring over the rest of the year.

Systems and Partnerships – Summary

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

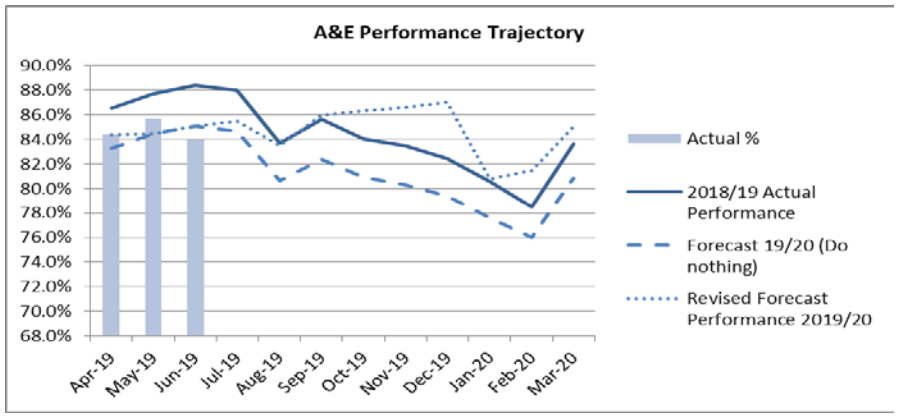
- A&E Performance Improved to 84.0% (acute footprint) in June-19 compared to the national performance of 86.4%.

- 62 day cancer performance for GP referral to treatment reduced by 0.1% to 63.2% in May-19 compared to April-19. National average performance (May-19) was 77.45%.

- RTT Performance deteriorated by 1.4% in June-19 to 68.6%, with the waiting list increasing in size by 178 patients overall compared to May-19. There were ten 52 week breaches in the month a reduction of 8 on the prior month. National average performance (May-19) was 86.9%.

- Diagnostics 6 week performance improved by 2.04% to 27.6% in June-19 compared to May-19. Small improvements were seen across most of the diagnostic modalities. National average performance (May-19) was 4.5%.

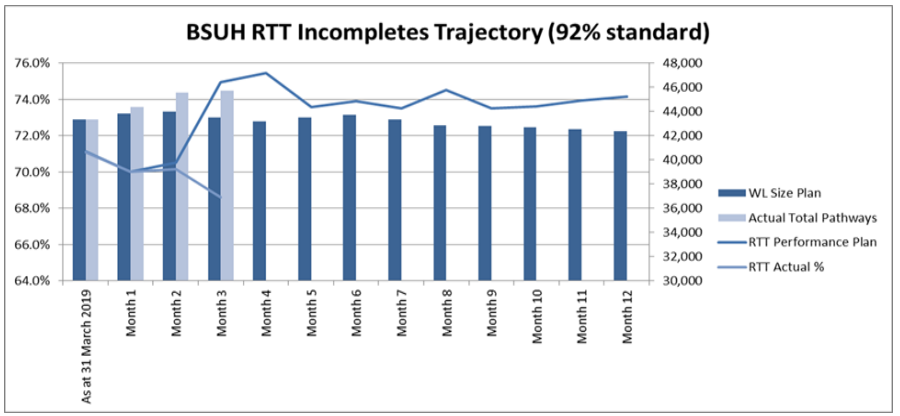
Systems and Partnerships – True North Metrics



- Trust A&E Performance for June-19 was 84.0% including the NHSE allocated type 3.
- This is the 1.7% lower than in May-19, and 4.4% lower than June-18. The performance is behind the agreed trajectory by 1.1%
- The trust had 2991 4 hour A&E breaches which was 837 (29%) more than the same month last year.
- The trust was below the national average performance of 86.4% in June-19.

Improvement Focus:

- Improvements at the front door relating to increased same day emergency care, ambulatory care and configuration for UCC. This includes work to improve patient streaming.
- Enhanced Targeted review of long stay (stranded) patients, expediting discharge.
- The Trust is also reviewing current bed configuration to optimise its use in accordance with patient demand.
- The Trust is launching a live emergency flow dashboard, revised site meeting format and new escalation triggers to deliver further improvement.



- Trust performance for RTT in June-19 was 68.6% for all specialties, a deterioration of 1.4% compared to May-19.
- There were 10 52 week waiters at end June-19. This was a reduction from 18 in the previous month.
- The RTT incomplete Waiting List rose by 178 waiters in June-19 compared the previous month.

Improvement Focus:

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

Systems and Partnerships – Cancer

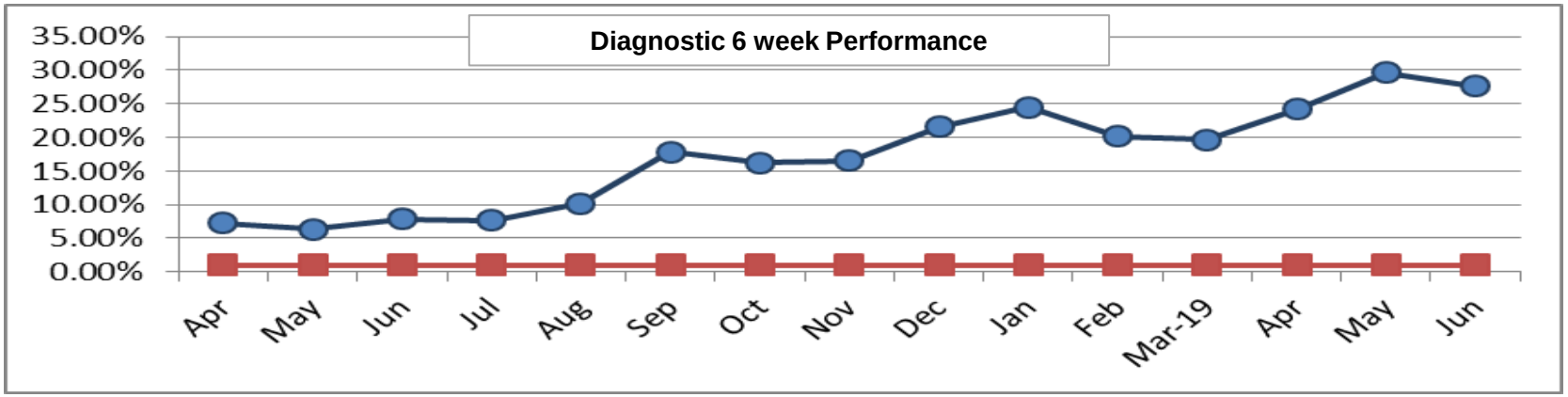
Monthly and YTD	Target/Plan	2019/20 YTD	May-19
2 week GP ref to 1st OP	93%/90%	79.9%	77.8%
2 week GP ref to 1st OP - breast symptoms	93.0%	79.4%	82.8%
31 day 2nd or subs trtmnt - surgery	94%/97%	94.0%	91.2%
31 day 2nd or subs trtmnt - drug	98%/98.8%	100.0%	100.0%
31 day 2nd or subs trtmnt - radiotherapy	94%/94.3%	100.0%	100.0%
31 day diag to trtmnt all cancers	96%/96.3%	92.3%	91.9%
62 day ref to trtmnt: screening	90%/83.3%	45.2%	51.9%
62 day ref to trtmnt : upgrade	85%/75.9%	79.2%	61.5%
62 days urgent GP ref to trtmnt : all cancers	85%/75%	63.2%	63.2%

- The Trust was compliant in 2 of 9 cancer metrics in May-19.
- The Trust was also non-compliant against the 62 day urgent referral to treatment target of 85%, with 63.2% of patients commencing treatment within 62 days this is a 0.1% reduction compared to April-19 and 16.8% lower than performance in May-18.
- 44 patients were treated passed the 62 day breach target out of a total of 119.5 treatments undertaken.
- The most challenged tumour sites are colorectal, upper GI and Gynaecology.

19/20 Improvement Actions

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

Systems and Partnerships – Diagnostics



- Trust diagnostics performance improved by 2.04% for June-19 compared to the previous month.
- Endoscopy and imaging capacity challenges are the biggest contributor to the difficult performance however all modalities have contributed to the improved position.
- Both imaging and Endoscopy are currently accessing additional capacity through the engagement of external companies.

Improvement Focus:

- The Trust have constructed and agreed recovery plans by modality for imaging and endoscopic modalities which aim to reduce performance to a compliant position by Sep-19.
- Around 500 Non obstetric ultrasound scans are being outsourced to an external provider.
- Extra sessions have been identified through the Superintendents converting admin days into clinical time.
- Additional evening and weekend sessions are running in US/CT/MRI.
- Reviewing cardiac CT protocol to become radiographer led (implementation Nov 19)
- Reviewing Cardiac MRI guidelines

Financial Performance - Summary

Sustainability

Financial Management

Target: Break Even

- For June, the Trust is reporting a deficit of £5.42m excluding PSF, FRF and MRET income, which is in line with plan.

- Performance for the year-to-date is in line with plan and 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, including PSF, FRF and MRET (£1.9m) of £25.7m.

- At the end of Q1, the Trust has delivered a deficit of £17.8m and has earned £4.27m of PSF and FRF income. In additional the Trust has also received confirmation of £0.61m of 2018/19 post accounts reallocation PSF.

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

Financial Performance – Key Metrics

Finance and Use of Resources Risk Rating — A

YTD

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

At the end of June the aggregate finance rating is a 3, in line with the plan. The distance from plan and agency spend ratings are below plan; however overall the combined rating is in line with plan.

Control Total (Surplus) / Deficit £k — G

	Plan	Actual / Forecast	Variance
Year-to-date exc PSF/FRF/MRET	16,423	15,810	613
Year-end Forecast exc PSF/FRF/MRET	52,995	52,385	610
Year-to-date	13,575	12,962	613
Year-end Forecast	25,746	25,136	610

The Trust deficit in Month 3, excluding PSF/FRF/MRET is in line with the plan. As a result of delivering the underlying control total the Trust has earned £1.42m of PSF/FRF/MRET in-month (£4.27m year-to-date for 2019/20). In addition, the Trust has received £0.61m of 2018/19 post accounts reallocation.

Efficiency and Transformation Programme £k — G

	Plan	Actual / Forecast	Variance
Year-to-date	2,896	3,182	286
Year-end Forecast	27,070	27,070	0

In Month 3, £1.27m of savings have been delivered against a plan of £1.07m. Year-to-date the Trust has delivered £3.18m against a plan of £2.90m and the Trust is forecasting full delivery of the £27.07m requirement.

Capital £k — A

	Plan	Actual	Variance
Year-to-date	24,148	18,909	5,239
Year-end Forecast	166,310	166,310	0

Strategic Capital: expenditure of £17.66m; which is £4.95m behind plan due to slippage on the 3Ts project.
Operational Capital: expenditure of £1.25m; which is £0.29m below plan.

Schemes are progressing through the capital investment group.

Financial Performance – Key Metrics

Income £k — A

	Plan	Actual / Forecast	Variance
Year-to-date	(154,515)	(151,738)	(2,777)
Year-end Forecast	(632,224)	(632,834)	610

Income was below plan by £0.38m in-month giving a year-to-date adverse variance of £2.78m. Of this total, £2.02m relates to Patient Care Activities income and £0.76m to Other Operating Income.

Operating Costs £k — G

	Plan	Actual / Forecast	Variance
Year-to-date	163,021	159,720	3,301
Year-end Forecast	647,150	647,150	0

In June, operating costs were £0.95m 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 £0.04m, the key driver being medical expenditure which is £1.51m above budget.

Agency Ceiling £k — A

	Ceiling	Actual / Forecast	Variance
Year-to-date	3,037	3,236	(199)
Year-end Forecast	11,783	11,783	0

Agency expenditure in June was £1.06m, exceeding the agency ceiling target by £0.05m in-month (£0.20m year-to-date)

Cash £k — G

	Plan	Actual	Variance
Year-to-date	3,004	10,765	7,761
Year-end Forecast	3,004	4,271	1,267

At the end of June the cash balance was £10.8m against a plan of £3.0m, which is due to lower than planned payments to suppliers.

Financial Performance - Action & Recommendations

There are no actions required of the Board.

The Board is asked to note the following:

- The Trust breakthrough objective of reducing medical expenditure has made significant progress and outputs will be tracked via the Medical Workforce Operational Productivity Steering Group.;
- Activity plans have been reviewed and issued to Divisions and new Executive-led oversight and scrutiny arrangements are in place which will support delivery;
- The AIC contract with Sussex and East Surrey CCG Alliance has been signed and contract documentation has been received from NHS England and the Trust is aiming to complete signatures by the end of July 2019.
- The Trust is forecasting delivery of the control total of £25.7m deficit including securing PSF and FRF in full.

Our People - Improving Staff Engagement

People

Staff Engagement
Target: Top 20% Engagement Score

- **June Pulse Survey**
  The engagement score is 7.0 out of 10 (10 being the highest) which is the same as last month.
  6 out of the 9 engagement questions are above the 2018 National Average, these are “I would recommend my organisation as a place to work”, which is the new breakthrough objective, “If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation”, “I look forward to going to work”, “I am enthusiastic about my job” “I am able to make suggestions to improve the work of my team/department”, and “I am able to make improvements happen in my area of work.”

- **Breakthrough Objective**
  Our new breakthrough objective of “I would recommend the Trust as a place to work” was agreed in June. This question was 3.8% under the average Acute Trust score and 22% below the Best Acute Trust score. This question also has the potential to positively influence the 9 engagement questions and our overall engagement theme score.
  9 staff feedback forums, paper and on-line surveys and divisional focus groups in Facilities & Estates and Central Clinical Services were held across June and July to capture additional feedback from staff on the breakthrough objective question.
  The feedback was collated and an A3 workshop was held with senior representatives invited from across the divisional and corporate areas. The feedback was discussed and potential actions identified for improvement. Key actions for improvement have been identified and further work is underway to agree improvement plans. The plans will be finalised by the end of July.

- **Health & Wellbeing**
  Planning meetings with wards for 5 pilot areas for ‘wellbeing programme’ completed for Elderly Care, Cancer Centre, 8a West, HWP, Children’s hospital. Programme to run July/August.
  Wellbeing Toolkits prepared. To be distributed in July to areas identified as lowest scoring for Health & Wellbeing.
  Series of video podcasts advertising our physical wellbeing activities – swimming and tap dancing released June.
  Monthly ‘what’s on Wellbeing’ posters for June displayed in staff restaurants / lifts.
  Monthly wellbeing newsletter via email.
  New Stress Management policy to be submitted to the Trust Executive Committee in July 2019.
  Health & Wellbeing stand at welcome days.

Our People - Improving Staff Engagement (continued)

People

Staff Engagement
Target: Top 20% Engagement Score

- **Equality & Diversity**

1500+ staff contacted to update their ESR data – part of Corporate objective to increase equality monitoring amongst our workforce

There will be BSUH representation at all 3 main Prides within the City: Disability Pride – 14th July 2019; Trans Pride – 20th July 2019; Brighton Pride – 3rd August 2019

Supporting Staff/Patients Trans Guidelines re formatted

Work continues in collating evidence for Stonewall Workplace Equality Index (WEI) for submission in September 2019

- **Recruitment & Retention**

The trust's latest recruitment advertising campaign - #BelongHere – will launch on 29th July, in time for Brighton Pride. Featuring real members of BSUH staff, the campaign highlights the diverse, inclusive and welcoming culture within the trust. It will use posters and video screens alongside social media and text message marketing to encourage applications to roles throughout BSUH. It is hoped the campaign will create a large amount of interest in all of our job adverts.

The campaign will be fully evaluated in August/September and lessons learned will be incorporated into future campaign planning.

The trust continues to drive forward in filling vacancies due to the national shortages in Nursing. Four Nursing events were held throughout the month of June. Through these, 17 whole time equivalent (WTE) Registered Nurse Band 5 were appointed of which 8 WTE were Newly Qualified Nurses and 17 WTE were Healthcare Assistants.

Our People - Improving Staff Engagement and Communications

People

Staff Engagement
Target: Top 20% Engagement Score

- **Patient First STAR awards**. The winners of this year's STAR awards were revealed this month at a special ceremony at the Brighton Metropol. The evening was hosted by chief executive Marianne Griffiths and chairman Alan McCarthy and provided an opportunity to recognise the wonderful contributions of our colleagues across the trust. Congratulations to all those 750 staff and volunteers nominated, all those shortlisted and the winners. The awards were promoted with increased content across all of the trust's internal and external channels leading to an increase in their reach compared to last year. The 2019 campaign ran from March 1 to July 4. The 2018 campaign was slightly shorter – ending in the middle of June.

  Facebook
  - Impressions for entire campaign (March – July 2019): 134035 (323% Increase compared to 2018 campaign)
  - Engagements for entire campaign (March – July 2019): 11340 (387% increase compared to 2018 campaign)*

  Twitter
  - Impressions for entire campaign (March – July 2019): 112166 (120% increase compared to 2018 campaign)
  - Engagements for entire campaign (March – July 2019): 5846 (268% increase compared to 2018 campaign)

- Recognition continues with the STAR of the Month award, open for nomimnations from staff, volunteers and the community. To nominate complete the form on info-net or email bsuh.communications@nsh.net

- The team issued a number of proactive press releases including Proudly Part of Pride, Stars Shine at Awards Event and Praise for BSUH Culture Change.

- Radio 4 carried out interviews with staff in the Emergency Department at RSCH as to illustrate the innovative work that is going on at the Trust to improve the recruitment and retention of junior doctors.

- The team has also supported preparations for the recruitment campaign timed around PRIDE

*Impressions = the amount of times a post has been seen
Engagements = the amount of times a post has been clicked on, commented on, interacted with

Our People - Capacity and Capability

In M3, overall workforce spend was £33.40m against a plan of £33.56m (an underspend of £160k). Year to Date workforce spend is marginally overspent by £40k against a plan of £100.7m.

Medical was the key driver of this YTD position with an overspend of £1.51m as well as Ancillary staff contributing a further £230k. The position was partially mitigated by significant underspends within the Nursing workforce (£333k) 'Other' Healthcare (£450k) which are largely AHP and STT staff and Management (£360k).

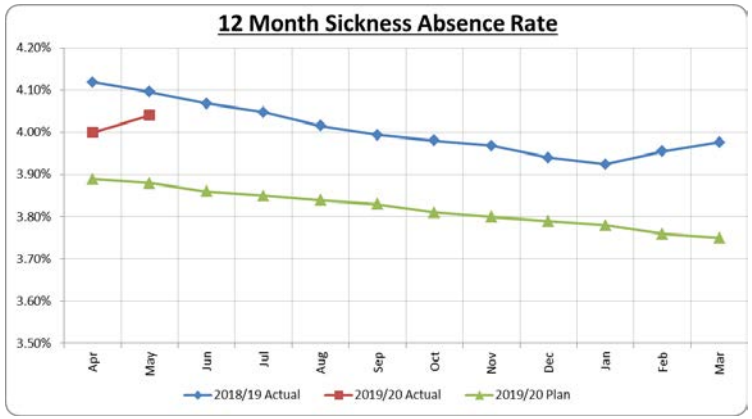
		Last Month	This Month	Variance
Worked	wte	8,090	8,110	↑
% Worked to Budget (WTE)	%	94.87	94.92	↑
Temporary Workforce (WTE)	%	6.82%	7.69%	↑
Agency	%	1.11	1.20	↑
Bank	%	5.71	6.50	↑

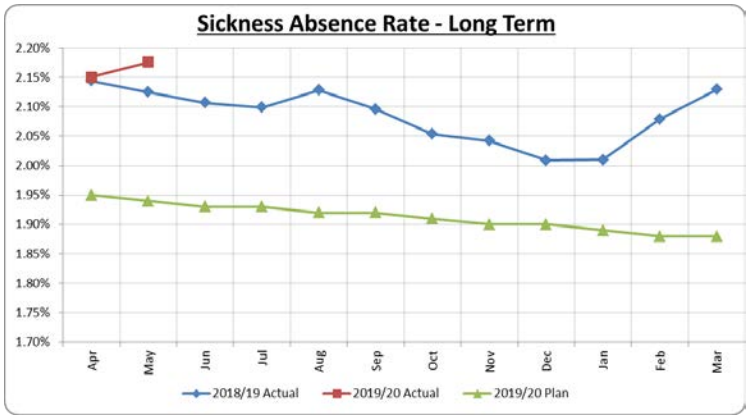
In June, agency costs of £1.06m represent 3.2% of the total pay bill and exceeded the M3 agency ceiling by £50k.

Year To Date, the Trust has exceeded its agency ceiling by £200k.

Nursing agency spend at £363k was £24k over its M3 ceiling (£298k YTD). Agency reduction within this staff group is an agreed workstream within the Efficiency Programme, with reductions of £1.7m expected to deliver from M4 onwards. Similarly, the consultant workforce are targeting c£500k of premium cost removal from targeted recruitment, role redesign and job planning benefits which result in reductions in premium cost activity.

Our People – Key Metrics





In May 2019 the 12 month sickness absence rate was 4.04%. It should be noted that despite an overall annual reduction there is a risk to the sickness absence target of 3.75% being achieved. This is because there has been a slight increase since January 2019 by 0.1-0.2% each month and latterly 0.4% (the sickness absence rate was 3.92% in January 2019).

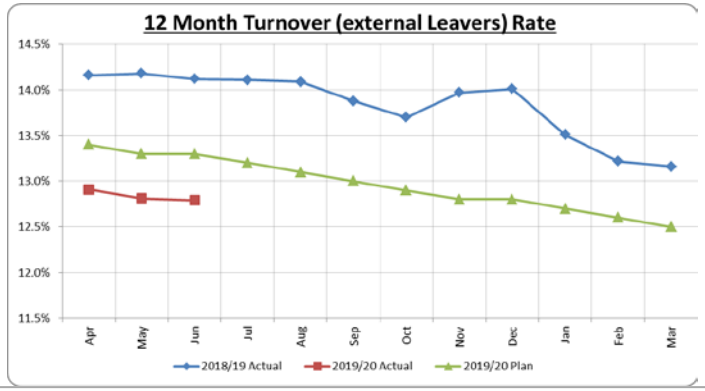
The staff groups with the highest absence rates continue to be nursing which is currently 4.12% for registered nurses although unregistered nurses has decreased slightly 0.3% in month. Ancillary remains high at 7.55%

Improvement Focus:
Hotspots areas have been identified for each division and work is being undertaken with these areas. The challenging areas continue to be some specific nursing wards and Estates and Soft FM. Focused work has been undertaken in Facilities and Estates for the past 18 months and so this needs to be refreshed.

The long term absence rate is 2.18%. All long term absences are reviewed monthly by senior HR representatives and appropriate contact and management is in place.

Improvement Focus:
A new Health and Well-being Policy will be launched this month with lunch time training and specific departmental meetings being targeted.

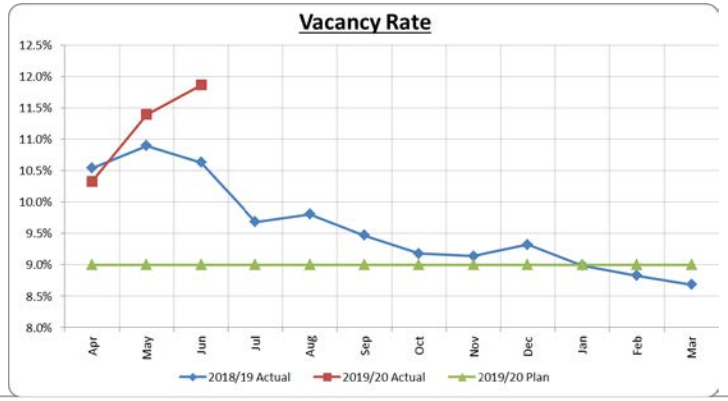
Our People – Key Metrics



- **Turnover:** In June the Trust's overall turnover rate is 12.8% against an overall Trust target of 12.5% by March 2020. Since June 2018 the Trust has seen a significant improvement of 1.3% in the turnover rate from 14.1% in June 2018 to 12.8% in June 2019. Children's & Women's at 10.3% and Specialist at 11.7% are the clinical divisions with the lowest turnover rates, with Medicine, Specialist and Central Clinical Services divisions all showing improvement in the last 12 months.

- **Improvement Focus:**

Reduce the number of leavers that have been employed by the Trust for less than 12 months
Increase face to face exit interviews for all leavers with less than 12 months service
Continue targeted support to line managers with high turnover rates
In depth focus on HCA and Admin staff

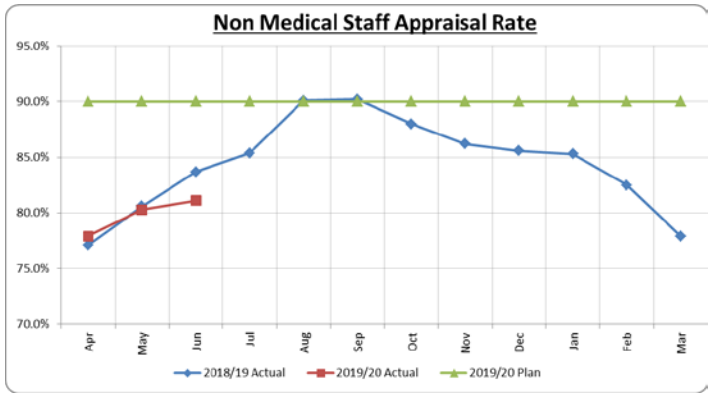


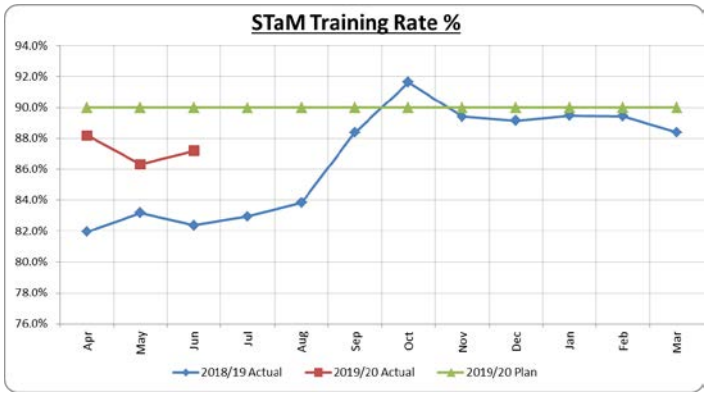
- **Vacancies:** In June the Trust's overall vacancy rate was 11.9% against an overall Trust vacancy target of 9% with Children's and Women's at 1.9% having the lowest vacancy rate, and Surgery at 14.6% the highest. The staff groups with the highest vacancy rates are medical, nursing, scientific, therapeutic and technical, and the ancillary support vacancies continue to be a challenging area.

- **Improvement Focus:**

Trust wide recruitment campaign linked to Pride
Continuation of nurse recruitment days

Our People – Key Metrics





- The Trust appraisal rate improved in June, to 81.1%, up 0.8% on May. This is the 2nd consecutive month seeing an improved position.

Improvement Focus, Appraisal:

- HRBPs continue to support the Divisions, providing data, raising hotspots at Divisional meetings and supporting the reporting process.
- Reports continue to be provided twice monthly, with managers having been advised of cut of dates for reporting completed appraisal.
- Appraisal rates continue to be discussed at all Divisional Driver meetings with particular focus on cost centres with low compliance.

- The Statutory and Mandatory (STAM) compliance rate for June is 88.6%,up 0.2% on May.
- 10 of the 3 subjects saw an increase. Of the remaining subjects just one saw a decrease in compliance – Information Governance (down 1% to 87%). The remainder experienced no change.
- Subjects that no longer achieve or have not achieved 90% compliance include Fire Safety (88%), Health and Safety (87%), Infection Prevention – Clinical (85%), Moving and Handling – Clinical (85%), Safeguarding, Safeguarding Children Level 3 (79%). Information Governance has not achieved the required target of 95% and has a 8% shortfall.
- Divisional STAM compliance shows 7 Divisions/Directorates with a compliance rate of 90% or

Improvement Focus, STAM:

- Reports continue to be provided twice monthly

Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	12	**Meeting:**	Trust Board	**Meeting Date:**	24 July 19
Report Title:	Finance and Performance Committee Report to Board				
Sponsoring Executive Director:	Patrick Boyle, Non-Executive Director				
Author(s):	Patrick Boyle, Non-Executive Director				
Report previously considered by and date:	N/A direct report to Board				
Purpose of the report:					
Information	✓		Assurance	✓	
Review and Discussion	✓		Approval / Agreement	☐	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	☐		Staff confidentiality	☐	
Patient confidentiality	☐		Other exceptional circumstances	☐	
Link to Trust Strategic Themes:					
Patient Care	✓		Sustainability	✓	
Our People	✓		Quality	✓	
Systems and Partnerships	✓				
Any implications for:					
Quality					
Financial					
Workforce					
Link to CQC Domains:					
Safe	☐		Effective	☐	
Caring	☐		Responsive	☐	
Well-led	☐		Use of Resources	☐	
Communication and Consultation:					

Executive Summary:

The Finance and Performance Committee met on 26 June 2019 and was quorate as it was attended by three Non-Executive Directors and the Chief Financial Officer, Chief Delivery and Strategy Officer, Chief Medical Officer, Chief Nurse and Chief Workforce and Organisational Development Officer . Attending the meeting were also the Finance Director, Chief Operating Officer, Director of Human Resources and Head of Efficiency.

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

Key Recommendation(s):

The Board is asked to **NOTE:**

The Trust reported a £5.67m deficit, excluding PSF, FRF and MRET, which was in line with plan for M2.

The Efficiency Programme is progressing in line with plan.

The Committee reviewed and approved a business case to replace the pharmacy robot and received assurance that minimal disruption to business as usual has been planned for.

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board

Date: 24 July 2019

From: Finance and Performance Committee

Agenda Item: 12

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Finance and Performance Committee	**26 June 2019**	**Martin Sinclair (Acting Chair)**	✓	☐

Declarations of Interest Made

There were no interests declared in relation to the business of the Committee.

Assurance received at the Committee meeting

- The Committee **RECEIVED** the financial performance reports for Month 2. The Committee was assured in respect of the Trust's performance against the plan for Month 2 and will continue to monitor and work to increase activity levels.
- The Committee **RECEIVED** an from the Chief Nurse update on the adjustments that will be made to nurse levels across the hospital and the use of agency staff, following a recent review of nursing workforce and the Committee was assured that nurse to patient staffing ratios were protected.
- The Committee **RECEIVED** the Efficiency Programme update, noting that in Month 2 the programme was on track to meet the end of year total savings of £27m and acknowledged the on-going support given to Divisions that have complex financial schemes, in preparation of the increased expectations in Month 4.
- 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 not compliant against the constitutional target for A&E; the Trust was compliant against 4 of the 9 Cancer metrics. Referral to Treatment compliance improved slightly in May and the Committee noted the increase in referrals. The Committee recognised that, regionally, there are challenges with Ear, Nose and Throat availability and are working with other Trusts in the region to formulate an action plan.
- The Committee **RECEIVED** and **APPROVED** a business case to replace the robot dispensing machine in pharmacy, which will improve efficiency in pharmacy and contribute to improved patient flow.
- The Committee **RECEIVED** an update on the development of a STP wide Carbon Emission Fund, proposing improvements across the BSUH estate which will enable the Trust to reduce it's carbon footprint, in line with NHS standards.
- The Committee **RECEIVED** assurance of the work that is being undertaken by the Executives and clinical leads to reduce the medical pay bill, in line with the Trust's control total.

Actions taken by the Committee within its Terms of Reference

Outside of the approval of the pharmacy robot business case there were no other actions that required a Committee decision at this meeting.

Items to come back to Committee (Items the Committee keeping an eye on)	
▪ The Committee has requested clearer insight in to how the trajectories are evidenced in the operational performance report.	
Items referred to the Board or another Committee for decision or action	
Item	**Referred to**
There were no other matters referred.	

Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	13	**Meeting:**	Board	**Meeting Date:**	24 July 2019
Report Title:	Audit Committee report to Board				
Sponsoring Executive Director:					
Author(s):	Lizzie Peers – Audit Committee Chair				
Report previously considered by and date:					
Purpose of the report:					
Information		☐	Assurance		✓
Review and Discussion		☐	Approval / Agreement		☐
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		☐	Staff confidentiality		☐
Patient confidentiality		☐	Other exceptional circumstances		☐
Link to Trust Strategic Themes:					
Patient Care		✓	Sustainability		✓
Our People		✓	Quality		✓
Systems and Partnerships		✓			
Any implications for:					
Quality					
Financial					
Workforce					
Link to CQC Domains:					
Safe		☐	Effective		☐
Caring		☐	Responsive		☐
Well-led		✓	Use of Resources		☐
Communication and Consultation:					

Executive Summary:

The Audit Committee met on the 10 July 2019 and was quorate as it was attended by three Non-Executive Directors. Attending the meeting were also the Trust's External and Internal Auditors, the Local Counter Fraud Specialist, the Director of Finance and the Company Secretary.

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

The Committee reviewed its effectiveness over the previous year and that of its key assurance providers, external audit, internal audit and the local counter fraud specialist. This was encapsulated in an annual report, which is included as an appendix to this report, and culminated in agreement that there were no issues identified that required a change to the Committee's terms of reference.

Key Recommendation(s):

The Board is asked to **NOTE:**

The assurances received through the reports received and that the Committee through its review of the BAF did not refer any matters to the executive for review.

The Committee referred one matter to the Quality Assurance Committee relating to the oversight of the delivery of the action plan in respect of the external review of the Trust's JAG accreditation to seek assurance that the action will be completed within the 6 month deadline.

The Committee reviewed its activity over the last year (2018/19) and did not identify any issues that would require a change to its terms of reference.

To: Trust Board Date: 24 July 2019

From: Audit Committee Chair Agenda Item: 13

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
Audit Committee	**10 July 2019**	**Lizzie Peers**	yes	no
			✓	☐

Declarations of Interest Made

No interests were declared.

Assurance received at the Committee meeting

- The Committee received the BAF and information on the supporting high scoring risks and agreed that the BAF encapsulated the key strategic risks, that the assigned oversight committees for each risk were appropriate and that the expected assurances were reasonable.
- The Committee was assured that the indicative Internal Audit plan from the new incoming auditors was broadly aligned to the Trust's key risks and the process being applied to the formulation of the detailed plan would refine this alignment further and improve the overall engagement of the Trust with the Internal Audit process-an area identified for improvement from the survey of Audit Committee members
- The Committee received positive assurance from the outgoing Internal Auditor over the Trust's processes for the Management of Sickness Absence and Recruitment and Retention. The Committee received management assurance that a robust action plan is in place to deliver all identified improvement actions.
- The Committee received assurance from the Trust's Local Counter Fraud Specialist that fraud risks were being managed and that the self review tool did had not identified any key gaps in the work of the LCFS.
- The Committee received some high level management assurance over the actions being taken in respect of information governance and general data protection regulation improvement actions. The Committee sought that ahead of the next meeting that the priority of any outstanding action be graded and the key risks highlighted. This would be shared with the members of the Committee ahead of the next meeting. The Committee will then consider if further assurance is needed at its next meeting.
- The Committee received management assurance over the oversight and tracking of any improvement recommendations resulting from external reviews being undertaken across the Trust.
- The Committee reviewed its effectiveness over the previous year and that of its key assurance providers, external audit, internal audit and the local counter fraud specialist. This was encapsulated in an annual report, which is included as an appendix to this report, and culminated in agreement that there were no issues identified that required a change to the Committee's terms of reference. There was some useful improvement feedback from the survey of Audit Committee members which would be taken forward by Trust Directors and the Chair.

Brighton and Sussex University Hospitals NHS Trust

Actions taken by the Committee within its Terms of Reference
• The Committee agreed that the newly appointed Internal Auditor over the first quarter of the year should progress with a number of its mandated reviews ahead of bringing the formal plan to the next meeting. • The Chair and relevant Trust Directors to meet with Internal Audit, External audit and the LCFS lead to discuss the areas from improvement identified from the Committee effectiveness survey.
Items to come back to Committee (Items Committee keeping an eye on)
• The Internal Audit plan from the newly appointed internal auditors would be presented to the next meeting. • Further information on the Trust's controls over the payment for agency invoices due to repeat overcharging by some agencies. • A developed process for tracking External Audit and LCSF recommendations similar to that applied to those made by Internal Audit. • Revised, prioritised action plan of progress against information governance and general data protection regulation improvement actions

Items referred to the Board or another Committee for decision or action	
Item	**Referred to**
The oversight of the delivery of the action plan in respect of the external review of the Trust's JAG accreditation to seek assurance that the action will be completed within the 6 month deadline.	Quality Assurance Committee

Brighton and Sussex University Hospitals NHS Trust

To: Audit Committee Date: July 2019

From: Chair of the Audit Committee Agenda Item: 13

FOR ENDORSEMENT

DRAFT - ANNUAL REPORT FROM THE AUDIT COMMITTEE TO THE BOARD 2018/19

1.00 INTRODUCTION

1.01 The purpose of this report is to formally report to the Board on the work of the Audit Committee during the period 1 April 2018 to 31 March 2019 and to set out how the Committee has met its terms of reference and key priorities.

1.02 The Audit Committee's Terms of Reference require it to report annually to the Board outlining the work it has undertaken during the year and where necessary, highlighting any areas of concern.

2.00 EXECUTIVE SUMMARY

2.01 The Audit Committee has the delegated authority to act on behalf of the Board in accordance with the Constitution, Standing Orders, Standing Financial Instructions and Scheme of Delegation. It follows best practice guidance as set out in the NHS Audit Committee Handbook providing a form of independent check upon the management of the Trust.

2.02 The Committee is responsible for providing assurance to the Board that appropriate systems of internal control and risk management are in place covering all corporate and clinical areas of the Trust. In carrying out this work the Audit Committee obtains assurance from the work of the Internal Audit, External Audit and Counter Fraud Services.

2.03 The Committee independently reviews, monitors and reports to the Board on the attainment of effective control systems and financial reporting processes.

2.04 The Committee reviews the financial year-end Annual Report, Annual Accounts and Annual Governance Statement prior to Board approval and sign off.

2.05 The Committee was pleased to see the adoption of a strong Board Assurance Framework and its embedding over the latter half of the year, allowing this to shape the Committee's workplan in the coming year(s).

3.00 COMMITTEE MEMBERSHIP AND MEETINGS

3.01 The Committee comprises solely of independent Non-Executive Directors in line with the Code of Governance for NHS Trusts. There are three Non-Executive Directors who are allocated to the Committee although all Non-Executive Directors, except the Chair, can attend the meeting. Following the implementation of the management contract with Western Sussex Hospitals NHS Foundation Trust in 2017/18 two Non-Executive Director advisers also regularly attend the Audit Committee, which strengthens the oversight that the Committee is able to provide.

3.02 The Chief Financial Officer, Chief Workforce and Organisational Development Officer, Finance Director, Company Secretary, Local Counter Fraud Specialist, Internal and External Auditors are regular attendees at meetings of the Committee. Other senior Trust officers also attend Committee meetings for specific items at the Committee's request.

3.03 The table below details the membership and attendance of Committee members in respect of the period 1 April 2018 to 31March 2019.

Name	Apr	May	Jul	Oct	Jan	Total
Martin Sinclair (Non-Executive Director and Committee Chair)	✓	✓	✓	✓	✓	5 of 5
Kirstin Baker (Non-Executive Director)	×	✓	✓	✓	×	3 of 5
Joanne Crane (Non-Executive Director)	✓	×	×	×	✓	2 of 5
Jon Furmston (Associate non-voting Non-Executive Director)	✓	✓	×	✓	✓	4 of 5
Lizzie Peers (Associate non-voting Non-Executive Director)	✓	✓	×	✓	✓	4 of 5

3.04 In order to share learning and to ensure linkages are made across Trust Committees the membership of the Audit Committee includes a member of the Quality Assurance Committee (Joanna Crane) and the Audit Committee Chair is a member of the Finance and Investment Committee. Following a review of the Board Committees at the end of 2018/19 the Chair of the renamed Finance and Performance Committee (Patrick Boyle) has become a member of the Audit Committee as has the Chair of the Quality Assurance Committee (Mike Rymer).

4.00 CYCLE OF BUSINESS

4.01 The Audit Committee agenda is based upon an agreed forward work plan which is reviewed and approved at the start of the financial year.

4.02 Audits are agreed jointly by both the Executive and the Non-Executive Committee members at the start of the year and are focused on areas of perceived highest risk alongside those required by the Head of Internal Audit to formulate his opinion.The Audit Committee receives the reports of those audits and tracks the implementation of recommendations at each of its meetings.

4.03 In order to maintain independent channels of communication, the members of the Audit Committee hold a private meeting collectively with External Audit, Internal Audit and Counter Fraud ahead of each Audit Committee. This provides all parties the opportunity to raise any issues without the presence of management.

4.04 The Committee followed its agreed annual work plan throughout the year and received a series of post project reviews and executive presentations around internal audit, external audit and Local Counter Fraud Services.

5.00 INTERNAL AUDIT

5.01 Internal audit provide an independent and objective opinion on the degree to which risk management, control and governance support the achievement of the Trust's objectives.

5.02 The Trust's Internal Auditor for the year was Grant Thornton.

5.03 The Internal Audit plan for 2017/18 was approved by the Audit Committee in April 2018. The plan was based upon discussions held with management and the Audit Committee and was constructed in such a way as to gain a level of assurance on the main financial and management systems reviewed and those of perceived risk.

5.04 The Head of Internal Audit presents a progress report to each of the Committee's meetings. The report sets out progress against the agreed audit plan, and the principal outcomes from audits completed in the period since the previous meeting. The Committee also receives a summary of all reports together with the full report of any audit with a Limited Assurance rating.

5.05 During the year the Audit Committee received 13 finalised Internal Audit reports, with those in draft and in progress being carried forward to 2019/20. Internal Audit Reports receive two Assurance ratings; one relates to the Design of the system being reviewed while the other relates to the Effectiveness of the system being reviewed. Internal Audit can provide Assurance Levels of: 'full', 'significant', 'partial, or 'no' assurance. Of the audits relevant to this period all received assurance levels of either significant or partial and have action plans are in place, and monitored, to ensure recommendations are addressed. None of the audits received 'no' assurance. This is a significant improvement in the control environment from that reported on by internal audit last year.

5.06 The Head of Internal Audit stated in his Head of Internal Audit Opinion that "overall [his] opinion for the period 1 April 2018 to 31 March 2019 based on the scope of reviews undertaken and the sample tests completed during the period, is that significant assurance with some improvements required can be given on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control. The level of non-compliance in certain areas, including medicines management puts some of its objectives at risk".

5.07 Internal Audit provided opinions of "significant assurance" (green rated opinions) across the areas of risk management, the operation of the Trust's quality governance management groups, data quality, financial systems and the data protection and security toolkit. There were no "no assurance" opinions (red rated opinions) from Internal Audit this year.

5.08 The Committee received regular reports on the progress made by management in implementing Internal Audit recommendations and was pleased to see the significant improvement in the adoption and implementation of audit recommendations across the year, but recognised there continues work to do to complete all recommendations in a timely manner. The Committee reflected that work needs to be done by Internal Audit to ensure the importance of internal audit is well understood at all levels of management.

5.09 The Committee asked that a similar tracking system be established for other key external reviews where improvement recommendations are made that fall outside the tracking undertaken through the clinical governance processes.

5.10 At the end of 2018/19 the Audit Committee oversaw the process for the appointment of the Trust Internal Audits; endorsing a joint procurement approach with Western Sussex Hospitals NHS Foundation Trust and recognising the benefits of a consistent supplier and approach.

6.00 LOCAL COUNTER FRAUD SERVICE (LCFS)

6.01 The Counter Fraud service is provided by a directly employed Counter Fraud Specialist and reports quarterly to the Committee. The reports describe proactive work to prevent or deter fraud and also set out the results of reactive work undertaken in response to referrals about suspected fraud.

6.02 A work plan for 2018/19 was agreed with the Finance Director and approved at the Audit Committee in April 2018. The work plan outlined the core Local Counter Fraud Specialist (LCFS) activities to be undertaken during the financial year within the agreed resources. Key activities undertaken during the financial year include areas of strategic governance, inform and involve, prevent and deter and hold to account.

6.03 In addition the update report from LCFS included an organisational risk profile, updated each meeting, which helps to provide a 'tracker' of where the Trust sits in relation to key fraud risks.

6.04 During the year the LCFS participated in a number of proactive projects to prevent or detect fraud. The LCFS also advised on improvements to policies and procedures, to reduce the risk of fraud.

6.05 The Local Counter Fraud Specialist reports annually on behalf of the Trust to the Counter Fraud Authority in relation to compliance against the Standard for Providers. The Trust has again achieved an overall status of GREEN for the year 2018/19 as shown below:

Area of Activity	**SRT Rating**
Strategic governance	Green
Inform and involve	Green
Prevent and deter	Green
Hold to account	Green
Overall rating	Green

6.06 During the year the Audit Committee asked that the Specialist work closely with the appointed Counter Fraud provider RSM at Western Sussex Hospitals NHS Foundation Trust.

7.00 BOARD ASSURANCE FRAMEWORK

7.01 The Committee was pleased to see the adoption of a strong Board Assurance Framework (BAF) and its embedding over the latter half of the year, receiving detailed reports on the strength of control and actions taken to mitigate these identified strategic risks which enabled the Committee to support the Board in its oversight of the Framework. The BAF will form the baseline for the Committee's workplan in the coming year(s).

8.00 YEAR END REPORTING

8.01 The Committee reviewed and approved the Annual Report and Accounts and the Annual Governance Statement allowing the Audit Committee members to be appropriately engaged in the preparation of the Annual Report and Accounts.

8.02 The Committee also received the assurance report to External Audit from the Chief Financial Officer and Audit Committee chair and endorsed its content that there were no matters that had not been disclosed to the Auditors.

8.03 The Committee received a report on the Trust's processes for registering declarations of interest, the receipt of gifts, hospitality and sponsorship along with the compliance with the fit and proper persons regime. The Committee was informed of the work planned for 2019/20 to increase the return rate for declarations of interest.

9.00 EXTERNAL AUDIT

9.01 External Audit report to the Trust on the findings from their audit work, in particular their review of the financial statements and the Trust's economy, efficiency and effectiveness in its use of resources.

9.02 The Trust's external auditors are Ernst and Young LLP (EY).

9.03 EY reported quarterly to the Committee. These reports included approval of the approach to the audit of the financial statements. The table below summarises the key elements of external audit work undertaken during the year:

Area of Work	**Conclusion**
Opinion on the Trust's:	
Financial statements	Unqualified opinion - the financial statements give a true and fair view of the financial position of the Trust as at 31 March 2019 and of its expenditure and income for the year then ended.
Parts of the remuneration and staff report to be audited	There were no matters to report.
Consistency of the information in the performance report and accountability report with the financial statements	Financial information in the performance report and accountability report and published with the financial statements was consistent with the Annual Accounts.
Reports by exception:	
Consistency of Annual Governance Statement	The Governance Statement was consistent with External Audit's understanding of the Trust.
Consistency of the Annual Report within knowledge we have acquired during the course of our audit	There were no matters to report.
Referrals to NHS Improvement (formerly Monitor)	There were no matters to report.
Public interest report	There were no matters to report in the public interest.
Value for money conclusion	An except for opinion was provided which was an improvement from the qualified opinion provided in 2017/18.
Examining the contents of the Trust's Quality Report and testing of two mandated performance indicators and one indicator selected by the Council of Governors	External audit issued a qualified limited assurance report, but reported that the quality account itself was a balanced refection of the Trust.

Area of Work	Conclusion
Reporting to NHS Improvement (formerly Monitor) on the Trust's consolidation schedules	External audit concluded that the Trust's consolidation schedules agreed to the Trust's audited financial statements.
Reporting to the National Audit Office (NAO) in line with group instructions	There were no matters to report.

9.04 During the year the Audit Committee oversaw the extension to the External Audit appointment in line with the contract with EY.

10.00 REPORTING TO THE TRUST BOARD

10.01 The Committee reported to the Trust Board after each meeting. A summary of the key points of discussion at each meeting, for example highlights of the internal audit reports or any formal recommendations were provided to the Board.

11.00 COMMITTEE SELF ASSESSMENT QUESTIONNAIRE

11.01 Committee members and regular Trust attendees completed a short committee assessment questionnaire based on the questionnaire within HFMA NHS Audit Committee handbook. The responders were able to provide comments to support their answers where they felt they would be useful.

11.02 For each question the responder was asked to state of they would strongly agree, agree, degree, strongly disagree or neither agree or disagree with the statement made. For each question the responder was able to indicate that they didn't know, as for some questions not every responder would be expected to know). The questionnaire was split over four areas, the operation of the committee in general, external audit, internal audit and counter fraud delivery.

Summary of results

Audit Committee in general

11.03 Of the 11 questions, excluding don't know responses, there were 2 questions which were not agreed or strongly agreed with by all responders. One question / statement was in relation to the link between the Audit Committee and Quality Assurance Committee and comments provided in support of the answers reflected that a good relationship was in place but formalising the link would be beneficial, this has been done through the introduction of a standing agenda item for formal receipt of cross referred matters. The second statement was in relation to the Committee's degree of influence in the Trust to support improvements and the supporting narrative reflected that whilst there has been significant improvement there was still some work to be done to support the drive to complete recommendations for improvements consistently on time.

External Audit

11.04 Of the 10 questions, excluding don't know responses, 8 of the questions did not receive positive responses from all responders. For two of these many of the responders reflected on the specific remit that External Audit have and this shapes their work, but they would still wish to share more sharing of knowledge from their wider client base to help shape the debate and work of the Audit Committee. The main areas flagged for improvement across the remaining 6

questions related to communication and engagement with the Trust, referencing the issues experienced at year end. Whilst many of the matters referred to will be for the management and auditors to work through the Committee will seek, through its receipt of information across the year, to see further improvements in the working relationships between the audit team and the Trust and where possible the language used within the reports is made less technical.

Internal Audit

11.05 There were 10 questions in this section, again excluding don't know responses then 7 of the questions did not receive positive responses from all responders. The Trust has tendered for its Internal Audit service which has resulted in a new provider from 2019/20. The comments provided reflect the improvements expected from the new provider especially in respect of adding value from their wider client base both the specific reviews undertaken but also in the wider reporting to the Committee and engagement with the Trust. The Committee will monitor the new supplier's deliver of these expectations over the year.

Local Counter Fraud

11.06 There were 10 questions in this section, excluding don't know responses then 4 of the questions did not receive positive responses from all responders. The main theme identified across these questions was a desire to see a clearer articulation of the impact of recommended improvements. There was one further area commented on, which whilst not stopping the responders all providing a positive response, related to the desire to see the LCFS engage with the rapidly changing area of cyber fraud.

12.00 CONCLUSION

12.01 The Audit Committee of Brighton & Sussex University Hospitals NHST Trust is of the view that it has taken appropriate steps to perform its duties as delegated by the Board and it has no cause to raise any issues of significant concern with the Board arising from its work during 2018/19.

12.02 In making this statement, the Committee members acknowledge the support given to it by management, in particular the Chief Financial Officer, Chief Workforce and Organisational Development Officer, the Trust Finance Director and the Company Secretary, and by the internal and external auditors along with the local counter fraud specialist.

12.03 During 2019/20, the Committee will keep under review its working arrangements and ensure it continues to develop its own practice to improve its own effectiveness.

13.00 RECOMMENDATIONS

12.01 The Committee is asked to:

- **Endorse** this Annual Report be provided to the Board

Martin Sinclair
Chair of the Audit Committee
July 2019

Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	14	**Meeting:**	Board	**Meeting Date:**	24 July 2019
Report Title:	**Q1 Board Assurance Framework – 2019/20**				
Sponsoring Executive Director:	Glen Palethorpe, Group Company Secretary				
Author(s):	Glen Palethorpe, Group Company Secretary				
Report previously considered by and date:	Audit Committee – 10 July 2019				

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

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

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

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

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

Communication and Consultation:

The Board Assurance Framework has been prepared in conjunction with each of the five Chief Officers, focussing on respective strategic objectives and determining their associated strategic risks.

Executive Summary:

Introduction

The Executive Team have met to consider the key strategic risks for 2019/20 which have then been placed within the 2019/20 opening Board Assurance Framework (BAF). The Executives have also considered these risks in relation to the Trust's stated risk appetite when considering their target score and the actions needed to achieve or maintain that target score.

BAF Summary

The table overleaf shows by risk the Q1 score and the target risk score, noting that some of the risks are at their target score and thus the BAF process for those risks will be about securing assurance that this acceptable (target) level of risk is maintained

BAF: Strategic Objectives and Strategic Risks (Key: I = Impact L = Likelihood T = Total)	Risk Scores					
	Opening risk			Target		
	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	2	**4**
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	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	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	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	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	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	2	**8**
4. Quality Improvement ***Quality Assurance Committee***						
4.1 We are unable to deliver and demonstrate compliance with regulatory requirements or clinical standards adversely impacting on patient safety and our registration and accreditation by regulatory and supervisory bodies	3	4	**12**	3	3	**9**
4.2 We are unable to deliver service improvements and improve safety, care quality and outcomes for our patients or demonstrate that our services are clinically effective	3	2	**6**	3	2	**6**
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	3	4	**12**	3	3	**9**
5.2 We are unable to define and deliver the strategic intentions, plans and optimal configuration that will enable our services to be sustainable, leading to an adverse impact on their future viability.	4	3	**12**	4	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	3	**12**

Risk Appetite

The Board approved, as part of the approval of the Risk Management Strategy in April 2019, no change to the Trust's risk appetite. The Trust's agreed risk appetite is included as at Appendix A to this paper, and is referred to when determining the target risk score for each risk, noting that there may be more than one component to be considered when determining the individual target risk score.

Wider reporting

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.

The BAF will be reported to each of the Board Committees to allow their oversight and assurance to be provided to the Board.

The Audit Committee considered the BAF along with the key highly scoring risks that underpin the BAF and felt its revised structure regarding having a direct mapping of the sources of assurance to the key control was an improvement. The Committee agreed to consider which of the BAF risks it intended to review in more detail over the year to complement the reviews undertaken by the Quality Assurance and Finance and Performance Committees.

At the year end the Trust's Annual Governance Statement which forms part of the Trust's annual report will make reference to the Trust's Board Assurance process.

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 first quarter of the year 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.

Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	16	**Meeting:**	BSUH Public Board	**Meeting Date:**	24/07/19
Report Title:	**Workforce Disability Equality Standard (WDES)**				
Sponsoring Executive Director:	Denise Farmer, Chief of OD and Workforce.				
Author(s):	Equality, Diversity and Inclusion Team.				
Report previously considered by and date:					

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

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

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

Any implications for:	
Quality	
Financial	
Workforce	Areas for improvement have been highlighted in the report relating to the experiences of disabled staff at BSUH. Projects will need to be put in place to ensure that any areas for improvement can be met.

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

Communication and Consultation:

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

Executive Summary:

The WDES was mandated into the NHS Standard Contract in April 2019. The WDES shares similar metrics as the Workforce Race Equality Standard.

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

The report shows areas for improvement including: bullying and harassment, disabled staff feeling that the organisation values their work and representation of disabled staff throughout most levels in the Trust.

There are a number of areas where the Trust is markedly better than the average acute trust including: disabled staff believing that the Trust provides equal opportunities (Trust 83.5% / Acute Ave 77.4%) and staff feeling that they are under pressure to attend work despite not feeling well enough to perform their duties (Trust 30.1% / Acute Ave 34.1%). The Trust also has a 1:1 ratio for disabled candidates and non-disabled staff being appointed from shortlisting in its recruitment processes.

A working group for the WDES has been established and is in the process of developing an action plan in response to the data.

Key Recommendation(s):

This report has been submitted to the Board for approval – submission of BSUH WDES stats must be completed by 1 August 2019

Brighton and Sussex University Hospitals NHS Trust

Brighton and Sussex University Hospitals NHS Trust

Workforce Disability Equality Standard 2019

Introduction

There has been legal protection for workers with disabilities for many years, making it unlawful to treat a worker with a disability less equally than workers without a disability. The most recent legislation that offers this protection is the Equality Act 2010.

The act goes further than just banning unfair behaviour to workers with disabilities, it also places public sector organisations under duty to seek opportunities to proactively address areas of equality of opportunity and promoting good relations between workers with disabilities and those without.

Whilst there have been improvements with societal attitudes towards people with disabilities, they have not necessarily moved as quickly as the act (and its predecessors) had intended. This being the case, there are still many inequalities surrounding the employment of workers with disabilities. The employment rate of people with disabilities is 51.3%, versus those without 81.4%, this means a difference of 30.1%. This difference is often referred to as the disability employment gap. Given that 22% of adults of working age have a disability, more needs to be done to close this gap. (Briefing Paper 7540, People with Disabilities in Employment, 30 November 2018, Andrew Powell: House of Commons Library).

Breaking down disability further the picture for people with mental ill health and learning disabilities is far worse. 1 in 4 adults and 1 in 10 children experience mental health illnesses in their lifetime (NHS England) however, the stigma around mental health is still rife within the UK. In the 2016 green paper Improving Lives: The Work, Health and Disability Green Paper, states that only 32% of people with mental illness were in work. There are approximately 1.5 million people in the UK with some form of Learning Disability, of which 17% of people of working age are in paid employment. It is estimated that 28% of adults of working age with mild or moderate learning disabilities, 10% of adults of working age with severe learning disabilities and 0% of adults of working adults with profound learning disabilities are in employment (Emerson and Hatton, 2008).

The inequalities can be vast, and may include inflexible recruitment practices that do not take the needs of the candidate's disability, providing adequate reasonable adjustments in the workplace, progression into more senior roles, overrepresentation in employee relations procedures, poor attitudes to those with a disability and poor access to development opportunities. These inequalities help to build a picture of poor employment/retention rates and experiences of employment.

The Workforce Disability Standard was introduced in April 2019 by NHS England, it was developed to demonstrate compliance with:

- UK Government's pledge to increase the number of disabled people in employment – this was made in November 2017
- The NHS Constitution – relating to the rights of staff
- The 'social model of disability' - recognising that it is the societal barriers that people with disabilities face which is the disabling factor, not an individual's medical condition or impairment
- The Equality Act 2010 – specific requirements not to discriminate against workers with a disability, advancing equality and fostering good relations
- 'Nothing about us without us' - a phrase used by the disability movement to denote a central principle of inclusion: that actions and decisions that affect or are about people with disabilities should be taken with Disabled people.

The standard allows NHS organisations to review the experiences and outcomes of both staff with and without disabilities. The standard provides a framework for NHS organisations to review their key employment cycle policies, practices and processes to identify if inequalities (listed above) exist, and gives them an opportunity to engage with disabled workers to put actions in place to address areas of inequality.

There are some specific issues that impact workers with disabilities and NHS organisations, these include:

- Significant under reporting of the numbers of staff who declare themselves as having a disability
- 15% difference between Electronic Staff Records (ESR) and Staff Survey declaration rates. ESR is the integrated Human Resources and Payroll system.
- Lack of representation of Disabled staff at senior levels
- Disabled staff consistently report:
    - higher levels of bullying and harassment
    - less satisfaction with appraisals and career
    - lack of development opportunities.

Through this programme and with annual reporting it is hoped that NHS Organisations will see many benefits including, continuous improvement for workers with a disability, better understanding of the needs of workers with a disability, improved data (declaration rates), improvements to the culture, improved employment and retention.

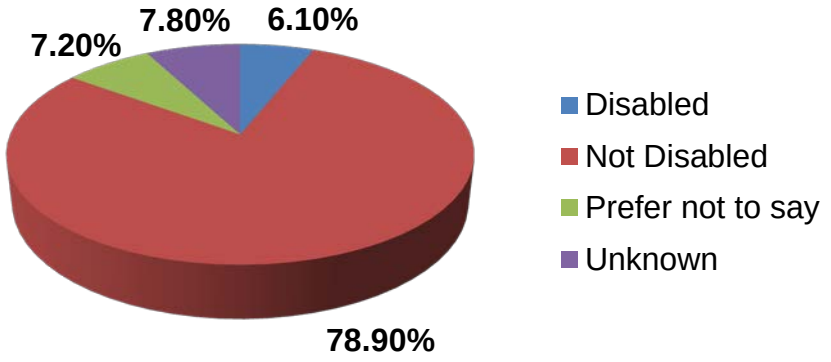
Background Information

1) Total number of staff:

2019
8487

Proportion of staff with a disability employed within this organisation at the date of this report:

	2019	
	Headcount	% of Staff
Disabled	514	6.1%
Not Disabled	6700	78.9%
Prefer not to say	608	7.2%
Unknown	665	7.8%
Total	8487	100.0%



2019

2) Self-reporting

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

	2019	
	Headcount	% of Staff
Disability Status Declared	7214	85.0%
Disability Status Not Declared	1273	15.0%
Total	8487	100.0%

b) Have any steps been taken in the last reporting period to improve the level of self-reporting by disability?
We collect information relating to disability as part of the recruitment process.

c) Are any steps planned during the current reporting period to improve the level of self-reporting by disability?
The Trust is planning to undertake an exercise to improve the workforce declaration of diversity monitoring data across all protected characteristics.

3) Workforce Data

a) What period does the organisation's workforce data refer to?
1st April 2018 to 31st March 2019.

4) How is disability defined under the standard?

The standard uses the definition of disability that can be found in the Equality Act 2010. Under the act a person is considered as having a disability if they have a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on their ability to do normal daily activities.

5) Population Demographic 2011 Census (Southeast England)

	Census 2011
Activity limited a lot	6.9%
Activity limited a little*	8.8%

* Within this section there will be some (not all) people who would meet the test under the Equality Act 2010 as being disabled, but it is impossible to say what proportion.

Workforce Disability Equality Indicators

For each of the indicators, the standard compares the metrics for staff with a disability and staff without a disability.

Metric 1 - Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (VSM) (including executive board members) compared with the percentage of staff in the overall workforce.

Cluster 1: AfC Band 1, 2, 3 and 4
Cluster 2: AfC Band 5, 6 and 7
Cluster 3: AfC Band 8a and 8b
Cluster 4: AfC Band 8c, 8d, 9 and VSM (including Executive Board members)
Cluster 5: Medical and Dental staff, Consultants
Cluster 6: Medical and Dental staff, Non consultant career grade
Cluster 7: Medical and Dental staff, Medical and dental trainee grades

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

	Non-Clinical					
	Disabled	**Not Disabled**	**Not Known**	**Total**	**Disabled %**	**Not Disabled %**
Cluster 1	186	1477	162	1825	**10.2%**	80.9%
Cluster 2	24	324	51	399	**6.0%**	81.2%
Cluster 3	8	96	9	113	**7.1%**	85.0%
Cluster 4	3	39	7	49	**6.1%**	79.6%
Total	**221**	**1936**	**229**	**2386**	**9.3%**	**81.1%**

In the table above in the column labelled 'Disabled %' the green cells demonstrates representation that is either equal or more than the general representation of disabled staff in the workforce (6.1%). The red cell shows an underrepresentation when compared to the general representation of disabled staff in the workforce.

What the data tells us:

- There is a higher representation of disabled staff in AfC bands 1-4, this is where the highest concentration of disabled staff are.
- There is a marginally lower representation of disabled staff in AfC bands 5-7.
- There is a higher representation of disabled staff in AfC band 8a and 8b.
- The representation of disabled staff within band 8c-9 and VSM reflects the overall representation of disabled staff in the workforce.

	Clinical					
	Disabled	**Not Disabled**	**Not Known**	**Total**	**Disabled %**	**Not Disabled %**
Cluster 1	71	1,042	183	1296	5.5%	80.4%
Cluster 2	166	2,628	526	3320	5.0%	79.2%
Cluster 3	15	181	34	230	6.5%	78.7%
Cluster 4	0	22	10	32	0.0%	68.8%
Cluster 5	6	317	129	452	1.3%	70.1%
Cluster 6	1	33	20	54	1.9%	61.1%
Cluster 7	34	541	142	717	4.7%	75.5%
Total	**293**	**4764**	**1044**	**6101**	**4.8%**	**78.1%**

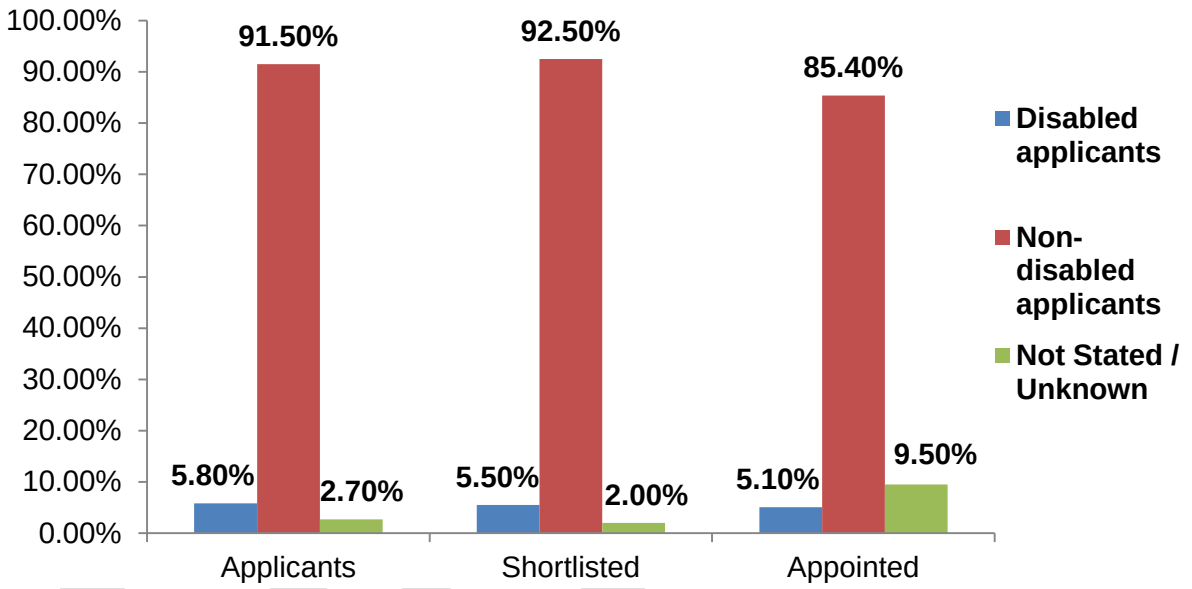
In the table above in the column labelled 'Disabled %' the green cells demonstrates representation that is either equal or more than the general representation of disabled staff in the workforce (6.1%). The red cell shows an underrepresentation when compared to the general representation of disabled staff in the workforce.

What the data tells us:

- Disabled staff have a slightly higher than representation within AfC bands 8a-8b.
- In all other bands disabled staff have a lower than representation when compared to the overall representation of disabled staff in the workforce.
- Disabled staff are underrepresented in senior management and consultant grades.

Metric 2 - Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts. This refers to both external and internal posts.

	Applicants		Shortlisted		Appointed		Relative Likelihood of being appointed
	Number	%	Number	%	Number	%	
Disabled applicants	1152	5.8%	618	5.5%	35	5.1%	0.05663
Non-disabled applicants	18056	91.5%	10508	92.5%	592	85.4%	0.05634
Not Stated / Unknown	534	2.7%	230	2.0%	66	9.5%	0.28696
Total	**19742**	**100.0%**	**11356**	**100.0%**	**693**	**100.0%**	



The likelihood of non-disabled candidates being appointed from shortlisting:
592 / 10508 = 0.05634

The likelihood of disabled candidates being appointed from shortlisting:
35 / 618 = 0.05663

The relative likelihood of non-disabled candidates being appointed from shortlisting compared to disabled staff is: 0.05634 (non-disabled candidates) / 0.05663 (disabled candidates) = **1.00 times.**

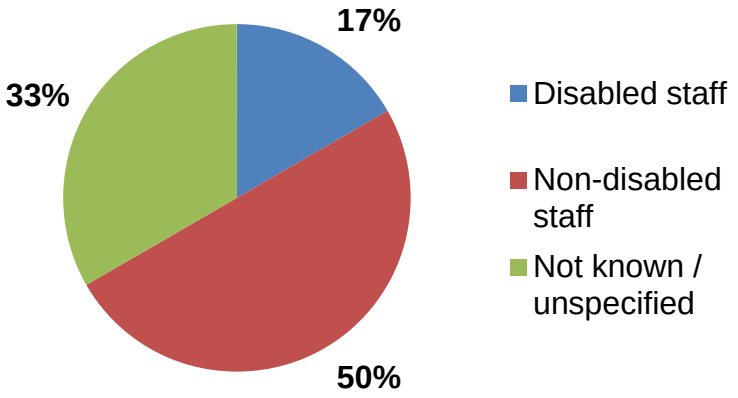
Disabled Candidates		1.00
Non-Disabled Candidates		1.00

In this instance the data suggests disabled candidates and non-disabled candidates have an equal chance of appointed from shortlisting.

Metric 3 - Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

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

	Number of Capability Procedures	Number in Workforce	Relative Likelihood of entering procedure
Disabled staff	1	514	0.0019455
Non-disabled staff	3	6700	0.0004477
Not known / unspecified	2	1273	0.001571



The likelihood of non-disabled staff entering the formal capability process:
1 / 514 = 0.0019455

The likelihood of disabled staff entering the formal capability process:
3 / 6700 = 0.0004477

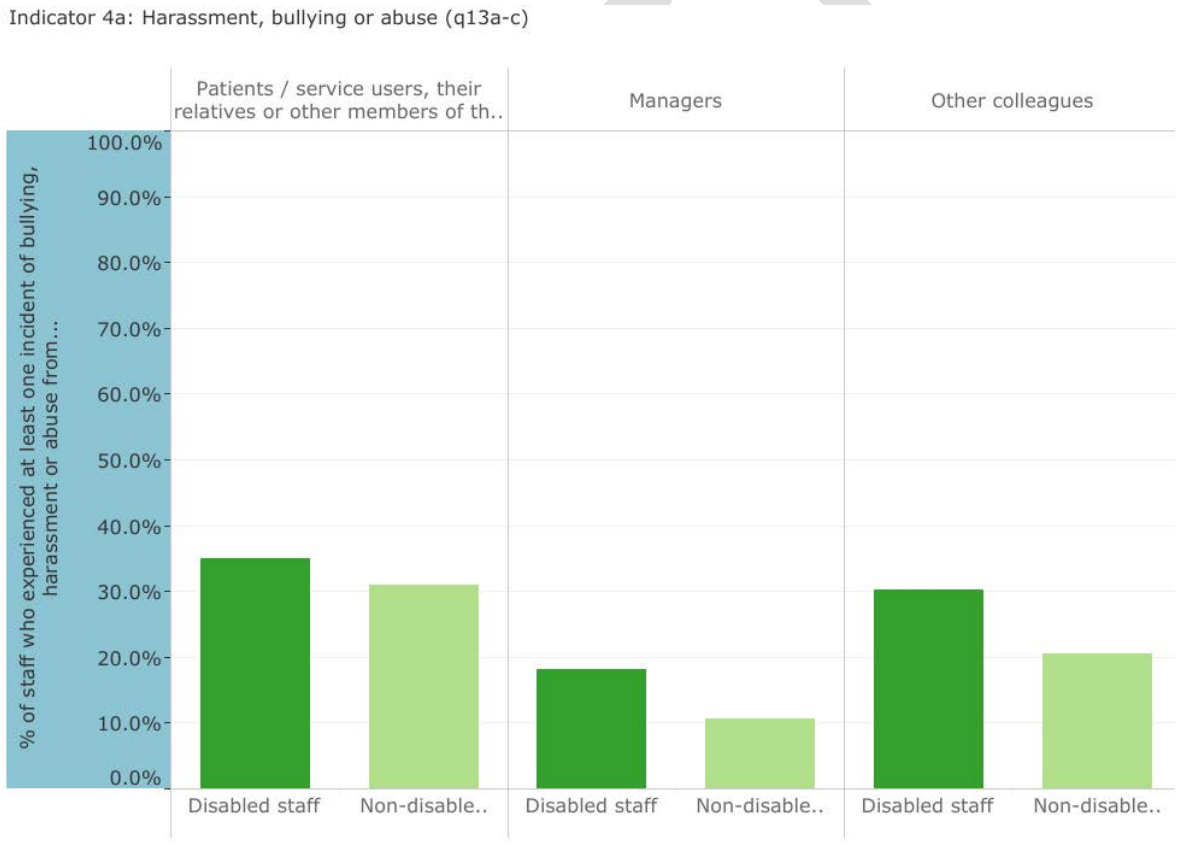
The relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff is: 0.0019455 (Disabled Staff) / 0.0004477 (non-disabled Staff) = **4.35 times.**

In this instance the data suggests that disabled staff members are more likely than non-disabled staff to enter into a formal capability process.

Metric 4a - Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:

- Patients/service users, their relatives or other members of the public
- Managers
- Other colleagues

	Patients/service users, their relatives or other members of the public	Managers	Other colleagues
Disabled staff	35.0%	18.2%	30.1%
Non-disabled staff	31.0%	10.7%	20.5%

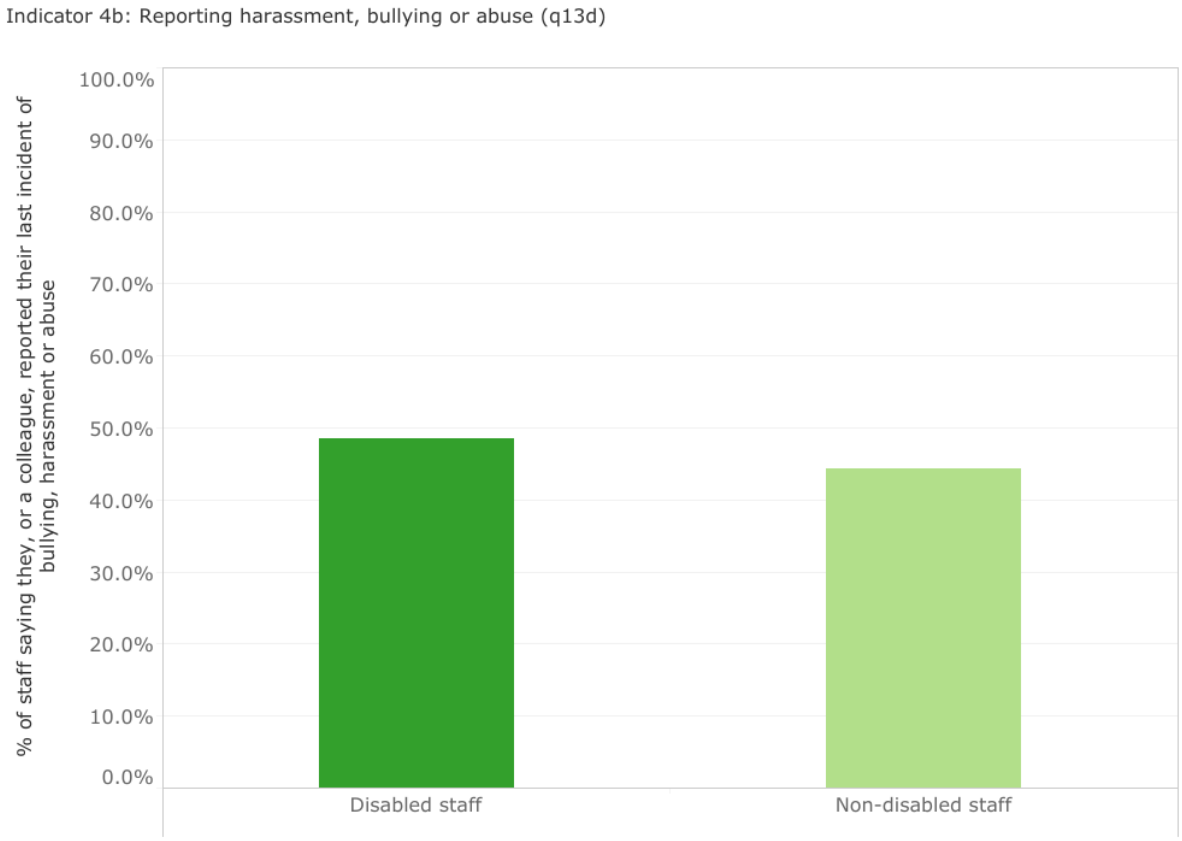


What the data tells us:

- Displayed as a likelihood:
  - Disabled staff are 1.13 times more likely to experience harassment, bullying or abuse from patients/service users, their relatives or other members of the public than non-disabled staff.
  - Disabled staff are 1.70 times more likely to experience harassment, bullying or abuse from managers than non-disabled staff.
  - Disabled staff are 1.47 times more likely to experience harassment, bullying or abuse from other colleagues than non-disabled staff.

Metric 4b - Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

Disabled staff	**48.4%**
Non-disabled staff	44.4%

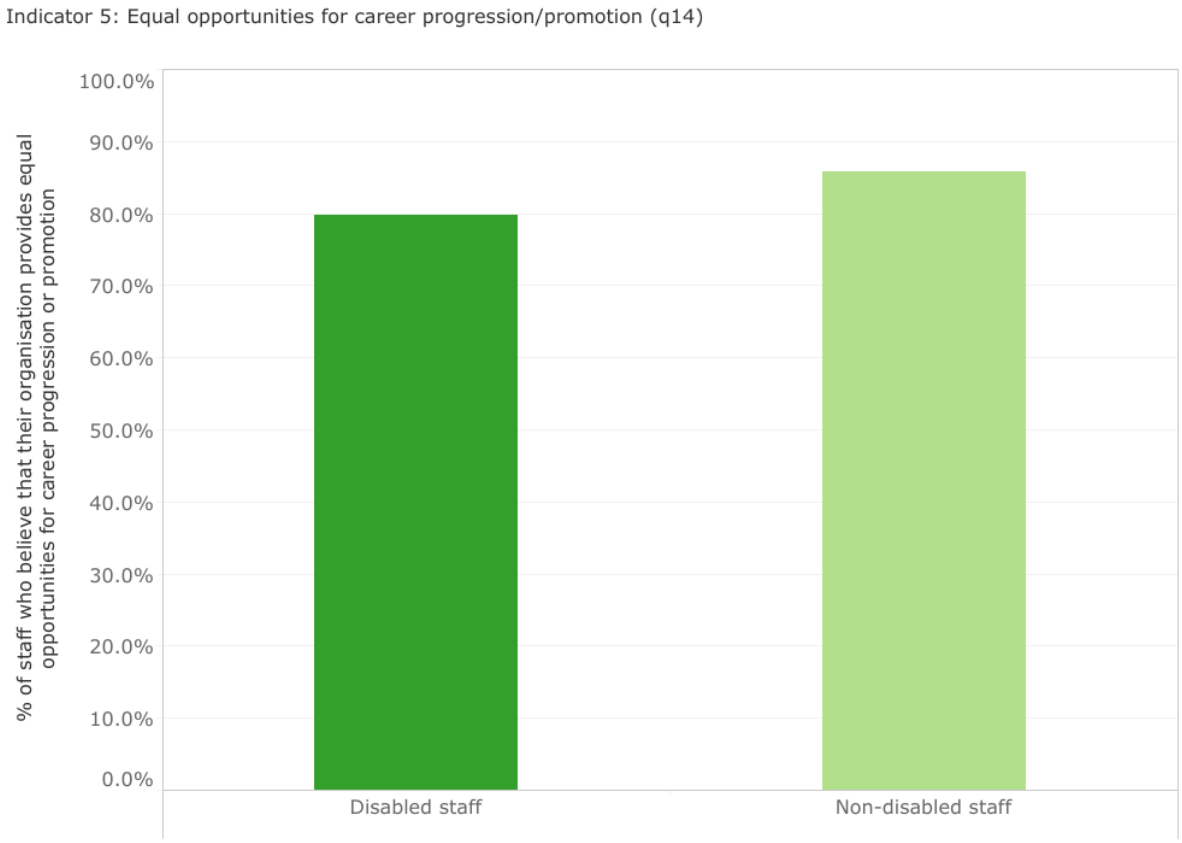


What the data tells us:

- Displayed as a likelihood:
  - Disabled staff are 1.09 times more likely to report incidents of harassment, bullying or abuse at work than non-disabled staff.

Metric 5 - Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.

Disabled staff	**79.8%**
Non-disabled staff	85.8%

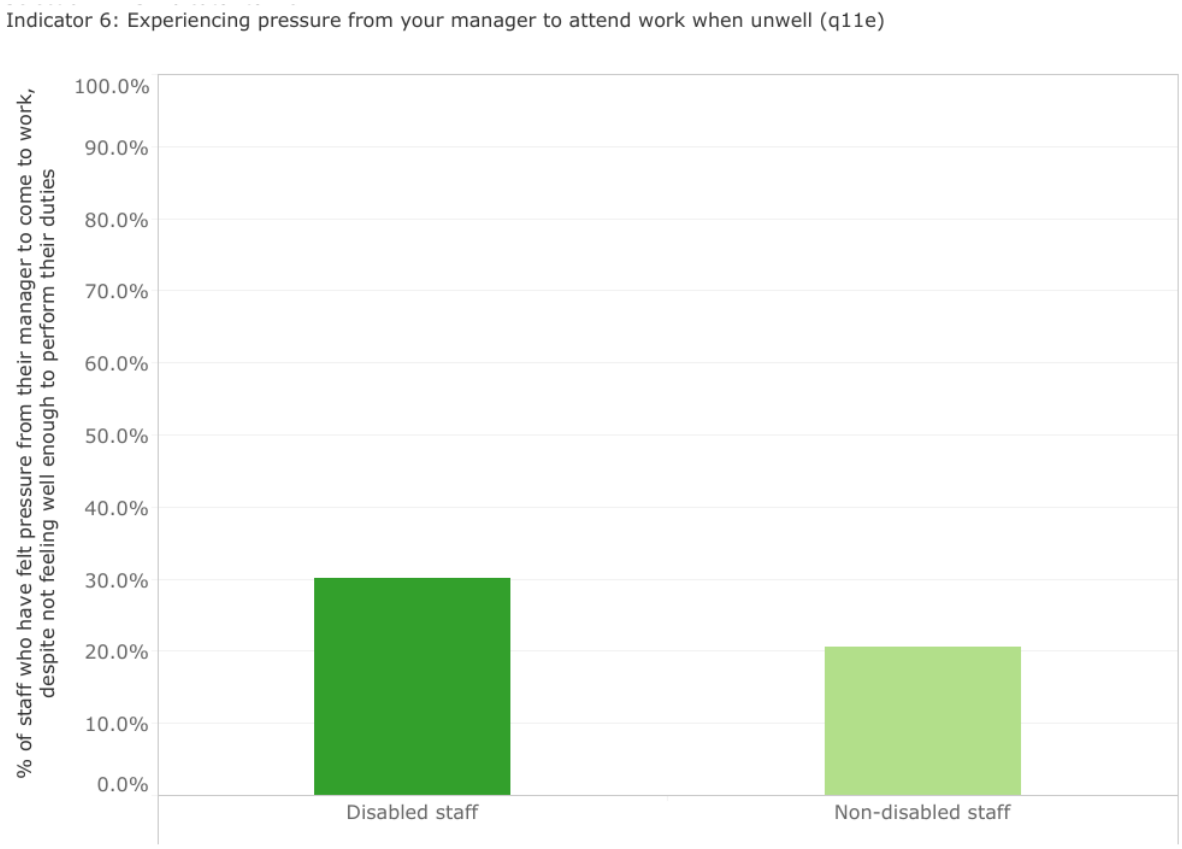


What the data tells us:

- Fewer disabled staff feel that the Trust provides equal opportunities for career progression or promotion than non-disabled staff.

Metric 6 - Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

Disabled staff	**30.1%**
Non-disabled staff	20.6%

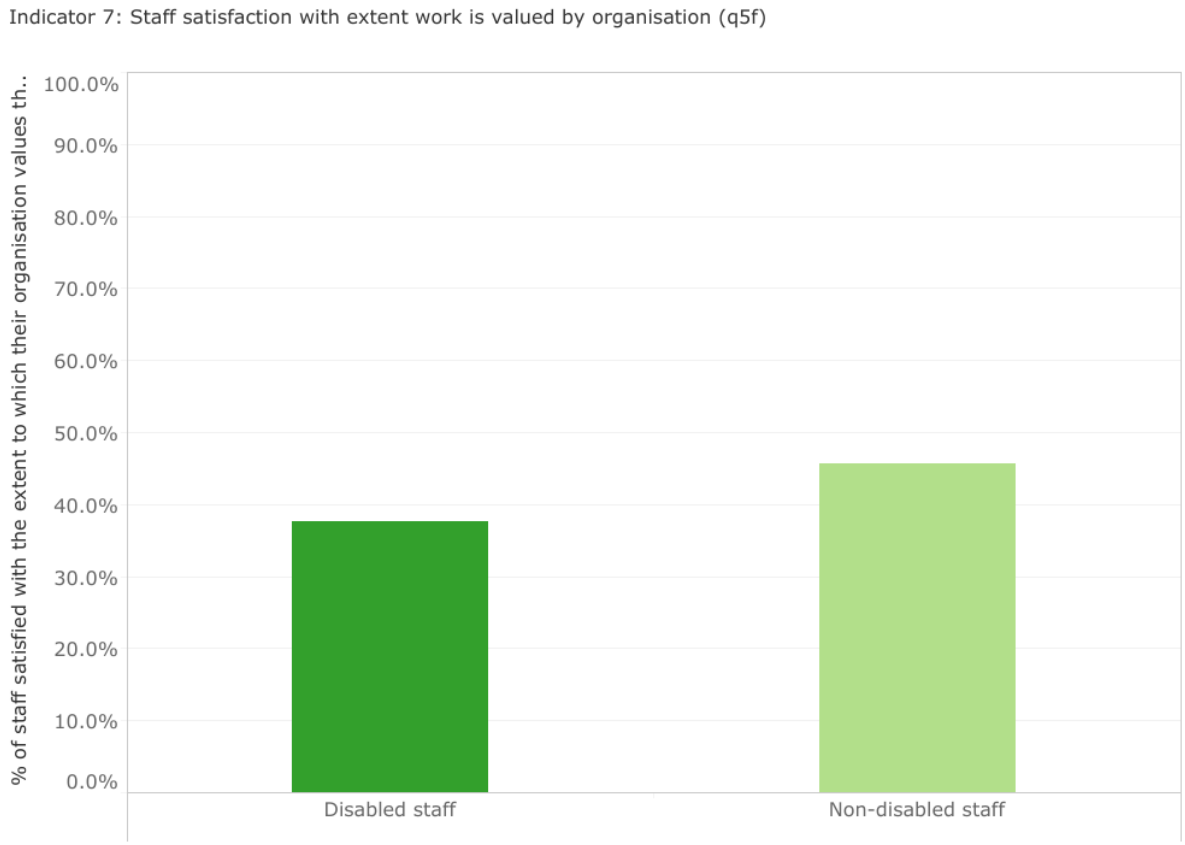


What the data tells us:

- Displayed as a likelihood:
  - Disabled staff are 1.46 times more likely to have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties than non-disabled staff.

Metric 7 - Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

Disabled staff	**37.6%**
Non-disabled staff	45.7%

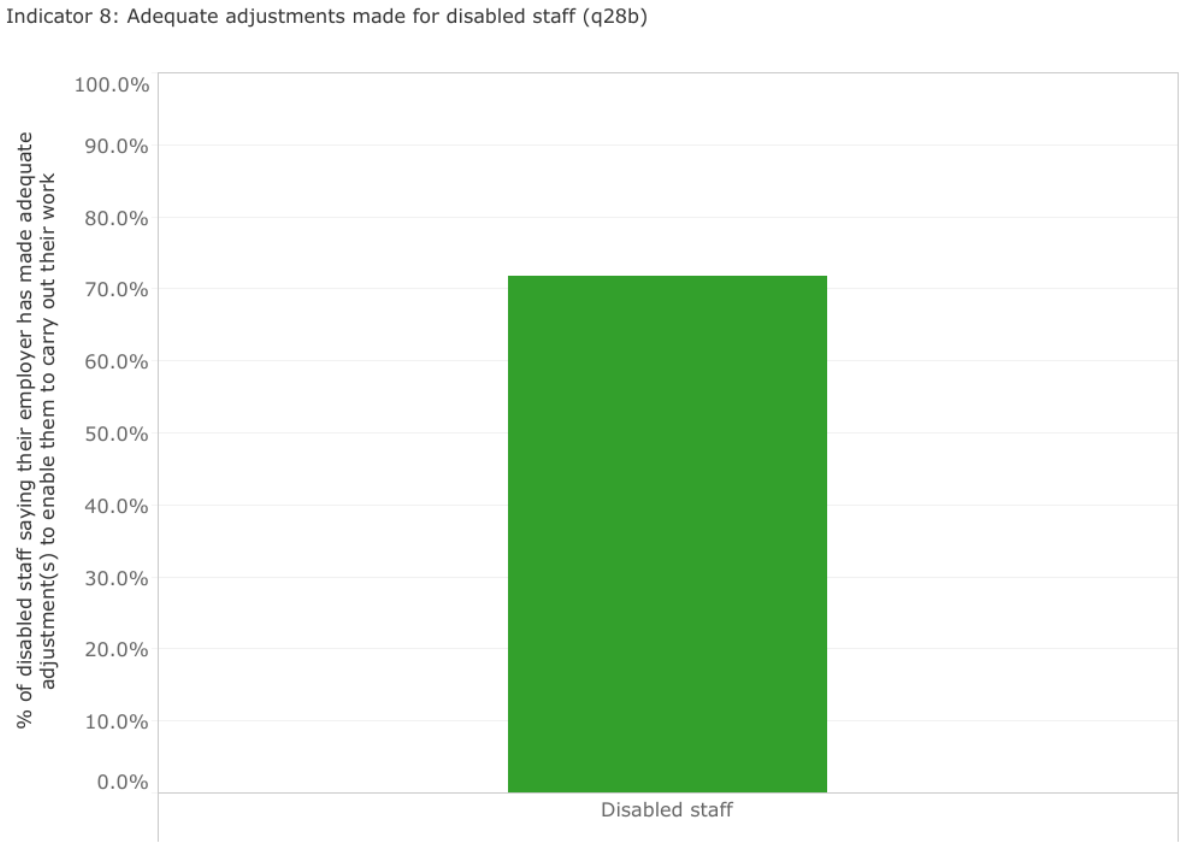


What the data tells us:

- Fewer disabled staff feel that they are satisfied with the extent to which their organisation values their work than non-disabled staff. However, the overall scores for both groups is quite low.

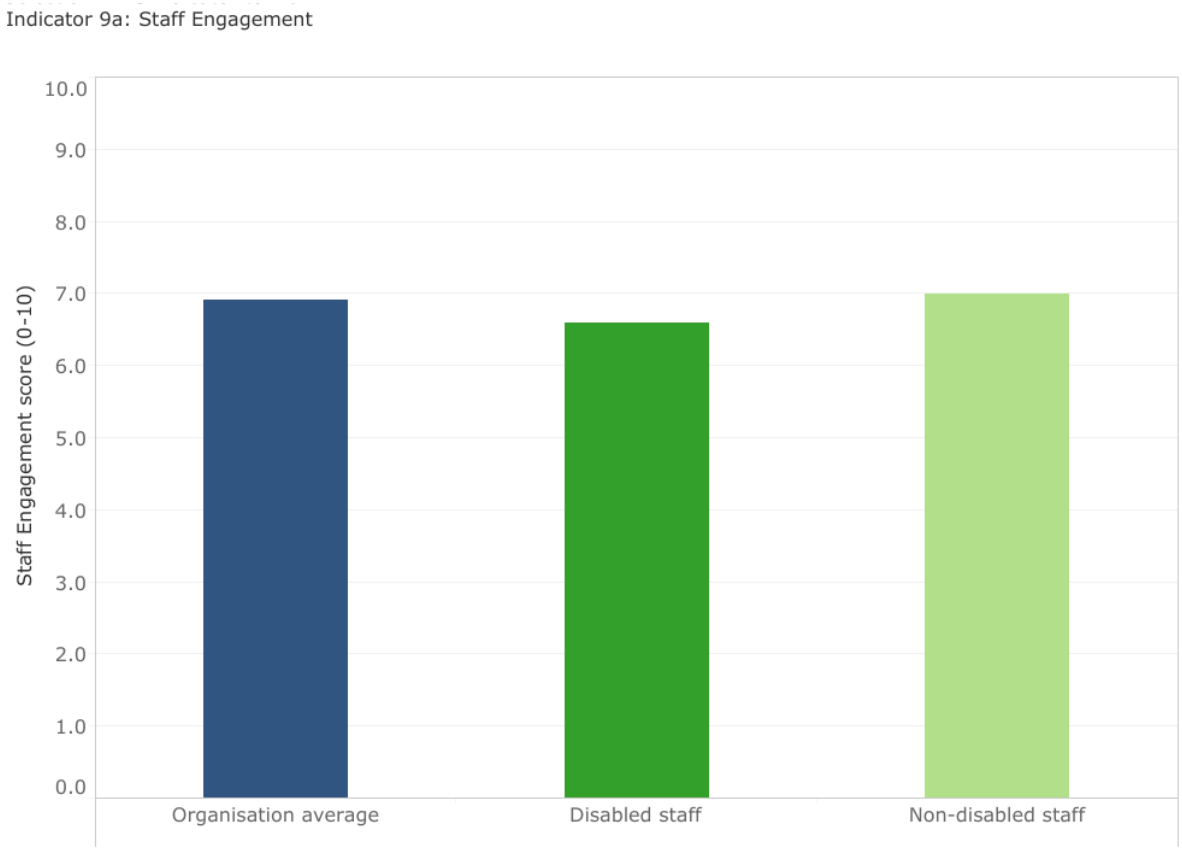
Metric 8 - Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.

Disabled staff	**71.8%**



Metric 9a - The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.

Disabled staff	6.6
Non-disabled staff	7.0
BSUH average	6.9



Metric 9b - Has your trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?

Yes – In February 2019 the Trust signed of a Terms of Reference for the Disability Staff Network, from that point forward the network was formally recognised by the Trust. The aim of the network is to provide an avenue for staff to discuss disability related issues. The network reports to the Diversity Matters Steering Group, which is chaired by the Chief Executive and the Chief Workforce and Organisational Development Officer.

Metric 10 - Percentage difference between the organisation's board voting membership and its organisation's overall workforce, disaggregated:

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

	Overall Workforce		Voting Board Membership		
	Number in workforce	% in workforce	Number on board	% of board	% Difference
Disabled	514	6.1%	0	0.0%	**-6.1%**
Non-disabled	6700	78.9%	7	46.7%	**32.2%**
Not known	1273	15.0%	8	53.3%	**-38.3%**
Total	8487	100.0%	15	100.0%	

(ii) The organisation's Board executive membership and its overall workforce

	Overall Workforce		Executive Board Membership		
	Number in workforce	% in workforce	Number on board	% of board	% Difference
Disabled	514	6.1%	0	0.0%	**-6.1%**
Non-disabled	6700	78.9%	7	46.7%	**32.2%**
Not known	1273	15.0%	8	53.3%	**-38.3%**
Total	8487	100.0%	15	100.0%	

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

This is the launch report for the Workforce Disability Equality Standard, which sets a benchmark to measuring progress.

a. Any issues of completeness of data
None

b. Any matters relating to the reliability of comparisons with previous years
Not applicable – this is the launch report for the Workforce Disability Equality Standard.

Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	17	**Meeting:**	Trust Board	**Meeting Date:**	24 July 2019
Report Title:	Safeguarding Adult Annual Report 2018 –2019				
Sponsoring Executive Director:	Clare Williams, Interim Chief Nurse				
Author(s):	Joanna Henderson, Lead Nurse for Safeguarding Adults				
Report previously considered by and date:					
Purpose of the report:					
Information		✓	Assurance		✓
Review and Discussion		☐	Approval / Agreement		☐
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		☐	Staff confidentiality		☐
Patient confidentiality		☐	Other exceptional circumstances		☐
Link to Trust Strategic Themes:					
Patient Care		✓	Sustainability		☐
Our People		✓	Quality		✓
Systems and Partnerships		☐			
Any implications for:					
Quality	Nothing to note in the report				
Financial	Nothing to note in the report.				
Workforce	A review of the training following the Intercollegiate document for Adults published August 2018				
Link to CQC Domains:					
Safe		✓	Effective		☐
Caring		✓	Responsive		✓
Well-led		✓	Use of Resources		☐
Communication and Consultation:					
Trust Safeguarding Committee, Trust CCG QRG					
Executive Summary:					
The Adult Safeguarding report provides the board with an outline of the statutory requirements and outlines the safeguarding achievements from 18/19 and key priorities for 19/20.					
Key Recommendation(s):					
The Committee is asked to note the report					

Annual Report to the Board of Directors
July 2019
Safeguarding Adults, Mental Capacity Act, Learning Disabilities and Domestic Violence

1. Introduction

The Care Act (2014) provides the statutory framework for safeguarding adults. Sections 42 – 47 of the Act set out the legal duties and responsibilities in relation to safeguarding. Key responsibilities lie with Local Authorities, working in partnership with the Police and NHS.

The Care Act safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs),
- is experiencing, or at risk of, abuse or neglect,
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about working together to support people to make decisions about the risks they face in their own lives and protecting those who lack the mental capacity to make those decisions.

Making Safeguarding Personal (MSP) is the national approach to safeguarding adults with the aim of ensuring the response to safeguarding is person led and outcome focused. The key principle is to engage with the adult in a way which supports and empowers them to make choices and have control about how they live their lives.

2. Safeguarding Adults in BSUH

The Safeguarding Adults agenda is a key component of Patient Safety in BSUH. The Lead Nurse for Safeguarding Adults reports directly to the Nurse Director. In addition to the Lead Nurse, the team consists of a 0.54 wte Safeguarding Nurse, a Mental Capacity and Safeguarding Adults Lead Educator and a 0.67 Safeguarding Team Administrator. Affiliated to the team are a Health Independent Domestic Violence Advocate (IDVA), who works at RSCH and is employed by RISE (a domestic violence charity) and 2.5 wte Learning Disability Liaison Nurses, who work in BSUH and are employed by Sussex Partnership Foundation Trust and Sussex Community Foundation Trust.

The BSUH Safeguarding Steering Group meets on a quarterly basis, bringing together Safeguarding Children, Adults, MCA and DoLS, Domestic Violence Learning Disabilities and Dementia. The steering group is chaired by the Nurse Director and there is attendance from all the clinical divisions. In line with the clinical governance structure, this steering group reports to the Patient Safety Group.

The Nurse Director is a member of both the West Sussex and Brighton and Hove Safeguarding Adults Boards (SAB) and the Safeguarding Team members actively participate in sub committees of both Safeguarding boards.

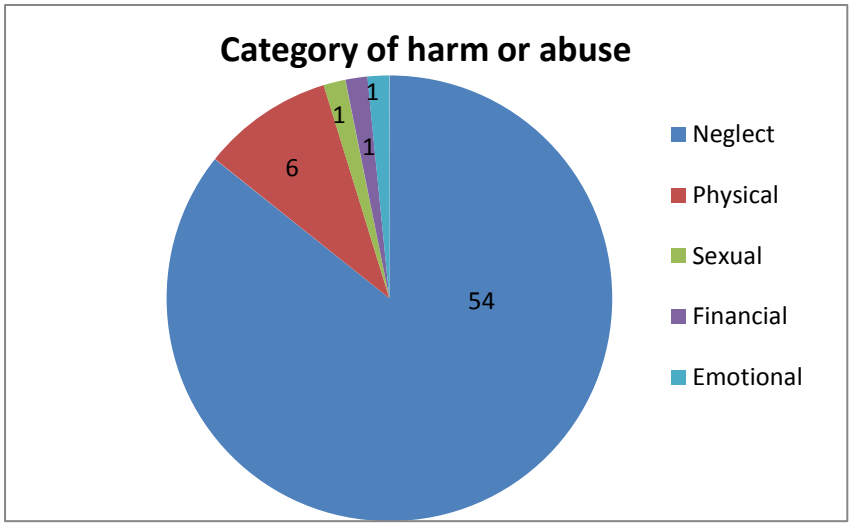
The Lead Nurse Safeguarding Adults attends the monthly Nursing and Midwifery Board. Safeguarding updates provided to NMB concentrate on the learning from safeguarding incidents and changes to practice and procedures. Safeguarding Adults also forms part of the standard agenda for the clinical division's clinical governance meetings.

In practice there is, in a number of instances, a link between safeguarding, complaints and serious/moderate Incidents. As a result the Nurse Director attends the Serious Incident Review Meeting monthly and manages the head of patient experience and complaints as well as to the head of patient safety. A weekly safety huddle has been instituted with the Chief Nurse, Nurse Director, Medical Director, medico legal, quality, complaints and patient safety leads, which enables triangulation of incidents including safeguarding.

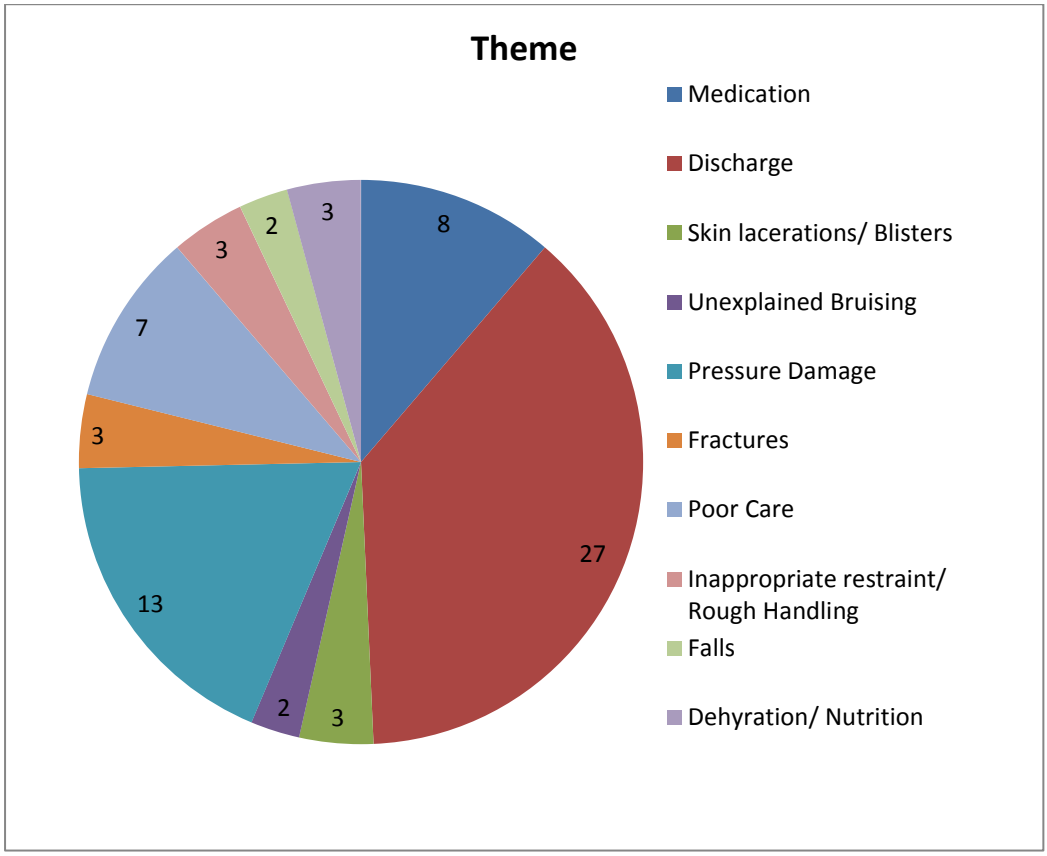
Safeguarding Activity April 2018 to March 2019
Section 42 Enquiries

As part of their statutory duties, The Care Act requires Local Authorities to make enquiries, or ensure others do so, when they believe that an adult is subject to, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to stop or prevent abuse or neglect, and if so, by whom.

There were 60 Section 42 "Causing others to undertake enquiry" received by the Safeguarding team whereby concerns were raised regarding the care provided by BSUH. Each section 42 enquiry relates to an individual adult although may include more than one category of harm or abuse and relate to more than one theme



Neglect or acts of omission (which often include issues relating to poor discharge) accounted for 86% of the allegations received. This is an increase from the previous year when 67% of concerns received were in the category of neglect.



Similar to the previous year, a review of safeguarding concerns received shows the predominant theme of Discharge (38% of section 42 enquiries received). A further breakdown of these shows a range of issues to include elderly patients discharged with cannula in situ, discharge without medication, failed discharge. Many of the outcomes from the section 42 enquires showed a need to improve communication with Care Homes / care providers prior to discharge and also a need to improve nursing documentation.

A significant area of focus has been the increased number of safeguarding concerns raised regarding the care provided on Poynings ward. As a result, West Sussex Social Services raised an overarching Organisational Safeguarding as part of their statutory responsibilities. Learning outcomes were similar across many of the individual safeguarding enquiries and in particular highlighted the need for more specialist training for staff working in dementia specialist wards. The Security Training Officer has provided bespoke de-escalation training to the nursing staff on Poynings. A university accredited Tier 3 Dementia Training programme has been implemented with places taken up by both nursing and therapy staff across both dementia specialist wards at PRH and RSCH, as well as other clinical areas such as ED and Care of the Elderly wards.

As part of their safeguarding assurance responsibilities the CCG undertook separate site visits to both Poynings and Newhaven Wards.

Learning from Safeguarding Adult Reviews

In accordance with Section 44 of The Care Act (2014), local Safeguarding Adults Board (SAB) have a statutory duty to conduct a Safeguarding Adults Review (SAR) if

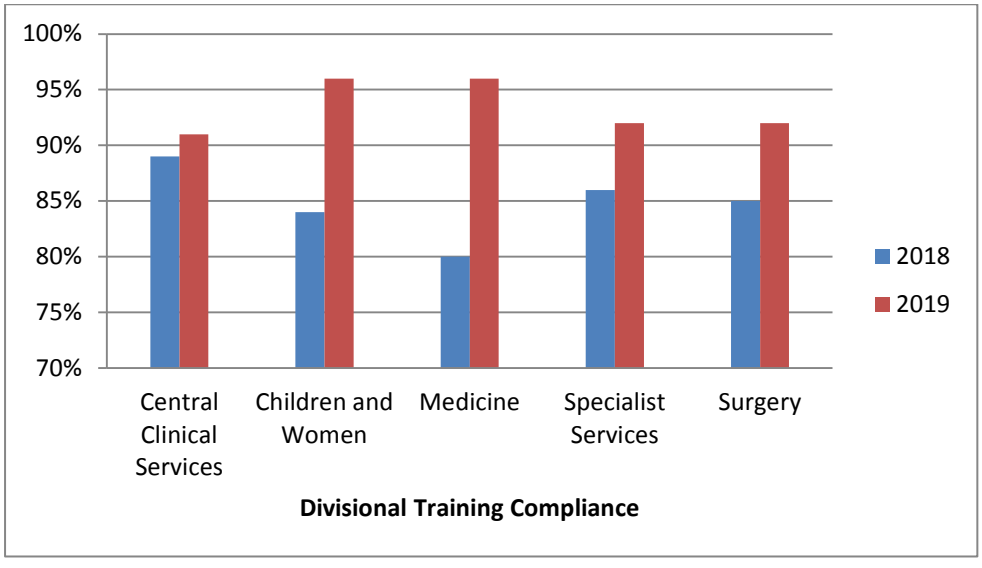
- An adult has died as a result of abuse or neglect and there is concern that partner agencies could have worked together more effectively, or
- An adult has not died but the SAB suspects they have experienced serious abuse or neglect. For the purpose of the SAR, something may be considered serious abuse or neglect where the adult would likely have died but for an intervention, or, the adult has suffered permanent harm or reduced capacity or quality of life (whether physical or psychological effects).

BSUH has a duty to share relevant information with the SAB when requested to do so as part of a SAR or Learning Review; and to support the development and implementation of action plans to prevent future deaths or serious harm occurring again as appropriate.

The Brighton and Hove SAB commissioned a Learning Review in the case of DMS – an adult in his 40s with both a mild Learning Disability and Mental Health needs who suffered abuse as a child resulting in significant trauma. As an adult he had a period in prison in his early 20s and since 2011 has spent significant periods of time street homeless. At the time of his involvement with BSUH, DMS was detained under Section 3 MHA and was supported by both the Learning Disability and Mental Health Liaison Nurses. He now resides in specialist supported living environment. The learning review highlighted the need to develop pathways for the multi-agency approach to the management of high risk or complex cases; to improve information sharing and risk assessment. Recommendations also include that the SAB seek assurances regarding training in line with standards that reflect the legislative requirements of the Care Act 2014 and The Mental Capacity Act 2005

Training

Divisional Safeguarding Adults training compliance:



There has been a significant improvement in compliance with mandatory training for Safeguarding Adults which stands at 92%, above the 90% Trust target for STAM compliance.

Nursing and Midwifery Induction and clinical mandatory updates include a 'Safeguarding Day' which incorporates all the statutory requirements for both Safeguarding Adults and Children and Mental Capacity Act training. The training is interactive involving group work and discussion, and is based on case scenarios from previous safeguarding enquiries; this was recognised as good practice in the internal audit 2018. E-learning is also available should staff be unable to attend face to face sessions.

The safeguarding team continue to review and update training to reflect developments in legislation and also learning from safeguarding enquiries. The clinical mandatory updates include a specific theme or area of focus which is reviewed annually. This year's focus has been on raising awareness of Modern Slavery. The training for 2019/20 is being revised to include a focus on the theme of self-neglect.

The Intercollegiate Document for Adults was published in August 2018 and sets out the minimum training requirements for all health care staff in relation to adult safeguarding.

3. Prevent

Prevent is one of four strands in the Government's counter terrorism strategy, CONTEST. The revised strategy was launched by the Home Secretary in June 2018 and reinforces safeguarding at the heart of Prevent; to ensure children or adults vulnerable to any form of radicalisation are supported as they would be if at risk from exploitation from a range of other harms such as criminal exploitation, gangs and sexual exploitation.

Brighton and Hove remains a priority city in accordance with the Home Office classification of risk. The Nurse Director is the Trust Prevent lead and BSUH is represented at the Brighton and Hove Prevent Board by the Lead Nurse Safeguarding Adults.

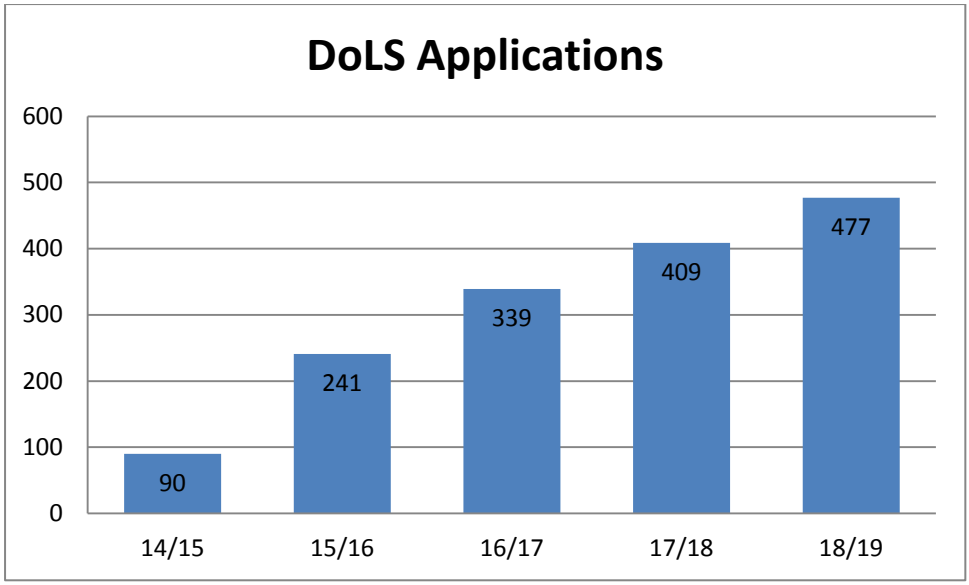
Prevent Training and Competencies Framework identifies the minimum training standards for staff working in healthcare and is supported by the Intercollegiate Document for Adult Safeguarding

Emerging trends in health related Prevent referrals are mental health. Level 3 e-Learning programmes have been developed specifically for mental health professionals and subsequently level 3 e-learning for other health care professionals is now available.

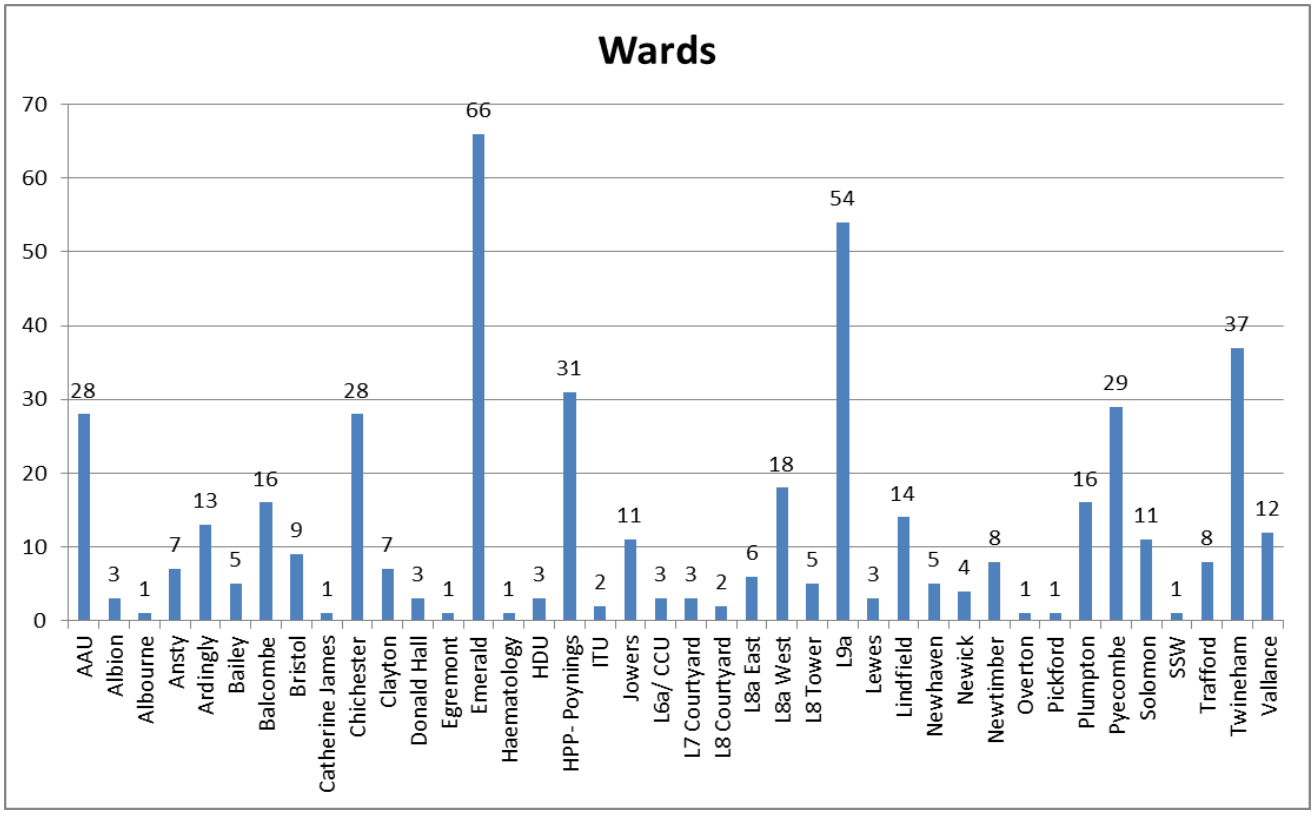
4. Mental Capacity and DoLS

Deprivation of Liberty Safeguards (DOLS) activity 2018 - 2019

In line with the national trend BSUH has seen a year on year increase in the number of DoLS applications submitted to the Local Authorities for authorisation.



DoLS applications by clinical area April 2018 - March 2019



The Mental Capacity (Amendment) Bill was introduced to the House of Lords in July 2018. The Bill seeks to replace DoLS with a new scheme called Liberty Protection Safeguards. One of the key aims of the Bill is to strengthen protection and rights for vulnerable adults who lack mental capacity, and in particular to strengthen the safeguards for approving a deprivation of liberty whilst at the same time streamlining the processes for this.

It is expected the new arrangements will come into effect late 2020 and until then the existing DoLS processes remain in place.

Mental Capacity Audit

As part of the Brighton and Hove SAB Quality Assurance Sub-Group's programme of audit activity for 2018-19 it was agreed to conduct a multi-agency audit of a sample of safeguarding cases to evaluate the effectiveness of the application of the Mental Capacity Act Code of Practice

The audit group comprised representatives from the following services:

- Brighton & Hove Health & Adult Social Care (HASC)
- Brighton & Hove Clinical Commissioning Group (CCG)
- Brighton & Sussex University Hospitals NHS Trust (BSUH)
- Sussex Partnership NHS Foundation Trust (SPFT)
- Sussex Community NHS Foundation Trust (SCFT)
- Sussex Police

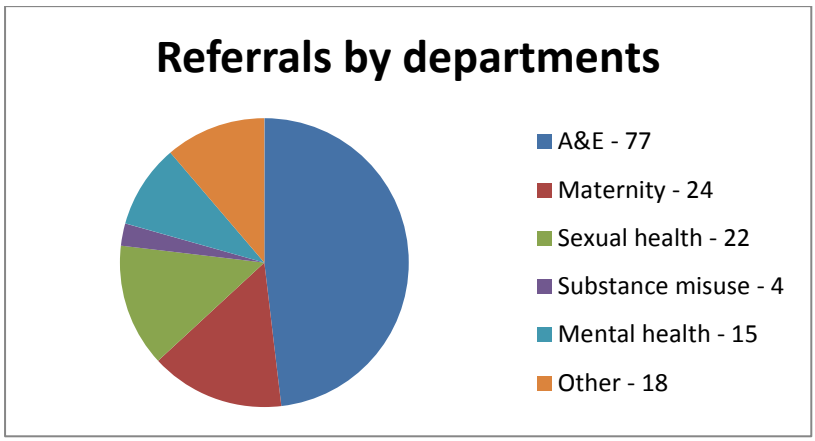
The audit identified several areas of good practice such as timely safeguarding referrals and good involvement with family/friends and good use of advocacy where appropriate. Recommendations for improvement across all agencies include the need to improve the standard of documentation both for decision specific mental capacity assessments and best interest decision making.

The need to improve documentation in this area was also highlighted as an area for improvement following the CCG Safeguarding assurance site visit to Poynings ward.

5. Domestic Violence and Abuse

The Health Independent Domestic Violence Advisor (HIDVA) is employed by RISE at The Portal and is based at RSCH, to support people experiencing domestic violence and abuse (DVA), in Accident and Emergency (A&E), Maternity and Sexual Health Clinic. The HIDVA provides training and consultancy for staff working in the three target departments.

TOTAL referrals to HIDVA service in April 2018- March 2019 – 160 (previous year– 168)



The HIDVA continues to raise awareness about domestic abuse in later life and last year received 11 referrals for patients who were 66 years old and older.

Domestic Abuse training is included in:

- HCA Care Certificate programme
- Nursing and Midwifery Induction
- Level 2 Safeguarding training for all staff
- Level 3 Safeguarding training for midwives
- Regular updates for Sexual Health departmen

6. **Learning Disabilities**

Patient Activity

Total no of referrals for this year was 310

Recorded Deaths of PWLD 13

Inappropriate referrals 26

There is LDLT support in RSCH and PRH. This consists of 2 FTE @RSCH employed by SPFT . 0.5 FTE at PRH employed by SFT. All pts who access the RSCH are supported by the BH LDLT team. WS LDLT based at PRH is commissioned to provide support to WS pts only. When possible they will provide some ward support to pts from outside ES. If they are unable to do this. BH LDLT covers. They provide support for pts accessing PRH from BH.

246 pts were referred from RSCH

146 BH

34 ES

30 WS

36 Other locality outside local counties.

64 pts were referred from PRH

38 WS

15 BH

11 ES

Learning Disabilities Mortality Review (LeDeR**)/SJR**

BH LDLT report all deaths of PWLD who died at BSUH to the LeDeR programme.
They complete the SJR with a colleague from BSUH.
They represent BSUH at the LeDeR steering group feeding back directly to the Mortality Steering group.

Training.

Training is regularly provided to as part of the overall NHS England safeguarding strategy including:

- HCA certificate training programme
- Nurses and Midwifery Induction and the Level 2 Clinical Update.
- Band 4 training programme
- A bespoke session has been provided to Claude Nichol

However, current changes in the mandatory training have seen a reduction in the focus of this training on LD. This is concerning and recommend in light of the NHS long term plan a clear training plan for LD awareness if considered.

The service has provided practice placement to one student nurse and a RTP nurse during this period.

Service Development.

This year has seen the change of role for one of the BH LDLT to Lead liaison receiving direct 1:1 meetings with the Nurse Director. It has been recognised by LDLT and BSUH the importance of this and in the interim period whilst this post is vacant another member of the BSUH senior leadership team has agreed to continue with supervision.

The BH LDLT has had maternity leave vacancy during 11 months of this report period, creating additional strain on the LDLT service. However, their return to 0.7 FTE and appointment of a .6 FTE band 3 post will mean the service should be at full workforce capabilities for much of 2019-2020 and the clear service developments set out within the LDLT programme plan.

7. Priorities for 2019 /20

To improve the discharge experience for patients, supporting the implementation of actions as part of the Patient Experience Breakthrough Objective and the Quality Improvement Project for 2019 /20

To see a reduction in section 42 enquiries relating to the theme of discharge

To fully embed the training requirements for Safeguarding Adults, Prevent and MCA in line with the Intercollegiate Document and competency frameworks

To increase training compliance for MCA and action findings from MCA audit

Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	17	**Meeting:**	Trust Board	**Meeting Date:**	24 July 2019
Report Title:	Safeguarding Children Annual Report 2018 –2019				
Sponsoring Executive Director:	Clare Williams, Interim Chief Nurse				
Author(s):	Debi Fillery, Nurse Consultant Safeguarding Children & Young people				
Report previously considered by and date:					

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

Any implications for:	
Quality	Activity is increasing and work is underway to review the current team structure
Financial	Nothing to note in the report.
Workforce	Training statistics continue to improve

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

Communication and Consultation:

Trust Safeguarding Committee, Trust CCG QRG

Executive Summary:

The Child Safeguarding report provides the board with an outline of the statutory requirements and outlines the safeguarding achievements from 18/19 and key priorities for 19/20.

Key Recommendation(s):

The Committee is asked to note the report

Child Protection and Safeguarding Children
Annual Report to the Board

2018/19.

Introduction

The Safeguarding Annual Report provides a clear outline of our Statutory requirements, and outlines the safeguarding achievements from 2018 – 2019 and the priorities for 2019/20.

The overarching principles as defined by The Children Act 1989 and 2004 remain unchanged & state that:-

- the welfare of the child is *paramount* and that all practitioners are required to protect children, prevent the impairment of health and development and ensure they are provided safe and effective care in order to fulfil their potential.

The Department for Education (DfE) updated the *statutory* guidance '*Working Together to Safeguard Children*' (2018) setting out the safeguarding functions for organisation relating to children. The core requirements are broadly unchanged but include emerging safeguarding themes since the last revision in 2015 and add more detail to the assessment and information sharing processes.

BSUH responds to these statutory instructions by having robust governance arrangements in place. The BSUH Named professionals address the requirements of Section 11 of The Children Act 2004 & to support safe recruitment, undertake audit, staff training & to give supervision to staff while encouraging the Divisions to listen to the '*voice of the child'* and to '*think family'* when considering developments.

Significant improvements have been demonstrated in training compliance across all areas which are monitored through the Trust's Safeguarding Steering Group and reports to the Patient Safety Group

BSUH continues to work in a multi-disciplinary, multi-agency way following the Sussex Child Protection and Safeguarding Procedures when required.
National and local safeguarding arrangements for partnership working are being revised in order to comply with the Children and Social Work Act 2017. Safeguarding Partnerships which include the Local Authority, Police and CCGs will replace Local Safeguarding Children's Boards from September 2019.
The Safeguarding Partners are working to develop plans for the future arrangements and how these will be implemented across the region. Any associated impact is yet to be quantified.

Contextual summary of issues and relevant documents published in 2018/19 with BSUH actions

BSUH provides hospital services for the local geographical area and have some tertiary services for patients across the South east. There are 4 A&E departments. The 'Royal Alexandra Children's Hospital (RACH) cares for 45,000 children every year and the Care Quality Commission rated it as '*outstanding*'.

BSUH is situated in an area of high deprivation. In June 2018 Brighton & Hove had **370** children who were subject of a child protection plan making it the 17th highest out of 151 Local Authorities in England down from 10th in 2017.

Quarter	Sept 2010	Sept 2011	Sept 2012	June 2013	June 2014	June 2015	June 2016	June 2017	June 2018
Total No of children with a CP Plan for B&H	411	395	340	300	328	385	381	380	**370**
B&H per 10,000	88	85	N/A	59.9	59.9	57.1	74.7	74.2	**72.1**
National average per 10,000	N/A	36	N/A	37.8	37.9	42.1	42.9	43.1	**43.3**
Statistical neighbour						44.4	42.1	45.3	**49.8**
League table (n=152)			8th	15th	24th	33rd	25th	10th	**17th**

The B&H LSCB annual report documents that in 2018:

- 1,976 open Children in Need cases
- There were 418 children in care (CiC).
- 4.9% of households have no household members who speak English as main language compared to England average of 4.4%.
- one in 12 residents (21,833 or 8.3 per cent) aged over three years English is not their main or preferred language.
- at 31 March 2018, 157 children are allocated to children's disability team.
- In B&H in March 2019

Emotional abuse	176
Neglect	132
Multiple categories	7
Sexual abuse	7

Attendances to BSUH children's emergency dept/A&E has increased as illustrated in the table below

April 2018-March 2019. Of the 33,355 attendances 353 had CP plans (an increase of 35).

April 2018-March 2019	Children under 5	Children under 17	Children under 18	Total	
RACH	15715	12267	719	28701	↑3057
PRH	190	3679	371	4240	↓1065
RSCH	16	45	353	414	↑ 217
Total	**15921**	**15991**	**1443**	**33355**	**↑2211**

The number of child protection medicals remains stable

	2016/17	2017/18	2018/19
CP medicals	109	112	112

The National context

There have been some fundamental changes to child safeguarding which are noted below and The Trust should ensure that the needs of the children are not lost during the transition to the new arrangements.

The Children and Social Work Act 2017 made 34 recommendations – 19 with regard to LSCBs, 10 regarding Serious case reviews & 5 in terms of Child death overview panel (CDOP). It removes the legal authority of Local Safeguarding Children Boards (LSCBs) which will in future reside with a new partnership made up of Clinical Commissioning Groups (CCG), Local Authorities and local police. They must, make decisions about the geographical footprint, funding and criteria for intervention and the scrutiny of the effectiveness of their arrangements by an independent person. Descriptions of the working arrangements will have to be published, as will regular reports on the work of the partnership.

BSUH Actions:

- BSUH is part of the current LSCB and the named professionals have been involved with discussions about the future arrangements which will be in place by Sept 2019.

Working together to safeguard children 2018 (replaces Working Together 2015)
The statutory guidance sets out what organisations and agencies that have functions relating to children must and should do to safeguard and promote the welfare of all children and young people under the age of 18 in England. The guidance covers: the legislative requirements. the framework for the three local safeguarding partners; and child death review partners. Guidance is provided on: assessing need and providing help including early help; organisational responsibilities; multi-agency safeguarding arrangements; local and national child safeguarding practice reviews; and child death reviews.

BSUH Actions:

- The BSUH named professionals have undertaken the bi annual section 11 audit and challenge event producing an action plan which will be monitored via the safeguarding committee.
- BSUH is part of the current LSCB and the named professionals have been involved with discussions about the future arrangements which will be in place in September 2019.
- The BSUH named professionals are part of a group reviewing the CDOP arrangements locally to ensure compliance. A business case has been sent to the CCG as additional funds are required to meet the commitment to the increased response and monitoring.

Child sexual abuse & exploitation, Criminal exploitation, County lines & Modern Slavery

1. The Independent inquiry into sexual abuse (IICSA)

The IICSA was established in 2015 to explore whether institutions were taking seriously, their duty of care to protect children from sexual abuse in England and Wales. It was set within a background of high profile cases of systematic failures including hospital staff being implicated in the facilitation of abuse in the Saville scandal. Subsequent high profile cases have involved celebrities, politicians and doctors who were previously trusted individuals.

2. Criminal exploitation & County lines

Criminal exploitation includes County Lines which is the police term for urban gangs supplying drugs to suburban areas and market and coastal towns using dedicated mobile phone lines or deal line. It involves gangs using children and vulnerable people to move drugs and money. It is a major issue involving drugs, violence, gangs, criminals, sexual exploitation, modern slavery and missing persons. The county lines activity has a devastating impact on children and young people, vulnerable adults and local communities.

According to the Brighton & Hove LSCB annual report there are an estimated 720 lines across England and Wales. At least 283 lines originate in London (conservative estimate) and these

predominantly impact forces in the south and east but some also affect forces further north. The Police and Brighton & Hove City Council have closed down over 20 premises in the past two years using Closure Orders under the 2014 Anti-Social Behaviour Policing and Crime Act. There have been incidents of violence associated with these addresses with knives and other weapons reportedly being used.

3. Modern Slavery Act 2015.

Child trafficking is a crime against a person and child smuggling is a crime against the state. **Human trafficking victims** are tricked, forced, threatened or coerced into moving to a situation where they are exploited for labour, sexual acts, domestic service, identity abuse, removal of organs or other criminal acts. This movement can be between countries or within their own country. **People smuggling** is a business transaction between a person wishing to enter a country illegally & their facilitator & always involves illegal border crossing.
The most common primary types of exploitation for referrals into the Child Trafficking advice centre (CTAC) service were criminal exploitation (65) sexual exploitation (72) and labour exploitation (43).

BSUH Actions

- BSUH continues to store notes which may be required by the IICSA and this will continue to have a financial impact.
- The BSUH safeguarding newsletter updated staff on modern slavery in May, June & August 2018.
- 2018/19 safeguarding training at all levels includes information and scenarios about criminal exploitation, sexual abuse & child sexual exploitation & modern slavery & how to respond using the sexual abuse referral centres (SARC) & local initiatives such as the adolescent, vulnerable & risk meeting (AVRM).
- As a result of the LSCB CSE audit, listening to the '*voice of the child'* has been promoted.
- The 2018/19 training on adverse child hood experiences (ACE) highlights the need to be trauma informed and think holistically about assessments and support.
- A member of the sexual health team represents BSUH on the AVRM.
- The sexual health team have a specific vulnerability assessment tool.
- Children's emergency department have a safeguarding assessment system which considers vulnerability including CP-IS checks.
- Adult A&E has screening questions which ask if an adult has children and if they are safe.
- NHS England 'Child Sexual Exploitation advice for healthcare staff' A pocket guide to provide practical information to healthcare staff to safeguard children and young people was introduced in January 2017, and has been added to the BSUH safeguarding web page.
- The chaperone guidance has been updated.
- The BSUH safeguarding web page has links to various information and resources about these topics

The impact of Mental health issues

Children and young people have their own mental health concerns which impact on their lives and they also may have to cope with parental mental health issues. Living in a household where parents or carers have mental health problems does not mean that a child will experience abuse or even be affected negatively in any way. With appropriate support, many parents with mental health problems are able to manage their condition and minimise its impact on their children. But sometimes it does affect their ability to cope with family life & this may affect children differently according to their age, development and personality.
Practitioners should assess whether a parent or carer's mental health problems pose a risk to the child's safety and wellbeing, and whether these risks can be mitigated with appropriate support.

BSUH Actions

- BSUH safeguarding training includes information on how parental mental health may affect children & young people.
- BSUH has included screening questions in A&E asking if adults have any children and if they are safe.
- The adult mental health liaison team is aware of assessing the impact of mental health issues on any children in the family.
- Staff are reminded of how to make safeguarding children referrals related to parental ill health.
- There is a paediatric mental health liaison team based at the children's hospital who support children and young people who attend with mental health issues. There are close links with CAMHS.
- A basic audit has been undertaken looking at adult presentation to A&E to highlight that children need to be considered when adults present..

Female Genital Mutilation (FGM)

In England, Wales and Northern Ireland, the Female Genital Mutilation Act 2003 made the practice of FGM and failure to protect a girl from FGM illegal. The Act also introduced Civil FGM Protection Orders, allowing for those who are at risk, or know someone at risk of FGM, to make an application to the Family Court to have the breach dealt with as a contempt of court.

The NHS England pocket guide highlights that FGM is child abuse.
Mandatory reporting by NHS hospitals continues.
NHS England launched the FGM Information Sharing (FGM-IS) system in maternity units across England. FGM-IS is a national IT system that allows healthcare professionals across England to systematically share information about a family history of FGM

BSUH Actions.

- The BSUH Trust FGM policy has been updated and includes risk assessment documents and information relating to support of women affected by FGM. It is linked to the Pan Sussex child protection procedures and various professional documents.
- BSUH continues to report anonymously the Victims of FGM which are disclosed. None have been under 18.

BSUH	2014	2015	2016	2017	2018
Disclosures	22	26	22	13	13

- BSUH has completed the maternity FGM-IS project of adding information onto the national spine for girls who may be affected by FGM.
- There are links with the Brighton VAWG (Violence against women and girls) and Front Door for families to ensure a strategic approach.
- The FGM pocket guide (NHS England) is available
- The Safeguarding Team continue to provide support when required.

CP-IS (Child Protection Information service)

CP-IS is the national system connecting local authorities child social care IT systems with those used by the NHS in unscheduled care settings, to provide information on those children who are considered to be at risk and are subject to a Care plan or are 'Looked After'. (https://systems.hscic.gov.uk/cpis).

Actions

- CP-Is is in place in children's emergency department, adult A&E at PRH maternity and using smart cards. It is to be introduced shortly to adult A&E at RSCH

- The IT support required for CP-IS has been explored and would cost £79,000 plus £11,000 annual support costs. The monitoring continues to be undertaken manually which is inefficient. However recent audits show the smart card system is being used.
- As some areas (eg. outpatients dept) do not have access to CP-IS the original flagging system continues to be used.

The General Data Protection Regulation (GDPR) and child protection. (NSPCC)

The General Data Protection Regulation (GDPR) came in to force on 25th May 2018. It is an EU law that sets out guidelines for the collection and processing of personal information and aims to give individuals more rights over how their data is used. GDPR is incorporated into the UK's domestic law under the powers in the European Union (Withdrawal) Act 2018, and will continue to apply to the UK after Brexit.

GDPR emphasises the importance of asking children for consent before sharing personal information.

If a child is mature enough you should give them the opportunity to decide whether they agree to their confidential information being shared. If a child doesn't have the capacity to make their own decisions, you should ask their parent or carer (unless this would put the child at risk).

However, if you have a child protection concern, you must share information with the relevant agencies, even if you have not been given consent. GDPR does not affect this principle.

PREVENT has continued to be high on the agenda during the last year. NHS Trusts are now obliged to 'have due regard to the need to prevent people from being drawn into terrorism', in accordance with the 'Prevent duty' outlined in Section 26 of the Act. WRAP (Workshop to Raise Awareness of Prevent) training has continued over the last year with sessions delivered during the mandatory training and ad hoc sessions. It should be noted that Brighton is a high priority area and the recent serious case review W&X indicates the need to be vigilant and assess children who may be traumatised as well as abused.

Training for trainers has recently been undertaken in BSUH to increase opportunities for training in individual/key areas.

The safeguarding professionals went to a training session on how the far right can affect the Prevent agenda as a reminder that it is not confined to stereotypical groups.

Corporate responsibilities & statutory Leads during 2018/19
Child Protection / Safeguarding Children workload

Corporate Responsibilities

The Chief Executive is the Accountable Officer of the Trust and as such has overall responsibility for ensuring it meets statutory and legal requirements and adheres to guidance issued by the Department of Health, Department for Education and Skills, Commissioners and local Safeguarding Children Boards.

The Safeguarding Children Lead Director is the Chief Nurse who is accountable to the Chief Executive and has delegated responsibility for safeguarding children and young people. The Chief Nurse oversees safeguarding children arrangements within the Trust and is the named person on its Local Safeguarding Children Board, supported by the Named professionals.

Each Trust has a statutory duty to provide a Named Nurse and Doctor and a Named Midwife if providing midwifery care. They are accountable to the Nurse Director & their role is to support other professionals in their agencies to recognise the needs of children, including rescue from possible abuse or neglect. Named professional roles should always be explicitly defined in job descriptions. Professionals should be given sufficient time, funding, supervision and support to fulfil their child welfare and safeguarding responsibilities effectively (Working together 2018).

BSUH Safeguarding Named Professionals		WTE
Lead Director	Chief Nurse	
Named Doctor	Consultant paediatrician	4pa
Named Nurse	Nurse Consultant Safeguarding Children & Young People	1.0
Safeguarding nurse	Job share currently	1.0
Liaison nurse		0.72
Named Midwife	Community midwifery matron	no ring fenced time
Safeguarding Midwife	Midwife	0.8
HR Lead	HR Director	

The Named Doctor provides clinical advice and Level 3 training to medical colleagues. The training programme includes teaching for paediatricians and other professionals working with children ensuring local knowledge is evidence based with external speakers attending to discuss their services.. She also attends local multiagency meetings to ensure good multidisciplinary working and networking within the community.

The consultant-delivered child protection medical service continues but the number of CP medicals are rising year on year. **(132 in 2018, 26 more than in the whole of 2017).**

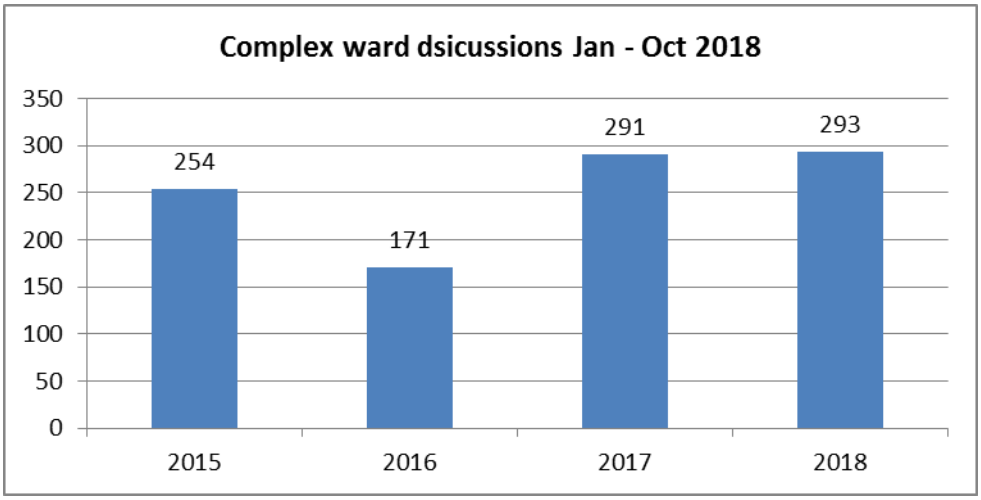
She is the primary chair at weekly peer review meetings, during these educational meetings complex cases are discussed providing peer support and education. This helps to maintain consistency and quality within the safeguarding process and report writing driving service improvement. Suggested amendments or clinical suggestions made by the quorate are communicated to the lead consultant.

She has an overview of complex cases, attending strategy meetings to support colleagues, or occasionally as their proxy. She has written numerous paediatric child protection guidelines for the trust. There is also an audit of injuries presenting to A&E in under one year olds and the use of consent forms for skeletal surveys in keeping with the most recent Royal College of Radiologists Guidelines - results being analysed.

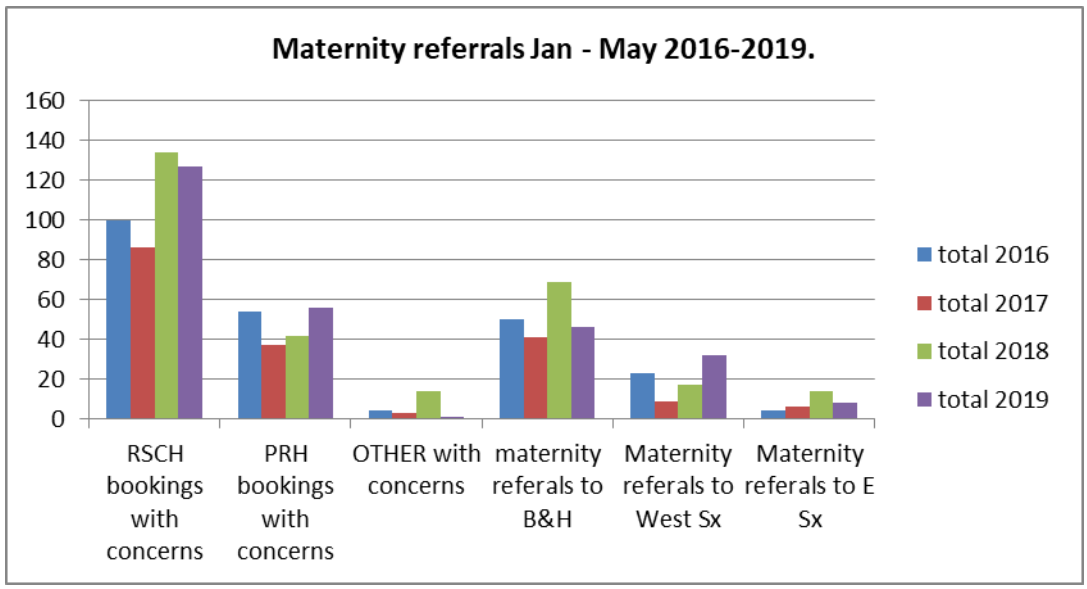
The Named Nurse and safeguarding team.

The Named Nurse is a statutory role and she is supported by a safeguarding nurse and the liaison nurse.

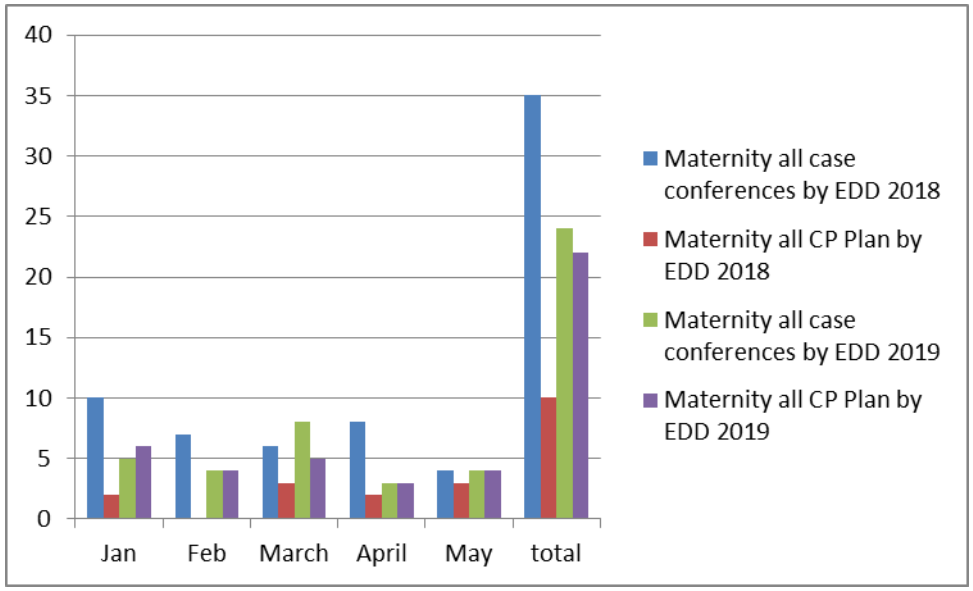
The daily ward round continues to ensure advice and co-ordination of care is available.
In 2018 from Jan – Sept 1133 discussions were needed & 293 were complex



The maternity referrals are also noted to be consistent year on year.



Although the number of case conferences has fallen in 2019 the number of children being put on a plan has risen suggesting a more complex caseload.



Governance & multiagency working during 2018-2019

The BSUH Safeguarding Children Steering Group Meets quarterly Chair Lead Director the Chief Nurse
1. Ensures internal governance arrangements are in place and effective and reports to the Board once a year. There are reports to the quality & performance committee twice a year & the CCG assurance group quarterly. 2. Works towards completing the BSUH safeguarding action plan. 3. Maintains and monitors the Section 11 audit with evidence available electronically and updated as required 4. Addresses & disseminates learning from Government strategic documents, SCR & audit.

Policies & guidance introduced or updated

1) The Safeguarding policy & FGM policy, has been updated in 2019.
2) The domestic abuse policy and supervision strategy is awaiting ratification.
3) Paediatric on line clinical guidance is available
4) Information sharing posters have been renewed.
5) The safeguarding children web page is up to date with links to various resources.

Audits undertaken

Section 11 audit & challenge	Ward discussion overview
Overview of CP medicals	Training evaluation
LSCB notes audit x 2 (Neglect & children who have been sexually abused, How is the Voice of the Child heard by LSCB partner agencies?)	Child referral form from adult area quality audit
	CP-IS documentation
FGM audit	The maternity documentation audit.

Training

The Trust learning and development strategy reflects the requirements in the Intercollegiate guidance. An updated version was written in Jan 2019.

All levels have explicit learning outcomes and a recommended length of time.

The content is based on learning from serious case reviews, LSCB outcomes, National and local topics of concern. Specifically in 2018 the subjects covered have been County lines, adverse child hood events, child sexual exploitation, assessment framework.

The total BSUH workforce requires some level of statutory safeguarding children training.

1. Level 1 (At induction & All non clinical staff) requires 3 yearly update.
2. Level 2 (All clinical staff who see adults) requires 3 yearly update
3. Level 3 (All clinical staff who see children **and unscheduled care - PRH A+E**) require annual update

The safeguarding team facilitated 188 sessions equating to approx. 300 hours of training.

The compliance levels are much improved & consistent.

Level 1 Oct figures= 94% March 2019 94%

Level 2 Oct figures = 88% March 2019 88%

Level 3 Oct figures = 84% March 2019 80%

The sessions continue to be well evaluated.
Training is monitored by Directorates and during personal appraisals.

Communication & IT

- Information sharing related to safeguarding should not be affected by the new General Data Protection Regulations (GDPR).
- Information sharing between the Trust and the community heath visitors and school nurse continues using the summary sheets (paragons).
- In B&H information relating to young people who self-harm is shared with key safeguarding leads in schools if the YP agrees.
- The BSUH staff safeguarding web site & monthly newsletter provides information.
- The CP-IS system and manual flagging system continues as a robust safeguarding checking system for all areas for those children/YP with a CP plan.
- A request for a central safeguarding page on Panda is being considered to ensure staff have a central point for safeguarding documentation.

Safeguarding Supervision

- There have been no changes to the process of Supervision due to lack of capacity.
- There have been no serious incidents in this timeframe.
- The Named Doctor & Nurse continue to fulfil their statutory role by offering supervision on a case by case basis & to those with complex caseloads.
- A weekly psycho-social meeting is facilitated to discuss cases and provide training. This is shared with the psychology team.
- The safeguarding midwife gives supervision to the maternity team, TMBU/SCBU, community midwives and those with high risk caseloads.
- Maternity safeguarding birth plans are filed in the mother's notes & in the baby notes.
- The safeguarding paperwork is filed in the child's notes.
- The Named professionals receive supervision from the designated professionals.
- There is monthly written feedback to the Nursing and Midwifery Board. This information should be disseminated to the Directorate teams via their quality and safety meetings

External regulation and inspection by LSCB, Care Quality Commission (CQC), commissioners (CCG) & JTAI (Joint targeted area inspections).

External monitoring of safeguarding arrangements based on the Section 11 (s11) of the Children Act (2004) is a responsibility of the LSCB (Local Safeguarding Children Board), Ofsted and the Care Quality Commission (CQC).

The bi-annual S11 audit was completed again combined with a peer challenge BSUH actions related to addressing the training figures, team staffing and the updating of the managing allegations policy.

The CQC interviewed the Named Nurse for children and the Lead Nurse for adults.

The CCG exception reports are provided on a quarterly basis and the main issues have related to training figures, the internal safeguarding review action plan, the new Looked after children (LAC) standards. & team review.

The JTAI themed inspections may occur at any time. The current topic for deep dive is about children who have been sexually abused within the family & those coping with mental health issues. The monitoring information has been given to the Designated Nurse for quick dissemination should a visit occur.

Partnership working

- Safeguarding is a shared responsibility dependant on excellent interagency and joint professional working. Strategic work is often set by local LSCB (Local Safeguarding Children's Board) in B&H and West Sussex which allows constructive challenge and the continual improvement of care.
- The Named Nurse and Named Doctor represent the Trust at the B&H LSCB Board meetings and various sub groups.
- The Named Nurse links to West Sussex and East Sussex Local Safeguarding Children Boards via the Designated Nurses and Designated Doctors for Child Protection, and the health sub group of the West Sussex LSCB..
- The BSUH Nurse Consultant represents the Trust at the various domestic abuse fora and the VAWG (Violence against women and girls) strategic meetings.

Reports written by the Named Nurse & contribution include:-

1. The section 11 audit completed for B&H LSCB & attended the challenge event
2. A report for B&H LSCB on the safeguarding children audits undertaken by BSUH
3. Contribution to 2 B&H audits
4. Contribution to serious case review x 3
5. A BSUH safeguarding update to contribute to the LSCB annual report.

Serious Case Review & themed reviews

Serious Case Reviews are held to investigate cases in order to learn from the event in a constructive way in order to improve services and multiagency working.

BSUH included these learning points within the training for 2019.

Within B&H One serious case reviews have been published this year. One concerned the death of a 17 year old boy and led the LSCB to evaluate the safeguarding response to children as they approach adulthood.
There are currently 2 cases being reviewed & learning will be shared later in 2019.

West Sussex SCR have not been listed but can be seen on the LSCB website. However some of the learning has related to injuries in children under 1 or child sexual exploitation.

The 2017/18 SCR system has been replaced with a system of national and local reviews. A National Panel has been established. This will be responsible for commissioning and publishing national reviews and investigating cases which will lead to national learning.
Local partners will be required to carry out reviews into cases which are considered to lead (at least) to local learning. These should be published.
The planned '*What Works'* Centre for children's social care will analyse and share lessons from local and national reviews.

Safeguarding Children Human Resources Report

Safer recruitment

All staff at the Trust are employed in accordance with the NHS pre-employment check standards. All relevant staff employed at the Trust undergo a DBS check prior to employment change or role or promotion and those working with children have an enhanced level of assessment.

Allegations against staff

The guidance on managing allegations against staff is being updated.

During the period 2018/19 there have been 5 incidents which have been discussed with the Local Authority Designated Officer (LADO) team. After exploration none reached child protection thresholds, however as a result the chaperone policy was updated and re-launched.

Paediatric Mental Health

The B&H CCG fund the mental health support service for children in B&H with long term health issues linked with BSUH and the Paediatric mental health liaison team (MHLT) which is the multi-disciplinary team (occupational therapy, nursing, psychiatry) which was established at Royal Alexandra Children's Hospital in Nov 2016. The service has been invaluable and operates between 9am-8pm Mon – Fri and 10am-6pm Sat, Sun and bank holidays and offers a service to the Royal Alexandra Children's Hospital patients, families and staff.

Improvements to the process for sharing information with schools in B&H has been introduced by gaining the YP consent to alert the safeguarding lead in the relevant school so support can be given.

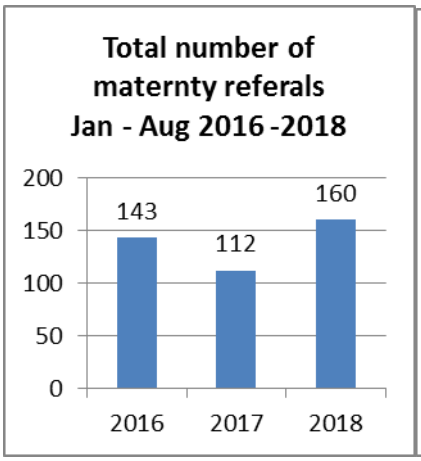
The RACH has recognised that staff feel apprehensive about caring for young people with mental health issues. Therefore have become involved with the **We Can Talk** project which has been developed directly in response to the views, experiences and needs of young people and those working in acute hospital settings. It has been co-produced with young people with lived experience of mental health difficulties, hospital staff and mental health professionals. For more information please visit www.wecantalk.online.

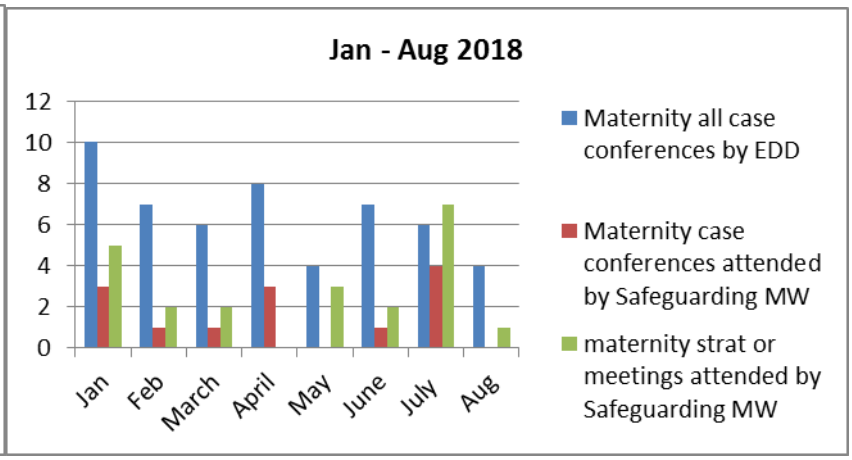
The safeguarding team have undertaken a basic audit of all YP who attend the children's emergency department with self-harming behaviour which has been shared with the CCG.
212 YP attended within a 3 month period Jan-March 2019.

Maternity Report

Achievements and Progress in relation to Maternity 2018/19

- At BSUH the Named Midwife role is combined with the community midwifery manager's post.
- The pre-birth safeguarding workload is rising as demonstrated below & a business case is being developed to increase the safeguarding midwife time in response to the risk involved.





- A 0.6 WTE Mental Health midwife has been recruited and this individual will support the safeguarding agenda for this caseload of women.
- Safeguarding supervision is given on a one to one basis with case oversight by the safeguarding midwife who also gives specific safeguarding supervision to the community midwifery teams and the specialist midwives.
- The community midwives have all received laptops which should improve the level of documentation for the midwifery booking process and sending referrals.
- The new maternity notes have improved information gathering about social issues & to review the risks at 28 & 36 weeks gestation. The documentation has been audited and the results will be fed back to the maternity team. Improvements need to be made in continuity & documentation.
- A shared drive has been implemented to ensure child protection plans are available to key senior staff ensuring good transfer of information minimising error.
- Midwives continue to ask routinely about FGM but the figures continue to suggest that this area does not have a large population of women who are victims of FGM.
- The Level 3 safeguarding and domestic abuse training compliance has improved to stand at over 84%.

Maternity Action plan 2019-2020

- The statutory named midwife role is being reviewed and funding considered within the workforce planning.
- To support the new Mental Health midwife in relation to safeguarding children for this caseload of women.
- A review of safeguarding supervision is required to ensure staff are supported and a quality service is maintained.
- To continue to monitor and audit the pre-birth safeguarding workload and make recommendations as required (ongoing).
- To implement any recommendations from any serious case reviews. (B&H Baby Alex)

Domestic Violence and Abuse Report (DVA)

Domestic abuse takes many forms, from physical and sexual abuse, to controlling and coercive behaviour that isolates victims from their families and has long-term, shattering impacts on their children. It affects those from all walks of life and victims can be young and old. The SafeLives' Impact Report 2017-18 documents that **'***People impacted by domestic abuse live behind any front door, work in any office, live on any street. They are our colleagues and our friends. They are the nurses who patch us up, the police officers who keep us safe, the teachers who support our kids. They are our colleagues and our friends.'*

Of all the babies born in the UK today - and every day – around 250 of the girls will go on to have an abusive relationship in later life, unless changes are made. In total, we know 1.5 million girls and 700,000 boys (0-15 years olds) in the UK today will grow up to have an abusive partner at some point in their adult life. (Safelives website Oct 2018)

Achievements and Progress in relation to Domestic Abuse 2018/19

1. The BSUH domestic abuse policy has been updated & awaits ratification.
2. The NICE Quality Standard – Gap analysis action plan has been completed.
3. The Domestic abuse training continues with the help of the HIDVA as part of the level 2 training and other specific areas such as A&E & maternity. 891 people had specific training.
4. The B&H CCG are funding Health independent domestic abuse advocate/advisor until March 2019, currently proposals are being made for this funding to continue,
5. The IDVA info sharing agreement was updated in May 2018
6. Posters and the use of 'amber cards' and 'bar code tissues' help promote the service.
7. There were 158 referrals to HIDVA service Sept 2017 – Sept 2018
   - 85 short term pieces of work
   - 80% patients engaged with HIDVA service.
   - 19 (12%) have been identified as high risk of harm from DV.
8. BSUH is represented at the various strategic groups relating to Domestic abuse and to Violence against Women and Girls (VAWG).
9. MARAC (Multi-agency Riask assessment committee) co-ordinates planning for high-risk cases of domestic abuse, stalking and 'honour'- based violence. In 2018 the BSUH commitment is considered to total 3 -4 days pcm but the changing format of the MARAC & issue of increasing numbers has been escalated to the CCG.
10. The process of flagging of Victims discussed at MARAC has been implemented by the safeguarding children team.

Domestic Abuse Action plan 2019-2020

- To review how BSUH supports the domestic abuse strategic agenda.
- To review and continue the BSUH commitment to the B&H MARAC.
- To continue to link with the B&H VAWG strategy
- To continue to support the current domestic abuse training available within BSUH
- To work with the CCG to provide evidence of the success of the HIDVA project so that funding will continue.
- To monitor the flagging system for those people who are discussed at MARAC.

Key issues & Action plan for 2019 – 2020

As the safeguarding agenda is continuously developing, in both its complexity and scope, our priorities and processes must also evolve while still keeping sight of the fact that safeguarding is everyone's business irrespective of role or position

The new 'Working Together' 2018 document has been published and BSUH will need to respond to the changes to the LSCB's which are moving to become Safeguarding partnerships, and the transition from Serious Case Reviews to National and Local Reviews.

In addition to general statutory requirements which apply to the whole Trust, there are specific action plans for various specialities within the BSUH Trust itemised and monitored in the Safeguarding children committee action plan which will obviously respond to additional issues which arise through out the year.

1. To participate in the new safeguarding partnership arrangements which replace the LSCB
2. To complete the review of the safeguarding children team and ensure that it is fit for purpose as was suggested in the internal review & previous annual reports.
3. To continue to have Directorate assurance & evidence that 'safeguarding children' is discussed and that staff are aware of their role and responsibilities.
4. To update any safeguarding policies which become out of date in 2020.
5. To audit the 'Facing the future: standard for children in emergency care settings'. (RCPCH, 2018) and updated standards for safeguarding children and young people in emergency care settings in the UK.
6. To continue to raise awareness and embed the skills and knowledge around learning relating to safeguarding children.
7. To implement the CP-IS process in RSCH adult A&E setting and work toward making it an electronic system linked with symphony.
8. Continue & complete the work itemised in the Safeguarding Children & Young People Committee action plan.
9. To ensure the maternity action plan is addressed and the named midwife role is reviewed.
10. To ensure the domestic abuse action plan is addressed & that the IDVA service is supported.

Debi Fillery
Nurse Consultant Safeguarding Children and Young People
May 2019

NHS
Brighton and Sussex University Hospitals NHS Trust

Safeguarding Adult & Children Annual Report

July 2019

Safeguarding Adult

Brighton and Sussex University Hospitals NHS Trust

Success

- Training compliance
- Internal audit – all actions complete

Challenges

- Workforce vacancy
- MCA

Safeguarding Adult

Brighton and Sussex University Hospitals NHS Trust

Priorities 19/20

- Patient experience breakthrough objective
  - Improving the discharge experience for patients
- Reduction in Section 42 relating to discharge
- Review the TNA for Safeguarding Adults, Prevent & MCA in line with Intercollegiate Document, increasing training compliance

Safeguarding Child

Brighton and Sussex University Hospitals NHS Trust

Success

- Increase in Training compliance
- Resources to promote resources

Challenges

- Increase in activity
- Balancing workforce and activity

Safeguarding Child

Brighton and Sussex University Hospitals NHS Trust

Priorities 19/20

- Review of TNA for Safeguarding Children
- Participate in the new safeguarding partnership arrangements which replace the LSCB.

Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	18	**Meeting:**	Board of Directors	**Meeting Date:**	24/07/19
Report Title:	CNST Maternity Safety Standards				
Sponsoring Executive Director:	Clare Williams				
Author(s):	Kim Rogers / Sue Alcock				
Report previously considered by and date:					
Purpose of the report:					
Information	☐		Assurance	☐	
Review and Discussion	☐		Approval / Agreement	✓	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	☐		Staff confidentiality	☐	
Patient confidentiality	☐		Other exceptional circumstances	☐	
Link to Trust Strategic Themes:					
Patient Care	✓		Sustainability	✓	
Our People	☐		Quality	✓	
Systems and Partnerships	☐				
Any implications for:					
Quality	Improved patient outcomes in Maternity and Neonatology				
Financial	Worth 10% of annual maternity premiums (£865k) plus possibility of additional monies dependent on size of pot.				
Workforce					
Link to CQC Domains:					
Safe	✓		Effective	✓	
Caring	✓		Responsive	✓	
Well-led	✓		Use of Resources	✓	

Communication and Consultation:

For internal review and approval at Trust Board

Executive Summary:

For the second year, NHS Resolution is running the Clinical Negligence Scheme for Trusts (CNST). Trusts that can demonstrate they have achieved all ten maternity safety actions will recover the element of their contribution to the CNST maternity incentive fund (£865,022 for BSUH) and will receive a share of any additional unallocated funds.

Last year BSUH successfully met all ten criteria, securing a total of just under £1.5million.

The 10 criteria are as follows:

1. Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?
2. Are you submitting data to the Maternity Services Data Set to the required standard?
3. Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme (ATAIN)?
4. Can you demonstrate an effective system of medical workforce planning to the required standard?
5. Can you demonstrate an effective system of midwifery workforce planning to the required standard?
6. Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?
7. Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?
8. Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?
9. Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-

monthly with Board level champions to escalate locally identified issues?
10. Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?

BSUH has successfully achieved compliance in 2019 for all ten safety actions and has provided commentary and evidence to the Board. The Board must consider the evidence and nominate a signatory to complete the Board declaration form for submission to NHS Resolution.

It should be noted that Trusts do need to submit the report or any evidence to NHS Resolution. NHS Resolution will use external data sources to validate some of the trust's responses, as detailed in the technical guidance.

Key Recommendation(s):

- Confirmation from the Board they accept BSUH's compliance with the ten maternity safety actions.
- Confirm who will act as signatory to the declaration (Appendix 2) on behalf of the Board
- Approve Action Plan (Appendix 1)

CNST Maternity Safety Standards

Brighton and Sussex University Hospitals NHS Trust

1. INTRODUCTION

1.1 For the second year, NHS Resolution is running the Clinical Negligence Scheme for Trusts (CNST). Trusts that can demonstrate they have achieved all ten maternity safety actions will recover the element of their contribution to the CNST maternity incentive fund (£865,022 for BSUH) and will receive a share of any additional unallocated funds.

1.2 Last year BSUH successfully met all ten criteria, securing a total rebate of just under £1.5million.

1.3 A working group has met regularly to collate evidence and commentary for the Board to evidence BSUH compliance with the ten maternity safety actions.

2. FORMAL VALIDATION PROCESS

2.1. Trusts are expected to provide a report to their Board (this Report) demonstrating achievement, with evidence, of each of the ten actions. The Board must consider the evidence and complete the Board declaration form for submission (Appendix 2).

2.2. Completed Board declaration forms must be discussed with the commissioner(s) of the trust's maternity services, signed off by the Board and then submitted to NHS Resolution by 12 noon on Thursday 15 August 2019.

2.3. It should be noted that Trusts do need to submit the report or any evidence to NHS Resolution. NHS Resolution will use external data sources to validate some of the trust's responses.

2.4. Board declaration forms will be reviewed by NHS Resolution and discussed with the Collaborative Advisory Group. There is currently no indication of when NHS Resolution will provide a response.

3. ACTION REQUIRED

3.1. The evidence to meet the Safer Standards for Maternity Care has been put forward, reviewed and approved by the Divisional Director of Operations, Interim Chief Nurse and Chief Medical Officer. The Board of Directors is now asked to self-certify the Trust is compliant to the ten standards based on the Safer Standards for Maternity Care.

3.2. The Board is also asked to review and approve the Action Plan to reduce junior doctors lost educational opportunities due to rota gaps (Appendix 1)

4. MAIN REPORT – EVIDENCE OF ACHIEVING THE 10 SAFETY ACTIONS

Board Report on Brighton & Sussex University Hospitals Trust progress against the Clinical Negligence Scheme for Trusts (CNST) initiative scheme maternity safety actions

Date: July 2019

Further information about the CNST scheme, including the technical guidance, can be found at www.resolution.nhs.uk

1. Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths	Met Y/N
Required Standard *a) A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 have been started within four months of each death.* *b) At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death.* *c) In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought.* *d) Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans.*	
Trust's Commentary and Evidence The Trust is using the National Perinatal Mortality Review Tool (PMRT) which became available from the Department of Health in February 2018. The tool is used to review all perinatal deaths from 22+0 gestation to 28 days after birth as well as babies who die after 28 days following neonatal care. The tool was developed to ensure a national standardised approach and high quality reviews across England, Scotland and Wales. For BSUH there were a total of 11 eligible cases during the time period (from 12 December 2018 to present), 6 at PRH and 5 at RSCH (Item 1.2). 100% of reviews were started within four months of each death. Monthly PMRT meetings are booked for the year ahead alternately at PRH and at RSCH (Item 1.1). Additional resource has been secured to ensure that all reviews take place within 4 months. For all cases the dedicated Bereavement Midwife will contact parents and incorporate their views to the review. Parents are always made aware of the review. Additionally, a leaflet developed for parents, which explains the review process, is currently going through the approval process (Item 1.3).	**Yes**

PMRT is discussed at Directorate Level Safety & Quality Meetings with local action plans created for each case. If required, cases are escalated to the Quality Governance Steering Group chaired by the Medical Director. The Board receives a monthly quality report from the steering group which is used to escalate business, no PMRT cases have been escalated over the last 12 months. The Trust follows an exception reporting model and the governance structure is attached as Item 1.4 for reference.  1.1 PMRT Meeting Dates 2019.pdf  1.2 PMRT Cases (names removed).xls  1.3 PMRT - Patient information leaflet.do  1.4 BSUH Governance Structure	
2. Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	**Met Y/N**
Required Standard *This relates to the quality, completeness of the submission to the Maternity Services Data Set (MSDS) and readiness for implementing the next version of the dataset (MSDSv2).*	
Trust's Commentary and Evidence The Maternity Services Data Set (MSDS) is a patient-level data set that captures key information at each stage of the maternity care pathway including mother's demographics, booking appointments, admissions and re-admissions, screening tests, labour and delivery along with baby's demographics, admissions, diagnoses and screening tests. The MSDS at BSUH has been submitted in line with required standards and deadlines from October 2018 to April 2019. Item 2.1 is evidence from NHS Digital that MSDS to January 2019 meets all standards, this report is not yet available for data to April 2019. Site specific data is not available.  2.1 MSDS Scorecard from NHS Digital.xlsx	**Yes**
3. Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?	**Met Y/N**
Required Standard *a) Pathways of care for admission into and out of transitional care have been jointly approved by maternity and neonatal teams with neonatal involvement in decision making and planning care for all babies in transitional care.* *b) A data recording process for transitional care is established, in order to produce commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2.* *c) An action plan has been agreed at Board level and with your Local Maternity Systems (LMS) and Operational Delivery Network*	

(ODN) to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews. *d) Progress with the agreed action plans has been shared with your Board and your LMS & ODN*	
Trust's Commentary and Evidence NHS Improvement identified 20% of admissions of full term babies to neonatal units could be avoided. Avoiding Term Admissions Into Neonatal units (ATAIN) has been introduced as a national programme to reduce harm leading to avoidable admissions to neonatal units for babies born at or after 37 weeks, it focuses on: •respiratory conditions •hypoglycaemia •jaundice •asphyxia (perinatal hypoxia-ischaemia) The Trust operates a full transitional care service in line with national criteria and covers both PRH and RSCH sites. It is fully embedded at BSUH and continues to be delivered in line with the programme framework, therefore much of the evidence remains as 2018 (Items 3.1 to 3.4). The ATAIN 2019-20 Action Plan (Item 3.5) was provided to the Board in March 2019 for review and discussion and was well received (Item 3.6). 3.1 Care of the Newborn Immediately 3.2 Hypoglycemia Pathway - Postnatal \ 3.3 Newborns with Signs of Resp Distres 3.4 Coding for Transitional Care.doc 3.5 ATAIN Action Plan 2019-20.xlsx 3.6 BSUH Board Cover Sheet and exti	**Yes**
4. Can you demonstrate an effective system of medical workforce planning?	**Met Y/N**
Required Standard *a) Formal record of the proportion of obstetrics and gynaecology trainees in the trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey question: 'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.' In addition, a plan produced by the trust to address lost educational opportunities due to rota gaps.* *b) An action plan is in place and agreed at Board level to meet Anesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6.*	
Trust's Commentary and Evidence Every year the General Medical Council (GMC) carry out a survey that is sent to all training doctors. The national training surveys are a core part of the work carried out to monitor and report on the quality of the postgraduate medical education and training in the UK. Item 4.1, slide 18, shows that 83% of responders disagreed with the statement ''In my current post, educational/training	**Yes**

opportunities are rarely lost due to gaps in the rota". An Action Plan has been developed (Appendix 1) to address these issues, once this is approved by the Board it will be sent to Royal College of Obstetricians and Gynecologists (RCOG) prior to the CNST submission deadline. An audit of Anesthesia Clinical Services Accreditation (ACSA) standards (Item 4.2) finds that we are fully compliant with all standards and so no action plan is required.  4.1 O and G - question item breakdo  4.2 ACSA Standards (CNST).xlsx	
5. Can you demonstrate an effective system of midwifery workforce planning?	**Met Y/N**
Required Standard *a) A systematic, evidence-based process to calculate midwifery staffing establishment has been done.* *b) The obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during that shift) to enable oversight of all birth activity in the service* *c) Women receive one-to-one care in labour (this is the minimum standard that Birthrate+ is based on)* *d) A bi-annual report that covers staffing/safety issues is submitted to the Board*	
Trust's Commentary and Evidence The National Maternity Review, Better Births, a five year forward view (2016) called for care to become safer and more personalised, focusing on workforce as a core factor in achieving this. Birthrate Plus® is the only national tool available for calculating midwifery staffing levels. By working with individual trusts to understand their activity, case mix, demographics and skill mix Birthrate Plus® can calculate an individual ratio of clinical midwives to births for maternity services. The Trust has purchased the Birthrate+ Acuity Tool, which recommends a staffing ratio of 1:26 (Item 5.1). A subsequent business case had led to an increase in establishment of 14 WTE which along with a reduction in birthrate has improved the ratio to 1:27. Maternity Co-ordinations have supernumerary status, Workforce Templates are provided for maternity services at RSCH and PRH (Items 5.2 and 5.3). The monthly Maternity Dashboard (Item 5.4) evidences 100% compliance with targets of 1:1 care in labour. The department has sustained 99-100% compliance with this standard since August 2017. The process for ensuring adequate workforce numbers includes a weekly meeting, with minutes distributed to all staff (Item 5.5). Staff maybe re-allocated to ensure adequate cover, maternity bank staff are available and daily huddles ensure adequate resource on the day. A Daily Acuity Dashboard (Item 5.6) is used at PRH and RSCH units to show the number of midwives allocated to the delivery suite and patient activity. To cover last minute sickness the team has a text group to contact midwives for bank availability.	**Yes**

The Red Flag Procedure is provided as Item 5.8. In line with the policy all incidents are reported onto the Datix system which includes details of review, lessons learnt and actions identified. Over the past 12 months there was one red flag incident reported by maternity services in relation to workforce issues, this was related to a delay of more than 30 minutes in providing pain relief. The incident was reviewed and investigated by the Risk Co-ordinator in line with the Trust's incident review process.

The Midwifery Escalation Protocol (Item 5.6) includes issues with midwifery staffing levels if this resulted in clinical risk. The suite of BSUH workforce tools and processes has led to effective mitigation of unit closures, having had zero closures over the last two years.

A Nursing Workforce Report is regularly submitted to the Board, the report from January 2019 is submitted as evidence (Item 5.9)


5.1 BSUH BR+ Final Report Dec 2017.pdf


5.2 WF Template Mat RSCH - 0017405.


5.3 WF Template Mat PRH - 0017406.x


5.4 Workforce Measures Mat Dashb


5.5 Weekly update 1ST JULY 2019.docx


5.6 Daily Acuity Dashboard.pdf


5.7 MP058 Midwifery Escalation Protocol V3


5.8 Red Flag Procedure.pdf


5.9 Nursing Workforce Report to

6. Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?	Met Y/N
Required Standard *Board level consideration of the Saving Babies' Lives (SBL) care bundle (Version 1 published 21 March 2016) in a way that supports the delivery of safer maternity services.* *Each element of the SBL care bundle implemented or an alternative intervention in place to deliver against element(s).*	
Trust's Commentary and Evidence Despite falling to its lowest rate in 20 years, one in every 200 babies is stillborn in the UK which is more than double the rate of nations with the lowest rates. The Saving Babies' Lives Care Bundle (SBL) brings together four key elements of care based on the best available evidence and practice in order to help reduce stillbirth rates; 1.Reducing smoking in pregnancy 2.Risk assessment and surveillance for fetal growth restriction 3.Raising awareness of reduced fetal movement 4.Effective fetal monitoring during labour	**Yes**

At BSUH the criteria for all four elements of Saving Babies' Lives (SBL) have been followed since being introduced in 2016 and all standards are currently met.

BSUH aims to support women to stop or reduce smoking in pregnancy. We record smoking status for all women at booking (item 6.6) and offer carbon monoxide testing and refer if to smoking cessation services if accepted.

Women have access to leaflets (Item 6.5) for monitoring fetal movements and the Day Assessment Unit Protocol (Item 6.3) is available to staff when women are seen at outpatients outside of normal antenatal appointments.

Fetal movement is discussed at every appointment and the pathway for reduced fetal movement is followed for women with reduced episodes of fetal movement (Item 6.2).

We have a robust fetal monitoring guidance policy (Item 6.4) and use the fresh eyes approach for all women in labour.

All women have symphysiofundal height measured at each antenatal appointment which can identify growth outside of normal range and where required women are referred to the day assessment unit for review and ongoing management.


6.1 Growth Assessment Protocol


6.2 Reduced Fetal Movements Protocol.


6.3 Day Assessment Unit Protocol.pdf


6.4 Fetal Heart Monitoring Protocol.p


6.5 My Babys Movements (leaflet).p


6.6 Smoking Status at Booking.docx

7. Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?	**Met Y/N**
Required Standard *User involvement has an impact on the development and/or improvement of maternity services.*	
Trust's Commentary and Evidence A Maternity Voices Partnership (MVP) is a NHS working group: a team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care. BSUH regularly attend Maternity Voices Partnership (MVP) meetings for our local partnerships in Brighton & Hove and Mid-Sussex (minutes provided in Item 7.1) and other joint meetings. Minutes provide evidence of actions and BSUH involvement including improving prevention. The meeting is chaired by a parent demonstrating user engagement. Walking the Patch report (Item 7.2) shows feedback collected from 67 new mums at RSCH which provides both qualitative and	**Yes**

quantitative feedback. Item 7.4 is a locally produced presentation of the 2018 maternity survey results (conducted by Picker) and the actions that are being developed in response to local findings.

In March 2019, the Whose Shoes event at Brighton was held incorporating commissioners, service users and families, the MVPs and staff from all areas of the service. The event uses a thought provoking board game as a catalyst to meaningful discussion and pledges to inform rapid and long term improvement actions. Subsequently, the Whose Shoes game is also now used on education days and staff local inductions.

BSUH Friends and Family Test (FFT) for June 2018 are shown in the table below. It can be seen that we receive excellent results with between 95% and 100% recommendation levels. The overall response rate for all maternity services since January is 21% which is higher than the national average.

	Birth Services		Postnatal Services	
	Responders	**Would Recommend**	**Responders**	**Would Recommend**
PRH	11	100%	35	94.2%
RSCH	67	98.5%	37	97.3%
Total recommendation	78	99%	72	95%

7.1 Minutes from MVP March 2019.pdf

7.2 Walking the Patch 2018 (RSCH).p

7.3 Fifteen Steps to Maternity (PRH).docx

7.4 Maternity Picker Survey Results and A

8). Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	**Met Y/N**
Required Standard *90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year.* ***Required Evidence*** *Evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year through Board sight of a staff training database or similar.*	
Trust's Commentary and Evidence The Trust's Statutory and Mandatory (STAM) training includes in-house multi-professional maternity skills training, unannounced skills and drills and TOAST (Team Obstetrics and Anaesthetic Simulation Training). TOAST is a one day course that was designed at Whipps Cross & Barts NHS trust in London. The faculty consists of an Obstetrician, Anaesthetist and Midwife educator. The course focuses on team building and understanding individual's roles and	**Yes**

responsibilities to improve professional relationships. It includes simulation but predominantly is group work and sharing how we can enhance effective team performances. The course has 15 candidates from the MDT to include: obstetric consultant, registrar, SHO, midwives, theatre team, anesthetists and maternity support workers.

The department's training year runs from January to December and where training has not yet been attended, it has been scheduled within the training year.

Staff Group	All staff	Attended training in training year	% Attended
Midwives	267	242	91%
OBS Cons	10	9	90%
OBS Drs	20	18	90%
Anaesthetists	10	10	100%
Support	45	40	90%
Theatre	5	5	100%
All	357	324	91%

9. Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues? — **Met Y/N**

Required Standard

a) The Executive Sponsor for the Maternal and Neonatal Health Safety Collaborative (MNHSC) is actively engaging with supporting quality and safety improvement activity within:
i. the trust
ii. the Local Learning System (LLS)
b) The Board level safety champions have implemented a monthly feedback session for maternity and neonatal staff to raise concerns relating to relevant safety issues
c) The Board level safety champions have taken steps to address named safety concerns and that progress with actioning these are visible to staff

Trust's Commentary and Evidence — **Yes**

Maternity safety champions at every level – trust, regional and national – work across regional, organisational and service boundaries to develop strong partnerships and promote the professional cultures needed to deliver better care. They play a central role in ensuring that mothers and babies continue to receive the safest care possible by adopting best practice.

At BSUH the Board level safety champion is currently the Chief Medical Officer, who chairs the Quality and Governance Steering Group, previously this was the Chief Nurse however there is currently a vacancy in the substantive role. The Divisional level safety leads are the Head of Midwifery and Lead Obstetrician.

A number of agendas and presentations (Items 9.1 to 9.4) are provided as examples of safety events, meetings and networks which the safety champions have recently attended. Local Learning System (LLS) meetings have been attended along with regional events. Regular one to ones are held between Board level and Divisional level safety champions.

The service has been actively working with the Health Safety Investigation Branch (HSIB) since May 2018 and the Board level and Divisional level safety champions have recently met twice with HSIB to discuss findings following the conclusion of investigations into several referred cases, and further engagement sessions are scheduled.

The Maternity Dashboard (Item 9.7) provides risk and safety performance measures and is available to all staff – specifically under the 'Clinical Indicators' category.

Performance against safety metrics are reviewed as part of the Trust's Strategic Delivery Review (SDR) framework which reports to the Executive Team. This process ensures in-depth analysis of performance, identification of contributory factors and the development of sustainable action plans for improvement. An example of this is the Countermeasure Summary for 3rd and 4th degree tears (Item 9.8). This improvement project has realised a substantial reduction of tears with an average rate of 2.3% for the last 6 months, from a high of 7.7%

At service level, Band Representative Meetings are held monthly, at RSCH and PRH, and provide a regular forum to raise and discuss issues including safety. The Action Log from a Band Representative Meeting is provided as Item 9.9 , where relevant concerns are escalated through the governance system. The Trust's Freedom to Speak up Guardian provides a way for staff to escalate concerns and risks that will affect staff and patients safety. The Guardian provides a quarterly report to the Board ensuring that they have oversight of concerns raised by staff.


9.1 Agenda 1 - LMS Safety Event Agenda


9.2 Agenda 2 - Safety Champion Saf


9.3 MASTER - Safety Champions Breakout.


9.4 MASTER - Safety Event Agenda (Circ).


9.5 MatNeo Collaborative Survey


9.6 Deterioration of either mother or baby


9.7 BSUH Maternity Dashboard 201905.x


9.8 CMS 3rd and 4th degree.pptm


9.9 Band Representatives Mee

10. Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	**Met Y/N**
Required Standard *Reporting of all qualifying incidents that occurred in the 2018/19 financial year to NHS Resolution under the Early Notification scheme reporting criteria.*	

Trust's Commentary and Evidence From 1 April 2017 it was required to report within 30 days all maternity incidents of potentially severe brain injury, namely all babies born at term (≥37 completed weeks of gestation), following labour, that had a potentially severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the categories: • Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) or • Was therapeutically cooled (active cooling only) or • Had decreased central tone AND was comatose AND had seizures of any kind At BSUH the legal services department are be informed by clinical teams within 14 days that a notifiable severe brain injury incident has occurred. The trust legal services department report the incident to NHS Resolution within 30 days of the incident. There were a total of seven Early Notification Scheme (ENS) cases that qualified within the reporting period. With a further two cases were reported but did not qualify. Cases are monitored through direc escalated to the Patient Safety Group (attended by the legal department) if there is learning of note, no cases have been escalated over the time period. Cases are monitored through Directorate Level Safety & Quality Meetings in line with the departmental governance process. If required, cases are escalated to the Patient Safety Group in line with the Trust's exception reporting model.  10.1 ENS April 18 to March 19.xlsx	**Yes**

5. NEXT STEPS AND RECOMMENDATIONS

5.1. Confirmation from the Board they accept BSUH's compliance with the ten maternity safety actions (at Trust Board 24/7/19)

5.2. Confirm who will act as signatory to the declaration (Appendix 2) on behalf of the Board (at Trust Board 24/7/19)

5.3. Share the report and evidence with Commissioners, it should be noted that Commissioners' formal approval is not required (Kate Hassan)

5.4. Send the Action Plan (Appendix 1) to Royal College of Obstetricians and Gynecologists (Kim Rogers)

5.5. Ensure signature and submit the signed declaration form (Appendix 2) by mid-day 15 August 2019 (Kim Rogers)

Appendix 1 – Action Plan Junior Doctors

Action Plan to reduce junior doctors lost educational opportunities due to rota gaps					
Baseline 2018/19		83% of junior doctors disagreed with the statement that 'In my current post, educational/training opportunities are rarely lost due to gaps in the rota'			
Item No	**Improvement Action**	**Lead Responsible**	**Expected date for completion**	**RAG rating**	**Progress/comments**
1	Appoint 2 MTI posts	Tosin Ajala / Holly Reid	01/09/2019		Awaiting visas
2	Appoint a minimal access fellow	Tosin Ajala / Holly Reid			Completed
4	Seek opportunities for academic posts (research/education)	Ryan Watkins	01/12/2019		In progress
5	Appoint a resident consultant on call	Jo Sinclair	01/10/2019		Job plan in preparation
6	Provide protected study leave time to allow for ultrasound training	Sonali Kaushik	01/01/2019		Complete
7	Provide protected teaching time on a Tues PM (bleep free)	Sonali Kaushik	01/01/2019		Complete
8	Provide 30mins teaching time in every OP clinic	Sonali Kaushik / Holly Reid	01/01/2019		Plan prepared but delayed until RTT position improved
9	Appoint colposcopy fellow	Vuivun Wong / Holly Reid	01/07/2019		Advert out
10	Consider introduction of ACPs to specialty. Engaging with HEE Workforce Transformation Team	Ryan Watkins	01/01/2020		Meeting being scheduled with HEE WTT

Appendix 2 – CNST Board Declaration Form

Maternity incentive scheme - Board declaration Form

Trust name	**Brighton & Sussex University Hospitals NHS Trust**
Trust code	**T631**

An electronic signature must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT			-	
Q2 MSDS			-	
Q3 Transitional care			-	
Q4 Medical workforce planning			-	
Q5 Midwifery workforce planning			-	
Q6 SBL care bundle			-	
Q7 Patient feedback			-	
Q8 In-house training			-	
Q9 Safety Champions			-	
Q10 EN scheme			-	
Total safety actions	-	-		
Total sum requested			-	

Sign-off process:	
Electronic signature	
For and on behalf of the board of	Brighton & Sussex University Hospitals NHS Trust
Confirming that:	

The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

The content of this form has been discussed with the commissioner(s) of the trust's maternity services

If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)

We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group will escalate to the appropriate arm's length body/NHS System leader.

Name:	
Position:	
Date:	

Brighton and Sussex University Hospitals NHS Trust

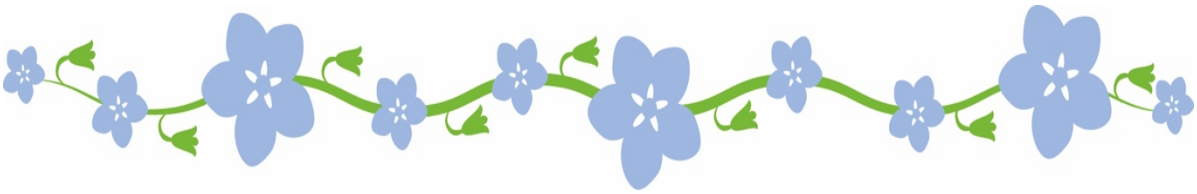
Agenda Item:	19	**Meeting:**	Trust Board	**Meeting Date:**	24 July 2019
Report Title:	Dementia Strategy 2019-2022				
Sponsoring Executive Director:	Clare Williams, Interim Chief Nurse				
Author(s):	Katy Mundy, Lead Dementia Nurse				
Report previously considered by and date:					
Purpose of the report:					
Information		✓	Assurance		☐
Review and Discussion		☐	Approval / Agreement		✓
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		☐	Staff confidentiality		☐
Patient confidentiality		☐	Other exceptional circumstances		☐
Link to Trust Strategic Themes:					
Patient Care		✓	Sustainability		☐
Our People		✓	Quality		✓
Systems and Partnerships		☐			
Any implications for:					
Quality	Nothing to note				
Financial	Nothing to note				
Workforce	Maintain compliance with training at Tier 1/2				
Link to CQC Domains:					
Safe		✓	Effective		☐
Caring		✓	Responsive		✓
Well-led		✓	Use of Resources		☐
Communication and Consultation:					
Key stakeholders who led and acknowledged in the Strategy and the Dementia Steering Group					
Executive Summary:					
The Dementia Strategy outlines the trusts approach to the care of our patients with Dementia and sets out a 3 year action plan for delivery.					
Key Recommendation(s):					
The Committee is asked to note the report and approve					

BSUH Dementia Service

NHS Brighton and Sussex University Hospitals NHS Trust

Dementia Strategy

2019 - 2022



Brighton and Sussex University Hospitals NHS Trust

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Introduction

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

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

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

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

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

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

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

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

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

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

Brighton and Sussex University Hospitals NHS Trust

Dementia Strategy Statement

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

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

Strategy Focuses

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

Coming into Hospital

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

Ongoing Care/Environment

- A reduction in inpatient bed moves
- Individualised responsive person centred care planning
- Right professional leading on care
- Partnership working with family , carers and loved ones
- Management of behavioural and psychological symptom's

Discharge Planning and Community Links

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

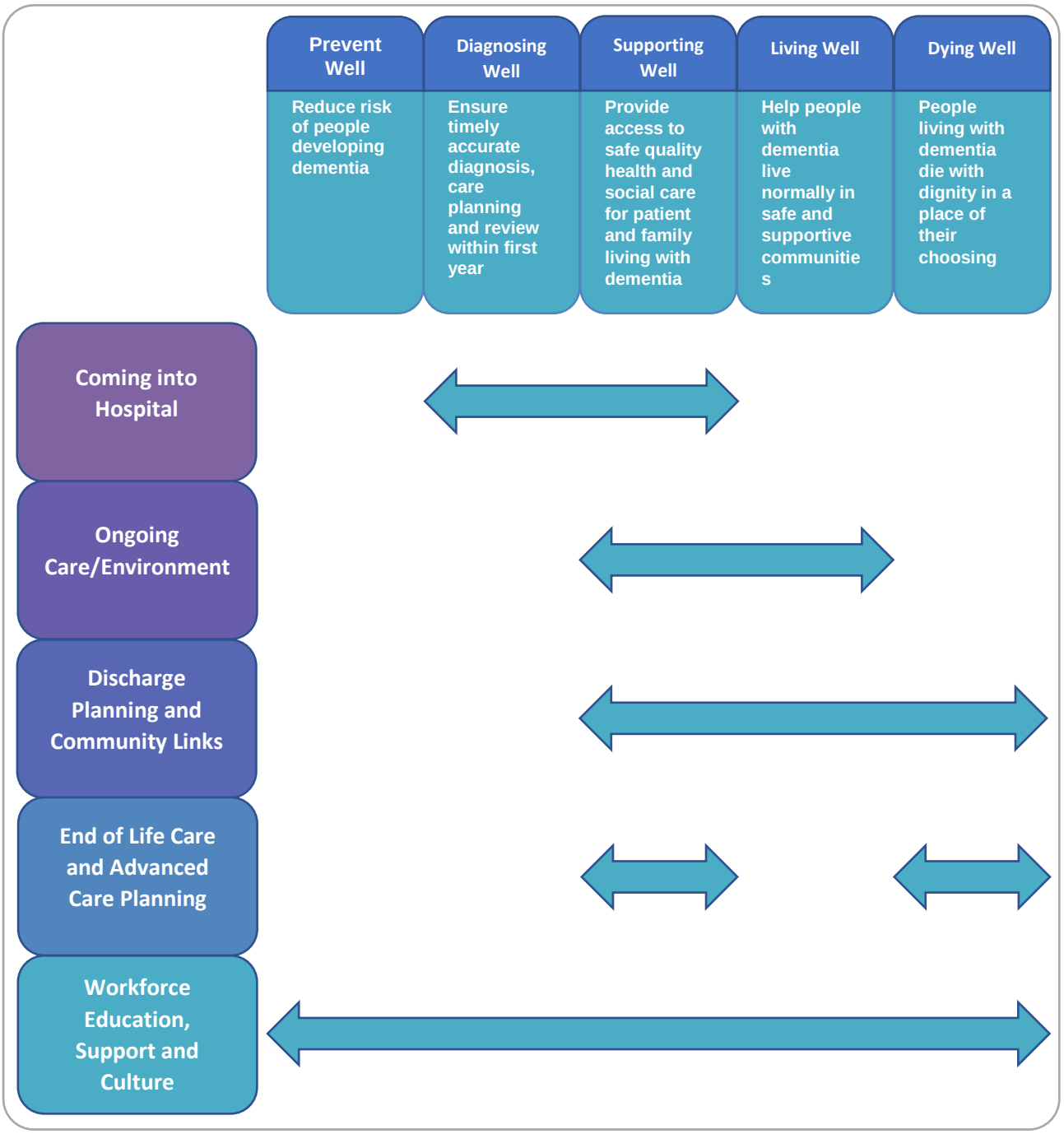
End of Life Care and Advanced Care Planning

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

Workforce Education, Support and Culture

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

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



Brighton and Sussex University Hospitals NHS Trust

Coming into Hospital

Commitment Statement

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

We Pledge to ensure:

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

Ongoing Care/Environment

Commitment Statement

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

We pledge to:

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

Discharge Planning and Community Links

Commitment Statement

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

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

We pledge to ensure:

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

End of Life Care and Advanced Care Planning

Commitment Statement

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

We pledge to:

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

Workforce, Education, Support and Culture

Commitment Statement

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

We Pledge to:

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

Strategic priority 3-year delivery plan

Coming into Hospital			
We Pledge:	**Year One**	**Year Two**	**Year Three**
A clear pathway developed for people living with dementia to access specialist dementia support and to the dementia specialist wards.	Clear pathways developed into the specialist dementia wards A visible presence in ED and the acute floor from the dementia service to ensure that patients are directed where possible to the dementia specialist wards.		A carer's booklet to be provided on admission to sign post carers into the care available for a loved one with dementia and information that may be useful to support them.
An Individualised approach to Outpatient areas in regards to how they can provide better Dementia care.	A yearly focus on separate outpatient areas to ensure that they are equipped to manage the needs of people with dementia utilising them.		
The Completion of dementia and delirium assessments on admission.	90% targets of dementia and delirium screening to be met	100% screening targets to be met	100% screening targets to be maintained and an embedded culture.

Embed the 'This is me' support tool as an integral part of the admission process and the care of people living with dementia accessing our hospital services.	The "This is Me'' document will become an integral document on every ward within 24 hours of admission	The ''This is Me'' document will form part of the audit process to ensure that there is a 100% compliance in ward areas	
Consistent Dementia care across all hospital sites no matter what service people access.	Bespoke training offered to all areas of the trust to ensure that ward areas feel confident to manage a person with dementia and any complex needs they may have.	A dementia awareness month to be held yearly to promote and showcase the achievements around dementia care within the trust	The dementia champions to hold sit and see sessions on their ward around dementia care and feedback any positive changes or issues for collaborative learning.

Ongoing Care/Environment			
We Pledge:	**Year One**	**Year Two**	**Year Three**
To Reduce the number of inpatient bed moves a person experiences	Work with the clinical site teams to understand and work with barriers that may be in place Monitor bed moves for patients that are reviewed by the outreach service and identify any triggers and recurrent themes.	An engagement programme with ward areas to reduce the number of people requiring specialist dementia wards	
Provide individualised and responsive person-centred care planning that ensures a person living with dementia that is admitted into the acute trust is understood and their needs are met.	Dementia champions are recruited for every ward/ area to assist and role model person centred care. The Bolton pain assessment chart is used to identify pain management issues with people with a cognitive impairment trust wide	Finger food menus are available on all wards. A personalised bed space with familiar objects, clothing pictures of a loved one, or things that provide comfort. Care need assessment charts are redesigned based on a (strengths-based model).	Ensure the needs of people with dementia and that are part of the LGBQT community are addressed and met. A reduction in preventable falls in the least restrictive way.
Ensure the right professional leads on the care of a person with dementia with clear pathways and close working with the Older People's Mental Health (OPMH) services.	Early sign posting to either the dementia service or the older peoples mental health team. Clear pathways are developed and publicised into the services Clear guidance on referring into the memory assessment service.		

Ensure Family, carers and friends are recognised as partners in the care of their loved one with dementia and are offered support and guidance where needed.	John's campaign is an integral part of the trusts ethos combined with partnership working with a person's chosen advocate. Consistence ward signage that reflects the ethos of johns campaign	Carers are encouraged to ask for support and sign posted to services.	A Dementia café to be set up to provide support to carers
Develop a trust wide policy for the management of behavioural and psychological symptoms when a person is distressed we will look at psychological intervention first and not pharmacological.	Work with clinical staff at looking at triggers and solutions rather than just the behaviour A reduction in the anti-psychotic medications for people with dementia by ongoing training and support.	On-going work/review on the acute floor in terms of support/distress management.	
Provide meaningful activities are encouraged and available in the acute wards	The recruitment of an activities co coordinator amongst ponying's, Ardingly and Plumpton ward at the Princess Royal Hospital (PRH)	Comfort bags developed and rolled out to all wards in the trust and outpatient areas.	Investment in the Rita system across wards at PRH and ED.

	An initial roll out of activity boxes/ comfort bags in ED by working with ED and the acute floor to see what would be appropriate		
Ensure consistency in dementia friendly environments	Collaborative working to ensure that the work on the 3Ts project is dementia friendly.	The wards with a high proportion of people with dementia using them to become consistent in dementia friendly decoration.	Maintain and monitor the environment to ensure that it is conforming to dementia friendly standards

Discharge Planning and Community Links			
We Pledge:	**Year One**	**Year Two**	**Year Three**
Discharge planning from admission	The dementia service to be part of the discharge steering group. Start to develop a care pathway to assist in the discharge process for people who have delirium superimposed onto dementia.	Actively working with the discharge team to ensure that the dementia service is involved at the start of someone's hospital journey	
Ward staff are aware and supported with complexity of dis-charge planning	Ward staff are aware to contact the dementia service early on in a person stay in order that we can support them through complex discharge planning. A nurse to be part of the care home assessment process when assessing people with dementia	Education and training around the need for capacity assessment's around discharge planning and best interest meetings and the less restrictive option for a person.	
Patients are dis-charged with dignity and clear communica-tion	People with dementia to be discharged with appropriate clothing. Honest and transparent conversations with community and nursing home providers around the needs of people with dementia. Comprehensive handover to new	Network building with nursing home providers to form trusting relationships.	A reduction in readmission to the trust through improved communication/ planning

	care providers with a comprehensive nursing discharge letter.		
Improved understanding of availability support services and ensuring these are clearly sign posted.	Initial fact finding and networking within the STP. Relationship building with our local community mental health partners	Work closely with relevant services within the STP to build direct pathways from the acute trust into the services.	

End of Life Care and Advanced Care Planning			
We Pledge:	**Year One**	**Year Two**	**Year Three**
Undertake advanced care planning when the individual can still make decisions.	Early advanced care planning conversations clearly documented at a stage where by the person with dementia is able to make choices.		
Have honest conversations about an individual's progression of dementia and advanced care planning before the final admission.	Conversations become an integral part of care planning around the progression and prognosis of their advancing dementia and any interventions that they would like are clearly communicated and documented. Onward care providers are aware of any advanced wishes around the person's end of life care.	Carers are sign posted to community support around dementia and end of life decision making.	
Support staff feel confident and competent to discuss dying and advanced care planning.	Early involvement from the palliative care team prior to the person with dementia actively dying to provide support to the staff, person, family and carers.		

Deliver person centred holistic care end of life care.	Ensure that a person who is end of life is able to choose where in the hospital ward, they want to die. Ensure that pain is recognised early on and that appropriate analgesia is prescribed. Ensure early involvement of the palliative care team to support and ensure that the right pain medication is being used.	Work towards a carer's passport for people visiting someone who is end of life.	
Provide psychological support for staff who have been supporting a person and their loved ones through the dying and be-reavement process.	Ensure debrief sessions to be available where staff have supported patients and loved ones they through the dying process and afterwards through the bereavement process and may have found this challenging		

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

Deliver BSUH annual dementia conference	Annual dementia conference to be held to ensure that all staff groups have the opportunity to learn about dementia within our trust and the latest evidence based work around dementia		
Support staff after distressing incidents	Incidents relating to people with dementia are reported and the staff member is given emotional support where review of incidents where required.	Dementia team to have undergone hot debrief training in order to initially be able to provide some support to staff in distress.	

Acknowledgements

This strategy was authored by:

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

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Lead OT at PRH, BSUH

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Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	20	**Meeting:**	Board	**Meeting Date:**	24 July 2019
Report Title:	**Medical Appraisal and Revalidation Annual update**				
Sponsoring Executive Director:	George Findlay				
Author(s):	Dr Rachael James Deputy Medical (Standards)/Lead for Appraisal and Revalidation Caroline Wiggs, Medical Appraisal and Revalidation Manager				
Report previously considered by and date:	Trust Executive Committee				
Purpose of the report:					
Information		☐	Assurance		✓
Review and Discussion		☐	Approval / Agreement		✓
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		☐	Staff confidentiality		☐
Patient confidentiality		☐	Other exceptional circumstances		☐
Link to Trust Strategic Themes:					
Patient Care		✓	Sustainability		☐
Our People		✓	Quality		✓
Systems and Partnerships		☐			
Any implications for:					
Quality					
Financial					
Workforce					
Link to CQC Domains:					
Safe		✓	Effective		✓
Caring		✓	Responsive		☐
Well-led		✓	Use of Resources		☐
Communication and Consultation:					

Executive Summary:

This paper updates the Board on the end of year position with regard to medical appraisal and revalidation and seeks Board sign off of the NHS England statement of compliance.

There has been sustained improvement in end of year appraisal rate this year compared to the previous year.

- 2018-19 end of year appraisal rate for all doctors with a prescribed connection for revalidation **93%** (vs 92% in 2017-18.)
- For substantive medical and dental staff only, end of year appraisal rate was **93%** (vs 93% in 2017-18.)

Key Recommendation(s):

The Board is asked to

Note the assurance provided within this report.
Endorse that the report, along with Appendix C - Annual Organisational Audit will be shared with the higher level Responsible Officer (RO) at NHS England.
Approve Appendix D - Statement of Compliance, confirming that the organisation is in compliance with the regulations, prior to its submission to the higher level RO.

Medical Appraisal and Revalidation Annual update

1. Background

1.1 For the purposes of revalidation, all licensed doctors are required to both participate in annual appraisal and collect supporting information about their practice – to improve patient care and outcomes and to increase public confidence in the medical system.

1.2 Provider organisations have a statutory duty to support their Responsible Officer (RO) in discharging his / her duties[1] and Trust Boards are expected to oversee compliance by:

- monitoring the frequency and quality of medical appraisals and ensuring that annual appraisals take place.
- checking that effective systems and processes are in place to monitor the conduct and performance of doctors;
- confirming that periodic feedback from patients and colleagues informs the appraisal and revalidation process
- providing appropriate pre-employment checks (including pre-engagement for locums) to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

2. Appraisal, pre-employment checking and Revalidation Activities:

2.1

Number of doctors with a prescribed connection at 31 March 2019 - **710**
Number of completed appraisals as at 31 March 2019 - **663**

2.2 The number of doctors with a prescribed connection to BSUH has increased steadily over the last 3 years, to **718** on 9th April 2019 with the addition of Dental. Throughout the year, the trust also loses doctors who have already been appraised, and recruits doctors yet to be appraised. The appraisal workload at BSUH is therefore substantial. It is not possible to reduce the number of prescribed connections to BSUH, which is contractually dictated.

2.3 The Medical Appraisal and Revalidation (MAAR) team monitor internal compliance with appraisal progress weekly, and review appraisal outputs against GMC and NHSE standards.

2.4 To ensure compliance, the MAAR team align and update the ESR and GMC Connect databases weekly; quality assure appraisal audit quarterly; provide feedback to appraisers at bi-yearly network meetings; provide individual feedback to medical appraisers.

(Further details about compliance with national requirements are included in Appendix B - Annual Organisational Audit).

2.5 The end of year appraisal number could have been increased with a greater pool of trained appraisers.

See Appendix A, section A - Audit of all missed or incomplete appraisals.

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

2.6 The MAAR team also undertake pre-engagement background checks for all new doctors starting in year.

Numbers of new doctors (including all new prescribed connections) who have commenced working at BSUH in last 12 months (including locum doctors) are outlined below:

New permanently employed doctors	36
New temporary employed doctors (inc.. doctors in training)	498
Locums brought in to the designated body through 'staff bank'	215
TOTAL	**749**

2.7 Revalidation Recommendations

The MAAR team provides the oversight and administrative support for all doctors being revalidated each year.

• Revalidation recommendations in last 12 months (1st April 2018 to 31st March 2019)	**138**
• Recommendations completed on time	138
• Recommendations not completed on time	0
• Positive recommendations	125
• Deferral requests	12
• Non-engagement notifications	1*

***** *Doctor subsequently held medical appraisal meeting.*

2.8 Service-Level Agreements

BSUH have SLAs in place with St Peter & St James Hospice and Martlets Hospice Hove (effective 1st January 2019). Responsible Officer is Dr Rachael James; the MAAR team provide oversight and administrative support.

3. Appraiser Support and Development

Current numbers of appraisers - 81 April 2019 (74 in April 2018)
Current appraisee / appraiser ratio - 10:1 April 2019* (9:1 in April 2018)

***** *There are a handful of appraisers with a lower ratio agreed with Lead for Appraisal and Revalidation and Medical Appraisal and Revalidation Manager.*

3.1 The above ratio is high and a consequence of lower than required appraiser numbers.

3.2 Capacity within job plans is cited as the major challenge to more rapid appraiser recruitment. Several experienced appraisers are also approaching retirement age or have stepped down due to other commitments.

3.3 The RO, Lead for Revalidation and Appraisal and the Divisional Chiefs are collaborating to identify additional appraisers, the goal being to achieve a ratio 1:6.

3.4 The expectation in each Division is that 20% of substantive middle grades and consultants are trained appraisers.

3.5 Regular scheduled appraiser training is now in place to make the role of the medical appraiser more attractive and to ensure that newly identified appraisers are trained in line with NHSE Guidelines.

3.6 In October 2017, improvements to training and support for appraisers were introduced, incorporating:

- New (quarterly) internal training, (reflecting current NHSE Guidelines).
- Twice yearly external appraiser network and skills training sessions.
- Monthly drop-in sessions (both sites) to support all doctors with the appraisal and revalidation process; there is additional remote access support and 121 training.

4. Quality Assurance (QA)

4.1 The MAAR teams Quality Assure both the appraisal process and each individual appraisal portfolio, including:

- Appraisal inputs: pre-appraisal declarations; supporting information; PDP's; and sign off;
- Annual record of the appraisee's workload, self-reflection and CPD.
- 360° feedback to identify any outliers and support requirements.
- Appraisal audit by department - annually (Q4).

4.2 MAAR review all appraisal portfolios post completion and return any with patient identifiable data present. There were no IG breaches were reported in 2018-19.

See also Appendix A, section B - Quality assurance of appraisal inputs and outputs.

5. Revalidation Governance

5.1 Doctors are supplied with individualised data by the Patient Safety Teams, Complaints Team, Medical HR (conduct and capability) and GMC (external complaints and investigations). All data is collected and upload by MAAR onto the doctor's appraisal portfolio.

5.2 There is a prescribed timeline for appraisal in line with national guidance and pre and post appraisal checks are undertaken to minimise the risk of deferrals. Progress checking is by email, telephone and face-to-face contact if required.

5.3 All revalidation recommendations are reviewed 120 days in advance, to allow time for missing information or corrections to be rectified before the submission deadline.

5.4 To ensure that the minimum requirement of 15 colleague and 20 patient feedback responses is met, the 360 feedback period has been recently extended from 12 weeks to 24 weeks.

5.5 To spread appraisal meetings more evenly across the year, appraisers are allocated a maximum of 3 doctors per quarter.

Dr George Findlay, Chief Medical Officer and Deputy Chief Executive Officer

Dr Rob Haigh, BSUH Medical Director

Dr Rachael James, Deputy Medical (Standards)/Lead for Appraisal and Revalidation

Caroline Wiggs,

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3.4 The expectation in each Division is that 20% of substantive middle grades and consultants are trained appraisers.

3.5 Regular scheduled appraiser training is now in place to make the role of the medical appraiser more attractive and to ensure that newly identified appraisers are trained in line with NHSE Guidelines.

3.6 In October 2017, improvements to training and support for appraisers were introduced, incorporating:

- New (quarterly) internal training, (reflecting current NHSE Guidelines).
- Twice yearly external appraiser network and skills training sessions.
- Monthly drop-in sessions (both sites) to support all doctors with the appraisal and revalidation process; there is additional remote access support and 121 training.

3. Quality Assurance (QA)

4.1 The MAAR teams Quality Assure both the appraisal process and each individual appraisal portfolio, including:

- Appraisal inputs: pre-appraisal declarations; supporting information; PDP's; and sign off;
- Annual record of the appraisee's workload, self-reflection and CPD.
- 360° feedback to identify any outliers and support requirements.
- Appraisal audit by department - annually (Q4).

4.2 MAAR review all appraisal portfolios post completion and return any with patient identifiable data present. There were no IG breaches were reported in 2018-19.

See also Appendix A, section B - Quality assurance of appraisal inputs and outputs.

4. Revalidation Governance

5.1 Doctors are supplied with individualised data by the Patient Safety Teams, Complaints Team, Medical HR (conduct and capability) and GMC (external complaints and investigations). All data is collected and upload by MAAR onto the doctor's appraisal portfolio.

5.2 There is a prescribed timeline for appraisal in line with national guidance and pre and post appraisal checks are undertaken to minimise the risk of deferrals. Progress checking is by email, telephone and face-to-face contact if required.

5.3 All revalidation recommendations are reviewed 120 days in advance, to allow time for missing information or corrections to be rectified before the submission deadline.

5.4 To ensure that the minimum requirement of 15 colleague and 20 patient feedback responses is met, the 360 feedback period has been recently extended from 12 weeks to 24 weeks.

5.5 To spread appraisal meetings more evenly across the year, appraisers are allocated a maximum of 3 doctors per quarter.

Dr George Findlay, Chief Medical Officer and Deputy Chief Executive Officer
Dr Rob Haigh, BSUH Medical Director
Dr Rachael James, Deputy Medical (Standards)/Lead for Appraisal and Revalidation
Caroline Wiggs, Medical Appraisal and Revalidation Manager

Appraisal and Revalidation KPI Data

Appendix A

A – Audit of all missed or incomplete appraisals

Doctor factors (total)	**Number**
Maternity leave during the majority of the 'appraisal due window'	3
Sickness absence during the majority of the 'appraisal due window'	3
Prolonged leave during the majority of the 'appraisal due window'	1
Suspension during the majority of the 'appraisal due window'	0
New starter within 3 month of appraisal due date	4
New starter more than 3 months from appraisal due date	17
Postponed due to incomplete portfolio/insufficient supporting information	0
Appraisal outputs not signed off by doctor within 28 days	3
Lack of time of doctor	3
Lack of engagement of doctor	1
Other doctor factors	0
(describe)	
Appraiser factors	**Number**
Unplanned absence of appraiser	2
Appraisal outputs not signed off by appraiser within 28 days	0
Lack of time of appraiser	3
Other appraiser factors (describe)	0
(describe)	
Organisational factors	**Number**
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	7
Other organisational factors (describe)	0
Total number of all missed or incomplete appraisals (approved)	**47**

B - Quality assurance of appraisal inputs and outputs

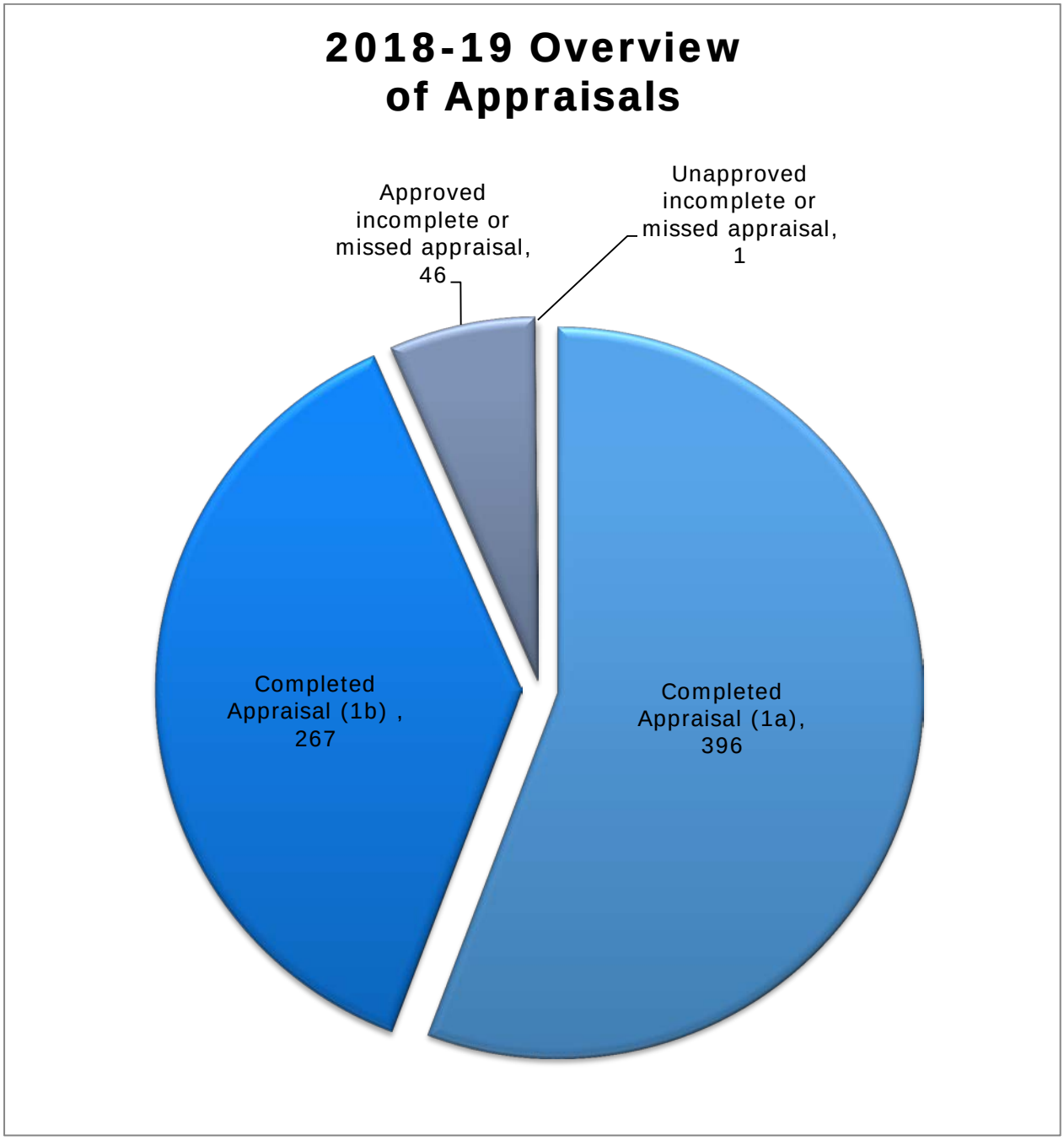
	Number of appraisal portfolios sampled (to demonstrate adequate sample size)	Number of the sampled appraisal portfolios deemed to be acceptable against standards
Appraisal inputs	**Number audited**	**Number acceptable**
Scope of work: Has a full scope of practice been described?	76	76
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	76	57
Quality improvement activity: Is quality improvement activity compliant with GMC requirements?	76	57
Patient feedback exercise: Has a patient feedback exercise been completed?	76	35
Colleague feedback exercise: Has a colleague feedback exercise been completed?	76	34
Review of complaints: Have all complaints been included?	76	76
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	76	76
Is there sufficient supporting information from all the doctor's roles and places of work?	76	76
Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)? Explanatory note: For example • Has a patient and colleague feedback exercise been completed by year 3? • Is the portfolio complete after the appraisal which precedes the revalidation recommendation (year 5)? • Have all types of supporting information been included?	76	37
Appraisal Outputs		
Appraisal Summary	76	76
Appraiser Statements	76	76
Personal Development Plan (PDP)	76	76
Total number of appraisals completed		**663**

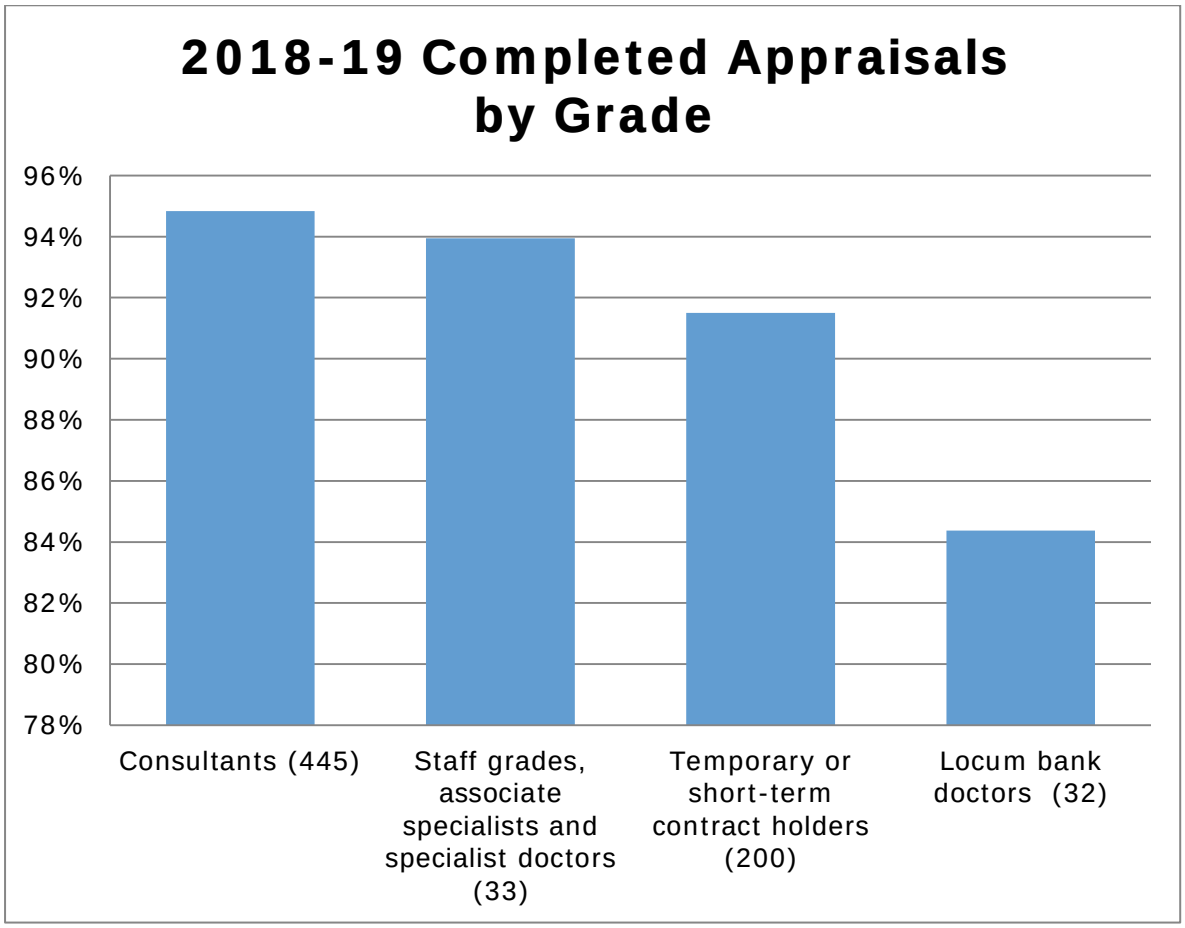
C - Audit of revalidation recommendations

Revalidation recommendations between 1 April 2018 to 31 March 2019	
Recommendations completed on time (within the GMC recommendation window)	138
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	**138**
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	N/A
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	0
New starter/new prescribed connection established more than 2 weeks from revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible officer error	0
Inadequate resources or support for the responsible officer role	0
Other	0
TOTAL	**138**

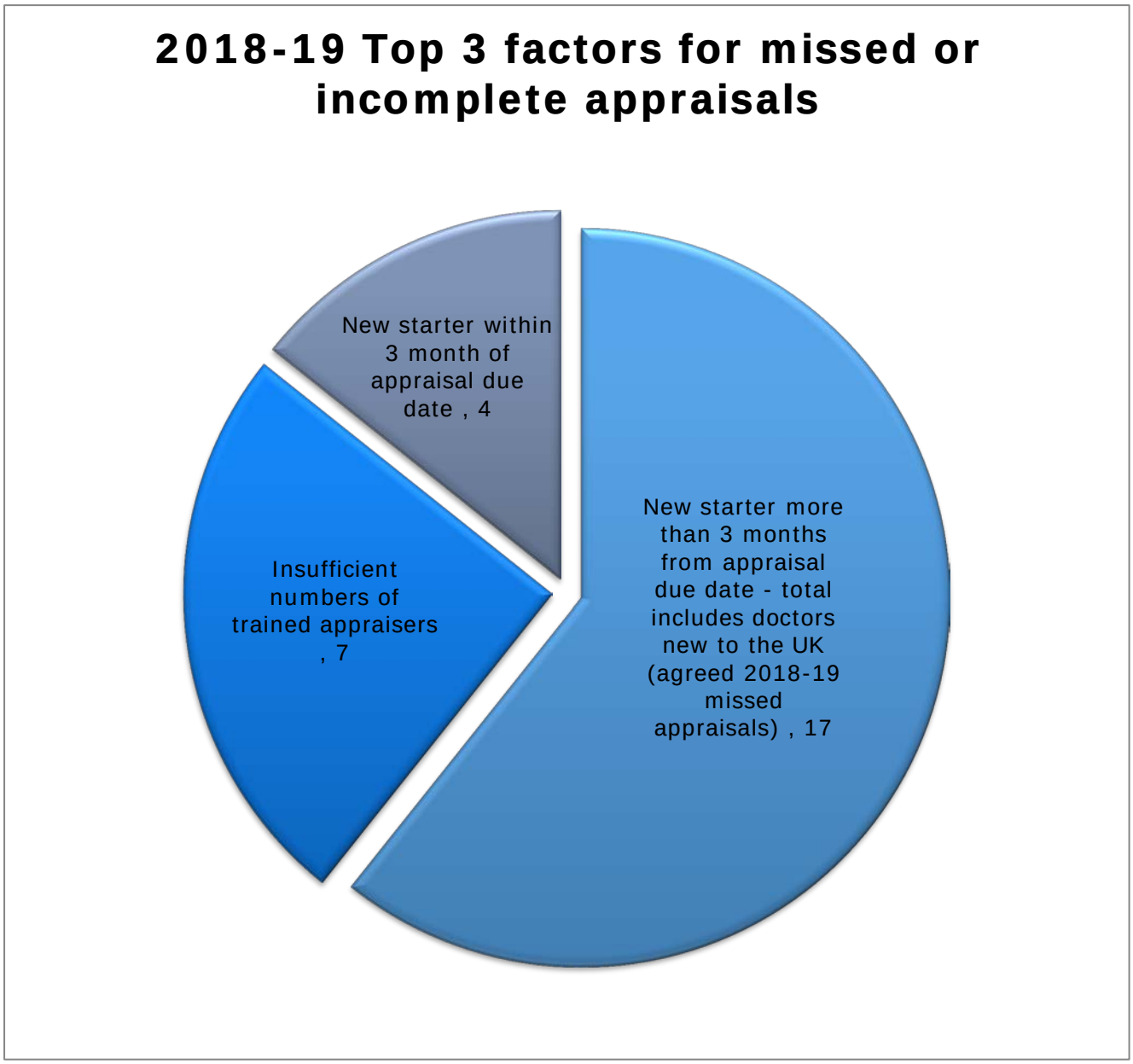
Appraisal and Revalidation KPI Dashboard

Appendix B

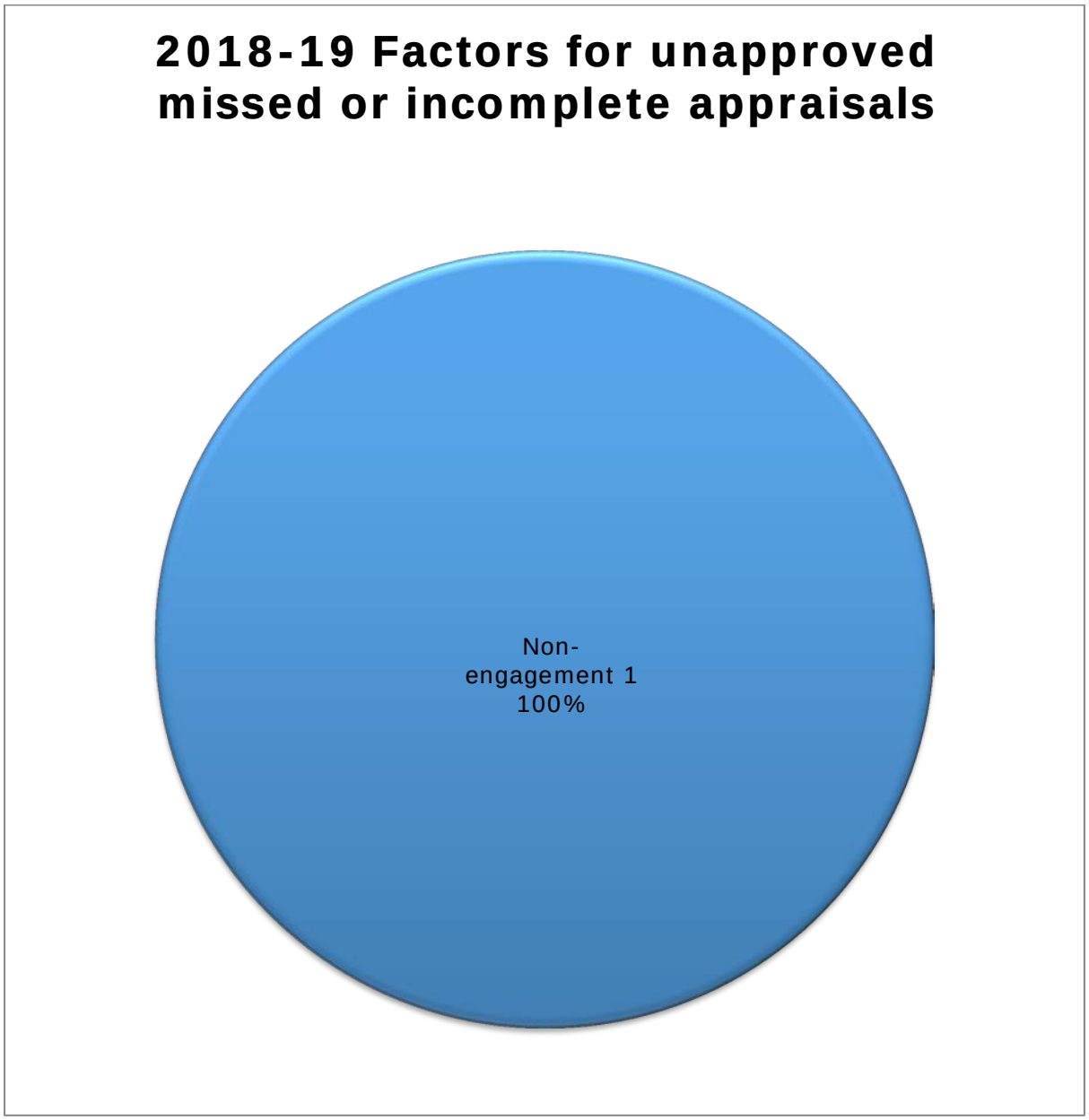



2018-19 Completed Appraisals by Grade
96%
94%
92%
90%
88%
86%
84%
82%
80%
78%
Consultants (445)
Staff grades, associate specialists and specialist doctors (33)
Temporary or short-term contract holders (200)
Locum bank doctors (32)

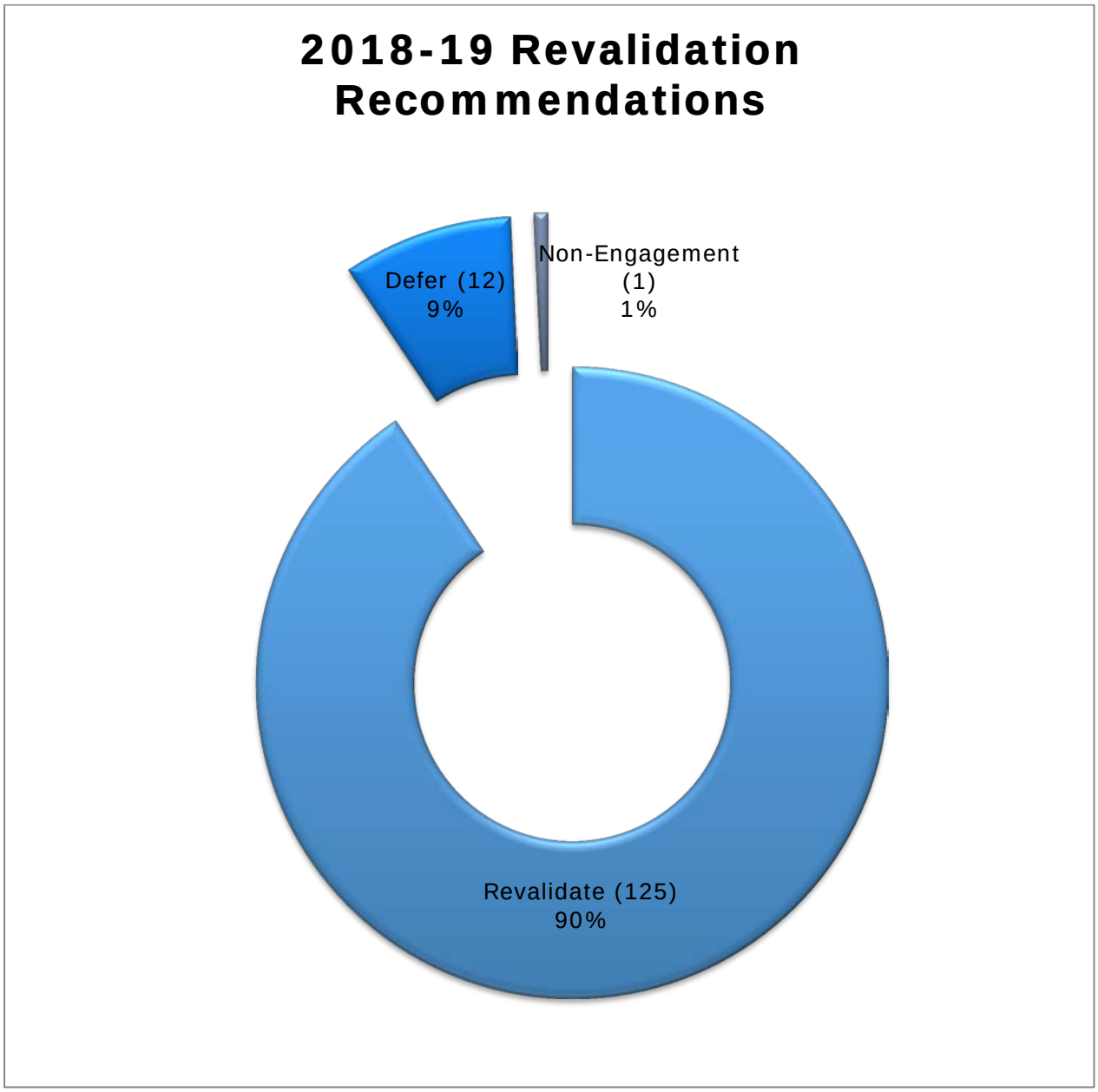
A – Audit of all missed or incomplete appraisals



B – Audit of unapproved missed or incomplete appraisals



C – Audit of revalidation recommendations



Annual Organisational Audit (AOA)
End of year questionnaire 2018-19

NHS England INFORMATION READER BOX		
Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	000182
Document Purpose	Resources
Document Name	Annual Organisational Audit Annex C (end of year questionnaire)
Author	Lynda Norton
Publication Date	24 March 2019
Target Audience	Medical Directors, NHS England Regional Directors, GPs
Additional Circulation List	
Description	The AOA (Annex C of the Framework for Quality Assurance) is a standardised template for all responsible officers to complete and return to their higher level responsible officer via the Revalidation Management System. AOAs from all designated bodies will be collated to provide an overarching status report of progress across England.
Cross Reference	A Framework for Quality Assurance for Responsible Officers & Revalidation April 2014 Gateway ref 01142
Superseded Docs (if applicable)	2017/18 AOA cleared with Publications Gateway Reference 07760
Action Required	
Timing / Deadlines (if applicable)	
Contact Details for further information	Lynda Norton Professional Standards Team Quarry House Leeds LS2 7UE 0113 825 1463

Document Status

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Annual Organisational Audit (AOA)

End of year questionnaire 2018-19

Version number: 1.0

First published: 4 April 2014

Updated: 24 March 2015, 18 March 2016, 24 March 2017, 23 March 2018,

January 2019

Prepared by: Lynda Norton Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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Contents

1 Introduction

The Annual Organisational Audit (AOA) is an element of the Framework of Quality Assurance (FQA) and is a standardised template for all responsible officers to complete and return to their higher level responsible officer. AOAs from all designated bodies will be collated to provide an overarching status report of the responsible officer function across England. Where small designated bodies are concerned, or where types of organisation are small, these will be appropriately grouped to ensure that data is not identifiable to the level of the individual.

As the first cycle of medical revalidation is now complete, it is the right time to update the FQA and its underpinning annexes. The update started by reviewing the AOA and taking account of the feedback received at the beginning of this work, we have produced a slimmed down questionnaire for responsible officers to compete for the 2018/19 exercise.

In response to feedback from designated bodies, we have simplified the categories of appraisals in the 2018/19 AOA to:

- Category 1 - a single figure of completed medical appraisals
- Category 1a – fully compliant appraisal figure (optional)
- Category 2 – no change (‘approved missed’ e.g. maternity, sickness)
- Category 3 – no change (‘unapproved missed)

This slimmed down AOA concentrates primarily on the quantitative measures of previous AOAs, the numbers of doctors with a prescribed connection and their appraisal rates. As the systems and processes that support medical revalidation are established, the emphasis has moved to reporting on how these should be developed year on year through the newly revised Board report instead. The Board report is also a component of the FQA. In time, we expect to introduce suitable quantitative measures about the remaining components of the responsible officer function, for example responding to concerns, monitoring of performance and identity checks.

The AOA 2018/19 questionnaire is divided into four sections:

Section 1: The designated body and the responsible officer
Section 2: Appraisal
Section 3: Annual Board report and Statement of Compliance
Section 4: Additional Comments

The questionnaire is to be completed by the responsible officer on behalf of the designated body for the year ending 31 March 2019. Inputting the information can be appropriately delegated. The completed questionnaire should be submitted before or by the deadline

The final date for submission will be detailed in an email containing the link to the electronic version of the form, which will be sent after 31 March 2019.
Whilst NHS England is a single designated body, for this audit, the national, regional and local offices of NHS England should answer as a ‘designated body’ in their own right..

Following completion of this AOA exercise, designated bodies should:

- Consider using the information gathered to produce a status report and to conduct a review of their organisations’ appraisal developmental needs.
- Complete their Board report and submit it to NHS England by 27 September 2019. The Board report template has also been revised as described above and now includes the annual statement of compliance. The new version will enable designated bodies to review and develop their systems and processes. It will also enable them to provide assurance that they are supporting patient care by fulfilling their statutory obligations in respect of the responsible officer function.

For further information, references and resources can be found at page 16 www.england.nhs.uk/revalidation

2 Guidance for submission

Guidance for submission:

- A small number of questions require a ‘Yes’ or ‘No’ answer. To answer ‘Yes’, you must be able to answer ‘Yes’ to all the statements listed under ‘to answer ‘Yes’’
- Please do not use this version of the questionnaire to submit your designated body’s response.
- You will receive an email with an electronic link to a unique version of this form for your designated body.
- You should only use the link received from NHS England by email, as it is unique to your organisation.
- Once the link is opened, you will be presented with two buttons; one to download a blank copy of the AOA for reference, the second button will take you to the electronic form for submission.
- Submissions can only be received electronically via the link. Do not complete hardcopies or email copies of the document.
- The form must be completed in its entirety prior to submission; it cannot be part-completed and saved for later submission.
- Once the ‘submit’ button has been pressed, the information will be sent to a central database collated by NHS England.
- A copy of the completed submission will be automatically sent to the responsible officer.
- Please be advised that Questions 1.1-1.3 may have been automatically populated with information previously held on record by NHS England. The submitter is responsible for checking the information is correct and should update the information if and where required before submitting the form.

3 Section 1 – The Designated Body and the Responsible Officer

Section 1	The Designated Body and the Responsible Officer	
1.1	**Name of designated body:** Brighton & Sussex University Hospitals NHS Trust	
	Head Office or Registered Office Address if applicable line 1 The Royal Sussex County Hospital	
	Address line 2 Eastern Road	
	Address line 3	
	Address line 4	
	City Brighton	
	County East Sussex	Postcode BN2 5BE
	Responsible officer: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	GMC registered last name ***** Phone *****
	Medical Director: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	No Medical Director ☐ GMC registered last name ***** Phone *****
	Clinical Appraisal Lead: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	No Clinical Appraisal Lead ☐ GMC registered last name ***** Phone *****
	Chief executive (or equivalent): Title ***** First name ***** GMC reference number (if applicable) Email *****	Last name ***** Phone *****

1.2	**Type/sector of designated body:** (tick one)	NHS	Acute hospital/secondary care foundation trust	☐
			Acute hospital/secondary care non-foundation trust	☑
			Mental health foundation trust	☐
			Mental health non-foundation trust	☐
			Other NHS foundation trust (care trust, ambulance trust, etc)	☐
			Other NHS non-foundation trust (care trust, ambulance trust, etc)	☐
			Special health authorities – NHS Litigation Authority, now NHS Resolution, NHS Improvement, NHS Blood and Transplant, etc)	☐
		NHS England	NHS England (Local office)	☐
			NHS England (regional office)	☐
			NHS England (national office)	☐
		Independent / non-NHS sector (tick one)	Independent healthcare provider	☐
			Locum agency	☐
			Faculty/professional body (FPH, FOM, FPM, IDF, etc)	☐
			Academic or research organisation	☐
			Government department, non-departmental public body or executive agency	☐
			Armed Forces	☐
			Hospice	☐
			Charity/voluntary sector organisation	☐
			Other non-NHS (please enter type)	☐

Please do not use this version of the form to submit your response.

1.3	**The responsible officer's higher level responsible officer is based at:** [tick one]	NHS England North	☐
		NHS England Midlands and East	☐
		NHS England London	☐
		NHS England South East	☑
		NHS England South West	☐
		NHS England (National)	☐
		Department of Health	☐
		Faculty of Medical Leadership and Management - for NHS England (national office) only	☐
		Other (Is a suitable person)	☐
1.4	**A responsible officer has been nominated/appointed in compliance with the regulations.** To answer 'Yes': • The responsible officer has been a medical practitioner fully registered under the Medical Act 1983 throughout the previous five years and continues to be fully registered whilst undertaking the role of responsible officer. • The responsible officer has been formally nominated/appointed by the board or executive of the organisation.		☑ Yes ☐ No

4 Section 2 – Appraisal

Section 2	Appraisal						
2.1	IMPORTANT: Only doctors with whom the designated body has a prescribed connection at 31 March 2019 should be included. Where the answer is 'nil' please enter '0'. **See guidance notes on pages 12-14 for assistance completing this table**		1	1a	2	3	
		Number of Prescribed Connections	Completed Appraisal (1)	(Optional) Completed Appraisal (1a)	Approved incomplete or missed appraisal (2)	Unapproved incomplete or missed appraisal (3)	Total
2.1.1	**Consultants** (permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government /other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work).	445	422	242	22	1	445
2.1.2	**Staff grade, associate specialist, specialty doctor** (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other public body staff).	33	31	15	2	0	33
2.1.3	**Doctors on Performers Lists** (for NHS England and the Armed Forces only; doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs).	0	0	0	0	0	0
2.1.4	**Doctors with practising privileges** (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade).	0	0	0	0	0	0
2.1.5	**Temporary or short-term contract holders** (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc).	200	183	128	17	0	200
2.1.6	**Other doctors with a prescribed connection to this designated body** (depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc).	32	27	11	5	0	32
2.1.7	**TOTAL** (this cell will sum automatically 2.1.1 – 2.1.6).	710	663	396	46	1	710

Please do not use this version of the form to submit your response.

2.1	**<u>Column - Number of Prescribed Connections:</u>** **Number of doctors with whom the designated body has a prescribed connection as at 31 March 2019** The responsible officer should keep an accurate record of all doctors with whom the designated body has a prescribed connection and must be satisfied that the doctors have correctly identified their prescribed connection. Detailed advice on prescribed connections is contained in the responsible officer regulations and guidance and further advice can be obtained from the GMC and the higher level responsible officer. The categories of doctor relate to current roles and job titles rather than qualifications or previous roles. The number of individual doctors in each category should be entered in this column. Where a doctor has more than one role in the same designated body a decision should be made about which category they belong to, based on the amount of work they do in each role. Each doctor should be included in only one category. For a doctor who has recently completed training, if they have attained CCT, then they should be counted as a prescribed connection. If CCT has not yet been awarded, they should be counted as a prescribed connection within the LETB AOA return. **<u>Column - Measure 1 Completed medical appraisal:</u>** A *completed annual medical appraisal* is one where either: a) All of the following three standards are met: i. the appraisal meeting has taken place in the three months preceding the agreed appraisal due date*, ii. the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting, iii. the entire process occurred between 1 April and 31 March. Or b) the appraisal meeting took place in the appraisal year between 1 April and 31 March, and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor, but one or more of the three standards in a) has been missed. However, the judgement of the responsible officer is that the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation. For doctors who have recently completed training, it should be noted that their final ACRP equates to an appraisal in this context. **<u>Column - Measure 1a (Optional) Completed medical appraisal:</u>** For designated bodies who wish to and can report this figure, this is the number of completed medical appraisals that meet all **three** standards defined in Measure 1 a) above. This figure is not reported nationally and is intended to inform the internal quality processes of the designated body.	

Column - Measure 2: Approved incomplete or missed appraisal:

An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of a *Category 1 completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal for it to be counted as an *Approved incomplete or missed annual medical appraisal*.

Column - Measure 3: Unapproved incomplete or missed appraisal:

An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of a *Category 1 completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal.

Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*.

Column Total:

Total of columns 1+2+3. The total should be equal to that in the first column (Number of Prescribed Connections), the number of doctors with a prescribed connection to the designated body at 31 March 2019.

* Appraisal due date:

A doctor should have a set date by which their appraisal should normally take place every year (the 'appraisal due date'). The appraisal due date should remain the same each year unless changed by agreement with the doctor's responsible officer. Where a doctor does not have a clearly established appraisal due date, the next appraisal should take place by the last day of the twelfth month after the preceding appraisal. This should then by default become their appraisal due date from that point on. For a designated body which uses an 'appraisal month' for appraisal scheduling, a doctor's appraisal due date is the last day of their appraisal month.

For more detail on setting a doctor's appraisal due date see the Medical Appraisal Logistics Handbook: (NHS England 2015).

2.2	**Every doctor with a prescribed connection to the designated body with a missed or incomplete medical appraisal has an explanation recorded** If all appraisals are in Categories 1, please answer N/A. To answer Yes: • The responsible officer ensures accurate records are kept of all relevant actions and decisions relating to the responsible officer role. • The designated body's annual report contains an audit of all missed or incomplete appraisals (approved and unapproved) for the appraisal year 2018/19 including the explanations and agreed postponements. • Recommendations and improvements from the audit are enacted. **Additional guidance:** A missed or incomplete appraisal, whether approved or unapproved, is an important occurrence which could indicate a problem with the designated body's appraisal system or non-engagement with appraisal by an individual doctor which will need to be followed up. **Measure 2: Approved incomplete or missed appraisal:** An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of a *Category 1 completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal for it to be counted as an *Approved incomplete or missed annual medical appraisal*. **Measure 3: Unapproved incomplete or missed appraisal:** An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of a *Category 1 completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*.	☑ Yes ☐ No ☐ N/A

5 Section 3 – Annual Board Report and Statement of Compliance

Section 3		
3.	The last Annual Board Report was signed off on: 25/07/2018 The last Statement of Compliance was signed off on: 05/11/2018	

6 Section 4 – Comments

Section 4	Comments	
4	Please note Dr Rachael James is Deputy Medical Director and Lead for Medical Appraisal and Revalidation at Brighton & Sussex University Hospitals NHS Trust.	

Please do not use this version of the form to submit your response.

7 Reference

Sources used in preparing this document

1. The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2013)

2. The Medical Profession (Responsible Officers) (Amendment) Regulations 2013 (Her Majesty's Stationery Office, 2013)

3. The Medical Act 1983 (Her Majesty's Stationery Office, 1983)

4. The National Health Service (Performers Lists) (England) Regulations 2013

5. Revalidation: A Statement of Intent (GMC and others, 2010)

6. Guidance on Colleague and Patient Questionnaires (GMC, 2012)

7. Effective clinical governance for the medical profession: A handbook for organisations employing, contracting or overseeing the practice of doctors (GMC 2018)

8. The GMC protocol for making revalidation recommendations: Guidance for responsible officers and suitable persons (GMC, 2012, updated in 2014)

9. Providing a Professional Appraisal (NHS Revalidation Support Team, 2012)

10. Appraisal in the Independent Health Sector (British Medical Association and Independent Healthcare Advisory Services, 2012)

11. Joint University and NHS Appraisal Scheme for Clinical Academic Staff (Universities and Colleges Employers Association, 2002, updated in 2012)

12. Preparing for the Introduction of Medical Revalidation: a Guide for Independent Sector Leaders in England (GMC and Independent Healthcare Advisory Services, 2011, updated in 2012)

13. Medical Appraisal Logistics Handbook (NHS England, 2015)

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex E - Statement of Compliance

Statement of Compliance

Version number: 2.0

First published: 4 April 2014

Updated: 22 June 2015

Prepared by: Gary Cooper, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Publications Gateway Reference: 03432

NB: The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

Designated Body Statement of Compliance

The board / executive management team of **Brighton & Sussex University Hospitals NHS Trust** can confirm that

- an AOA has been submitted,
- the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)
- and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

Yes

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

Yes

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

Our current appraiser/appraisee ratio is 1:10. We are having a significant recruitment drive to reduce this to nearer 1:8-1:6.

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent);

Yes

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

Yes

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1] (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring that information about these matters is provided for doctors to include at their appraisal;

Yes

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Yes

8. There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner works;[3]

Yes

9. The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licenced medical practitioners[4] have qualifications and experience appropriate to the work performed;

Yes

10. A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance.

Yes

Signed on behalf of the designated body

Official name of designated body: **Brighton & Sussex University Hospitals NHS Trust**

Name: Dame Marianne Griffiths, DBE

Role: Chief Executive,
Brighton & Sussex University Hospitals NHS Trust

Signed:

Date:

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	21	**Meeting:**	Board	**Meeting Date:**	24 July 2019
Report Title:	**Company Secretary Report**				
Sponsoring Executive Director:		Glen Palethorpe, Group Company Secretary			
Author(s):		Glen Palethorpe, Group Company Secretary			
Report previously considered by and date:					
Purpose of the report:					
Information		☐	Assurance	✓	
Review and Discussion		☐	Approval / Agreement	✓	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		☐	Staff confidentiality	☐	
Patient confidentiality		☐	Other exceptional circumstances	☐	
Link to Trust Strategic Themes:					
Patient Care		✓	Sustainability	✓	
Our People		✓	Quality	✓	
Systems and Partnerships		✓			
Any implications for:					
Quality					
Financial					
Workforce					
Link to CQC Domains:					
Safe		✓	Effective	✓	
Caring		✓	Responsive	✓	
Well-led		✓	Use of Resources	✓	
Communication and Consultation:					

Executive Summary:

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

Annual report and accounts

The Trust was required to submit its audited annual report and accounts to NHS I by noon on the 29 May. Following this the Trust is required to combine these with the Trust's quality account and then submit these as one combined file to NHS I by the 31 July. The Trust made this submission on the 17 July 2019.

The Trust has published its annual report and accounts on the Trust's web site at https://www.bsuh.nhs.uk/about-us/our-performance/annual-reports-and-plans/

Quality Account

The Trust was required to submit its audited quality account to NHS Choices by the 30 June and place this on the Trust's website. The Trust complied with this requirement. The Trust's quality account can also be found on the NHS Choices website at https://www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=955

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

The Trust is required to receive reports on learning from deaths. The Board is reminded that the detail of this report has been scrutinised by the Quality Assurance Committee especially in respect of the Trust's processes for learning from the review of deaths. The focus continues to improve the Trust's processes. The outcome of this learning manifests itself in the Trust's mortality indices; these are tracked within the routine report to the Board as part of the Integrated Performance Report.

Key Recommendation(s):

The Board is recommended to

NOTE the Trust has complied with the requirements to submit the Trust's annual report and accounts to NHS I and has published these documents on its website.

NOTE the Trust has complied with the requirement to submit the Trust's Quality Account and publish this on the NHS Choices web site.

NOTE the Trust's learning from deaths report and note that in accordance with the requirements of National Guidance on Learning from Deaths, BSUH has; published a policy on how it responds to and learns from deaths; published the specified data on deaths quarterly; and implemented a process for undertaking SJRs on the required deaths.

Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	21	**Meeting:**	Trust Board	**Meeting Date:**	July 2019
Report Title:	Learning from Deaths Report				
Sponsoring Executive Director:	Dr George Findlay - Chief Medical Officer, Rob Haigh - Medical Director				
Author(s):	Rob Haigh – Medical Director, Della Morris - Safety & Quality Lead				
Report previously considered by and date:	Quality Assurance Committee				
Purpose of the report:					
Information	✓		Assurance	✓	
Review and Discussion	☐		Approval / Agreement	☐	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	☐		Staff confidentiality	☐	
Patient confidentiality	☐		Other exceptional circumstances	☐	
Link to Trust Strategic Themes:					
Patient Care	✓		Sustainability	☐	
Our People	☐		Quality	✓	
Systems and Partnerships	☐				
Any implications for:					
Quality	The Trust's True North Objective is for the mortality rates (HSMR) to be in the lowest 20% of Trusts.				
Financial					
Workforce	Human Resource Implications: There are training and protected time requirements for clinical staff undertaking SJR's.				
Link to CQC Domains:					
Safe	☐		Effective	☐	
Caring	☐		Responsive	☐	
Well-led	☐		Use of Resources	☐	
Communication and Consultation:					
Not applicable					
Executive Summary:					
This report is produced in line with National Guidance on Learning from Deaths, and provides the Trust Board with information relating to local implementation of the guidance; recent Structured Judgment Review activity; and the themes and learning that are emerging from this work.					
Key Recommendation(s):					
The Board is asked to NOTE the report.					

Learning from Deaths 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 also included on rates of review and mortality statistics.

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 SJRS.

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.

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.

6.2 In March 2019, the CQC published SJR guidance. This identified five measures of good practice:

- values and behaviours that encourage engagement with families and carers
- clear and consistent leadership
- a positive, open and learning culture
- staff with resources, training and support
- positive working relationships with other organisations

6.3 The BSUH Quality Account for 19/20 commits to strengthening practice in the above areas.

7. Mortality Review Outcomes

7.1 A DoH recommended dashboard is used to illustrate SJR activity at BSUH (see attachment).

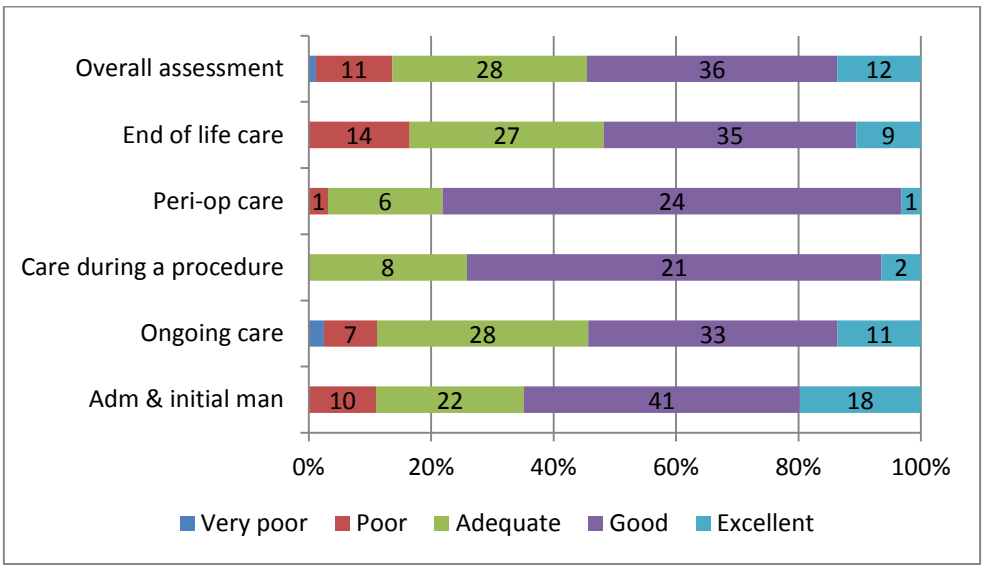
7.2 The table below shows the last 4 quarters data for BSUH (LD refers to deaths of patients with learning disabilities).

	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20	Total
Total Deaths (adult inpatients not LD)	338	421	477	352	1,588
Total deaths reviewed using SJR (adult inpatients not LD)	55	27	37	9	128
Deaths avoidable >50% (adult inpatients not LD)	0	1	0	0	1
LD Deaths	2	8	5	0	15
LD deaths reviewed using SJR	2	6	3	0	11
LD deaths avoidable >50%	0	0	0	0	0
Total % of adult deaths reviewed	**16.3%**	**7.8%**	**8.4%**	**2.84%**	**8.8%**

7.3 All deaths that have been recorded as avoidable have been fully investigated in line with Trust policy.

7.4 The percentage of deaths reviewed from the most recent quarter is inevitably lower due to delays accessing patient records and allocating reviews. However, overall there has been a fall in the percentage of deaths reviewed; most of the deaths are reviewed by the Palliative Care Team, and this is reflected by the themes that are identified. The Divisional teams will be targeted to improve representation and participation in SJRs.

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



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

Figure 1

7.6 Two themes have been identified for further review: Deaths following MET/Cardiac Arrest calls and deaths of patients receiving non-invasive ventilation. All deaths fulfilling these criteria are to now be reviewed using SJR, the results presented to TMRG.

7.7 The Overall care Assessments of patients who died during 18/19 have been reviewed by the Lead Clinical Nurse for Palliative and EOLC and a Core Medical Trainee. The major themes to emerge from this review were a failure to recognise dying and the absence of a treatment escalation plan. Opportunities to share learning across the Trust are being reviewed by the TMRG and include the Staff Stories forum and the Grand Round.

7.8 Recognising that the SJR requires a detailed notes review, TMRG have developed a tab on the PANDA to record the outcomes of the SJR and associated learning. Embedding this functionality will now be taken forward with the PANDA team.

7.9 The TMRG are also working with the ME's on embedding ME questions into PANDA, enabling junior doctors to submit data remotely saving time and allowing flexibility around this process. This work will be taken forwards in quarters 2 and 3.

8. SHMI[2] & HSMR[3]

8.1 SHMI data available is for the 12 months to Dec 2018; the SHMI for BSUH is 97.89.[4]

8.2 The trend in SHMI for in month and rolling data is shown below in Figure 2

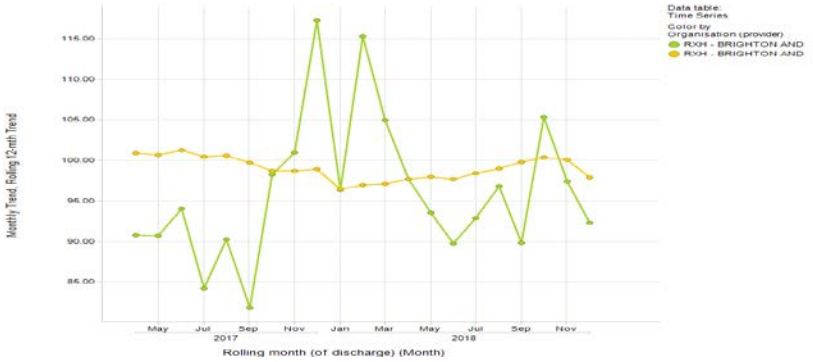


Figure 2

8.3 HSMR data available is for the 12 months to Mar 2019. HSMR for BSUH is 93.43.[5]

8.4 The trends for in month and rolling HSMR is shown below in figure 3

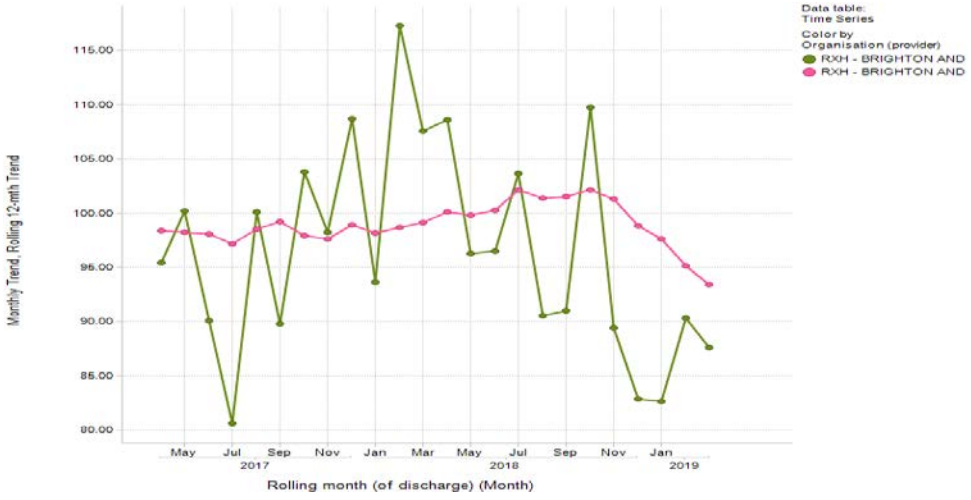


Figure 3

[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] National average is 100

8.5 Detailed data reviews are underway for the procedural / diagnostic groups ‘Urethral Catheterisation of Bladder’, ‘Ventilation Support’ and ‘Other Fractures’ as the SHMI is above 100 (i.e. above natural average) in these three.

8.6 Review of weekend vs weekday HSMR and SHMI demonstrates that HSMR is higher for patients admitted on a weekday; whereas SHMI is unchanged whether patients are admitted weekdays or weekend. When HSMR is recalculated for all patients, rather than a group of 56 diagnoses, this difference disappears, confirming that the reported HSMR variance relates to case mix, rather than true outcome difference.

9. Summary

9.1 In accordance with the requirements of National Guidance on Learning from Deaths, BSUH has; published a policy on how it responds to and learns from deaths; published the specified data on deaths quarterly; and implemented a process for undertaking SJRs on the required deaths.

9.2 The scheme to bring trained staff together monthly to undertake SJRs has continued. The aim is to improve SJR confidence and capacity, share learning and ensure multidisciplinary input.

9.3 The Lead Clinical Nurse for Palliative and EOLC Medical Trainee have identified failure to consistently identify dying and the absence of a treatment escalation plans as themes for improvement.

9.4 A PANDA SJR tool will be further developed by the IT team.

9.5 Work is in the initial stages to embed the ME processes into PANDA.

9.6 Deep dive reviews are commissioned into mortality alerts associated with ‘Urethral Catheterisation of Bladder’, ‘Ventilation Support’ and ‘Other Fractures’.

10. Recommendation

10.1 The Board is asked to note the reporting recognising that QAC has reviewed this area in more detail.

Dr Rob Haigh

BSUH Medical Director

18.07.2019

Questions from the public

Question from Mr Tony Graham:

Background

At the January Meeting of the Board, I had asked about the ongoing problems involving Delayed Transfers of Care and local capacity for the discharge of patients with complex needs. Pete Landstrom responded with reference to a CCG & Local Authority commitment of £3.1m around intermediate care, mentioning that SCFT were closely involved in these discussions. Marianne Griffiths had been pessimistic about any potential for adding to BGH plans. She then referred to the 'quick fix' of spot purchase beds - saying that "the Trust needs to resource long term, which the CCG is willing to fund. A plan around this is expected in June."

The Question

Has this plan materialised? If so, what does it involve eg in its scale, nature and delivery time-frame?