Brighton and Sussex University Hospitals NHS Trust

# Meeting of the Board of Directors

10:30 to 13:00 on Wednesday 29th May 2019

Trust Headquarters, Royal Sussex County Hospital, Brighton BN2 5BE

## AGENDA – MEETING IN PUBLIC

| | | | | |
|---|---|---|---|---|
| 1. | 10:30 | **Welcome and Apologies for Absence**<br>To note | Verbal | Chair |
| 2. | 10:30 | **Declarations of Interests**<br>To note | Verbal | All |
| 3. | 10:30 | **Minutes of Board Meeting held on 27th March 2019**<br>To approve | Enclosure | Chair |
| 4. | 10:35 | **Matters Arising from the Minutes**<br>To note | Enclosure | Chair |
| 5. | 10:40 | **Chief Executive's Report**<br>To receive and note overview of the Trust's activities | Enclosure | Marianne Griffiths |
| 6. | 10:50 | **2019/20 Operational Plan**<br>To receive | Presentation | Oliver Phillips |
| | | **INTEGRATED PERFORMANCE REPORT** | | |
| 7. | 11:05 | **Introduction from the Chief Executive**<br>To receive and note overview of the Trust's activities | Enclosure | Marianne Griffiths |
| 8. | 11:10 | **Quality Performance**<br>To receive and agree any necessary actions | Enclosure | George Findlay |
| 9. | 11:20 | **Operational Performance**<br>To receive and agree any necessary actions | Enclosure | Jayne Black |
| 10. | 11:30 | **Financial Performance**<br>To receive and agree any necessary actions | Enclosure | Karen Geoghegan |
| 11. | 11:40 | **Organisational Development and Workforce Performance**<br>To receive and agree any necessary actions | Enclosure | Denise Farmer |
| | | **ASSURANCE REPORTS FROM COMMITTEES** | | |
| 12. | 11:50 | **1. Report from Quality Assurance Chair**<br>**2. Report from Finance and Performance Chair**<br>**3. Report from Audit Chair**<br>To receive assurance from Committee and recommendations from the Committee | Verbal<br>Enclosure<br>Enclosure | Mike Rymer<br>Patrick Boyle<br>Martin Sinclair |
| | | **SERVICE PRESENTATION** | | |
| 13. | 12:10 | **Maternity Service Presentation**<br>To receive assurance over application of patient first processes | Presentation | Carly Knell<br>Ryan Watkins |

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| | | **QUALITY** | | |
| 14. | 12.25 | **Learning from Deaths Quarterly Update**<br>To note and agree any necessary actions | Enclosure | George Findlay |
| | | **WELL LED & COMPLIANCE** | | |
| 15. | 12:35 | **Annual Provider Licence Self Certifications**<br>To approve for publication on the web site | Enclosure | Glen Palethorpe |
| | | **OTHER** | | |
| 16. | 12:45 | **Any Other Business**<br>To receive and agree any necessary actions | Verbal | Chair |
| 17. | 12:50 | **Questions from the public**<br>To receive and respond to questions submitted by the public | Verbal | All |
| 18. | 13:00 | **Date and time of next meeting:**<br>The next meeting in public of the Board of Directors is scheduled to take place at 10:30am on 29th May 2019 in the Boardroom, Headquarters, Royal Sussex County Hospital, Brighton. | | |
| 19. | | **To resolve to move to into private session**<br>*The Board now needs to move to a private session due to the confidential nature of the business to be transacted* | | |

**Trust Board of Directors Quoracy**

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

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

Brighton and Sussex University Hospitals NHS Trust

Minutes

**Minutes of the Board of Directors (Public) meeting held at 9.30am on Wednesday 27th March 2019 in the Meeting Room, Level 6, Trust Headquarters, Royal Sussex County Hospital, Eastern Road, Brighton**

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| **Present:** | Alan McCarthy | 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 |
| | 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/03/19/1 WELCOME AND APOLOGIES** **Action**

1.1 The Chair welcomed those present to the meeting.

1.2 Apologies for absence were received from Lizzie Peers and Jon Furmston.

**B/03/19/2 DECLARATIONS OF INTEREST**

2.1 There were no declarations of interest.

**B/03/19/3 MINUTES FROM THE PREVIOUS MEETING**

3.1 The minutes of the meeting held on 30th January 2019 were approved as a correct record.

**B/03/19/4 MATTERS ARISING**

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

4.2 PB/07/18/6.8 – The Board were advised that the Dementia Strategy will be prepared ahead of the Quality Committee in May and then taken to the next Board meeting.

4.3 PB/10/18/11 – Joanna asked if the Infection Control Report was in the public domain and Glen advised that the main detail of the report is included within Quality Account, which is a public document.

4.4 PB/1/19/6a – Denise said that Health and Safety Executive had responded confirming receipt of the Trust's response and that no further action was required.

**B/03/19/5 Chief Executive's Report**

5.1 The Chair opened the report by congratulating Dame Marianne Griffiths on being named top-rated Chief Executive for the second year running by the Health Service Journal and Marianne thanked the Board and introduced her report.

5.2 **Staff survey**
Marianne was delighted to see such a significant improvement in the Staff Survey response rate from 36% in the previous year to almost 60% and recognised the importance of capturing and acting on the feedback.

5.3 Marianne received really positive results from Listening into Action who fed back that BSUH ranked 3rd highest in improvement across the country and was placed first of all acute Trusts, which was a significant improvement on the previous year.

5.4 **Our Staff**
Marianne informed the Board that there is a recruitment campaign seeing a posters signposting recruitment opportunities at BSUH at London Victoria station which is impactful but Marianne recognised that work continues to support recruitment to the Trust. On the 2nd March, Nicola Ranger was asked to speak at Nursing Time Conference and made 7 job offers on the day and discussed potential roles with a further 90 people, which are being followed up.

5.5 **LGBTQ+**
Marianne thanked Denise Farmer and Nick Groves for the first LGBTQ+ conference the Trust had held, which was extremely well attended and oversubscribed. Marianne acknowledged the work that is being undertaken to update Trust policies to make them more effective and the outcomes from the conference will feed into this. Furthermore, the Trust has returned to Stonewall who have ranked BSUH at 143, work is on-going to improve this further.

5.6 **Chief Nurse**
Marianne formally thanked Nicola for the all the work she has done across both Trusts and advised that a decision has been made to recruit two Chief Nurses, one for each Trust, due to the extent of work Nicola has been involved in.

5.7 **Temporary Changes to Operational Leadership**
Marianne thanked Rab McEwan for the work he has done as Chief Operating Officer and informed the Board that Jayne Black will take on the COO role in the interim from April 2019.

5.8 Marianne drew the report to a close by praising the newest ward, Level 11 which had improved flow in the hospital and received incredible feedback from patients and staff alike.

5.9 Patrick Boyle asked what the Trust is doing to tackle smoking and drinking and whether this is funded from central government for the NHS and the Trust in this area of public health policy. Marianne confirmed that is it something the Trust is focussing on independently and it is one of the Trust's CQUINs. Joanna Crane added that the CQUIN fed through to the Quality Report which is discussed at the Quality Committee and that the activity of the Trust may be useful, to align with practice at WSHFT.

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

## PERFORMANCE

### B/03/19/6 QUALITY REPORT

6.1 Nicola Ranger highlighted the key points from the Quality Report.

6.2 Nicola drew the Board's attention to the flu outbreaks at PRH and confirmed that despite the outbreaks, the Hospital dealt with these swiftly and effectively and work is being done with the wards to learn and prevent any further incidents.

6.3 The Board was advised that the Trust has seen an increase in complaints. The Trust is working closely with PALS to look at the complaints and what can be done to reduce the number by cascading learning.

6.4 Results from the Family and Friends Test showed concerns over appointment waiting times. The lowest scoring theme is A&E wait times but Nicola recognised that winter pressures will have had an impact on the responses. Work has been completed with the key wards to look at the content of the feedback they have received.

6.5 Patrick Boyle referred to section 4.2.2 of the report whereby Health Service Investigation Branch (HSIB) is investigating two deaths in Maternity. George Findlay reminded the Board that all deaths that meet the mandatory criteria are reported and the HSIB investigations were recently introduced across the country as standard practice. George acknowledged that there are concerns with the investigations, particularly about the level of communication that is maintained with the families as the HSIB investigate. George explained that the Trust is conducting its own investigations into the deaths, which will allow the Trust to involve the families and provide support throughout.

6.6 Referring to the FFT rates in Outpatients, Marianne noted that that have been steadily improving since July and are at a high level of patient satisfaction. Pete Landstrom added that actions undertaken by Outpatients Directorate had contributed to the improvements.

6.7 George informed the Board that the HSMR rates in Paragraph 3.2.1 were incorrect and there were no concerns with mortality or Learning from Deaths.

6.8 **ACTION:** HSMR rates in the Quality Report to be corrected. **GF**

6.9 The Board **NOTED** the Quality Report and the assurance provided by George regarding the Trust correct positon regarding Mortality and the learning from deaths process.

### B/03/19/7 OPERATIONAL PERFORMANCE REPORT

7.1 Pete Landstrom summarised key points from the report and advised that there had been a 9% increase in attendances to ED in February 2019 compared to that in February 2018.

7.2 Also in February 2019, the Trust saw an increase in non-elective admissions and Pete drew the Board's attention to the 99.7% average occupancy of beds at the RSCH which translated to approximately one empty bed in the hospital throughout the whole of February.

7.3 Pete acknowledged that there are still a number of patients who waited too long to be admitted and the number of patients who waited longer than 12

hours in ED were similar to the figures in January 2019. There were no further 12 hour breaches after the Level 11 Ward opened on 25th February.

7.4 The national 4 hour wait standard in A&E has seen improvement and was now near to how the Trust was performing the previous year and that meeting the 4 hour target remains a key objective for the Trust.

7.5 The 62 day pathway compliance rate reduced to the same rate as in December 2018; however, the Board noted that the total number of patients on pathways over 62 days had reduced over the past 3 months. The total number of patients that were seen through the pathways increased by almost 50% and the Trust is treating significantly more patients than the historical average.

7.6 Issues with PAS meant that the Trust had been incorrectly over reporting, which had an effect on the performance figures. Work is on-going to resolve the issues with PAS.

7.7 Additional diagnostic appointments and clinics at weekends were operating to assist the delays that remain in Endoscopy. The Trust expects to see further improvements in Diagnostics and Endoscopy through this work.

7.8 Kirstin Baker asked whether improved flow through the Hospital was as a result of fewer people attending ED. Pete informed the Board that ED had not seen a material reduction in attendances but a lot of work has been undertaken to provide alternatives for suitable attendees, such as the facility to book out of hours GP appointments. George Findlay acknowledged that there are also significant peaks throughout the day and an increase in Ambulances too, which is a contributor to the delays.

7.9 Patrick Boyle asked about the RTT performance. Pete advised the Board that there is significant work being undertaken to provide robust recovery trajectories and that the performance is affected by a few key specialities.

7.10 The Board was informed that the Trust will focus on the Constitutional Targets in the coming year and priority will be given to Cancer and Diagnostics. Pete informed the Board that the Trust will work to return to, and maintain the 95% 4 hour wait time target in A&E at PRH. Pete also recognised that A&E at RSCH will require its own set of trajectories, as meeting the 95% target will prove more challenging until Stage One of the capital improvement project is operational.

7.11 **ACTION:** Pete to bring A&E trajectories to the Finance and Performance Committee meeting. **PL**

7.12 The Board **NOTED** the report.

**B/03/19/8 ORGANISATIONAL WORKFORCE AND DEVELOPMENT**

8.1 Denise Farmer highlighted key points from the report, emphasising the work that has been, and continues to be done on the retention of staff and the reduction of the pay bill and agency premiums.

8.2 Denise drew the Board's attention to the Appraisal KPI within the Workforce report. Appraisals are of real importance to the Trust and Denise was disappointed that the figure had not improved at the rate she expected and explained that it should be used as an opportunity to take a different approach to appraisals through revised policies and the Agenda for Change contract refreshment.

8.3 Denise updated the Board on the progress of the WRES Action Plan, which is being updated by a working group who are looking at the plan in conjunction with the results from the Staff Survey and it will include the disability standards improvement plan.

8.4 **ACTION:** Denise to bring the WRES Action Plan to the next Board meeting.

8.5 The Staff Survey performance increased across the Board and Denise reiterated Marianne's earlier point that there was significant improvement to the number of staff that responded. The Trust has recently started collecting monthly data to track staff engagement and the results of the Staff Survey, although not identical in the information that is captured, validated the staff survey data and confirmed the reported views from the CQC.

8.6 Alan asked if the Trust has an issue with their Gender Pay Gap and Denise confirmed that the Trust does not have a problem but that the Trust, like all NHS Trust's, sees the Consultant's Excellence Awards impacting on the reported gap.

8.7 The Board **NOTED** the Organisational Development and Workforce Report.

**B/03/19/9 FINANCIAL PERFORMANCE REPORT**

9.1 Karen Geoghegan updated the Board with M11 performance and explained that the Trust is delivering against its financial trajectory and performance is £0.10m ahead of plan, excluding PSF.

9.2 Karen confirmed that the Trust is on track to deliver the Control Total deficit of £65.4m and efficiency plans are also expected to deliver in full for this year.

9.3 The Trust and CCG have come to an agreed the year position which de-risks the financial position for the Trust.

9.4 Karen advised the Board that Finance have completed some significant work on the Trust's capital spend, which has seen an improvement in the month towards delivering the capital programme.

9.5 Given the Operational Performance challenges, the Chair felt that all those involved have done extremely well to improve the financial position and stabilise the deficit.

9.6 The Board **NOTED** the Financial Performance Report.

**B/03/19/10 REPORT FROM 3TS COMMITTEE TO BOARD**

10.1 Kirstin Baker verbally updated the Board on the 3T's Committee that she chaired the previous day.

10.2 Pete informed the Board that the confirmed delivery of some aspects of Stage 1 has been delayed; however, Stage 1 is still on track to be delivered against the initial timetable.

10.3 The Board was advised that a soft market testing exercise is being conducted before Stage 2 goes out to tender to ensure VFM is maintained. A paper on the outcome of the exercise will be brought to Board.

10.4 The Board **NOTED** the update.

**B/03/19/11 LEADERSHIP, CULTURE AND WORKFORCE REPORT**

11.1 Denise provided assurance to the Board of the information contained within the report and added the Trust is in a better position to work on further improvements and developments, now that the full results of the Staff Survey had been received.

11.2 The Board **NOTED** the report.

**B/03/19/12 MATERNITY INCENTIVE SCHEME**

12.1 Nicola Ranger provided the Board with an explanation of the scheme that the Trust is seeking to take part in again the year.

12.2 There were 10 key safety actions that the Trust had to achieve to receive further funding for Maternity and if these are achieved then the Trust could receive payment reduction against it maternity insurance premium of £1m. Last year, BSUH excelled and met fully the criteria set, securing the Trust a further £500k in reduced insurance premiums.

12.3 Nicola informed the Board of the 10 key safety actions and explained that in August, the Trust will submit their results for this year.

12.4 Nicola referred to safety action 3 and asked the Board to recognise that because the Trust can provide more intensive support, having to transfer neonatal babies can be avoided.

12.5 The Board were advised that this item will come to future Board meetings more regularly and it was suggested that it may be of further use for members of the scheme to attend to present the item. Joanna also suggested that the Quality Committee would benefit from a more comprehensive paper on the scheme.

12.6 **ACTION:** Advise the team who work on the Maternity Incentive Scheme to attend the Quality Assurance Committee ahead of the potential for a presentation of a future Board meeting. **NR**

12.7 The Board **NOTED** the report.

**B/03/19/13 BOARD ASSURANCE FRAMEWORK**

13.1 Glen Palethorpe introduced Board Assurance Framework (BAF), which was previously considered by the Trust Executive Committee on 5th March.

13.2 A number of risks have reduced to their target risk score and Glen added that further assurance was received at the Finance and Investment Committee earlier in the day, when the Chief Finance Officer confirmed that the Trust continues to be on track to deliver the efficiency programme and this will support the further reduction in these related risks.

13.3 Risk against constitutional targets, recorded in Section 5, increased to 15 in February and Glen advised that Trust reduced performance as discussed earlier at the Board was the driver for the increased risk but acknowledged that increased efforts have maintained it in March.

13.4 Glen reminded the Board that the BAF will be referred to within the Trust's Annual Governance Statement which will be provided in draft to the Audit Committee in April and return to Board in May as part of the Trust's annual

report.

13.5 Alan recognised the risk against patient safety but asked for further explanation of this risks score. George acknowledged that the rating may appear counterintuitive against the Trust's strong Friends and Family responses; however, this BAF risk is different.

13.6 The Board agreed that in effect this risk is different to that around experience and the Trust's deteriorating performance meant a differentiated score was appropriate to the risk that measured experience which was supported by positive FFT and other feedback mechanisms.

13.7 Joanna commented that section 3.2 in respect of being unable to effect cultural change, did not reflect the Staff Survey and CQC results. Denise acknowledged that staff morale and sustainability have improved but change in culture had not yet been embedded across the Trust. Marianne added that the Trust has improved culture but further work remains to change it. Glen reminded the Board that the BAF was reviewed at the beginning of February, prior to the Trust receiving the Staff Survey results.

13.8 The Board **NOTED** the Board Assurance Framework and **AGREED** it should be used to inform the Trust's Annual Governance Statement.

**B/03/19/14 USE OF TRUST SEAL**

14.1 Glen presented the record of the Trust Seal use in 2018/19 and noted that the Seal had not been used since November 2018.

14.2 The Board **NOTED** the report.

**B/03/19/15 TERMS OF REFERENCE**

15.1 Glen Palethorpe presented the Finance and Performance Terms of Reference, which was previously reviewed at the Finance and Investment Committee and recommended to the Board for approval. In reviewing their Terms of Reference, the Finance and Investment Committee recognised the strong linkage between Finance and Performance across the Trust. The Committee agreed that the operational performance of the Trust should be included in the remit of the Committee meetings, thus the decision was to retitle the meeting to Finance and Performance Committee.

15.2 The Board were advised that the Terms of Reference will be subject to review once the Performance element of the meeting is developed over the coming year.

15.3 The Board were advised that the Terms of Reference for all Committees were included, for reference and informed the Board that the Terms of Reference for the 3Ts Committee will be brought to Board for approval at a future meeting.

15.4 The Board **APPROVED** the Terms of Reference.

**B/03/19/16 STP – POPULATION HEALTH CHECK**

16.1 Marianne Griffiths informed the Board that she met with her STP colleagues recently and they requested that the Board had sight of the Population Health Check.

16.2 The Board were informed that it serves as a good diagnostic tool and there has

been significant, positive engagement since it was implemented.

16.3 It provides clear background to the STP's priorities and plan for the future. Marianne also advised that the STP have tasked to produce an overarching action plan, which will be brought to Board through the usual governance routes, once it is received.

16.4 In the region, with the exception of one, all providers are rated as 'good' or 'outstanding' and there are none in special measures. Marianne also noted that the financial health of the region has improved.

16.5 The Board were advised that the Population Health Check will form the base of 3Ts being able to form the cornerstone of the Trust. Denise advised that the workforce plan will be looked into further and Alan emphasised the need for this to be clinically led.

16.6 The Board **RECEIVED** the Population Health Check.

**PB/10/18/20 QUESTIONS FROM THE PUBLIC**

20.1 The Board answered questions from the public, which were previously circulated to Board members.

1. Karen confirmed that the efficiency savings target for the next year is £27 and the team are working closely with clinical leads to plan for how it will be achieved.

2. Mr Graham was advised that the Trust has dedicated responsibility for the PFI for The Royal Alexandra Children's Hospital and there is a dedicated Director who holds responsibility for the contract; reviewed monthly and subject to consumer process, where appropriate. Karen confirmed that at the end of the PFI contact, the building will revert to ownership by the Trust. Karen also responded to a further question regarding the Trust's confidence in holding PFI holders to account and advised that further resources and focus had been put in in the last 9 months.

20.2 Mr Shetty, an Anaesthetist and ITU Registrar who has worked for BSUH for 6 months, attended to praise the patient safety and care he had witnessed at both RSCH and PRH. He informed the Board that he holds a Cardiac bleep since he joined the Trust and felt that the escalation plan at the Trust is extremely robust. George thanked him for his comments and correlated Mr Shetty's comments on escalation plans to the Trust's Breakthrough Objective around the deteriorating patient.

**Francesca Carroll**
**Board and Committee Administrator**
**March 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.<br>*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.<br>*Update – 10/5/19* the strategy on the agenda for both future QAC and Board. |
| | | | | | |
| 27th March 2019 | PB/03/19/7.11 | **Operational Performance Report –** it was agreed that it may be helpful for Pete to bring the trajectories to the next Board meeting. | Pete Landstrom | 29th May 2019 | Complete – included in Operational Performance Report. |
| 27th March 2019 | PB/03/19/8.4 | **WRES update –** There is a working group who are using the results from the Staff Survey to refresh the WRES action plan. Denise to bring back an updated action plan | Denise Farmer | 29th May 2019 | This matter is proposed to be closed as details of the action plan will be included within the LCW update. |
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Brighton and Sussex University Hospitals NHS Trust

# Chief Executive's Report

Dame Marianne Griffiths

May 2019

# Content

- Celebrations: April and May
- Diary highlights
- Looking ahead

# Celebrations

## A cup of cheer

A series of thank you events were held across the organisation in April to recognise the work of our staff over winter and during our recent CQC inspection. Along with saying a personal thank you to over 1,000 staff and volunteers, every staff member and volunteer who came received a reusable cup with the words 'Good Work, Great People' and '#ProudtobeBSUH' on it along with a 'have a cuppa on us' voucher.

The reusable cup was an idea from Trust staff to say thank you in a meaningful way and help to try and reduce the 64,000 single use cups that we use and throw away every year.

## Patient First Improvement System: Graduation day

Wave 4 of our PFIS programme graduated in April, with colleagues from Albourne, Balcombe, Ansty, Clayton, Plumpton and SRC celebrating the end of their training. Fifteen months since the beginning of the programme, 25 areas have now taken part and another 18 are underway.

## Marathon effort

A huge thank you to all the BSUH runners and helpers who turned out for the Brighton Marathon last month, which saw more than 14,000 competitors and 150,000 spectators cheering them along the route. The medical team, led by A&E consultant Dr Rob Galloway, was made up of staff from across our and neighbouring trusts and provided an invaluable service on the day.

# Celebrations

## International nurses and ODP days

International Nurses Day is celebrated every year all around the world on 12 May to commemorate the birthday of Florence Nightingale and to mark nurses' contributions towards people's health. Parties were held at PRH and RSCH for nurses and midwives to come together and celebrate their profession and of course eat cake

Operating Department Practitioner Day was on 14 May. It celebrates the ODP profession and aims to create more awareness about the vital role ODPs play in our theatres and in patient care.


## HELP service marks 10 years

HELP (Health, Employee Learning and Psychotherapy) the BSUH confidential support, counselling and psychotherapy service, celebrates its 10th anniversary  this month.

Set up by former A&E nurse Donna Butler, HELP offers short-term, solution-focused sessions using a range of integrated therapies, such as Cognitive Behaviour Therapy, Gestalt therapy, using the arts as therapy, and EMDR (Eye Movement Desensitisation and Reprocessing.)

# Celebrations

## Mentoring scheme launched

Our trust's first ever LGBTQ+ Mentoring Scheme launched to an enthusiastic reception on  29 April . The scheme is designed to provide support  to colleagues to develop their careers,  as well as learn from others.

## Investing in services

The board has agreed to fund £4.6m in endoscopy services across the County and Princess Royal hospitals. This is one the largest investments in equipment upgrade that the Trust has made in recent years and includes the complete replacement of all endoscopy scopes across both sites over the next two years as well as the replacement of all sterilisation and decontamination equipment.

In addition, the Endoscopy department under went a successful Joint Advisory Group on GI Endoscopy (JAG) inspection at the end of April. JAG accreditation is an important external endorsement of services . The inspection team were very complimentary about the nursing leadership and recognised the significant work that had been undertaken in the department over the past 18 months.

# Diary highlights

- Meetings with partner organisations
- Sustainability and Transformation Partnership
- Sharing our story:
    - Lean Academic Conference
    - Hosted Improvement event

- New consultants day
- NHS retirement fellowship
- Thank you events
- Acute Network
- East Sussex Women of the Year

# Looking ahead

## STAR Awards: July 4

The 2nd annual Patient First Star Awards event takes place on July 4, supported by Brighton and Sussex University Hospitals Charity and Brighton and Hove Albion Football Club. This year more than 750 nominations were received, celebrating the work of our staff and volunteers across the trust.


## Stonewall submission

At our first LGBTQ+ Inclusion Conference this year, we committed to becoming a Stonewall Top 100 Employer for its Workplace Equality Index (WEI), and to creating continuing year-on-year improvements for our LGBTQ+ staff. We now have 100 days until the date of our intended WEI submission on 6th September.

We are currently ranked 143 out of 445 entrants last year, which was a demonstration of how much we already do well. A number of projects are underway to support our goal to further improve the experience of our LQBTQ+ staff.

## We're going back to Pride

In August the trust is going back to Trans Pride, Disability Pride and will be a part of the Brighton & Hove Pride Parade. Last year's Pride Parade was a great way to build our networks and to feel part of a community within the trust. All BSUH staff, students and volunteers are welcome to take part, regardless of whether you identify as LGBTQ+ or not.

We are also planning a major recruitment campaign to tie in to the Pride events which will feature advertising along the Pride route and digital advertising at both Brighton and London Victoria train stations.

Brighton and Sussex University Hospitals NHS Trust

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| **Agenda Item:** | 6 | **Meeting:** | Trust Board in Public | **Meeting Date:** | 29 May 2019 |
| **Report Title:** | 2019/20 Operational Plan | | | | |
| **Sponsoring Executive Director:** | Pete Landstrom, Chief Delivery and Strategy Officer | | | | |
| **Author(s):** | Oliver Phillips, Director of Strategy and Planning | | | | |
| **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 | Sets out the Trust's ambitions for Quality for 2019/20 | | | | |
| Financial | Provides a summary of the Trust's financial expectations for 2019/20 | | | | |
| Workforce | Provides the key Workforce improvements for 2019/20 | | | | |
| **Link to CQC Domains:** | | | | | |
| Safe | ✓ | Effective | ✓ | | |
| Caring | ✓ | Responsive | ✓ | | |
| Well-led | ✓ | Use of Resources | ✓ | | |
| **Communication and Consultation:** | | | | | |
| The full Operational Plan was approved by the Trust Board in March and submitted to NHS Improvement in April 2019 | | | | | |
| **Executive Summary:** | | | | | |
| The Trust's Operational Plan is a key document which, on an annual basis, summarises the Trust's approach to delivery of Access, Workforce, Quality and Financial targets and standards. It also summarises the Trust's Strategic Direction, outlining the Trust's True North, Breakthrough Objectives, Strategic Initiatives and Corporate Projects.<br><br>The attached slides provide a high level summary of the Operational Plan, which was required to be submitted to NHSI at the beginning of April 2019. The summary will be posted on the Trust's website. | | | | | |
| **Key Recommendation(s):** | | | | | |
| The Board is asked to REVIEW the summary Operational Plan prior to the plan being posted on the Trust's website. | | | | | |

# Brighton and Sussex University Hospitals Trust

## 19/20 Operational Plan

# Introduction – BSUH Operational Plan 2019/20

Brighton and Sussex University Hospitals NHS Trust

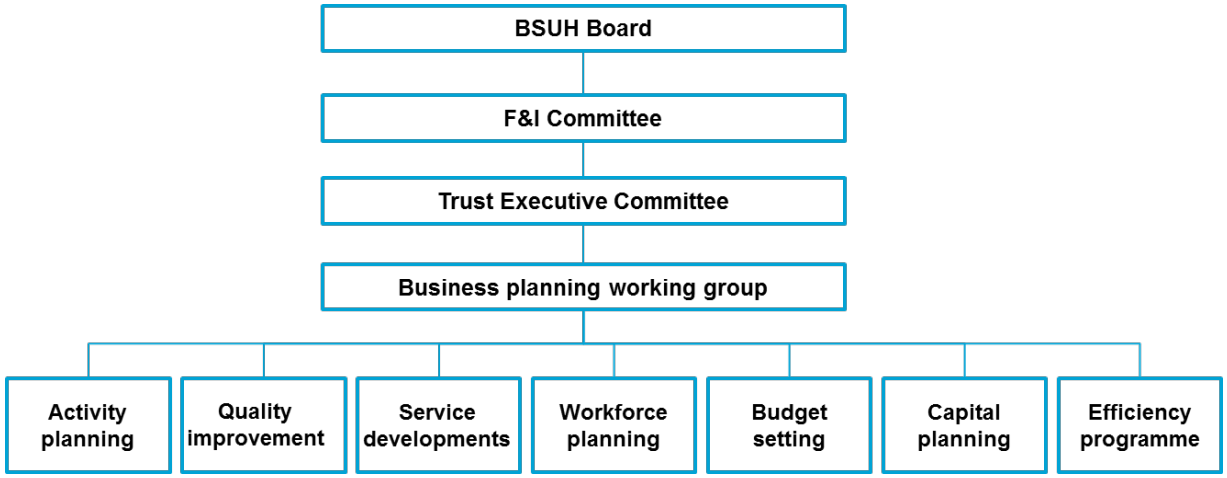
- Our Operational Plan for 19/20 demonstrates how we intend to build on the solid foundations we have created at BSUH over the past two years
- Our revised Strategic Initiatives focus on the significant issues that will face the Trust over the next 3-5 years across performance, finance, culture, quality and system development
- Our Corporate Projects have been refreshed for 19/20 – and include the Major Trauma Centre, the development of our Emergency Department, the Pathology Network and improvements to our Estate
- The Operational Plan sets out how during 19/20 we are going to achieve our ambitions, across all of our True North domains

# The Trust's approach to developing the plan

Brighton and Sussex University Hospitals NHS Trust

## Governance

Business planning has been led by a multifunctional team across BSUH with control provided by directors, regular reporting to Trust Executive and Board oversight




## High level process

The integrated process has brought together top-down strategic planning with divisional prioritisation

### October

Business planning approach agreed at Trust Executive Committee

### November to February

Strategic initiatives, corporate projects and breakthrough objectives

Integrated operational planning across quality, performance, activity, workforce and finance

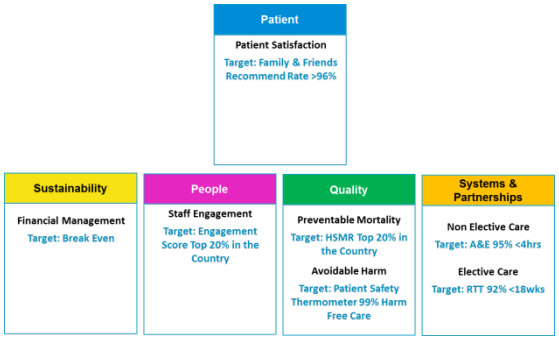
### March/April

Cascade through Catchball process

# Strategy Deployment Framework

Brighton and Sussex University Hospitals NHS Trust

## True North



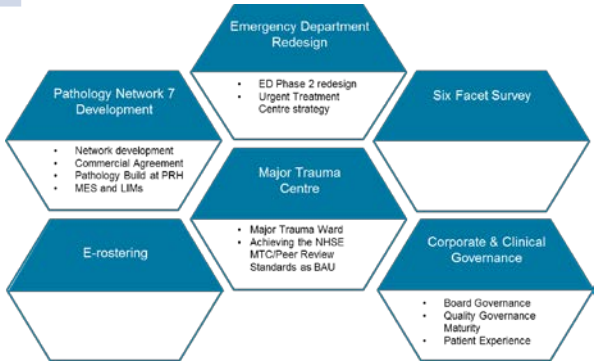

## Breakthrough Objectives

| True North Domain | 2019/20 Proposal for Operational Plan |
|---|---|
| Patient | Reduction in complaints where staff attitude is cited as an issue |
| Sustainability | Reduction in Medical Pay |
| People | Staff believe that Care is the top priority for the organisation |
| Quality | Improvement in cancer treatment |
| Systems & Partnerships | Reduction in the numbers of patients waiting >4hrs who are not admitted |

## Strategic Initiatives

| Patient First | Leadership Culture and Workforce | 3Ts Build Programme | Clinical Sustainability and Transformation | Operational Productivity | Research and Education |
|---|---|---|---|---|---|
| **Strategy Deployment**<br>• Strengthening SD flow and Board links<br>**PFIS**<br>• Embedding & standardising PFIS maturity within Divisions<br>**Improvement Projects**<br>• Supporting Operational Productivity Work streams<br>**Improvement Capacity**<br>• Focusing improvement skills on org priorities | **Corporate & Clinical Leadership**<br>• Finalising Corporate and Divisional structures<br>**Leadership Development Programme**<br>• Implementation of the Leadership Strategy<br>**Cultural Transformation Programme**<br>• Continuation of Cultural development and equalities work<br>**Organisational Workforce Planning & Processes**<br>• Launch of the BSUH Workforce Strategy inc 3Ts | **Build and transition to Phase 1**<br>• Completion of Phase 1 and Transition Operation Plan for 2021<br>• Workforce planning to support transition and maximise efficiencies as part of MTFP<br>**Phase 2 & 3 development**<br>• Confirm Phase 2 and 3 Scope linked to Estates Master planning | **Sustainability**<br>• Estates Rationalisation & Master planning<br>• Medium Term Financial Plan<br>**Developing Clinical Networks**<br>• Provider to Provider links<br>• Cancer Provider Review<br>**Clinical Strategy Implementation**<br>• Oversight of Clinical Strategy Implementation<br>• QVH clinical links<br>**ICS/ICP Development**<br>• Understanding and development of roadmap for ICS and ICP | **Outpatient Productivity**<br>• Productivity and utilisation<br>• Outpatient Transformation and new models of care to support 3Ts Phase 1<br>**Theatre Efficiency**<br>• Productivity and Theatre Utilisation<br>• Maximisation of Day case capacity and Activity<br>**Length of Stay**<br>• GIRFT based LOS opportunities – specialty rolling programme | **Education**<br>• Developing our relationship with BSMS and maximising our integrated education strategy<br>**Research**<br>• Supporting and Developing our Trust Research including development of a research strategy and business plan |

## Corporate Projects



# BSUH True North

## 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

# Breakthrough Objectives for 2019-2020

Brighton and Sussex University Hospitals NHS Trust

| True North Domain | 2019/20 Proposal for Operational Plan |
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| **Patient** | Reduction in complaints where staff attitude is cited as an issue |
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| **People** | Staff believe that Care is the top priority for the organisation |
| **Quality** | Improvement in cancer treatment |
| **Systems & Partnerships** | Reduction in the numbers of patients waiting >4hrs who are not admitted |

# Strategic Initiatives

Brighton and Sussex University Hospitals NHS Trust

| Patient First | Leadership Culture and Workforce | 3Ts Build Programme | Clinical Sustainability and Transformation | Operational Productivity | Research and Education |
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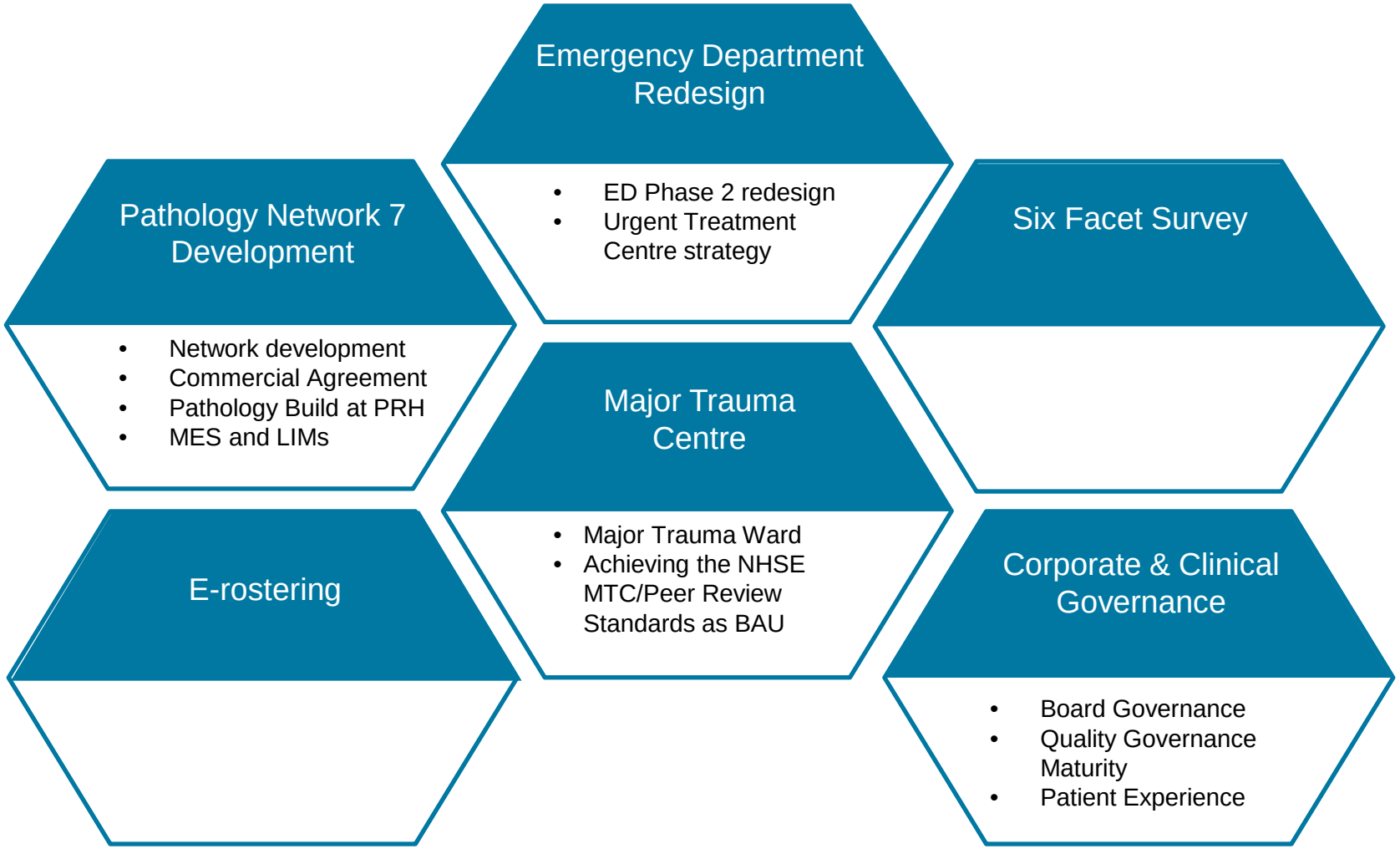
| **Strategy Deployment**<br>• Strengthening SD flow and Board links<br><br>**PFIS**<br>• Embedding & standardising PFIS maturity within Divisions<br><br>**Improvement Projects**<br>• Supporting Operational Productivity Work streams<br><br>**Improvement Capacity**<br>• Focusing improvement skills on org priorities | **Corporate & Clinical Leadership**<br>• Finalising Corporate and Divisional structures<br><br>**Leadership Development Programme**<br>• Implementation of the Leadership Strategy<br><br>**Cultural Transformation Programme**<br>• Continuation of Cultural development and equalities work<br><br>**Organisational Workforce Planning & Processes**<br>• Launch of the BSUH Workforce Strategy inc 3Ts | **Build and transition to Phase 1**<br>• Completion of Phase 1 and Transition Operation Plan for 2021<br>• Workforce planning to support transition and maximise efficiencies as part of MTFP<br><br>**Phase 2 & 3 development**<br>• Confirm Phase 2 and 3 Scope linked to Estates Master planning | **Sustainability**<br>• Estates Rationalisation & Master planning<br>• Medium Term Financial Plan<br><br>**Developing Clinical Networks**<br>• Provider to Provider links<br>• Cancer Provider Review<br><br>**Clinical Strategy Implementation**<br>• Oversight of Clinical Strategy Implementation<br>• QVH clinical links<br><br>**ICS/ICP Development**<br>• Understanding and development of roadmap for ICS and ICP | **Outpatient Productivity**<br>• Productivity and utilisation<br>• Outpatient Transformation and new models of care to support 3Ts Phase 1<br><br>**Theatre Efficiency**<br>• Productivity and Theatre Utilisation<br>• Maximisation of Day case capacity and Activity<br><br>**Length of Stay**<br>• GIRFT based LOS opportunities – specialty rolling programme | **Education**<br>• Developing our relationship with BSMS and maximising our integrated education strategy<br><br>**Research**<br>• Supporting and Developing our Trust Research including development of a research strategy and business plan |

# Corporate Projects

Brighton and Sussex University Hospitals NHS Trust



# BSUH 19/20 Summary

Brighton and Sussex University Hospitals NHS Trust

## Start point

- Trust in Quality and Financial Special Measures
- Poor culture and reputation
- Five CEOs in five years
- 2nd worst staff survey in the country

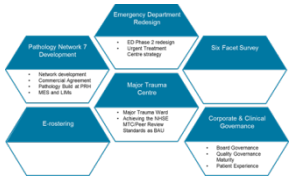



## Organisational goals

- Exit Quality Special Measures
- Exit Financial Special Measures
- Building an organisational culture that will sustain improvement into the longer term
- Building on A&E improvements
- Progressing the 3Ts programme

## Progress to date

- Moved from an ‘inadequate’ to a ‘good’ CQC rating and exited Quality Special Measures
- Delivered control total and efficiency plan for past two years and exited Financial Special Measures
- Staff engagement & culture significantly improved




## Priorities for 19/20

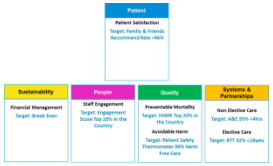
- Improve performance against Constitutional Standards
- Launch of Clinical Strategy implementation
- Base year of Medium Term Financial Plan
- Deliver a control total (excluding PSF and FRF) of £51.148m deficit for 2019/20
- Deliver efficiency requirement of £27.07m
- 3Ts transition planning
- ‘4Rs’ Workforce Strategy: Recruitment, Retention, Resource Optimisation and Risk Management

# Activity and Finance

Brighton and Sussex University Hospitals NHS Trust

## Start point

- £68.5m deficit in 2016/17
- In Financial Special Measures from August 2016
- Weak control environment
- No CIP Plan in place for 2017/18



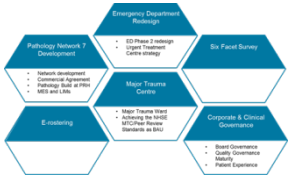

| True North Domain | Current 2018/19 Breakthrough |
|---|---|
| Patient | Reduction in complaints where staff attitude is cited (BEING REFRESHED) |
| Sustainability | Medical pay reduction (TBC) |
| People | Staff believe Care is the Top Priority of the organisation (BEING REFRESHED) |
| Quality | Improvement in Cancer Treatment (TBC) |
| Systems & Partnerships | Reduction in the numbers of patients waiting >4hrs who are not admitted |

**Organisational goals**

- Stabilise and improve the Trust's financial position
- Deliver and embed recurrent efficiency planning

## Progress to date

- Delivered control total and efficiency plan in 2017/18 and 2018/19
- Strengthened control environment, PMO, financial reporting and governance, financial leadership and capacity
- Undertook comprehensive assessment of drivers of the deficit from 2014/15 to 2016/17
- Exited Financial Special Measures
- Use of Resources - Requires Improvement
- Developed Medium Term Financial Plan/proposition




**Priorities for 19/20**

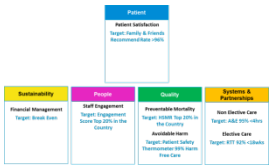
- Deliver a control total (excluding PSF and FRF) of £51.148m deficit for 2019/20
- Deliver efficiency requirement of £27.1m
- Outpatient Productivity
- Theatre Utilisation
- Maximisation of Day case capacity and Activity
- GIRFT based LOS opportunities

# NHS Constitutional Standards

Brighton and Sussex University Hospitals NHS Trust

**Start point**

- Deteriorating performance for A&E
- Elective targets with increasing numbers of 52 week RTT waits



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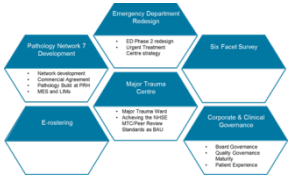
| People | Staff believe Care is the Top Priority of the organisation (BEING REFRESHED) |
| Quality | Improvement in Cancer Treatment (TBC) |
| Systems & Partnerships | Reduction in the numbers of patients waiting >4hrs who are not admitted |

**Organisational goals**

- Non Elective Flow target: A&E 95% <4hr
- Elective Flow target: RTT 92% <18wks
- Improvement in cancer treatment times

**Progress to date**

- Reduction in patients waiting 52 weeks
- Despite some early in year A&E improvement more recently there has been a deterioration in performance including 12 hour breaches
- PAS issues emerged following the implementation of the Medway PAS system




**Priorities for 19/20**

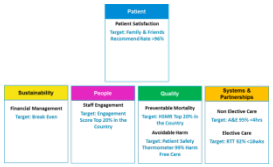
- Recovery of the constitutional standards
- Emergency Department redesign
- Length of Stay and early discharge improvement
- Community beds review
- Outpatient transformation
- Endoscopy investment
- Embedding of new PAS

# Quality

Brighton and Sussex University Hospitals NHS Trust

## Start point

- CQC rating of Inadequate
- In Quality Special Measures
- Must Do and Should Do requirements relating to Governance, Leadership, Culture and Strategy

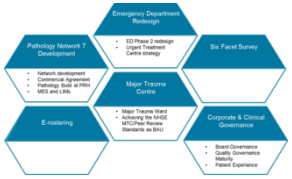



## Organisational goals

- Preventable Mortality target: HSMR Top 20%
- Avoidable Harm target: Harm Free Care
- Patient Satisfaction target: >96%
- Improving Cancer Outcomes

## Progress to date

- Established & rolled out Patient First
- Moved from an ‘inadequate’ to a ‘good’ CQC rating
- Improvements in harm-free care
- Improvements in delivering 7-day services
- Established quality governance assurance framework




## Priorities for 19/20

- Deliver Quality Improvement Plan
- Launch of Clinical Strategy implementation
- Developing Clinical Networks
- Major Trauma Centre
- Response to CQC recommendations
- Reducing Mixed Sex Accommodation

# Workforce

Brighton and Sussex University Hospitals NHS Trust

**Start point**

- Severely damaged culture dominated by equality and inclusion issues
- Poor staff engagement (bottom 20%)
- Instability of senior leadership

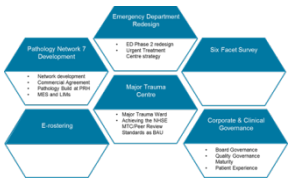



**Organisational goals**

- Staff Engagement Score Top 20% in the Country
- Workforce KPI performance in upper quartile

**Progress to date**

- Staff engagement significantly improved - staff survey improved in 2/3 of the 90 questions, 21 stayed the same or slightly better in 2019
- LQBQT+ Network conference
- WRES progress




**Priorities for 19/20**

- Recruitment - BSUH as 'employer of choice'
- Improve retention
- Workforce optimisation
- Reduce medical workforce premium spend by £5M
- Corporate & Clinical Leadership
- Leadership Development Programme
- Cultural Transformation Programme
- Organisational Workforce Planning & Processes

# Integrated Performance Report

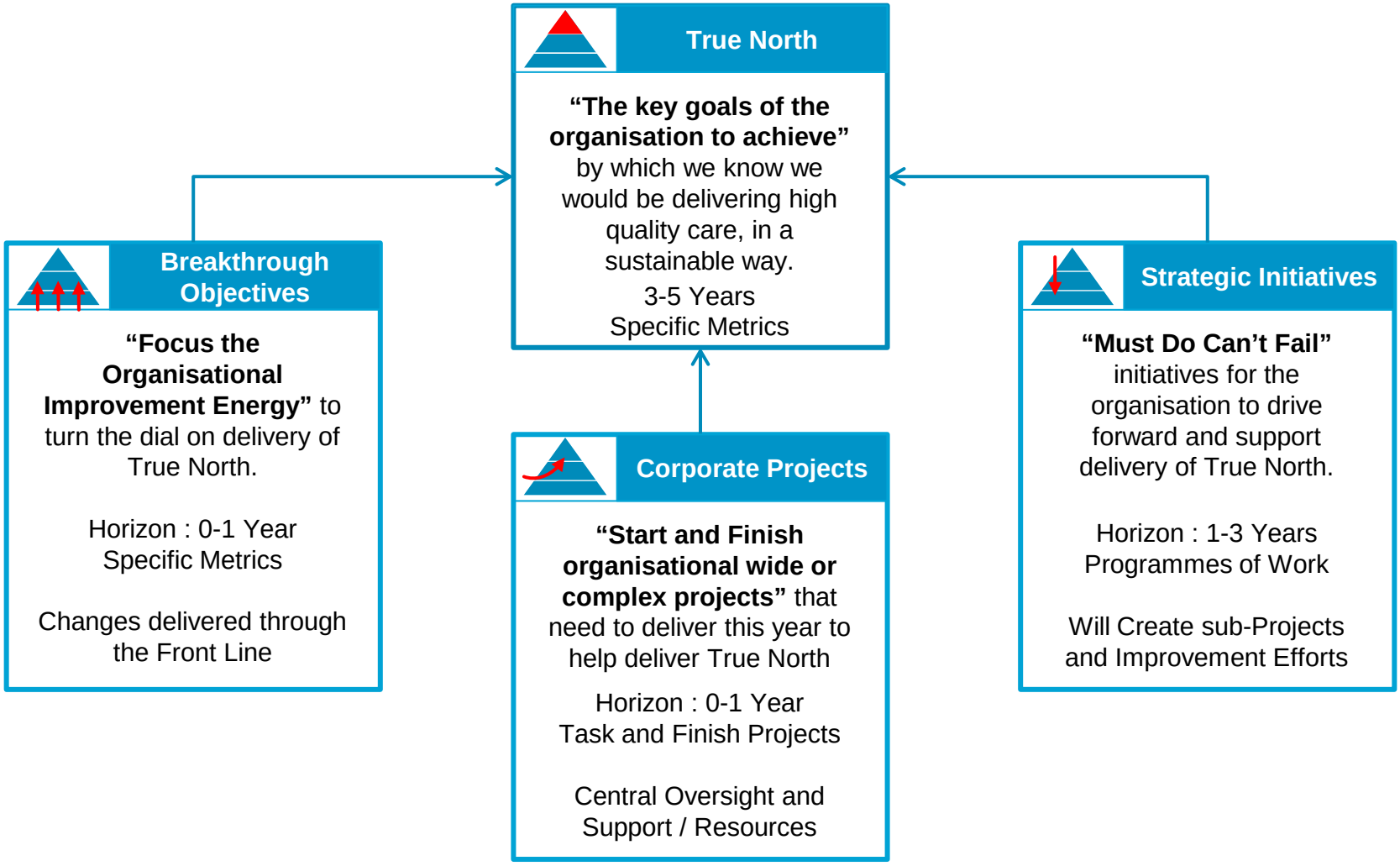
# May 2019

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

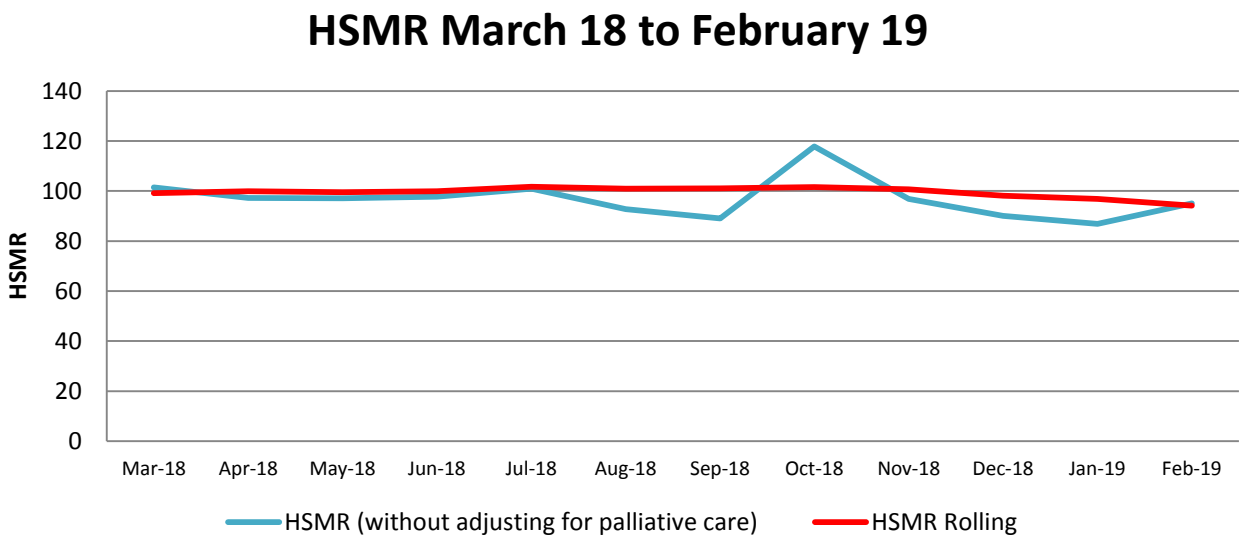
**Quality**

**Preventable Mortality**

**Target: HSMR Top 20% in the Country**

**Avoidable Harm**

**Target: Patient Safety Thermometer 99% Harm Free Care**



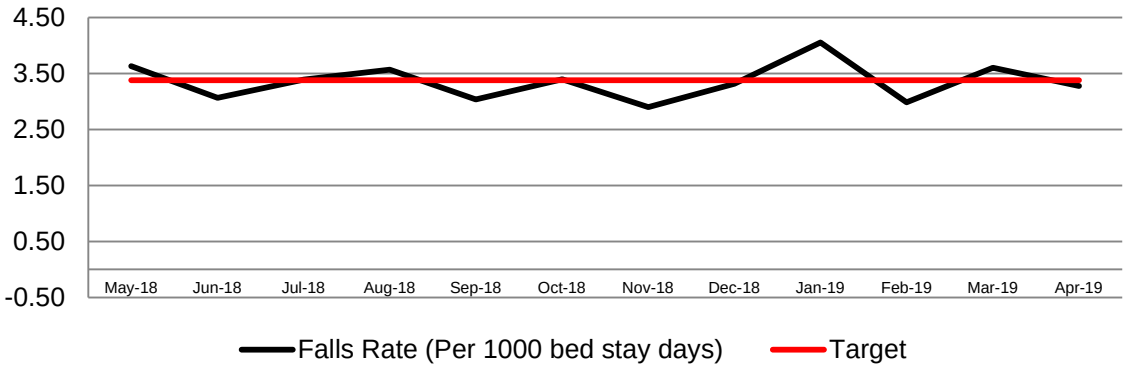

HSMR is lower than expected at 94.11 for the last 12 months (down from 99.11 for the prior 12 month period)

The rolling 12 month mortality rate continues on a downward trend

The harm-free care score for the past 12 months was 95.43 against the target of 95%. The national average is 94.2%.

# Quality Performance

## Inpatient falls rate per 1000 bed days




**Quality**

**Inpatient Falls**

**Target: 3.38 falls per 1000 bed stay days**

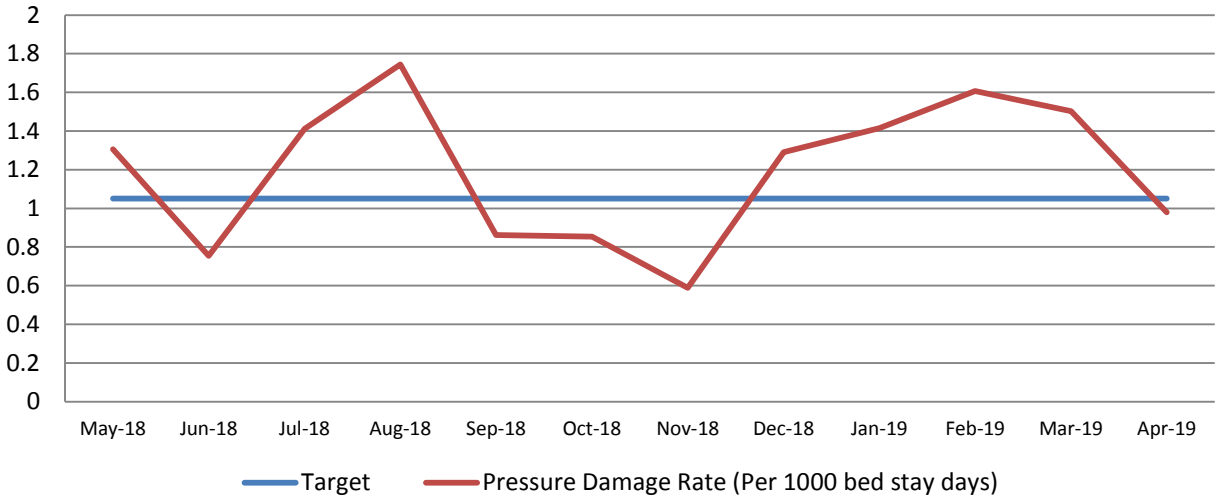
**Pressure Ulcers**

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

The rate of inpatient falls for the past 12 months was 3.32. The national rate of falls is 6.62.

The rate of pressure ulcers for past 12 months is 1.20 against a target of 1.05; primarily due to a rise in patients being admitted with existing pressure ulcers

## Pressure ulcer rate per 1000 bed days

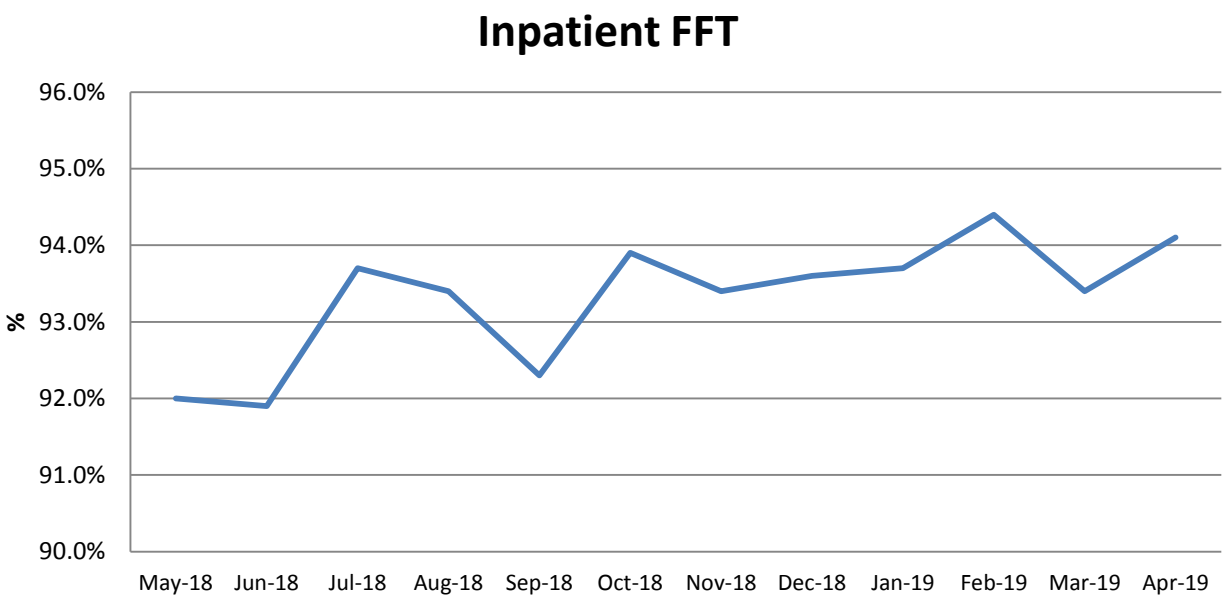


# Quality Performance

**Quality**

**Friends and Family Test**

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




In April the Inpatient FFT was 94.7%, there has been a improvement throughout 18/19.

The Emergency Department FFT is 90% in April 2019, the national average has never exceeded 86%, the national average response rate is 12% and BSUH's rate is 18%

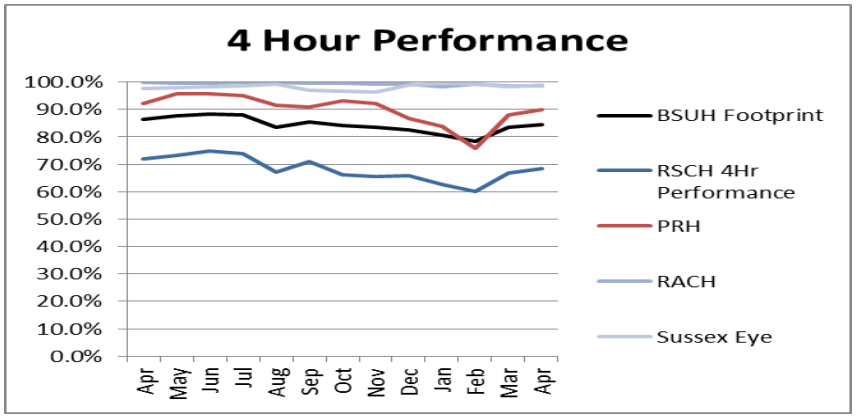
In March 2019 over 6000 people who used our services provided feedback.

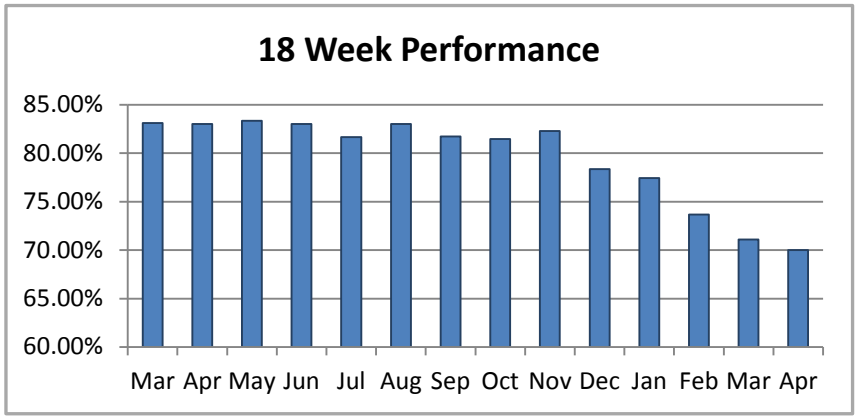
# Operational Performance – Summary

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

- A&E Performance Improved to 84.4% (acute footprint) in April-19 compared to the national performance of 85.1%.
- 62 day cancer performance for GP referral to treatment improved by 13% to 72.9% in March-19 and the overall number of patients waiting more than 62 days reduced by 9.5% through the course of the month .
- RTT Performance deteriorated by 1.1% in April 19 to 70.1%, with the waiting list increasing in size by 1014 patients overall.
- Diagnostics 6 week performance deteriorated by 4.49% to 24.2% in April linked to capacity constraints predominantly in imaging.

# Operational Performance – True North Metrics




- Trust A&E Performance for April 2019 was 84.4% including the NHSE allocated type 3.
- This is the same position as reported in Mar-18, and -2.1% worse than April 2018.
- The trust had 2882 4 hour A&E breaches which was 573 (24.8%) more than the same month last year.
- The trust was below the national average performance of 85.1% in April-19.

- Trust performance for RTT in April 19 was 70.1% for all specialties, a deterioration of -1.1% since Mar-19.
- There were 14 52 week waiters at end Apr-19.
- The RTT incomplete Waiting List rose by 1014 waiters in Apr-19 compared to March.

**Improvement Focus:**

- Improvements at the front door relating to increased same day emergency care, ambulatory care and configuration for UCC
- Targeted reduction in long stay (stranded) patients, expediting discharge
- Additional physical bed capacity in Quarter 4

**Improvement Focus:**

- Delivery of the commissioned activity levels to stabilise the RTT position.
- Finalise the capacity and demand plans by speciality including identifying any gaps and mitigation schemes.
- Operational productivity strategic initiative to support efficiency improvement.
- Priority work to clear 52 week backlog

# Operational Performance – Cancer

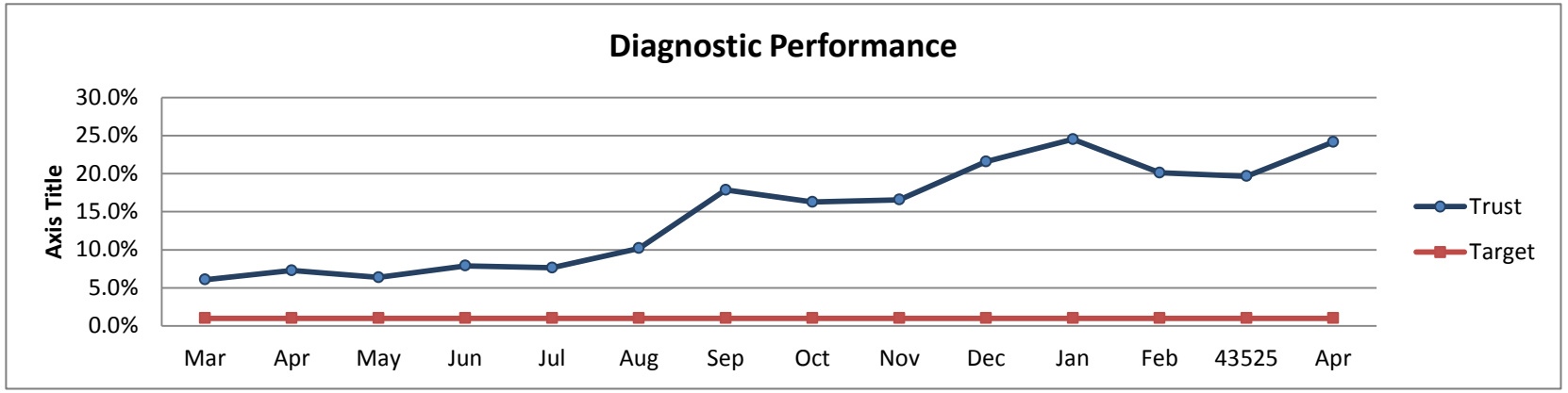
| Cancer Performance | Target | 2019/20 YTD | Apr-19 |
|---|---|---|---|
| 2 week GP ref to 1st OP | 93.0% | 86.7% | 86.7% |
| 2 week GP ref to 1st OP - breast symptoms | 94.0% | 92.2% | 92.2% |
| 31 day 2nd or subs trtmnt - surgery | 98.0% | 100.0% | 100.0% |
| 31 day 2nd or subs trtmnt - drug | 94.0% | 100.0% | 100.0% |
| 31 day 2nd or subs trtmnt - radiotherapy | 96.0% | 98.8% | 98.8% |
| 31 day diag to trtmnt all cancers | 90.0% | 95.3% | 95.3% |
| 62 day ref to trtmnt: screening | 90.0% | 88.1% | 88.1% |
| 62 day ref to trtmnt : upgrade | 85.0% | 80.0% | 80.0% |
| 62 days urgent GP ref to trtmnt : all cancers | 92.0% | 72.9% | 72.9% |

- The Trust was compliant in 4 of 9 cancer metrics in Mar-19.
- The Trust was also non-compliant against the 62 day urgent referral to treatment target of 85%, with 72.9% of patients commencing treatment within 62 days this is a 12.7% improvement compared to February and 1.9% higher than performance Mar-18.
- 33.5 patients were treated passed the 62 day breach target out of a total of 123.5 treatments undertaken.
- The most challenged tumour sites are colorectal, upper GI and Gynaecology.

**19/20 Improvement Actions**

- Diagnostic recovery plan to support cancer recovery
- Joint work with the CCG on specific pathways to minimise delay
- 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)
- Development and Implementation of Risk Stratified Pathways for Care - Stratified pathways for breast, colorectal and prostrate to improve the quality and effectiveness of care and support to those living with and beyond cancer are to be developed - Q1
- Prostate-specific antigen (PSA) Monitoring - GP Surveillance of Patients with Prostate Cancer in Primary Care releasing capacity at the Trust (Q1)

# Operational Performance – Diagnostics




- Trust diagnostics performance for Apr 2019 was 24.16%.
- This is a deterioration from 19.67% in march Mar-19.
- Endoscopy and imaging capacity challenges are the biggest contributor to the difficult performance
- Endoscopy are currently utilising an in source provider to boost internal capacity.

**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.
- The associated activity and recovery trajectory is reviewed weekly with NHSi.
- Options for additional capacity and productivity in both imaging and endoscopy are under scope.

# Financial Performance - Summary

**Sustainability**

**Financial Management**

**Target: Break Even**

- At the end of April, the Trust is reporting a deficit of £6.73m excluding PSF, FRF and MRET income.

- Performance is in line with plan and the Trust is on trajectory to deliver an underlying deficit of £53.0m which will earn an additional £25.4m of PSF and FRF funding. The Trust will also receive £1.9m of MRET funding. This will achieve the year-end control total deficit, including PSF, FRF and MRET, of £25.7m

- At the end of Q1, the Trust needs to deliver a deficit of £17.8m in order to earn £3.81m of PSF and FRF income. In 2019/20 there are no performance or access targets associated with the payment of PSF and FRF income. MRET income of £0.46m will be paid for Q1 as the Trust has accepted its control total.

- 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 April the aggregate finance rating is a 3; each of the individual metrics are in line with plan.

## Control Total (Surplus) / Deficit £k — G

| | Plan | Actual / Forecast | Variance |
|---|---|---|---|
| Year-to-date exc PSF/FRF/MRET | 6,733 | 6,732 | 1 |
| Year-end Forecast exc PSF/FRF/MRET | 52,996 | 52,996 | 0 |
| Year-to-date | 5,309 | 5,308 | 1 |
| Year-end Forecast | 25,747 | 25,747 | 0 |

The Trust deficit in month 1, excluding PSF/FRF/MRET is in line with the plan. As a result of delivering the underlying control total the Trust has earned £1.27m of PSF and FRF.

## Efficiency and Transformation Programme £k — G

| | Plan | Actual / Forecast | Variance |
|---|---|---|---|
| Year-to-date | 798 | 841 | 43 |
| Year-end Forecast | 27,070 | 27,070 | 0 |

The efficiency programme has delivered £0.84m in month 1, which is £0.04m above the target. The forecast is to deliver the plan in full.

## Capital £k — A

| | Plan | Actual | Variance |
|---|---|---|---|
| Year-to-date | 7,093 | 9,617 | (2,524) |
| Year-end Forecast | 146,760 | 146,760 | 0 |

**Strategic Capital:** expenditure of £9.5m; £2.5m above plan. Month 1 reflects a provision up to contract value for 3Ts which is £4m more than work completed and agreed cashflow. This will be adjusted by end of Q1.
**Operational Capital:** expenditure is £104k is £275k below plan, of which £100k relates to charitable funded schemes and £175k relates to service developments.

# Financial Performance – Key Metrics

## Income £k — R

| | Plan | Actual / Forecast | Variance |
|---|---|---|---|
| Year-to-date | (50,824) | (48,939) | (1,885) |
| Year-end Forecast | (632,768) | (632,768) | 0 |

Income was below plan by £1.88m in-month, of which £1.33m relates to activity related income and on £0.55m relates to other operating Income.

Key drivers are NHSE (£0.4m) and MSK (£0.3m) performance against plan.

## Operating Costs £k — G

| | Plan | Actual / Forecast | Variance |
|---|---|---|---|
| Year-to-date | 54,454 | 52,671 | 1,783 |
| Year-end Forecast | 647,694 | 647,694 | 0 |

In April, operating costs were £1.8m below plan, mainly due to underspends relating to activity and £0.44m for PbR exclusions. Pay is overspent by £0.2m, the key driver being medical expenditure which is £0.62m above budget.

## Agency Ceiling £k — A

| | Ceiling | Actual / Forecast | Variance |
|---|---|---|---|
| Year-to-date | 1,016 | 1,056 | (40) |
| Year-end Forecast | 11,783 | 11,783 | 0 |

Agency costs of £1.01m, were £0.04m above the agency ceiling. Agency expenditure in Month 1 equates to 3.1% of the total pay bill and is below the average of previous months, despite the 2 bank holidays in April.

## Cash £k — G

| | Plan | Actual | Variance |
|---|---|---|---|
| Year-to-date | 3,004 | 3,760 | 756 |
| Year-end Forecast | 3,004 | 3,004 | 0 |

At the end of April the cash balance was £3.8m 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 2019/20 Sustainability Breakthrough Objective is to reduce medical pay overspend by c£5m. Significant progress has been made in the develop the management information, enhance the control environment and secure engagement necessary to deliver.

- Demand and capacity plans are being developed to ensure alignment with the activity plan and performance trajectories that have been agreed with commissioners and submitted to NHSI.

- A contract position has been agreed with the CCG Alliance and signature is expected by the end of May. Progress has been made with NHS England; contract values are agreed and contract documentation is expected imminently.

- The Trust is forecasting delivery of the £25.7m deficit control total which includes securing PSF and FRF allocations in full.

# Improving Staff Engagement

**People**

**Staff Engagement**
**Target: Top 20% Engagement Score in the Country**

**April pulse survey** results show that overall the Trust Staff Engagement Score was 6.9 against the current Trust target of 7.0. Although methodologically there is not a complete correlation between the national staff survey and our pulse survey it does provide us with good indicative data. This month the data showed that 3 out of the 9 engagement questions are above the national average results for 2018. These are "I would recommend my organisation as a place to work", "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation" and "I am able to make improvements happen in my area of work." The Chief Operating Officer division including F&E has the highest Staff Engagement score at 7.6 out of 10 (which would match the best performing Trust in the 2018 staff survey) and they are also the most improved percentage points improvement this month, and for Clinical Divisions Children's and Women's have the highest result at 7.3 out of 10.

**Staff friend and family test** our quarterly submission for the Friend and Family test in April has shown the highest rating in over five years in staff agreeing that they would recommend BSUH as a place to work and as a place for their friends and relatives to receive treatment. It also shows that those who do not agree they would recommend BSUH to their friend and family as a place to work or to receive treatment is at the lowest point.

**Health and Wellbeing** activities continue including staff MOT's have taken place at PRH in April. A full schedule was booked due to targeting specific teams rather than generic emails. Focus groups and staff feedback held throughout April/May to gather information to inform the updated wellbeing plan Two strong themes coming out for staff are there wish for us to meet their basic needs and mental health. Two video interviews of staff on twitter to support BSUH 'proudly international'. These have been successful and views totaling 1000 as of mid-May. More videos are planned with the theme #BSUHgreatplacetowork. BUZZ articles this month have featured NHS and local discounts and staff benefits. Monthly posters for May have been displayed in staff restaurants and key locations around the Trust to promote our H&W support for staff.

**Equality, Diversity and Inclusion** continues to be a key priority. The new LGBTQ+ mentoring scheme was launched. A new Disability Staff Network has been launched. The Chief Executive met with members of the Workforce Race Equality Standard Working Group to discuss progress since the conference. The Stonewall top 100 employers action plan continues at pace. The 2018 Workforce Disability Standard has been prepared for launch in the summer and the Working Group has commenced.

**Agenda for Change Contract Refresh** plans continue to be implemented

# Improving Staff Engagement and Communications

**People**

**Staff Engagement**
**Target: Top 20% Engagement Score in the Country**

**Recruitment and Selection**: April 2019 saw a shift of tempo to our recruitment campaigns with a greater focus being placed on driving engagement via our social media platforms. These campaigns have included a series of Nursing podcasts, specialist campaign support for a number of struggling vacancies, alongside the promotion of local press material featuring our staff.

In addition, the Trusts advertisement placed at London Victoria in January 2019 continues to run free of charge. This advert, alongside the above has continued to direct potential applicants to our nursing portal. Preparations are also underway for the largescale recruitment/ media campaign being devised to support this year's Brighton Pride event and the RCN Nurses Day on the 14th May 2019. Anyone with an interest in the above should be encouraged to visit https://www.facebook.com/BSUHRecruitmentTeam/ or https://twitter.com/BSUHRecruitment

Lastly, the Trust held 2 Nursing Recruitment events in April 2019 which saw the successful recruitment of 13 Band 5 Nurses (8 external and 5 internal staff moves).

**Thank you events: Good Work, Great People:** Two *Thank You* events took place on 9 April (PRH) and 17 April (RSCH) where staff were thanked in person and given a reusable cup and coffee voucher. To date more than 6,000 cups have been distributed at both our main sites and satellite sites around Brighton & Hove and East Sussex. This was promoted via info-net, email, screensavers and social media – with staff tagging photos of themselves with their thanks using #ProudToBeBSUH.

**Staff Survey and communications channels:** Four communications questions were included in the staff survey to improve the team's understanding of the channels staff use to keep informed. The questions looked at team cascades, use of the info-net and the weekly staff newsletter. Staff were also asked which channel they found most effective for keeping up-to-date about the latest news in the trust. This feedback is now being used to inform the development of our communication channels.

**Patient First Star Awards:** Nominations for the annul staff and volunteer recognition awards were open for one month. The awards were promoted internally using all channels including Buzz, the Chief Executive's Weekly Message, Trust Brief and info-net. The awards were also widely promoted externally on our social media channels and in press releases sent to all local media outlets. We received double the number of nominations this year – 750 compared to 370 in 2018.

# Workforce  Capacity and Capability

In M1, overall workforce spend was £34.26m against a plan of £33.96 (an overspend of £196k). Medical was the key driver of this position with an overspend of £620k as well as Ancillary staff contributing a further £121k. The position was partially mitigated by significant underspends within the Nursing workforce (£292k) and 'Other' Healthcare (£124k) which are largely AHP and STT staff.

In April, agency costs of £1.01m represent 3.1% of the total pay bill and are over the M1 agency ceiling of £1.0m. However, expenditure in M1 was below the average of previous months, despite two bank holidays in April.

Worked hours is reduced this month due to a reduction in availability of temporary staffing likely to be due to Easter holidays.

The Board has recently approved a new business case for significant change management programme and IT system to transform rostering, job planning, measuring safer staffing levels and a new bank system. Implementation will commence in August.

| | Measures | Last Month | This Month | Variance |
|---|---|---|---|---|
| Worked | WTE | 8,180 | 8,138 | ↓ |
| % worked to budget (WTE) | % | 98.88 | 95.46 | ↓ |
| Temporary Workforce (WTE) | % | 8.02 | 6.68 | ↓ |
| Agency | % | 1.41 | 0.98 | ↓ |
| Bank | % | 6.60 | 5.70 | ↓ |

# Operational Performance – Key Metrics

| KPI | Target | Current position | Comments |
|---|---|---|---|
| **True North**<br>**Staff engagement score**<br>(out of 10 with 10 being the best)<br>2018 best performing Trust scored 7.6 | Above national average<br><br>2018 average is currently 7.0 | 6.9 | In 2017 our engagement score was in the bottom 20% of all acute Trust's. We are now just below average which is a significant improvement. Our target for the 2019 survey next is to be above average.<br>We continue to collect this information monthly as part of our pulse survey.<br>Refreshed score based on 2018 annual staff survey. |
| **Break through Objective**<br>**Staff believe that Care of patients / service users is the Trust's top priority**<br>(Q21A)<br>2018 best performing Trust scored 88.3% | Above national average 76.7% | 76.8% | Our score in 2017 was in the bottom 20% at 67.7% so this represents a significant improvement.<br>Refreshed score based on 2018 annual staff survey. |
| **Appraisal compliance** | 90.0% | 77.9% | Our 90% target was last achieved in May 2018.<br>Currently clinical Divisions were 78.7% compliant (down 0.5%), with Corporate divisions 73.2% compliant (up 1.9%).<br>SDR and the Trust Executive Management Committee will continue to be the forum to manage and drive performance to 90% plus. |
| **Statutory and mandatory training compliance** | 90.0% | 87.3% | This is the first time in a year that we haven't hit our target of 90%. |
| **Sickness rate**<br>Rolling 12 month | 3.75% by March 2019 | 3.99% | Our 12 month sickness absence rate as at March 2019 was 4.12% |
| **Staff Turnover** | 12.5% by March 2019 | 12.9% | Our turnover rate is the lowest it has been since 2016.<br>Reducing turnover in key areas remains a top priority. |

Brighton and Sussex University Hospitals NHS Trust

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|---|---|---|---|---|---|
| **Agenda Item:** | 12 | **Meeting:** | Trust Board | **Meeting Date:** | 29 May 2019 |
| **Report Title:** | Finance and Performance Committee Report to Board | | | | |
| **Sponsoring Director:** | | Patrick Boyle, Non-Executive Director | | | |
| **Author(s):** | | Patrick Boyle, Non-Executive Director | | | |
| **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 Finance and Performance Committee met on 30 April 2019. It was quorate with four NEDs and was attended by the Chief Executive, Chief Finance Officer, Trust Finance Director, Chief Delivery and Strategy Officer, Human Resources Director and Director of Efficiency & Delivery.

The Committee recognised that this was the first meeting under its revised terms of reference and incorporating detailed performance information. During the meeting the Committee reflected on the level of information needed to effectively fulfil its terms of reference. It was agreed that the usual business rules as applied across the Trust would be applied to the information presented to the Committee and that counter measure reports would also be provided to set out the actions being taken, if a deteriorating trend is identified. It was also agreed that the tracking of performance improvements against the Trust's agreed trajectories would be added to the performance reports for the next meeting.

The Committee through its receipt of the finance and performance information was assured over the processes applied in respect of the delivery of the Trust's control total for 2018/19, and the delivery of the 2018/19 efficiency programme. It was recognised that delivery represented an outstanding result, given the huge demand, workforce and financial challenges faced.

The Committee were also pleased to note work on the 2019/20 efficiency programme and was assured over the work continuing over the next few weeks to progress the maturity of the identified schemes.

Reports were also received and discussed on workforce and procurement.

The Committee also reviewed and agreed to recommend to the Board they approve a business case for the adoption and implementation of workforce system.

**Key Recommendation(s):**

The Board is asked to **NOTE:**

That the Trust delivered its agreed control total and delivered a deficit of £65.335m excluding PSF. As a result the Trust earnt in total £14.39m PSF, this level of PSF was some £7m more than the original plan because the Trust had successfully delivered its financial control total. The whole Trust is to be thanked for achieving this outstanding result.

The level of assurance that flowed through to this Committee especially in respect of the 2019/20 efficiency programme development and the work being undertaken to progress the maturity of the schemes within the programme.

The Committee will continue to review the depth and scope of information it receives over the first quarter of 2019/20 seeking to apply the Trust's business rules for escalated information where deterioration has occurred or there is an increased risk of a deteriorating position occurring.

The Committee recommended to the Board they approve a business case for the adoption and implementation of workforce system.

To: Trust Board Date: 29 May 2019

From: Patrick Boyle, Finance and Performance Committee Chair. Agenda Item: 12

**COMMITTEE HIGHLIGHTS REPORT TO BOARD**

| Meeting | Meeting Date | Chair | Quorate | |
|---|---|---|---|---|
| **Finance and Performance Committee** | **30 April 2019** | **Patrick Boyle** | **yes** | **no** |
| | | | ✓ | ☐ |

**Declarations of Interest Made**

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

**Actions taken by the Committee**

The Committee received the suite of Financial Performance reports. The Committee was assured over the processes applied in respect of the delivery of the Trust's control total for 2018/19, capital programme and the management of its cash balances. The Committee recognised the hard work undertaken across the Trust to deliver the agreed control deficit of £65.335m excluding PSF. The Committee noted that as a result the Trust earnt in total £14.39m PSF, this level of PSF was some £7m more than the original plan because the Trust had successfully delivered its financial control total.

The Committee received the developing Workforce performance report and was assured over the actions described to address the Trust's continued improvements across a range of workforce metrics.

The Committee was very pleased to receive the report on the full delivery of the 2018/19 efficiency programme. The Committee was assured over the 2019/20 processes, having received information from the Director of Efficiency and Delivery on the maturity of the schemes within the 2019/20 efficiency programme had the work taking place over the forthcoming weeks to further progress the rest of the schemes within the programme. It was recognised that there were some highly complex schemes and some more challenged areas. The Committee was assured that these would be subject to appropriate robust governance and oversight to support delivery whilst still delivering business as usual activity. It was agreed that the Committee would receive and seek more detailed information and assurance on the risks areas, as needed.

The Committee received the suite of Operational Performance reports. In recognition of this being the first meeting with its enhanced focus on performance the Committee reflected on the level of information it needed to effectively fulfil its Terms of Reference. The Committee agreed it would utilise the business rules applied across the Trust to require information, supported by counter measure reports if a deteriorating trend is identified. The Committee was informed that for future reports that the performance improvement trajectories would also be added to allow the Committee. From discussion of the performance dashboards, the Committee was assured that actions had been identified and were being taken to improve performance.

The Committee was assured over the Trust's procurement activity, recognising the limitations of the national model hospital metrics.

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

The Committee asked that business rules be applied and they receive information on the counter measure performance as Medicine delivers their key efficiency schemes across 2019/20 and on any other key areas of performance where these measures are needed.

| |
|---|
| The Committee agreed they will continue to review the depth of information it receives over the first quarter of the year seeking to apply the Trust's business rules for escalated information where deterioration has occurred or there is an increased risk of a deteriorating position occurring. |

| **Items referred to the Board or another Committee for decision or action** | |
|---|---|
| **Item** | **Referred to** |
| The Committee recommended to the Board they approve a business case for the adoption and implementation of workforce system. | Board for approval |

Brighton and Sussex University Hospitals NHS Trust

| | | | | | |
|---|---|---|---|---|---|
| **Agenda Item:** | 12 | **Meeting:** | Trust Board | **Meeting Date:** | 29 May 2019 |
| **Report Title:** | Audit Committee Report to Board | | | | |
| **Sponsoring Executive Director:** | Martin Sinclair, Non-Executive Director | | | | |
| **Author(s):** | Martin Sinclair, Non-Executive Director | | | | |
| **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 10th April 2019 and was attended by the Chief Finance Officer, Trust Finance Director, Group Company Secretary and Local Counter Fraud Specialist along with the Trust's Internal and External Auditors.

The meeting was quorate with three Non-Executive Directors in attendance.

**Key Recommendation(s):**

The Board is asked to **NOTE:**

The Audit Committee are keeping under review the improvements being made to secure an improved response rate in respect of declarations of interest.

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board

Date: 29th May 2019

From: Martin Sinclair, Audit Committee Chair.

Agenda Item: 12

**COMMITTEE HIGHLIGHTS REPORT TO BOARD**

| Meeting | Meeting Date | Chair | Quorate | |
|---|---|---|---|---|
| **Audit Committee** | **10th April** | **Martin Sinclair** | yes | no |
| | | | ✓ | ☐ |

**Declarations of Interest Made**

Jon Furmston informed the Committee that his wife has a new job and has updated his declaration.

**Actions taken by the Committee**

- The Committee **NOTED** the Draft Head of Internal Audit Opinion and asked Grant Thornton to give consideration to their opinion given the amount of progress that had been made in 18/19.
- The Committee **NOTED** the Internal Audit reports and April Progress Report. The feedback on a number of reports was positive. The GDPR follow up and Procurement of Medical Devices and Infrastructure reports were discussed in further detail as Grant Thornton identified provided only partial assurance.
- The Committee **APPROVED** the LCFS Internal Workplan for 19/20
- The Committee **NOTED** the progress of Ernst & Young's external audit and received positive feedback on the improved relationship between the Trust and Auditors.
- The Committee **APPROVED** the preparation of Annual Accounts on a Going Concern basis.
- The Committee **AGREED** the Annual Governance Statement represented a balanced view and based on the planned update should then be submitted in the annual report.
- The Committee **AGREED** with the wording of the Audit Committee assurance letter to Ernst & Young.

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

Ian Arbuthnot has been asked to attend the next Committee meeting in July to provide an update on the completion of Phase 1 of the Data Mapping Exercise which has a deadline of December 2019.

Improvements required to educate staff and build on relationships between staff and Internal Auditors so that the Auditors can obtain the information they required to effectively deliver their reports.

The Audit Committee are keeping under review the improvements being made to secure an improved response rate in respect of declarations of interest from senior clinicians.

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

| Item | Referred to |
|---|---|
| No items required Board action or decision. | |

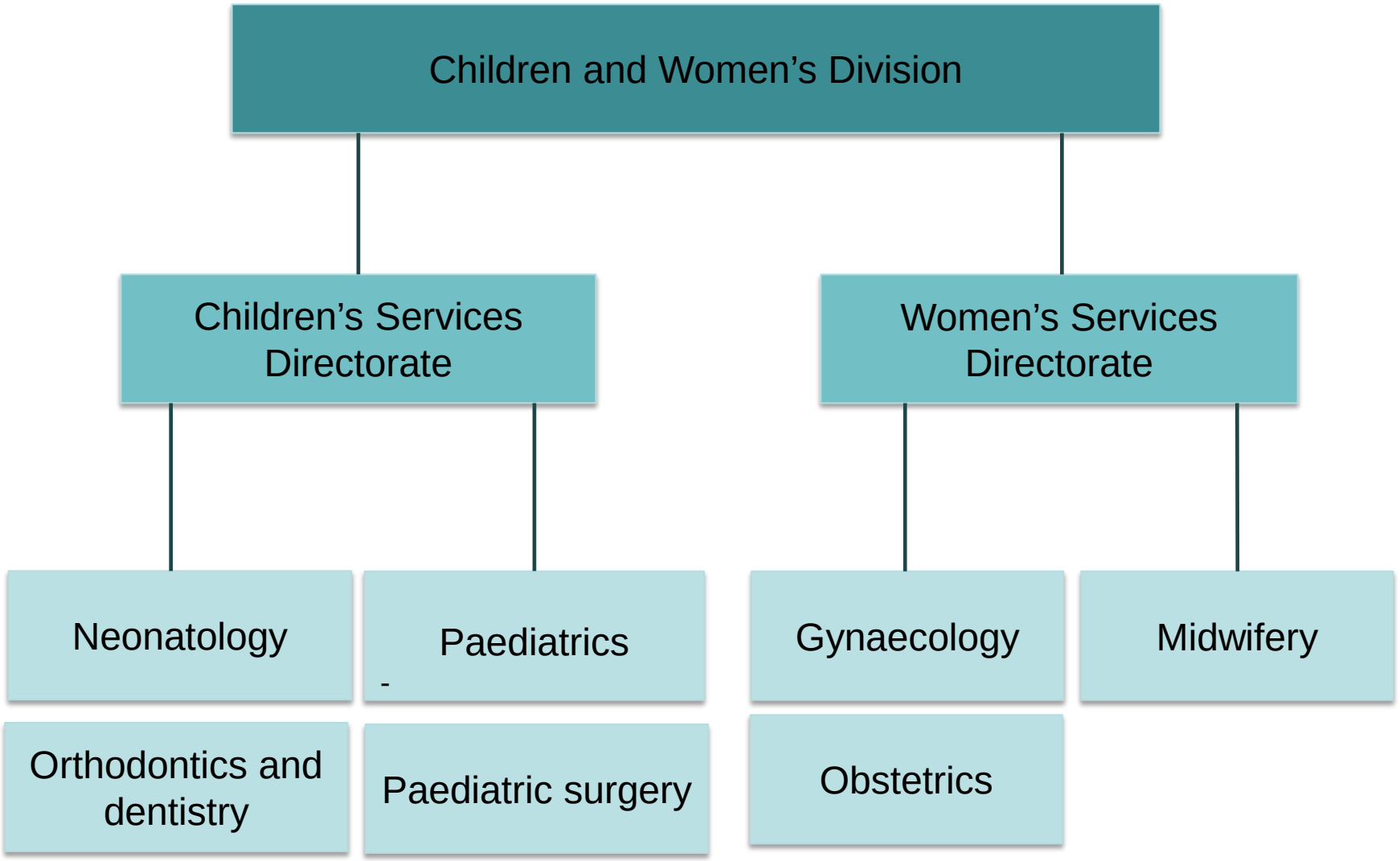
Brighton and Sussex University Hospitals NHS Trust

# Maternity

## Welcome to our services

**Carly Knell - Divisional Director of Operations**
**Dr Ryan Watkins - Chief of Service**
**Amanda Clifton – Head of Midwifery and Gynaecology Nursing**

# Introduction



# Maternity Services Overview

- Overview of Service
- Our achievements – we are proud of
- Challenges – what we're doing

# Our Services

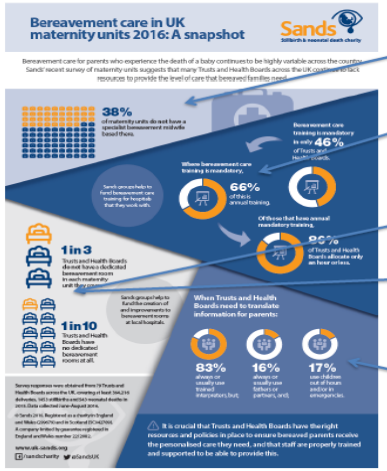
- We deliver over 5000 babies each year
- Services are delivered in RSCH and PRH
- Community services delivered from Hove to Newhaven and as far north as East Grinstead
- We deliver an award winning homebirth service with rates consistently higher than the national average
- We offer a range of specialist services such as:
  - Diabetes
  - Perinatal Mental Health
  - Teenage Pregnancy
  - Birth Stories and VBAC clinics
  - Gender Inclusivity
  - Gold Standard Bereavement Service
  - One Stop for women on prescribed or non-prescribed medication
  - Support for homeless women and the traveller community

# Our Specialist Services

Sands
Stillbirth & neonatal death charity

**Gold Standard Bereavement Facilities at BSUH**

NHS
Brighton and Sussex University Hospitals
NHS Trust




**BSUH has two specialist bereavement midwives, covering a full time role across both sites.**

Mandatory bereavement education for *all* midwives in 2018, in addition to fully funded SANDS training days

RSCH – The Willow Suite
- Stand alone suite with delivery room and family room
- Self contained with kitchenette and bathroom
- Located away from Labour Ward
- Memory making facilities

PRH – The Willow Room
- Located away from Central Delivery Suite
- Newly refurbished in October 2017
- Self contained with shower room
- Not currently used for delivery

Interpreters used on wards and for all consultant follow up appointments where needed.

Dedicated pregnancy loss consultant leads based at each site

## Kate Middleton, Prince William and Prince Harry praise local midwife on World Mental Health Day


A BSUH midwife has received royal recognition for supporting a patient with a history of mental illness during her teenage pregnancy.

Mitch Denny, a midwife at Brighton and Sussex University Hospitals NHS Trust, and Morgan, a patient and local resident, have met with the Duke and Duchess of Cambridge, as well as Prince Harry, in connection with World Mental Health Day.

## BSUH among the best in the country for homebirths

BSUH has one of the best homebirth rates in the country thanks to the hard work and dedication of the Midwifery Team.

A recent homebirth rate for women living in the Royal Sussex County Hospital area was 9.1%, which is almost four times the national rate of 2.3%. The rate for those living in the Princess Royal Hospital area was also better than the rest of the country at 2.8%, giving the Trust and overall homebirth rate of 6.4%.

# Our Education

**We have developed enhanced training programmes:**

- Developed workbooks to support Maternity Care Assistants in their learning and development
- Developed regional teaching for Nursery Nurses
- Training in Advanced Neonatal Life Support (NLS) is being rolled out
- Deliver home birth emergency workshops with paramedics using their Simbulance, reflecting women's stories and experiences
- Increased frequency of CTG training to annual training
- Voted Best Allied Health Professional Teacher by 4th year medical students in 2018


# Maternity Services Overview

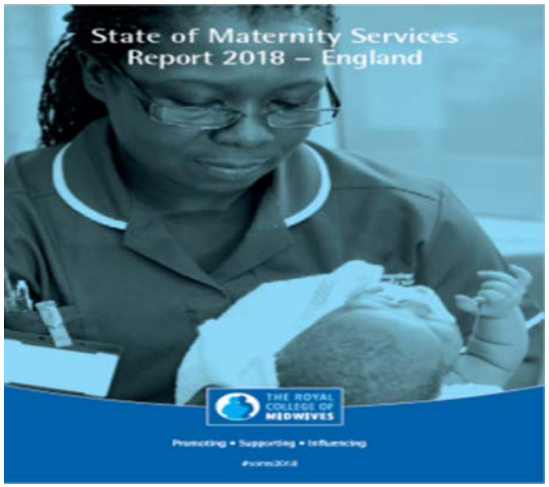
- Overview of Services
- Our achievements – we are proud of
- Challenges – what we're doing

# Patient Safety and Outcomes



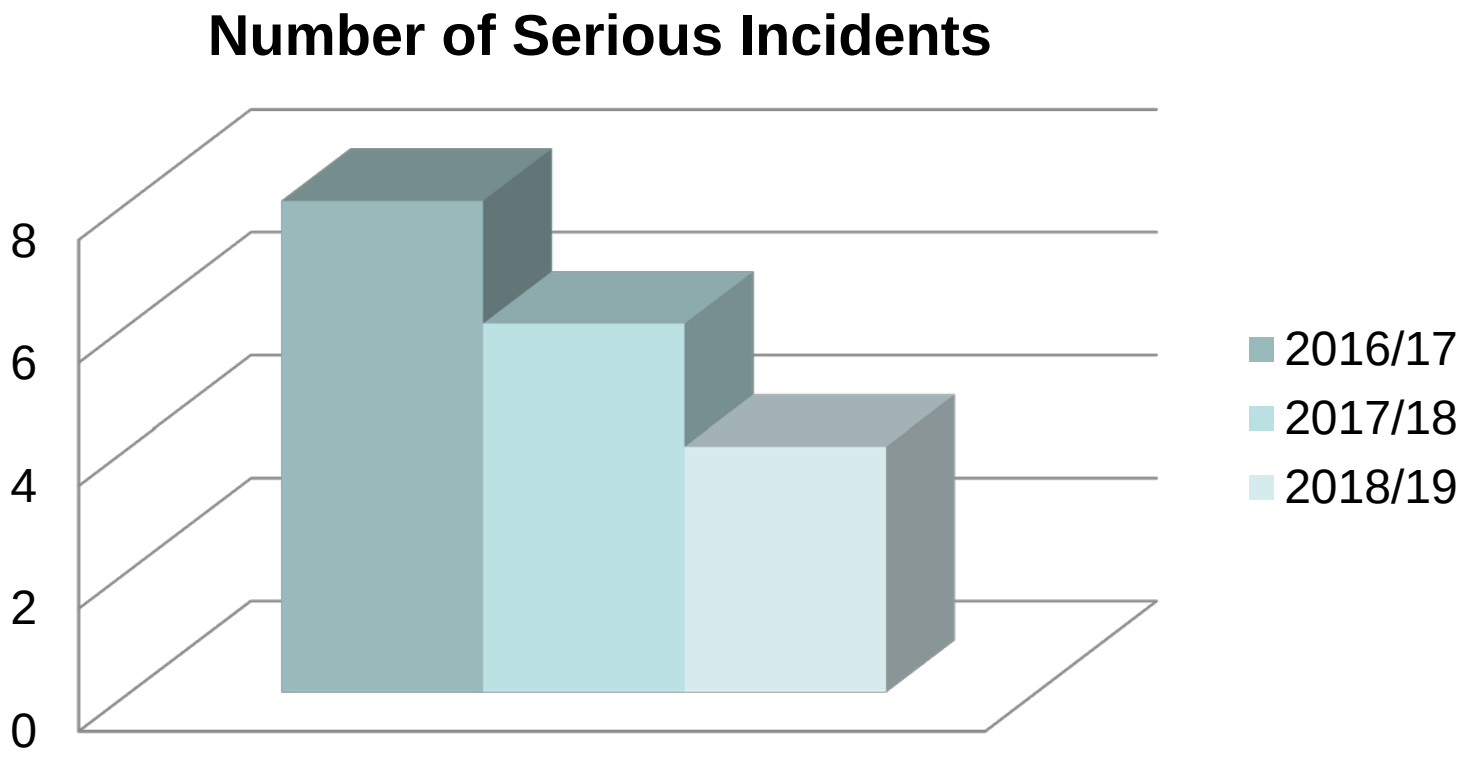








# Patient Safety and Outcomes



# Patient Safety and Outcomes

**We investigate and learn from incidents:**

- All incidents are handled by the directorate's risk co-ordinator who leads investigation and management
- We report, investigate and learn from all incidents, complying with targets for Duty of Candour
- We are engaged with the work of the National Patient Safety Collaborative  to achieve better rates of IUFD and stillbirth, with local staff leading this work nationally
- Actions and learning arising from SI, incident and complaint investigations are disseminated

Safety & Quality meeting

SIRM

Weekly cross site case reviews


Weekly

Datix

Meetings

Monthly morbidity & Mortality meeting


Perinatal Meeting

# Patient Safety and Outcomes

- Brighton & Hove CCG has moved from ‘needs improvement’ to ‘outstanding’ for performance within the NHSE Maternity Transformation Programme
- The introduction of our ORB project in 18/19 our rates of 3rd and 4th degree tears have reduced substantially, with an average rate of 2.3% for the last 4 months, from a high of 7.7%
- We have sustained 99-100% compliance with 1:1 care in labour since August 2017
- We achieved full compliance with the national CNST Premium Incentive Scheme in 18/19
- CQC issued the Maternity Services with an improved rating in 18/19

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Maternity | Good ↑ Jan 2019 | Outstanding ↑ Jan 2019 | Good →← Jan 2019 | Good →← Jan 2019 | Good →← Jan 2019 | Good →← Jan 2019 |

# Workforce and Staff Engagement

- We are established to a 1:30 ratio
- We are fully established
- We don’t use agency
- Our sickness rates has continually improved, currently at 4.3%
- Our appraisal rate is currently 90.6%
- Our staff engagement score is currently 7.3 and is higher than the Trust and national average

# Service User Engagement

- Our current FFT rate is 96.4%
- Our response rate of 21.9% is higher than national average
- MVP give regular “walk the patch” feedback
- 15 Steps to Maternity challenge
- LMS Stakeholder engagement
- Collaborative working with Maternity Voices Partnerships

# Service User Engagement


#MATEXP



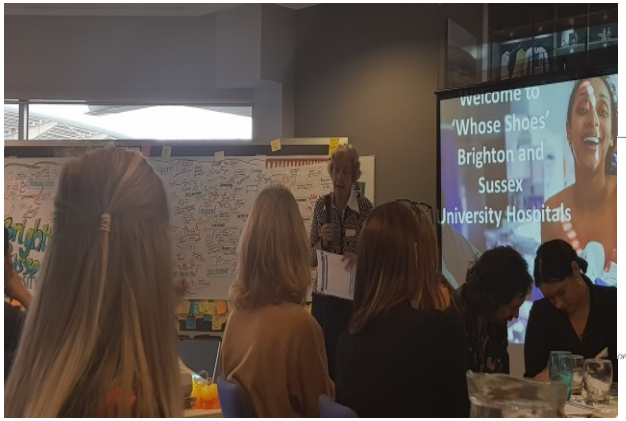



Photo credit: Gill Phillips

# Maternity Services Overview

- We needed to improve – you said
- Our achievements – we are proud of
- Challenges – what we're doing

# Our Challenges

- **Environment**
  - Obstetric Theatres
  - Midwifery-Led Unit
- **IT Systems**
  - Maternity Smart Replacement
  - Introduction of EMRS
- **Productivity**
  - Improved efficiency in LoS
- **Medical Workforce**
  - Junior doctor vacancies

# Our Challenges

- **Acuity and complexity**
  - Birthrate Plus Assessment
  - Expansion of Specialist Services
  - Fetal Medicine Network

- **Delivery of national initiatives**
  - Maternity Transformation Programme
  - Better Births – Continuity of Carer
  - Saving Babies Lives Care Bundle v2
  - Maternity and Neonatal Health Safety Collaborative

- **Finance**
  - Breakeven budget
  - Tariff reductions
  - Cost improvement

Brighton and Sussex University Hospitals NHS Trust

| | | | | | |
|---|---|---|---|---|---|
| **Agenda Item:** | 14 | **Meeting:** | Trust Board in Public | **Meeting Date:** | 29 May |
| **Report Title:** | **Learning from Deaths Quarterly Update** | | | | |
| **Sponsoring Executive Director:** | Dr George Findlay (Chief Medical Officer) and Nicola Ranger (Chief Nursing and Patient Safety Officer) | | | | |
| **Author(s):** | Dr Stephen Drage - Deputy Medical Director: Safety and Quality, Della Morris - Safety & Quality Lead, Rob Haigh – Medical Director | | | | |
| **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 | Reviews of deaths identifies positive areas of practice and areas where improvements can be made to the quality of care provided to patients and to the experience of both patients and their family and friends. |
| Financial | Reviewers and coordination of activity |
| Workforce | There are training requirements and allocated protected time for individuals to undertaken the full review element of this process |

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

**Communication and Consultation:**

**Executive Summary:**

This report has been produced in line with National Guidance on Learning from Deaths, to provide the Trust Board with information relating to the implementation of the guidance, the percentage of inpatient deaths that have been reviewed using a Structured Judgment Review and the themes and learning that are emerging from this work.

The Trust's True North Objective is for the mortality rates (HSMR) to be in the lowest 20% of Trusts.

**Key Recommendation(s):**

The Board is asked to **NOTE** the report.

## 1. Purpose

1.1 There are approximately 1600 deaths occurring in BSUH every year. For many people death under the care of the NHS is an inevitable outcome and they experience excellent care. However, some patients experience poor care resulting from a variety of factors. The purpose of reviews of deaths which problems in care may have contributed to is to learn in order to prevent a recurrence.

1.2 This paper updates the board on the implementation of the Learning from Deaths Policy across BSUH. Data is also included on rates of review and mortality statistics.

## 2. Background

2.1 Learning from Deaths National Guidance

2.1.1 The CQC report 'Learning, Candour and Accountability' published in December 2016 in the wake of the Southern Health/Conor Sparrowhawk controversy outlines the importance of mortality review as a source of learning for improvement. Subsequent to this, in March 2017, the National Quality Board published guidance /requirements for Trusts on mortality review processes and Learning from Deaths. This included:

- Trusts to publish updated policy on how it responds to and learns from deaths
- Trusts to collect and publish specified data on deaths quarterly
- All deaths to be scrutinised by a Medical Examiner or Coroner
- Case record review (Structured Judgement Review) of cases:
  - Where bereaved families and carers or staff have raised a significant concern
  - All deaths of patients with learning disabilities
  - All deaths in a particular diagnosis or treatment group where an alarm has been raised
  - All deaths where patients were not expected to die
  - Death where learning will inform improvement work
  - A further sample of other deaths

2.1.2 BSUH's Learning from Deaths Policy was ratified in 2017.

2.1.3 The specified data has been collected on a quarterly basis using the National Learning from Deaths Dashboard (attached) since Q1 17/18. However, based on feedback from clinicians, the RCP have removed the question regarding 'avoidability' of death from the recommended Structured Judgement Review Tool, but this remains in the Dashboard which is provided by NHSE. Data regarding 'avoidability' of death is now collected from the outcomes of Serious Incident investigations.

2.2 Medical Examiners

2.2.1 After 1st April 2019, a National Medical Examiner (ME) programme for in-hospital deaths will be implemented. In the first instance this will be a 'non-statutory' programme but the aspiration is that the role of the ME will be enacted into law within 2 years. The Royal College of Pathologists is leading on this programme. Funding details remain unconfirmed, but are initially likely to mirror current arrangements.

2.2.2 BSUH were part of a pilot to introduce Medical Examiners, this service is currently only established at the Royal Sussex County Hospital. 8 new Medical Examiners have recently been appointed bringing the total number to 10 at the RSCH.

## 3. Governance

3.1 The Medical Director is the Board Level lead with responsibility for providing executive leadership and overall responsibility for delivering the Learning from Deaths Agenda

3.2 The Deputy Medical Director: Safety & Quality 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 in turns reports to the Quality Governance Steering Group.

## 4. Process

4.1 Deaths associated with the criteria detailed in 2.1.1 are identified through the Serious Incident Review Group, Complaints, Medical Examiners, Medico-legal Department, Learning Disabilities Team, mortality statistics.

4.2 Cases are allocated to a trained reviewer to complete the Structured Judgment Review and share the findings with the care team for the patient.

4.3 Any deaths identified as potentially being the result of failures in care are recorded on the DATIX incident reporting system and reviewed at the Serious Incident Review Group for consideration of a Serious Incident Investigation.

4.4 The SJR tool is embedded into the PANDA system using an electronic form which facilitates data collection and analysis. All Consultants have been given access to submit and review SJRS.

4.5 Deaths of patients with Learning Disabilities are all referred to the Leder Programme for independent review of the full care pathway. However, concerns have been raised that the LeDer Programme is struggling with capacity to undertake the volume of reviews required. This has resulted in delays to reports reaching BSUH; the TMRG have therefore made the decision, to undertake in-house SJRs for all LeDer deaths to ensure timely learning from these deaths

## 5. Training

5.1 SJR training

5.1.1 BSUH have rolled out an in house training programme to support initial training provided by the Royal College of Physicians. Nine training sessions have been delivered across both the RSCH and PRH to a variety of Clinicians, Nurses, CMTs and AHPs.

5.1.2 In total 62 staff have been trained to undertake SJRs, 37 of whom have been trained in BSUH.

5.1.3 The Royal College of Physicians have released an online training package to train staff to undertake SJR. Review of this system by the TMRG showed that it was closely aligned with the DATIX module released by the RCP for capturing data from SJR reviews. As BSUH are capturing this information using a bespoke form created in the PANDA system the online training was not found to be suitable for training staff in BSUH.

5.2 Medical Examiner training

5.2.1 The Medical Examiners are required to complete an online training programme, the online ME training package is being updated and will in future include face to face sessions. It is not clear whether existing MEs will require re-training.

## 6. Involving Families and Carers

6.1 As part of the Medical Examiner review, the Medical Examiner speaks with the family/carers of the patient to ask if they have any concerns regarding the care that was received. If concerns are raised the Medical Examiner refers the case for SJR as detailed in 2.1.1.

6.2 In March 2019, the CQC published 'A review of the first year of NHS trusts implementing the national guidance'. The review identified five factors to help trusts put the guidance into 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 Reducing Mortality project detailed in BSUH Quality Accounts for 19/20 encompass a commitment to focus on strengthening practice in the areas identified by the CQC.

## 7. Outcomes from Mortality Review

7.1 Structured Judgement Reviews

7.1.1 The DoH provides a dashboard for Trust's to publish data on the number of deaths that have been reviewed in their organisations. See attachment.

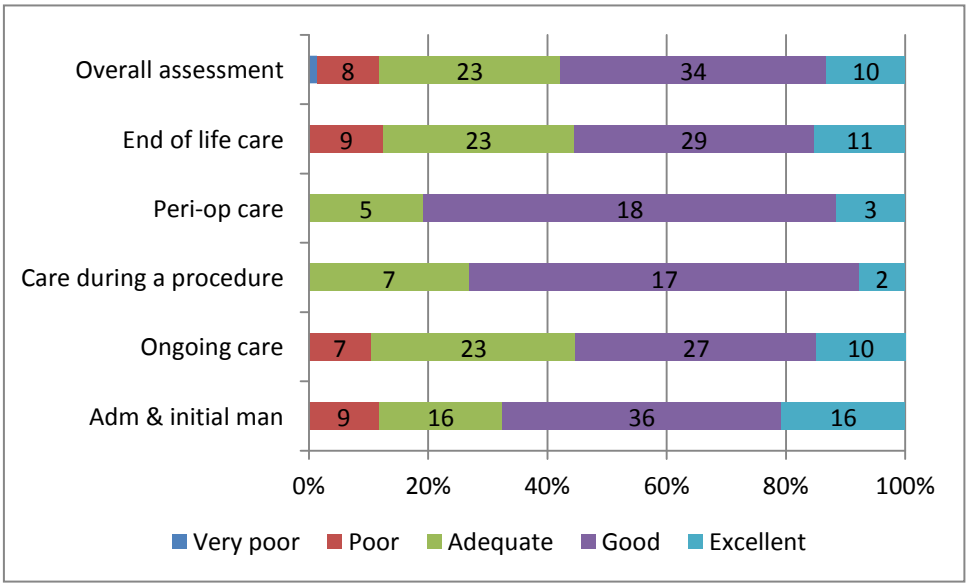
7.1.2 The table below shows the last 4 quarters data for BSUH. LD refers to deaths of patients with learning disabilities.

| | Q1 18/19 | Q2 18/19 | Q3 18/19 | Q4 18/19 |
|---|---|---|---|---|
| Total Deaths (adult inpatients not LD) | 365 | 340 | 416 | 470 |
| Total deaths reviewed using SJR (adult inpatients not LD) | 53 | 52 | 22 | 30 |
| Deaths avoidable >50% (adult inpatients not LD) | 1 | 0 | 1 | 0 |
| LD Deaths | 1 | 2 | 6 | 4 |
| LD deaths reviewed using SJR | 1 | 2 | 4* | 0* |
| LD deaths avoidable >50% | 0 | 0 | 0 | 0 |
| **Total % of adult deaths reviewed** | **14.8%** | **15.8%** | **6.2%** | **6.3%** |

* awaiting SJR review

7.1.3 All deaths that have been recorded as avoidable >50% have been fully investigated in line with Trust policy.

7.1.4 The SJRs review 6 discreet areas of care. Table 1 shows the level of care the patients have been recorded as receiving in the last 4 quarters[1].




7.1.5 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 will be reviewed using SJR.

[1] Q1, Q2, Q3 & Q4 18/19

7.1.6 Overarching themes arising from the Overall Assessment in 18/19 are currently being reviewed by the Lead Clinical Nurse for Palliative and EOLC together with a Core Medical Trainee and will be presented to the Trust Mortality Review Group.

## 8. Capacity and Risk

8.1 The Deputy Medical Director: Safety & Quality chairs the Trust Mortality Review Group (TMRG). This post is now vacant and a new chair has not yet been allocated.

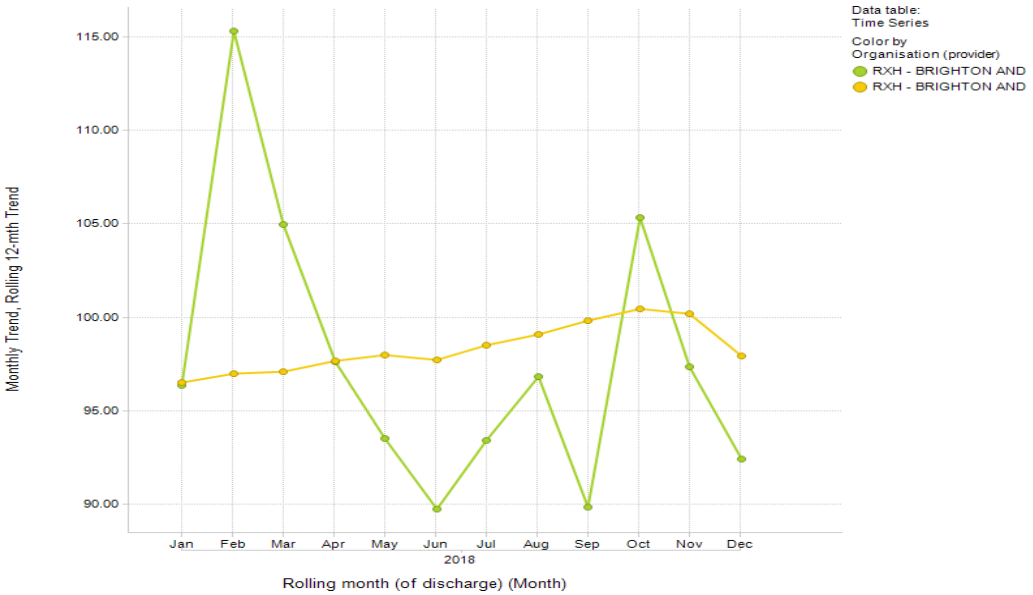
8.2 Whilst 62 staff have been trained to undertake SJR, there is no capacity in Consultant job plans to undertake the reviews which take approximately 60-90 mins per review. Several trained reviewers have indicated they have no capacity to take on SJRs. No clinicians have been allocated dedicated sessions to undertake the reviews.

8.3 There is a lack of administrative resources to identify patients, distribute case notes and monitor compliance which means that this process is currently working very slowly.

## 9. Summary Hospital Level Mortality Indicator (SHMI)[2] and Hospital Standardised Mortality Ratio (HSMR)[3]

9.1 The latest SHMI data available is for the period to Dec 2018. The SHMI value for BSUH is 97.94.[4]

9.2 The trend in SHMI for in month and rolling data is shown below:




9.3 The latest HSMR data available is for the period to Jan 2019. The HSMR value for BSUH is 96.55.[5]

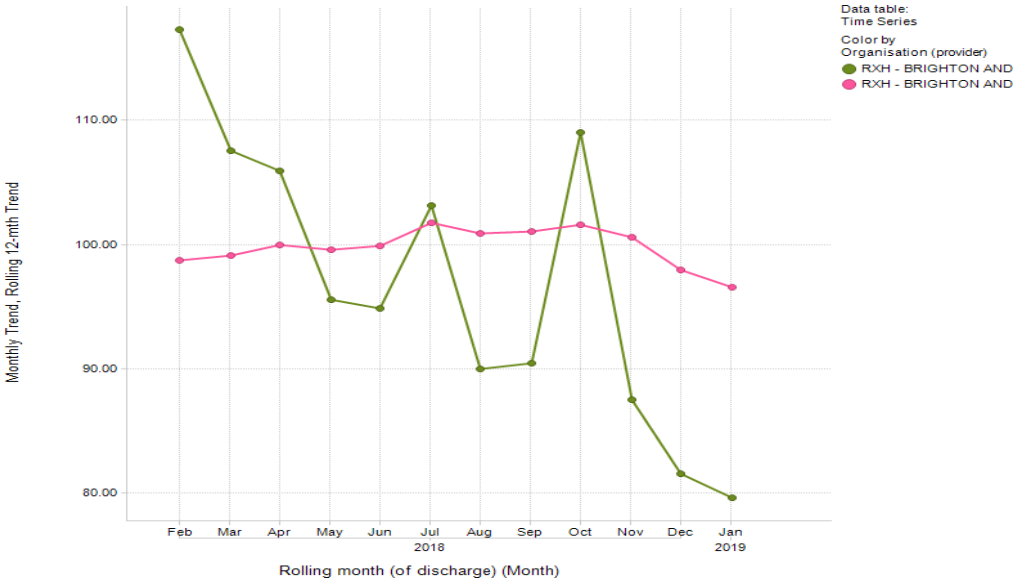
9.4 The trend in HSMR for in month and rolling data is shown below:

[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




## 10. Summary

10.1 In accordance with the requirements from the 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 deaths specified in 2.1.1.

10.2 As an early adopter pilot site, BSUH have a Medical Examiner system in place at the RSCH and are actively looking as solutions to extend this service to the PRH site.

## 11. Progress since last report

11.1 Introduced a pilot scheme for 6 months to bring trained staff together on the last Friday of the month to work together to undertake SJRs. The aim is to improve confidence and ability to undertake SJRs, share learning and ensure multidisciplinary input into the reviews.

11.2 The Lead Clinical Nurse for Palliative and EOLC together with a Core Medical Trainee are reviewing the clinical themes from the SJRs.

11.3 Working with the Mortality Lead for Intensive Care, the Lead Clinical Nurse for Palliative and EOLC and a Core Medical Trainee to review best practice in M&M meetings with a view to incorporating department M&M review into the PANDA tool.

## 12. Recommendation

12.1 The Board is asked to receive and discuss the implementation of the Learning from Deaths Policy and the learning from the outcomes of the mortality reviews.

Brighton and Sussex University Hospitals NHS Trust

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|---|---|---|---|---|---|
| **Agenda Item:** | 15 | **Meeting:** | Trust Board | **Meeting Date:** | 29 May 2019 |
| **Report Title:** | Provider Licence Conditions – Annual Self Certifications | | | | |
| **Sponsoring 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:**

As part of the Trust's provider licence the Trust is required to make a self declaration against a number of the licence specific conditions. The Trust's self declarations must be published on its web site.

NHS improvement provide a template for these declaration where explanations are required if the Trust can not provide a compliant declaration. Only for condition FT4 does the template allow for a rationale to be included for the Trust's ability to signify compliance to be included therefore as well as the required template a short explanatory paper has been prepared to allow the Board to understand the supporting rationale for the compliant declaration being recommended.

**Key Recommendation(s):**

The Board is asked to **APPROVE :**

That the Trust is compliant for each element within the required annual declarations.

That the template declarations be placed on the Trust's website in accordance with NHS I's requirements.

## Introduction

The Board is required to make a number of declarations at the year end. Trusts are required to publish their declaration on their web site.

## Certifications

There are three sets of declarations required, these are attached using the provided NHS I templates.

Declaration 1 – this relates to NHS Provider License General Condition 6 - Systems for compliance with license conditions (FTs and NHS trusts) and for FTs that are providers of designation Commissioner Requested Services are required to make an extra declaration on their Continuity of Services condition 7 - Availability of Resources.

Declaration 2 - this relates to NHS Provider License General Condition FT4 – Corporate Governance and for FTs only there is a separate Declaration 3 relating to the Training for Governors.

## Trust Position

**Declaration 1 (appendix 1)**

**General Condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)**

The Board is required to confirm it is compliant with the following certification, or explain why it can't certify itself as compliant.

**Following a review for the purpose of paragraph 2(b) of license condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the license, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.**

**It is recommended the Board a positive "confirmed" declaration is made.** Whilst the Trust is identified at being at risk of being non-compliant with its licence by NHS I as indicated that the Trust is within segment 3, NHS I has removed the Trust from segment 4 linked to the removal of the Trust being in special measures for both quality and financial matters. The Trust has established plans to deal with these risks and continues to engage with NHS I through regular assurance meetings where the Trust's performance is discussed.

**Continuity of Service condition 7 – Availability of Resources**

**This declaration is not applicable as the Trust is not a Foundation Trust**

**Declaration 2 (appendix 2)**

**Condition FT4 - Corporate Governance Statement**

The Board is required to indicate it is compliant with the following statements or if not state why it is non-compliant.

1) The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

**It is recommended the Board signify its compliance** as the Board is assured from the work of the Audit Committee, its Internal and External Auditors and their opinions received during the year. The Board's view as to its governance processes is reflected within the Trust's Annual Governance Statement.

2) The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.

**It is recommended the Board signify its compliance** as the Chief Financial Officer and Trust Board Secretary has made the Board, Audit Committee and Executives aware of monitor guidance and any impact / improvements to be made within Trust systems as a result.

3) The Board is satisfied that the Trust implements:

(a) Effective board and committee structures;
(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
(c) Clear reporting lines and accountabilities throughout its organisation.

**It is recommended the Board signify its compliance** as these processes were referred to and their effectiveness was considered by the Accountable Officer when drafting the Trust's Annual Governance Statement with this description then considered by the Audit Committee as it endorsed the AGS for submission to the Auditors. Respective Committee reporting to the Board is operating effectively as evidenced by the regular reports to the Board from each Committee Chair.

4) The Board is satisfied that the Trust effectively implements systems and/or processes:

(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;
(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;
(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
(h) To ensure compliance with all applicable legal requirements.

**It is recommended the Board signify its compliance** as the Board both directly and through its Committee structure has been assured that the Trust's designed systems of internal control have been operating effectively and as intended over the year. Where issues have arisen during the year, for example in respect of operational performance, timely actions have been implemented to improve these areas, albeit the Trust has recognised and reported that it has not met the constitutional targets.

The Trust has delivered its control total and efficiency programme and the Audit Committee has recommended based on the information it has received that the Trust can prepare its financial statements on a going concern basis.

Assurance is obtained as to the quality of the data supporting the Trust's performance reporting through the annual internal audit work programme. The Board has received regular assurance over the delivery of the Trust's control total and efficiency plan.

Key risks and associated assurance have been reported to the Audit Committee and Board during the year through receipt and review of the Trust's Board Assurance Framework. Internal Audit has provided positive assurance over the Trust's risk management processes.

5) The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:

(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;
(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
(e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
(f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

**It is recommended the Board signify its compliance** as there is clear leadership and accountability for the delivery of high quality and safe services within the Trust. This is detailed with the Trust's Quality Account and the statements contained therein. The Board both directly and through its Committee structures ensures that a focus is maintained on the delivery of quality services. There is regular reporting to the Board and our Commissioners of the delivery against the Trust's established quality priorities. These priorities are set in conjunction with the Trust's clinical strategy and annual plan. The effectiveness of these processes was again considered by the Accountable Officer in drafting the Annual Governance Statement which in turn was subject to consideration by the Audit Committee prior to its submission to the Auditors and inclusion within the Annual Report. Internal Audit has provided positive assurances over the Trust's quality management and oversight groups recognising the improvements made during 2018/19 in implementing the recommendations made by the Good Governance Institute.

The CQC has rated the Trust as "good" overall and outstanding for caring providing further evidence to the Board on the quality of the Trust's services.

Whilst the Trust is required to have undertakings with NHS I as the Trust is within segment 3 of NHS I's Single Oversight Framework, NHS I in the latest undertakings state "The Trust has taken effective action to address its governance failures since the undertakings of March 2017, but further improvements are required" [regarding operational performance improvement]

6) The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.

**It is recommended the Board signify its compliance** as the Trust has established a process that ensures that all Board Members are "fit and proper" persons. This process has been applied to Board appointments made in the year. An annual

review of all Board Members continuation as fit and proper persons has been undertaken and reported to the Audit Committee at the end of the year. The Board through its receipt of Workforce, Leadership and Organisational Development reports has been assured over the actions being taken to mitigate the workforce risks in relation to recruitment and retention. Regular reporting is provided to the Board on the Trust's compliance with the nursing safer staffing levels and the revalidation of its nursing and medical workforce. All transformation schemes are subject to a detailed quality impact assessment and this rigor includes those schemes which include any workforce reduction and through this process the Board is assured that the Trust retains an appropriately qualified workforce to deliver its services. The Trust has a number of established Executive and Senior Management development programmes these activities are designed to support and strengthen the personnel on the Board, those reporting to the Board and those within the rest of the Trust.

**Declaration 3 (appendix 2)**

**Training of Governors**

This declaration is not relevant as the Trust is not a Foundation Trust.