Brighton and Sussex University Hospitals NHS Trust

Meeting of the Board of Directors

9.30am to 11.50am on Wednesday 30th May 2018
Meeting Room, BSUH Trust HQ, Royal Sussex County Hospital, Brighton

AGENDA – MEETING IN PUBLIC

1.	9.30	**Welcome and Apologies for Absence**		Chair
2.	9.30	**Declarations of Interests**		All
3.	9.30	**Minutes of Board Meeting held on 28th March 2018** To approve	Enclosure	Chair
4.	9.35	**Matters Arising from the Minutes** To note	Enclosure	Chair
5.	9.40	**Chief Executive's Report** To receive and agree any necessary actions	Enclosure	MG
		PERFORMANCE		
6.	9.50	**Quality Report** To note and agree any necessary actions	Enclosure	GF/NR
7.	10.05	**Organisational Development and Workforce** To note and agree any necessary actions	Enclosure	DF
8.	10.20	**Performance Report** To note and agree any necessary actions	Enclosure	PL
9.	10.35	**Financial Performance Report** To note and agree any necessary actions	Enclosure	KG
		PATIENT SAFETY/EXPERIENCE ITEMS		
10.	10.50	**Nursing Staffing and Capacity Levels Report** To note and agree any necessary actions	Enclosure	NR
11.	11.00	**Quarterly Learning from Deaths Report** To note and agree any necessary actions	Enclosure	GF
12.	11.10	**Adults Annual Safeguarding Report 2017/18** To note and agree any necessary actions	Enclosure	NR
13.	11.20	**Healthy Food CQUIN** To note and agree any necessary actions	Enclosure	NR
		GOVERNANCE ITEMS		
14.	11.30	**Use of Trust Seal** To note	Enclosure	CK
15.	11.35	**Provider Self Certification** To approve	Enclosure	CK

OTHER ITEMS

16.	11.40	**Other Business**	Verbal	Chair
17.	11.50	**Resolution into Board in Private:** To pass the following resolution "that the Board now meets in private due to the confidential nature of the business to be transacted"	Verbal	Chair
18.	11.50	**Date of Next Meeting** The next meeting in public of the Board of Directors is scheduled to take place on Wednesday 25th July 2018 in Lecture Theatre 1, Euan Keat Education Centre, Princess Royal Hospital, Lewes Road, Haywards Heath RH16 4EX	Verbal	Chair
19.	11.50	**Close of Meeting**	Verbal	Chair
20.	11.50	**Questions from members of the public** Following the close of the meeting there will be an opportunity for members of the public to ask questions about the business considered by the Board.	Verbal	Chair

Chipo Kazoka
Interim Company Secretary

Brighton and Sussex University Hospitals NHS Trust

Minutes

Minutes of the Board of Directors (Public) meeting held on 28th March 2018 at 9.00 in the Boardroom, St Mary's Hall, Royal Sussex County Hospital, Eastern Road, Brighton

Present:	Mike Viggers	Chairman and Non-Executive Director
	Kirstin Baker	Non-Executive Director
	Joanna Crane	Non-Executive Director
	Mike Rymer	Non-Executive Director
	Martin Sinclair	Non-Executive Director
	George Findlay	Chief Medical Officer
	Denise Farmer	Chief Organisational Development and Workforce Officer
	Karen Geoghegan	Chief Finance Officer
	Pete Landstrom	Chief Delivery and Strategy Officer
	Nicola Ranger	Chief Nursing and Patient Safety Officer
In attendance:	Patrick Boyle	Non-Executive Director Advisor
	Jon Furmston	Non-Executive Director Advisor
	Lizzie Peers	Non-Executive Director Advisor
	Andy Gray	Director of Corporate Governance
	Sally Reeves	Assistant Board Secretary
	Clare Stafford	Director of Finance
	Helen Weatherill	Director of Human Resources
	Caroline Owens	Freedom to Speak Up Guardian
	Brian Courtney	Interim Director of Corporate Governance

GENERAL BUSINESS **ACTION**

PB02/18/1 Welcome and Apologies

1.1 The Chair welcomed those present to the meeting.

1.2 Apologies were received from Professor Malcolm Reed and Marianne Griffiths.

PB02/18/2 Declarations of interest

2.1 There were no declarations of interest.

PB02/18/3 Minutes of Previous Meeting

3.1 The minutes of the meeting held on 31st January 2018 were approved as a correct record.

PB02/18/4 Matters Arising

4.1 The matters arising were noted.

4.2 **PO01/18/7.4:**
The Retention and Recruitment paper which was to be included in the March Organisational Development Workforce Report will focus on the nursing population and will be brought back to the next meeting to outline actions in place together with a roadmap that will deliver improvements in that section. **DF**

PB02/18/5 Chief Executive's Report

5.1 In Marianne Griffiths' absence, George Findlay introduced the Chief Executive's Report, previously circulated, and highlighted key points.

5.2 A 'critical incident' was declared at BSUH on 5th March to respond to the record numbers of patients coming into the emergency departments following the severe cold weather. This enabled the focus to be shifted and the hospital was in a much better position at the end of the critical incident.

5.3 The Health and Social Care Secretary, Jeremy Hunt MP, visited the Royal Sussex County Hospital (RSCH) in February, as part of a series of visits to Trusts across Sussex. He reflected on the work he had seen at the hospital, particularly around the Emergency Department, the 24 hour consultant cover and the significant improvements made in the 52 week waits patient backlog, and gave his personal thanks to all NHS staff who have worked so hard through the busiest winter in years.

5.4 Performance is not where it needs to be, but improvements are being made across the Trust and the teams in A&E, HIV and Audiology have been nominated for national awards. The annual STAR awards to celebrate staff and teams who have gone the extra mile is now open for nominations, hundreds of which are expected, with the winners being announced at a special awards ceremony in June to coincide with the NHS's 70th anniversary.

5.5 BSUH reached a milestone in March with the opening of the Emergency Ambulatory Care Unit (EACU) at the RSCH to treat medical and surgical patients who might otherwise have had to be admitted. The Unit has been up and running since January 2018 and is a significant step for the Trust in the first of a three-phase improvement programme in ED facilities and additional Emergency Care beds which will come on stream in the next 18 months.

5.6 The 2017 NHS staff survey results have been published. More than 4,000 staff took the time to respond and the results showed an increase in the percentage of staff who agreed that patient care is the organisation's top priority (up 4%). There was also an increase in the number of staff who would recommend BSUH to friends and family as a place to work (up 5%) or receive treatment (up 3%). However, one of the main areas identified as needing critical improvement is around staff experiencing violence or harassment from patients, carers and the public. This is being addressed as part of the Patient First Improvement System (PFIS) roll-out in a number of wards where this is a significant problem.

5.7 Patient First continues to be rolled out across BSUH and, despite winter pressures, progress is being made:

- The radiographer discharge trial has had promising results, saving each patient discharged an average of 45 minutes waiting time.
- The Blood Sciences team has increased the number of blood test results requested by A&E within 60 minutes.
- Improvement boards are starting to appear across the RSCH as the first wave of wards have had their PFIS training and teams have started to hold their regular improvement huddles.
- A number of wards at the Princess Royal Hospital (PRH) are due to start their PFIS Wave 2 training this month.

5.8 Patrick Boyle asked whether activity has settled down at the hospital following the busy winter period. George responded that it was still busy and although

there has not been a step change in activity, it appears to be returning to normal. Pete Landstrom added that mid-February to mid-March was the most pressured period and that was reflected in the national picture; every hospital in the region was escalated to the highest level. Now at BSUH there are empty beds to start the day, but patient volumes have not significantly reduced.

5.9 The Chair acknowledged that bed occupancy levels were unprecedented over what has been an incredibly busy period. He added that the EAC model had been implemented during the busiest time and asked for his thanks to be fed back to the staff and the builders who had been so accommodating.

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

PERFORMANCE

PB02/18/6 Quality Report

6.1 George summarised key points from the report, which was previously circulated and taken as read.

6.2 There was an increase in crude Trust mortality in January and February, which mirrors the national mortality rate and a pattern seen in BSUH every year. The Hospital Standardised Mortality Ratio (HSMR) is relatively steady, measuring 97.66 in December. This figure puts the Trust in the top 50% of organisations and better than average, but the aim is to be in the top 20% as per the True North objectives.

6.3 At the last Board some concern was raised around 'in hospital' and 'out of hospital' mortality. George reported that 'in hospital' deaths are 9.2% below the expected number, whilst 'out of hospital' deaths are 10.6% above the expected rate. The trend lines for Summary Hospital-Level Mortality Indicator (SHMI), SHMI in hospital, SHMI out of hospital are all coming down.

6.4 Mike Rymer suggested the 'out of hospital' component of SHMI is monitored and emphasised the importance of maintaining it. George gave assurance that the figures on emergency readmissions within 30 days are closely monitored and they are a key indicator of the possibility of discharging people too early. Pete Landstrom added that the Trust is actively working with partners on this to ensure that immediate medical needs are managed. Patient care is sometimes outstripping what the community services can provide and a slight gap has emerged in the community.

6.5 George was asked at the last Board to provide detail on Fractured Neck of Femur. There is some information in the report which was circulated but, due to winter pressures and gaps in staff, further detailed information will be provided in the next report. George gave assurance that the Trust is outperforming in this area and its figures are among the lowest in the country.

6.6 With regard to the Fractured Neck of Femur data, Jon Furmston asked whether the data on the 24 and 36 hour Time to Theatre could be included as this proved to be a good learning point in Western Sussex Hospitals Trust (WSHT). Pete added that the Surgical division is measuring Time to Theatre as part of their division objectives.
ACTION: 24 and 36 hour detail to be included in the Fractured Neck of Femur data in the next Quality report. **GF**

6.7 Nicola Ranger reported on infection prevention activity at BSUH. An Event has been organised between the infection control teams in WSHT and BSUH to

share learning between the two trusts, due to the flu impact at Worthing.
ACTION: A report to be brought back to Board on the learning around infection control this winter, deadline to be confirmed by Nicola. **NR**

6.8 Work on pressure ulcers is continuing and only one grade 3 pressure damage incident was reported from December to February, which is an improvement.

6.9 The Friends and Family Test (FFT) was discussed at the last Board and agreement is now in place for the FFT to be rolled out Trust-wide in April which will help to capture inpatient feedback. Data collection will start in May.

6.10 Mixed sex breaches have risen again due to operational activity. Nicola advised that the staff are mindful of this and keen to improve, but are aware that this is not likely to happen until the extra 70 beds are found.

6.11 Lizzie Peers asked about the short notice cancellation of clinics and how this fits in with the current rostering work. Pete explained that the Trust is trying to understand better how to deploy its staff, for example through job planning. Cancellations have been impacted by all the emergency pressures and steps have been taken to pull key clinicians out of clinics to deploy them on front line clinics. The Trust is going into the new year with a tighter baseline capacity.

6.12 Lizzie also highlighted the figures around patients at risk of malnutrition. Nicola reported that the process of assessing patients within four hours of admission needs to be streamlined. There is a more suitable tool available which could improve the process and which is being explored. The percentages are increasing and Nicola is confident that staff are adept at flagging any patients of concern. The Malnutrition Universal Screening Tool (MUST) scores will be included in the Quality report going forward.

6.13 In response to Patrick's question regarding the availability of data from the Patient Voice Survey, Nicola confirmed that the findings would be shared at the Patient Experience Committee. The Trust needs to be clear how the data is going to be used. The survey consists of 25 questions, the feedback is fairly lengthy and currently the data has to be analysed manually. Therefore, moving to FFT with a robust electronic system will help to focus on the data. The Complaints team is collating the information and have managed to clear a huge backlog.
ACTION: Patient feedback report to be brought to a future Board. **NR/GF**

6.14 Joanna Crane voiced concern that compliance of the surgical safety checklist was down to 90% and asked for assurance around what has been omitted, particularly in light of the never events that have happened over the past year.
ACTION: George to review the surgical safety checklist figures and report back to Joanna outside the meeting. **GF**

6.15 The Chair thanked George and Nicola for their report and praised the staff for the fantastic achievement of a 3% improvement on falls, which is a real reflection of the care patients receive on wards.

6.16 The Board **NOTED** the Quality Report.

PB02/18/7 Organisational Development and Workforce

7.1 Denise Farmer presented the report, which was previously circulated, and highlighted key points.

- **Workforce, efficiency and effectiveness:** sickness absence remains high

at 4.3%. Work is ongoing and a report will be brought back to Board.

- **Recruitment:** since October 2017, 161 Health Care Assistants (HCAs) have been recruited, with a further two recruitment events scheduled for the end of March. The latest qualified nurse recruitment day resulted in the appointment of 23 new nurses and Facilities Management have appointed 32 housekeepers.
- **Retention:** considerable activity has led to a marginal improvement. The Trust's 12 month turnover rate (external leavers) was 14.3% in February 2018, the same level seen in February 2017.
- **Appraisal:** The Trust's appraisal rate decreased further in February to 71.7% and remains a concern. More of a cycle is required and this is an area of focus.
- **Staff survey:** the full staff survey feedback reports for all Trusts in England and Wales were published in early March 2018. A separate Trust Board Report has been prepared on the Trust's Survey results. Violence and aggression towards staff is also an area of concern in WSHT so joint working is an option being explored.
- **STAR awards:** 160 nominations have been received to date; the aim is for at least 300. People are being encouraged to nominate as this is an opportunity to celebrate and will give the Trust positive stories to share.
- **Rostering:** a pilot has been agreed and this will help to inform whether workforce is being used efficiently.
- **Patient First:** events were held recently to recognise staff groups who have difficulty in attending. Approximately 250 staff were visited by the Executive Team and resulted in positive feedback.

7.2 The Chair asked about the Workforce Disability Equality Standard (WDES) and when a report of the outputs was likely to come back to Board. Denise explained that the Trust is keen to prioritise those recommendations that will have the biggest impact on the workforce and the results will be published in the Autumn.

7.3 Patrick acknowledged the work being done to recruit HCAs and housekeeping staff, and asked what was being done regarding recruitment to nursing vacancies. Nicola responded that although turnover has improved, no significant impression has been made in the nursing vacancies. Domestic recruitment is consistently between 12 and 20 per month, with an additional 48 nurses coming from the Philippines. The Trust has a robust monthly recruitment programme and there is work going on to ensure that all new staff have a career programme in place. PRH is still proving a challenge however.

7.4 Mike Rymer remarked on the increase in staff turnover by 2.9% year on year in Scientific, Therapeutic and Technical posts and asked about the possibility of reporting back in six months' time. Denise responded that this would be possible and there had been a fair amount of interest from these particular staff groups in the Patient First roll-outs. The aim would be to capitalise on that and stem the retention.

7.5 Regarding the staff survey, Kirstin Baker commented on the positive news that the response rates had increased, but that it is important now to do something with those responses. Denise agreed and responded that the Trust's overall engagement plan and breakthrough objective is around care. There is variation at divisional level and at staff level, the least engaged groups being Facilities and Estates and Medical. There is a national emphasis on health and wellbeing and this is an area in the Trust that needs to be addressed.

7.6 Continuing on the subject of the staff survey, Joanna Crane asked whether it

would be possible to analyse by protective characteristics, which would prove particularly useful when reviewing the feedback around physical violence. Denise confirmed that this is already considered. She added that there has been some improvement around discrimination and the aim is to set up an Equalities Group as there is in WSHT.

7.7 The Chair asked Nicola to draw out particular requirements at PRH. He added that the Facilities and Estates team is to be congratulated for the positive work that is ongoing.

7.8 The Board **NOTED** the report.

PB02/18/8 Performance Report

8.1 Pete Landstrom gave an update on Month 11 performance, which includes a period of significant and sustained emergency pressures in February.

A&E

8.2 Key February figures to note:

- There was a 4% increase in A&E attendances and a high level of acuity. This is a pressure that has been widely shared across regional hospitals.
- 82% of patients waited less than 4 hours, which is disappointing compared to January, but is an improvement on last year.
- The first half of February started fairly well, but a big step change from mid-February onwards resulted in a deterioration in performance to 80%.
- 18 patients waited longer than 12 hours, 16 of these breaches occurred in the last week of February. Pete gave assurance that every patient breaching 12 hours has a detailed review and Root Cause Analysis (RCA).
- Delayed Transfers of Care (DTOCs) increased marginally to just over 5%. The Trust continues to work closely with the Clinical Commissioning Group and the wider system on a daily – sometimes hourly – basis for support.

8.3 The Emergency Ambulatory Care Unit (EACU) is fully operational and being accessed by over 40 patients a day. This is a huge step forward for the Trust and Pete paid tribute to the staff. The feedback from patients and staff has been outstanding, just after two weeks.

8.4 The Trust has maintained a reduction in non-admitted breaches throughout winter and, although still lower than previously, the increased A&E department volumes and surges in activity have resulted in an increase in breaches in these areas. As the emergency pressures and impact from the cold weather decrease it is imperative the initial gains are remade and maximised through the new EACU coming on line.

8.5 In terms of quality and process improvement measures, there has now been a sustained increase of over 55% in patients having a consultant/senior medical review within 15 minutes of attending A&E. Response times for Pathology have increased significantly to 93% of tests coming back within an hour, which has had a huge impact on a number of areas.

8.6 With regard to patient flow, there has been a small reduction in patients waiting to see specialty doctors; there is more work to be done here. A great amount of work has gone into discharges and there has been a small increase in the number of pre-midday discharges which has reaped benefits in patient flow.

8.7 Performance was 82% at the time the report was issued. It is currently 84% and has been 88% consecutively for the past few days. There are robust plans

in place for Easter with all system partners and both RSCH and PRH have empty beds and are on Green status today.

8.8 Pete reported that nationally A&E performance has been challenged with the lowest ever figures in February (85%). March was also a challenging month. The pressure is now easing, but a number of places remain extremely busy. Recommendation rates in A&E have remained really high from patients despite the pressures.

Cancer

8.9 The Trust was compliant with seven out of nine metrics in January, which was an increase on previous months, but remained below the 62 day treatment target for GP referrals (85.0%). Actual performance for January was 75%.

8.10 The total patients breaching the 62 day GP referral standard was improved with 27.5 breaches against a forecast trajectory of 34.0.

8.11 There is more work to be done with the CCG, specifically around the initial conversation with the GP. There will be considerable focus on cancer in the coming months with improvements needed on performance and timings. A Cancer Board has now been established and will be chaired by a medic and attended by Pete.

8.12 Regional context of the 62 day performance standard for January 2018 shows BSUH being the highest performing tertiary cancer centre and sixth overall regionally.

Referral to Treatment (RTT)

8.13 In line with the Trust's Breakthrough Objective for elective flow, there were 28 patients waiting more than 52 weeks for treatment as of the end of February. This is a significant reduction from the 152 patients waiting longer than 52 weeks in February 2017 and a credit to the clinical and operational teams. Every patient has been offered a date before the end of March.

Diagnostic waiting times

8.14 The Trust compliance for February was 3.5% over six week waiters across all diagnostic modes, which is non-compliant against the <1% national target, but is an improvement from the January position.

8.15 CT breaches continue to increase with a reported 132 diagnostic six week breaches in February. Reducing this backlog is the focus whilst the department also manages the reappointment of cancelled sessions due to on-going equipment failures. The programme to replace one CT scanner at PRH is underway.

8.16 Mike Rymer remarked that the ability to keep people safe during the recent pressures has been fantastic. He asked about the demand for the CT scanner and whether it is managed appropriately. Pete responded that more could be done and better gatekeeping would help, but without managing to cause delays. There is sufficient capacity when all the scanners are working, but the continued breakdowns have made it difficult. There is an opportunity for a more engaging programme of demand management to be done with the Central Clinical Services (CCS) division.

8.17 The Chair reiterated the unprecedented demand that the Trust has been under and the work of the staff who have been working under intense pressure. He acknowledged that the bed situation is a problem and that the early discharge project is good for patients as well as patient flow through the system. The

Chair thanked Pete for the progress made in reducing the 52 week waits.

8.18 The Board **NOTED** the Performance Report.

PB02/18/9 Financial Performance Report

9.1 Karen Geoghegan detailed the Trust's financial position year to date, highlighting key points from her report for Month 11:

9.2 **Income**

- At the end of February the Trust reported a deficit of £60m, £300k better than forecast.
- The financial sustainability/risk rating remains at 4.
- Income earnings are £5.6m below plan.
- Income from NHS England and Public Health England is significantly below plan this year. There have also been continued reductions from MSK work.

9.3 **Pay**

- Overall Pay is £5.9m below plan, with underspends in most staff categories. February is the first time there has been an underspend.
- The overall reduction in pay bill is an area requiring focus.
- Agency expenditure remains below the ceiling, but is £2.3m higher than the equivalent period last year and above the ceiling set for next year. Significant work is ongoing in exiting high cost agency.
- Due to the control total a low level of interest is being paid on capital loans.

9.4 **Efficiency**

- The Trust expects to deliver £20m of efficiency savings in full by the end of March, which is a significant achievement and looks positive for next year.

9.5 **Capital expenditure**

- This is significantly behind plan. Funding has been received for the Emergency Department development, although the profile of spend is different from the business case, and the Trust has been successful in agreeing this.
- There is a backlog of maintenance in the estate, but the component has been successfully deferred to next year.

9.6 **Cash**

- This is slightly better than plan in February, assisted by the Capital Plan.

9.7 In summary, the Trust is in a fragile position with a number of issues which need to be concluded over the next month, particularly Specialised Commissioning.

9.8 The Chair remarked on the importance of structure in the organisation and delivering cost improvements; the take up in the divisions has been fantastic. Pay is going to be a real area of focus, particularly around agency, for next year. He added that the Capital Plan and the programme of work presented at the previous day's Finance and Investment Committee showed real structure and Robert Cairney and his team have done a great job.

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

PATIENT SAFETY / EXPERIENCE ITEMS

PB02/18/10 Learning from Deaths

10.1 George summarised key points from the quarterly report, which was previously circulated.

10.2 The specified data has been collected on a quarterly basis using the National Learning from Deaths Dashboard since Q1 2017/18. However, based on feedback from clinicians, the Royal College of Physicians (RCP) has removed the question regarding 'avoidability' of death from the recommended Structured Judgement Review (SJR) Tool, but this remains in the Dashboard which is provided by NHSE.

10.3 BSUH were part of a pilot to introduce Medical Examiners and this service is currently only established at RSCH. The Trust Mortality Review Group (TMRG) is working with the Medical Director to appoint a Lead Medical Examiner post who would oversee the existing service and expansion into the PRH site.

10.4 The importance of this process is to provide learning and improve patient care. There are two key learning points: firstly to recognise seriously ill patients and escalate them appropriately; and secondly poorly recognising end of life care and ensuring a patient has a better death, which is imperative.

10.5 Any patients not expected to die have a SJR and there have been a number of issues surfacing around conversations being had with patients before surgery. Some coding issues have also arisen. George stated that this is work in progress and a process which is becoming embedded and should provide more learning in the future.

10.6 Reflecting on the discussion around palliative care, Mike Rymer asked how good the provision is and whether the Trust has an End of Life Board. George advised that Stephen Bass is the Trust's Specialist in End of Life Care. There is no Board currently, but this is a recommendation that George would take forward. Regarding palliative care provision, there are a number of palliative care physicians and there are the resources to do the job. However, those patients at risk of dying in the next year need to be recognised. The figures demonstrate that patients who die in the Trust have had multiple admissions during the 12 months before they die.

10.7 Continuing the discussion, Joanna Crane said she was surprised at the number of deaths in elective admissions and proposed a 'deep dive' via the Quality Assurance Committee. George agreed and suggested inviting Stephen Bass to give a presentation at a future Committee.
ACTION: Stephen Bass to be invited to give a presentation at a future QAC. **GF**

10.8 Joanna also asked about deaths in women and children as there appeared to be no reference to this group in the report. George responded that there were two maternal deaths in that period, although not drawn out of this particular report as there is a separate procedure. A new methodology is being introduced to assess maternal deaths.

10.9 Lizzie Peers asked if there was a programme of work around improving coding in the Trust. George reported that non-coding does not appear to be a major issue. The induction for junior doctors specifically includes time with the coders. Karen Geoghegan added that there has been a high level coding review and the accuracy of coding was found to be good. There is further work to do around ensuring the patient notes capture how it is coded and there is good work already ongoing in the relationship between coders and doctors. George is aware that local rules to help with coding need to be established. Electronic patient records will help and this forms part of the Trust's IT strategy

for the future.

10.10 The Chair requested detail in the narrative going forward around deteriorating patient. **GF**

10.11 The Board **NOTED** the Quarterly Report.

OTHER ITEMS

PB02/18/11 Freedom to Speak Up

11.1 George introduced Caroline Owens, the Freedom to Speak Up Guardian, who gave a presentation on her role and an update on the policy, which was previously circulated and presented to the Trust Executive Committee.

11.2 Caroline has been in post for a year and is one of a number of FTSU national guardians. She gave an update on 2017 activity and outlined plans for 2018.

11.3 Fifty requests for support have been received in 2017. In BSUH the most common themes are around patient safety, patient care, bullying/harassment and behaviour/relationship issues. Requests have been received from all directorates and across all professional groups.

11.4 Caroline reported that changes in leadership have impacted on staff and some people have found it difficult to settle. Patient First is a great vehicle to support speaking up because it encourages people to share and talk about the things that matter.

11.5 At the National Guardian's Conference in March Simon Stevens, NHS Chief Executive, identified five marker questions, specifically on speaking up, from the staff survey and compared figures between white and BME populations. In BSUH the BME cohort is fairly small, but the numbers were positive.

11.6 In response to Joanna Crane's query about patient safety concerns and how they are resolved, Caroline gave an example of a member of staff being signposted, with the relevant authorities being involved and the situation resolved through appropriate channels.

11.7 Lizzie Peers highlighted the high numbers of requests received from the Head and Neck directorate and wondered whether there was a particular issue there. Caroline explained that sometimes a member of staff reports an issue that they cannot resolve, then others follow suit. The information is gathered individually to make a case, but if there are a number of people with the same issue the cases can be resolved all at once; this could be the explanation for the high numbers coming from Head and Neck.

11.8 Kirstin Baker was interested to see the different splits/themes emerging and asked how the number of complaints in BSUH compares to other Trusts. Caroline responded that it is possible to get that information, although it is difficult to compare different stories and issues across different trusts.

11.9 Jon Furmston acknowledged that having a FTSU Guardian is an important route for staff to raise issues, but asked whether any work had been done to see why people have not raised particular issues via management, for example through a lack of assurance in confidentiality. It would be good to know what the issues are before they get to an 'explosive' point. Martin Sinclair agreed and suggested using the variety of outlets and safeguarding controls throughout the Trust to work together and share learning, considering any

patterns that can be highlighted. Denise suggested a de-triangulation system, which has been set up in WSHT. The key is to find out what else people have tried and what has failed before going to Caroline.

11.10 The Chair agreed with the points made above about the reasons people refer to the FTSU Guardian and is hopeful that the structure in place will put the Trust in a better place. He added that Patient First is key to this work.

11.11 The Board **APPROVED** the Freedom to Speak Up policy.

PB02/18/12 Gender Pay Gap Report

12.1 Gender pay reporting legislation requires employers with 250 or more employees from April 2017 to publish statutory calculations every year showing how large the pay gap is between their male and female employees.

12.2 Denise Farmer presented the report, previously circulated, which outlines how the new legislation may affect the Trust. A similar report was produced for WSHT and has been seen by the Board. The Trust is required to publish this report by the end of the month. Denise pointed out that this is not to be confused with Equal Pay, which deals with the pay difference between men and women who carry out the same jobs, similar jobs or jobs of equal value.

12.3 Denise summarised the key data for Brighton, highlighting the mean hourly rate which shows males earning 17.6% more than females. For those staff on Agenda for Change (AfC) the gap is reversed and females earn 6.1% more than males. This changes again with the Medical and Dental staff. The gap also seems to be smaller in Partnership Trusts, but it is not yet clear why that is the case.

12.4 Interestingly the figures start to skew at the application of bonuses through Clinical Excellence Awards and The Trust needs to understand what is driving this. However, there is no action plan currently.

12.5 A Gender Pay Working group will be established in April 2018 to carry out further investigations into data and advise on any proposed actions that may reduce the gap. The Gender Pay Group will report in to the Leadership, Culture and Workforce Programme Executive Steering Committee.

12.6 The Chair thanked Denise for her report. He agreed with the comments that this topic should form part of the Equality and Diversity agenda and emphasised the importance of not losing sight of this data. **DF**

12.7 The Board **NOTED** the Gender Pay Gap Report.

PB02/18/13 Board Declaration of Interest Disclosure

13.1 Andy Gray summarised the report which was previously circulated.

13.2 It is good corporate governance practice for Directors to declare any professional or personal interests which are relevant to their roles at the Trust. This ensures that any relevant interests are identified proactively and are managed to ensure that there is no actual or perceived improper influence over decisions taken by the Board. The Trust's policy on declaration of interests requires that Directors declare at meetings any interests which are directly relevant to matters being discussed at those meetings. Directors are also required to record their interests in the Register of Interests. It is good practice for this to be received by the Board annually in public.

13.3 The Board has agreed an enhanced Fit and Proper Person declaration to support the requirements of the CQC Fit and Proper Person test and these have been signed by all Directors.

13.4 The Board **NOTED** the Register of Interests.

PB02/18/14 Any Other Business

14.1 There was no other business to report.

PB02/18/15 Resolution into Board in Private

15.1 The Board resolved to meet in private due to the confidential nature of the business to be transacted.

PB02/18/16 Date of the next meeting

16.1 The next meeting will be held on 30th May 2018 in the Boardroom, St Mary's Hall, Royal Sussex County Hospital, Brighton.

PB02/18/17 The Chair formally closed the meeting.

PB02/18/18 Questions from members of the public

18.1 The first question was around Radiotherapy activity. The Board was asked to clarify the remark made at the November meeting of the Board – but not minuted – to the effect that the Trust is no longer responsible for the development of radiotherapy in West Sussex, bearing in mind that BSUH is the only Trust based in Sussex commissioned by NHS England to provide radiotherapy services. Secondly, the Board was asked to confirm that there will now be discussions with the Surrey and Sussex Cancer Alliance following the completion of work on behalf of the Alliance on demand and capacity modelling for radiotherapy.

18.2 Pete clarified that BSUH was never solely responsible for the development of radiotherapy in West Sussex. As the Cancer Centre based in Brighton, the Trust is commissioned to deliver services for parts – but not all – of West Sussex. However, as the member of the public is aware, the Trust has been working very hard to progress the discussion around the development and location of future radiotherapy across Sussex. BSUH is committed to working with the Cancer Alliance (who do cover the whole of West Sussex) to ensure the best possible care and access for patients, and will continue to do so.

18.3 A member of the public asked whether the staff survey results should be made available openly. Denise responded that the results are usually published via the Board in Public and that this would be followed up. With regard to the Friends and Family Test, the member of the public asked whether the Board would consider looking at the online customer surveys by John Lewis or M&S as an example to follow as they reduce the need for manual inputting. Nicola responded that the test is currently used nationally by the NHS so the Trust would be unable to do anything for the moment, but there will be a national review in the future and she would be happy to take suggestions. **DF**

18.4 The final question from the public was regarding the Workforce Race Equality Standard (WRES), which was scheduled to be discussed at today's meeting, but was not on the agenda. Denise responded that the Board needs to receive the report, agree the action plan then it will be brought back to the next Public

meeting. The Chair gave assurance of the amount of work going on around this subject and offered to share some of the work being done. The report should be ready for the Public Board in May.

Sally Reeves
Assistant Board Secretary
March 2018

Signed as an accurate 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
31st January 2018	PB01/18/6.7	**Quality Report:** deep dive on Fractured Neck of Femur patients to be provided.	George Findlay	April 2018	To be included in the Quality Report
31st January 2018	PB01/18/7.4	**Organisational Development and Workforce:** Retention and Recruitment Strategy to be brought back to the Board.	Denise Farmer	April 2018	To be included in the Organisational Development and Workforce Report
31st January 2018	PB01/18/7.8	**Organisational Development and Workforce:** Follow up required on local housing options for essential workers.	Denise Farmer	May 2018	To be included in the Organisational Development and Workforce Report
31st January 2018	PB01/18/7.12	**Organisational Development and Workforce:** Equality and Diversity national benchmark data, when available, to be brought back to Board.	Denise Farmer	tbc by Denise	Data to be included when available
31st January 2018	PB01/18/10.4	**Patient Experience Report:** Consider a creative way of obtaining feedback from those who cannot represent themselves.	Nicola Ranger	May 2018	
28th March 2018	PB02/18/6.6	**Quality Report:** 24 and 36 hour detail to be included in the Fractured Neck of Femur data.	George Findlay	April 2018	To be included in the April 2018 Quality Report
28th March 2018	PB02/18/6.7	**Quality Report:** report to be provided on the learning around infection control this winter.	Nicola Ranger	June 2018	To be included in the Quality Report
28th March 2018	PB02/18/6.13	**Quality Report:** patient feedback report to be brought to a future Board.	Nicola Ranger	June 2018	Agenda item – May Public Board?
28th March 2018	PB02/18/6.14	**Quality Report:** surgical safety checklist figures to be reviewed and reported back to Joanna Crane (outside the meeting).	George Findlay	April 2018	
28th March 2018	PB02/18/10.7	**Learning from Deaths:** Stephen Bass to be invited to give a presentation at a future QAC.	George Findlay	tbc	Agenda item for QAC – date tbc
28th March 2018	PB02/18/10.7	**Learning from Deaths:** detail in the narrative around deteriorating patient to be provided going forward.	George Findlay	June 2018	To be included in the Quarterly Learning From Deaths report (from June 2108)
28th March 2018	PB02/18/12.6	**Gender Pay Gap:** this data to form part of the Equality and Diversity agenda.	Denise Farmer	tbc	To be included in Equality and Diversity report

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board

Date of Meeting: 30th May 2018 Agenda Item: **5**

Title
Chief Executive's Report
Responsible Executive Director
Marianne Griffiths, CEO
Prepared by
CEO
Status
Public
Summary of Proposal
Update for Board Members
Implications for Quality of Care
None applicable to this report
Link to Strategic Objectives/Board Assurance Framework
None applicable to this report
Financial Implications
None applicable to this report
Human Resource Implications
None applicable to this report
Recommendation
The Board is asked to: NOTE this report
Communication and Consultation
N/A
Appendices
Report

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board
Date: 30th May 2018

Chief Executive's Report

(23 May 2018)

Emergency Ambulatory Care Unit Opened

In April, we officially opened the new Emergency Ambulatory Care Unit at the Royal Sussex County Hospital. The new unit is one of the first in the country where medical and surgical teams work alongside each other to treat emergency patients who do not need to stay in overnight. It is an integral part of how we are planning to build on the improvements in the emergency department.

The staff on the unit have been fantastic at getting it up and running at a time when we have been in the busiest winter I can recall – and it was great to celebrate the opening with them, ably assisted by Brighton and Hove Albion stars Bruno and Anthony Knockaert.

Welcoming Lewes Victoria Hospital

The staff of the Lewes Victoria Hospital joined BSUH in April. We have been providing services at the Lewes Vic for several years, so it makes perfect sense for us to formally take on its facilities and staff – who get fantastic feedback from their patients about the quality of their care. I'm delighted to have the team join the BSUH community.

PRH A&E

At a time when A&E departments across the country are struggling under the pressures of increasing patient numbers, the team at PRH A&E is bucking the trend with four hour wait numbers among the best in the country.

In March, when the national average fell below 80%, PRH A&E maintained 88.6%, and in April, the team managed to ensure 92.3% of patients seen and discharged or admitted within four hours of their arrival. This has also been at a time of regularly supporting diverted ambulance attendances, increasing the number of patients seen.

At the same time, the PRH A&E itself is benefiting from a recent facelift. A redevelopment that saw investment of £960,000 from NHS England to support GP streaming has enabled us to refresh all the Majors cubicles, making them bigger and safer, incorporating medical gasses into the walls and saving staff from having to struggle with gas canisters. The redevelopment also resulted in a new resuscitation room, a new handover room and two new GP consulting rooms.

A patient who visited recently from out of area was asked why they had made the journey to PRH and said: "It's clean and you get seen quickly."

Stroke Unit

Our stoke team achieved an "A" rating in the Royal College of Physicians SSNAP (Sentinel Stroke National Audit Programme) survey. It's the first time BSUH has been rated so highly in the SSNAP survey and is a direct result of us investing in the service by centralising our stroke services on the County site.

The SSNAP survey looks at a range of metrics related to how quickly stroke patients can access imaging, treatment and therapies when they are admitted to hospital following a stroke.

Thanks to investment in our services, we are now able to offer seven-day therapies, including speech and language therapy and physio and occupational therapy. As a result, more of our patients are receiving the support and treatment they need more quickly, helping improve their recovery and reduce hospital stays.

Our SSNAP "A" rating puts us in the top 20% of Trusts in the country for stroke services and I couldn't be more proud.

CQC engagement events
A year after the CQC found "significant improvements" across the Trust, inspectors are making a fresh series of visits, looking at different parts of our hospitals in turn. It is a change in approach that gives us the opportunity to showcase the further improvements we have made to our patient care and demonstrate how we have responded to their findings last year.

On Friday 27 April, a small team of inspectors held an "engagement event" with our Critical Care teams at PRH and RSCH. The Critical Care team at RSCH have engaged with Wave One of the Patient First Improvement System (PFIS) training and the PRH team have just started their training as part of Wave Two.

I'm grateful to all of our colleagues who worked so hard to prepare for the visit, and who ensured that the inspectors really saw the very best that the teams have to offer our patients.

At the time of writing, colleagues in our Emergency Department are preparing to greet the CQC inspection team and showcase the outstanding work they're putting into continually improving patient care.

Patient First – latest news
The Patient First programme continues to roll out throughout BSUH, and a graduation event has recently been held for those colleagues who were a part of the first Wave of training. Wave 2 has had a very positive reception so far, and the lessons learned from both Waves are being taken forward into the next eight wards and departments to go through the programme at the Royal Sussex County (RSCH):

- 8A East
- 8A West
- Trafford
- Chichester
- Emerald
- Baily
- Vallance
- EACU

The benefits from Patient First are already being seen across BSUH, including ward level actions which are benefitting patient care, Patient First is helping colleagues to 'think differently' about problems and providing a framework to find solutions.

I am encouraged by the results so far, and heartened by stories from colleagues about how the Patient First way is becoming part of 'business as usual'.

WRES Conference
At the time of writing, the finishing touches are being put to the 2018 WRES (Workforce Racial Equality Standard) Conference, which will be held at the Brighton Metropole on Tuesday 29th May.

The Conference is open to colleagues from across the Trust community (including our volunteers) and will examine our performance in the 2017 National WRES Survey. We're going to be asking colleagues for their feedback on the survey, and for ideas to help us improve.

These will form the basis of the way in which we promote inclusivity and tackle discrimination. From talking to colleagues on our Wards, I've found that many are keen to attend and play a part in making positive change, so I am looking forward to a positive, vibrant event.

Celebrating Apprentices
Providing opportunities for learning and development is key to creating a highly skilled, sustainable, workforce. Following on from our National Apprenticeship week events in March, I'm delighted to hear that three of our wonderful apprentices received awards at the Health Education Kent, Surrey and Sussex (HEKSS) awards recently.

- Andrej Balsianok, a Physiotherapy Technical Instructor at PRH: Advanced (Level 3) Clinical Apprentice of the Year Runner Up Award
- Yvan Vazquez, a Senior HCA in Renal at RSCH: Advanced (Level 3) Clinical Apprentice of the Year Runner Up Award
- Nena Coomber, a Practice Development Apprentice Administrator and Jamie-Lee Roberts, a High Cost Drugs Technician/Administrator in Pharmacy were both runners up in the Working Above and Beyond the Call of Duty Award.

STARS Awards
374 Patient First STAR award nominations were received from patients, staff and volunteers. The nominations are heartfelt and a privilege to read, full of wonderful quotes - "He makes our ward a happier place", "This kind of help improves patient care without it actually being seen or recognised", "We regard him as a super hero".

There were stories of blankets, a special breakfast service and books, many mentions of putting the patient first and Patient First. We read about someone who has the "smile of an angel", someone who is "a true angel", a team someone is "honoured to work with" and a patient describing a nurse's "exceptional human-ness".

The winners will be announced in June.

Recognition from the British Medical Journal
'Transforming the A&E Workforce' and 'HIV Testing in the Community' both competed in the coveted Innovation category in the British Medical Journal's annual awards recently. 'HIV Testing in the Community' took the gold prize against stiff competition, and 'Transforming the A&E Workforce' was Highly Commended.

'HIV Testing in the Community' is a world-first initiative and a partnership between The Martin Fisher Foundation, Brighton and Sussex Medical School, BSUH and the Brighton Sauna. Lead by Dr Gillian Dean, HIV Consultant here at BSUH, the pilot attracted funding from the HIV Innovations Grant from Public Health England.

The initiative uses a smart vending machine, piloted in the Brighton Sauna, to dispense free HIV self-testing kits to a traditionally difficult to reach group of individuals. Installed in June

2017, the machine dispensed an average of 35 test kits a month – approximately four times more tests than outreach workers were able to complete prior to the pilot. The community have welcomed the pilot scheme with over 95% of users saying that they would recommend this type of test to others.

This project shows exactly how effective partnership working can be and I'm delighted that we're at the forefront of the work to eliminate HIV.

'Transforming the A&E Workforce', led by Dr Rob Galloway, has helped the Trust to revolutionise A&E staffing. The A&E team across the Royal Sussex County Hospital and Princess Royal Hospital is now staffed by 20 consultants, 24 middle grade positions and 22 new non-training clinical fellows. A&E is open 24hours a day in Brighton, and from 08.00 to 23.00 at the Princess Royal in Haywards Heath.

This has been achieved with a new staff rota system, creating greater flexibility and allowing staff to choose the shifts they worked to suit their other commitments as long as all the needed clinical shifts were covered.

There have been significant reductions in the waiting time to see a doctor, complaints have been reduced and the percentage of individuals coming back into A&E after discharge is substantially reduced.

In addition to the substantial benefits to patient care, this new approach has greatly improved educational opportunities throughout A&E, improved staff retention and reduced sickness levels in medical staffing teams. It has also helped us to substantially reduce our expenditure on locum doctors which stood at nearly £1million in 2013.

I'm delighted by the success of these projects which showcase the patient-centred care approach our teams are taking to finding new, efficient and effective ways to deliver modern healthcare.

Research award
A pioneering piece of research led by Dr Lucia Macken, under the supervision of Dr Sumita Verma, is one of the four finalists short listed for the national Lancet Award for "outstanding research activity that contributes to excellent patient care".

The REDUCe trial focuses on symptom management for patients with advanced liver disease, where patients need fluid regularly drained from their abdomen. Currently, this needs to be carried out in a hospital setting; however the REDUCe team are researching the use of long-term abdominal drains to try and move care to the community.

If the research supports home care, then this would positively transform the patients' quality of life – meaning that they wouldn't need to continually make the journey to hospital for their treatment. This change would save each patient hours every week as well as considerable expense too.

The team have been working on this research project since 2013, winning the research grant in 2014 and starting the study in 2015. It will conclude in September this year and, if positively received, may expand nationally.

Finalists will be announced at the end of the month.

Brighton and Sussex University Hospitals NHS Trust

To: Board of Directors

Date of Meeting: 30th May 2018 Agenda Item: **6**

Title
Quality Report Month 1
Responsible Executive Director
Dr George Findlay (Chief Medical Officer) and Nicola Ranger (Chief Nursing and Patient Safety Officer)
Prepared by
Mark Renshaw, Deputy Chief of Safety, Rob Haigh Medical Director
Status
Public
Summary of Proposal
The report describes performance against safety and quality key performance indicators in Month 1, in the domains of safety, effectiveness and patient experience
Implications for Quality of Care
The report includes exceptions in respect of pressure damage which is at its highest since 2012-13 and implementation of the alert - Restricted use of open systems for injectable medications.
Link to Strategic Objectives/Board Assurance Framework
This report incorporates key national, regional and local quality indicators relating to quality and safety providing assurance for the Board and highlighting issues of concern. **A safety and quality scorecard is appended**
Financial Implications
Future reports will include KPIs that have potential financial impact (e.g. CQUIN)
Human Resource Implications
Safer staffing levels are incorporated in the safety and quality scorecard
Recommendation
The Board is asked to NOTE the report.
Communication and Consultation
Not applicable
Appendices
None

1 INTRODUCTION

1.1 This report brings together key national, regional and local indicators relating to quality and safety. The purpose of the report is to bring to the attention of the Trust Board quality performance within Brighton and Sussex University Hospitals NHS Trust (BSUH).

KEY QUALITY OBJECTIVES

2.1 Dashboard Definitions

2.1.1 A Safety and Quality Scorecard is appended to the Board report. Key indicators are detailed in table 1. Figures are in-month figures (e.g. the number of falls reported in April) unless otherwise stated.

2.1.2 Exception reports are included under the relevant section of this report (i.e. under the broad headings Effectiveness, Safety and Experience).

2.1.3 Only the current financial year and year to date values are RAG rated, with the exception of those metrics reported in arrears with no data in the current financial year where the most recent data-point of last year is RAG rated.

2.2 Overview of Key Quality Objectives

2.2.1 The following table shows performance against key, top level quality indicators.

Table 1: key performance indicators

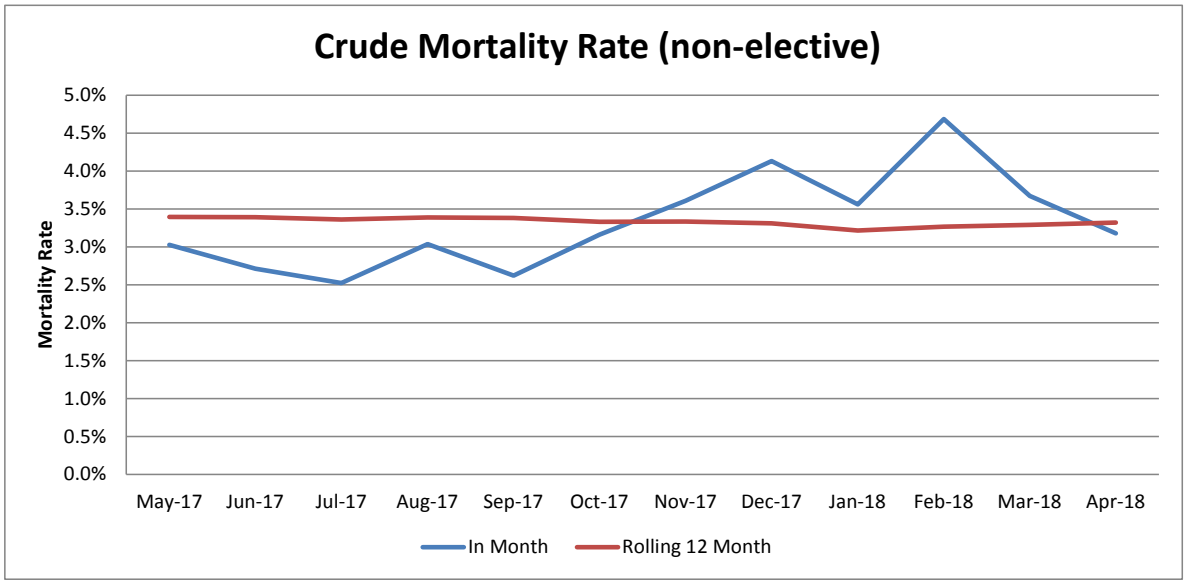
Indicator	February	March	April
Trust crude mortality rate (non-elective)	4.68%	3.67%	3.18%
Hospital Standardised Mortality Ratio (Rolling)	*See section 3.2.1 and 3.2.2*		
Safety Thermometer (Harm-Free Care)	95.9	96.0	96.6
Number of Serious Incidents Requiring Investigation	9	8	4
Never Events	0	1	0
Grade 3 and 4 Pressure Ulcers	0	2	2
Falls resulting severe harm or death	2	1	0
Numbers of hospital attributable MRSA	0	0	0
Numbers of hospital C. diff cases	3	5	0
The Friends and Family Test: Percentage Recommending Inpatients	97.1%	96.8%	93.7%
The Friends and Family Test: Percentage Recommending A&E	88.8%	89.7%	85.9%
Mixed Sex Accommodation breaches (number of breaches)	84	49	67
Number of formal complaints	40	38	48

3 EFFECTIVENESS

3.1 Crude Trust Mortality – Non-Elective

3.1.1 Figure 1 below illustrates the Trusts in-month and 12 month crude mortality rate for non-elective admissions. At the end of April the 12 month rolling mortality rate was 3.32%. (crude mortality rates are influenced by seasonal variation).

Figure 1: In-month and Rolling 12 month Crude Mortality Rate for non-elective admissions

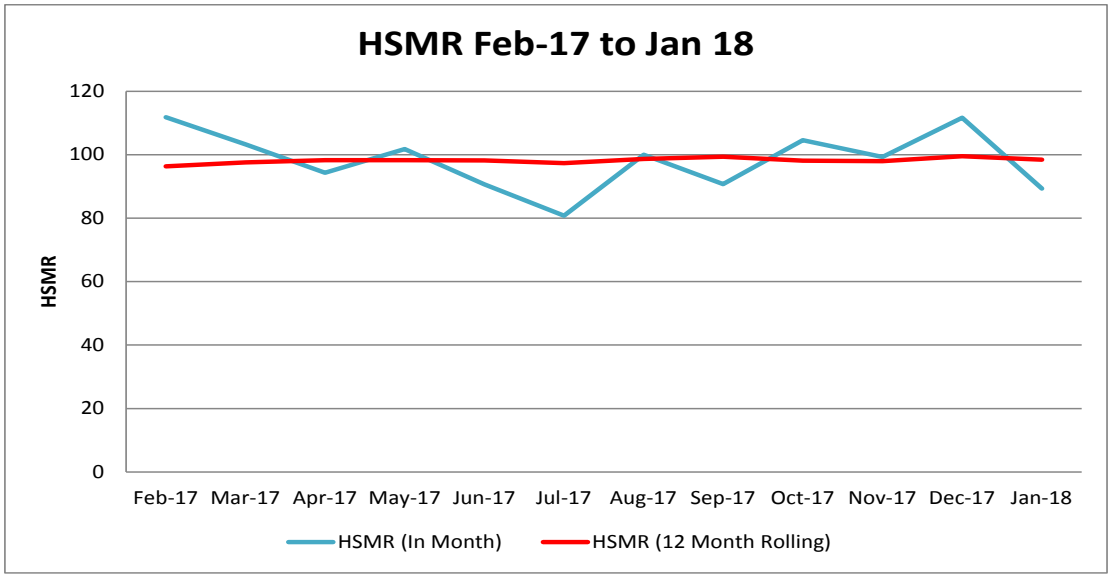


3.2 Hospital Standardised Mortality Ratio (HSMR)

3.2.1 Note: As a result of issues with NHS Digital's external supplier, Office for National Statistics, most relevant data is not available. Consequently, SHMI and HSMR have not been updated this month.

3.2.2 HSMR is only available for the month of January, so was reported in the April board minutes. To recap, during January, 109 patients died against an expected number of 122.06 – HSMR 89.3. In the 12 months to December the HSMR was 98.4[1] (LCI 93.11, UCI 103.91). See figure 2 below.

Figure 2: In-month and Rolling 12 month Hospital Standardised Mortality Ratio



Twelve months ago the annual HSMR was 99.90 (LCI 91.34.3, UCI 102.70).

[1] *A value greater than 100 means that the patient group being studied has a higher mortality level than NHS average performance*

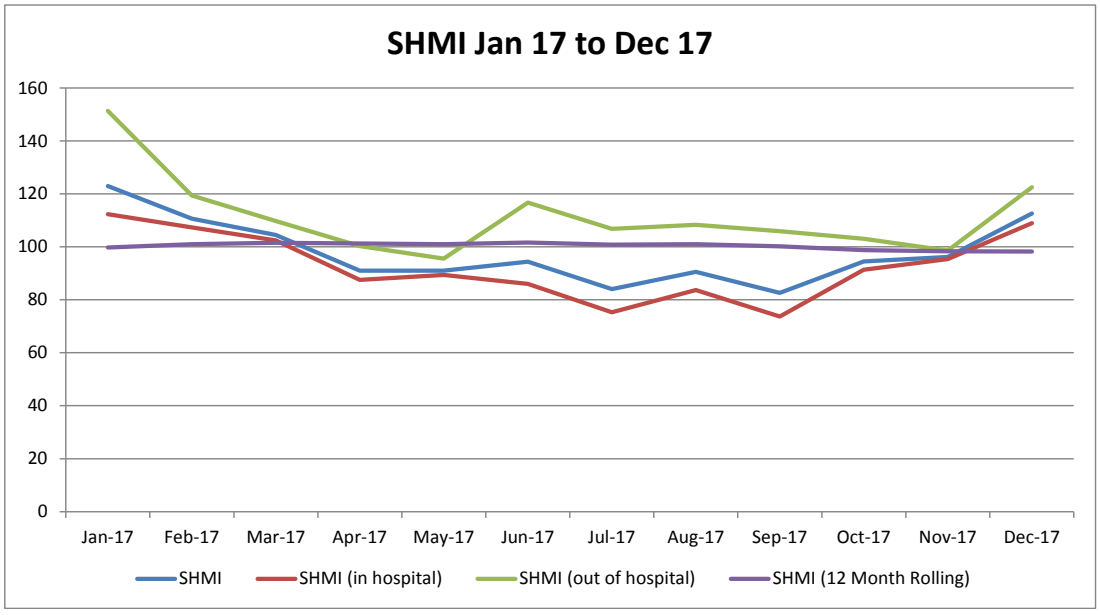
3.3 Summary Hospital-Level Mortality Indicator (SHMI)

3.3.1 The latest SHMI (12 months up to December 2017) is 98.18, i.e. mortality is 1.82% below the expected value. Table 2 below shows the in and out of hospital SHMI for the period January to December 2017. During this period 2362 patients died (expected number of 2405). In hospital deaths make up 69% of the total number of deaths, and are 6.9% below the expected number. Out of hospitals deaths are 11.69% above the expected rate. The 12 month rolling SHMI, is coming down.

Table 2: SHMI

Discharge Month	SHMI	SHMI (in-hospital)	SHMI (out of hospital)	Rolling 12 Month SHMI
Jan-17	122.91	112.28	151.31	99.74
Feb-17	110.62	107.36	119.37	100.97
Mar-17	104.42	102.43	109.69	101.53
Apr-17	91.00	87.47	100.27	101.21
May-17	91.00	89.37	95.55	100.97
Jun-17	94.38	86.01	116.68	101.62
Jul-17	84.01	75.32	106.80	100.82
Aug-17	90.58	83.68	108.32	101.02
Sep-17	82.60	73.66	105.87	100.19
Oct-17	94.50	91.33	103.03	98.79
Nov-17	96.18	95.36	98.59	98.33
Dec-17	112.58	108.97	122.45	98.18
Total	98.18	93.1	111.69	100.28

Figure 3: In-month and Rolling 12 Month SHMI



4 SAFETY

4.1 Patient Safety Alerts

One patient safety alert is currently open - Confirming removal or flushing of lines and cannulae after procedures. Closure of this alert is on schedule (August deadline).

4.2 Serious Incidents Requiring Investigation (SIRIs)

4.2.1 There were 21 Serious Incidents declared during the period February to April. One of these incidents is currently graded as death, three as severe, and two as moderate

4.2.2 15 of the Serious Incidents involved 12 hour breaches and 3 were patient falls.

4.2.3 The 6 SI's, that were not 12 hour breaches, currently undergoing investigation are:

Title of investigation	**Harm Caused**
Fall on L8a East (LT)	Moderate
Fall on Lindfield	Moderate
Fall on Poynings (PT)	Severe
Management of Subdural	Severe
Recovery from Maternal Cardiac Arrest	Severe
Never Event - NG Tube	Death – now closed

4.3 Infection prevention

4.3.1 There were no outbreaks of norovirus during April 2018.

4.3.2 National Influenza surveillance has now been discontinued for the season.

4.3.3 There have been no further cases of measles since 10th April 2018. In total, 5 staff cases were linked to an index case, which was declared as an outbreak. Contact tracing was completed for all cases in conjunction with Public Health England (PHE) and Occupational Health. Surveillance remained in place for further cases for 21 days following exposure and no further cases were recorded.

4.3.4 There were zero cases of Trust apportioned Clostridium difficile infections during April 2018.

4.3.5 The Trust trajectory for 2018/19 is 45 cases for CDI.

4.3.6 There were no Trust apportioned MRSA bacteraemias reported in April 2018, (the last Trust assigned case was January 2018 - although this was not related to concerns around ward based clinical care); the MRSA bacteraemia tolerance for 2018/19 is zero cases.

4.3.7 There is no national Trust objective set for meticillin-sensitive Staphylococcus aureus (MSSA) blood stream infections. The Trust reported 31 cases for fiscal year 2017/18. 9/31 were associated with a peripheral venous cannula and an action plan to address this risk and prevent further occurrences will be submitted to the Infection Prevention Committee on 24th May 2018

4.3 Inpatient Falls

4.3.1 The adult inpatients falls rate for the period February to April was 3.32 falls per 1000 bed days.

4.3.2 The rate of falls for the last financial year is 3.33 falls per 1000 bed stay days; this was the lowest recorded falls rate ever for the Trust.

4.4 Tissue Viability

4.4.1 During the period February to April there were four grade 3 and 58 grade 2 hospital acquired pressure damage incidents reported. Damage to the sacrum, buttocks and heels remains the most common form of pressure damage. Inadequate documentation of skin assessment and changes of position are recurring themes.

4.4.2 The rate of pressure damage per 1000 bed stays days during the period February to April was 0.86. The pressure damage rate for 2017/18 was 0.68 incidents per 1000 bed stay days.

4.4.3 The wound care team are currently producing a paper in response to concerns about the increase in pressure damage rates, which also covers complex wounds.

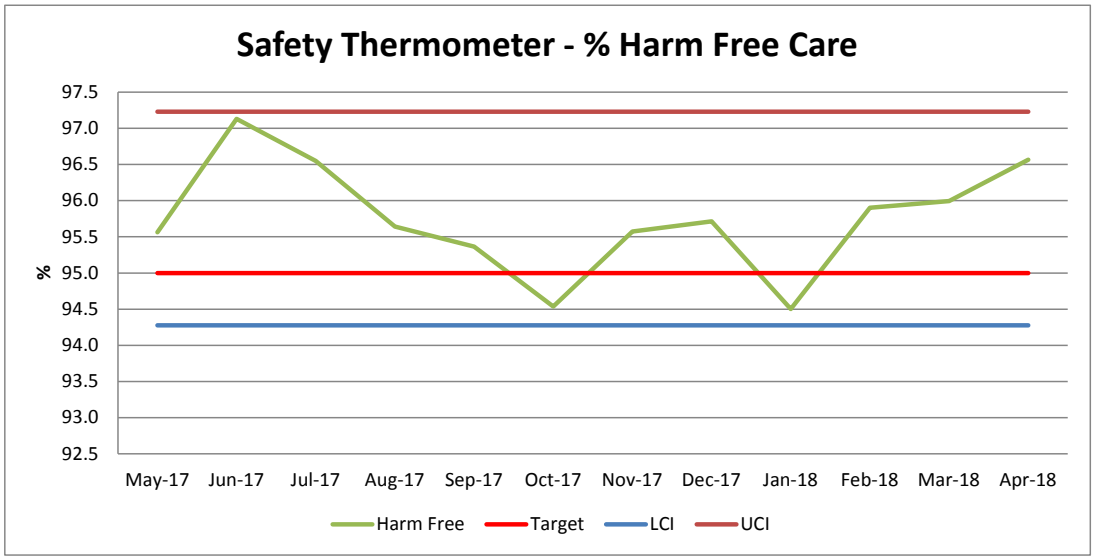
4.4.4 During the last financial year, 1758 Pressure Damage Referrals to the Wound Care Team were made via the Datix Incident reporting system; these referrals represented 1320 patients:

- 74% of patient presented to the Trust with existing Pressure damage
- 345 arrived via a nursing or care home
- 400 admissions resulted in an acquired pressure damage during their stay in hospital
- 226 patients had a Grade 3 or 4 Pressure Damage, 7 of which were acquired in hospital.

4.6 NHS Patient Safety Thermometer

4.6.1 The NHS Patient Safety Thermometer is used across all adult and neonatal wards. This tool looks at point prevalence of four key harms - falls, pressure ulcers, urinary tract infections and deep vein thrombosis (DVT) and pulmonary embolism (PE) in all patients on a specific day in the month. A dashboard is available to each ward showing Trust-wide and ward-level data for each individual harm as well as the harm-free care score. These numbers are also shared via the new ward screens.

Figure 5: Harm free care



4.6.2 The harm-free care score for the past 12 months was 95.75 against the target of 95%. The national average is 94.2%.

4.6.3 National data relating to the NHS safety thermometer is available below:

http://www.safetythermometer.nhs.uk/

4.7 Malnutrition Universal Screening Tool MUST

The Malnutrition Universal Screening Tool (MUST) is a screening tool used to identify and treat adults at risk of malnutrition.

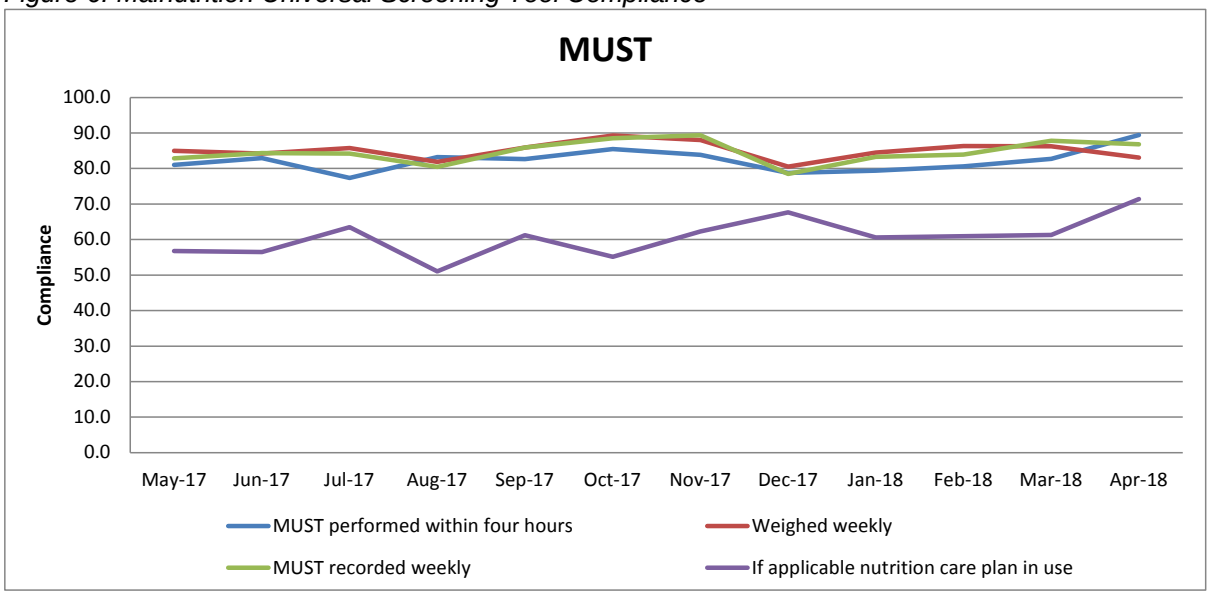
Data on MUST is captured via the Nursing Metrics database, which involves every adult ward screening 10 sets of notes each month. The analysis below is based on the review of 3529 sets of notes.

The proportion of patients receiving a full Nutritional Assessment and MUST score within four hours of admission / transfer to their ward has been increasing over the past 12 months. (Table 3 and Figure 6).

Table 3: Malnutrition Universal Screening Tool Complaince

Month	Full Nutritional Assessment and MUST scoring within four hours of admission / transfer to ward	Has the patient been weighed at least weekly	MUST recorded weekly as per NICE guidelines	If patient at risk of malnutrition is a nutrition care plan in use
May-17	81.0	85.0	82.9	56.8
Jun-17	83.0	84.2	84.4	56.5
Jul-17	77.4	85.8	84.2	63.5
Aug-17	83.2	81.9	80.4	51.0
Sep-17	82.7	85.9	85.9	61.2
Oct-17	85.5	89.3	88.5	55.1
Nov-17	83.8	88.0	89.3	62.3
Dec-17	78.8	80.6	78.5	67.7
Jan-18	79.4	84.5	83.3	60.6
Feb-18	80.6	86.3	83.9	60.9
Mar-18	82.7	86.3	87.8	61.3
Apr-18	89.4	83.1	86.8	71.4
Total	81.9	85.2	84.6	60.4

Figure 6: Malnutrition Universal Screening Tool Compliance



5. PATIENT EXPERIENCE

5.1 PALS and Complaints

5.1.1 The Trust received an average of 38 formal complaints per month during 2017/18.

5.1.2 1,213 concerns were received by the Trust between February and April (PALs and Complaints Team).

5.1.3 Of these, 1,073 concerns were resolved locally and 140 required a written response. During 2017/18, 95% of Early Resolutions were resolved within 25 working days and 54% of formal complaints have been closed within 40 working days.

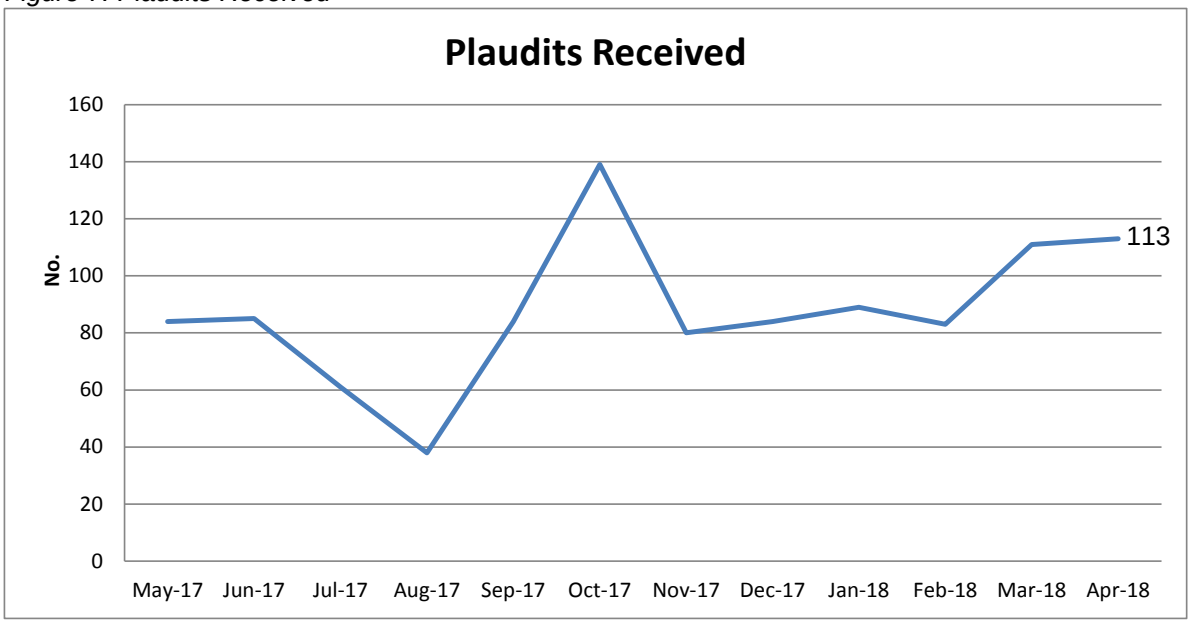
5.1.4 Currently the Trust has eight formal complaints remaining open over six months.

5.1.5 The Trust currently has three complaints at second stage review by the Parliamentary and Health Service Ombudsman.

5.1.6 48 formal complaints citing the poor attitude of staff were reported between February and April.

5.1.7 Figure April plaudits = 113.

Figure 7: Plaudits Received



5.2 Friends and Family Test (FFT)

Patients who access hospital services are asked whether they would recommend the Trust to their friends or family if they needed similar treatment. Patients who access inpatient, outpatient, day-case, A&E and maternity are all offered the opportunity to respond to this question.

Table 4: Friends and Family Test

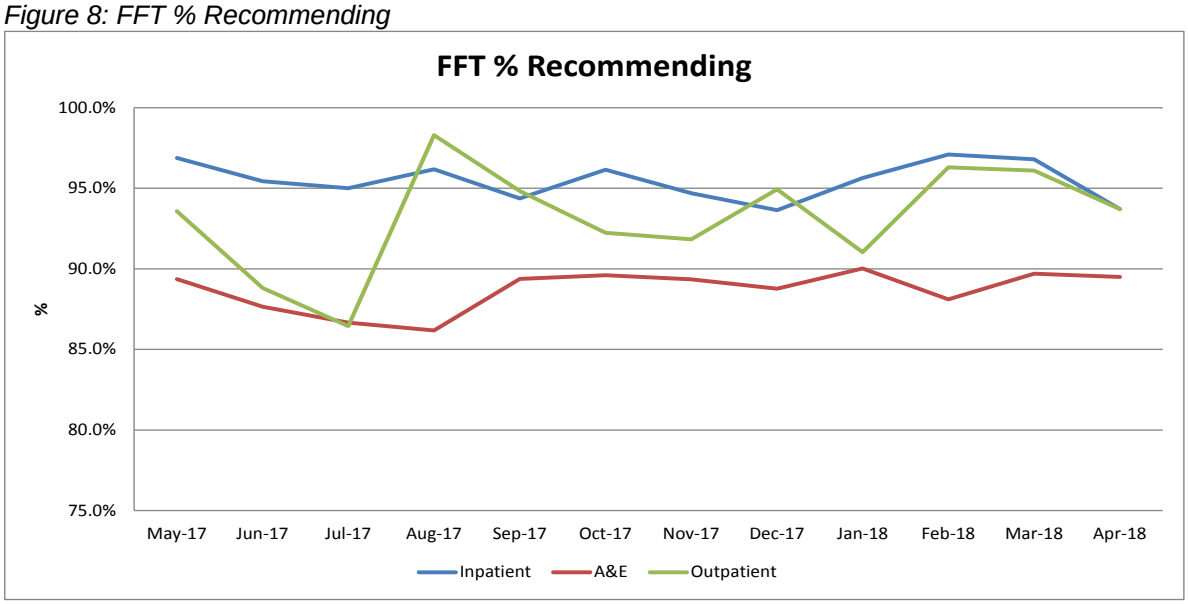
	Percentage recommending BSUH in February to April
Inpatient care	92.0%
A&E	88.7%
Maternity	97.0%
Outpatient	93.7%

5.3 Friends and Family Test Response Rates:

5.3.1 In April responsibility for collecting Friends and Family data switched from internal departments to an external company who now collect this data via text. Last month 7360 responses were received, 30% of the inpatient population.

Figure 8 plots the percentage of patients recommending the care they received. Over the past 12 months the percent recommending A&E and outpatients has risen whilst inpatients has dropped.

Figure 8: FFT % Recommending

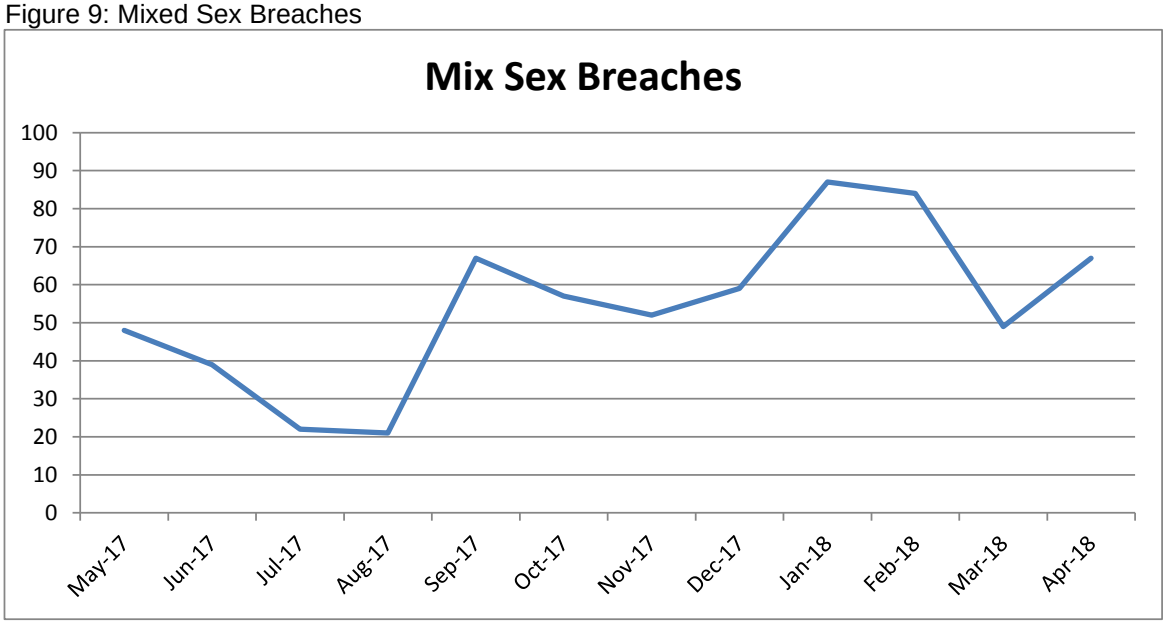


Over the past 12 months the 95.5% of inpatients have recommended the Trust compared to the national average of 96.6%.

5.5 Mixed Sex

5.4.1 In April 67 mixed sex accommodation breaches were reported, these are reflective of the operational pressures faced by the Trust at the time.

Figure 9: Mixed Sex Breaches



6. CARE QUALITY COMMISSION (CQC)

6.1.1 The CQC feedback and Trust response are discussed in a separate Board agenda item.

7. RECOMMENDATION

7.1 The Board is asked to note the contents of this report.

QUALITY SCORECARD

		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	18/19 YTD Actual	YTD Target	Target	Amb
EFFECTIVENESS																		
	Effectiveness domain score																	
	Trust-wide mortality																	
E01	Trust crude mortality rate (non-elective)	2.89%	3.03%	2.71%	2.52%	3.04%	2.62%	3.16%	3.61%	4.13%	3.56%	4.71%	3.67%	3.18%	3.18%	tbc	tbc	
E02	Crude mortality rate (non-elective): 12 month rolling	3.43%	3.40%	3.39%	3.36%	3.39%	3.38%	3.33%	3.33%	3.31%	3.22%	3.27%	3.29%	3.32%	3.32%	tbc	tbc	
E03	Trust Hospital Standardised Mortality Ratio (HSMR) (rolling 12m)	98.24	98.04	97.86	96.91	98.32	99.26	97.98	97.80	99.53	98.61	98.79				<100	<100	
E04	Summary Hospital-level Mortality Indicator (SHMI) (rolling 12m)	99.19	98.57	98.71	97.51	97.38	97.99	96.59	96.18	112.5						<100	<100	
	Improve mortality in specific conditions																	
E07	Crude non-elective mortality for Renal failure	6.67%	15.00%	4.76%	15.15%	8.16%	3.45%	10.81%	15.15%	10.26%	13.16%				9.85%	18.60%	18.60%	
	Reduce mortality following hip fracture																	
E09	SMR for hip fracture (all diagnoses/procedures) (rolling 12M)	90.1	84.2	85.5	84.5	89.9	101.0	93.8	95.4	92.7						100	100	
E10	30 day mortality rate following hip fracture (rolling 12M)	8.3%	5.9%	0.0%	4.9%	11.6%	1.6%	7.4%	0.0%	0.0%						5.70%	5.70%	
	Reduce the rate of readmission following discharge from the Trust																	
E11	Emergency readmissions within 30 days %	9.8%	8.4%	8.2%	8.2%	7.8%	8.7%	8.2%	8.9%	8.8%	8.0%					10.50%		
	To improve maternity care by encouraging natural chilbirth																	
E13	C-Section Rate	33.3%	32.5%	30.1%	29.8%	29.1%	28.9%	29.8%	27.1%	28.2%	32.9%	30.7%	32.5%	31.9%	31.9%	26%	26%	
E14	% Mothers requiring forceps for delivery	4.6%	6.7%	5.6%	7.6%	6.2%	5.9%	8.8%	6.6%	5.9%	5.3%	8.4%	6.1%	6.2%	6.2%	<15%	<15%	
E15	% Deliveries complicated by post-partum haemorrhage	0.5%	0.6%	1.2%	1.0%	0.6%	1.1%	0.2%	0.5%	0.5%	0.0%	0.0%	0.4%	0.7%	0.7%	1%	1%	
E16	Maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
E17	Admission of term babies to neonatal care	5.2%	3.0%	4.0%	5.3%	4.0%	5.2%	4.7%	4.9%	3.0%	4.4%	7.6%	3.1%	5.9%	5.9%	<4%	< 10%	
	Caring for the elderly patient																	
E18	% Emergency admissions staying over 72h screened for dementia	91.9%	93.8%	90.0%	92.6%	96.3%	95.3%	90.4%	93.1%	94.8%	91.1%	94.4%	81.4%			90%	90%	
E19	% Patients identified as at risk of dementia for whom further investigations are carried out	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			90%	90%	
E20	% Patients with identified dementia referred to specialist services	93.3%	86.7%	95.0%	91.7%	82.6%	92.9%	90.9%	88.2%	89.7%	100.0%	88.9%	94.7%			90%	90%	
E25	Number of admissions for patients with dementia flag															NA	NA	
E39	Ward moves for patients flagged with dementia															tbc	tbc	
E42	Night-time ward moves for patients flagged with dementia (23:00 - 07:00)															tbc	tbc	
E43	Documentation Audit: % patients with dementia with Knowing Me document															75%	75%	

QUALITY SCORECARD

		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	18/19 YTD Actual	YTD Target	Target	Amb
	Stroke care																	
E26	% CT scans undertaken within 12 hours	98.2%	98.1%	98.4%	98.3%	97.9%	96.2%	100.0%	96.6%	96.0%	98.1%	97.6%	100.0%			95%	95%	
E27	% Stroke thrombolysis within 60 minutes of hospital arrival															95%	95%	
E28	% Swallow screen for stroke patients within 4 hours of admission															95%	95%	
E29	% of stroke patients admitted to stroke unit within 4 hours of admission	56.7%	70.2%	72.3%	68.3%	60.0%	67.2%	64.3%	61.7%	54.5%	56.6%	47.8%	56.7%			90%	90%	
E30	% high risk TIA patients seen within 24 hours	85.0%	75.0%	94.4%	73.3%	71.4%	90.6%	69.2%	75.9%	73.7%	80.0%	71.4%	63.2%	56.3%	56.3%	60%	60%	
	Ensure active engagement with research																	
E21	Patients recruited to interventional studies within CRN portfolio	175	136	172	172	165	120	172	172	151	104	98	107		1744	tbc	tbc	
E22	Patients recruited to observational studies within CRN portfolio	287	115	203	161	149	140	176	214	239	135	106	211		2136	tbc	tbc	
E23	Local Clinical Research Network (LCRN) Score	462	251	375	333	314	260	348	386	390	239	204	318			1410	1410	
	Data Quality																	
E24	NHS IC Data validity summary (YTD)	98.0	98.0	98.1	98.1	98.1	98.1	98.1	98.2	98.2	98.2				98.2	96.6	96.6	
E37	% inpatients with electronic discharge summaries produced	49.0%														tbc	tbc	

QUALITY SCORECARD

		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	18/19 YTD Actual	YTD Target	Target	Amb
SAFETY																		
	Safety domain score (Patient Aggregate Safety Score - PASS)																	
	Safer staffing																	
S36	Safer Staffing: Average fill rate - registered nurses/ midwives (day shifts)	92.1%	92.4%	91.7%	90.4%	90.5%	90.2%	91.1%	91.5%	90.1%	89.9%	89.4%	87.4%	92.7%		95%	95%	
S37	Safer Staffing: Average fill rate - registered nurses/ midwives (night shifts)	93.2%	92.6%	92.5%	91.8%	92.0%	92.3%	93.6%	93.3%	93.1%	93.2%	90.3%	92.5%	93.7%		95%	95%	
S38	Safer Staffing: Average fill rate - care staff (day shifts)	96.6%	95.5%	95.5%	95.1%	94.4%	95.3%	94.6%	96.1%	96.1%	96.7%	99.8%	97.1%	96.8%		95%	95%	
S39	Safer Staffing: Average fill rate - care staff (night shifts)	110.6%	112.9%	111.7%	112.1%	113.5%	112.0%	114.4%	116.0%	113.0%	114.7%	113.6%	117.1%	113.1%		95%	95%	
S41	Care Hours Per Patient Day (CHPPD)	9.70	9.70	9.70	9.30	9.50	9.40	9.20	9.60	9.50	9.50					tbc	tbc	
	NHS safety thermometer																	
S02	Safety Thermometer: % of patients harm-free	95.2%	95.7%	97.1%	96.6%	95.6%	95.4%	94.5%	95.6%	95.7%	94.5%	95.9%	96.0%	96.6%	96.6%	95.70%	95.70%	
S03	Safety Thermometer: % of patients with no new harms	98.43%	98.80%	99.16%	98.96%	99.27%	98.29%	98.46%	98.56%	98.57%	98.51%	99.06%	98.82%	99.29%	99.3%	99%	99%	
S29	% of patients with catheters and UTIs where best practice protocol was not followed.															0.1%	0.1%	
	Monitoring of clinical incidents																	
S04	Total incidents	796	894	914	891	890	919	922	910	920	986	883	981	855	9042	8122-10988	8122 - 10988	303-944
S05	Total moderate, severe or death incidents	8	5	6	11	4	13	10	7	9	16	9	5	15	89	153	153	
S06	Total serious incidents (SIRIs)	4	4	2	2	4	3	5	5	6	5	9	8	4	4	60	60	
S07	Number of outstanding CAS alerts	0	0	1	1	1	1	1	0	0	0	0	0		1	0	0	
	Improve safety of prescribing																	
S08	Total incidents involving drug/prescribing errors	135	112	123	98	114	126	113	125	130	129	105	125	126	1205	1056-1428	1056 - 1428	
S09	Moderate/severe incidents involving drug/prescribing errors	1	1	1	1	0	1	0	0	1	0	0	0	1	6	5	5	
	Reduce incidence of healthcare acquired infections																	
S14	Number of hospital attributable MRSA cases	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
S15	Number of hospital C.diff cases	1	3	3	9	4	5	4	9	3	7	3	5	0	0			
S28	Number of C. diff cases where a lapse in the quality of care was noted															16	16	
S16	Number of reportable MSSA bacteraemia cases						2	4	2	3	5	1	4	2		tbc	tbc	
S17	Number of reportable E.coli cases						5	2	7	4	6	6	4	5		tbc	tbc	

QUALITY SCORECARD

		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	18/19 YTD Actual	YTD Target	Target	Amb
	Improve theatre safety for patients																	
S18	Full compliance with WHO Surgical Safety Checklist	94.7	98.0	95.8	97.6	97.0	96.8	97.2	98.0	98.1	95.9	90.5	95.0	98.2	98.2	100%	100%	
S19	NEVER events	0	0	1	0	0	0	1	0	1	0	0	1	0	0	0	0	
S30	SSIs: Total hip replacement (YTD is rolling 12 months)															1.1%	1.1%	
S33	SSIs: Total knee replacement (YTD is rolling 12 months)															1.5%	1.5%	
S34	SSIs: Large bowel surgery (YTD is rolling 12 months)															12%	12%	
S35	SSIs: Breast surgery (YTD is rolling 12 months)															3.8%	3.8%	
	Reduce number of falls in hospital																	
S21	Falls resulting in harm	85	76	93	75	80	87	80	106	83	110	86	77	91	91	456	456	
S22	Falls resulting in severe harm or death	1	1	0	0	1	3	2	3	2	5	2	1	3	3	1	1	
S40	Repeat falls	4	6	7	6	7	7	7	13	9	11	10	9	10	10	113	113	
S23	Falls assessment within 24hrs of admission	98.7	98.3	98.7	98.7	98.7	98.4	99.4	98.5	99.0	99.4	99.3	97.5	98.4	98.4	80%	80%	
S24	Avoidable falls identified on the Safety Thermometer	0.00	0.12	0.36	0.35	0.24	0.61	0.12	0.24	0.48	0.34	0.23	0.00	0.12	0.26	0.76%	0.76%	
	Pressure ulcers																	
S25	Grade 2 pressure ulcers	18	12	16	10	17	13	17	12	18	13	15	22	21	21	156	156	
S26	Grade 3 & 4 pressure ulcers	0	0	0	1	0	2	0	0	0	2	0	0	1	1	11	23	
	Other safety metrics																	
S11	VTE Assessment Compliance	92.8%	92.8%	92.8%	92.0%	92.0%	91.8%	93.2%	92.9%	93.0%	93.0%	92.5%	92.6%			95%	95%	

QUALITY SCORECARD

		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	**18/19 YTD Actual**	YTD Target	Target	Amb
EXPERIENCE																		
	Experience domain score																	
	Friends and Family Test																	
X38	Trust Friends and Family Recommend %: Inpatient	96.7%	96.9%	95.4%	95.0%	96.2%	94.4%	96.2%	94.7%	93.6%	95.6%	97.1%	96.8%	92.0%	92.0%	95%	95%	
X39	Trust Friends and Family Recommend %: A&E	88.7%	89.4%	87.6%	86.7%	86.2%	89.4%	89.6%	89.3%	88.8%	90.0%	88.1%	87.9%	89.5%	89.5%	93%	93%	
X40	Maternity Friends and Family Recommend %: Antenatal care (36 weeks)	100.0%	100.0%	100.0%	N/A	100.0%	83.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95%	95%	
X41	Maternity Friends and Family Recommend %: Delivery care	96.8%	98.2%	97.1%	96.5%	98.8%	98.8%	97.8%	97.6%	98.5%	98.7%	98.7%	97.7%	96.9%	96.9%	95%	95%	
X42	Maternity Friends and Family Recommend %: Postnatal ward	90.4%	94.9%	89.7%	94.9%	90.8%	96.5%	96.9%	93.9%	93.2%	92.2%	90.5%	93.8%	97.7%	97.7%	95%	95%	
X43	Maternity Friends and Family Recommend %: Postnatal community care	80.0%	96.5%	96.6%	91.3%	94.0%	85.7%	96.0%	90.3%	92.3%	96.9%	89.7%	93.5%	96.0%	96.0%	95%	95%	
X44	Trust Friends and Family Recommend %: Outpatient	93.8%	93.6%	88.8%	86.4%	98.3%	94.8%	92.2%	91.8%	94.9%	91.0%	96.3%	96.1%	93.7%	93.7%	95%	95%	
	Friends and Family Test response rates																	
X24	Trust Friends and Family Response Rate: Inpatient	7.9%	12.1%	13.4%	11.1%	11.6%	13.4%	10.9%	14.8%	11.5%	12.6%	8.9%	11.1%	30.2%	30.2%	40%	40%	
X25	Trust Friends and Family Response Rate: A&E	18.1%	19.1%	19.6%	16.2%	16.9%	17.7%	16.3%	21.5%	20.2%	18.5%	17.3%	20.5%	21.5%	21.5%	23%	23%	
X33	Maternity Friends and Family Response Rate: Delivery care	22.3%	24.0%	25.1%	17.3%	17.6%	18.0%	20.0%	19.6%	15.3%	16.0%	22.8%	20.4%	21.9%	21.9%	40%	40%	
	Reduction in patients suffering a bad experience dealing with the Trust																	
X08	Percentage of re-booked outpatient appointments															7.80%	7.80%	
X09	Clinics cancelled with less than 6 weeks notice for annual/study leave	48	41	49	38	43	32	62	57	40	37	85	74	92	92	281	281	
X11	PALS contacts relating to appointment problems (pior % of total appts)															0.08%	0.08%	
X12	Reduce patients cancelled on the day of surgery for non-clinical reasons															337	337	
X13	Breaches of mixed sex accommodation arrangements	76	48	39	22	21	67	57	52	59	87	84	49	67	67	0	0	

QUALITY SCORECARD

		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	**18/19 YTD Actual**	YTD Target	Target	Amb
	Cleanliness / PLACE Survey																	
X16	Internal PLACE compliance : RSCH															95%	95%	
X17	Internal PLACE compliance : PRH															95%	95%	
	Improve our customer service and become a more caring organisation																	
X18	Number of complaints	26	24	30	31	49	39	39	36	37	53	49	43	48	48	tbc	tbc	
X19	Complaints where staff attitude or behaviour is an issue	12	19	12	17	13	18	13	15	13	14	10	9	29	29	tbc	tbc	

Brighton and Sussex University Hospitals NHS Trust

To: Meeting of the BSUH Trust Board

Date of Meeting: 30th May 2018 Agenda Item: **7**

Title
Organisational Development and Workforce Performance Board Report
Responsible Executive Director
Denise Farmer, Chief Workforce and OD Officer
Prepared by
Helen Weatherill, Director of HR
Status
Public
Summary of Proposal
This report details the Trust's performance in relation to workforce supply, development and engagement of its workforce to improve the organisations culture.
Implications for Quality of Care
There is a direct correlation between a highly engaged, performing workforce and quality of care.
Link to Strategic Objectives/Board Assurance Framework
Supports the delivery of the Trust's True North Objectives
Financial Implications
Supports effective and efficient financial performance
Human Resource Implications
As above
Recommendation
The Board is asked to: NOTE this report
Communication and Consultation
n/a
Appendices
Appendix 1: Workforce Scorecard – Month 1 2018/19 Appendix 2: Report on 2017 Staff Survey

To: Trust Board Date: 30th May 2018

From: Denise Farmer, Chief Workforce and OD Officer Agenda Item: 7

FOR INFORMATION

WORKFORCE AND ORGANISATIONAL DEVELOPMENT REPORT

1. Introduction

This paper sets out the key headlines relating to the Trust's workforce as at 30th April 2018.

2. Workforce Capacity

2.1 In April the Trust Establishment increased by 59 WTE to stand at 8,273, while staff in post increased by 27 WTE to 7,399. As a result of this the Vacancy rate increased to 10.6%, putting it slightly above target. The WTE mix of vacancies shows that 344 are Nursing, 184 are Admin & Clerical, 169 are S,T&T, 87 are Ancillary Support and 90 are Medical, with a Trust total of 874 WTE.

Staff from Lewes Victoria Hospital successfully transferred to BSUH in April. There was a total of 31 staff, with 18 going into the Surgery Division and another 13 transferring into Central Clinical Services.

2.2 Bank spend was £1.5m during the month of April 2018, a decrease of £0.2m on March. The reduction is largely due to a decrease in Nursing Bank spend which reduced by £214k on March 2018.

2.3 Agency spend decreased by £0.3m to £1.0m for the month. There were reductions across all staff groups, but it was the Ancillary Support group which had the biggest overall reduction in spend reflecting the successful recruitment drives over the last six months.

3. Staff Turnover

3.1 The Trust's 12 month Turnover rate (external leavers excluding Training Grade Doctors) was 14.1%, this is the third month a Turnover reduction has been seen, although it remains above target.

3.2 The ST&T staff group remains the area seeing the highest Turnover at 17.6%, but Unregistered Nurses (15.0%) and Admin & Clerical staff (15.2%) also have high Turnover rates. As part of the new Divisional structure a new role of Head of Professions was created. This role has now been filled and the post holder started on 21st May 2018. One of the key priorities for the Head of Professions will be to address the vacancies and reduce turnover within these professional groups. The plan and progress against the plan will be managed through the Workforce Efficiency Working Group.

4. Recruitment and Selection

4.1 Two nurses from the international recruitment campaign joined the Trust in April, and another seven are due to join on 18th May.

Various Nursing Recruitment open days were held throughout April, with the aim of reducing the level of vacancies within Unregistered Nursing and Registered Nursing Band 5. As a result of these events, there are currently 12 WTE of Unregistered Nursing and 43 WTE of Nursing Band 5, going through the pre-employment checking part of the recruitment process. Due to this success, more open days are being planned for future points in time.

In addition to Trust wide open days Divisional Recruitment Days are now being piloted, starting with Surgery on 21st May. Each Division will hold rolling monthly recruitment days across sites, to recruit into their Band 2 and Band 5 Nursing vacancies.

4.2 Retention of Health Care Assistants

The Trust employs nearly 1000 wte HCAs. In April 2017 there were 135 wte HCA vacancies and over the last six months the recruitment process for HCAs has been redesigned and regular open days have been held. Once all the appointees commence in post there will be approximately 10 vacancies.

This position will not remain static unless the current turnover rate significantly reduces. The turnover rate of HCAs on 1st April 2017 was 19.9%. This has significantly reduced to 15% over the last 12 months which is a significant improvement; however 15% is still much higher than the Trust's target of 11%. The retention strategies that have been adopted to date include:

- HCA clinical forums – staff engagement events – with an action tracker approach "You said we did"
- Bands 2-4 skills pathway – providing existing staff with the ability to develop new skills.
- Proposed recruitment of Band 3 in all clinical areas to support new starters acting as clinical role models.
- Increase in availability of apprenticeship for existing staff through the apprenticeship pathway.
- New 5 day care certificate programme with practice development support.
- 4 new trainee nursing associates commenced their training in March 2018
- Career Clinics to provide advice to our staff on all the opportunities available.

Nurse Retention

The Trust currently employs 2569 wte qualified nurses and midwives. There are currently 260 wte vacancies. The number of vacancies on 1st April 2017 was 220 wte. Since then we have successfully recruited 250 wte, however 318 wte staff have left. Improving retention therefore remains a key priority and the following initiatives have been introduced over the last six months:

- Recruitment strategies – targeted at Return to practice, flexible working initiatives
- Opportunity to step on to a 1,2 or 3 year development programme.

- 12 month preceptorship programme that is mandated and meets the HEE standards and encompasses our Year 1 development programme.
- Multiple Rotations programmes showcasing the skills that can be gained working at WSHT.
- Year 2 development programme that enables staff to undertake in-house mentorship programme and a clinical course within their current clinical area.
- Year 3 development programme that provides key leadership development.
- Portfolio of in-house modules, economical approach to increase numbers of education opportunities at a reduced cost.
- Staff engagement opportunities through various forums using the "you said we did".
- Career Clinics to provide advice to our staff on all the opportunities available

Over the last 13 months turnover has reduced from 14.1% to 12.5%.

The Senior Nursing and HR Leadership Teams are currently in the process of developing a further plan as part of our Leadership, Culture & Workforce programme to target the variation in turnover and stability rates across the wards.

5. Workforce Efficiency

5.1 The Trust 12 month sickness absence rate is currently 4.17% (March 2018) which is the first time the 12 month rate has fallen below 4.20% since February 2016. The individual monthly absence rate for March was 3.70%, which is the second lowest rate for an individual month since May 2015. The most common cause of absence remains as Stress / Depression (19.5% of total reasons), and as part of Mental Health Awareness Week (14th to 18th May 2018), Trust wide communications will be circulated promoting the resources available to all staff in respect of stress and mental health.

If 12 month sickness absence is compared between Short Term and Long Term (28 days or more), it shows that Short Term has held at 1.97%, but that Long Term has reduced by 0.05% to stand at 2.20%. The focus on Long Term sickness remains, and since April there have been 17 returns to work from long term sickness and 7 other cases have been resolved.

The focus on Soft FM services is now showing a steady reduction in absence rates, with both the in-month and 12 month absence rates at the lowest level for the past year, at 5.3% and 6.7% respectively. Absence rates for long term sickness are also decreasing from 4.1% in November 2017 to 3.7% in March 2018.

The priority areas for Nursing have been re-defined with the Senior Nursing team and plans are in place.

6. Appraisals

6.1 The Trust appraisal rate has increased to 78.8% to date (11th May), an increase of 1.7% on April and an increase of 6.5% on March.

6.2 Of the 338 ward and Departments, 117 (34.6%) are at or above 90% compliance with a further 33 (9.7%) between 85% and 90% compliant.

6.3 Each Division receives monthly reports detailing staff who have not had an appraisal within the last 12 months, and those staff due an appraisal to the end of June. Also,

weekly reports are being produced and provided to the HR team so that any decline in appraisal rates can be picked up with the relevant leads in good time.

6.4 The HR team continues to work with Divisional teams to support improvement in hotspot areas, and to encourage additional completions in smaller areas where 100% is achievable. They also continue to support correction of any data issues, whether management or system related.

6.5 All Divisions are focusing on Appraisals through their performance management (SDR) processes and have applied our improvement methodology to developing suitable measures to improve compliance. In addition, further to the staff survey results being published, some Divisions are focusing on appraisal quality as a key area for improvement.

7. Workforce Skills and Development

7.1 The Statutory and Mandatory compliance rate (STAM) for May 2018 (based on the 11 Board reportable subjects) has increased to 83.4%, up 1.3% on April. Of these, ten have seen an increase in May with one (Manual Handling Inanimate Loads), remaining static. Four modules have a completion rate greater than 85%, four greater than 80%, with the remaining two achieving 75% (Manual Handling – Patients) and 74% (Safeguarding Children), though the latter did see the biggest improvement (up 5%) in May.

7.2 Divisional STAM compliance shows four Divisions with a completion rate greater than 90%, three Divisions between 85 and 90%, two between 80 and 85% and the last two sitting at 70% and 64%.

7.3 Reporting is currently at Divisional level, with a monthly master report which reports all subjects. However the HR team are working with the IRIS team to provide monthly Care Centre breakdowns.

7.4 STAM is a driver metric in some Divisions, and again work has been done to understand the root cause of the issues and ensure suitable measures are taken to improve compliance.

8. Health & Wellbeing

8.1 A Wellbeing project plan has been completed, outlining plans to promote wellbeing and prevent ill-health. The plans focus on MSK (ward based pilot); stress, and improving the perception of staff that the Trust takes action on Health and Wellbeing through available communication mechanisms (Trust level), highlights include:

- The launch of the new Health and Wellbeing Microsite, including details of support, activities and resources available to staff.
- A calendar of national and local health and wellbeing related events and campaigns has been implemented.
- The first of a regular wellbeing feature (‘What’s on Wellbeing’) was published in Buzz this week in support of Mental Health Awareness Week, raising awareness of the signs of stress and promoting the Trusts Health, Learning & Psychotherapy Service (HELP).
- A Health and Wellbeing one page summary for staff will shortly be published on the new Staff Engagement info-net pages.

- Development of “What’s on Wellbeing” promotional material designed to promote Wellbeing activities to staff including Yoga, Pilates, Choir, and Carers Support etc.
- NHS Employers has launched a new Health and Wellbeing Framework and diagnostic tool this month and the Trust will be completing a self-assessment against this framework in June.

9. Equality & Diversity

9.1 BSUH is a Disability Confident – Level 2 Organisation. It migrated to this firstly in 2016 when the Two Ticks Scheme came to an end, and then in 2017 when the submission earned Level 2 status. There are three levels, 1 – Disability Confident Committed, 2 – Disability Confident Employer and 3 – Disability Confident Leader.

Between September 2017 and October 2019 we are working to ensure that all the elements relating to Level 2 are fully embedded within BSUH, namely:

Theme 1 – Getting the Right People for your Business

- Actively looking to attract and recruit disabled people.
- Providing a fully inclusive and accessible recruitment process.
- Offering an interview to disabled people who meet the minimum criteria for the job.
- Flexibility when assessing people so disabled job applicants have the best opportunity to demonstrate they can do the job.
- Proactively offering and making reasonable adjustments as required.
- Encouraging our suppliers and partner firms to be Disability Confident.
- Ensuring employees have appropriate disability equality awareness.

Theme 2 – Keeping and Developing your people

- Promoting a culture of being disability confident.
- Supporting employees to manage their disabilities or health conditions.
- Ensuring there are no barriers to the development and progression of disabled staff.
- Ensuring managers are aware of how they can support staff that are sick and absent from work.
- Valuing and listening to feedback from disabled staff.

Work that underpins these requirements has been in place for many years and is actively supported by the HR Department, Occupational Health, HELP Services, EDI Team via the equality hub, F&E with their recruitment of people with Learning Disabilities and Possability People (an external Disability support organisation). It is our intention to have all the elements firmly in place by Spring 2019, which will enable our external validator’s time to assess all that we have in place. Once they are content that we are fulfilling all of the above we can then be known as a Disability Confident Leader”

9.2 Workforce Race Equality Standard (WRES)

The Trust has a comprehensive Leadership, Culture and Workforce Programme comprising of 13 different workstreams include equality and inclusion. The Chief Executive Officer personally leads this workstream and delivery of race equality and the Workforce Race Equality Standard (WRES) is one of the key stands of this programme. On 29th May 2018, the Board will be holding a WRES conference with the support of the whole national WRES team. Over 180 staff and leaders will be in attendance at the conference. The national WRES team will be presenting BSUH's WRES data highlighting areas where the Trust has improved and areas where more rapid progress needs to be made. As part of the conference staff will be invited and encouraged to help shape the plan for each of nine WRES indicators.

The Board has agreed that it will review this plan and publish it on the Trust's website by the end of July.

10. Staff Engagement

10.1 Policy Group Forum

A sub-group of Trust Council has been re-established to develop and review all non-medical Human Resources (HR) policies on employment issues. The group is formed of representatives from staff side, staff network groups, representatives from the Equality, Diversity and Human Rights team and HR and met for the first time this month. Attendees felt this was a positive step in working together collaboratively.

The group will be meeting monthly and have developed a policy schedule with the aim of reviewing two policies per month. In addition to this the forum are participating in two half day workshops (scheduled for May and June) to undertake an in-depth review of four key HR policies (Dignity at Work, Grievance, Managing Sickness Absence and Disciplinary).

10.3 Staff Survey

The HR team have set-up a dedicated Staff Engagement page on the staff info-net to help communicate Trust and Divisional on-going actions in response to our staff survey. Appendix 2 includes a summary of the Staff Survey results for 2017.

The Trust's breakthrough objective of "Care of Patients is the Organisation's top priority", has been identified appropriately as either a "driver" or "watch" metric, in Divisional Strategy Development Review "catch ball" discussions.

Staff engagement focus groups, and discussions with staff and managers across the Trust, are taking place in April and May to help formulate Divisional 'A3' improvement plans for staff engagement.

A monthly Staff Engagement scorecard and summary, using the monthly mini survey results from training events and IRIS (captured by the Learning & Development team), is being developed by HR, Learning & Development and the BSUH Central Information Unit and will be available as regular Board reports from June.

11. Exit Interviews

11.1 There were 91 leavers in March and 36 completed an Exit Questionnaire giving a response rate of 40%. This is lower than February at 60% and gives a three month average of 45%. The highest number of leavers who responded were from the Central Clinical Services, Children's & Women's and Surgery Divisions.

11.2 In March, no respondents indicated that their decision to leave had been influenced by their treatment in relation to any of the protected characteristics. Most of the leavers were in the age range of 21 to 30, and the majority were female.

11.3 The top three reasons given for leaving were cited as change of career, flexible working and better pay or reward. For the first time in seven months, lack of promotion or career opportunities did not appear as the top reason, or in the top three reasons for leaving.

11.4 Most of the leavers in March had between five and ten years' service in the Trust, and had been in their current role for one to three years.

11.5 The leavers who responded to the Exit Questionnaire in March indicated that some of the positive aspects of working at the Trust were good teamwork, caring and understanding managers, the positive impact of their work on patient care, diversity and flexible shifts.

11.6 The respondents stated that the Trust needed to do more to make staff feel valued, offer more flexible working and fairness in decisions on flexibility, provide development opportunities for staff and improve how staff speak and behave towards each other.

12. Leadership Training Update

12.1 Module One of the Leadership Programme has now been completed for Clinical Leaders and the Divisional leadership team.

12.2 Module Two of the Leadership Programme will be delivered by the Kings Fund and the initial cohort comprises the senior teams from all six Divisions. It commenced on 25th May and will run until the end of January 2018.

13 COMMUNICATIONS AND ENGAGEMENT

13.1 <u>Patient First Capability</u>

The communications team has continued to work with the trust's leadership team to support awareness and involvement in Patient First. The aim is to ensure colleagues are aware of Patient First, believe it will support improvement and can see how they are involved. The effectiveness of the campaigns is measured by a survey on the trust's online statutory and mandatory training portal.

By 31 April, 1,430 staff had taken part in the survey, with the results as follows:

	Month 1 (230 respondents)	**Month 2 (716 respondents)**	**Month 3 (998 respondents)**	**Month 4 (1,430 respondents)***
Have you heard of Patient First	Yes 85% No 15%	Yes 83% No 17%	Yes 84% No 16%	Yes 87% No 13%
Do you believe Patient First will help the Trust improve?	Yes 90% No 10%	Yes 93% No 7%	Yes 93% No 7%	Yes 93% No 7%
Can you see how you can contribute to improvement through Patient First?	Yes 86% No 14%	Yes 86% No 14%	Yes 86% No 14%	Yes 87% No 13%

*The survey now includes those staff attending Health and Safety updates in person, as well as those completing it online. Patient First continues to be promoted in a number of ways including in *Buzz,* facilitating open staff sessions and video.

13.2 Celebrating staff and volunteers – Patient First STAR awards

Nominations for the Trust's Patient First STAR awards closed on April 2, with 374 entries from colleagues and members of the public.

Launched at the end of February and supported by BSUH charity, the awards recognise the achievements of staff and volunteers. Shortlisting took place in April and large pink envelopes containing an invitation to the event are currently being presented to the shortlisted individuals, teams and volunteers. The winners will be announced on June 21.

There are ten categories including Leader of the Year, Innovator of the Year as well as Education and Team of the Year and winners of the trust's star of the month are automatically entered into the **Employee** of the Year.

13.3 Internal communications: Trust Brief

Plans for a trust-wide briefing cascade have been agreed at the Trust's Executive Committee, with a pilot taking place in Specialist Services throughout March and April. The brief, designed to be delivered in team meetings includes updates against the organisation's key objectives at both a trust-wide and divisional level.

Further testing, with the Surgery Division, will take place in May. The plan is to roll out across the organization in June, following improvements based on the pilot.

13.4 Events and external media

Workforce Race Quality Standard (WRES): The WRES conference will take place on Tuesday 23 May at the Metropole Hotel, Brighton from 1:30-4:30pm. Working with the Clinical Media Centre, the communications team developed branding (based on our Patient First branding) along with a poster and flyer for distribution across the Trust. This is now available to all colleagues and has been distributed widely by Marianne Griffiths, Barbara Harris and David Clayton-Evans.

Registration for the conference was launched in BUZZ w/c 30 April, announcing details to all staff and will include a follow-up piece each week. A dedicated section of the website for colleagues to find out more about the conference and, subsequently has also been created, and support has also been provided to the E&D team with the development of the agenda and biographies for the event.

Gender pay gap: The Brighton Argus reported that BSUH is one of only ten NHS bodies in the country where the median pay for women is greater than men. In its coverage on April 14, the paper reported that women working at the trust are paid one per cent more than ben based on the median average of hourly earnings.

The story also published data from the trust's own report which showed there are generally less women in higher paid positions than men and that a working group was being set up to advise on ways to reduce any gaps. It included the following statement from Barbara Harris, head of equality, diversity and inclusion: We are pleased our median gender pay rates are quite equal but there are gaps in areas like pay progression and bonuses, which we want to look at."

Name the Crane: Working with the team from 3Ts, the communications team has supported a social media campaign designed to involve the community in the hospital redevelopment as well as promote the trust's facebook and twitter accounts. The objective was to increase the number of people liking, or following, the trust's facebook page in order to be able to reach further with information and engagement in future.

Visitors to the platforms were invited to take part in a competition to name the four cranes, currently on site in Brighton.

The competition had two phases over a 28 day period; the first to encourage suggestions before people were invited to vote on their favorite from a shortlist.

Over the period, compared to the previous 28 days:

- the number of page likes increased by 54%
- the reach (30,110) increased by of 44%
- page followers increased by 60%

The clear winners, each with more than double the votes of any of the other options, were Buzby, Teddy and Florence. The suggestions came from Sean Warrington, who explained the reason for putting the names forward in his Facebook post:

"My son Buzby was in intensive care there [at the County Hospital] and was not expected to survive, however he pulled through and is doing amazingly thanks to the

amazing staff at this hospital. We also lost our son Teddy and daughter Florence in this hospital in 2014. I would love for the three of them to stand tall together, so I'm saying Buzby, Teddy and Florence."

Mr Warrington and his family will be invited to the site for a naming ceremony once the final crane is installed.

The largest of the cranes, nearest to the Children's Hospital, is being named in a separate competition being held amongst the Alex's young patients. Its result will be announced shortly.

14. **General Data Protection Regulations (GDPR)**

14.1 For the last six months the Head of Employee relations has lead a project group to ensure that all aspects of BSUH employment practices and policies were reviewed as part of the readiness for the new regulations.

BSUH Workforce Scorecard

April 2018

Key Performance Indicators		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	12mth position	Target	Amber	Trend
1 Workforce Capacity	*NB*																	
FTE - Budgeted		8,142.1	8,147.3	8,223.2	8,195.3	8,194.4	8,218.4	8,198.1	8,208.2	8,210.6	8,213.7	8,214.3	8,214.3	8,273.0	8,209.2			
FTE - Substantive contracted		7,285.0	7,259.1	7,250.7	7,251.8	7,279.4	7,285.2	7,306.7	7,356.3	7,332.8	7,352.4	7,358.9	7,372.0	7,398.9	7,317.0			
FTE - Substantive contracted variance from Budget		857.1	888.2	972.5	943.5	915.0	933.2	891.4	851.9	877.8	861.3	855.4	842.3	874.1	892.2			
Vacancy Factor (Substantive contracted FTE)		10.5%	10.9%	11.8%	11.5%	11.2%	11.4%	10.9%	10.4%	10.7%	10.5%	10.4%	10.3%	10.6%	10.9%			
Spend - Bank as a % of total staffing		4.5%	4.1%	5.2%	5.2%	5.3%	5.8%	4.8%	5.0%	5.9%	4.9%	6.3%	5.5%	5.1%	5.3%			
Spend - Agency as a % of total staffing		2.4%	3.1%	3.3%	3.2%	3.9%	4.3%	2.8%	3.2%	3.2%	4.0%	4.0%	4.4%	3.4%	3.5%			
2 Workforce Efficiency	*NB*																	
Absence - Sickness (12 month)	1	4.2%	4.2%	4.2%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.2%	4.2%			**4.2%**		
Absence - Sickness in month		3.7%	3.9%	3.9%	4.0%	4.2%	4.2%	4.3%	4.6%	4.7%	4.7%	4.1%	3.7%		4.2%			
Absence - Maternity in month		2.4%	2.5%	2.5%	2.4%	2.3%	2.5%	2.4%	2.3%	2.2%	2.3%	2.2%	2.3%		2.4%			
Absence - Annual Leave in month		7.9%	7.4%	6.8%	6.9%	9.6%	7.1%	6.0%	4.8%	8.2%	6.1%	6.8%	8.0%		7.1%			
Absence - Special, Study & Other Leave in month		2.7%	2.8%	2.8%	2.8%	2.9%	2.9%	2.9%	2.9%	3.0%	3.0%	3.2%	3.3%		2.9%			
Absence - Total in month		16.7%	16.6%	16.0%	16.2%	19.1%	16.7%	15.6%	14.6%	18.1%	16.0%	16.3%	17.3%		16.6%			
Sickness - Short Term (< 28 days)		1.7%	1.9%	1.9%	1.9%	1.9%	2.0%	2.0%	2.1%	2.2%	2.2%	1.9%	1.7%		2.0%			
Sickness - Long Term (> 27 days)		1.9%	2.1%	2.1%	2.1%	2.2%	2.3%	2.3%	2.4%	2.5%	2.5%	2.2%	1.9%		2.2%			
Sickness - Stress in month		0.8%	0.9%	0.9%	0.9%	0.9%	0.9%	1.0%	0.9%	0.9%	0.7%	0.6%	0.6%		0.8%			
Sickness - Gastro Intestinal in month		0.2%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.4%	0.4%	0.3%	0.3%	0.3%		0.3%			
Sickness - Other Musculoskeletal in month		0.3%	0.3%	0.4%	0.5%	0.4%	0.4%	0.4%	0.4%	0.2%	0.3%	0.3%	0.3%		0.3%			
Sickness - Cough, Cold & Flu in month		0.3%	0.3%	0.2%	0.2%	0.2%	0.3%	0.5%	0.5%	0.7%	1.0%	0.7%	0.5%		0.5%			
Sickness - Back in month		0.2%	0.3%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%		0.2%			
Episodes - New sickness episodes in month		1,087	1,235	1,215	1,147	1,265	1,187	1,343	1,422	1,603	1,569	1,247	1,158		1,290			
Episodes - On-going sickness episodes in month		360	329	348	351	349	334	289	322	345	305	299	288		327			
Episodes - Total sickness episodes in month		1,447	1,564	1,563	1,498	1,614	1,521	1,632	1,744	1,948	1,874	1,546	1,446		1,616			
Triggers - 3 sickness episodes in 6 months breaches		818	771	687	558	561	535	564	611	676	736	747	729		666			
Triggers - 5 sickness episodes in 12 months breaches		680	682	672	661	638	652	615	618	593	550	546	554		622			
Triggers - Long term sickness breaches		95	133	125	133	158	139	143	136	102	131	116	105		126			
Triggers - Total sickness management breaches		1,593	1,586	1,484	1,352	1,357	1,326	1,322	1,365	1,371	1,417	1,409	1,388		1,414			
Triggers - Number of staff breaching one (or multiple) triggers		1,078	1,080	1,013	947	949	920	925	967	962	1,001	998	959		983			
Maternity - Number of staff on maternity leave		201	203	207	196	199	204	205	190	190	188	197	201		198			
Turnover - Trust (12 month)		14.5%	14.6%	14.5%	14.3%	14.3%	14.1%	14.2%	13.9%	13.9%	14.1%	14.3%	14.2%	14.1%	14.2%	**13.8%**		
Turnover - Medical & Dental		8.5%	8.7%	8.6%	8.1%	9.0%	9.3%	10.0%	10.0%	10.0%	10.7%	10.3%	9.9%	10.3%	9.6%			
Turnover - Nursing & Midwifery		15.2%	15.8%	15.6%	15.5%	14.8%	14.3%	14.2%	13.6%	13.3%	13.3%	13.4%	13.5%	13.2%	14.2%			
Turnover - Scientific, Therapeutic & Technical		16.2%	15.8%	16.1%	15.3%	16.0%	15.9%	16.2%	15.8%	16.9%	17.4%	17.9%	17.1%	17.6%	16.5%			
Turnover - Admin, Clerical & Estates		14.3%	13.8%	14.1%	14.3%	14.8%	14.9%	15.1%	14.9%	14.6%	14.5%	14.8%	14.8%	15.2%	14.7%			
Turnover - Support Staffing		13.1%	12.9%	11.8%	11.4%	12.4%	12.4%	12.4%	12.3%	13.1%	13.9%	13.8%	14.3%	13.7%	12.9%			
3 Training & Personal Development	*NB*																	
% of appraisals up to date (excl Medical staff)		82.8%	81.3%	80.9%	80.2%	77.7%	76.2%	76.1%	75.9%	77.0%	74.3%	71.7%	72.3%	77.1%	76.7%	**79%**		

Notes: 1 Absence data is available one month in arrears.

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board **Date: 30 May 2018**

From: Denise Farmer, Chief Workforce and OD Officer **Agenda Item: 7**

FOR INFORMATION

ANALYSIS OF STAFF SURVEY 2017

1.0 INTRODUCTION

The National Staff Survey is undertaken each year by all NHS Trusts within England and Wales with the aim of capturing staff views on their experiences at work and NHS services.

For the 2017 survey, roll out to all substantive staff in the Trust was undertaken between October and December for the 2nd year. In previous years, a sample size of 800 staff were randomly selected. Picker administered the survey for the Trust and responses were received from 4,274 staff.

For 2017 BSUH opted for a mixed-mode option where most of the corporate divisions completed the staff survey on-line and paper staff surveys were delivered directly to managers for distribution to all other staff enabling them to encourage a higher staff response rate.

The full feedback report for all Trusts in England and Wales was published on 6th March 2018 and details a full description of 32 Key Findings (KF) and overall staff engagement scores. The report ranks the Trust's highest and lowest scores, including comparisons to the 2016 survey results and other acute trust's. In addition to staff engagement results, key findings are grouped into nine themes:

- Appraisals and support for development
- Equality and diversity
- Errors and incidents
- Health and well-being
- Working patterns
- Job satisfaction
- Managers
- Patient care and experience
- Violence, harassment and bullying

For each key finding, acute trusts are ranked against five benchmarking groups where the higher the score, the better:

- Highest (best) 20%
- Above (better than) average
- Average
- Below (worse than) average
- Lowest (worst) 20%

This paper summarises the Trust's headline results and aims to promote discussion on the corporate actions proposed.

2.0 SUMMARY OF RESULTS

The Trust's survey provider was Picker and the average mean response rate for the 49 Acute Trusts that used Picker was 45.5%. In comparison, the Trust's response rate for 2017 was 56.3% which has significantly improved on the 39.9% rate from the 2016 survey, and was the fifth highest score out of the 49 Acute Trusts using Picker.

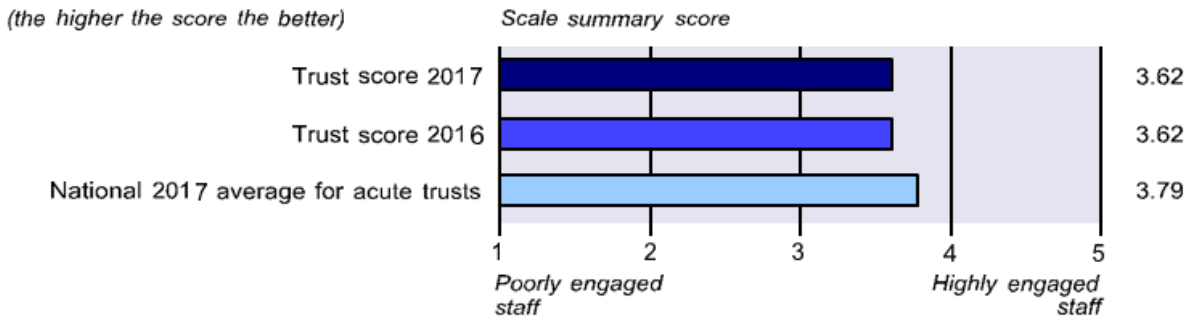
The table below shows an improvement in KF1 (recommending the Trust as a place to work) from 3.42 in 2016 to 3.49 in 2017. There is improvement in three key questions, Q21c, up by 5%, Q21d, up by 3%, and in the breakthrough objective, Q21a, "Care of Patients/service users is my organisation's top priority" which improved +4% to 68%.

Scores Q21a-d below are un-weighted scores feeding into KF1 in the Staff "Friends and Family" question, 'Staff recommendation of the organisation as a place to work or receive treatment. The percentage created is obtained by combining responses to those who "Agree" and "Strongly Agree" compared to the total number of staff that responded to the question.

		Your Trust in 2017	Average (median) for acute trusts	Your Trust in 2016
Q21a	"Care of patients / service users is my organisation's top priority"	68%	76%	64%
Q21b	"My organisation acts on concerns raised by patients / service users"	62%	73%	61%
Q21c	"I would recommend my organisation as a place to work"	47%	61%	42%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	58%	71%	55%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.49	3.76	3.42

Below is the Trust's overall staff engagement score for 2017 which has remained at 3.62, and therefore despite improvement in the Trust's breakthrough objective 'Care of patients/service users is my organisation's top priority, the Trust remains in the lowest 20% when compared with trusts of a similar type.

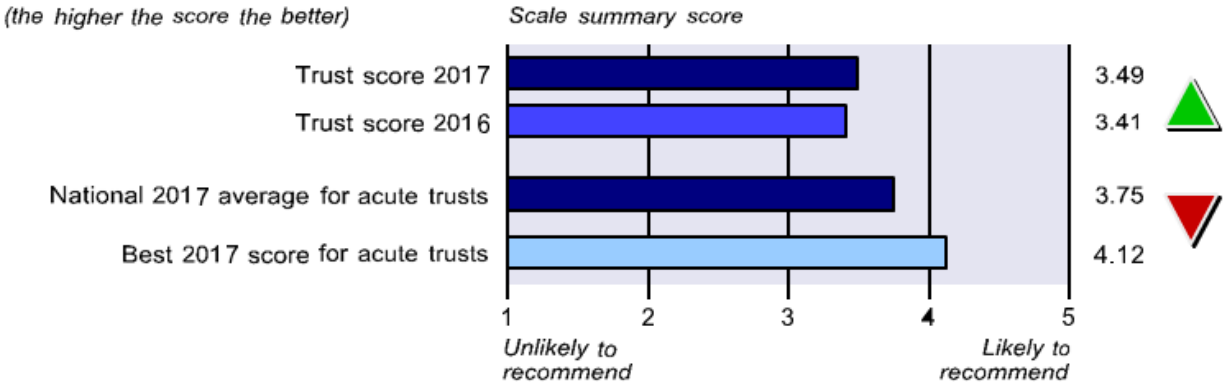
OVERALL STAFF ENGAGEMENT



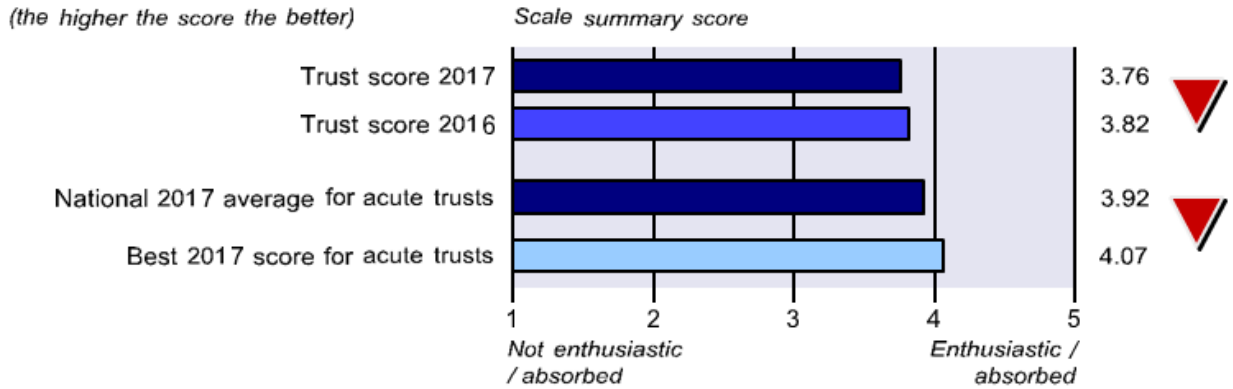
	Change since 2016 survey	Ranking, compared with all acute trusts
OVERALL STAFF ENGAGEMENT	• No change	! Lowest (worst) 20%
KF1. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of patients/service users is the trust's top priority, would recommend their trust to others as a place to work, and would be happy with the standard of care provided by the trust if a friend or relative needed treatment.)*	✓ Increase (better than 16)	! Lowest (worst) 20%
KF4. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	! Decrease (worse than 16)	! Lowest (worst) 20%
KF7. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)*	• No change	! Lowest (worst) 20%

JOB SATISFACTION KEY FINDINGS

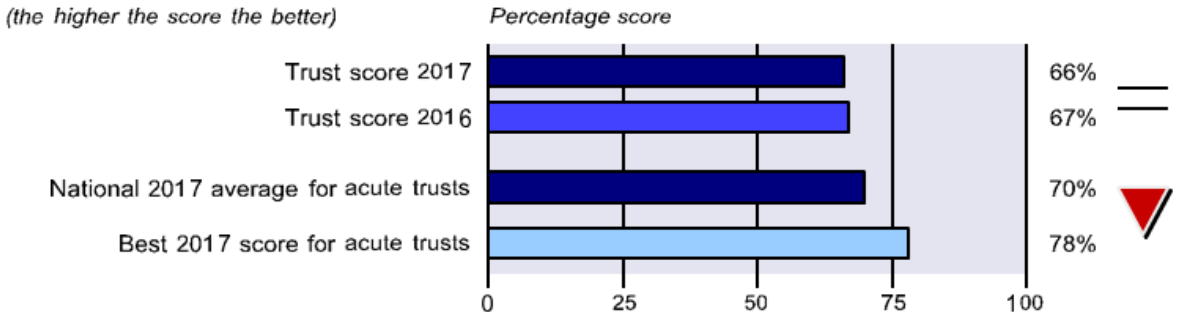
KEY FINDING 1. Staff recommendation of the organisation as a place to work or receive treatment



KEY FINDING 4. Staff motivation at work

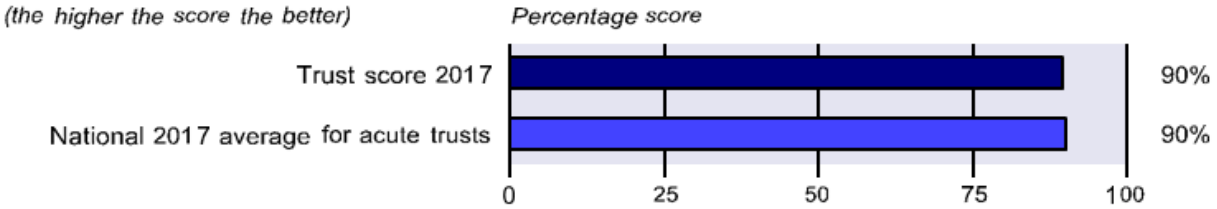


KEY FINDING 7. Percentage of staff able to contribute towards improvements at work



TOP ONE RANKING SCORE

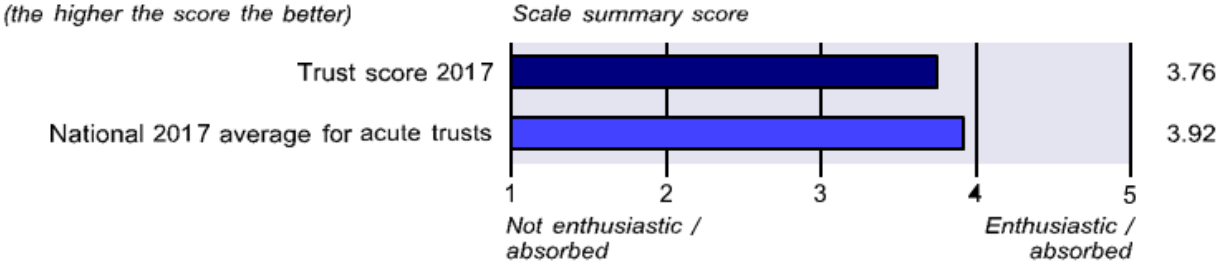
✓ KF3. Percentage of staff agreeing that their role makes a difference to patients / service users



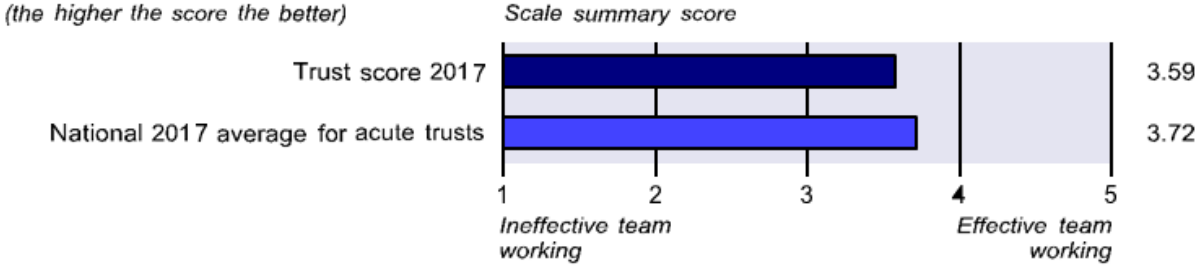
The Trust has one score where it compares favourably with other acute trusts and where success is to be celebrated.

BOTTOM FIVE RANKING SCORES

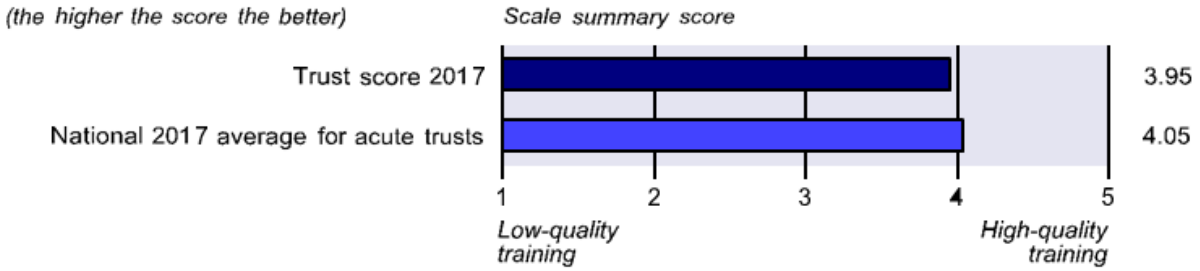
! KF4. Staff motivation at work



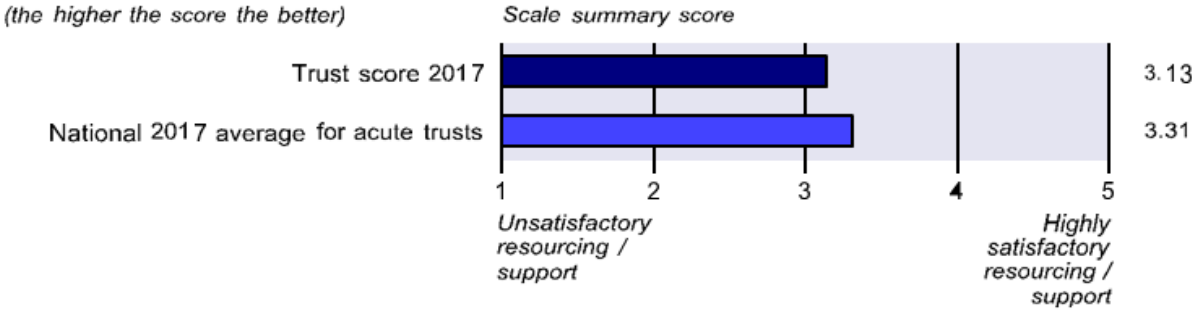
! KF9. Effective team working



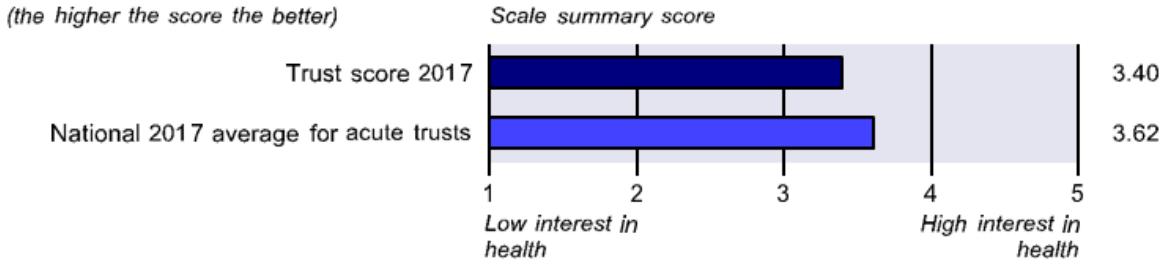
! KF13. Quality of non-mandatory training, learning or development



! KF14. Staff satisfaction with resourcing and support



! KF19. Organisation and management interest in and action on health and wellbeing



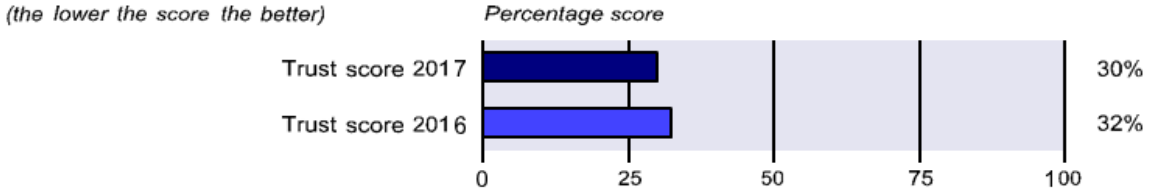
The Trust compares least favourably with other acute trusts in the above key findings and where improvement is most required. The largest areas of concern for the Trust is to improve in the overall organisational and management interest in health and well-being, including improvements in MSK and stress issues.

LARGEST LOCAL CHANGES

These results are the largest local Trust changes where staff experience has improved since the 2016 survey.

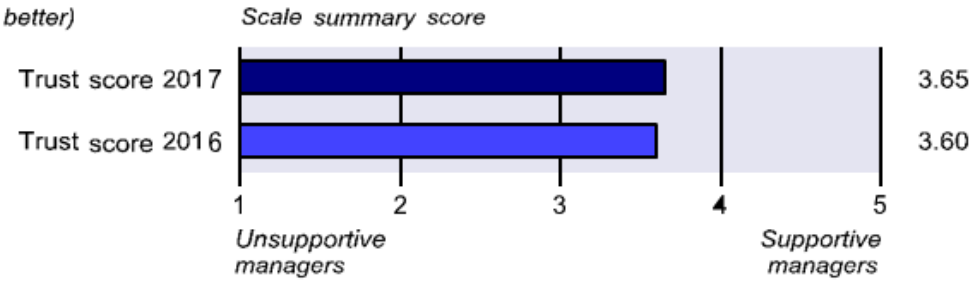
WHERE STAFF EXPERIENCE HAS IMPROVED

✓ KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months



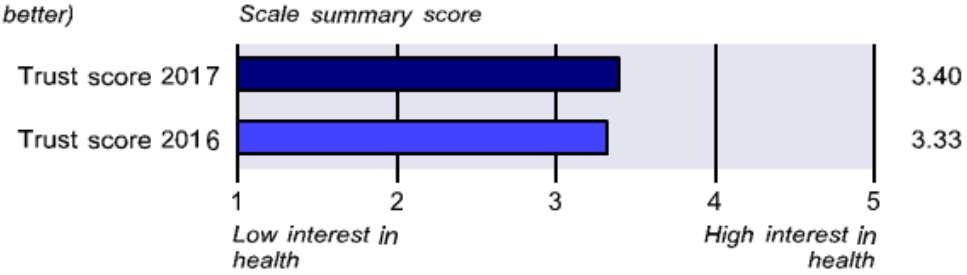
✓ KF10. Support from immediate managers

(the higher the score the better)



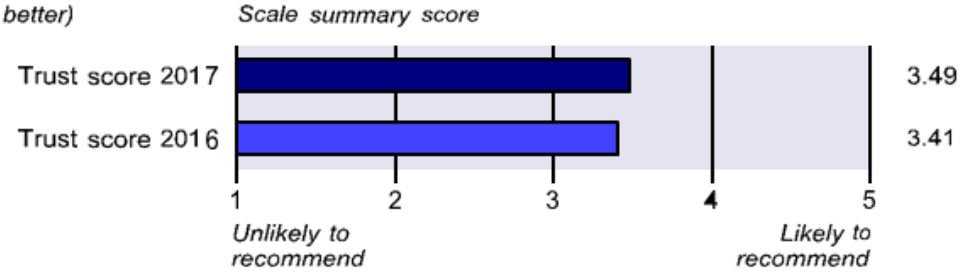
✓ KF19. Organisation and management interest in and action on health and wellbeing

(the higher the score the better)



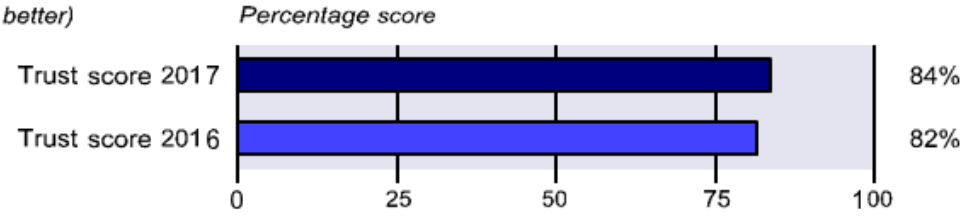
✓ KF1. Staff recommendation of the organisation as a place to work or receive treatment

(the higher the score the better)



✓ KF11. Percentage of staff appraised in last 12 months

(the higher the score the better)



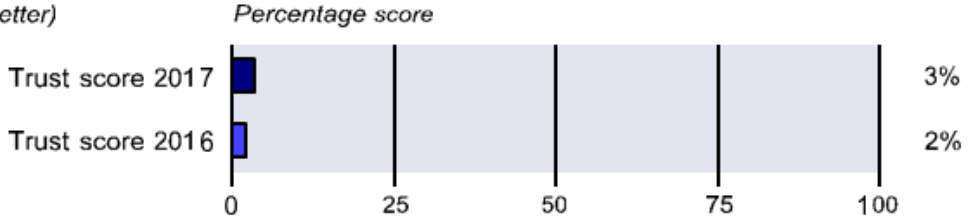
LOCAL AREAS OF CONCERN

The following are key findings which required improvement this year.

WHERE STAFF EXPERIENCE HAS DETERIORATED

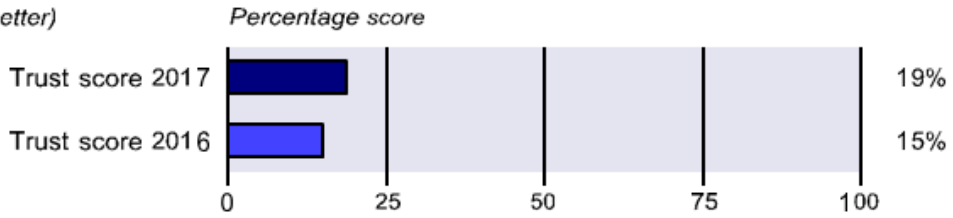
! KF23. Percentage of staff experiencing physical violence from staff in last 12 months

(the lower the score the better)



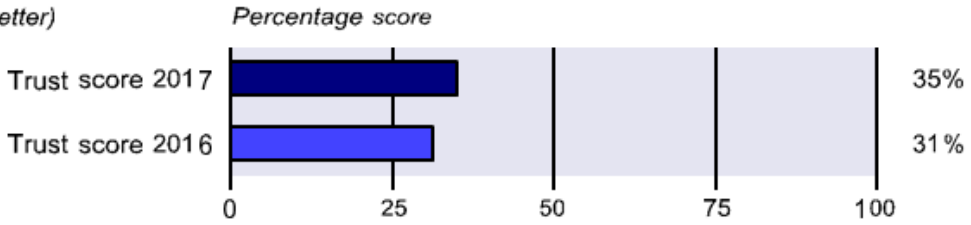
! KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



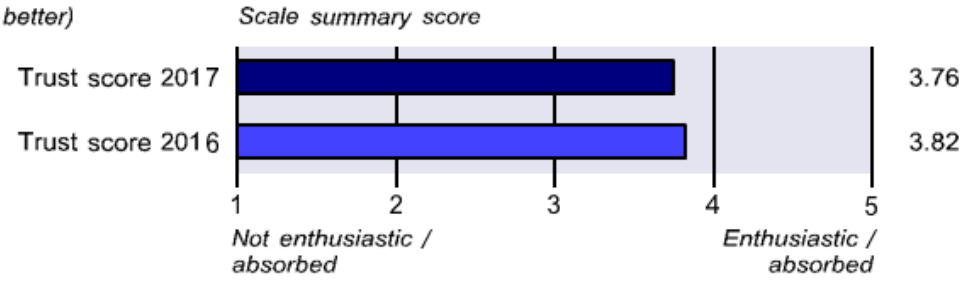
! KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

(the lower the score the better)



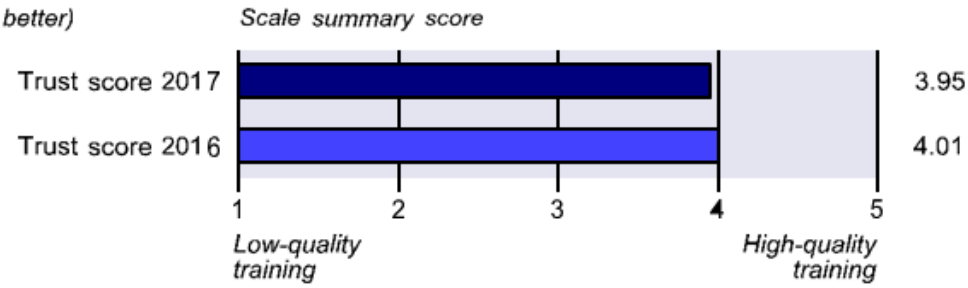
! KF4. Staff motivation at work

(the higher the score the better)



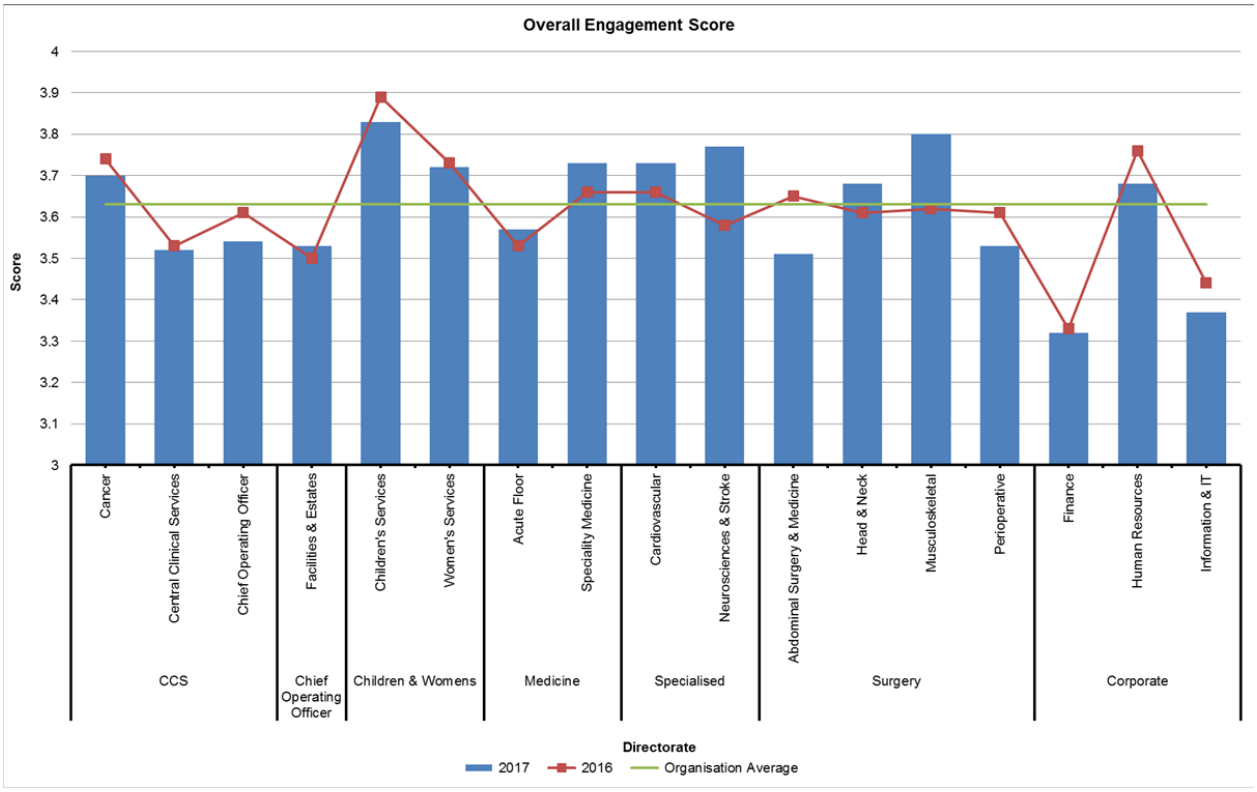
! KF13. Quality of non-mandatory training, learning or development

(the higher the score the better)



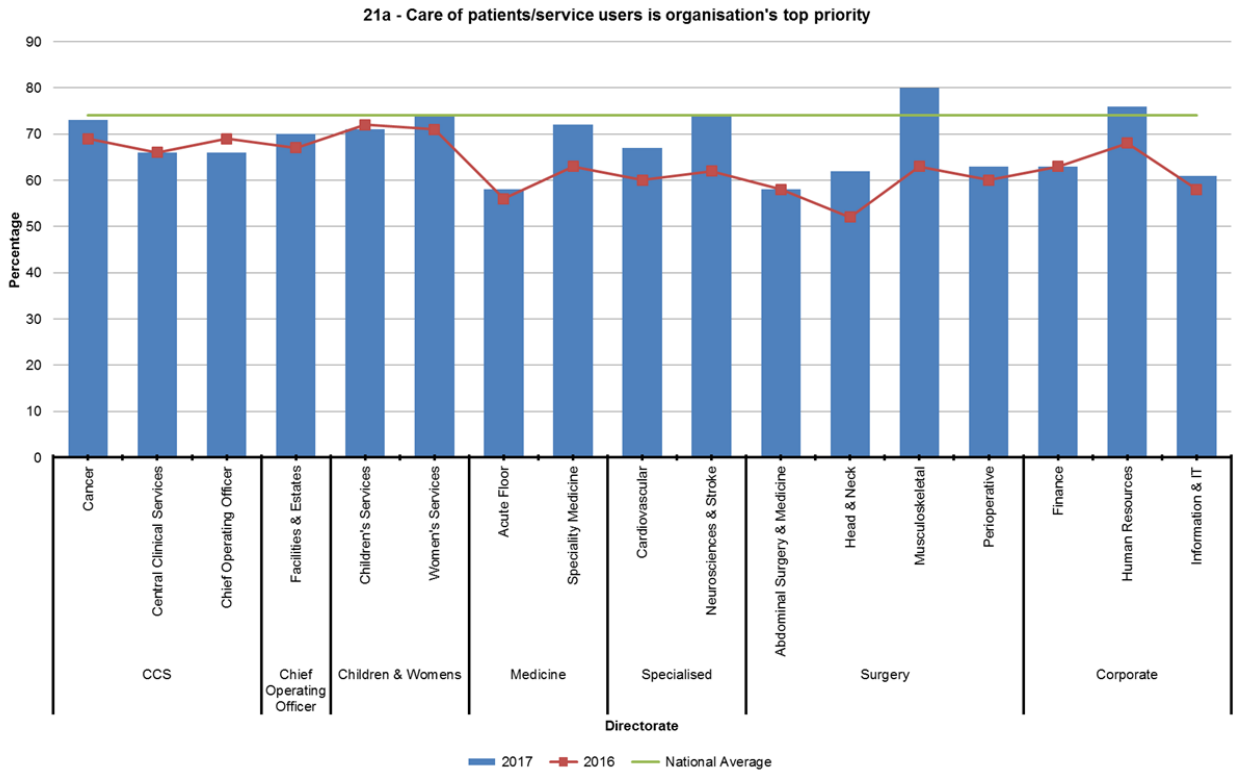
3.0 SUMMARY OF DIVISIONAL RESULTS

Overall staff engagement by Division



Staff engagement within the divisions has evidence changes with 9 out of 7 divisions achieving above (better than) the Trust's 2017 overall staff engagement score.

Trust breakthrough objective



There were two directorates, the Musculoskeletal and Human Resources directorates that achieved above (better than) in Q21a, the Trust's breakthrough objective, 'Care of patients/service users is my organisations top priority'.

Health & Well-being

In addition to the staff engagement questions staff were asked to answer questions on how the Trust supports the health & well-being of staff, here are the results:

Q	Health & Well-being	2016	2017	Variance	2017 Comparator (49 Acute Trusts)		2016 Comparator (49 Acute Trusts)	
7f	Immediate manager takes a positive interest in my health and well-being	63%	65%	up 2%	-1%	66%	-3%	66%
9a	Organisation definitely takes positive action on health and well-being	18%	21%	up 3%	-11%	32%	-13%	31%
9b	In the last 12mths have not experienced musculoskeletal (MSK) problems as a result of work activities?	70%	67%	down 3%	-7%	74%	-5%	75%
9c	Not felt unwell due to work related stress in last 12 months	56%	55%	down 1%	-7%	62%	-1%	64%

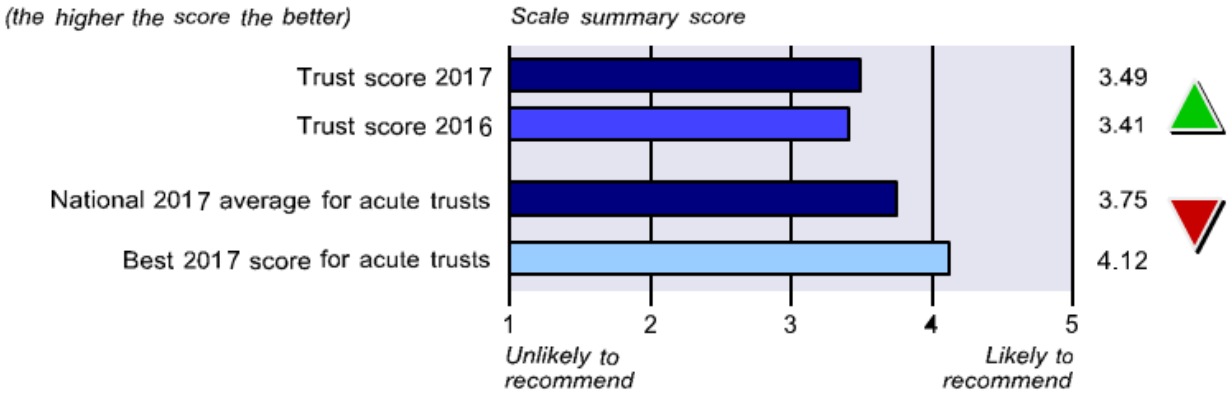
The Trust's 2017 results evidences positive increases in Q7f (+2%) and Q9a (+3%) since 2016. This reflects Trust-wide initiatives in the past 12 months to provide a broad range of health and well-being activities and a health and well-being plan has been developed to help improve results in this key area.

		Your Trust in 2017	Average (median) for acute trusts	Your Trust in 2016
	Health and well-being			
Q9a	% saying their organisation definitely takes positive action on health and well-being	21	32	18
Q9b	% saying they have have experienced musculoskeletal problems (MSK) in the last 12 months as a result of work activities	33	26	30
Q9c	% saying they have have felt unwell in the last 12 months as a result of work related stress	45	36	44

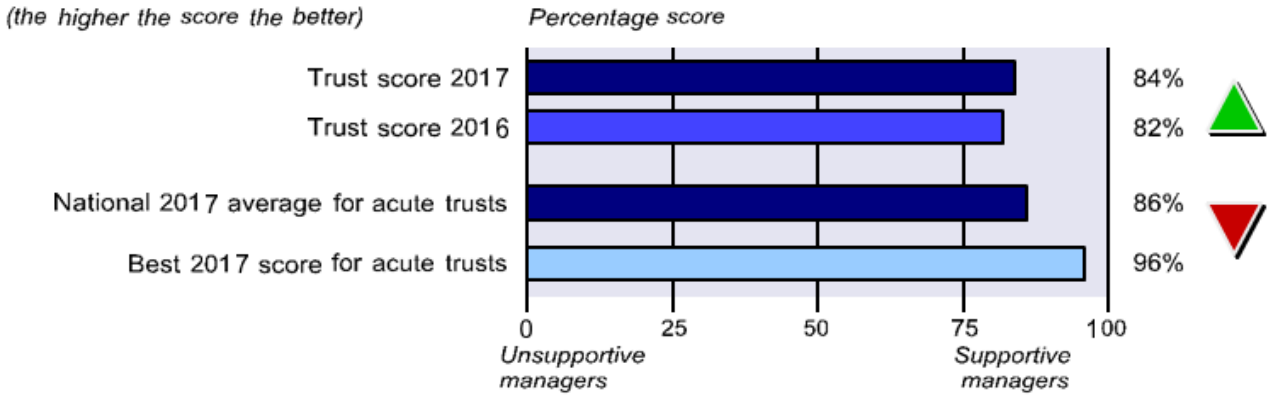
4.0 STAFF SURVEY KEY FINDINGS

Out of 32 Key Findings the Trust have ranked in the highest (best) 20% for the following 5 Key Findings and success should be celebrated, particularly as in 2016 there were no Key Findings in the highest 20%.

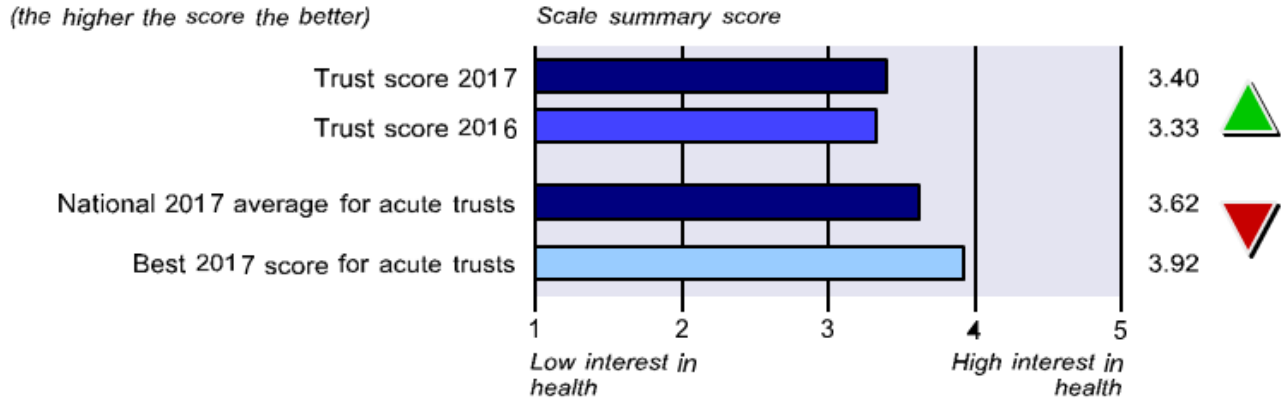
KEY FINDING 1. Staff recommendation of the organisation as a place to work or receive treatment



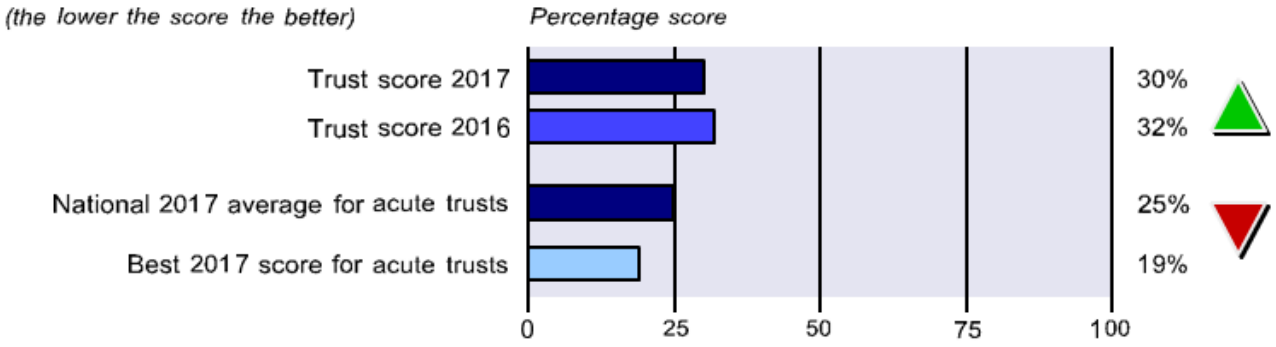
KEY FINDING 11. Percentage of staff appraised in last 12 months



KEY FINDING 19. Organisation and management interest in and action on health and wellbeing



KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months



5.0 CONCLUSION

The 2017 results show a positive 4% increase compared to 2016 in the Trust's breakthrough objective, "Care of patients/service users is my organisation's top priority". This is encouraging and we are continuing to focus on staff engagement with the overall aim of improving staff engagement across the Trust. As the Patient First initiative and Strategic Development programme process become embedded in the Trust in the next few months, then it is anticipated that these will help us further improve 2018 results.

6.0 LOOKING AHEAD TO 2018/19

In the next 12 months we will focus on:

- Continuing working towards achieving the Trust's breakthrough objective "Care of staff/patient users is the organisations top priority".

- Instigating corporate improvement plans to address 3 key issues arising from the results which have been identified as being:

  - Q8b – "Communication between senior management and staff is effective"
  - Q9a - "Organisation definitely takes positive action on health and well-being"
  - Q14a -"Not experienced physical violence from patients/services users, their relatives or other members of the public.

- Introducing a new Trust Ambassador initiative across the Trust to improve staff engagement.

- Developing a programme to reduce MSK injury and work-related stress to support delivery of the health & well-being CQUIN.

- Continue the roll-out of the Patient First and Strategic Development programmes to improve opportunities for staff to contribute ideas towards making improvements in the workplace and ensure this is linked to the achievement of the breakthrough objective.

- Raising the profile of the annual staff survey and its importance, and ensuring feedback and involvement of staff across the Trust.

- As part of the Trust's Leadership, Workforce and Culture programme, an Equality, Diversity and Inclusion initiative being lead by the Chief Executive.

- Staff will be asked to complete mini surveys on the 9 key engagement questions, an equality and diversity question and 3 questions on Patient First as part of feedback from statutory and mandatory training sessions.

- Reviewing areas within the Trust to offer a wider on-line option in the 2018 Staff Survey.

7.0 RECOMMENDATIONS

This paper highlights where the Trust needs to take immediate steps to build on improvements and address staff survey concerns. This will need strong leadership, involvement and genuine interest from all of the Divisional Management teams, staff, and the Human Resources teams, with alignment to the staff engagement strategy deployment programme**.**

The Board is asked to:

a) **NOTE** this paper

b) **Discuss** the content and make recommendations

Brighton and Sussex University Hospitals NHS Trust

To: Board of Directors

Date of Meeting: 30th May 2018 Agenda Item: **8**

Title
Month 1, 2018-19 Performance Report
Responsible Executive Director
Pete Landstrom, Chief Delivery & Strategy Officer
Prepared by
Giles Frost, Interim Director of Performance and Information
Status
Disclosable
Summary of Proposal
The paper sets out organisational compliance against national and local key performance metrics. The report summarises in year performance for Brighton & Sussex University Hospitals Trust, as detailed in the dedicated performance scorecard relating the NHSI Single Oversight Framework, National Constitutional Targets, and when relevant other operational indicators.
Implications for Quality of Care
Describes Quality Outcome KPIs
Link to Strategic Objectives/Board Assurance Framework
Compliance with National NHS Constitutional Standards
Financial Implications
Describes Operational KPIs which impact on Financial Sustainability and Efficiency
Human Resource Implications
Describes Operational KPIs which impact on Workforce
Recommendation
The Board is asked to: NOTE the Trust position against the NHS National Constitutional Standards
Communication and Consultation
Not applicable
Appendices
Operational Performance Scorecard

PERFORMANCE REPORT: MONTH 01, 2018/19

1. INTRODUCTION

1.1 This report summarises both current in year and projected performance for Brighton & Sussex University Hospitals NHS Trust, with further detail provided the Operational Performance Scorecard. This paper provides the Board with an update on performance on a specific basis against the NHS National Constitutional Standards.

2. SUMMARY PERFORMANCE

2.1 Brighton and Sussex University Hospitals NHS Trust emergency pressures eased marginally in April in line with the National and Regional position.

2.2 Key operational indicators during April to note:

- 14,287 A&E attendances compared to 13,258 in April 2017 (an increase of 7.8%).
- 4,494 non-elective spells compared to 4,637 in April 2017 (a 3% decrease in activity).
- Formally reportable Delayed Transfers of Care increased to 5.7% from 4.8% March 2018. This is an improvement however from 8.1% April-17.
- Average length of stay for patients decreased to 4.83 days for non-elective medicine in March 2018, compared to 5.05 days in March 2018, and 4.85 days April 2017. Non-elective surgery length of stay reduced to 5.1 days April 2018, compared with 5.2 days March 2018 but this was higher than April 2017 (4.52 days).
- Average Inpatient Bed Occupancy Trust wide was 97.1% March which peaked at 97.7% week ending 8th April. Occupancy each morning at 9am at the Royal Sussex County was on average 99.5% in April. Occupancy at this level hampers the ability to establish effective flow early in the day.

3. KEY AREAS OF PERFORMANCE

3.1 <u>A&E Compliance</u>

3.1.1 The Trust catchment was non-compliant against the National four hour standard in March, with 85.4% of patients waiting less than four hours from arrival at A&E to admission, transfer, or discharge. This is a continued improvement, and an increase of 2.2% from March 2018.

3.1.2 As part of the operational planning submitted to NHSI and NHSE in April, the Trust has an agreed recovery trajectory for A&E. The planned performance for the LHE was 85.8% in April, which is marginally higher than the Trust catchment achieved for the month. The Trust did exceed its target (82.9%) as part of the system plan with Type 1 performance of 83.3%

3.1.3 The Trust catchment (including Brighton Station Walk in Centre), began the month with performance of 85.1% week ending 7th March, dipped to 83.9% mid-month, but improved to 87.2% for the week ending 28th April.

3.1.4 There were 5 patients who waited longer than 12 hours in the A&E department from the decision to admit in April.

3.1.5 The Trust A&E performance is an aggregate of the Royal Sussex County Hospital Emergency Department, the Princess Royal Hospital Emergency Department, the Children's Emergency Department at the Royal Alexandra Children's Hospital, and the Emergency Eye Department at the Sussex Eye Hospital. The Trust has, in accordance with NHSI guidance, also included attendances at the Brighton Station Walk in Centre as part of reporting on a daily basis. This is to ensure greater consistency with A&E performance reporting for the catchment population in line with other health systems. The Trust does not report the Brighton WIC activity directly on a monthly basis, but this is reallocated back to the catchment LHE footprint post submission of the monthly information to NHSE by all providers.

3.1.6 Within the overall 85.4% performance, there remains significant variation by site. Each site observed an improved position relative to March. Performance by site in April 2018 is outlined below:

Site	**Total Patient Attendances**	**Total Patients Waiting >4 Hours**	**% Patients <4 Hour**
Royal Sussex County Hospital	7269	2034	72.0%
Princess Royal Hospital	3172	244	92.3%
Royal Alexandra Children's Hospital	2295	1	100.0%
Sussex Eye Hospital	1068	24	97.8%
Brighton Station Walk in Centre	1940	0	100.0%
Total Trust Catchment	**15744**	**2303**	**85.4%**

3.1.7 Performance at RSCH remained challenging with 72.0%, but saw a significant improvement of +3.1% compared with March 2018.

3.1.8 Performance at PRH was 92.3% which was +3.6% improvement from March 2018.

3.1.9 The Royal Alex Children's Hospital and Sussex Eye Hospital continued to exceed the National Target.

3.1.10 Waiting for admission to an inpatient ward remained the highest single reason for patients waiting longer than 4 hours in A&E. Difficulties in access to beds due to formal delayed transfers of care (DTOC) patients increased to 5.7%, an increase of 0.9% from March (the equivalent of 7 extra beds occupied per day in April relative to the preceding month). This is significantly lower than 8.1% in April 2017. The wider system and CCG continue to actively support the Trust to maintain lower levels of DTOCs, as this frees up beds to allow better patient flow.

3.1.11 As noted in the March report, the redesign of the Emergency Floor continued with the new Acute Assessment Unit (AAU), and the full Level 4&5 emergency ambulatory care unit fully operational from mid-March 2018.

3.1.12 At time of writing the Trust A&E performance has improved further to 86% for the catchment in May (to the 24th May). Within this, PRH performance has increased to above 95%.

3.1.13 Nationally and regionally A&E delivery has continued to be challenging but did show some recovery in April. National performance increased to 88.5% in April 2018 from 84.6% in March 2018 for all attendances. Board members should note these figures also include type 3 A&E attendances (such as minor injuries units) for non-acute providers. Regionally, compliance for the South of England remained at 90.3%, with NHS England South Surrey & Sussex Trusts generating aggregate compliance of 91.0%.

3.2 Cancer

3.2.1 The Trust was compliant against 7 out of 9 metrics in March (1 more than in the previous month) but remains below the 62 day treatment target for GP referrals (85.0%). Actual performance for February against this metric was 71.0%.

3.2.2 37 patients breached the 62 day GP referral standard against a forecast trajectory of 32.0. Total treated patients against the 62 day GP referral standard for March was 127.5 against a forecast plan of 126.5.

3.2.3 For context, latest comparative nationally published data relating to March 2018 shows national aggregate compliance for cancer attendance to be 82.2% for treatment within 62 days from GP referral (target 85.0%). In March 2018, just over a third of Trusts receiving GP referrals in England were non-compliant against this standard.

3.2.4 The work undertaken to better manage the Cancer PTL from the start of March 2017 has led to a reduction in total patients being tracked from approx. 1,600 to around 700-850. This has continued to remain stable over the past 6 months. Over the last two months the Trust has been focused on the clearance of long waiting patients who have breached the target. In line with the cancer delivery trajectory, it is anticipated performance in April and May will improve as a result of this focus on clearing the backlog of patients.

3.2.5 A dedicated Cancer Steering Group has been established to deliver robust multi-professional oversight and assurance of the cancer pathway and performance. The first meeting was in April 2018 and was clinically chaired by Dr Rob Haigh, Trust Medical Director, with all Divisions represented, and supported by the Chief Delivery and Strategy Officer. Focussed recovery plans are being monitored weekly with oversight from the Trust Director of Operations, with particular focus on breast, lung, colorectal and urological cancers.

3.3 Referral to Treatment (RTT/18 Weeks)

3.3.1 The Trust continues to be non-compliant against the National Constitutional Target of 92%, the Trust's reported position in April is 83.02%. This has held steady relative to March performance.

3.3.2 In line with the Trust Breakthrough Objective for elective flow there were 5 patients waiting more than 52 weeks for treatment as of the end of April, a reduction from 9 in March. Work continues and is on track to become 52 week compliant within the next 2 reporting months.

3.3.3 Latest published national data relates to March 2018 and shows national compliance has further reduced to 87.2% from 87.9%. This figure is exclusive of independent sector providers and does not reflect a number of large acute NHS providers that currently are not reporting RTT positions as part of agreed 'special measure' arrangements. Over half (58%) of Trusts were non-compliant in March.

3.4 Diagnostic Test Waiting Times

3.4.1 The Trust compliance for April was 7.28% over 6 week waiters across all diagnostic modes, which is non-compliant against the <1% national target, and a deteriorating position from March reported 6.06%. This represents 632 out of a total of 8677 patients.

3.4.2 CT breaches decreased slightly with a reported 170 diagnostic 6 week breaches in April, a reduction of 73 from March 2018 position. A recovery and capacity plan for CT has now been finalised with improvements in productivity and capacity, and key radiologist appointments secured, from April onwards, with capacity and demand balance being achieved by July 2018.

3.4.3 Sleep studies recorded 4 breaches at the end of April. As planned this is an improvement of the patient pathway which has seen the February 2018 position of 60 reduced in a short time-frame and sustained recovery for compliance is expected going forwards. Patients now referred to the sleep service have a first appointment with the nurse specialist thus reducing the waiting time for this element of the pathway.

3.4.4 Non obstetric ultrasound is an outlier against performance with a backlog of 249 over 6 week patients at the end of April (compared to 170 March 2018). The imaging department has undertaken 40 additional lists to help mitigate continued compliance risk for this modality, and is working closely with Brighton & Hove CCG support to better manage direct access demand which is exceeding current available supply. The Trust currently has four vacant stenography roles, which are being recruited to, but there remains a national shortage in available staff to fill these roles, and ultrasound remains a significant risk to the Trust recovery programme.

3.4.5 Overall diagnostic demand has increased 9.8% in the last 12 months which equates to circa an additional 350 referrals per week. In particular Non-Obstetric ultra-sound remains the biggest challenge both in terms of demand and capacity (workforce) constraints.

3.4.6 BSUH performance was worse than regional peers in March (the latest comparable national data); with South of England Region aggregate compliance of 1.2% and National compliance at 2.1%, compared to BSUH March performance of 6.1%. Just over a fifth of Trusts were non-compliant in March 2018.

4. RECOMMENDATION

4.1 The Board is asked to NOTE the Trust position against the National Constitutional Standards.

Pete Landstrom

Chief Delivery & Strategy Officer

22nd May 2018

Brighton and Sussex University Hospitals NHS

OPERATIONAL PERFORMANCE SCORECARD

APRIL 2018

		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	2018/19 YTD	2018/19 Target	Trend
NATIONAL AND OPERATIONAL PERFORMANCE TARGETS																	
O01	A&E : Four-hour maximum wait from arrival to admission, transfer or discharge	85.3%	86.0%	86.5%	81.9%	83.6%	84.3%	87.0%	86.3%	82.8%	82.6%	82.0%	83.2%	85.4%	85.4%	95%	
O01A	A&E : 12 hour maximum wait from arrival to admission, transfer or discharge	0	0	0	0	7	6	0	1	50	27	19	36		146	0	
O02	Cancer: 2 week GP referral to 1st outpatient	93.4%	94.1%	94.7%	94.8%	93.8%	95.1%	93.8%	94.1%	94.8%	94.0%	94.1%	93.4%		94.2%	93%	
O03	Cancer: 2 week GP referral to 1st outpatient - breast symptoms	96.4%	98.2%	95.0%	94.4%	96.1%	96.2%	97.7%	96.0%	94.0%	95.2%	95.8%	94.3%		95.8%	93%	
O04	Cancer: 31 day second or subsequent treatment - surgery	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.6%	97.3%	100.0%	97.1%	100.0%	100.0%		99.1%	94%	
O05	Cancer: 31 day second or subsequent treatment - drug	100.0%	100.0%	97.5%	100.0%	100.0%	100.0%	98.7%	100.0%	100.0%	98.0%	100.0%	100.0%		99.5%	98%	
	Cancer: 31 day second or subsequent treatment - radiotherapy	100.0%	99.4%	99.3%	100.0%	98.6%	100.0%	98.5%	99.5%	100.0%	99.5%	100.0%	100.0%		99.5%	94%	
O06	Cancer: 31 day diagnosis to treatment for all cancers	99.1%	99.5%	100.0%	98.6%	99.2%	98.3%	99.6%	100.0%	98.3%	97.9%	100.0%	99.6%		99.2%	96%	
O07	Cancer: 62 day referral to treatment from screening	87.2%	76.7%	71.8%	80.0%	77.8%	78.4%	75.0%	78.4%	75.0%	74.3%	22.2%	38.7%		70.0%	90%	
O08	Cancer: 62 day referral to treatment from hospital specialist	88.9%	75.0%	100.0%	94.7%	85.7%	60.0%	72.7%	77.8%	76.9%	92.9%	72.7%	100.0%		84.6%	90%	
O09	Cancer: 62 days urgent GP referral to treatment of all cancers	86.1%	81.1%	74.3%	68.8%	81.4%	78.3%	80.3%	68.2%	80.3%	74.8%	73.0%	71.0%		76.6%	85%	
O14	RTT - Incomplete - 92% in 18 weeks	85.2%	86.1%	86.9%	87.0%	86.8%	86.0%	86.1%	86.3%	84.5%	84.6%	83.6%	83.1%	83.0%	83.0%	92%	
	RTT - Incomplete - 52Week Waiters	94	102	96	80	84	71	59	47	49	28	28	9	5	5	0	
O15	RTT delivery in all specialties (Incomplete pathways)	10	10	13	13	12	12	13	13	14	12	13	13	13	13	0	
O16	Maximum 6-week wait for diagnostic procedures	0.5%	0.9%	0.7%	0.6%	1.0%	0.7%	0.9%	1.3%	3.4%	4.3%	3.5%	6.1%	7.3%	7.3%	<1%	
O17	Cancelled operations not re-booked within 28 days	3	1	4	5	7	9	5	4	11	15	14	12	2	2	0	
O18	Urgent operations cancelled for the second time	0	0	2	1	2	5	3	0	1	0	0	2	0	0	0	
O19	Clinics cancelled with less than 6 weeks notice for annual/study leave	48	41	49	38	43	32	62	57	40	37	85	74	92	92	-	
O20	Mixed Sex Accommodation breaches	76	48	39	22	21	67	57	52	59	87	84	49	67	67	0	
O33	Delayed transfers of care	8.1%	7.4%	7.2%	8.3%	7.9%	8.1%	6.5%	5.1%	4.6%	4.9%	5.3%	4.8%	5.7%	5.7%	3%	
IMPROVING CLINICAL PROCESSES																	
O23	% hip fracture repair within 36 hours	76.90%	74.40%	67.00%	83.34%	57.50%	58.10%	81.12%	80.00%	65.72%	75.50%	85.46%	78.30%	87.00%		90%	
O24	Patients that have spent more than 90% of their stay in hospital on a stroke unit[+]	75.00%	80.70%	83.08%	85.00%	77.78%	82.76%	87.50%	85.25%	83.64%	84.91%	76.09%	80.00%		81.86%	80%	

Brighton and Sussex NHS University Hospitals

OPERATIONAL PERFORMANCE SCORECARD

APRIL 2018

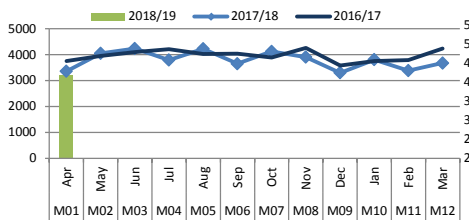
		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	2018/19 YTD	2018/19 Target	Trend
OPERATIONAL EFFICIENCY																	
O36	Average length of stay - Elective	2.43	2.12	2.51	2.22	2.35	2.53	2.61	2.21	2.43	2.23	2.54	2.14	2.29	2.29		
O37	Average length of stay - Non-elective Surgery	4.52	5.03	5.01	4.87	5.38	5.36	4.80	4.90	5.10	5.21	6.13	5.21	5.10	5.10		
O38	Average length of stay - Non-elective Medicine	4.85	4.16	4.42	4.50	4.61	4.56	4.65	4.94	4.71	4.67	4.82	5.05	4.83	4.83		
O39	Day case rate (CQC day case basket of procedures) source: HED (reported 2-3 months in arrears)	82.7%	87.7%	84.6%	87.2%	87.5%	86.9%	87.1%	84.9%	86.2%	85.3%	78.0%			85.7%	75.0%	
O40	Elective day of surgery rate (DOSR)	94.8%	95.5%	94.9%	95.3%	95.1%	94.2%	95.5%	95.3%	95.2%	95.4%	93.2%	94.8%	95.1%	95.1%	90.0%	
O41	Did not attend rate (outpatients)	6.1%	6.6%	6.6%	6.9%	7.4%	7.3%	7.2%	7.8%	8.0%	8.2%	7.6%	8.1%	7.4%	7.4%	6.00%	
SUSTAINABILITY																	
O43	Bank staff - % of all staff pay	4.5%	4.1%	5.2%	5.2%	5.3%	5.8%	4.8%	5.0%	5.9%	4.9%	6.3%	5.5%	5.1%	5.1%	7%	
O44	Agency staff - % of all staff pay	2.4%	3.1%	3.3%	3.2%	3.9%	4.3%	2.8%	3.2%	3.2%	4.0%	4.0%	4.4%	3.4%	3.4%	2%	
O46	% nurses who are registered	73.0%	72.4%	72.1%	72.0%	71.8%	71.5%	71.8%	71.4%	71.1%	70.4%	70.5%	70.1%	69.4%		74%	
O47	% Staff appraised	82.8%	81.3%	80.9%	80.2%	77.7%	76.2%	76.1%	75.9%	77.0%	74.3%	71.7%	72.3%	77.1%		85%	
O48	Sickness Absence: % Sickness(reported one month in arrears)	4.2%	4.2%	4.2%	4.3%	4.3%	4.3%	4.2%	4.2%	4.2%	4.3%	4.2%	4.2%			3.5%	
O49	Staff Turnover: Turnover rate (YTD position)	14.5%	14.6%	14.5%	14.3%	14.3%	14.1%	14.2%	13.9%	13.9%	14.1%	14.3%	14.2%	14.1%	14.1%	12%	
ACTIVITY																	
A01	Day Cases	3355	4050	4232	3790	4228	3652	4122	3906	3302	3809	3385	3675	3212	3212		
A02	Elective Inpatients	1192	1259	1388	1299	1290	1240	1243	1305	1070	1192	1138	1268	1167	1167		
A03	Non-elective inpatients	4637	4890	4499	4680	4547	4579	4653	4674	4506	4727	4082	4635	4494	4494		
A04	Outpatient First attendances	8620	11132	10935	10169	10496	9950	10409	11282	8192	10982	9779	10387	9709	9709		
A05	Outpatient Follow-up attendances	21604	26190	25085	23710	24294	24133	25029	26341	19722	25891	22795	23757	22523	22523		
A06	Outpatients with procedure	7143	8096	8111	7362	7946	7826	7886	8580	6665	8422	7257	7828	8003	8003		
A07	A&E Attendances	13258	14089	13810	14037	13201	13055	13484	13698	13460	13485	12656	14516	14287	14287		

Notes:

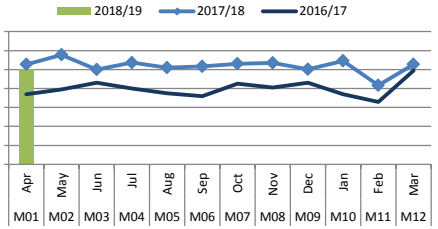
1 National reporting for these performance measures is on a quarterly basis. Data are subject to change up to the final submission deadline due to ongoing data validation and verification.
2 Data are provisional best estimates and will be amended to reflect the position signed-off in the relevant statutory returns in due course.
3 Staff sickness is reported one month in arrears.

Activity Trends

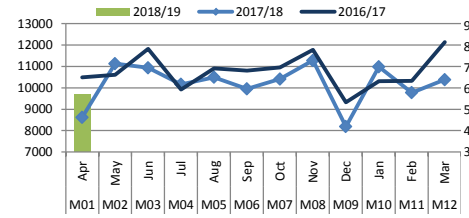
Day Cases



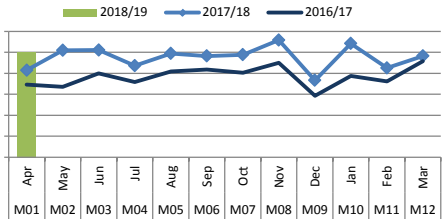
Non-elective Inpatients



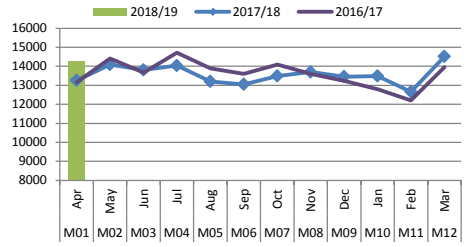
First Outpatients



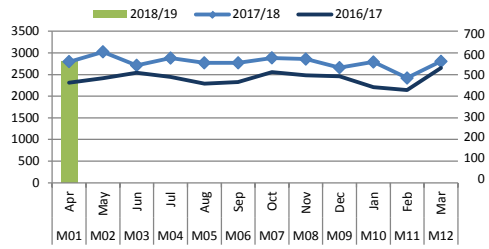
Outpatients with Procedure



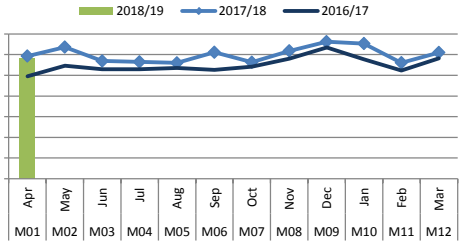
A&E Attendances



Emergency Admissions (age 0-64)



Emergency Admissions (age >85)



Brighton and Sussex University Hospitals NHS Trust

To: Trust Board

Date of Meeting: 30th May 2018 Agenda Item: **9**

Title
Finance Report Month 1 2018/19
Responsible Executive Director
Karen Geoghegan, Chief Financial Officer
Prepared by
Adam Shields, Assistant Director of Finance – Planning
Status
Public
Summary of Proposal
The Trust submitted a final plan to NHS Improvement with a deficit position of £65.4m, in line with the agreed control total. 2018/19 contracts have now been agreed with CCG commissioners and NHSE Specialised Commissioning. Month 1 financial performance is line with the deficit plan of £7.4m. The Finance Report Month 1 2018/19 provides further detail on Month 1 performance and highlights key risks to delivery of the control total and mitigations.
Implications for Quality of Care
Financial planning principles have been established to ensure that expenditure budgets reflect anticipated activity levels and that agreed staffing levels are maintained.
Link to Strategic Objectives/Board Assurance Framework
Financial Implications
These are noted within the Finance Report Month 1 2018/19.
Human Resource Implications
N/A
Recommendation
The Board is asked to NOTE: • Trust Month 1 financial performance is in line with plan; • The key risks that will need to be mitigated in order for the Trust to meet its 2018/19 control total deficit of £65.4m; • The further actions to be taken finalise Divisional and Directorate budgets
Communication and Consultation
N/A
Appendices
1. Finance Report Month 1 2018/19 - Summary

Brighton and Sussex University Hospitals NHS Trust

Report to:	Trust Board
Meeting date:	30th May 2018
Report from:	Karen Geoghegan, Chief Financial Officer
Author:	Adam Shields, Assistant Director of Finance – Planning
Title:	Finance Report Month 1 2018/19

Purpose

1. The purpose of this is paper is to detail financial performance of the Trust in April 2018, highlighting income and expenditure (I&E), capital, cash management and key risks. This report also provides an update on 2018/19 planning and the contract position with the Trust's main commissioners.

Executive Summary

2. The Trust submitted the final 2018/19 plan to NHS Improvement (NHSI) on 30th April 2018 as required. This plan delivers a deficit position for the year of £65.4m, in line with the agreed control total. The monthly phasing of the plan is shown in Table 1.

Table 1: 2018/19 Financial Plan Phased Net Position

£m	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Total
Deficit	7.41	5.66	6.37	4.64	4.23	5.86	3.89	4.90	6.03	4.46	7.03	4.93	65.40

3. The Trust has agreed an Aligned Incentive Contract (AIC) with CCG commissioners; with a contract value of £286m. This is £4m less than the income quantum included in the submitted plan but has no adverse impact for the Trust as planned costs for future growth will not be incurred. The internal plan has been updated to reflect these changes in income and expenditure expectations and Month 1 reporting is on that basis.

Table 2: Comparison of Submitted and Revised Plans

£m	30.4.18 Plan Submission	Plan per Month 1 Reporting	Change
Income	(576.64)	(572.64)	4.00
Pay	375.78	373.62	(2.16)
Non-pay	224.85	223.00	(1.84)
Operating Expenditure	600.62	596.62	(4.00)
Non-operating costs	49.31	49.31	0.00
Total Income & Expenditure	**73.30**	**73.30**	**0.00**
Technical Adjustments	(7.90)	(7.90)	0.00
Net Position	**65.40**	**65.40**	**0.00**

4. Contract discussions have also concluded with NHSE Specialised Commissioning; with an agreed contract value of £161.6m. Given recent agreement, the impact is not reflected in the plan for Month 1 reporting.

5. The Trust is reporting Month 1 financial performance in line with plan; an actual deficit of £7.41m against the deficit plan of £7.41m – see Table 3.

Table 3: I&E Summary and Key Financial Metrics

Values in £m	Month 1		
	Plan	Actual	Variance
Income	(47.13)	(46.11)	1.03
Pay	31.90	30.96	(0.95)
Non-pay	18.92	18.85	(0.07)
Operating Expenditure	50.82	49.80	(1.02)
Non-operating costs	3.13	3.11	(0.02)
Total Income & Expenditure	**6.81**	**6.80**	**(0.01)**
Technical adjustments	0.60	0.61	0.01
Net Reported Position	**7.41**	**7.41**	**(0.00)**
EBITDA	4.34	4.36	0.02
CIPs (per PMO plan)	1.19	1.21	0.02
Capital	7.11	5.18	(1.93)
Cash	10.50	14.53	4.03

6. Month 1 income was below plan by £1.03m. Reflection of the NHSE Specialised Commissioning contract agreement in the plan would reduce this underperformance by c£0.5m.

7. The income shortfall is offset by underspends in operating expenditure; pay is £0.95m below plan and non-pay £0.07m below plan. Reflection of the NHSE contract in the plan would reduce this underspend by c£0.5m.

8. The Trust's cash position is supported by monthly revenue deficit funding from the Department of Health and capital investment loans and Public Dividend Capital (PDC) for the capital programme. The revenue loan funding for April was £6.6m.

Income

9. The internal plan for Month 1 reporting has been revised to reflect the CCG AIC. Table 2 provides the comparison between the 30th April plan and the revised plan.

10. Total income was £46.11m in-month; £1.03m below the revised plan. This is driven by adverse variances on CCG contract income of £0.42m and NHSE contract income of £0.75m.

11. For 2018/19 the basis of contract income reporting has changed to reflect actual in-month activity volumes, rather than estimated volumes. This is to improve transparency and understanding of the Trust's income position and also clinical service engagement. Work to achieve the change is progressing iteratively. For Month 1 the bases of reporting are:

    - Inpatient, Outpatient and A&E activity: actual April activity, priced as coded or for uncoded activity at an average tariff by specialty and point of delivery:

- Other activity (critical care, radiotherapy, renal dialysis, etc.): January-March average activity adjusted for working days or calendar days, priced as above

12. CCG contract income of £22.98m is £0.42m behind plan, but no impact of the AIC has been factored into the position in Month 1.

13. NHSE contact income is behind plan by £0.75m in total. £0.34m of this relates to Specialised Commissioning activity underperformance, prior to the impact of the contract agreement which would improve the position by c£0.5m. A further £0.43m is due to PbR exclusion drugs and devices income underperformance; this is offset by equal and opposite expenditure.

14. Table 4 shows a summary of the income position in Month 1.

Table 4: Income Performance Against Plan

Values in £m	Month 1		
	Plan	Actual	Variance
NHS Trusts Income	(0.70)	(0.79)	(0.09)
CCG Income	(23.40)	(22.98)	0.42
NHSE Income	(15.47)	(14.72)	0.75
NCA Income	(0.47)	(0.52)	(0.05)
SMSKP Income	(1.96)	(1.89)	0.07
Commissioning Income - Non Activity	(0.40)	(0.36)	0.04
Department Of Health Income	(0.00)	(0.00)	(0.00)
Private Patients Income	(0.43)	(0.27)	0.16
Injury Cost Recovery	(0.12)	(0.10)	0.02
Local Authority Income	(0.33)	(0.36)	(0.03)
Overseas Visitors Income	(0.02)	(0.01)	0.01
Other Patient Related Income	0.02	(0.13)	(0.15)
Income from Activities	**(43.27)**	**(42.12)**	**1.15**
Education & Training Income	(2.24)	(2.27)	(0.03)
Research & Development Income	(0.37)	(0.45)	(0.08)
Income Generation	(0.18)	(0.15)	0.03
Other Income	(1.08)	(1.12)	(0.04)
Other Operating Income	**(3.86)**	**(3.98)**	**(0.12)**
Total Income	**(47.13)**	**(46.11)**	**1.03**

NB Variances in brackets reflect overachievement of income against plan

Operating Expenditure

15. Operating expenditure is underspent in Month 1 by £1.02m, comprised of a pay underspend of £0.95m and a non-pay underspend of £0.07m.

Pay

16. The pay underspend comprises underspends in all staff categories with the exceptions of Ancillary Staff and Other Staff, as shown in Table 5. This is in part due to a 2018/19

planning assumption that a proportion of vacancies that were not backfilled in 2017/18 would be recruited into; while this is reasonable, the posts would not have been filled to the level assumed.

Table 5: Pay Variances to Plan

£m	Month 1		
	Plan	Actual	Variance
Medical & Dental Staff	9.44	9.37	(0.07)
Nursing & Midwifery	11.95	11.69	(0.26)
Other Healthcare Staff	4.34	4.09	(0.25)
Management	1.47	1.37	(0.10)
Administrative & Clerical	3.06	2.77	(0.29)
Ancillary Staff	1.26	1.30	0.04
Maintenance & Works	0.24	0.21	(0.03)
Other Staff	0.16	0.16	0.00
Total pay	**31.90**	**30.96**	**(0.95)**

17. Per NHSI Month 1 reporting guidance, pay expenditure includes an accrual for a 1% pay award, equating to £0.30m, pending the outcome of discussions on revised terms and conditions for staff on Agenda for Change contracts.

18. Month 1 agency expenditure of £1.01m was marginally (£1k) above the agency ceiling for the month, but lower than the 17/18 Quarter 4 monthly average of £1.28m. 2017/18 agency expenditure was in line with the £12.8m ceiling so meeting the 2018/19 £11.8m ceiling will require further actions to reduce expenditure. These include: exit from use of high cost, non-framework agencies, improved recruitment and retention and application of rostering best practice across the Trust.

Non-pay

19. In-month non-pay is underspent by £0.07m in total; a £0.18m underspend on PbR exclusions and CDF drugs is partly offset by overspends across other areas of non-pay.

20. Part of the overspend relates to the hire of a CT scanner at PRH whilst installation of the new scanner takes place. The hire is due to finish at the end of May resulting in a pressure of £100k.

Non-operating Costs

21. Non-operating costs are on plan in Month 1 with a combined favourable variance of £0.02m.

Performance Against Delegated Budgets

22. Budget sign-off meetings have been held with four out of five clinical divisions, and the Facilities and Estates Directorate during May. All budgets have been signed-off by management teams with any outstanding issues being captured for investigation and resolution as required.

23. Funding for pay inflation and specific non-pay inflation items has not yet been delegated. Additionally, the efficiency programme has not been reflected in full; pending final sign off for some of the schemes.

Efficiency Programme

24. The total efficiency requirement for the year is £30m and plans equivalent to the target have been identified. There are currently £17.2m of schemes rated as having a delivery risk of medium or low. The remaining £12.8m of schemes are rated as higher risk due to the complexity of schemes; with some subject to more development and detailed plans.

25. At Month 1 £1.21m of savings have been delivered against a target of £1.19m.

Key Risks

26. There are a number of key risks to delivery of the £65.4m control total deficit as described below, along with mitigating actions.

27. **CCG Contract**
An AIC has been agreed with the CCGs which mitigates financial risk for the Trust and the wider system. In addition there was wider agreement on partnership working opportunities that require further discussion. However, this will require the Trust to manage activity and cost within the framework of an agreed income quantum.

28. **NHSE Specialised Commissioning Contract**
Agreement has now been reached on the 2018/19 contract. This is a PbR based contract so the Trust will get paid for the activity it delivers; underperformance is therefore an income risk. The contract also limits the Trust's 2018/19 exposure to some legacy charging issues with transitional arrangements agreed.

28. Efficiency Programme
The programme is at a more advanced stage of development and delivery than at the same time in 2017/18. However, at £30m the 2018/19 saving requirement is £10m higher and there are still £12.8m of schemes that have a delivery risk rating of high. Development of the programme continues to be led by the PMO with regular Executive oversight.

29. PAS Replacement
The Trust's PAS system is in the process of being replaced. If the work to do this is not completed the deadline, an additional payment of £1.4m will have to be made to the supplier of the current system. Additionally, if problems arise with the new system the dataset required to secure payment for activity from commissioners may not available for a period of time. The project is currently on track and is overseen by the PAS Programme Board.

Cash

30. The Trust received £6.6m of revenue deficit funding in April and has requested a further £5.0m in May.

31. Capital funding is a combination of Public Dividend Capital (PDC) and Capital Investment Loans. The Trust has carried forward unspent PDC and Loan funding from 2017/18 amounting to £8.1m so no further funding has been requested in April. The next drawdown is planned for May but will depend on capital expenditure in May.

32. The cash balance remains at a relatively high level at £14.5m with unspent loans and PDC from 2017/8 carried forward, lower strategic capital expenditure and the early settlement in March of the final agreed commissioning values for 2017/18. No PDC or loan funding was drawn down in April.

Capital

33. The strategic capital forecast for the year is £137.8m. This comprises £101.9m for 3Ts, £13.9m for the Emergency Floor scheme, £9.0m for the Emergency Backlog Maintenance scheme, £11.5m for the Pathology scheme and a residual £1.4m for the Radiotherapy East scheme. Strategic expenditure in April amounted to £7.0m. The Operational programme forecast for the year is £25.5m; this includes over programming of £6.9m. Expenditure in April is minimal, but in line with the plan.

Conclusions and Recommendations

34. To note:

- Trust Month 1 financial performance is in line with plan;
- The key risks that will need to be mitigated in order for the Trust to meet its 2018/19 control total deficit of £65.4m;
- The further actions to be taken to finalise Divisional and Directorate budgets.

Finance Report Month 1 2018/19

Summary

Brighton and Sussex University Hospitals NHS Trust

Summary

A control total deficit of £65.4m has been set by the Trust in agreement with NHSI, and the year to date position is slightly below the year-to-date plan of £7.414m. The capital programme is underspent and cash receipts are higher than planned. The Efficiency and Transformation Programme has delivered in excess of £1.2m in the first month of the financial year.

Finance and Use of Resources Risk Rating — R

YTD

	Plan	Actual / Forecast	Variance
Year-to-date	4		(4)
Year-end Forecast	4		(4)

The Trust hasn't received actual ratings from NHSI in month 1. Whilst we can calculate them using the metric formulas, there will be an over-ride. Metrics will be reported next month.

Control Total (Surplus) / Deficit £k — G

	Plan	Actual / Forecast	Variance
Year-to-date	7,414	7,411	(3)
Year-end Forecast	65,400	65,397	(3)

The Trust is reporting a deficit of £7.411m compared to the YTD plan of £7.414m. The forecast is to slightly underspend compared to budget

Agency Ceiling £k — G

	Ceiling	Actual / Forecast	Variance
Year-to-date	1,009	1,010	1
Year-end Forecast	11,783	11,783	0

Agency costs of £1.01m represent 3.3% of the total pay bill and are slightly over the Month 1 agency cap of £1.009m. Agency expenditure was significantly less than M12, but the agency cap has reduced by £1m year on year. The total cost of Agency, bank and substantive staff usage was below the Month 1 budget.

Income £k — R

	Plan	Actual / Forecast	Variance
Year-to-date	(47,132)	(46,105)	1,027
Year-end Forecast	(572,638)	(571,611)	1,027

Total income was £46.11m in-month, £1.03m below the plan revised for the impact of the CCG aligned incentive contract agreement. This is driven by adverse variances on CCG contract income of £0.42m and NHSE contract income of £0.75m.

Operating Costs £k — G

	Plan	Actual / Forecast	Variance
Year-to-date	50,820	49,801	(1,019)
Year-end Forecast	596,623	595,604	(1,019)

Operating costs for the year are underspent against budget, primarily due to pay costs, and with a small underspend on non pay costs. The Forecast is to continue to underspend in these areas to offset forecast income reductions, in order to come in on budget.

Agency Expenditure — G

Expenditure as % of total Pay bill (YTD)	**2016-17**	**2017-18**	**2018-19**
Medical	1.1%	0.7%	0.8%
Nursing	1.0%	0.9%	1.3%
Other staff groups	1.0%	1.1%	1.2%
All Agency	**3.2%**	**2.6%**	**3.3%**

Agency costs have increased as a proportion of the total paybill compared to the same period last year, primarily in the area of nursing, but are in line with the ceiling.

Cash £k — G

	Plan	Actual	Variance
Year-to-date	10,500	14,529	4,029

The revenue deficit funding for April was £6.6m. No PDC or loan funding has been drawn down in April because £8.1m has been carried unspent from 2017-18. The
The year-end level of cash holding is higher than planned because of early settlement of the final 2017/18 SLA invoices, and the unspent capital funding carried over from 2017/18 and the lower than planned capital expenditure in April.

Capital £k — A

	Plan	Actual	Variance
Year-end Forecast	165,086	163,249	(1,837)

The strategic capital expenditure is lower than planned in April and there has been minimal operational expenditure in April which is broadly in line with the plan. The operational plan approved by the Board included £1.1m for a replacement CT scanner. This scheme was brought forward and completed in 2017/18. This is the main change in the year end forecast compared to plan.

Efficiency and Transformation Programme £k — G

	Plan	Actual / Forecast	Variance
Year-to-date	1,186	1,207	21
Year-end Forecast	30,000	30,000	0

The efficiency programme has delivered the £1.2m in Month 1 which is £0.02m in excess of the internal target and £0.124m short of the NHSI target. Work is under way to finalise placeholder projects due to start in Quarter 2, and the forecast is to acheive the full plan of £30m.

Key risks include:
CCG contract income: the Trust will need to manage activity and cost within the framework of an agreed income quantum.
NHSE Specialised Commissioning Contract: being PbR based, the Trust will need to deliver the planned level of activity to secure the level of income assumed.
Delivery of the £30m efficiency requirement in full.
PAS replacement: if this is delayed an additional payment of £1.4m has to be made to the current supplier. Also issues with the new system may prevent submission of the required activity dataset to secure income from commissioners.

Brighton and Sussex University Hospitals NHS Trust

To: Board of Directors

Date of Meeting: 30th May 2018 Agenda item: **10**

Title
6 Monthly Nurse Staffing and Capacity Levels
Responsible Executive Director
Nicola Ranger Chief Nurse
Prepared by
Caroline Davies, Nurse Director
Status
Public
Summary of Proposal
The purpose of this report is to present to the board a review of ward nurse staffing level as directed by the National Quality Board (NQB).
Implications for Quality of Care
The provision of safe high quality patient care is dependent on having adequate nurse staffing levels, this paper outlines how this is achieved.
Link to Strategic Objectives/Board Assurance Framework
This report incorporates key national, regional and local indicators relating to quality and safety providing assurance for the Board and highlighting issues of concern.
Financial Implications
Nil
Human Resource Implications
Safer staffing levels are incorporated in the safety and quality scorecard
Recommendation
The Board is asked to NOTE the report.
Communication and Consultation
Not applicable
Appendices
None

Report to the Board of Directors

Nurse Staffing and Capacity Levels

May 2018

1. Introduction

The purpose of this report is to present to the board a review of ward nurse staffing level as directed by the National Quality Board (NQB). The NQB has stipulated that; 'Boards must take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability'. Within their recommendations it states that every six months as required by the NHS England *Hard Truths* report*,* which the board of directors should receive and discuss at a public board meeting a report on staffing capacity and capability. This was requirement came following a number of national reports.

- The Francis report on Mid Staffordshire (2013) resulted in the publication of a number of documents focussing on the importance of safe nurse staffing levels.
- Keogh review into the quality of care and treatment provided in 14 hospital trusts in England (2013)
- Cavendish review (2013), an independent enquiry into healthcare assistants and support workers in the NHS and social care setting.
- Berwick report on improving the safety of patients in England (2013)
- 'How to ensure the right people, with the right skills, are in the place at the right time. A guide to nursing, midwifery and care staffing capacity and capability' (National Quality Board 2013).
- Hard Truths. The journey to putting patients first' (DH, 2013)

As a result of the recommendations 'Safe staffing for Nursing in adult inpatient wards in acute hospitals' (NICE 2014) was developed, this provides detail on the methodology for undertaking a staffing review.

2. Vacancies in April 2018

Registered nurse workforce capacity across the local region and nationally remains a challenge to all health providers. BSUH has a recruitment campaign that is focussed on national and international recruitment to reduce the current RN nurse shortfall. There remains focussed activity on nursing recruitment and retention (please see retention paper

for detailed initiatives); and the development of a recruitment and retention strategy, which is monitored through the Workforce Efficiency Steering Group. There is particular focus for both recruitment and retention at Princess Royal Hospital, as there is a vacancy rate for Registered Nurses (RNs) of just over 20%.

HR is supporting sickness management with a focus on 8 wards and departments with a sickness rate of over 6%, this has proved successful in critical care at RSCH, where sickness has reduced from 6.9% in October 2017 to 1.6% in March 2018.

The ongoing increase in both registered and unregistered nursing staff that was apparent in the early part of 2017 has been halted through rigorous recruitment and retention activity. We are employing 10 more registered nurses than we were in October 2017, which is although modest is in line with our forcast, given the national recruitment difficulties. During the next 4 months 40 Filipino nurses will be starting (primarily at PRH) and we recruited 61% of the students who qualified from the University of Brighton in February an increase of 30% from the cohort who qualified in September 2017.

The recruitment of 47 Healthcare Assistants (HCAs) has greatly supported the delivery of care and following a successful recruitment campaign this number should reduce to less than 20 in the next 3 months.

Vacancies	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	March 18
Registered	287	282	282	273	278	279
Unregistered	140	129	110	106	94	93
Total	427	411	392	379	372	372

Any shortfalls in staffing are discussed three times daily at the operational meetings and where required staff will be moved to accommodate extra capacity staffing and areas that need additional support.

Bank and agency staff are used as required to ensure the nurse to patient ratio remains within acceptable levels. Heads of Nursing, Directorate Lead Nurses, Matrons and the Practice Educators have also worked on the wards as required.

The graph below reflects the actual spend and percentage of spend for this financial year

Since the beginning of October 2017, we are actively managing the withdrawal from non-framework, high- cost agencies, we ceased using these agencies at RSCH at the end of February 2018 and in the past month have been using less than 10 a week at PRH, the plan

is to stop the use of the nonframework agencies at PRH by the end of August 2018. Authorisation for non-framework agency shifts is with the Nurse Director.

The Heads of Nursing monitor any overtime and sickness, following the *managing sickness absence policy* with HR support. In addition, working with the roster-pro lead, it is planned that a new rostering policy was agreed in march 2018, which will enable robust management of rotas and monitoring against agreed KPIs.

Meetings continue to take place between senior nursing staff and staff side to enable detailed discussions to take place in partnership regarding current and future workforce.

The table below shows the average staffing fill rates across the Trust. As the table below demonstrates challenges remain in filling registered nurse shifts. The shortfall in registered staffing is, partially, compensated for by an 'over- fill' in Healthcare assistants, to support care. As there has been a decrease in fill rates for registered nurses there has been an increase for unregistered. However, the Safer Staffing Alliance states there is evidence that care is compromised where there are more than 8 patients (beds) to 1 registered nurse, when any area drops below this level it is escalated to the Heads of Nursing, Nurse Director and on Call Executive, as appropriate.

Nurse Staffing Fill Rates Oct 2017 – March 2018

	Oct - 17	Nov-17	Dec-17	Jan- 18	Feb- 18	Mar - 18
Day						
RN	**91.1%**	**91.5%**	**90.1%**	**89.9%**	**87.2%**	**87.4%**
HCA	**94.6%**	**96.1%**	**96.1%**	**96.7%**	**99.8%**	**97.1%**
Night						
RN	**93.6%**	**93.3%**	**93.1%**	**93.2%**	**90.3%**	**92.5%**
HCA	**114.4%**	**116%**	**113%**	**114.7%**	**113.7%**	**117.1%**

Wards with vacancies over 20% are regularly reviewed using the clinical incidents, patient feedback and safety metrics data to ensure the staffing levels are not impacting on patient safety.

3. Care Hours per Patient Day (CHPPD)

In Lord Carter's final report, '*Operational Productivity and performance in English acute hospitals: Unwarranted variations'*, better planning of staff resources is crucial to improving

quality of care, staff productivity and financial control. The Carter Team found there is not a consistent way to record and report staff deployment, meaning that trusts could not measure and then improve on staff productivity.

The report recommended that all trusts start recording Care Hours Per Patient Day (CHPPD) – a single, consistent metric of nursing and healthcare support workers deployment on inpatient wards and units. This metric enables trusts to have the right staff mix in the right place at the right time, delivering the right care for patients.

From 1 May 2016, all trusts were requested to report back monthly CHPPD data to NHS Improvement so that they can start to build a national picture of how nursing staff are deployed.

Also enabling trusts to see how their CHPPD relates to other trusts within a speciality and by ward in order to identify how they can improve their staffing.

Care Hours per Patient Day (CHPPD) Oct 2017 – March 2018

		October	Nov	Dec	January	February	March
RSCH	**Registered Nurse**	6.8	7.3	6.9	6.8	6.7	6.8
	Un-Registered	3.2	3.4	3.2	3.2	3.5	3.4
	Total	**10**	**10.7**	**10.1**	**10**	**10.2**	**10.2**
PRH	**Registered Nurse**	5.1	5.2	5.1	5.9	5.7	5.8
	Un-Registered	3.4	3.6	3.6	3.4	4.1	4.3
	Total	**8.5**	**8.8**	**8.7**	**9.1**	**9.8**	**10.1**

This table reflects that in March each patient at RSCH had an average of 6.8 of a registered nurses time and 3.4 of un-registered; a total of 10.2 hours in a 24 hour period.

BSUH hours will be higher than some other Trusts as there are two adult ICU, cardiac ICU, Children's HDU and neonatal Level 3 (ICU) all areas where staffing is one to one/ one to two care. The Trust has staffing levels that are comparable with other Major Trauma Centres.

The table below details the total number of filled and un-filled hours for trained and un-trained staff for the months, including the percentage.

We have areas where the CHPPD are higher as expected e.g. ITU, HDU. Our medical and surgical wards vary between 6.5 hours and 8.8 hours.

The detail below gives a fuller picture of the reasons for a red 'flag' (levels of 80% or below).

	Oct	Nov	Dec	Jan	Feb	March
No of ward with less Than 80% fill	**4**	**1**	**5**	**8**	**8**	**4**

The numbers of wards that flagged rose in January and February (although remained lowered than the same period in 2017), and this is primarily driven by sickness on critical care at PRH and vacancies on Twineham ward. Mitigations remain that staff are moved to other areas requiring assistance, to ensure all areas are kept safe. Shifts are escalated to bank and agency and, managers, practice educators; nurse specialists provide additional clinical support.

4. Nursing Templates

Calculating staffing requirements is not straight forward and is dependent upon a number of factors. These include; the dependency (acuity) of patients on nursing care and factors such as skill mix of staff available and others including the culture and leadership of the team. The last acuity staffing review was undertaken in January/February 2018 using the Shelford Model and whilst the review is complete further work is being undertaken to compare findings with previous audits .

5. Recruitment

Recruitment is becoming more challenging, the projects at BSUH include;

- 6 annual trust days, focusing on newly qualified nurses, generic band 5s, flexible working and Return to Practice
- The individual Directorates are leading individually on their bespoke adverts and have rolling fortnightly recruitment plans.
- HCA recruitment is open to all, so that people recruited based on their aptitude rather than previous experience. The care certificate and focussed support will be given to those without experience.
- A new 12 month preceptorship programme for newly qualified nurses – consisting of 12 mandatory days of education.
- Rotational programmes are being developed which will include an acute pathway, using high vacancy areas. This will enable nurses to gain a breadth of experience across specialities.

- 40 Filipino nurses have been recruited, first 2 arrived in April and the rest will be coming into post over the next 4 months. A further business case is being developed for international recruitment.
- Improving student experience; to include in-house simulation and training dates, with a plan to recruit these students when they qualify, which has already seen an increase from 30% to 61% of Brighton students being employed at BSUH post qualification.
- Increasing student numbers, in addition to increasing the number of student commissions with Brighton University, students will now be placed at BSUH from the Universities of Surrey, Portsmouth and Southampton as well as Brighton.

Other actions that have been taken to support the nursing and midwifery workforce include;

- International recruitment in Europe, this market has reduced dramatically, although there continues to be a few new recruits monthly from the EU.
- Retire and return policy has been agreed – to encourage experienced nurses to extend their careers
- Agency line bookings for areas most challenged, this also supports the withdrawal from the more expensive agencies.

Please see Retention paper for the strategy relating to retention

6. Staffing data in each inpatient area

The Trust displays information about the number of nurses, midwifes and care staff present and the number planned, in each clinical area, on each shift. The format of the presentation has been reviewed by service users and some changes made to ensure it is useful for service users. This data is also published on the BSUH external website, in a visible, clear and accurate format for the public.

7. Summary

This report provides information on all wards and departments at BSUH. The Chief Nurse is satisfied that nurse and midwifery staffing in all areas meet safe staffing requirements.

Recruitment of nursing and midwifery staff is essential and will need to continue at pace, locally, nationally and internationally. However, the supply of nurses and midwives is limited and focussed activity in the Trust will be on retaining staff, increasing our student numbers and how we develop our own people to become skilled registered practitioners. These measures particularly important as universities are reporting up to a 32% reduction of applicants following the removal of the bursary for student nurses / midwives.

Brighton and Sussex University Hospitals NHS Trust

To: Board of Directors

Date of Meeting: 30th May 2018 Agenda Item: **11**

Title
Learning from Deaths Quarterly Report
Responsible Executive Director
Dr George Findlay (Chief Medical Officer) and Nicola Ranger (Chief Nursing and Patient Safety Officer)
Prepared by
Dr Stephen Drage – Deputy Medical Director: Safety and Quality, Della Morris – Safety & Quality Lead and Mark Renshaw – Deputy Chief of Safety
Status
Public
Summary of Proposal
This report has been produced in line with National Guidance on Learning from Deaths published in March 2017, to provide the Executive with information relating to 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. As this relates to new national guidance the report also provides an update on progress made to roll out this across the Trust.
Implications for Quality of Care
For many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS. 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.
Link to Strategic Objectives/Board Assurance Framework
The Trust's True North Objective is for the mortality rates (HSMR) to be in the lowest 20% of Trusts.
Financial Implications
Human Resource Implications
Recommendation
The Board is asked to NOTE the report.
Communication and Consultation
Not applicable
Appendices
None

1. Learning from Deaths Dashboard

1.1 The Department of Health provide a dashboard for Trust's to use to publish data on the number of deaths that have been reviewed in their organisations. See attachment

1.2 Table 1 shows the quarter 4 data for BSUH. The number of Structured Judgement Reviews (SJRs) completed is increasing due to an increased capacity to undertake reviews. LD refers to deaths in patients with learning disabilities. These deaths are reviewed independently of the Trust by the LEDER programme.

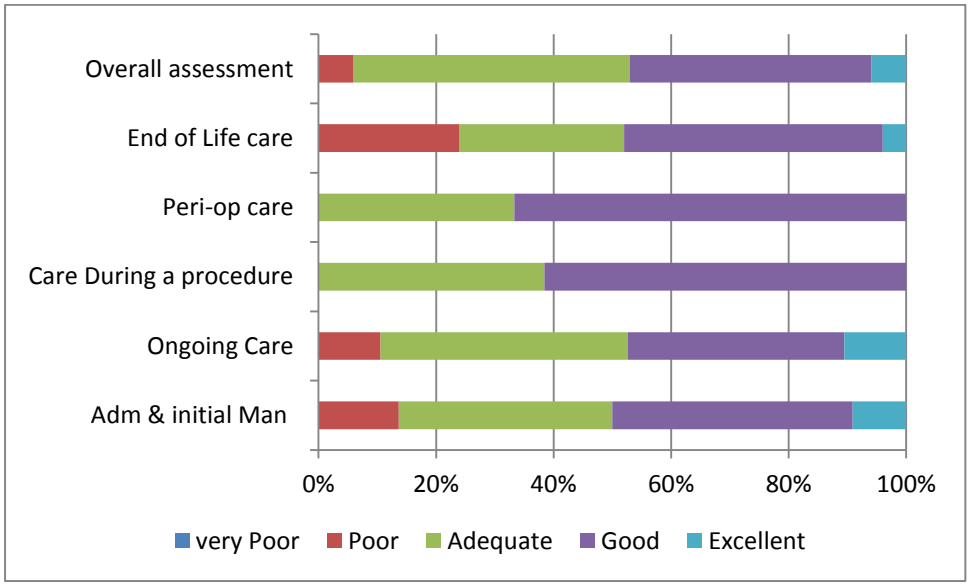
1.3 There was one death in March 2018 where the death was felt to be >50% due to problems in care. This patient's death followed the misplacement of a nasogastric tube and is therefore classified as a Never Event under national guidance. An investigation is currently underway into the circumstances surrounding the patient's death.

	Total Deaths (not LD)	Total Deaths Reviewed (not LD)	Deaths Avoidable > 50% (not LD)	LD Deaths	LD Deaths Reviewed	LD Deaths Avoidable > 50%	Total % of deaths reviewed
Jan 18	150	4	0	1	0	0	2.6%
Feb 18	169	1	0	0	0	0	0.6%
March 18	155	14	1	3	0	0	9%
Total (Q4)	474	19	1	4	0	0	4%

2. Outcomes from Structured Judgement Reviews

2.1 The SJRs review 6 discreet areas of care. The charts below show the level of care that the patients have been recorded as receiving.

- Admission and Initial Management
- On-going care
- Care during a procedure
- Perioperative care
- End of Life care
- Overall assessment of care



2.2 National guidance requires the Trust to review deaths that are unexpected and the Trust Mortality Review Group (TMRG) has a rolling programme to review all deaths following elective admissions. In Q4, 7 cases recorded as deaths following elective admissions, however, on review none of the patients were found to have been elective admissions. The TMRG are working with the Clinical Administration team to improve the reporting of 'Type of Admission'.

2.3 Many of the reviews carried out have identified minor issues or good care. The predominant theme arising where improvements could be made is in relation to end of life care. Specifically, it has been frequently noted that the likelihood that the patient was nearing the end of their life could have been identified sooner. Earlier identification may have allowed earlier input from palliative medicine.

2.4 The Deputy Medical Director: Safety and Quality presented to the Grand Round on Weds 16th May on the subject of learning from deaths including case presentations of 2 'avoidable' deaths (subject of SIs). The cases both related to deaths from venous thromboembolism (VTE) where different actions could have been taken that may have prevented the deaths. Further actions arising from these incidents include revisions to the Trust guidance on diagnosis and treatment of VTE and also a review of the current VTE service.

3. Roll out of Learning from Deaths Programme across BSUH

3.1 Departmental M&M Leads have an open invitation to attend the TMRG. Many Leads are taking this opportunity to learn more about this programme of work and take this back to implement in their departments.

3.2 25 Consultants and Specialist Nurses across the 5 clinical divisions are trained to undertake SJRs. There are 4 training sessions booked across both the RSCH & PRH site during June and July to increase the Trust's capacity to undertake reviews.

3.3 Following the appointment of a new Lead Consultant for Palliative Care who has been previously trained in SJR methodology, the capacity to undertake SJRs has increased with a particular focus on end of life care.

3.4 The Safety & Quality Team are working with the Bereavement Office and the Medical Examiners to introduce a new database, using the DATIX system to more accurately capture the outcomes of the Medical Examiner reviews of deaths.

3.5 This DATIX database is also being used to capture the findings of the SJRs, to enable more detailed analysis of themes and issues arising from the reviews.

3.6 Although the number of SJRs is increasing the number of reviews using SJR methodology is low. At present there is no dedicated time allocated within job plans for SJR. A single SJR takes approximately one hour to complete which is a significant increase on the time previously allocated to mortality review by specialities. The planned training will increase the capability of staff to perform these reviews. TMRG are working with colleagues from WSHFT to quantify the resources required for a comprehensive mortality review programme.

4. Medical Examiner Programme

4.1 BSUH was part of a pilot programme to introduce the review of every death by a medical examiner. The review includes a discussion with bereaved relatives. The pilot was successful and the programme was continued. The national implementation of ME is due to take place in April 2019.

4.2 The ME programme is now the backbone of our mortality review programme. The Medical Director and Deputy Medical Director wish to strengthen and expand the current programme in anticipation of the national implementation. It has not been possible to expand the programme to PRH due to funding and remuneration arrangements for MEs. Medical Director and Deputy Medical Director are meeting with Mark Howard who is currently the ME link with TMRG to clarify current arrangements.

Brighton and Sussex University Hospitals NHS Trust

To: Board of Directors

Date of Meeting: 30th May 2018 Agenda item: **12**

Title
Annual Safeguarding Adults, Mental Capacity Act, Learning Disabilities and Domestic Violence
Responsible Executive Director
Nicola Ranger Chief Nurse
Prepared by
Caroline Davies, Nurse Director Joanna Henderson, Lead Nurse adult safeguarding
Status
Public
Summary of Proposal
The purpose of this report is to appraise the Board of the main developments in the national and local safeguarding adults agenda since April 2017; to provide assurance of how the Trust fulfils its statutory duties with respect to safeguarding vulnerable adults, including those lacking mental capacity and those with learning disabilities.
Implications for Quality of Care
The provision of safe high quality patient care is dependent on the most vulnerable patients being Safeguarded and that staff are educated to understand and protect these people from harm
Link to Strategic Objectives/Board Assurance Framework
This report incorporates key national, regional and local indicators relating to safeguarding providing assurance for the Board and highlighting issues of concern.
Financial Implications
Nil
Human Resource Implications
Nil
Recommendation
The Board is asked to NOTE the report.
Communication and Consultation
Not applicable
Appendices
Nil

Annual Report to the Board of Directors
May 2018
Safeguarding Adults, Mental Capacity Act, Learning Disabilities and Domestic Violence

1. Introduction

Adult safeguarding is the process of protecting adults with care and support needs from abuse and neglect and the key responsibility lies with Local Authorities (in partnership with the Police and the NHS).

In April 2015 The Care Act (2014) came onto statute in England. This included statutory requirements in relation to Safeguarding Adults, for the first time in British law.

Section 42 of the Care Act represented a major change in practice; moving from a process-led to a person centred approach, emphasising an approach based on risk assessment, which takes into account an individual's preferences, circumstances, and lifestyles to achieve a proportionate tolerance of acceptable risks to the individual.

Practice now concentrates on the wishes of the vulnerable adult[1]. The enquiry must be person led and outcome focused, there must be engagement with the adult and / or their carer, offering choice and control, leading to an improvement in quality of life, wellbeing and safety.

The local Safeguarding Adults Boards have a statutory duty to work and to share information to enable protection of individuals, all the Chief Executive Officers of statutory organisations in Brighton and Hove and West Sussex have signed an information sharing agreement.

2. Safeguarding Adults in BSUH

The Safeguarding Adults agenda is a key component of Patient Experience and Safety in BSUH. The Nurse Director manages the team, who consist of a Lead Nurse for Safeguarding Adults, 0.6 wte Safeguarding Nurse, a Mental Capacity and Mental Health trainer, who also leads on the Deprivation of Liberties Safeguards (DoLS). Affiliated to the team are a Health Independent Domestic Violence Advocate (IDVA), who works at RSCH and is employed by RISE (a domestic violence charity) and 2.5 wte Learning Disability Liaison Nurses, who work in BSUH and are employed by Sussex Partnership Foundation Trust and Sussex Community Foundation Trust.

The BSUH Safeguarding Steering Group meets on a quarterly basis, bringing together Safeguarding Children, Adults, DoLS, MCA, Domestic Violence and Learning Disabilities; there is attendance from all the clinical divisions, this committee will now report to the Patient Safety Group, in the new clinical governance structure. The Nurse Director is a member of both the West Sussex and Brighton and Hove Adult Safeguarding Boards (SAB) and team members participate in sub committees of both

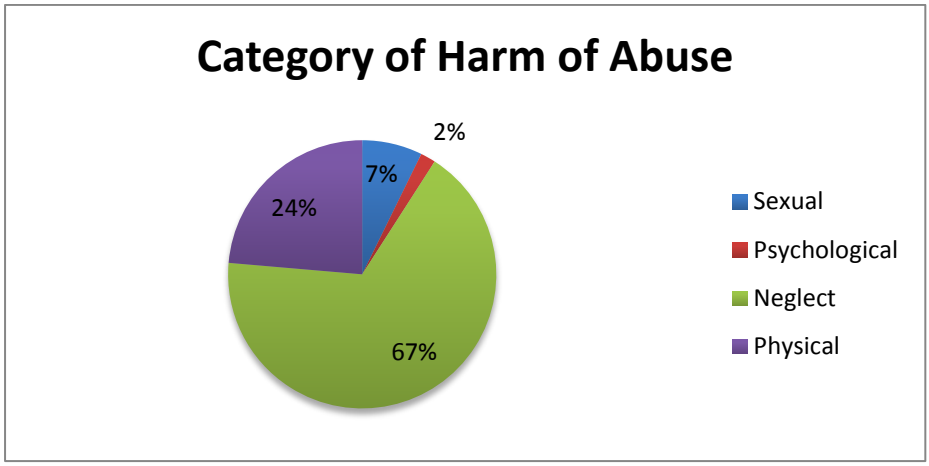
[1] Vulnerable adult is defined as anyone over the age of 18 who is or may be in need of community care services by reason of disability, age or illness; and is or may be unable to take care of unable to protect him or herself against significant harm or exploitation. Categories of abuse include; physical, psychological, sexual, neglect, self-neglect, domestic, financial, organisational, discriminatory and modern slavery.

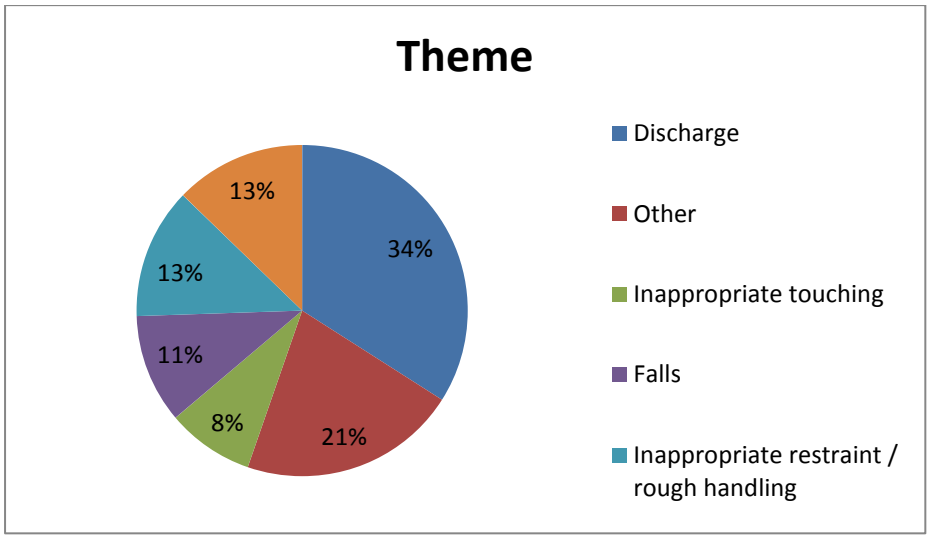
Safeguarding boards. Other members of the Safeguarding team are active members of SAB subgroups.

Adult Safeguarding is a key focus on the agenda for monthly the Nursing and Midwifery Board. This concentrates on the learning from Safeguarding incidents and changes to practice and procedures including DoLS, MCA, Domestic Violence and Learning Disabilities. Safeguarding Adults will also form part of the standard agenda for the clinical division's clinical governance meetings.

There is also a number of instances, a link between safeguarding, complaints and serious/moderate Incidents. As a result the Nurse Director attends the Serious Incident Review Meeting monthly and manages the head of patient experience and complaints as well as to the head of patient safety. During 17/18 a weekly safety huddle has been instituted with the Chief Nurse, Nurse Director, Medical Director, Chief of Safety, medico legal, quality, complaints and patient safety leads, which enables triangulation of incidents including safeguarding. In the future this may be further developed.

Safeguarding Activity April 2017 to March 2018
Section 42 Enquiries





There were 54 Section 42 “Causing others to undertake enquiry” received by the team which is similar to the two previous years (15/16 there were 54 and 16/17 50). Again, similar to the previous years, discharge remains an underlying theme in safeguarding concerns raised against BSUH. Issues raised include poor communication between hospital and nursing home staff /care providers regarding specific care plans e.g. wound care; or changes in care needs. The Head of Nursing for Discharge and Partnership has formed a multi- agency discharge practice group to improve aspects of discharge.

Neglect or acts of omission (which often include issues relating to poor discharge) accounts for 67% of the allegations received. This is a reduction from the previous year when 76% of concerns received were in the category of neglect.

Allegations of physical abuse in the last year has seen an increase of 9%, these include use of inappropriate restraint and allegation of rough handling. This requires further review and investigation.

Seven allegations of abuse were received against individual staff members relating to either physical or sexual assault. All cases were formally reviewed and resulted in two members of staff being dismissed; three allegations investigated by Sussex police with no further action and final two allegations are part of on-going review.

During the last year the Safeguarding team have continued their role in investigation of safeguarding concerns and supporting other to undertake the investigations. However, as the team have become well known throughout the Trust and their expertise valued by clinicians, they are increasingly doing more proactive work with teams who are caring particularly vulnerable patients with mental capacity and/or mental health problems. This change in emphasis means that patients are being truly safeguarded and their best interests considered at an earlier stage.

Learning from Section 42 Enquiries

Following safeguarding concerns regarding the use of inappropriate restraint, bespoke training has been developed by the Lead Nurse for Safeguarding Adults and the MCA /Mental Health Education Lead to support staff working in AMU, Neurosurgery and Sussex Rehab Centre. The training focuses on issues regarding Mental Capacity, DoLS, use of restraint, supporting patients who require 1to1 supervision and safeguarding.

A safeguarding enquiry relating to skin damage caused by a patient’s finger nails cutting into the palms of their hand, resulted in new policy being developed for all nursing staff relating to cutting of non- diabetic finger and toe nails.

Following a Safeguarding Investigation at the end of 2015, a multi-disciplinary group was formed to improve the delivery of mouth care within the Trust. This steering group has been fully established 2 years and BSUH has continued funding for a specialist in mouthcare following from Health Education England (HEE) initial funding for one year.

Audits in 17/18 have shown a significant improvement in care and knowledge of all health professionals in relation to mouth care, compared to the baseline audit in the summer of 2016.

There have been no serious incidents or safeguarding concerns raised about this element of care in the past 12 months.

Learning from Safeguarding Adult Reviews

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

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

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

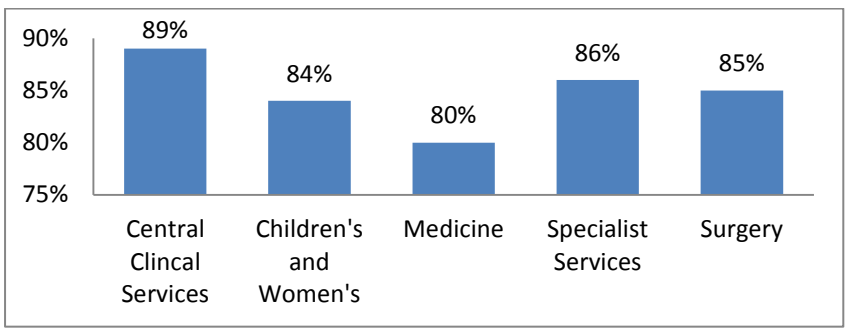
Following recent SARs across Sussex, the SABs have identified an underlying theme relating to self-neglect. Although BSUH had minimal involvement with the adults subject to the SARs the learning outcomes are applicable to healthcare professionals:

- Need for a greater awareness of self-neglect and the role of 'safeguarding'
- Utilising safeguarding as a mechanism to hold multi-agency /strategy/ professionals meeting
- The interface between Mental Capacity Act and Mental Health Act and the impact on physical health
- Recognising coercion and controlling behaviour and the possible impact on an 'unwise decision'
- Organisational accountability – robust documentation to evidence decision making

Of particular concern within Brighton and Hove is the level of homelessness and vulnerability. The Lead Nurse Safeguarding Adults is working closely with partner agencies to improve multi-agency information sharing with regard to the risk assessment and safety planning for those who frequently attend the Emergency Department and who are identified as at serious risk of harm or abuse.

Training

Divisional training compliance:



Compliance with mandatory training for Safeguarding Adults stands at 82% This falls short of the Trust target for STAM compliance of 90%, however this is 10% higher than April 2017 and continues on an upward trajectory.

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

The safeguarding team continue to review and update training to reflect developments in legislation and also learning from safeguarding enquiries. In addition to Level 1 and Level 2 training, specialist level 3 training is to be developed and implemented in line with the learning and development strategy.

Internal Audit March 2018

The objective of the audit was to evaluate and test the Trust's arrangements for safeguarding vulnerable adults and applying Deprivation of Liberty Safeguards (appendix 1). The auditors rated the internal controls as amber and an action plan has been developed.

Two areas were noted as Good practice; the Trust's Policy, which is in line with best practice and has recently been updated to reflect changes to the Safeguarding environment and a sample of Safeguarding Concern forms showed that these were handled effectively**.**

One area is noted for particular development and this was that the training compliance was less than 90%

3. Prevent

Prevent is one part of the Government's counter terrorism strategy, CONTEST, which is led by the Home Office (Building Partnerships, Staying Safe. Department of Health 2011). Prevent aims to safeguard adults, or children, who may be vulnerable to any form of radicalisation.

Following the death of siblings W and X in Syria in 2014, the Brighton and Hove Local Safeguarding Children Board commissioned a Serious Case Review, to evaluate the multi-agency responses (in Brighton and Hove) to the needs of vulnerable adolescents at risk of exploitation through radicalisation.
The serious case review was published in July 2017. It identified 13 findings which have been grouped into four priority areas:

- Working with trauma
- Working with high risk adolescents
- Working with children vulnerable to radicalisation
- Working with minority ethnic groups

Brighton and Hove remains a priority area in accordance with the Home Office classification of risk. BSUH has a named Prevent Lead - Caroline Davies, Nurse Director and BSUH is represented at the Brighton and Hove Prevent Board by the Lead Nurse Safeguarding Adults.

4. Mental Capacity and DoLS

Deprivation of Liberty Safeguards (DOLS) activity 2017 - 2018

Between May 2014 and April 2015 BSUH submitted **90** DoLS applications

Between April 2015 and March 2016 BSUH submitted **241** DoLS applications

Between April 2016 and February 2017 BSUH submitted **339** DoLS applications

Between **April 2017 and March 2018** BSUH submitted **409** DoLS applications

As awareness and understanding of the Mental Capacity Act and DoLS has improved, BSUH has seen a year on year increase in applications to the local authority; this is a trend throughout England. In 2017/18 applications were most frequently made from the following specialities; ortho-geriatrics, dementia and neurosurgery.

Mental Capacity Act (MCA) and MCA Training Update:

The mandatory training compliance for the Mental Capacity Act is 78 %, whilst not yet reaching the 90% target; this is an increase of 8% from April 2017. 323 staff have booked onto upcoming open session for dates March – September 2018.

In the last year, in addition to mandatory training dates, bespoke sessions have been provided in key clinical areas that have potentially high 'activity' relating to MCA/DoLS.

A MCA v MHA flow-chart has been developed, jointly with SPFT and medico-legal services, following a complex emergency department case. This has been circulated to clinicians and available in the 'micro-guide'.

The Safeguarding team have supported clinical staff in complex cases. These have included a Maternity case involving a mother who was declining a C-Section, despite the evidence of foetal distress. The Safeguarding team supported the clinicians through the MCA process and also with the After Action Review

Deprivation of Liberty Safeguards (DoLS) update

The Department of Health MCA policy lead approached the Safeguarding team at BSUH to arrange a visit to examine the implementation of the MCA, particularly DoLS, in practice and to discuss the Law Commission's proposals for the potential 'new DoLS,' the Liberty Protection Safeguards. The feedback from this visit was extremely positive.

The Lead Nurse for Safeguarding Adults and the MCA/ MH Lead Educator maintain their Best Interest Assessor (BIA) status, using this framework to advise clinical staff, and have ensure they have attended BIA Legal Updates to ensure up to date knowledge. The latest 39 Essex Street Guidance, 'Deprivation of Liberty in a Hospital Setting' (Feb. 2018) has been incorporated into the statutory training.

The Safeguarding Team were asked to do a presentation on DoLS, at the Royal College of Nursing Branch study day in 2017.

5. Mental Health

The MCA/MHA education lead has provided training on the Health Care Certificate for BSUH Health Care Assistant's (HCAs) throughout the year, on the subject of 'Raising Awareness and Reducing Stigma.' Incorporated in this training is the use of 1-1 nurse observation. 205 HCAs have received this training April 2017 – March 2018.

MHA training, 'targeting' specific clinical areas has commenced to nursing and medical staff, and was included in the induction for new A&E FY1 and FY2 doctors

The Quarterly Mental Health Governance meeting, which was chaired by the MCA/MHA education lead, has been superseded by a new Mental Health Steering Group, which is chaired by the medical directors from both BSUH and SPFT, this will report to the Patient Experience and Engagement Group, in the new clinical governance structure.

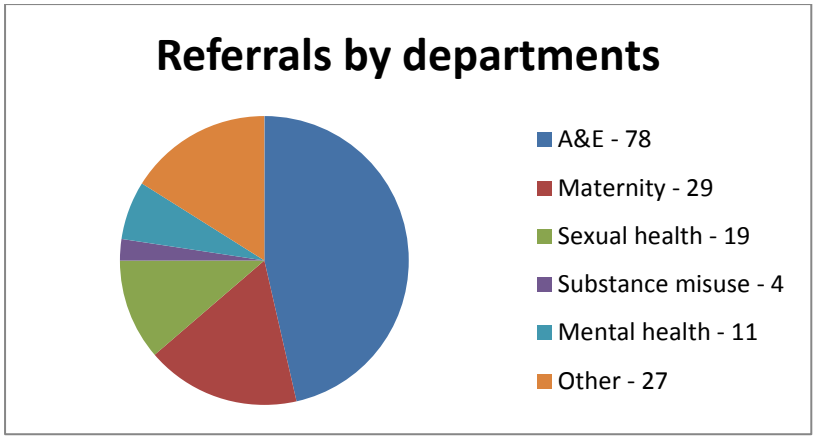
6. Domestic Violence and Abuse

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

Training
Numbers of staff trained:
Midwives' training – 267 (45min DVA session);

- Nursing and midwifery induction – 261 (45 min DVA session);
- Level 2 safeguarding training – 186 (1hr DVA session);
- Social workers based at the hospital – 11 (1hr DVA session);
- Junior doctors at A&E – 22 (1hr DVA session A&E specific);
- A&E nurses – 22 (1hr DVA session A&E specific);
- HCA – 28 (45 min DVA session).

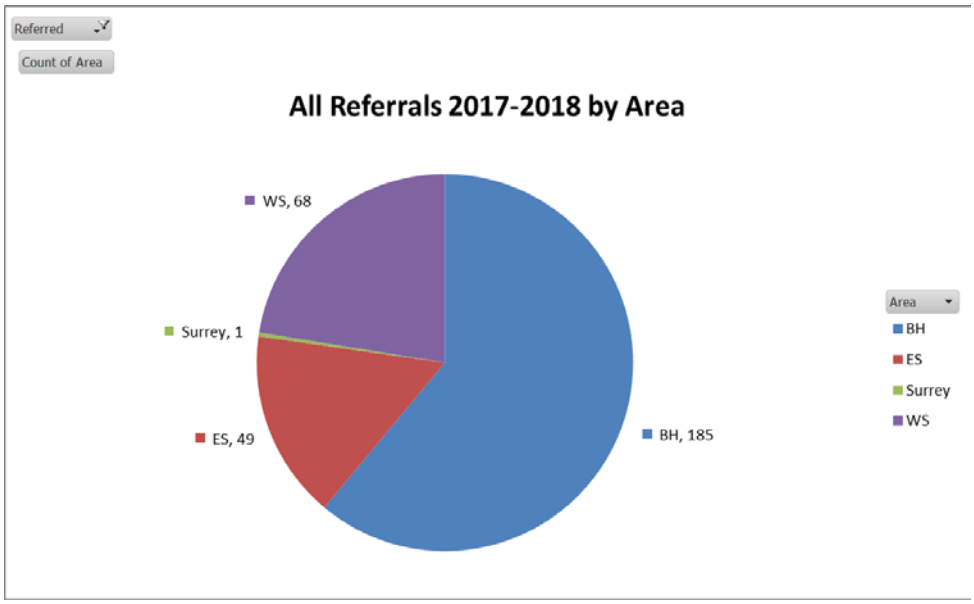
Referrals
Number of referrals: TOTAL to HIDVA service in April 2017 - March 18 – 168.
64% patients engaged with HIDVA service.
All those who have engaged received safety advice according to the risks/needs disclosed and those wishing further support were linked with the wider specialist service. In more complex cases HIDVA took an active part in developing a safe discharge plan and liaising with specialists in BSUH and community.

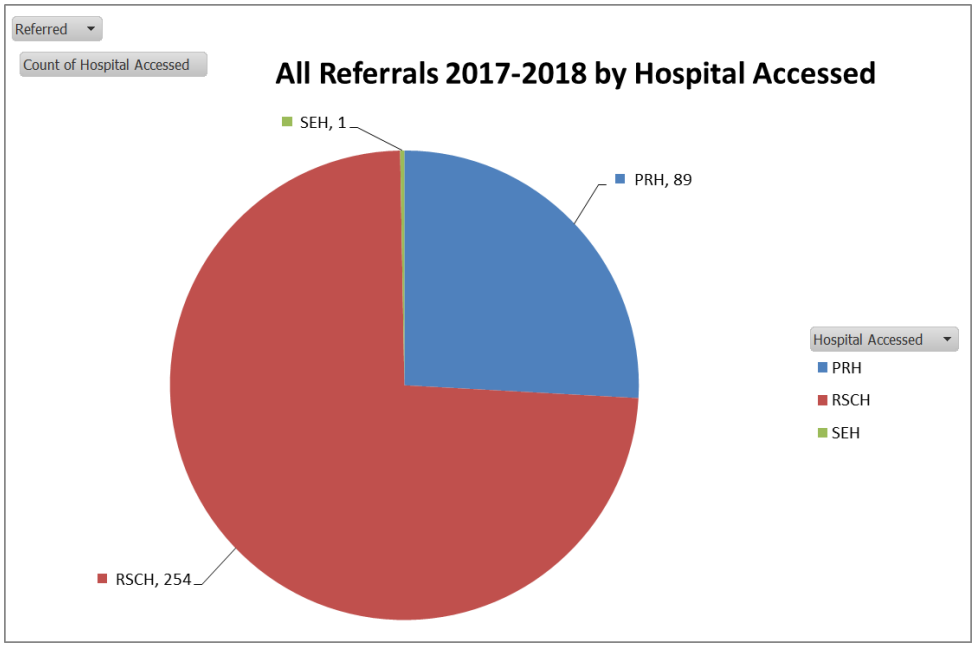


It has been noted that HIDVA (in comparison with the rest of RISE team) has been receiving more referrals for older victims – 17.5% were 51- 90 years old and 6% were 66 and over.

7. **Learning Disabilities**

Patient Activity





The activity is similar to previous years.

Learning Disabilities Mortality Review (LeDeR**)**
The mortality review for People with a Learning Disability (PWLD) was recommended by The Confidential Inquiry (CIPOLD) into the deaths of PWLD (CIPOLD 2010 - 2013) and following the premature deaths of people with mental health problems and learning disabilities in Southern Health (December 2015). The report into this Trust recommended that there is a national programme of mortality reviews for all PWLD.

LDLT have completed the Local Area Reviewer training for LeDeR in August 2017. LeDeR has been 'live' in the South East of England since September 2017. LDLT are responsible for notifying the LeDeR programme of deaths of PWLD who are inpatients at BSUH at the time of their death and they undertake structured judgement reviews with the Chief of Safety. Feedback from the findings of the LeDeR reviews is reported to BSUH Mortality Group.

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

- HCA Care certificate training programme
- Nurses and Midwifery Induction and the Level 2 Clinical Update.
- Band 4 training programme for our Nursing associates
- A bespoke session has been provided to Claude Nichol
- The LDLT are working to establish a ward/dept based Link Nurse System. Bi- monthly sessions to be coordinated form Mid 2018.

The service is now registered with Greenwich University as a Student Placement for Learning Disability Nursing Students.

Service Development.

LDLT have identified a client need in relation to nutrition and hydration following a number of incidents where there was a delay in feeding patients, as a result a multi-professional group has developed a pathway for patients with feeding tubes. This will eliminate this risk of a patient having a delay in receiving nutrition and may result in fewer PWLD being admitted to hospital, the results will be audited.

A sedation pathway for PWLD, who require sedation for minor procedures, such as, venepuncture or x-rays has been developed with the anaesthetists. This is being piloted in May 2018.

8. Priorities for 2018/19

- To fully implement the actions from the internal audit (March 2018), through the 18/19 Safeguarding workplan.
- To ensure full implementation of the learning and development strategy and increase the training attendance to the Trust target of 90%.
- To develop further work on the DATIX system to enable learning from themes and trends.
- To undertake the audit of Mental Capacity assessments and DoLS referrals and action findings of this audit.

Brighton and Sussex University Hospitals NHS Trust

To: Board of Directors

Date of Meeting: 30th May 2018 Agenda Item: **13**

Title
Healthy food for NHS staff, visitors and patients CQUIN - End of Year Report 2017/18
Responsible Executive Director
Nicola Ranger (Chief Nursing and Patient Safety Officer)
Prepared by
Della Morris - Safety & Quality Lead; Amy Bourne – Safety, Quality and CQUIN Project Manager
Status
Public
Summary of Proposal
The purpose of this paper is to brief the Trust Board of the progress made on all four sites, to achieve the CQUIN 2017-18 project - NHS staff health and wellbeing, Indicator 1b; Healthy food for NHS staff, visitors and patients
Implications for Quality of Care
The aim of our involvement in the project is to be a positive role model with regards to healthy eating, and support wider public health aims around reducing obesity levels and associated health problems.
Link to Strategic Objectives/Board Assurance Framework
True North objective for People - Staff Engagement (Top 20%)
Financial Implications
Commissioning for Quality and Innovation (CQUIN) projects have a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care. The value of Indicator 1b - Healthy Food CQUIN during 2017/18 is £283,716
Human Resource Implications
N/A
Recommendation
The Board is asked to NOTE the report and the commitments and achievements outlined within.
Communication and Consultation
Actions have been undertaken in collaboration with internal and external food and retail outlets at BSUH.
Appendices
None

Brighton and Sussex University Hospitals NHS Trust

Healthy food for NHS staff, visitors and patients CQUIN

End of Year Report 2017/18

Title
NHS Staff Health and Wellbeing – 1b Healthy Food CQUIN – End of Year Report 2017/18
Author
Della Morris – Safety and Quality Lead Amy Bourne – Safety, Quality and CQUIN Project Manager
Project Team
Amy Bourne – Safety, Quality and CQUIN Project Manager Christina Connolly – Head of Hotel Services Terry McGuigan – Retail Manager Della Morris – Safety and Quality Lead
Purpose
The purpose of this paper is to brief the Trust Board of the progress made on all four sites, to achieve the CQUIN 2017-18 NHS staff health and wellbeing, Indicator 1b; Healthy food for NHS staff, visitors and patients
Expected Benefits of Project
PHE's report "Sugar reduction – The evidence for action" published in October 2015 outlined the clear evidence behind focussing on improving the quality of food on offer across the country. Almost 25% of adults in England are obese, with significant numbers also being overweight. Treating obesity and its consequences alone currently costs the NHS £5.1bn every year. Sugar intakes of all population groups are above the recommendations, contributing between 12 to 15% of energy tending to be highest among the most disadvantaged who also experience a higher prevalence of tooth decay and obesity and its health consequences. Consumption of sugar and sugar sweetened drinks. It is important for the NHS to start leading the way on tackling some of these issues, starting with the food and drink that is provided & promoted in hospitals. The purposes and aims of involvement in the CQUIN project include: • The NHS being a positive role model with regards to healthy eating and reduction in sugar consumption • Supporting a wider PHE initiative aiming at reducing levels of obesity and associated health problems
CQUIN Requirements
Commissioning for Quality and Innovation (CQUIN) projects have a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care. Indicator 1b: Healthy food for NHS staff, visitors and patients is a specific set of changes which affect every food and drink outlet on NHS premises. This emphasises the responsibility of retailers and food service providers who operate within the NHS to focus on making healthier food and drink more widely available.

During 2017/18, providers were expected to build on the 2016/17 CQUIN by:

Firstly, maintaining the four changes that were required, and achieved in full, in the 2016/17 CQUIN:

1) The banning of price promotions on sugary drinks and foods high in fat, sugar or salt (HFSS).
2) The banning of advertisements on NHS premises of sugary drinks and HFSS foods
3) The banning of sugary drinks and HFSS foods from checkouts;
4) Ensuring that healthy options are available at any point including for those staff working night shifts.

Secondly, introducing three new changes to food and drink provision:

1) 70% of drinks lines stocked must be sugar free (less than 5 grams of sugar per 100ml).
2) 60% of confectionery and sweets do not exceed 250 kcal.
3) At least 60% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g

Achievements

Brighton and Sussex University Hospitals NHS Trust (BSUH) have demonstrated a strong commitment to improving the population's health through the promotion of healthier food choices. The hospital's role as a health promoter is embedded in the ethos of the food outlets operating on site, as we continue to provide balanced food options for all patients, visitors and staff.

<u>Internal Food Outlets</u>

Royal Sussex County Hospital (RSCH) -Terraces Restaurant, Waves, Subway Franchise,

Princess Royal Hospital (PRH) - Bluebells Restaurant

The Hotel Services Department has worked with all of the BSUH outlets to:

- Maintain the 2016/17 CQUIN requirements for price promotions, advertising, checkouts and healthy option availability
- Achieve in full the 17/18 CQUIN, ensuring that the number of CQUIN compliant drinks, confectionery and pre-packed sandwich lines adhere to the national percentages.

<u>External Retail Outlets</u>

Royal Sussex County Hospital (RSCH) – Compass (Costa café/Amigo shop), WH Smith, Royal Voluntary Services

Princess Royal Hospital (PRH) – Royal Voluntary Services, League of Friends

The CQUIN project team has also worked with our external retail outlets to ensure that they are aware of the CQUIN requirements and are taking action to achieve them.

External providers are required to evidence their engagement by providing the Trust with a signed document committing to keeping the changes. Signed documents and action plans have been received from Compass, WH Smith and Royal Voluntary Services.

In addition to achieving the CQUIN indicators, the following positive actions have also been undertaken:

- All retail items have been reviewed and a wider range of healthier alternatives introduced.
- The number of HFSS stock lines have been reduced (specifically chocolate and crisp ranges).
- Continued collaboration with our franchise outlet partners *Subway South Coast* to remove price promotions on any HFSS product.
- Main course meal deals have been developed and advertised to encourage healthy, balanced and informed choices.
- Regular walkabouts of internal and external outlets, to include taking photographs of display areas, to

ensure staff are aware of, taking steps towards, and complying with the CQUIN aim.

- Attendance at Brighton and Hove Food Partnership events, including 'Nudging Healthier Food Choices'
- Development of a Patient First project to improve food availability out of hours, for staff and public.
- Sourcing of a trial of a 24/7 hot food vending service across the Trust, containing balanced choices.

CQUIN 18/19

During 2018/19, the CQUIN requires that all outcomes previously described continue but a further shift in percentages is required:

- 80% of drinks lines stocked must be sugar free (less than 5 grams of sugar per 100ml).
- 80% of confectionery and sweets do not exceed 250 kcal.
- At least 75% of pre-packed sandwiches and other savoury pre-packed meals available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g.

BSUH remain committed to delivering continuous improvement and promoting healthier eating options for patients, relatives and staff.

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board

Date of Meeting: 30th May 2018 Agenda Item: **14**

Title
Notification of Sealed Documents
Responsible Executive Director
Marianne Griffiths, Chief Executive Officer
Prepared by
Chipo Kazoka, Interim Company Secretary
Status
Disclosable
Summary of Proposal
It is a requirement of the Trust Standing Orders (Section 8.3) that a register of sealing is maintained and use of the Common Seal is reported to the Trust Board at least annually. This report covers the period 1st February 2018 to 30th April 2018. Appendix 1 details use of the Common Seal during this period.
Implications for Quality of Care
None identified.
Link to Strategic Objectives/Board Assurance Framework
Links to good governance requirements, Trust Standing Orders state reporting requirement to Trust Board.
Financial Implications
None identified
Human Resource Implications
None identified.
Recommendation
The Board/Committee is asked to: NOTE use of the Trust seal.
Communication and Consultation
Not applicable.
Appendices
Appendix I: Register of Use of Common Seal 1st February – 30th April 2018

Appendix 1

BSUH – Use of Seal 1st February – 30th April 2018

Register reference	Dated	Document	Signed in the presence of (1)	Signed in the presence of (2)
268	26/02/2018	Deed to formalise use of Switch Room and Transformer within the Social Club Building at Princess Royal Hospital, Haywards Heath.	Karen Geoghegan	Pete Landstrom
269	25/04/2018	Lease of substation (GRP Kiosks) and casements at the Royal Sussex County Hospital.	Karen Geoghegan	Pete Landstrom
270	25/04/2018	Transfer of electricity substation, Eastern Road Brighton.	Karen Geoghegan	Pete Landstrom
271	25/04/2018	Deed of Settlement and Release. Decant works contract – Laing O'Rourke Construction Limited	Karen Geoghegan	Pete Landstrom
272	25/04/2018	Deed of Variation relating to Phase 4 contract - Laing O'Rourke Construction Limited.	Karen Geoghegan	Pete Landstrom
273	25/04/2018	Deed of Settlement and Release – Decant works contract – Laing O'Rourke Construction Limited.	Karen Geoghegan	Pete Landstrom
274	25/04/2018	Deed of Variation Phase 4 Contract – under Procure 21 Framework.	Karen Geoghegan	Pete Landstrom

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board

Date of Meeting: 30th May 2018 Agenda Item: **15**

Title
Provider Self Certification
Responsible Executive Director
Marianne Griffiths, Chief Executive Officer
Prepared by
Chipo Kazoka, interim Company Secretary
Status
Disclosable
Summary of Proposal
NHS Trusts are exempt from holding a provider licence but are required to comply with conditions equivalent to the licence that NHS improvement has deemed appropriate. NHS Trusts are therefore legally subject to the equivalent of certain licence conditions and in light of this are required to self-certify that they can meet the obligations set out in the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that they have complied with governance requirements. Consequently all provider NHS Trusts must self-certify the following after the Financial Year-End: • Condition G6 (3) - the provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution. • Condition FT4 (8) - the provider has complied with required governance arrangements. The Trust Board is asked to **Approve** the self-certification statements for 2017/18. **Appendix A: Self certification statements** **Appendix B: Self-certification: guidance for NHS Trusts** *(for information)* **Appendix C: Confirmation Statements (***for information)*
Implications for Quality of Care
None identified.
Link to Strategic Objectives/Board Assurance Framework
Good Corporate Governance Standards.
Financial Implications
No direct implications
Human Resource Implications
None identified.

Recommendation
The Board is asked to APPROVE that the self-certifications for 2017/18.
Communication and Consultation
Not applicable.
Appendices
Appendix A: Provider Self-Certification Condition G6(3) and FT4 (8) Appendix B: Self-Certification: guidance for NHS Trusts Appendix C: Confirmation Statements

Declaration Required by General Condition G6

The Board is required to respond 'Confirmed' or 'Not Confirmed'. Explanatory information should be provided where required.

1	Following a review for the purpose of the paragraph 2b of the licence, the Board of Brighton and Sussex University Hospitals are satisfied that in the financial year most recently ended, the provider has taken all necessary precautions to comply with the conditions of the licence, any requirements imposed on it under the NHS Act and have regard to the NHS Constitution.		Please Respond

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name		**Name**	
Capacity		**Capacity**	
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6 (3)

A	

FT4 Declaration

Corporate Governance Statement (Foundation Trusts and NHS Trusts)

Corporate Governance Statement	Response	Risks and Mitigating actions
1. The Board is satisfied that the Licensee 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.		*Please Respond*
2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time		*Please Respond*
3. The Board is satisfied that the Licensee has established and 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.		*Please Respond*
4.The Board is satisfied that the Licensee has established and 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		*Please Respond*
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 Licensee, 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 Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		*Please complete Risks and Mitigating actions*
6. The Board is satisfied that there are systems to ensure that the Licensee 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.		*Please Respond*

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name:		**Name:**	
Date:		**Date:**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

NHS Improvement

Self-certification: guidance for NHS trusts

March 2018

collaboration trust respect innovation courage compassion

Introduction

1. Last year was the first year that NHS trusts self-certified. Although NHS trusts are exempt from needing the provider licence, they are required to comply with conditions equivalent to the licence that NHS Improvement has deemed appropriate.

2. The Single Oversight Framework (SOF) bases its oversight on the NHS provider licence. NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions (including Conditions G6 and FT4) and must self-certify under these licence provisions.

3. NHS trusts are required to self-certify that they can meet the obligations set out in the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that they have complied with governance requirements. **The self-certification requirement set out in Condition CoS7(3) does not apply to NHS trusts.**

4. This note provides guidance on the annual self-certification that NHS trusts are required to conduct in accordance with the requirements of the provider licence. It does not provide guidance on self-certifications that may be required, for example, under the annual planning review (APR).

What is required?

5. Providers need to self-certify the following after the financial year end:

NHS provider licence conditions

- The provider has taken all precautions necessary to comply with the licence, NHS acts and NHS Constitution (Condition G6(3)).
- The provider has complied with required governance arrangements (Condition FT4(8)).

6. The aim of self-certification is for providers to carry out assurance that they are in compliance with the conditions.

7. It is up to providers how they do this. Any process should ensure that the provider's board understands clearly whether or not the provider can confirm compliance. We provide templates for boards to use in this process if they find them helpful.

8. This note explains what each provider licence condition means, as well as how to use the templates. Because it is up to each provider how it goes about self-certification, the guidance is necessarily high level and should be read alongside:

    a. the templates
    b. NHS provider licence (last updated February 2013)
    c. Single Oversight Framework (November 2017).

9. If you have any questions not addressed in this note or any of the additional documents referred to, please contact your regional lead.

Condition G6

10. Condition G6(2) requires NHS trusts to have processes and systems that:

    a. identify risks to compliance
    b. take reasonable mitigating actions to prevent those risks and a failure to comply from occurring.

    Providers must annually review whether these processes and systems are effective.

11. Providers must publish their G6 self-certification within one month following the deadline for sign-off (as set out in Condition G6(4)).

Using the template?

12. Providers should choose 'confirmed' or 'not confirmed' as appropriate for the declaration.

13. Providers choosing 'not confirmed' should explain why in the free text box provided.

Condition FT4

14. NHS trusts must self-certify under Condition FT4(8).

15. Providers should review whether their governance systems achieve the objectives set out in the licence condition.

16. There is no set approach to meeting these standards and objectives but we expect any compliant approach to involve effective board and committee structures, reporting lines and performance and risk management systems.

17. NHS trusts can find further information on governance by referring to:

    a. well-led framework for governance reviews (last updated September 2017)
    b. Single Oversight Framework (November 2017).

Using the template?

18. Providers must select ‘confirmed’ or ‘not confirmed’ for each declaration as appropriate and set out relevant risks and mitigating actions in each case.

19. Providers choosing ‘not confirmed’ for any declaration should explain why in the free text box provided.

Sign off

20. The board must sign off on self-certification.

Deadlines

21. Boards must sign off on self-certification no later than:

    a. Condition G6: 31 May 2018
    b. Condition FT4: 30 June 2018.

Audits

You are no longer required to return your completed provider licence self-certifications or templates to NHS Improvement. Instead, from July 2018 NHS Improvement will contact a select number of NHS trusts and foundation trusts to ask

for evidence that they have self-certified. This can either be through providing the completed templates if they have used them, or relevant board minutes and papers recording sign-off.

0300 123 2257 **enquiries@improvement.nhs.uk** **improvement.nhs.uk**

APPENDIX C: CONFIRMATION STATEMENTS

Corporate Governance Statement	Risks and mitigating actions
1. The Board is satisfied that the Licensee 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.	The Board is satisfied that it complies with the Corporate Governance Code. The Trust's corporate governance structure is designed to ensure appropriate oversight and scrutiny and to ensure good corporate governance practice is followed. Board meetings are held in Public every two months and there is the opportunity for members of the public to ask questions of the Board. The Board also meets in private every month (except in August and December) to discuss matters which are commercially sensitive and/or are of a confidential nature. Board meetings follow a formal agenda which includes Patient Safety and Experience and a range of Strategic and Operational items including; clinical governance, financial and non-financial performance, together with performance against quality indicators set by the Care Quality Commission (CQC), NHS Improvement and by the Executive. These include measures for infection control targets, patient access to treatment, waiting times, length of stay, complaints data and the results of the Friends and Family Test The Trust has also developed a new Board Assurance Framework (BAF), through which the Board is provided with a mechanism for satisfying itself that its responsibilities are being discharged effectively; and informs the Board where the delivery of principal objectives are at risk due to there being any gaps in control and/or assurance.
2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement (NHSI) from time to time	The Trust ensures that it adheres to the NHS Code of Governance and the Single Oversight Framework (issued by NHS Improvement).

	The Board takes account of the NHS Constitution in its decisions and actions, as they relate to patients, the public and staff. The Board of Directors is compliant with the principles, rights and pledges set out in the Constitution.
3. The Board is satisfied that the Licensee has established and 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.	The Board has robust committee structure which includes the following committees: Audit Committee, Finance and Investment Committee, Quality and Risk Committee, Appointment and Remuneration Committee and the Charitable Funds Committee. All committees are properly constituted with clear terms of reference. There is a clear scheme of matters reserved for the Board's own decision making and those that it delegates to its committees. Each committee has an executive lead providing the link to the committee and the organisational structure within their executive remit.
4.The Board is satisfied that the Licensee has established and 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	The Board of Directors develops the Trust's yearly objectives using the principles embedded within its Patient First Programme and has identified 'True North' objectives for the Trust. All objectives are quantifiable and measurable and performance is reviewed through an appropriate sub-committee such as the Audit Committee or Quality and Risk Committee as well as the Board. The Board also receives a monthly report from the Chief Financial Officer on financial performance. Financial performance is highlighted and reviewed at the Trust Executive Committee to ensure that all senior leaders have visibility on the position and the actions required. Financial performance is further scrutinised in detail at the Finance and Investment Committee. The Audit Committee has overall responsibility for

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.	scrutinising the Trust's compliance with its duty to operate efficiently, economically and effectively. The Trust's compliance with healthcare standards including those set by the CQC, the NHS Commissioning board is scrutinised by the Quality and Risk Committee. Reports and minutes of the Audit Committee, Quality and Risk Committee and Finance and Investment Committee meetings are regularly presented to the Board. The risks to the Trust's ability to continue operating as a going concern are reviewed via the Board Assurance Framework which is scrutinised by the Quality and Risk Committee, Finance and Investment Committee, the Audit Committee and the Board itself. The Board is supported by the Company Secretariat function which ensures the preparation and dissemination of all Board and committee papers. The Company Secretariat, in conjunction with the executive team, also prepares forward plans setting out the work to be undertaken by the Board and each committee in each year. The secretariat provides an advisory service to the Board and its committees on the legal and compliance issues.
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	All Executive Directors are appointed by the Board's Appointment and Remuneration Committee which is made up of the Board's Non-Executive Directors. The Committee is also responsible for reviewing the annual performance of the executive directors. All Board meetings have agenda items covering quality of care provided to patients which is routinely provided in comprehensive reports to the Board.

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 Licensee, 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 Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	The Board also receives the annual staff survey report which details the level of engagement with staff (among other things) and the Board develops action plans for following up the outcomes of the survey reports. The Trust is subject to regular review visits from CQC and reports from these visits generate action plans which are reviewed by the Board to ensure that the Trust continues to provide high quality care to patients. The Board's continuing focus on quality care is monitored through the Patient First Programme. This is the True North of the organisation – the one constant to which the Trust must always set out direction of travel in order to achieve its vision. The Patient First is a continuous process of improvement within existing processes and pathways that leads to measurable improvements for our patients and staff.
6. The Board is satisfied that there are systems to ensure that the Licensee 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.	The Board's non-executive directors are appointed by NHSI and its executive directors are appointed by the Board's Appointment and Remuneration Committee (as stated above).