University Hospitals Sussex
NHS Foundation Trust

Meeting of the Board of Directors

10.00 to 13:30 on Thursday 02 February 2023

Boardroom, 2nd Floor Washington Suite, Worthing Hospital, Lyndhurst Road, Worthing, BN11 2DH

AGENDA – MEETING IN PUBLIC

1.	10.00	**Welcome and Apologies for Absence** To note	Verbal	Alan McCarthy
		Confirmation of Quoracy To note *A meeting of the Board shall be quorate and shall not commence until it is quorate. Quoracy is defined as meaning that at least half of the Board must be present this being nine Board members. With a minimum of two Executives and two Non-Executive Directors.*	Verbal	Alan McCarthy
2.	10.00	**Declarations of Interests** To note	Verbal	All
3.	10.00	**Minutes of UHSussex Board Meeting held on 10 November 2022** To approve	Enclosure	Alan McCarthy
4.	10.05	**Matters Arising from the Minutes** NONE	Enclosure	Alan McCarthy
5.	10.05	**Report from Chief Executive** To receive and note overview of the Trust's activities	Enclosure	George Findlay
6.	10.20	**ICS** To receive and note ICS activities	Verbal	George Findlay
		INTEGRATED PERFORMANCE REPORT		
7.	10.25	**Patient** To receive and agree any necessary actions	Enclosure	Maggie Davies
8.	10.30	**Research and Innovation** To receive and agree any necessary actions	Enclosure	Rob Haigh
	10.35	*After this section the Chair of the Patient Committee will be invited to provide their report included at item 15* To receive assurance from Committee and recommendations from the Committee		
9.	10.45	**Quality** To receive and agree any necessary actions	Enclosure	Maggie Davies Rob Haigh

	10.55	*After this section the Chair of the Quality Committee will be invited to provide their reports included at item 15* To receive assurance from Committee and recommendations from the Committee		
10.	11.05	**People** To receive and agree any necessary actions	Enclosure	David Grantham
	11.10	*At this point the Chair of the People Committee will be invited to provide their report included at item 16* To receive assurance from Committee and recommendations from the Committee		
11.	11.20	**Sustainability** To receive and agree any necessary actions	Enclosure	Karen Geoghegan
	11.25	*After this section the Chair of the Sustainability Committee will be invited to provide their report included at item 17* To receive assurance from Committee and recommendations from the Committee		
12.	11.35	**Systems and Partnerships** To receive and agree any necessary actions	Enclosure	Andy Heeps
	11.40	*After this section the Chair of the Systems and Partnerships Committee will be invited to provide their report included at item 18* To receive assurance from Committee and recommendations from the Committee		
13.	11.50	**Systems Oversight Framework** To receive and agree any necessary actions	Enclosure	Darren Grayson
	11.55	***5 Minute Break***		
		ASSURANCE REPORTS FROM COMMITTEES		
14.	-	**Report from Patient Committee *including Research and Innovation*** To receive assurance from Committee and recommendations from the Committee - **from the meeting held on the 24 January 2023**	Enclosure	Jackie Cassell
15.	12.00	**Report from Quality Committee** To receive assurance from Committee and recommendations from the Committee - **from the meeting held on the 29 November, 20 December 2022, and 24 January 2023 including:** - **Mental Health Strategy** To approve	Enclosure	Lucy Bloem
16.	12.10	**Report from People Committee** To receive assurance from Committee and recommendations from the Committee	Enclosure	Patrick Boyle

		- **from the meeting held on the 25 January 2023 including:** - **Gender Pay Gap** To approve for publication on the Trust Website		
17.	-	**Report from Sustainability Committee** - **from the meeting held on the 26 January 2023** To receive assurance from Committee and recommendations from the Committee	Enclosure	Lizzie Peers
18.	12.20	**Report from Systems and Partnerships Committee** - **from the meeting held on the 26 January 2023 including:** - **Emergency Preparedness and Resilience and Response Assurance (EPRR) Annual Report** To receive assurance from Committee and recommendations from the Committee	Enclosure	Bindesh Shah
19.	12.25	**Report from Audit Committee** - **from the meeting held on the 17 January 2023** To receive assurance from Committee and recommendations from the Committee	Enclosure	David Curley
20.	12.35	**Report from Charitable Funds Committee** - **from the meeting held on the 10 January 2023** To receive assurance from Committee and recommendations from the Committee	Enclosure	Lizzie Peers
21.	12.45	**Board Assurance Framework and Corporate Risk Register highlight report** To approve	Enclosure	Darren Grayson Glen Palethorpe
		QUALITY		
22.	12.50	**CQC Update** To note	Enclosure	Maggie Davies Rob Haigh Darren Grayson
23.	13.10	**Clinical Negligence Scheme for Trusts (CNST) Year 4** To approve for submission	Enclosure	Maggie Davies
		WELL LED & COMPLIANCE		
24.	13.15	**Company Secretary Report** To note	Enclosure	Glen Palethorpe
		OTHER		
25.	13.20	**Any Other Business** To receive any notified business and action	Verbal	Alan McCarthy
26.	13.20	**Questions from the public** To receive and respond to questions submitted by the public at least 48 hours in advance of the meeting.	Verbal	Alan McCarthy

27.	13.30	**Date and time of next meeting:** The next meeting in public of the Board of Directors is scheduled to take place at 10.00 on Thursday 04 May 2023. **To resolve to move to into private session** *The Board now needs to move to a private session due to the confidential nature of the business to be transacted*	Verbal	Alan McCarthy

Minutes

University Hospitals Sussex
NHS Foundation Trust

Minutes of the Board of Directors meeting held in Public at 10.00am on Thursday 10 November 2022, held in the Boardroom, Second Floor, Washington Suite, Worthing Hospital, Lyndhurst Road, Worthing, BN11 2DH and virtually via Microsoft Teams Live Broadcast.

Present:

Alan McCarthy MBE DL	Chair
Dr George Findlay	Chief Executive
Patrick Boyle	Non-Executive Director
Jackie Cassell	Non-Executive Director
Claire Keatinge	Non-Executive Director
Lucy Bloem	Non-Executive Director
Professor Paul Layzell	Non-Executive Director
Lizzie Peers	Non-Executive Director *(Via MS Teams)*
David Curley	Non-Executive Director *(Via MS Teams)*
Bindesh Shah	Non-Executive Director *(Via MS Teams)*
Lillian Philip	Associate Non-Executive Director *(Via MS Teams joined during item 20 BAF & Corporate Risk Register)*
Dr Andy Heeps	Chief Operating Officer and Deputy CEO
Karen Geoghegan	Chief Financial Officer
Maggie Davies	Chief Nurse
David Grantham	Chief People Officer
Rob Haigh	Deputy Chief Medical Officer
Darren Grayson*	Chief Governance Officer

*Non-voting member of the Board

In Attendance:

Ben Stevens	Managing Director – Scheduled Care & Cancer Services (For items 22 & 23 only)
Glen Palethorpe	Company Secretary
Tanya Nicholls	Board and Committees Manager

TB/11/22/1 WELCOME AND APOLOGIES FOR ABSENCE **ACTION**

1.1 The Chairman welcomed all those present to the meeting.

1.2 There were apologies for absence received from Sadie Mason.

TB/11/22/2 DECLARATIONS OF INTERESTS

2.1 There were no other interests declared.

TB/11/22/3 MINUTES OF THE MEETING HELD ON 04 AUGUST 2022

3.1 The Board received the minutes of the meeting held on 04 August 2022.

3.2 The minutes of the meeting held on 04 August 2022 were **APPROVED** as a correct record.

TB/11/22/4 MATTERS ARISING FROM THE MINUTES OF THE PREVIOUS MEETING

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

TB/11/22/5 Chief Executive Report

5.1 George Findlay introduced the Chief Executive's Report and began by highlighting that currently the whole environment of the NHS was incredibly pressured, George added that it was important to talk to frontline staff and colleagues to really understand how they are approaching the current challenges noting how impressed he and the whole executive team was by the dedication, innovation and resilience of staff whilst visiting different teams.

5.2 The Board was advised that Winter preparedness had been at the top of the Trusts agenda over the recent months and that the Winter Plan would be shared with the Board later on the agenda, George highlighted that he had been attending a twice monthly senior leadership system meeting in respect of Winter in addition to a weekly Winter Board meeting to ensure that there is a whole system approach to Winter.

5.3 George noted that the Trust had refreshed its Patient First strategy leading up to winter and highlighted that the Trust had added a sixth strategic theme of Research and Innovation which would sit within the Patient domain whilst it becomes fully established.

5.4 The Board was advised that the Trust had now fully recruited the new Clinical Leaders across all 4 divisions across the whole of the Trust. George noted the real importance of the hospital site specific leadership along with Managing Directors for both Planned Care and Cancer Services, and Unscheduled and Emergency Care who will be supporting Andy Heeps as Chief Operating Officer.

5.5 George shared with the Board that the Trust had welcomed the CQC at the beginning of October when they carried out a Well-Led inspection and held a number of interviews with several members of the team. It was noted that it was an opportunity for the Trust to share not only what we are proud of but also what the challenges are. It was noted that the Trust had since received a letter from the CQC confirming the initial in-person feedback the Trust received. Whilst the Trust must wait for the final report to get the full picture, it is still helpful to be able to share their immediate reaction to what they saw and heard at UHSussex.

5.6 The Board was advised that the CQC had also made an unannounced inspection of the upper gastro-intestinal cancer surgery service at RSCH in August and afterwards instructed the service should be suspended, George explained that this affects around four to six oesophago-gastric resection surgery patients a month. It was noted that these patients were continuing their treatment at Royal Surrey County Hospital in Guildford in line with their pre-existing treatments dates. George assured the Board that the Trust was working with the CQC and the Surrey and Sussex Cancer Alliance to agree next steps for the service at RSCH.

5.7 George provided the Board with a number of highlights in respect Capital projects underway at the Trust including the new 3Ts building that is due to be handed over to the Trust during November, the new medical day case unit at Worthing which would be the new Chemotherapy unit and several other exciting new projects that are underway.

5.8 George finished by acknowledging how hard staff at UHSussex were working and extended a big thanks to everyone.

5.9 Alan McCarthy thanked George for his report and took the opportunity to extend the thanks of the Non-Executive Directors to the Executive team acknowledging how busy they were also.

5.10 Lucy Bloem commented that letter from the CQC provided good feedback including that with the Clinical Operating model settling in it meant that the Trust was on the right trajectory. Lucy did acknowledge that the CQC had noted staff concerns in respect of being able to speak up and asked if the Executive team felt this was Trust wide or a number of isolated areas. George advised that the CQC had assured the Trust that they share any themes with UHSussex, but these had not yet been received, George added that it was sad when staff say that they feel they are unable to raise concerns but assured the Board that many do.

5.11 The Board **NOTED** the Chief Executive Report.

TB/11/22/6 Integrated Performance Report

6.1 The Chair introduced the Integrated Performance Report (IPR) explaining that Patient First was the Trust's methodology encapsulating the Trust's vision, values and goals.

6.2 Alan explained that the Trust had aligned its governance to Patient First, that the Integrated Performance Report is aligned to the Trust Committees and that the Committee Chairs would be invited to provide their Chairs report after each section of the IPR.

TB/11/22/7 Quality

7.1 Rob Haigh updated the Board on the key messages from the Quality section of the report in respect of mortality.

7.2 Rob advised the Board that the UHSussex 12 month rolling mortality rate for emergency admissions was 3.83% and in month for July was 4.03%, it was noted that the rolling 12-month rate continues to increase. The UHSussex rolling 12-month HSMR was 100.05. This is within the expected range with an in-month value for July of 107.04 that also lies within the expected range.

7.3 Rob highlighted that the rolling 12-month HSMR, without adjusting for specialist palliative care, had risen into the 'very high (>99.8%)' category.
The UHSussex rolling 12-month SHMI was 112.69 which remains within the expected range however continues an increasing trend, nearing the limits of triggering an outlier status, Rob explained that this follows the national trend and is almost certainly a consequence of untreated disease.

7.4 The Board was reminded that the Trust had recently carried out an external audit of its coding, the externally commissioned audit found that coding 'exceeded standards' across all cohorts, excluding the non-deceased cohort at both RSCH and PRH where the coding achieved 'standards met'. It was noted that the recommendations from the audit included ensuring access to full medical records to support the coding staff, reviewing the current coding policies, and aligning these at a Trust level along with adopting a consistent approach to coding all documented comorbidities.

7.5 Maggie Davies reminded the Board that the second Quality True North for the Trust was zero harm occurring to patients in our care and highlighted that the Trust was moving towards a new standardised system for capturing this information which would further support staff with learning from harm.

7.6 Maggie took the opportunity to commend the teams for their huge amount of work in respect of their learning and incident management processes and added that the Trust would be focussing on the new breakthrough objective of investigation, review and closure of all no and low harm incidents within 20 working days which had already showed an 80% reduction in open incidents during September.

7.7 The Board was advised that the two primary areas of avoidable harm were falls and pressure ulcers, Maggie explained that there is a significant amount of work under way in both of these areas to standardise work in respect of falls ensuring that there is bay watch in place on all wards and in respect of reducing pressure ulcers, the offloading of patients from ambulances as quickly as possible.

7.8 In respect of Infection, Prevention and Control (IP&C) the Board was advised that the Trust had seen an increase in Covid infections. Maggie explained that whilst there had been a change in testing nationally the Trust implemented the screening of patients in all Emergency Departments. Positively Maggie advised that the Trust was not seeing patients being admitted with Covid and many patients have been 'well' with Covid. Visiting has been maintained as much as possible and mask wearing was re-introduced in all clinical areas.

7.9 In respect of safer staffing Maggie explained that the overall fill rate had improved, along with the care hours per patient daily has also improved and is now only just below the national average. The Trust had more registered nurses at the Trust following very successful international recruitment.

7.10 The Chairman invited the Chair of the Quality Committee, Lucy Bloem, to update the Board on their recent meeting and the assurances received in relation to Quality.

7.11 Lucy advised the Board that the Committee had received a revised quality dashboard and the completion of these metrics was making good progress, the Committee also received the maternity dashboards and in October the MBRRACE (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries) Perinatal Mortality Surveillance Report January – December 2020 was received showing the Trust's overall perinatal mortality rate was between 5-15% lower than the group average.

7.12 It was noted that the Committee had received an update on the progress against the CNST submission and has made really good progress however, there remains a risk that the Trust may still not achieve full compliance.

7.13 Lucy advised that the Committee received the Q2 Learning from Deaths report, and the Committee had also assessed the clinical harms and was assured over process governance. It was noted that the Committee had also spent a significant amount of time discussing the CQC reports, their outcomes and the actions taken.

7.14 Alan McCarthy invited David Grantham to provide the Board with an update in respect of the recent notification of industrial action.

7.15 David explained that a number of trade unions had invited a ballot of their members for strike and the first of those to confirm is the Royal College of Nurses. The Board was advised that locally 2.5k nurses are able to vote, of those 60% did vote and of that 60%, 95% of nurses voted for strike action. George Findlay explained that this was likely to have an impact on planned care however, there was a system led emergency preparedness, resilience,

and response plan which the Trust would be taking part in due to the significant risk industrial action will pose across the system.

7.16 George reminded the Board that the dispute is between the trade unions and the government, the Trust is not in dispute with our staff and would support staff dependent on their own decisions.

TB/11/22/8 People

8.1 David Grantham presented the People section of the integrated performance report and explained that the Trust's True North for Our People is to be the Top Acute Trust for Staff Engagement.

8.2 The Board was advised that the Trust saw a reduction in the staff engagement indices during September to 6.6. It was noted that there had been some issues during September with Junior Doctors pay which may have impacted on the engagement score. David explained that the National Staff Survey was currently underway across the Trust, with all staff having the opportunity to take part.

8.3 It was noted that the People breakthrough objective had been updated. David explained that following feedback from the CQC that some staff felt that their voice was not heard, the new objective for the Trust was 'Staff voice that counts'. It was highlighted that this question had been added to the monthly pulse survey, that the Trust had recruited a new Freedom to Speak Up Guardian and the project charter for the breakthrough objective had been received and agreed by the People Committee.

8.4 The Board was advised that the strategic initiative for the People domain had been refreshed also with three delivery key workstreams, focussing on long-term strategic and Organisational Development focused pieces of work, requiring delivery over more than 1 year. These key workstreams are Health and Wellbeing, Leadership and Equality Diversity and Inclusion.

8.5 David drew the Board's attention to the People scorecard noting that the Trust had just over 14k of staff in post with a current vacancy rate of 8.34%, David explained that the Winter plan would see some of the additional escalation beds established as part of the bed plan which would enable the substantive recruitment of staff to support this additional capacity.

8.6 The Chairman invited Patrick Boyle Chair of the People Committee, to update the Board on their recent meeting and the assurances received in relation to People.

8.7 Patrick advised the Board that the Committee had received the project charter for the new breakthrough objective noting that this was a key objective for the Trust. It was noted that the Committee received feedback from the 2022/23 GMC survey and was assured that all the important issues raised within the survey results were being addressed.

8.8 Patrick explained that the Trust had was working to put in place mechanisms to support its staff not only in respect of Health and Wellbeing at work but also with support in respect of the current cost of living crisis with advice and support.

8.9 Lizzie Peers asked what resource the Trust had in place in respect of Freedom to Speak Up (FTSU) in addition to the culture and mechanisms within the Trust to encourage staff to speak up. David advised that the Trust was working with

teams so that they are fully informed that FTSU isn't the only way to raise concerns and that it is also through leadership and cultural changes.

8.10 George Findlay commented that it was important to get the right balance around speaking up as many staff do speak up and raise concerns and that many staff do so with openness and transparency to their line managers or through meetings, but this is often not seen as overtly speaking up. George added that he often receives emails from staff raising concerns which is positive and is encouraged that people are able to speak up to ensure the Trust is dealing with the difficult issues.

TB/11/22/9 Patient

Jackie Cassell joined the meeting at this point.

9.1 Maggie Davies presented the Patient section of the Integrated Performance Report and explained to the Board that the True North metric for the Patient Committee was to be in the top 20% of NHS Trusts in the country for recommendation by patients responding to the Friends and Family Test (FFT).

9.2 The Board was advised that a significant number of UHSussex patients were satisfied, Maggie highlighted that biggest change had been within the Emergency Department where the Trust had seen a deterioration across all sites since the beginning of 2022, although it was noted that satisfaction was had increased steadily during July and September.

9.3 Maggie explained that there were several increasing themes around the length of waiting but noted that there was a programme of work underway to ensure that the Trust engages well and communicates with patients in respect of long waiting times. It was noted that a new survey provider for all sites had been procured which would see all services encouraged to increase survey uptake.

9.4 Finally, Maggie highlighted that the Trust also receives a high number of plaudits from our patients and their families every month and although they are discussed less the Trust is working hard to ensure that these are shared with the teams.

9.5 The Chairman invited Jackie Cassell, Chair of the Patient Committee, to update the Board on their recent meeting and the assurances received in relation to patients.

9.6 Jackie advised the Board that the Committee had a positive and productive meeting and had received the quarterly Patient Experience Report and feedback from the national inpatient survey. It was noted that the Trust response had been 38% compared to the national average of 39%, the Committee had discussed further areas of opportunity in respect completion.

9.7 It was noted that the Committee had discussed the continued Patient First Methodology planned improvements and was pleased to hear that divisional level strategy deployment reviews were once again underway. Jackie noted that the Committee had also received a received and endorsed the new project charter for the Patient Strategic Initiative. The Committee requested an update in respect of the Trust harnessing patient first methodology for the Trust approach to health inequalities.

TB/11/22/10 Sustainability

10.1 Karen Geoghegan presented the Sustainability section of the IPR advising the Board that the update centred around the Trust's True North objective to break-even.

10.2 The Board was advised that the financial target for the Trust for 2022/23 was to breakeven and that the financial plan is based on the relevant financial framework, tariff requirement and impact of local application of funding allocations. In addition to a breakeven financial target the Trust also has an efficiency requirement for 2022/23 is £47.7m (3.7% of turnover).

10.3 Karen explained that at the end of quarter 2 the reported year-to-date deficit is £14.9m, which was £8m above plan. The cash balance of £63.8m was £21.9m less than plan at the end of month 6, Karen highlighted that this was not a cash flow risk and is in part due to improving the Trust performance against the Better Payments Practice Code. It was noted that Capital expenditure was £1m above plan, Karen explained that within this, expenditure for 3T's was on track, with expenditure on digital schemes ahead of trajectory and the forecast outturn remains on plan. Year to date, efficiency performance remains on plan, tactical schemes linked to drug schemes and procurement continue to deliver ahead of expectation.

10.4 The Board was advised that the key drivers for the deficit balance were due to reliance on insourcing and outsourcing of activity with the independent sector which has a significant financial impact. Continued significant operational pressure in the Trust emergency departments is impacting on flow through the hospitals and capacity, Karen explained that the cost to support urgent care demand through bed escalation and additional resources in ED's is also impacting.

10.5 Karen advised the Board that mitigating actions had been identified for these risks with Executive level oversight and that detailed financial performance information had been shared with Sustainability Committee, who continue to provide oversight of the delivery of the financial plan on behalf of the Board.

10.6 Alan McCarthy invited the Chair of the Sustainability Committee, Lizzie Peers, to update the Board on their recent meeting and the assurances received in relation to Sustainability.

10.7 Lizzie advised the Board that the Committee had spent a significant amount of time on the financial plan with particular focus on the risks and the mitigations in place, it was noted that the Committee had endorsed the sustainability BAF risks but highlighted that it would revisit the BAF score at the next quarter as the financial position was a symptom of the continued operational pressures.

10.8 Lizzie highlighted that the Committee had received the project charter for the new Productivity breakthrough objective, which it is hoped will support the Trust with reducing its reliance on the independent sector. It was noted that the Trust continues to deliver well against the Capital Plan with a number of the key projects already referenced as part of the CEO update. Finally, Lizzie explained that the Committee had also received an update on payroll transfer and positive comment that the new PAS was due to go-live across Worthing and St Richard's hospitals in early December.

10.9 Paul Layzell asked if the Trust had any further increased financial exposure as a result of the Trust improvement with the Better Payments Practice, Karen explained that the target is to have 95% of invoices paid and the Trust is currently at 83%. Karen explained that it was the approval of the invoice not

the processing of the payment that was driving this lower than desired performance and that the Trust continued to have a healthy cash balance.

TB/11/22/11 Systems & Partnerships

11.1 Andy Heeps presented the Systems and Partnerships (S&P) section of the Integrated Performance Report and drew out the following key points.

11.2 **A&E**
Andy advised the Board that the Trust treated 62.6% of patients within 4 hours of attending all A&E departments July to September 2022, and 63.5% to September 2022. National performance was 71.0% September 2022 and 71.1% during Q2. There was renewed pressure on Trust emergency departments in particular, with increases in long length of stay patients which results in constrained flow within the hospitals, exacerbated by the Omicron Covid-19 wave's re-emergence seeing patients being isolated. It was noted that the Trust had agreed that whilst the constitutional target of patients being seen within 4 hours at A&E remains a high priority, the Trust was focussing on reducing ambulance handovers to under 60 minutes and reducing the number of patients in the emergency department for over 12 hours noting there had been positive improvements in both of these areas.

11.3 **RTT**
The Trust had 54.3% of patients waiting longer than the target 18 weeks at the end of September 2022. National performance was 60.8% during August 2022. The total number of patients waiting for elective treatment at the Trust was 118,754, 26 of which were waiting over 104 weeks, due to either patient availability for planned treatment, or through the specialist complexity of their treatment. Although non-elective operational pressures had increased the Trust had remained committed to eliminating long waits for patients on an RTT pathway.

11.4 **Cancer**
It was noted that 55.2% of patients who commenced cancer treatment were treated within 62 days in August. National performance was 61.9%. Andy explained that there had been an increase in over 62-day and 104-day waits in Q2, from 534 at the end of Q1 to 714 at the end of Q2 for over 62-day patients, and from 120 patients at the end of Q1 to 161 at the end of Q2 for over 104 week waits.

11.5 **Diagnostics**
The Trust had 29.6% of patients waiting more than 6 weeks at the end of September for a diagnostic test against a 1% target. This Board was advised that this was a deterioration of 4.6% relative to the end of the Q1 position of 25.0%. The National average for August 2022 was 30.5% (this is latest available national performance).

11.6 Andy advised the Board that the Trust had 301 patients medically ready for discharge (MRD) and noted that there was continued focus on system working with partners to reduce not only MRDs but also the number of long length of stay patients. It was noted that within Emergency Care, work had continued with Sussex ICS partners to focus on alternatives to A&E attendance, and the Trust has 'gone live' with additional UTC capacity which will enable increased clinical capacity in the departments to treat patients attending. The Trust is also conducting a pilot in Worthing A&E for booking patients into the UTC.

11.7 The Chairman invited Patrick Boyle, the Chair of the Systems and Partnerships (S&P) Committee, to update the Board on their recent meeting and the assurances received in relation to Systems and Partnerships.

11.8 Patrick advised the Board that the Committee had received updates from both Managing Directors for Unscheduled and Emergency Care, and Scheduled Care and Cancer noting the significant pressure that continue to impact the emergency departments and the Trusts ability progress with its elective recovery programme with the level of momentum it would like.

11.9 It was noted that the Committee had received an update in respect of the new 3Ts hospital build and the significant amount of work it had taken to get to this point and the level of work still required to mobilise the occupation of the hospital, Patrick highlighted how once open the new hospital will help to decompress the RSCH site and will provide additional beds which will support flow and elective work not to mention the morale boost for staff.

11.10 Bindesh Shah asked if the Trust was seeing an increase in the number of cancer diagnosis and if these were further progressed than pre-pandemic levels. Andy explained that anecdotally there was an increase in all cancers and noted that the Trust was working closely with the Surrey and Sussex Cancer alliance to monitor this.

11.11 Alan McCarthy asked if the Trust was continuing with its clinical prioritisation and clinical validation of waiting lists, Andy confirmed that this was the case.

TB/11/22/12 System Oversight Framework

12.1 Darren Grayson presented the Systems Oversight Framework (SOF) section of the Integrated Performance Report and began by reminding the Board that the Trust had received the oversight framework which allowed for the ICB to take a view on the performance of all Trusts.

12.2 Darren explained that the oversight process was now underway with the review meetings schedule agreed between NHSE region, the ICB and each individual Trust. It was noted that the Trust was now in a regular rhythm of mature and productive meetings with the ICB which focussed on the monitoring and management function. It was noted that the Trust's position within the SOF for Q2 was Segment 3, Darren explained that this enables the Trust to access improvement support and some senior operational support which would be provided to the emergency departments with the ambition continuing to be improving performance.

12.3 Alan McCarthy thanked Darren and acknowledged that although the Trust would prefer not to be in Segment 3 the benefit is that the Trust will get additional support which should allow the Trust to move back to Segment 2 speedily.

12.4 George Findlay explained that the additional support was at request of the Trust to be used where we have challenging improvements to implement, it was note that the Trust had provided a proposal to the ICB which had been agreed and it was hoped that it would enable UHSussex to revert to some of the positive ways of working pre-pandemic.

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

The Board paused for a ten-minute break, all those present returned and the Board therefore was quorate when it recommenced.

TB/11/22/13 Report from Patient Committee Chair from the meeting on 01 November 2022

13.1 The Board **NOTED** the Report from the Patient Committee Chair, highlights of which had been received as part of the Integrated Performance Report

TB/11/22/14 Report from Quality Committee Chair from the meeting on 30 August, 27 September and 01 November 2022

14.1 The Board received and **APPROVED** the 2021/2022 Annual Organ Donation Report, which had been recommended by the Quality Committee for publication on the Trust website.

14.2 The Board received and **APPROVED** the 2021/2022 Annual Children's Safeguarding Report which had been recommended by the Quality Committee for publication on the Trust website.

14.3 The Board received and **APPROVED** the 2021/2022 Annual Adults Safeguarding Report which had been recommended by the Quality Committee for publication on the Trust website.

14.4 The Board **NOTED** the Report from the Quality Committee Chair, highlights of which had been received as part of the Integrated Performance Report.

TB/11/22/15 Report from People Committee Chair from the meeting on 02 November 2022

15.1 The Board received and **APPROVED** the Health and Wellbeing Strategy for publication on the Trust website.

15.2 The Board **NOTED** the Report from the People Committee Chair, highlights of which had been received as part of the Integrated Performance Report.

TB/11/22/16 Report from Sustainability Committee Chair from the meeting on 03 November 2022

16.1 The Board **NOTED** the Report from the Sustainability Committee Chair, highlights of which had been received as part of the Integrated Performance Report.

TB/11/22/17 Report from Systems & Partnerships Committee Chair from the meeting on 03 November 2022

17.1 The Board **NOTED** the Report from the Systems & Partnerships Committee Chair, highlights of which had been received as part of the Integrated Performance Report.

TB/11/22/18 Report from Audit Committee Chair from the meeting on 18 October 2022

18.1 David Curley, Chair of the Audit Committee, presented the Chair's report from the meeting held on 18 October and drew out the following key points.

18.2 David explained to the Board that the overarching theme of the meeting was assurance from the Trusts Internal Auditors, BDO and the Local Counter Fraud Services. In addition, David noted that the Committee had looked at where it was possible to make report enhancements for the BAF, Risk Register and H&S Report to allow the Committee to understand the processes for the oversight of assurances and actions where risks increase in the quarter. It was noted that the Committee had discussed including more detail within the

Executive summary of the BAF, to draw out the main themes and endorsement from other Board Committees

18.3 In addition, David explained that the Committee had discussed including if changes to agreed dates for Internal Audit recommendation are made that these include endorsement and review by the lead Executive and conformation of that would be incorporated into the tracking report. The Board was advised that the Committee had welcomed the Finance Director's suggestions for enhancing the processes for oversight of the delivery of agreed management actions resulting from internal audit reviews.

18.4 The Board **NOTED** the Chairs Report from the Audit Committee

TB/11/22/19 Report from Charitable Funds Committee Chair from the meeting on 11 October 2022

19.1 Lizzie Peers, Chair of the Charitable Funds Committee, presented the Chairs report from the meeting held on 11 October and drew out the following key points.

19.2 Lizzie advised the Board that the Committee had a good discussion in respect of the current level of market volatility and agreed that it would revisit the level of risk appetite the Charity wishes to hold with the markets with a view to spending.

19.3 It was noted that the Committee had received a high level spend plan in conjunction with ways in which the Charity can support spending, Lizzie explained that the Committee had also discussed and identified the possibility of having additional meetings to support the spending plan and delivery of approving bids.

19.4 Lizzie advised that the Committee had approved bids for the provision of a mental health first aid for staff, utilising monies from NHS Charities together and the provision of a further OCT Scanner, recognising that the provision of this extra machine allows for less movement of patients between different areas of the Trust. It also brings additional capacity into the Trust which will bring benefit as patients will be able to access a scanner earlier in their care pathway.

19.5 The Board **NOTED** the Chairs Report from the Charitable Funds Committee.

TB/11/22/20 Board Assurance Framework and Corporate Risk Register highlight report

20.1 Glen Palethorpe explained that the BAF had been reviewed by each of the Committees and was being presented to the Board for approval, it was noted that there had been one risk increase during the quarter in respect of Payroll but that it was anticipated that this would reduce imminently.

20.2 Glen highlighted that the BAF would be kept under active review as the Trust goes into Q3 due to a number of emerging pressures. It was noted that the report included a statement in respect of the highest risks from the Trust's Corporate Risk Register for the Board's information.

20.3 Alan McCarthy commented that there was a high level of risk detailed within the BAF and that the Trust was carrying more risk than ever before but noted that this was likely to be a similar to the picture nationally. George Findlay commented that the BAF reflected the challenges the organisation was

currently experiencing and assured the Board that the BAF is actively discussed and scrutinised at all Board Committees.

20.4 The Board **APPROVED** the Board Assurance Framework and **NOTED** the Corporate Risk Report, recognising that the respective Committees had reviewed and were recommending these risk scores as being a fair reflection of the risks facing the Trust.

TB/11/22/21 CQC Update

21.1 Maggie Davies introduced the CQC Update and advised the Board, and the report provided an update as to the recent CQC activity at the Trust, which was summarised as.

- On Thursday 11th August 2022 the CQC undertook an unannounced CQC inspection of upper GI surgery at Royal Sussex County hospital
- On Tuesday 4th and Wednesday 5th October 2022, the CQC undertook an announced well led inspection of UH Sussex. This included formal interviews, drop-in session for staff and some visits to clinical areas.
- On Wednesday 5th October 2022 there was an unannounced CQC inspection of neurosurgery at Royal Sussex County hospital

21.2 The Board was advised that following the inspection, the Trust received the Upper GI report which is being taken through the factual accuracy process prior to returning by 03 November 2022.

21.3 To support the embedding and sustainability of CQC required improvements, 'must dos' and 'should dos', trackers for each Division have been developed and reviewed (Surgery RSCH, ED RSCH & Maternity Services across all 4 sites). Maggie noted that there was an ICB & NHSE meeting being arranged to review Trust actions utilising these developed action trackers

21.4 The Board was advised that the Trust was awaiting both the neurosurgery report and well led report from the most recent inspections.

21.5 The Board **NOTED** the CQC Update Report.

TB/11/22/22 Winter Plan

22.1 Andy Heeps introduced the UHSussex Winter Plan and began by advising the Board that the Systems & Partnerships Committee had been presented with a detailed pack on the winter plan at its meeting the previous week.

22.2 Andy advised the Board that when discussing the Winter Plan for the year it had primarily been through the context of what winter would be like with the recognition of it being likely to be a very difficult winter.

22.3 Andy explained that the Trust had created an overarching plan to ensure that there is sufficient capacity to manage demand and maintain patient safety and patient flow throughout the winter period. The key principles supporting the winter capacity plan, which will be measured and reported on through the winter period, were as follows:

- 2019/20 activity phasing (adjusted for March as this was impacted by Covid)
- 2022/23 activity actuals to June forecast forward
- 2% activity growth assumption (in line with regional modelling)
- having a 95% bed occupancy
- determining an average 8am A&E admissions awaiting beds

22.4 The Board was advised that the Trust had produced its winter plan for 2022/23 across 4 categories with the following key objectives:
- Safely avoid admissions
- Safely increase capacity
- Safely reduce length of stay
- Maintain operational grip and control

22.5 Andy explained that there was no additional winter funding for the year so costs will be agreed and factored into the financial recovery plan. Management of cost control will be through the oversight Chief Finance Officer, Chief Operating Officer, and Managing Directors. The winter plan costs suggest a range of additional expenditure to a current run rate of:
- Best case £1.2m
- Mid-case £1.9m
- Worst case £3.4m.

22.6 It was noted that there were several other priority workstreams with a particular focus on support for Mental Health patients as it is increasingly becoming the case that a small number of patients account for a disproportionate number of bed days. The Board was advised that there was work underway and that the Trust would be hosting the senior ICB team in the coming weeks to allow them to experience first-hand the operational pressures the Trust is experiencing.

22.7 The Board discussed the benefit of adopting any successful new system wide working practices long term and making them business as usual, to benefit patients and support quality care in the future.

22.8 The Board **NOTED** the Winter Plan.

TB/11/22/23 Elective Recovery Self-Certification

23.1 Ben Stevens presented the Elective Recovery Self-Certification report and highlighted the following key areas.

23.2 The Board was advised that in the context of UHSussex the Trust is classified as a Tier 2 Trust for elective activity based on the current position of our waiting list, Ben explained that Tier 1 Trusts are the ones that are deemed to require the least input to deliver the 78-week waiting target.

23.3 It was noted that following self-assessment the Trust was compliant against 10 of the 12 actions, thus meaning further action was required in respect of elements D and H of the assessment criteria. Ben explained that as a result of this the Trust was unable to complete the self-certification by the 11 November and therefore there was the requirement to discuss mitigation and actions with the regional team.

23.4 Ben advised the Board that proposed actions would deliver the requirements of the final two elements in December and therefore enable completion of the self-certification, it was noted that risk assessments that related to the deliverability of the Trust's 78-week plan in the event of further waves of Covid or any potential industrial action were required and would be presented to the Systems & Partnerships Committee on 01 December ahead of Board sign off.

23.5 Patrick Boyle asked if there would be any sanctions for the Trust should it not be fully compliant. Ben advised that this would be discussed at regional level as to what and if anything would be put in place.

23.6 George Findlay commented that the context was important as the Trust believed it was adhering to all elements of the self-assessment, George

highlighted that the Trust was a Tier 2 organisation was due to the size of the waiting list. It was noted that had the assessment been in place prior to the merger neither BSUH nor WSHFT would have been classed as Tier 2 Trusts.

23.7 The Board **NOTED** the current position of the Elective Recover Self-Assessment and **AGREED** that further update would be presented to the Systems & Partnerships Committee in December.

TB/11/22/24 Strategic Priorities Refresh

24.1 Darren Grayson introduced the Strategic Priorities Refresh presentation and highlighted the following salient points.

24.2 The Board was advised that a suite of measures and projects are refreshed annually as part of the Trust's planning cycle; however over recent years this has been severely disrupted by the COVID-19 Pandemic - 2022/23 is therefore the Trust had taken the opportunity to refresh its strategic True North and Breakthrough Objectives, whilst also incorporating an additional Research and Innovation domain. Darren noted that the Trust was working through the metrics for the new domain and would need to develop its research strategy.

24.3 Darren explained that the Corporate Projects had been significantly revised, however two remain from the previous year, these being the PAS Implementation which is within the Sustainability domain and Electronic Workforce Deployment, which is overseen within the People domain. It was noted that the Trust had developed project charters which had been shared with the relevant Committees for its Corporate Projects.

24.5 The Board was advised that the new metrics and projects would be introduced at the November SDR meetings with the operational Divisions, having gone through the Catch-ball review process in September and October. An assessment of the key risks associated with the new True North, Breakthrough Objectives and Corporate Projects will need to be considered by the Committees, to ensure that this is fed through to the Trust's Board Assurance Framework

24.6 Patrick Boyle commented that the refresh had been shared with the Committees and it was bringing rejuvenated focus.

24.7 Lizzie Peers commented that the new corporate project for Surgery at Sustainability would allow full oversight and granular focus which would enable for even further support as is required.

24.8 The Board **NOTED** the Strategic Priorities Refresh.

TB/11/22/25 Company Secretary Report

25.1 Glen Palethorpe introduced the Company Secretary Report and drew out the following highlights.

25.2 The Board was advised that the Trust is required to receive reports on learning from deaths. The Board was reminded that the detail of these reports had been scrutinised by the Quality Committee. It was noted that the quarter 2 report had been adjusted in line with the comments made at the Quality Committee meeting on the 1 November 2022, specifically to include detail as to the factors contributing to the different assessments of the quality of care between sites including the numbers of reviewers and the changes to the mortality review panel so that Structed Judgement Review's from all sites are now considered.

25.3 Glen explained that the reports each highlight the Trust's processes for learning from the review of deaths and to utilise this learning to improve the Trust's processes. The outcome of this learning manifests itself within the Trust's mortality indices; these are tracked within the routine report to the Board as part of the Integrated Performance Report.

25.4 The Board was advised that the Trust had commenced the construction of its Board and Council of Governors meeting schedule for 2023/24. The Trust intends to maintain its meeting rhythm of quarterly meetings that will be open to the public to observe either in person at Trust HQ in Worthing or through MS Teams. The dates of these meetings were included within the report and published on the Trust website in due course.

25.5 It was noted that the Governors had approved the extension to the Term of Office for Lizzie Peers to 10 May 2024. This allows the Trust to retain Lizzie's experience and to provide enhanced continuity within the Board as the new non-Executives develop into their roles.

25.6 Finally, Glen was pleased to share with the Board that the Trust had a new lead governor. Lindy Tomsett who replaces Frank Sims as lead governor from 20 October 2022, noting that Frank remains the public governor for Brighton and Hove.

25.7 Alan McCarthy took the opportunity to thank Lindy and welcome her as new Lead Governor.

25.8 The Board **NOTED** the Company Secretary Report for Quarter 2.

TB/11/22/26 OTHER BUSINESS

26.1 There was no other business to discuss.

TB/11/22/27 Questions from Members of the Public

27.1 The Board received two questions from the public the first which was in relation to the recently suspended surgery within specialist upper GI at RSCH and was confirmed as answered by the member of public who was in attendance.

27.2 The second question was in relation to government monies in respect of supporting delayed transfers of care and whether the funding would be provided to Local Authorities or Integrated Care Boards. Andy Heeps explained that the Trust was not in a position to be able to clarify whom would be in receipt of the funding Local Authorities or the ICB, Andy added that the system had not received confirmation that there would be any additional funding. However, should the Trust be in receipt of any additional funding then there were many initiatives being considered which would support with medically ready for discharge patients, previously known as delayed transfers of care.

TB/11/22/28 Resolution into Board Committee

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

TB/11/22/29 The Chair formally closed the meeting

TB/11/22/30 DATE OF NEXT MEETING

30.1 It was noted that the next meeting of the Board of Directors was scheduled to take place at **10.00** on **Thursday 02 February 2023**.

Tanya Humphrys
Board & Committees Manager
10 November 2022

Signed as a correct record of the meeting

…….. Chair

..…… Date

NHS
University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	5	**Meeting:**	Trust Board	**Meeting Date:**	02 February 2023
Report Title:	Chief Executive's Report				
Sponsoring Executive Director:		Dr George Findlay, Chief Executive			
Author(s):		Dr George Findlay, Chief Executive			
Report previously considered by and date:					

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

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

Implications for Trust Strategic Themes and any link to BAF risks		
Patient	✓	
Sustainability	✓	
People	✓	
Quality	✓	
Systems and Partnerships	✓	

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

Communication and Consultation:

n/a

Executive Summary:

This report gives the Trust Board a summary of highlights from the Chief Executive and the work of UHSussex over the last quarter.

Key Recommendation(s):

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

University Hospitals Sussex
NHS Foundation Trust

To: Trust Board **Date: February 2023**

From: Chief Executive – Dr George Findlay **Agenda Item: 5**

CHIEF EXECUTIVE BOARD REPORT

1. THANK YOU

1.1 The past few months have been extremely challenging, and I wish to express my immense gratitude to all our staff who have done a phenomenal job in very difficult circumstances. It was widely predicted that this winter would be one of the toughest ever for the NHS and the early onset of seasonal pressures, high incidence of flu, Covid and Strep A infections, compounded by spates of industrial action, has ensured the last quarter exceeded these expectations.

1.2 For the first time, our Trust and all our NHS Sussex partners jointly declared a Critical Incident to help us mobilise the additional resources needed to maintain delivery of emergency services for those in most need of our care. Starting on 30 December, the Critical Incident lasted for a week before being stepped down to a system-wide Business Continuity Incident that has continued throughout the month of January.

1.3 To address the significant challenges we faced, countless colleagues worked additional shifts, longer hours, and provided support outside their normal roles. Unfortunately, some staff also had their leave cancelled at short notice to help ensure we could care for everyone in our hospitals. We owe a huge debt gratitude to all our staff for their stalwart commitment to our patients and the continued resilience they demonstrate in the face of such adversity.

1.4 I also want all our Sussex Health and Care System partners for their support, as well as our patients and their families for their patience and understanding during this difficult time. Sadly, during the Critical Incident and at other times of high demand it has been necessary to postpone some appointments and procedures to redirect staff and prioritise life-preserving care. Such decisions are never taken lightly, and I want to apologise to everyone affected in this way.

1.5 On behalf of all the communities our hospitals serve, I wish to take this opportunity to publicly acknowledge the outstanding work of my colleagues at University Hospitals Sussex (UHSussex) and say a heartfelt thank you to them all. These are testing times for the NHS and our staff are working relentlessly to provide safe, quality care and maintain delivery of our hospital services in exceptional circumstances.

2. INDUSTRIAL ACTION

2.1 Industrial action agreed by various unions has created additional challenges this winter too. While we were not impacted by the first strike days called by the Royal College of Nursing (RCN) before Christmas, two consecutive days in January did affect us and all our neighbouring hospitals in Sussex. A day of action involving ambulance service staff before Christmas also had an adverse impact on services. Further healthcare industrial action is scheduled in the near future, and we are also indirectly affected by train strikes and teacher strikes which affect staff availability and the ability of patients to access services.

2.2 Approximately 450 members of our nursing staff took part in the two days of industrial action organised by the RCN on 18 and 19 January. For these colleagues, we know this was an incredibly difficult decision for them to take. Industrial action is a last resort for health service workers and these strikes reflect the state of relations between the government and the unions representing NHS staff. Pay and conditions are part of this dispute, but it's also clear that those taking action want better for their patients, as well as for their colleagues and themselves.

2.3 The purpose of industrial action is of course to disrupt the normal running of the services it targets. It is not to put people's lives at risk and our teams worked very closely with the RCN, staff union representatives and clinical colleagues to make sure we were able to provide safe care to everyone who needed it during the strikes. To enable us to achieve this, some planned appointments had to be rescheduled and we are sorry for the impact this has for some patients and their families.

2.4 Industrial action is an emotive issue for all involved but I have been hugely impressed by the kind, professional and respectful way in which everyone has approached it. In particular, I want to single out our nursing leaders for handling a difficult situation with great skill, compassion and professionalism. Planning is now underway for the next wave of planned industrial action which includes RCN on 6 and 7 February, GMB (including ambulance service staff) on 6 and 20 February, and Chartered Society of Physiotherapists on 9 February.

3. LONG SERVICE AWARDS

3.1 One of the hardest aspects of the pandemic was that it forced us apart when we needed to come together most of all. And so, it was excellent to host once again our Long Service Awards for staff, bringing colleagues together face to face, away from the hospital, to thank them for their outstanding commitments and contributions at work over their many years of service.

3.2 Sadly, these events have had to be postponed due to COVID, but in January they recommenced with a wonderful occasion at Fontwell Racecourse, where 95 colleagues were recognised for their long service over 20 years, 30 years, 40 years and 40+ years. Their combined number of years of service totalled an incredible 2,256 years! Several further events are planned in the months to come for long service colleagues working for our Trust.

4. STAR OF THE MONTH

4.1 All our staff are stars, but each month a broad range of individuals and teams are nominated for special recognition after going above and beyond for patients and their families, or their colleagues. As part of the Start of the Month judging panel, one of the highlights of my role is to read the many wonderful and deserving nominations our staff receive. Here, I wish to publicly congratulate all our recent winners:

4.2 Worthing pharmacy technician **Abi Downham** won Star of the Month for personally delivering vital medications to patients at home when there was a disruption to the usual delivery process. Abi, who only recently qualified, was nominated by lead clinical trials pharmacist Jamie Richardson who commended her 'diligence, initiative and responsibility'.

4.3 Our **St Richard's Laundry Team** was nominated by non-executive directors Lizzie Peers and Patrick Boyle for their hard work before, during and after the recent £7 million refurbishment of the laundry department and service. In a surprise presentation, laundry and transport manager

Richard Knowles paid tribute to the team's professionalism and how they adapted to changing work environments, temporary redeployments and new equipment.

4.4 Characterised as the 'heartbeat of the hospital', the **Portering Team at Worthing Hospital** was by nominated patient experience and patient safety colleagues for the important role they played supporting the Emergency Department during and after the ambulance strikes when they created and supplied additional space where patients could be cared for. Their nomination credited their 'willingness, solution-focus and understated excellence' as well as the way in which their work 'makes a huge difference to patient dignity, experience and care'.

4.5 Star of the Month winners receive a £100 gift voucher, two runners up each receive a £25 gift voucher, and everyone nominated receives some recognition. The monthly scheme is currently paused ahead of the launch of our annual staff recognition Patient First Star Awards.

5. STROKE IMPROVEMENT PROGRAMME

5.1 For the past two years, we have been working with NHS Sussex and partner organisation on a comprehensive review of stroke services in the coastal area of West Sussex, which covers the population of Adur, Arun, Chichester, Worthing and south of Horsham. The review has been led by clinicians from our stroke services, general practice and the ambulance service and has helped to identify improvements we need to make to provide the best care to the people who live, work and visit our communities. The improvements are needed to also ensure we are meeting national guidelines for the treatment of stroke.

5.2 As a result, we have developed a proposal to create an Acute Stroke Centre (ASC) for the coastal area of West Sussex and locate it at St Richard's Hospital in Chichester. We are currently carrying out a public consultation to involve and seek the views of people living locally on our preferred option and proposed service change. We are confident our proposal would bring many benefits, including improved access to specialist stroke services 24 hours a day, seven days a week; a reduction in disabilities and death caused by strokes; and shorter hospital stays for people who have a stroke.

5.3 To make the changes, and realise these benefits, it would mean Worthing Hospital would no longer receive people who are experiencing a stroke. This would lead to an increase in the number of people with a stroke going to the proposed Acute Stroke Centre at St Richard's Hospital in Chichester and the Comprehensive Stroke Centre at Royal Sussex County Hospital in Brighton. Working together, the two stroke centres would ensure everyone in the coastal area of West Sussex would live well within a 60-minute ambulance journey to a stroke centre staffed by the right specialists, 24 hours a day, seven days a week.

5.4 The public consultation is running for 12 weeks, and we are encouraging our Trust members, patients and families, staff and stakeholders, and anyone living locally to share their feedback with us via the consultation questionnaire. Further information is available on the NHS Sussex website at www.sussex.ics.nhs.uk.

6. PRAISE FOR MATERNITY CARE

6.1 Our maternity teams have been praised by new mums in the CQC's Maternity 2022 survey, with results ranking us as the ninth best-performing hospital trust in the country. The annual

survey asks women and people from across the country about all aspects of their maternity care, including ante-natal, labour and birth, to post-natal. The results showed we performed better than most of the 121 participating Trusts in a number of questions, while in no area was the Trust rated below average.

6.2 In particular, the feedback from our service-users shows they felt listened to, treated with dignity and respect, and any concerns they had were taken seriously and acted upon. Nearly 330 women and people at University Hospitals Sussex participated in the annual survey in February 2021. The full results were published on 11 January and are available on the CQC and NHS Surveys websites.

7. PATIENT FIRST, PLANET FIRST

7.1 The Royal Sussex County Hospital is one of the first Accident & Emergency (A&E) departments in the country to trial using reusable suture instruments to improve the service's environmental impact. The pilot started on 20 January and removes the use of single-use suture kits which are designed for stitching wounds. These kits include scissors, needle holds, toothed forceps and untoothed forceps, and once used, are put into a sharps bin and incinerated.

7.2 It is estimated that switching to reusable suture instruments will save at least 2,240 kits from the incinerator every year and will save one kilo of carbon per use. The high-quality reusable instruments are sterilised on site and stored in special boxes to protect their 15-year life span. The trial is expected to last around four months and the team are looking forward to talking to patients about the switch.

7.3 These measures support our Trust-wide target to reduce our carbon footprint by 57% by 2025, as outlined in our Patient First, Planet First Green Plan that was published in January 2022. This plan was developed in response to the climate crisis and sets out our long-term commitment to become Net Zero by 2040 (based on emissions we control). We have also committed to reduce our carbon footprint plus (carbon emissions we influence) to Net Zero by 2045.

7.4 Since we launched the plan, we have made great inroads to achieving our goals through the efforts of our ten workstreams - including clinical, buildings and utilities, travel and transport and reduce, re-use and recycle. In February, we are showcasing many of the improvements introduced by our workstreams during our second UHSussex Environment Week.

8. LOUISA MARTINDALE BUILDING

8.1 In November, we were proud to announce that our new building at the Royal Sussex County Hospital is named after a pioneer in medicine and medical education for women, Dr Louisa Martindale CBE, who was a general practitioner and surgeon in Brighton and London, before becoming a world-renowned gynaecologist. The announcement marked a significant milestone in the project, as the new building was handed over from the contractor to the Trust.

8.2 More than one hundred thousand patients a year will be treated in the Louisa Martindale Building and, as the new main entrance for the hospital, we estimate more than one million people will pass through the Welcome Space each year. The eleven-storey building is currently

being equipped with more than 14,000 pieces of equipment and staff are being trained and familiarised with their work environments.

8.3 When LMB first admits patients this Spring, it will take people from the Barry Building - the oldest NHS building still in use in the country - to the newest. Stage 2 of the 3Ts development will see the Barry Building demolished to make way for a brand-new Cancer Centre for Sussex. Meanwhile, bringing LMB into operation will provide wider benefits as well. For example, it allows us to look again at our Emergency Department at RSCH where there is the potential to expand and improve the department, making use of space vacated by services moving into the new building. We are currently exploring the options and the practicalities of change in such a busy department.

9. INTERESTED TO FIND OUT MORE?

9.1 The news section of our website provides more detail and great images related to some of the events and achievements I have referenced above. Please visit www.uhsussex.nhs.uk/news. We are also very active on social media. Please join the conversation, comment, like and share by searching for @UHSussex on your favourite platform or use the hashtag #UHSussex. We also invite people living locally to join UHSussex as a member, volunteer in our hospitals or develop their career with us. With seven hospitals across Sussex and numerous satellite services, we are proud to be at the heart of the communities we serve. We wish to welcome others to our UHSussex family too. Visit www.uhsussex.nhs.uk/join-us - thank you.

10. RECOMMENDATIONS

10.1 The Board is asked to **NOTE** the Chief Executive Report for February 2023.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	7-13	**Meeting:**	Trust Board	**Meeting Date:**	02 February 2023
Report Title:	**Integrated Performance Report – Quarter 3 2022/23**				
Sponsoring Executive Director:	George Findlay, Rob Haigh, Maggie Davies, Andy Heeps, Karen Geoghegan, David Grantham and Darren Grayson				
Author(s):	George Findlay, Rob Haigh, Maggie Davies, Andy Heeps, Karen Geoghegan, David Grantham and Darren Grayson				
Report previously considered by and date:					

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

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

Implications for Trust Strategic Themes and any link to BAF risks		
Patient	✓	
Sustainability	✓	
People	✓	
Quality	✓	
Systems and Partnerships	✓	
Research and Innovation	✓	

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

Communication and Consultation:

Executive Summary:

Attached is the Trust's integrated performance report for quarter 3 of 2022/23

Within the Board's governance processes each patient first domain has an oversight committee and after each segment of the integrated performance report the respective Committee Chair will be asked to provide their feedback. (Note these reports are contained within the Board papers immediately after this report).

Key Recommendation(s):

To note the content and following receipt of the Committee assurance reports, consider if there are areas for referral back to the respective Committees where enhanced assurance is required.

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Integrated Performance Report

February 2023

Contents

University Hospitals Sussex
NHS Foundation Trust

Structure of the report

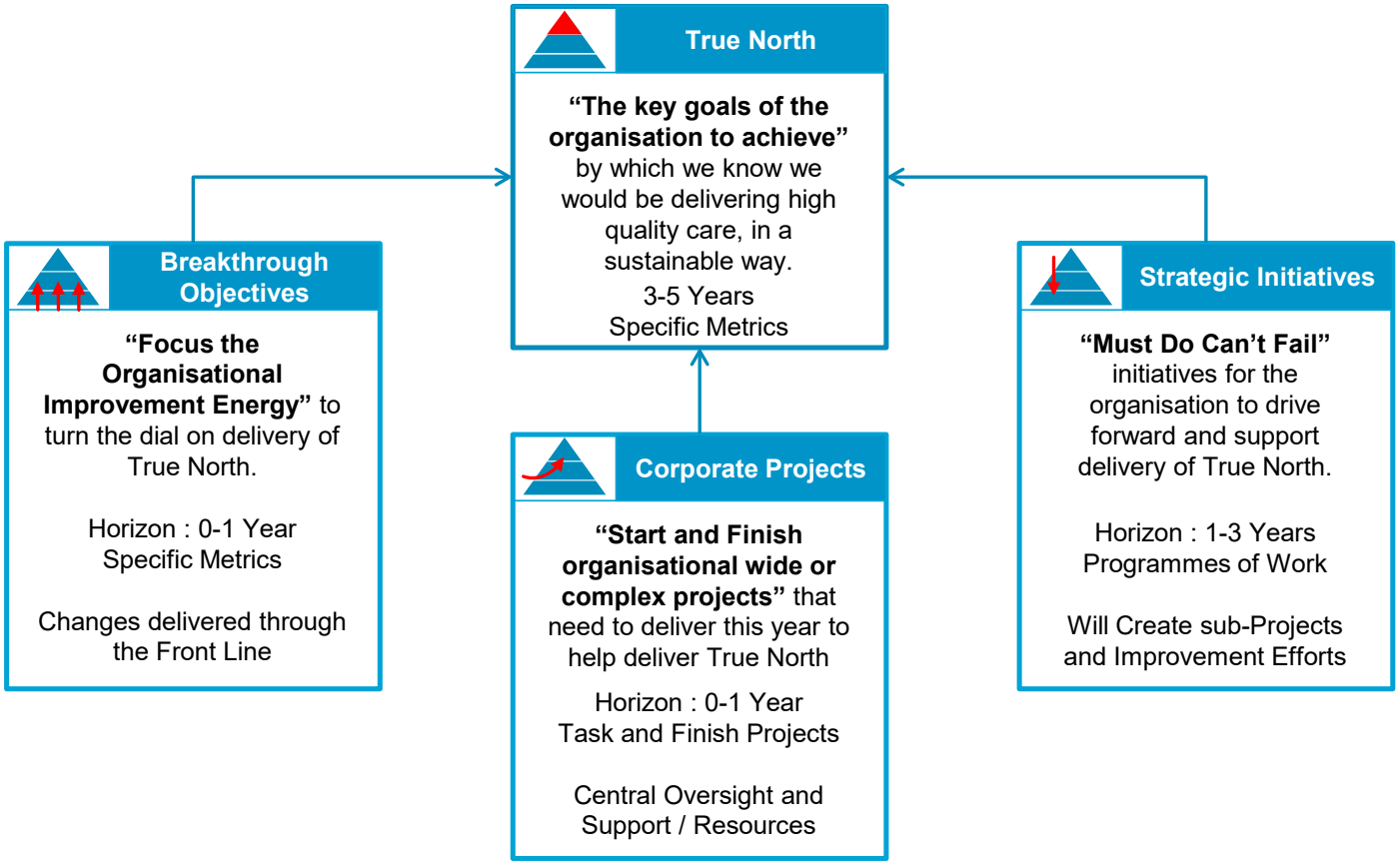
Patient First Strategy Deployment Framework
Patient First True Norths
Patient First Performance Updates

- Patient
- Research and Innovation
- Quality
- People
- Systems and Partnership
- Sustainability

System Oversight Framework

Patient First Strategy Deployment Framework

University Hospitals Sussex NHS Foundation Trust



Patient First True North

University Hospitals Sussex
NHS Foundation Trust

True North

The key goals of the organisation to achieve by which we know we would be delivering high quality care, in a sustainable way

Patient

Patient Experience:

To be in the top quartile nationally for patients rating their experience as good or very good for all touchpoints

Sustainability

Financial Sustainability:

For the Trust to achieve break even

People

Staff Engagement:

To be in the top quartile of Trusts for staff engagement, reaching top half of Trusts within 12 months

Quality

Mortality:
SHMI equal to or less than 100 for the trust and individual hospital sites

Harm:
Reduction of 5% in preventable harms

Systems & Partnerships

Planned Care:
By March 2023, no patient is waiting more than 78 weeks for treatment.

Cancer:
To achieve the 62 day standard

Emergency Care:
No patients to exceed a 12 hour wait in our emergency departments

Research and Innovation

Research:

Within 3 years to be in the top 20 Acute Trusts nationally for patients recruited into portfolio studies

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Patient

Integrated Performance Report Section

Patient: Key performance headlines

University Hospitals Sussex
NHS Foundation Trust

- Based on Friends and Family Test (FFT) data, the significant majority of patients (86% in Q3) are satisfied that they have a good or very good experience of their care with UHSx. Positivity ratings were maintained in most EDs but with Worthing declining slightly as a quarterly average and a considerable decline in positivity rating for RACH.
- 28,950 patients provided a survey response in Q3 of whom 86% (c24,900) patients left a positive review.
- For Q3 a better position on complaints is reported, with more complaints closed than received. However caseloads remain significantly higher than appropriate levels for complaints managers. A focus has been on the quality of complaints responses – ensuring robust quality assurance processes alongside operational demands has resulted in 24% closed in 25 days.
- 352 complaints were open at the end of Q3, a reduction on previous quarter. PALS received slightly fewer concerns and enquiries on the previous quarter accounted for by the quieter Christmas period. With additional officers appointed the PALS team is now at establishment.
- As such, the data for quarter 3 presents a maintained position against the true north ambition, in the context of challenging positions within the NHS and public opinion as a while, and across the trust with regard to demand, workforce and occupancy.
- Themes in negative patient feedback continue to relate to waiting (on site and for treatment), clinical treatment, communication and staff behaviours and discharge – these are the drivers behind the patient experience strategy 2022-25. Staff attitude and communication is now the priority change programme under the breakthrough objective programme and the other driver are addressed within the trust strategy.
- The results of the maternity patient survey 2022 have been published with the trust performance above the national average, and with response to no questions being below the national average. The maternity survey for 2023 commences shortly.
- The key risks to patient experience are patient satisfaction in EDs at WGH/ RACH and waiting time.

Complaints	Currently open	New October 22	New November 22	New December 22	Closed in 25 days: 40 days (target (65% in 25 days)
	352↓	89	99	97	24%↓
PALS		1080	1156	637	Total UHS Q2: 2821↓

Key:
↑Increased in positive direction since previous quarter
↑Increased negatively since previous quarter
↓Decreased negatively since last quarter
↓Decreased positively since last quarter
→Same as previous quarter

FFT (average positive ratings for Q3)	ED response rate	ED satisfaction rates						Inpatient response rates	Inpatient satisfaction		Maternity response rates	Maternity satisfaction		Outpatient satisfaction	
		W'g	SRH	RSCH	Alex	Eye	PRH	RSCH/PRH only	W/SRH	RSCH/PR	W/SRH RSCH/PR	W/SRH	RSCH/PR	W/SRH	RSCH/PR
	25%	73↓	73↑	76↑	72↓	92↑	85↑	26%	N/A	90↑	15%	91↑	96↑	N/A	94→
National average		75%							94%			94%		93%	

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Research and Innovation

Integrated Performance Report Section

Research and Innovation
Key performance headlines

University Hospitals Sussex NHS Foundation Trust

Breakthrough Objective	Research and Innovation	Executive Sponsor: Dr Rob Haigh Senior Responsible Officer: Prof Martin Llewelyn / Vivienne Colleran Metric and Target: 10% increase in total recruitment across all specialities to NIHR Portfolio studies.	On Track	Reporting Period: Jan 23

Baseline Target Last 12 Enrolment Months plus 10%								
Year	Qtr	Month	Participants Enrolled		Studies Enrolling in month	YTD Target	Cumulative % towards target	
			ODP	EDGE			ODP	EDGE
2022-23	Q3	OCT	253	296	177	350	72.29%	84.57%
2022-23	Q3	NOV	556	682	173	700	79.43%	97.43%
2022-23	Q3	DEC	758	992	159	1050	72.19%	94.48%
2022-23	Q4	JAN				1400		
2022-23	Q4	FEB				1750		
2022-23	Q4	MAR				2100		
2023-24	Q1	APR				2450		
2023-24	Q1	MAY				2800		
2023-24	Q1	JUN				3150		
2023-24	Q2	JUL				3500		
2023-24	Q2	AUG				3850		
2023-24	Q2	SEP				4200		
Oct 2022-Sept 2023	Summary		758	992	x̄ 169	1050	71.20%	94.48%

Breakthrough objective

- Breakthrough objective on track
- Breakthrough objective governance implemented
- Targeted development of specialities where there are significant opportunities to contribute to high quality research relevant to our services and patients

Wider strategic development

- Research and Innovation Strategy development started
- Chief Nurse Fellows programme launch Feb 23
- Call for second round of Clinical Fellows Feb 23
- New R&I webpages live and communications plan in place
- NIHR Regional Research Delivery Network hosting bid submitted
- Risk to R&I strategic development identified on the Board Assurance Framework

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Quality

Integrated Performance Report Section

Focus of this section

University Hospitals Sussex NHS Foundation Trust

1) HSMR True North is to receive a 10% reduction in crude mortality

2) Patient Safety True North is ‘Zero harm occurring to our patients when in our care’, with a breakthrough target to reduce the number of all harms categorised as ‘low’ or ‘moderate’ by 5 %.

3) Safer staffing

4) Infection Prevention and Control

HEDLines Indicator Dashboard: December 2022 (UHS)

Trust Performance: RYR – University Hospitals Sussex NHS Foundation Trust

Custom Indicator Set: Mortality Summary	Trust Performance			Benchmarking			
Indicator	Current	Previous	Change	Peer	National	Position	Module Link
HSMR (12 mth rolling) HES Inpatients (Dec 2022)	99.70 (Nov 2021 - Oct 2022)	99.02 (Oct 2021 - Sep 2022)	0.68 ↑	-	102.74	Within expected range	
HSMR (monthly) HES Inpatients (Dec 2022)	114.37 (Oct 2022)	98.31 (Sep 2022)	16.06 ↑	-	106.79	High (>95%)	
HSMR - Weekday mortality (12 mth rolling) HES Inpatients (Dec 2022)	99.34 (Nov 2021 - Oct 2022)	99.36 (Oct 2021 - Sep 2022)	-0.02 ↓	-	101.33	Within expected range	
HSMR - Weekend mortality (12 mth rolling) HES Inpatients (Dec 2022)	100.74 (Nov 2021 - Oct 2022)	98.02 (Oct 2021 - Sep 2022)	2.72 ↑	-	107.10	Within expected range	
HSMR - Without adjustment for specialist palliative care (12 mth rolling) HES Inpatients (Dec 2022)	108.94 (Nov 2021 - Oct 2022)	108.75 (Oct 2021 - Sep 2022)	0.19 ↑	-	102.53	Very high (>99.8%)	
SHMI (12 mth rolling) HES Inpatients, HES-ONS Linked Mortality Datasets (Dec 2022)	111.35 (Oct 2021 - Sep 2022)	110.73 (Sep 2021 - Aug 2022)	0.62 ↑	-	102.76	Within expected range	
SHMI (monthly) HES Inpatients, HES-ONS Linked Mortality Datasets (Dec 2022)	112.54 (Sep 2022)	112.93 (Aug 2022)	-0.39 ↓	-	105.69	Within expected range	
Crude in-hospital mortality rate (12 mth rolling) HES Inpatients and HES-ONS Linked Mortality Datasets (Dec 2022)	1.59% (Nov 2021 - Oct 2022)	1.57% (Oct 2021 - Sep 2022)	0.02 ↑	-	1.33%		
Crude mortality rate (12 mth rolling) HES Inpatients and HES-ONS Linked Mortality Datasets (Dec 2022)	3.11% (Nov 2021 - Oct 2022)	3.21% (Oct 2021 - Sep 2022)	-0.10 ↓	-	2.67%		
Crude mortality rate (monthly) HES Inpatients and HES-ONS Linked Mortality Datasets (Dec 2022)	2.31% (Oct 2022)	2.56% (Sep 2022)	-0.25 ↓	-	1.79%		

Mortality Metrics

University Hospitals Sussex
NHS Foundation Trust

The UHSx crude 12 month rolling mortality rate for non-elective admissions is 3.38% and in month for December was 4.31%. Monthly crude mortality has increased substantially, rolling 12 month rate continues to increase monthly.

The UHSx rolling 12 month HSMR is 99.7. This is within the expected range, however an in month value for October of 114.37 is considered 'high (>95%)'.
Rolling 12 month HSMR *without adjusting for specialist palliative care* has remained in the 'very high (>99.8%)' category.

The UHSx rolling 12 month SHMI is 111.35 which remains in the expected range however continues an increasing trend, nearing the limits of triggering an outlier status.

Indicator	Current	Previous	Change
Crude in-hospital mortality rate - Non-Elective Admissions (12 mth rolling)	3.38% (Jan 2022 - Dec 2022)	3.31% (Dec 2021 - Nov 2022)	0.07%
Crude in-hospital mortality rate - Non-Elective Admissions (monthly)	4.31% (Dec 2022)	3.07% (Nov 2022)	1.24%

CRUDE MORTALITY

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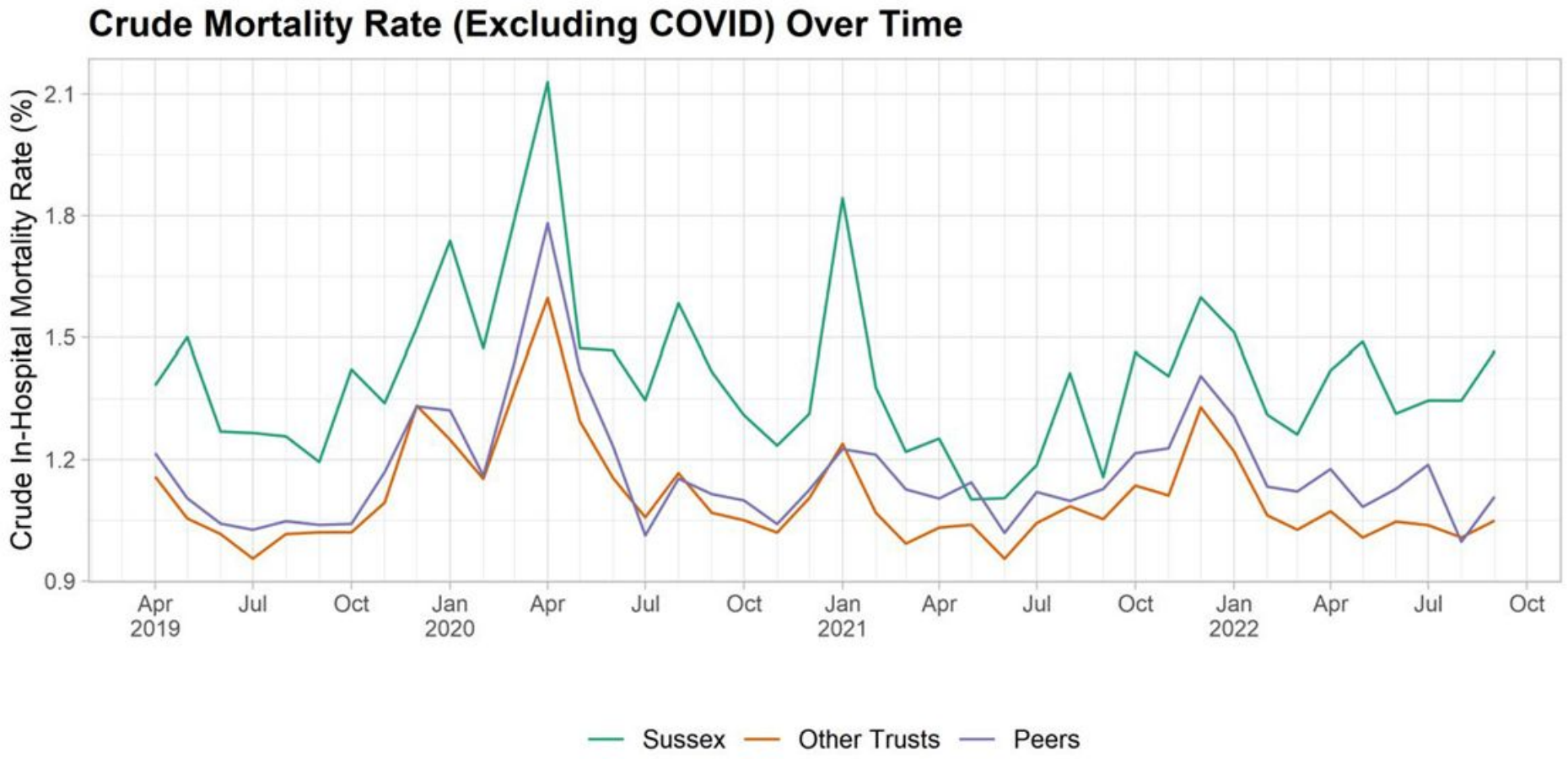

CRUDE MORTALITY

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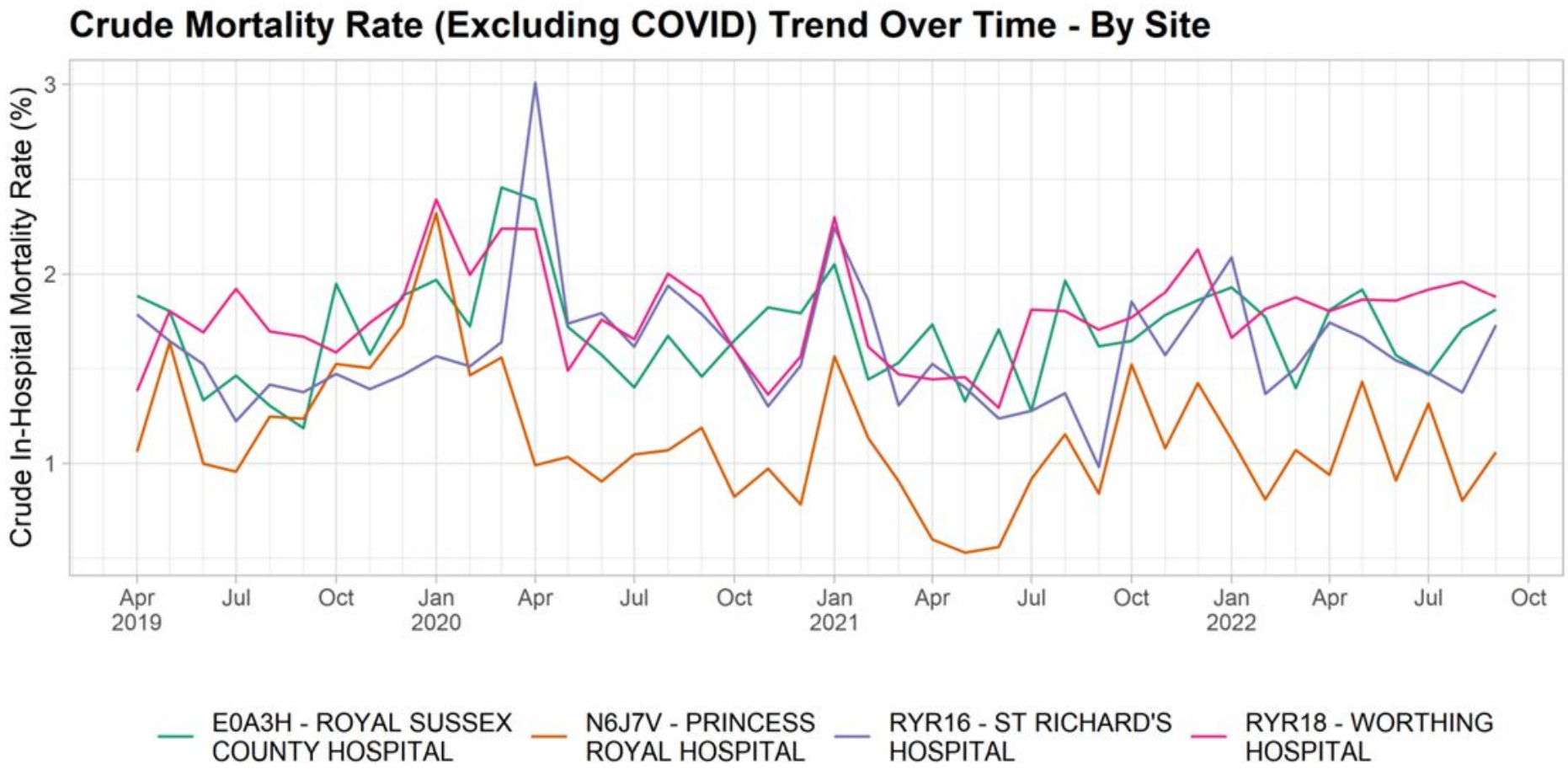

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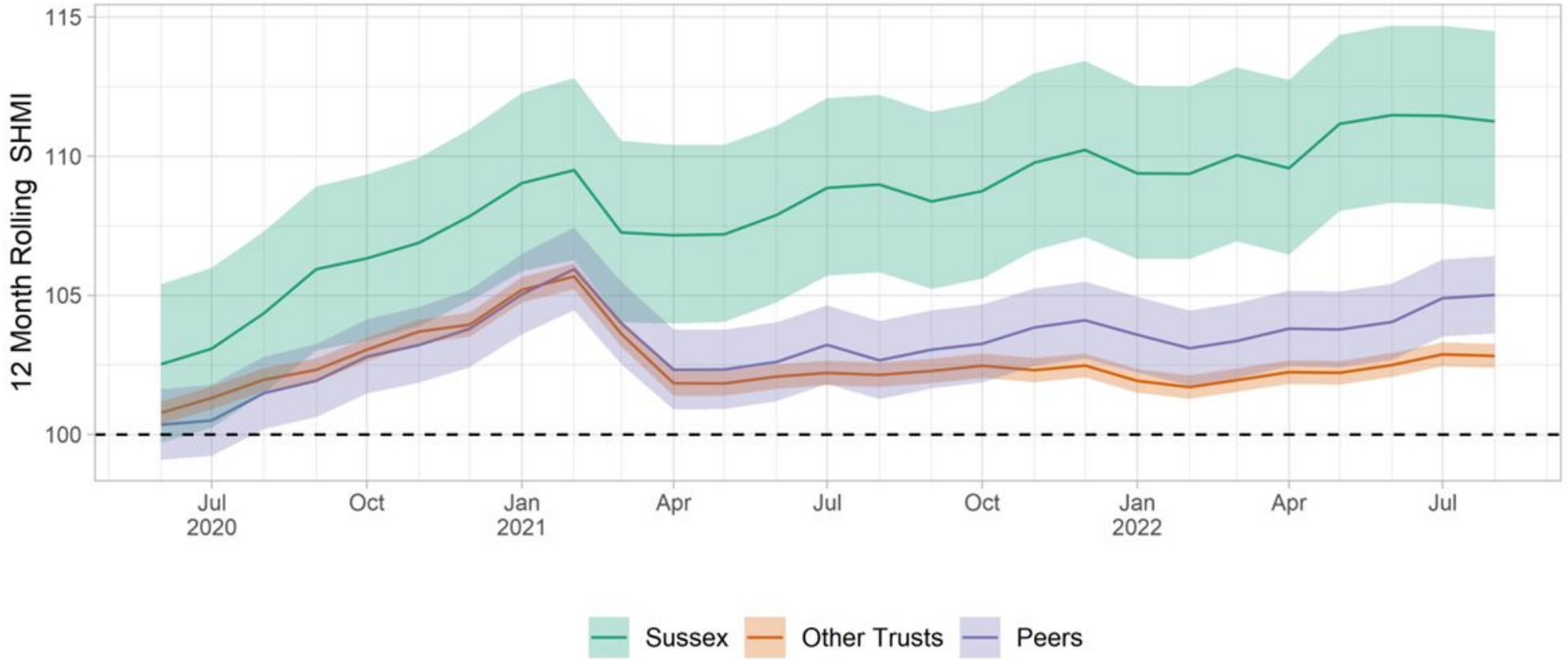
SHMI

12 Month Rolling Trend Over Time For SHMI

Areas surrounding lines represent 95% confidence intervals



Depth of Coding

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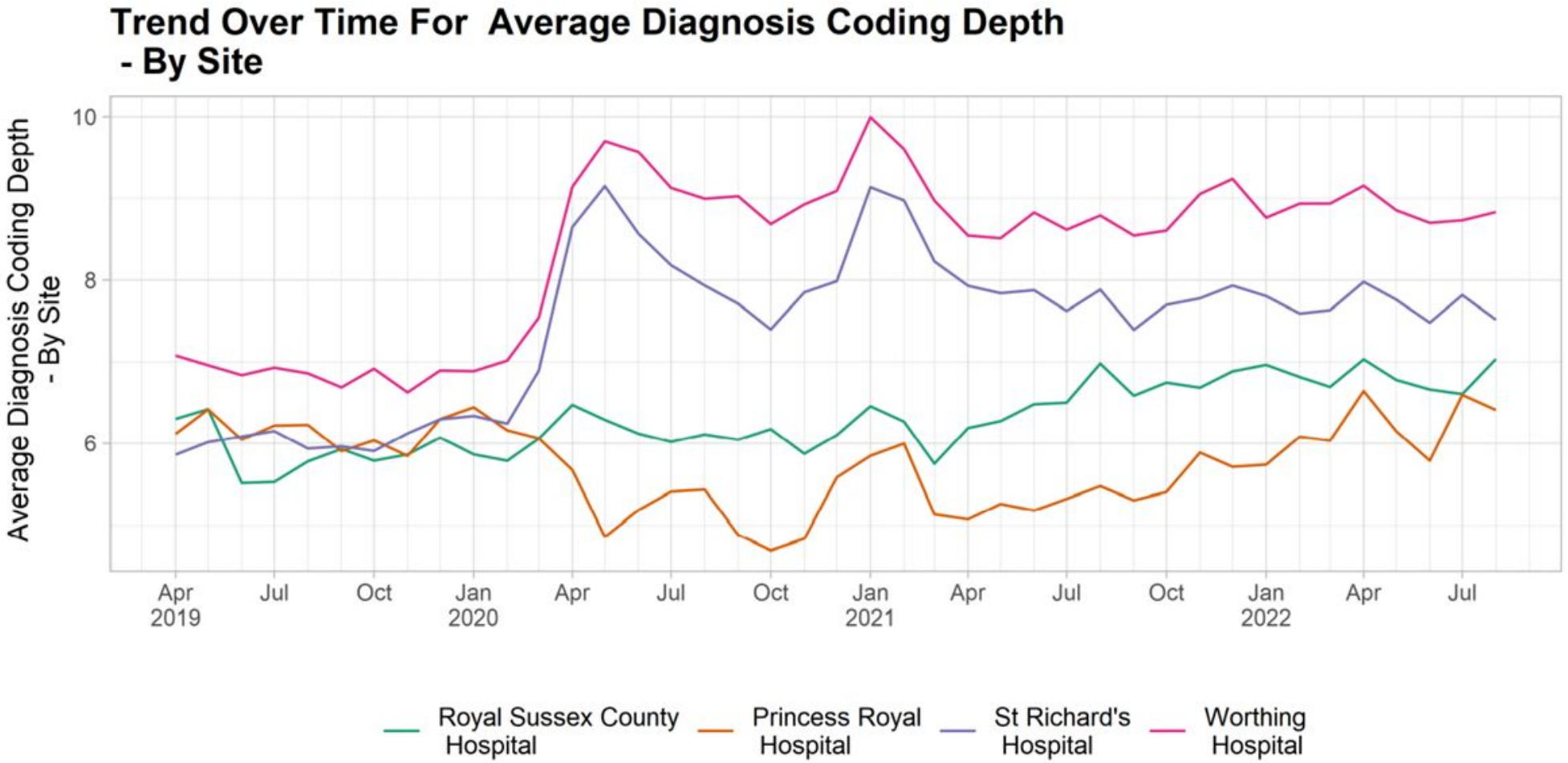

Mortality Summary

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12 Month rolling crude mortality continues to rise, and in month crude mortality has risen substantially from 3.07% in November to 4.31% in December. Monthly variance is expected however this is a significant increase brought on by a greater number of deaths in December across the Trust. In particular at SRH and WGH.

SHMI continues to be high across the Trust, in particular at RSCH and PRH with 12 month rolling figures of 121.66 and 120.06. Out-of-Hospital SHMI at PRH remains a significant outlier and concern at 158.28. However, a working theory regarding the categorising of Same Day Emergency Care activity is being investigated with the help of HED and early signs are positive that this may go some way to explaining the rise in SHMI.

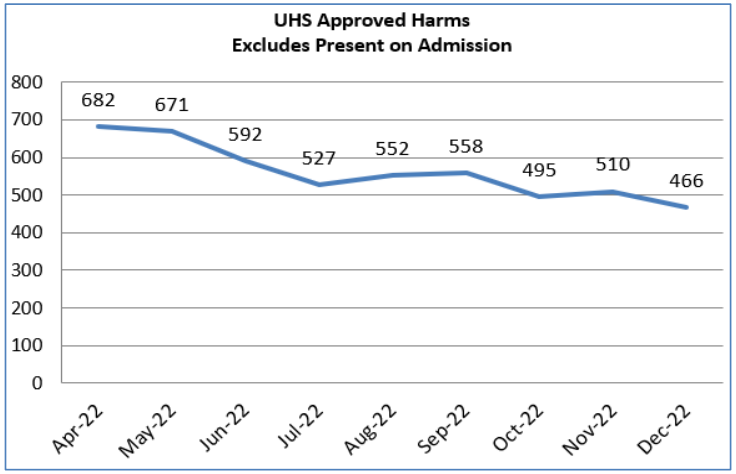
Patient Safety

University Hospitals Sussex
NHS Foundation Trust

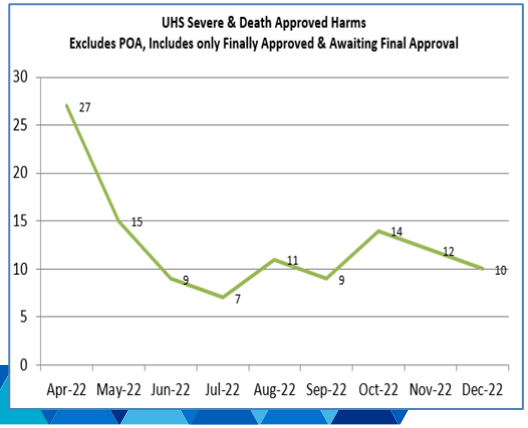
Trustwide it is expected that patients do not suffer harm whilst in our care. However, it is recognised that there are patients who suffer new harm which is acquired during their time in hospital. This has a significant impact on patients, families , carers and staff and within the wider organisation.

The **Quality True North** for harm at UHSussex is '*Zero harm occurring to our patients when in our care',* with a target to reduce the number of **all harms** categorised as 'low, moderate, severe harm and death' by 5%.

For actual harms (approved) graded as low, moderate, severe and death the numbers are detailed below. The highest percentage of reported patient safety incidents are graded as no harm (December 2022- 70%).



- *Actual harm (low/moderate Severe) reduced by 44 since Nov 22 (8%)*
- *Falls/PD/Medication/Staffing/IPC most commonly reported no/low harm*



37% reduction in severe harm/death since April 22 (Reduction Covid Nosocomial death)

Avoidable Harm– Key Metrics: Falls

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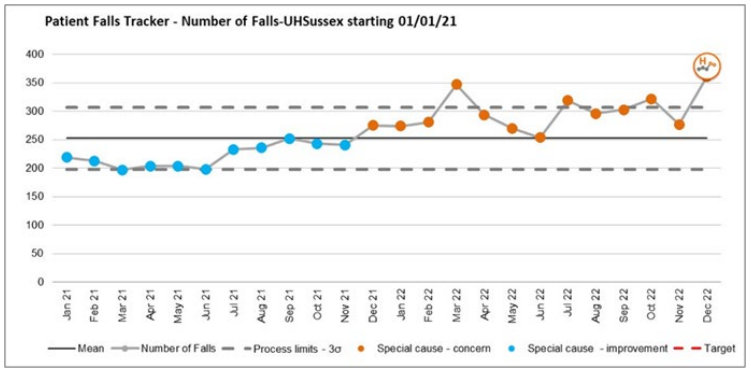

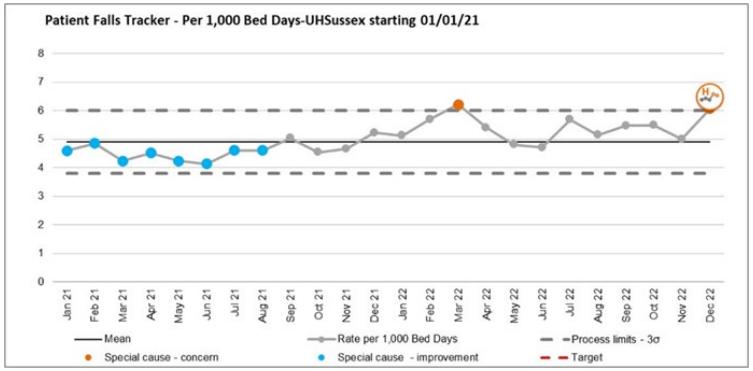

December 2022: 361 reported falls = 6.09 per 1,000 bed days; (rolling 12 month average 5.40)

Performance/ Themes:

- New baseline establishing; rate showing consistently higher number of falls compared to Q2 21
- After Action Reviews undertaken or underway for all falls graded as moderate/severe harm death; supported by harm free care nurses and patient safety team
- ED/EF/Admission areas across the sites continue to experience highest number of falls
- Themes identified include staffing impacting observation and post falls care issues
- Noted theme of patient extreme fatigue due to extended hours in A/E and night time transfers
- Night moves impact the individual patient and also patients on receiving areas, in particular the Emergency Floors
- This month has seen unprecedented pressures nationally with flow and capacity, resulting in BCI/ Sussex-Wide Critical Incident. High numbers of Flu A/B Covid and Norovirus outbreak result in high patient acuity and staff sickness. Bay closures and staffing reduce efficacity of Baywatch/cohort nursing

Improvement Actions:

Breakthrough; refresh of A3 underway; Key workstreams include:

- Staffing and flow– observation of pts
- Delirium(particularly night time falls)
- Frailty and Deconditioning
- Post Falls Care

Individual A3 plans to be developed for Deconditioning and Delirium (including night-time care)

Post Falls and Baywatch local improvement work ongoing

Post Falls rapid review tool in development to align across sites and with new RL DATIX IQ

Post Falls rapid review tool in development to align across sites and with new Datix IQ design

In the process of moving risk assessments and care plans to Patient Track: meetings in progress early January

Falls per location (December 2022)

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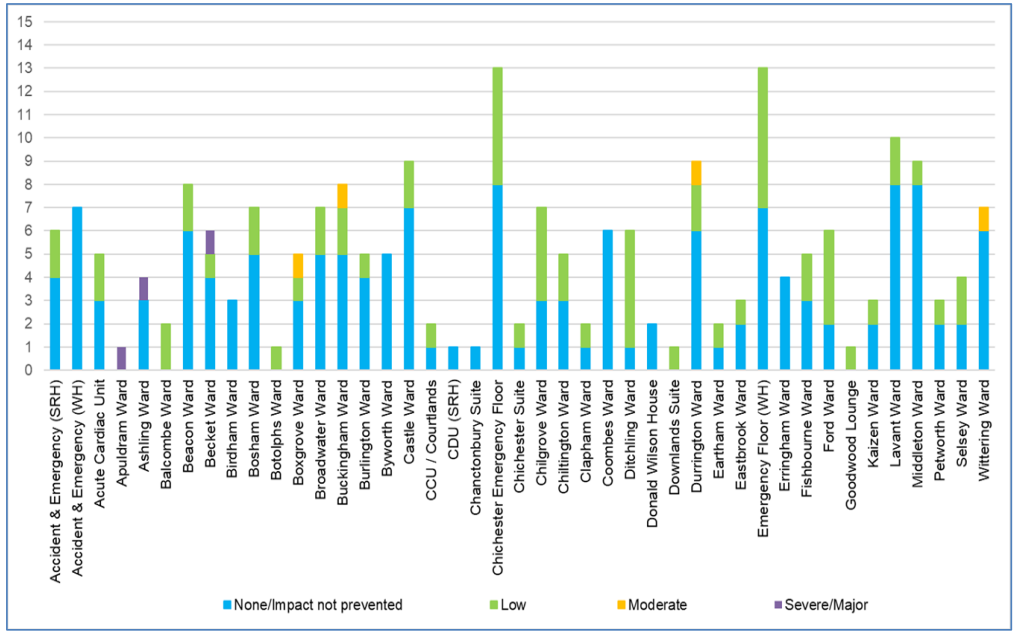
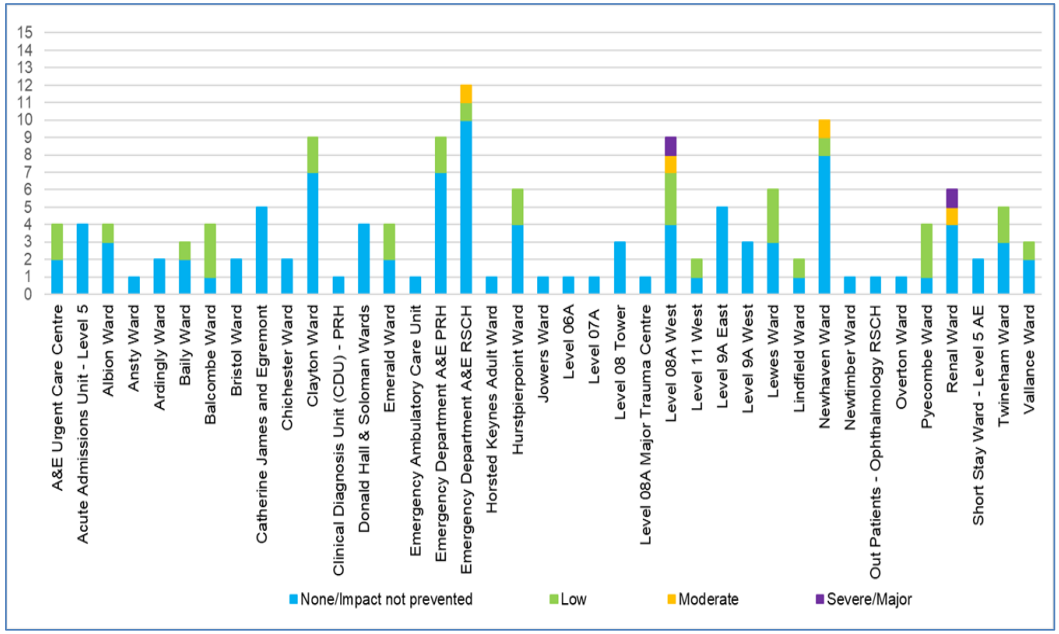
WH/SRH



PRH/RSCH



Avoidable Harm– Key Metrics: Pressure Ulcers

STOP THE PRESSURE.

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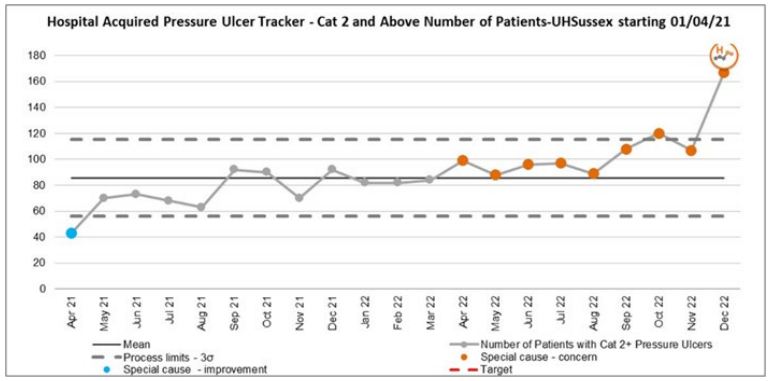

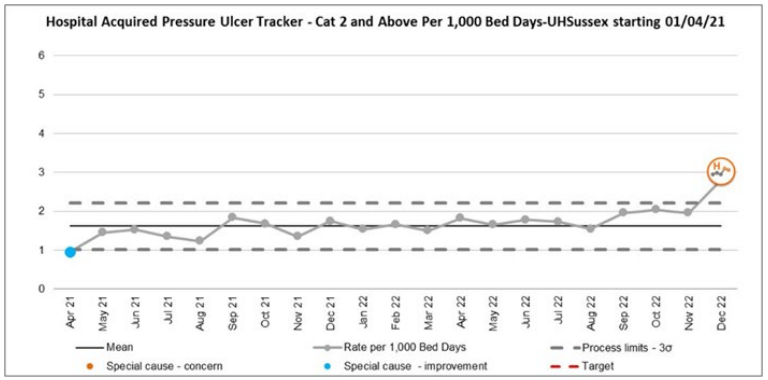

December 2022: 167 patients graded Category 2 and above pressure ulcers = 2.81 per 1000 bed days, (rolling 12 month average =1.83)

Performance/Themes :

- New baseline establishing - whilst rate shows little recent variation, the current picture is consistently higher than Q1 and 2 2021 with a significant rise noted in December indicative of system pressure
- The nationally recognised acute system pressures have resulted in extended waiting times for ambulances and longer waits in ED due to patient flow- both resulting in the potential for development of PD due to acuity and immobility, and high numbers of 'present on admission' PD.
- Sacral, moisture and heel DTI ulcers key themes
- Photography project at Worthing and SRH currently on hold due to IG / GDPR – impacting timely review – escalated as Trust Risk

Improvement Actions:

- Datix IQ project design phase continues, Datix IQ project design stage completed; Awaiting pressure ulcer module to be built for trial/review
- New AAR rapid review tool in design ; capturing the ASSKING bundle elements
- Patients assessed in ED and transferred to bed/air mattress at earliest opportunity
- TV Team at Worthing and SRH have provided a two week training package on Middleton ward.
- Erringham, Ditchling, Durrington + Buckingham have had pressure ulcer prevention training focussing on implementing the aSSKINg care bundle, during their away days.
- WGH EF are now providing Heel Pro Advance Pressure Off Loading Boots in accordance with the # NOF pathway; when patients are not admitted directly onto Broadwater ward

Improvement actions (harm reduction)

University Hospitals Sussex NHS Foundation Trust

- Analysis of all reported patient safety incidents (site, division, service, ward) continues month on month.
- Implementing RLDATIX IQ risk and incident management and assurance system Q4-Q1 2023.
- Targeted focus on reduction of low/moderate harms (falls and pressure damage) Falls and pressure damage are noted as top 2 themes in reported harms (moderate/low).
- This month has seen unprecedented pressures nationally with flow and capacity, resulting in BCI/ Sussex-Wide Critical Incident. High numbers of Flu A/B Covid and Norovirus outbreak result in high patient acuity and staff sickness. Bay closures and staffing reduce efficacity of Baywatch/cohort nursing.
- Patients who are medically fit/ready for discharge but experience a delay to discharge due to the continuity of community care are at increased risk of harm.
- RTT harm reviews indicate the potential for increased low harm reporting, early identification of at risk groups and patient categorisation.
- In line with the new Patient Safety Incident Response Framework, thematic reviews have commenced in Q2 2022/23. These reviews were initiated due to themes or ‘cluster’ incidents being identified via SI’s, trends identified via Datix reporting of incidents or concerns being raised by staff. The review provide a greater opportunity for detailed analysis and shared learning/improvement Trustwide.

Safer Staffing

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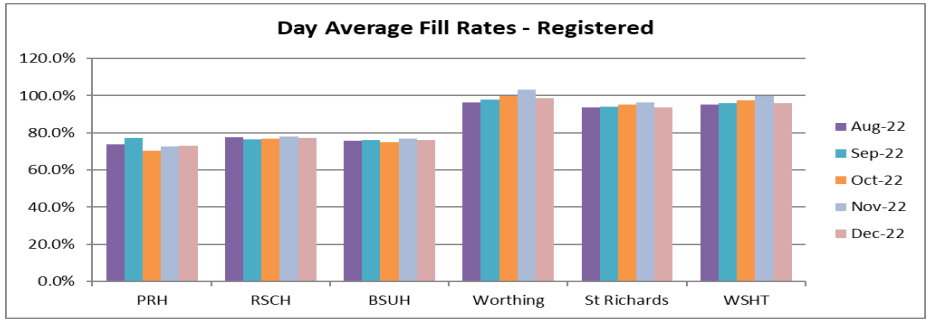
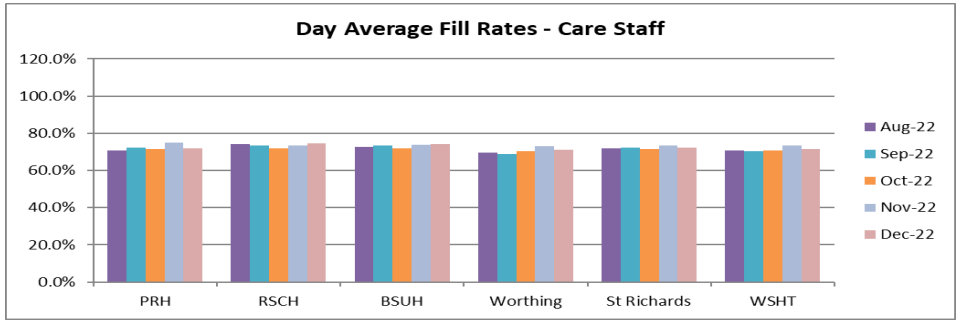
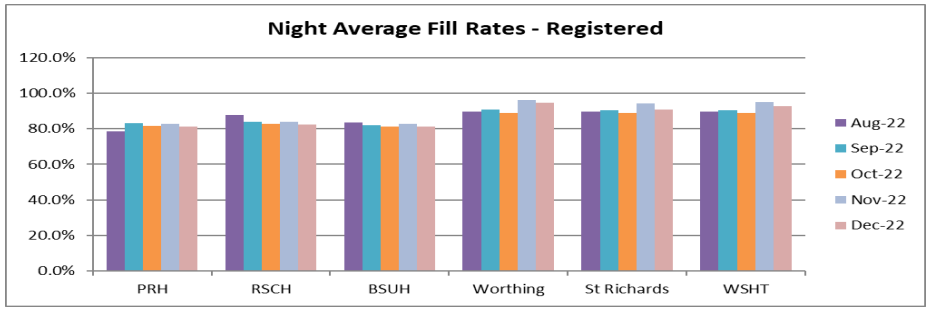
NHS Foundation Trust

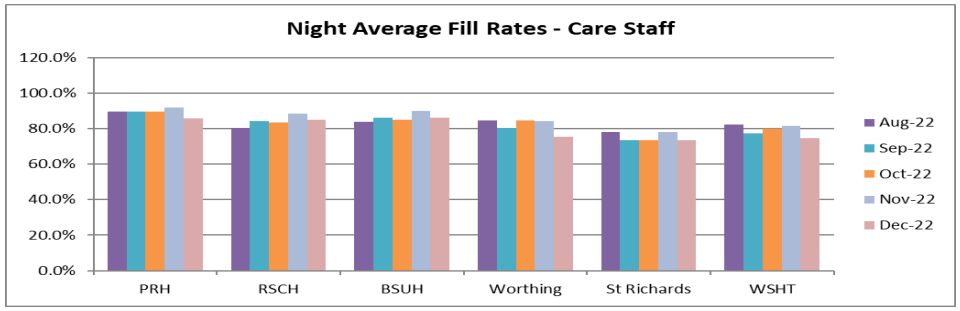
- In response to fluctuations in staffing levels, staffing huddles are held at least twice a day to ensure that areas with challenged staffing levels are supported. Unmitigated staffing shortfalls are escalated to the Director of Nursing.
- During December 2022, there has been a decrease in the overall fill rate for both Registered Nurses and Unregistered staff, however, there has been a slight increase with the Care Hours Per Patient Day (CHPPD) recorded at 7.53 (7.46 during the months of October and November 2022). This remains below the peer median score of 8.0 (Model Hospital data)
- The Trust introduced a nursing bonus scheme to incentivise nursing staff who work additional hours on bank on 28,29 and 30 December 2022.
- “Safe Care” has been fully implemented at PRH site and 96% of the eligible areas at RSCH. It is a tool providing live visibility of staffing levels and by matching with patient demand, can highlight areas which are short on workload-based care hours. This will ensure timely patient care sensitive information will be available to clinical staff. This is being rolled out to other sites specifically at WGH and SRH .
- Recruitment is on going on a regular basis both domestically and internationally.
- The Trust have successfully recruited circa 140 Health Care Assistants (HCA) since November 2022 via HCA Assessment days which were being held rotationally in four of our hospital sites.

Safer Staffing (Fill rates/CHPPD for Registered and Care Staff)









	CHPPD																							
	Registered								Care								Overall							
	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
PRH	4.45	4.23	3.92	3.79	3.72	3.59	3.72	3.67	3.86	3.60	3.30	3.29	3.34	3.44	3.41	3.27	8.31	7.83	7.22	7.08	7.06	7.03	7.13	6.94
RSCH	5.47	5.54	5.46	5.22	5.15	4.95	4.91	4.76	3.28	3.20	3.22	3.11	3.24	3.07	3.24	3.11	8.75	8.75	8.68	8.33	8.39	8.02	8.15	7.87
BSUH	**5.45**	**5.42**	**5.25**	**5.03**	**4.96**	**4.78**	**4.80**	**4.68**	**3.41**	**3.28**	**3.23**	**3.14**	**3.27**	**3.15**	**3.23**	**3.12**	**8.86**	**8.70**	**8.48**	**8.17**	**8.23**	**7.93**	**8.03**	**7.80**
Worthing	4.31	4.33	4.20	4.24	4.49	4.49	4.38	4.70	2.94	2.88	2.73	2.68	2.60	2.60	2.64	2.80	7.25	7.21	6.93	6.92	7.09	7.09	7.02	7.50
St Richards	4.12	4.35	4.38	4.35	4.50	4.50	4.39	4.58	2.52	2.33	2.38	2.32	2.34	2.22	2.24	2.32	6.64	6.68	6.76	6.67	6.84	6.73	6.63	6.90
WSHT	**4.22**	**4.34**	**4.28**	**4.29**	**4.50**	**4.50**	**4.38**	**4.64**	**2.75**	**2.63**	**2.58**	**2.52**	**2.48**	**2.42**	**2.45**	**2.56**	**6.97**	**6.97**	**6.86**	**6.81**	**6.97**	**6.92**	**6.83**	**7.20**
UHSussex	**4.84**	**4.89**	**4.77**	**4.67**	**4.74**	**4.65**	**4.60**	**4.66**	**3.08**	**2.96**	**2.90**	**2.84**	**2.90**	**2.81**	**2.86**	**2.87**	**7.92**	**7.84**	**7.68**	**7.51**	**7.64**	**7.46**	**7.46**	**7.53**

Infection Prevention and Control

Respiratory Virus Activity

Started to see increase in Influenza alongside Covid infection	7000+ Staff vaccinated for Flu and Covid by the Trust (September 22 - Jan 23)	Asymptomatic admission testing discontinued
Earlier discharge screening for community beds maintained (to identify positives and not delay discharge)	Screening of symptomatic patients in place	Local outbreaks continue to be managed by the IPC Team
Surge plans agreed with site teams	Visiting has been maintained	The mandate for masks has been maintained for clinical areas

FFP3 masks recommended when caring for patients with Covid or Flu	Significant staff sickness with respiratory infections noted.

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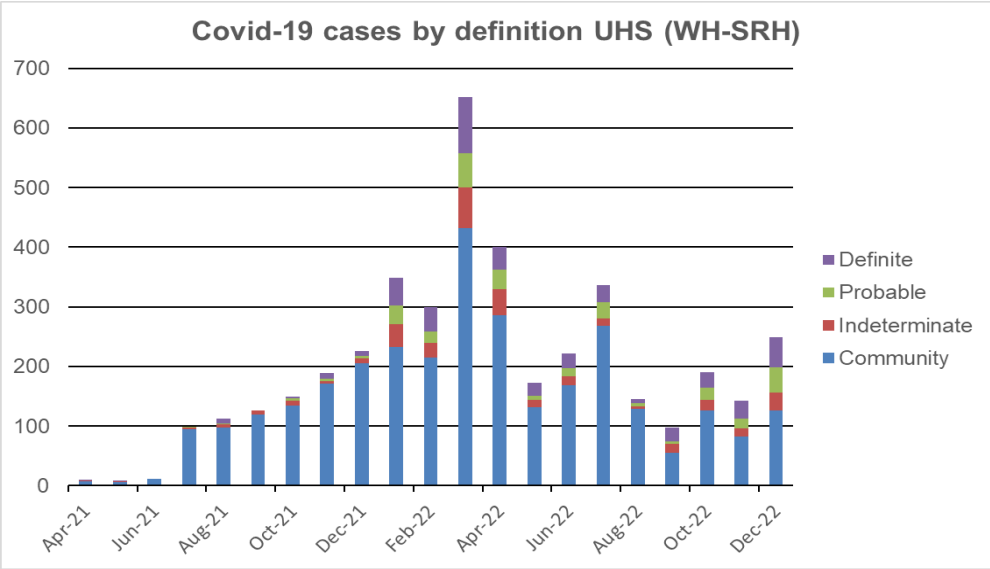
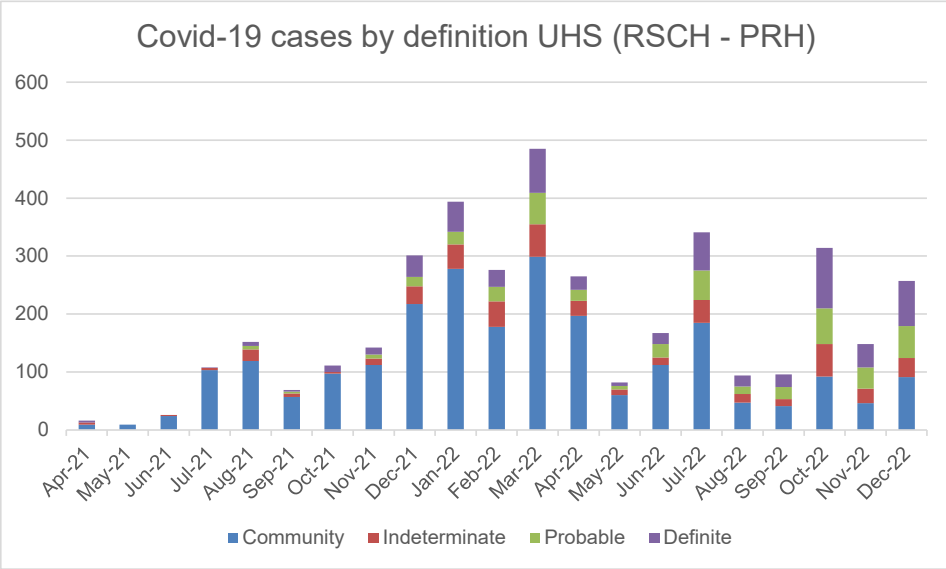
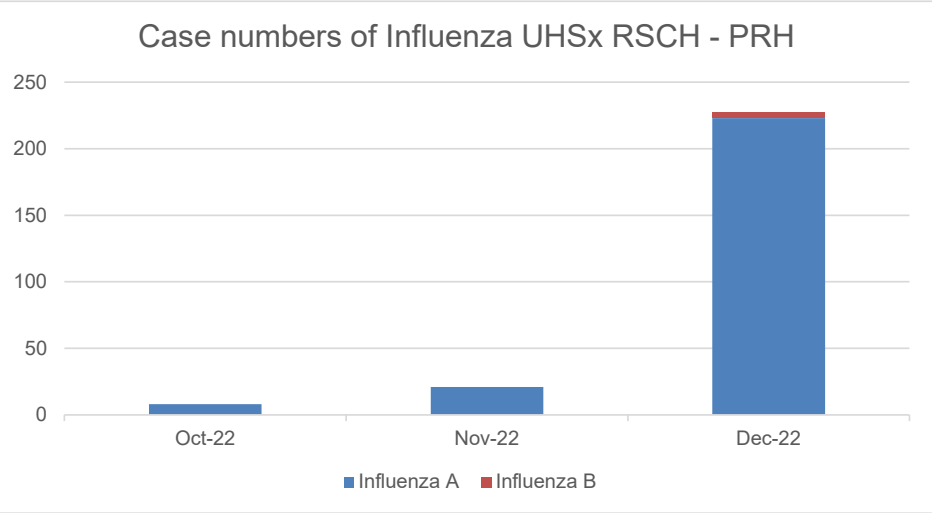
Covid -19 by attribution April 21 to December 2022







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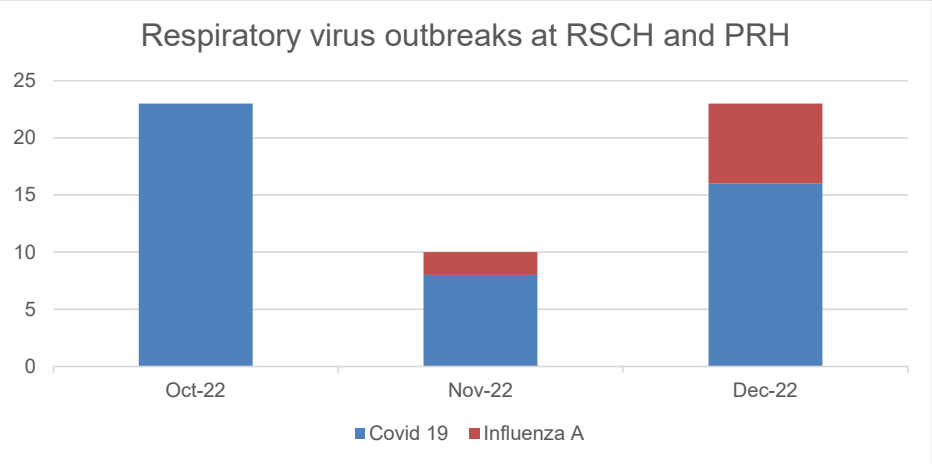
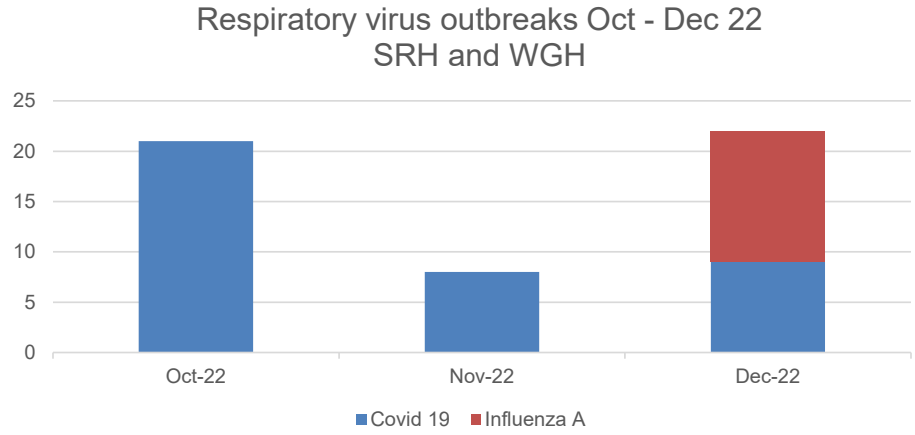
Respiratory Virus Outbreaks





Mandatory surveillance

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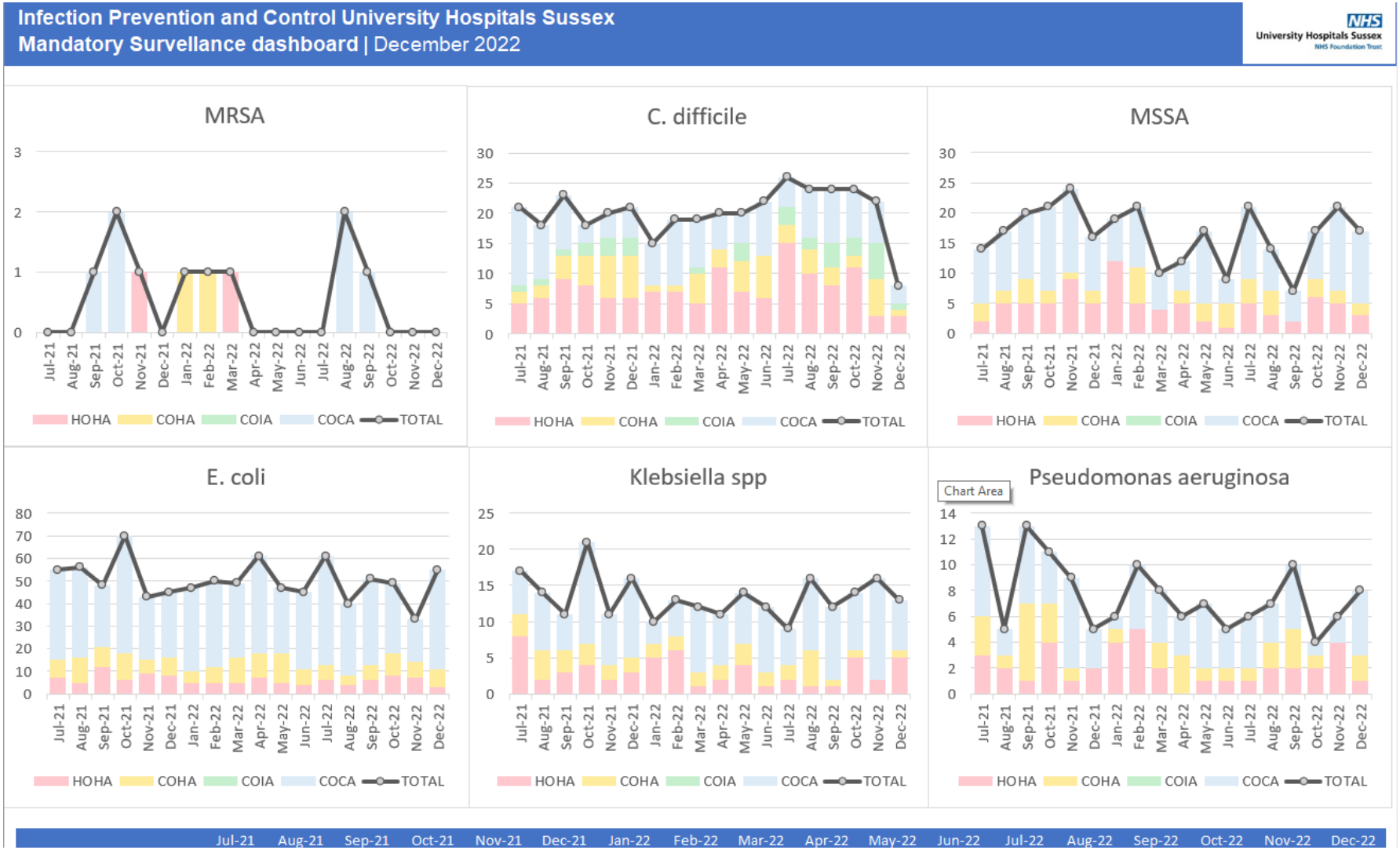
- Mandatory surveillance is reported monthly to the UK HAS on MRSA, MSSA, *C.difficile, E.coli, Klebsiella* species and *Pseudomonas aeruginosa*
- The following category definitions are used:

  HOHA: Hospital onset Hospital Associated, acquired after more than 48 hours in hospital

  COHA: Community Onset, Hospital Associated, acquired within 48 hours of admission to hospital, but patient had recent admission in last 28 days

  COIA: Community Onset, Indeterminate association, acquired within 48 hours of admission to hospital, but patient had recent admission in last 84 days

  COCA: Community Onset, Community Associated, acquired within 48 hours of admission to hospital, and no recent admission
- The chart on next slide show data up to December 2022


Infection Prevention and Control University Hospitals Sussex
Mandatory Surveillance dashboard | December 2022
NHS
University Hospitals Sussex
NHS Foundation Trust
MRSA
C. difficile
MSSA
E. coli
Klebsiella spp
Pseudomonas aeruginosa
Chart Area
HOHA
COHA
COIA
COCA
TOTAL
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22

Trust attributable mandatory surveillance data Q1-3 2022 against trajectory

University Hospitals Sussex NHS Foundation Trust

	Annual Trajectory		Q1	Q2	Q3	Q4	YTD
CDT	142	Trajectory	35	35	36	36	142
		Actual	33	39	30		102
		Variance	-2	+4	-6		-4
E.coli	158	Trajectory	40	40	39	39	129
		Actual	39	52	51		142
		Variance	-1	+12	+12		+25
Klebsiella	54	Trajectory	13	13	14	14	40
		Actual	13	26	18		57
		Variance	0	+13	+4		+17
Pseudomonas	38	Trajectory	9	9	10	10	28
		Actual	12	11	12		35
		Variance	+3	+2	+2		+7
MRSA	0	Actual	2	3	0		5
MSSA	n/a	Actual	22	18	25		65

Other

University Hospitals Sussex NHS Foundation Trust

Audits

- Commode cleaning 95-100% across the board
- IPC hand hygiene audits now on Tendable with training being rolled out.
- Hand hygiene 95%.
- **SSI**
- Commenced SSI surveillance in Cardiac at RSCH, and Orthopaedics at PRH.
- New surveillance nurse appointment for Surgery East
- Existing SSI surveillance in place at SRH and WGH.

IPC Team

- New structure agreed and initial appointments made.
- Adverts out for remaining posts

NHS
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NHS Foundation Trust

People

Integrated Performance Report Section

Focus of this section

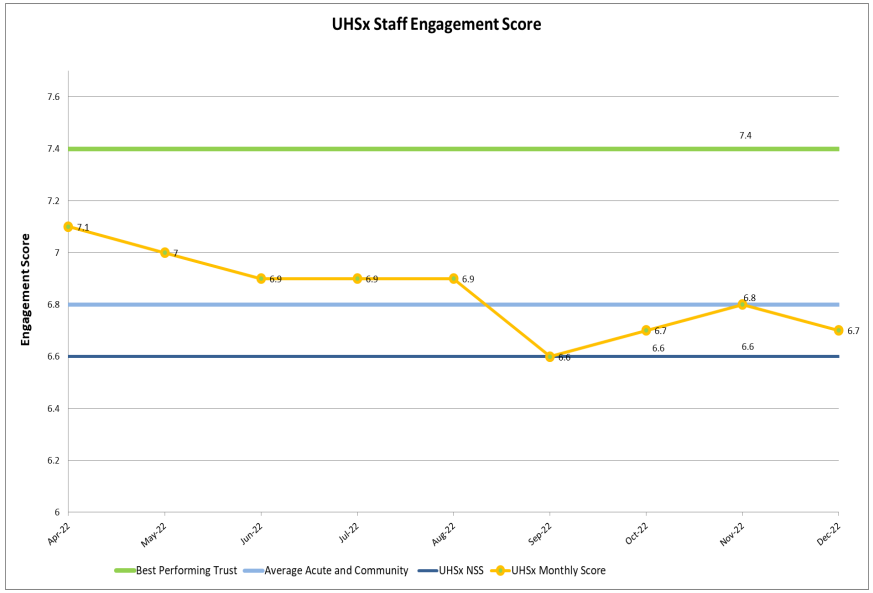
University Hospitals Sussex NHS Foundation Trust

- True North, Breakthrough Objective, Strategic Initiative and Corporate Project (as reported through SDR)
- People scorecard and commentary
- People risks and forward look

People True North

University Hospitals Sussex
NHS Foundation Trust

True North goal: Top acute trust for staff engagement. Target: to be within the top quartile of acute trusts for the staff engagement score (National Staff Survey). Current performance 6.7 (latest engagement measure from pulse survey):



The following pages summarise progress against the People Breakthrough Objective, Strategic Initiative and Corporate Project - which are all intended to improve our staff engagement score. Delivery assurance of our plans is reported through our People Committee and the SDR process.

Speaking up & Equality Diversity & Inclusion

University Hospitals Sussex NHS Foundation Trust

- New Freedom To Speak Up guardian starts 30th January
- New Equality Diversity & Inclusion team members now started & plan agreed
- Breakthrough on ‘staff voice that counts’
- Divisions engaged
- Monthly measurement and reporting through SDR

Breakthrough objective measure:

329Respondents. 320: RSCH/PRH 9: WGH/SRH/S’lands

Leadership, Culture and Organisational Development

University Hospitals Sussex NHS Foundation Trust

Summary Position

Steering group focussing on delivery of the EDI workstream and plan to do this.

The Violence Prevention and Retention work has started. This workstream will continue to report into the health and wellbeing programme as well as the Integrated Care Board.

The leadership programme has progressed with the initial 'top leaders' session on 13 January.

RAG	Workstream	Comments
	Leadership Skills	**Workstream Lead – Nick Groves** • 'Leading with Head & Heart programme' (NHS Elect) – 80+ staff now enrolled on 'bite size' versions of the four modules in early 2023. Planning underway for 2023/24 programme. • Following procurement, planning for Phase 1 (NHSP Academy) & Phase 2 (Roffey Park Institute) of COM/Corporate Director/Exec. Leadership Programme underway. Launch/Orientation Day (The King's Fund) 13/01/22. Arrangements underway for NHSP Academy and Roffey Park Institute to attend Exec. Huddle for briefing. Contracting underway. Recruitment to Projects Assistant underway. • Business Case and Exec. Briefing for Mentoring & Development Programme for New Consultants & SAS Doctors complete. Pending Exec. Huddle advance review. • 'Communication skills for doctors' training proposal – now part of Surgery Corporate Project (pilot). • Exec. Huddle Briefing submitted on next leadership programme priorities, and steer on priorities and sources of funding. • Iris Leadership Programme Signposting Page now live.
	Violence Prevention & Reduction	**Workstream Lead – Nikki Kriel** • (Out of scope, but key enabler) Trust Three-Year Health & Wellbeing Strategy & Year 1 Plan agreed by People Committee 02/10/22 and Trust Board 10/11/22. • LCD Steering Group agreed VPR Project Plan and VPR Group Membership 28/11/22 – VPR Group due to start meeting from January 2023 (Quarterly), wider Stakeholder Group also being established. • Data/metrics for baselines and KPIs to be established with VPR Group. • Datix Root Cause Audit progressing – due for completion December 2022. • Continuing to link with NHS Sussex VPR Programme.
	Equality, Diversity & Inclusion	**Workstream Lead – Nick Groves** • Appointments to all four vacant EDI Team posts made. Head of E&I starts 03/01/23. • EDI & Wellbeing Data Analyst in post, preparing to analyse results of NHS Staff Survey 2022 once received. Statistical analysis of Appraisal Evaluation (PCs) underway. • Three-Year EDI Strategy/Plan drafted. To be discussed at Trust Board of Directors Seminar on 08/12/22. • LYH/BSUH Charities Investment Case for Staff Networks (backfill for Network Chairs, non-pay for Disability History Month, Black History Month) – first draft complete, due for submission for January 2023 CFC. Enabled by Trust Board approval of Health & Wellbeing Strategy. • 'Lived experiences' training video/workshop in development with Staff Networks and external specialist provider (Inclusive Employers). Due to completion end March 2023. Will form part of Corporate Induction. • WRES and WDES Action Plans – holding note posted on extranet pending Trust Board approval of EDI Strategy. • Staffside Chair & Vice-Chair due to meet CEO & CPO 10/01/22.

Key stats – people scorecard (Dec)

University Hospitals Sussex NHS Foundation Trust

- 16,445 WTE posts*↑
- 14,868 WTE in post→
- 1,576 vacancy (9.59%)↑
- RN vacancy 7.75%↑
- HCA vacancy 20.37%↓

- Sickness in month 5.12%↓ (last 12 months 5.46%↑)
- Turnover 9.56%↓

- Appraisal (non-medical) 79.31%↓
- Consultant 89.28%↑

- STAM 87.94%→

- Latest staff engagement score 6.70%↓
- Recommendation 56.86%↓

*Winter plan saw the establishment increase by 100 to substantiate roles associated with additional bed capacity in use. Has impacted vacancy figure too.

People Committee Scorecard - UHSx

December 2022

	Key Performance Indicator	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Trend
	True North - Engagement	6.8	6.8	6.9	7.0	7.1	7.0	6.9	6.9	6.9	6.6	6.7	6.8	6.7	
	Breakthrough - Place to work (included in some of the surveys)	59.02%	62.02%	62.26%	66.67%	67.70%	64.93%	63.06%	62.22%	63.92%	59.57%	58.89%	59.74%	56.86%	
	Survey Responses	384	509	487	394	377	467	396	434	518	587	401	400	327	
Workforce Capacity	FTE - Budgeted	16,053.31	16,059.09	16,039.96	16,024.20	16,017.75	16,023.93	16,096.07	16,106.51	16,124.89	16,147.09	16,126.06	16,341.29	16,445.35	
	FTE - Substantive contracted	14,683.57	14,736.02	14,728.95	14,781.80	14,953.18	14,599.22	14,652.26	14,572.76	15,185.38	14,801.57	14,902.71	14,877.26	14,868.42	
	FTE - Substantive contracted variance from Budget	1,369.74	1,323.07	1,311.01	1,242.40	1,064.57	1,424.71	1,443.81	1,533.75	939.51	1,345.52	1,223.35	1,464.03	1,576.93	
	Vacancy Factor (Substantive contracted FTE)	8.53%	8.24%	8.17%	7.75%	6.65%	8.89%	8.97%	9.52%	5.83%	8.33%	7.59%	8.96%	9.59%	
	Vacancy Factor HCA Band 2 (Substantive contracted FTE)	13.59%	14.96%	15.66%	14.66%	16.29%	17.15%	19.34%	20.65%	18.55%	18.65%	18.36%	20.91%	20.37%	
	Vacancy Factor Nurse Band 5 (Substantive contracted FTE)	13.47%	12.17%	11.59%	10.37%	8.24%	9.91%	6.84%	8.08%	5.27%	7.01%	6.86%	7.16%	7.75%	
	Spend - Bank as a % of total staffing	8.80%	10.22%	8.44%	5.44%	8.38%	7.77%	8.83%	8.70%	9.10%	8.71%	8.92%	8.90%	9.32%	
	Spend - Agency as a % of total staffing	3.14%	3.07%	3.07%	3.31%	3.68%	5.04%	5.33%	5.53%	5.17%	4.65%	5.21%	5.70%	4.56%	
	Substantive Headcount	16,586	16,628	16,649	16,682	16,651	16,600	16,571	16,524	16,694	16,646	16,761	16,812	16,748	
Workforce Efficiency	Absence - Sickness (12 month)	4.10%	4.12%	4.21%	4.33%	4.48%	4.55%	4.57%	4.67%	5.27%	5.29%	5.40%	5.46%		
	Absence - Sickness in month	4.70%	4.72%	5.16%	4.83%	4.62%	4.39%	4.09%	5.33%	4.08%	4.16%	5.29%	5.12%		
	Absence - Maternity in month	2.00%	2.00%	1.95%	1.89%	1.86%	1.70%	1.80%	1.90%	1.86%	1.95%	2.08%	2.15%		
	Absence - Special, Study & Other Leave in month	8.59%	9.09%	8.85%	9.37%	8.58%	8.32%	8.49%	8.43%	7.75%	8.27%	8.23%	8.44%		
	Absence - Total in month	15.29%	15.80%	15.96%	16.09%	15.06%	14.40%	14.38%	15.66%	13.69%	14.38%	15.60%	15.71%		
	Sickness - Short Term (< 28 days)	2.24%	2.48%	2.51%	2.54%	2.33%	2.01%	1.92%	2.99%	1.94%	2.04%	3.04%	2.83%		
	Sickness - Long Term (>= 28 days)	2.46%	2.24%	2.66%	2.29%	2.29%	2.38%	2.17%	2.34%	2.14%	2.12%	2.25%	2.29%		
	Sickness - Stress in month	0.91%	0.87%	1.05%	0.85%	0.93%	0.98%	0.81%	0.89%	0.76%	0.81%	0.87%	0.98%		
	Sickness - Gastro Intestinal in month	0.33%	0.27%	0.40%	0.33%	0.37%	0.33%	0.37%	0.33%	0.32%	0.32%	0.31%	0.32%		
	Sickness - Other Musculoskeletal in month	0.44%	0.37%	0.52%	0.40%	0.36%	0.43%	0.37%	0.42%	0.42%	0.41%	0.40%	0.40%		
	Sickness - Cough, Cold & Flu in month	0.72%	0.46%	0.48%	0.48%	0.46%	0.38%	0.31%	0.31%	0.26%	0.38%	0.75%	0.69%		
	Sickness - Back in month	0.16%	0.13%	0.21%	0.17%	0.16%	0.22%	0.19%	0.23%	0.20%	0.19%	0.22%	0.23%		
	Episodes - New sickness episodes in month	2,932	2,630	2,604	3,058	2,668	2,734	2,609	3,236	2,573	2,721	3,878	3,595		
	Episodes - On-going sickness episodes in month	801	867	841	766	873	696	641	828	663	655	825	764		
	Episodes - Total sickness episodes in month	3,733	3,497	3,445	3,824	3,541	3,430	3,250	4,064	3,236	3,376	4,703	4,359		
	Maternity - Number of staff on maternity leave	396	401	392	370	374	337	362	372	378	375	406	418		
	Turnover - Trust (12 month)	8.87%	9.01%	9.00%	9.05%	9.17%	9.33%	9.39%	9.31%	9.28%	9.56%	9.60%	9.68%	9.56%	
	Turnover - Medical & Dental (12 month)	13.81%	13.45%	13.65%	13.73%	12.81%	12.23%	12.75%	11.84%	10.93%	10.46%	10.54%	11.17%	11.15%	
	Turnover - Nursing & Midwifery (12 month)	6.50%	6.38%	6.27%	6.00%	6.19%	6.26%	6.13%	6.02%	6.13%	6.39%	6.58%	6.81%	6.64%	
	Turnover - Scientific, Therapeutic & Technical (12 Month)	8.84%	9.16%	9.60%	9.39%	9.56%	9.68%	9.69%	9.28%	9.45%	9.03%	8.33%	8.60%	8.76%	
	Turnover - Admin, Clerical & Estates (12 months)	9.84%	10.32%	10.25%	10.60%	11.01%	11.32%	11.57%	11.74%	11.82%	12.64%	12.91%	12.55%	12.43%	
	Turnover - Support Staffing (12 months)	9.86%	9.98%	9.88%	10.23%	10.12%	10.48%	10.55%	10.66%	10.41%	10.65%	10.57%	10.80%	10.54%	
	Stability %	87.14%	87.07%	86.72%	86.49%	85.8%	85.5%	85.5%	85.4%	85.4%	85.4%	85.3%	85.1%	85.6%	
Training and Development	% of appraisals up to date All Staff (AfC Staff and Consultants Only)	71.01%	70.56%	71.27%	68.51%	68.93%	73.28%	77.33%	80.56%	80.03%	80.99%	80.50%	79.89%	79.31%	
	% of appraisals up to date Medical Staff (Consultants Only)	28.14%	27.45%	26.72%	28.28%	36.34%	87.53%	82.47%	90.33%	90.00%	89.04%	89.14%	89.25%	89.28%	
	% of appraisals up to date AfC Staff (excl Medical staff)	74.72%	74.28%	75.13%	72.01%	71.06%	72.34%	76.99%	79.92%	79.38%	80.47%	79.93%	79.27%	78.65%	
	STAM Weighted Average	83.41%	84.29%	85.39%	86.19%	85.35%	86.84%	88.07%	88.73%	88.36%	89.14%	88.40%	88.05%	87.94%	
	% In Date - Fire	81.15%	82.51%	83.42%	84.90%	84.59%	85.73%	86.60%	86.45%	85.76%	87.28%	86.22%	86.10%	85.45%	
	% In Date - Infection Control (Role Specific)	81.22%	82.43%	83.64%	84.83%	84.66%	85.55%	88.14%	87.78%	87.54%	88.74%	88.12%	88.27%	87.60%	
	% In Date - Back Training (Role Specific)	77.35%	78.53%	79.60%	81.28%	83.89%	85.60%	87.11%	88.44%	88.73%	88.85%	88.44%	88.08%	88.04%	
	% In Date - Child Protection (Role Specific)	86.13%	86.72%	87.84%	88.65%	83.18%	86.71%	88.39%	90.81%	90.29%	90.09%	89.94%	88.14%	88.44%	
	% In Date - Information Governance	79.26%	80.12%	81.45%	82.61%	82.45%	84.79%	85.70%	85.32%	84.62%	86.47%	85.34%	85.50%	84.60%	
	% In Date - Adult Protection	88.91%	89.54%	90.50%	90.91%	85.82%	88.74%	90.39%	92.36%	91.85%	91.73%	91.74%	91.15%	91.48%	
	% in Date - Equality & Diversity	88.84%	89.87%	91.02%	91.70%	91.92%	92.42%	93.16%	93.61%	92.67%	93.32%	92.54%	92.24%	92.43%	
	% in Date - Health & Safety	93.82%	93.34%	93.68%	93.21%	93.40%	93.31%	93.77%	93.80%	92.60%	93.98%	92.01%	91.63%	91.93%	
	% in Date - Resus	69.27%	71.05%	73.29%	73.26%	74.63%	74.62%	75.02%	75.64%	77.56%	78.13%	77.70%	77.80%	78.07%	
Capacity	Starters	139	209	201	190	189	202	157	140	691	223	369	199	113	
	Leavers	127	135	127	156	145	120	124	136	402	183	172	114	107	
COVID*	Absence	308	456	329	424	0	0	0	0	0	52	147	147	0	

Industrial Action & other risks

University Hospitals Sussex NHS Foundation Trust

Industrial Action

- Supported system response to Ambulance action
- Industrial action by RCN managed on 18 & 19 Jan
- Good engagement with our Trade Unions and staff – hope to capitalise on this partnership working in improvement work
- Approach of facilitating the right to strike balanced with safety and minimising impact
- Next RCN action 6 & 7 February

People risks (Q4)

- Further Industrial Action
- Recruitment
- Retention and morale
- Louisa Martindale Building opening (training, change management and recruitment)
- Maintaining sufficient staffing for the levels of activity / demand being experienced
- Staff absence / availability
- Staff stretch and the impact of that on their and patients' experiences

University Hospitals Sussex
NHS Foundation Trust

Sustainability

Integrated Performance Report Section

Sustainability True North – Financial Plan

University Hospitals Sussex NHS Foundation Trust

The Trust's True North domain for sustainability for 2022/23 is 'living within our means providing high quality services through optimising the use of resources'. Achievement is measured through the delivery of the financial plan which has 4 key metrics: Income & Expenditure, capital, cash and efficiency programme performance.

- The financial (I&E) target for 2022/23 is breakeven. As at the end of Q3, the Trust reported a year-to-date deficit of £18.9m; which is £13.9m adverse to plan.
- Achievement of the financial target is challenging; particularly in the context of urgent and emergency care pressures, elective activity requirements and excess inflation costs.
- Mitigating actions have been deployed to improve the deficit position but it is now unlikely that that the financial target will be achieved in full in 2022/23. The Trust is reviewing the current year end trajectory, in partnership with ICB colleagues and it is likely that in Month 10 there will be a change in the forecast year-end position.
- The cash balance of £74.2m is £8.7m less than plan at the end of Month 9, work continues on making timely payments to improve our performance against the Better Payments Practice Code.
- Capital expenditure is £9m above plan. Within this, expenditure for 3T's is on track, the underspends relate to service developments. Forecast outturn remains on plan.
- Year to date, Efficiency performance is £2.8m below plan, operational pressures have impacted on productivity scheme delivery. The forecast outturn is £6m deficit by year end.

Sustainability Key Metrics

University Hospitals Sussex NHS Trust

R

I&E £k	YTD Plan	YTD Actual	Variance
Income	(1,007,684)	(1,004,869)	(2,815)
Operating Costs	997,852	1,008,943	(11,091)
Finance Costs	15,298	15,080	218
Performance Adjustments	(516)	(274)	(242)
Overall performance	4,950	18,880	(13,930)

The actual position is a year-to-date deficit of £18.88m, which is a £13.93m deficit to plan. This is due to increased costs of insourcing and outsourcing, to deliver activity, and operational pressures linked to staff availability, bed capacity and flow.

A

Cash £k	YTD Plan	YTD Actual	Variance
	82,888	74,179	(8,709)

Cash is £8.87m less than the plan submitted to NHSE/I due to making higher than planned payments in order to maintain the Trust's Better Payments Practice Code (BPPC) performance and to accommodate the year-to-date deficit against plan.

The Trust year-to-date BPPC performance is 84% of invoices (volume), which represents 88% of payments (value), paid within agreed terms with suppliers. This is an improvement on Q2, but below the national target of 95%.

Work is progressing to improve the invoice approval process in order to improve the BPPC performance.

A

Capital £k	YTD Plan	YTD Actual	Variance
3T's Phase 1	(23,440)	(23,686)	246
Operational Schemes:			
Medical Devices / Digital	(8,844)	(9,408)	564
Service Developments	(27,237)	(22,236)	(5,001)
Estates	(15,301)	(10,466)	(4,835)
Charitable	(626)	(651)	25
Overall performance	(75,448)	(66,447)	(9,001)

The expenditure on the 3T's new hospital scheme is on track.
The underspend on service developments schemes mainly relates to centrally funded schemes for the CDC at Southlands and the Endoscopy unit at PRH, whilst the underspend on estates schemes relates mainly to the emergency department scheme.
The forecast outturn for capital is to achieve the agreed plan.

A

Efficiency £k	YTD Plan	YTD Actual	Variance
	29,972	27,188	(2,785)

The efficiency programme is £2.78m behind plan, which is predominantly within the 3% cost reduction and productivity schemes.

Underperformance against the 19/20 activity baseline, coupled with high levels of insourcing and outsourcing, continues to impact on productivity schemes delivery. Divisional tactical delivery are largely as planned, except for medical staffing schemes which continue to underperform.

Non NHS Income schemes continues to be below plan, mainly due to private patients capacity being used for NHS patients, to part mitigate operational pressures, impacting on private patient income.

Sustainability – Risks

University Hospitals Sussex NHS Foundation Trust

- **Elective Performance** - Risk that the Trust is unable to deliver required reductions in 78 week waits and recover to 100% of 19/20 activity levels.
  - Reliance on insourcing and outsourcing to the Independent Sector which has a significant financial impact.
  - Urgent care pressures and the critical incident in December have both resulted in elective activity cancellations.

- **Urgent Care** - There continues to be significant impacts on patient flow and hospital capacity.
  - This has resulted in a risk to delivery of elective activity, resulting in further use of the Independent Sector.
  - Additional bed capacity has opened and extra resources have been deployed within our emergency departments.
  - Increased levels of temporary staffing resulting in high agency costs have been required.

- **Efficiency -** Risk that the Trust does not have the capacity to achieve the level of efficiency required in addition to delivering elective Restoration & Recovery, whilst managing urgent care pressures and continuing covid constraints.

- **Inflation -** Risk that the Trust does not have the ability to mitigate the pressures from the significant utilities above inflation price increases. Current rates of inflation are c11%.

Sustainability - Actions & Recommendations

University Hospitals Sussex NHS Foundation Trust

There are no actions required of the Board.

The Board are asked to **NOTE** the following:

- The year-to-date performance as at the end of Q3 is £18.9m deficit.
- The efficiency programme delivery is £27.2m year-to-date, which is £2.8m away from plan.
- The Trust is reviewing the current year end trajectory, in partnership with ICB colleagues and it is likely that in Month 10 there will be a change in the forecast year-end position.
- Detailed financial performance information has been shared with Sustainability Committee; who continue to provide oversight on behalf of the Board.

NHS
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Systems & Partnerships

Integrated Performance Report Section

Systems & Partnerships Summary Q3

University Hospitals Sussex NHS Foundation Trust

- The Systems and Partnerships True North domain of ‘delivering timely, appropriate access to acute care\ as part of a wider integrated system’ is measured through the key national elective and emergency care access targets.

- The delivery of this is measured through the following NHS constitutional metrics:
  - A&E: treatment and admission or discharge within 4 hours;
  - Referral to Treatment (RTT): definitive treatment within 18 weeks;
  - Cancer: diagnosis and treatment within 62 days;
  - Diagnostics: investigation undertaken within 6 weeks.

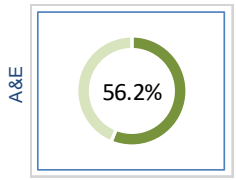
- The overall Trust performance against these measures at the end of Quarter 3 2022/23 has deteriorated for emergency care, with significantly increased pressure on operational services as a result of ongoing Covid impacts, and wider system challenges against these targets.

- There have been improvements made in cancer and longest RTT waits, and a deterioration in diagnostic waiting time performance Q4, in the context of winter and industrial action pressure.

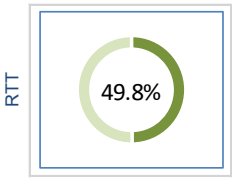
Performance Summary December-22 Q3

University Hospitals Sussex NHS Foundation Trust

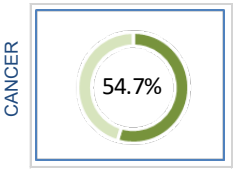
True North and NHS Constitutional Targets



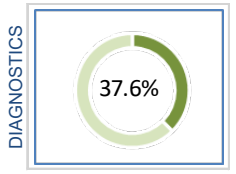
- The Trust treated 59.4% of patients within 4 hours of attending all A&E departments October to December , and 56.2% December 2022. National performance was 65% Sep-22
- There was renewed pressure on Trust emergency departments in particular with increases in long length of stay patients as a result of constrained flow, exacerbated by the Omicron Covid-19 wave's re-emergence, with additional pressures associated with Industrial Action.



- The Trust has 49.8% of patients waiting longer than the target 18 weeks at the end of Dec-22. National performance was 60.1% November-22.
- The total number of patients waiting for elective treatment at the Trust is 125,576, 15 of which were waiting over 104 weeks, due to patient availability, or specialist complexity. Although non elective operational pressures have increased the Trust has remained committed to eliminating longest waits for patients on an RTT pathway.



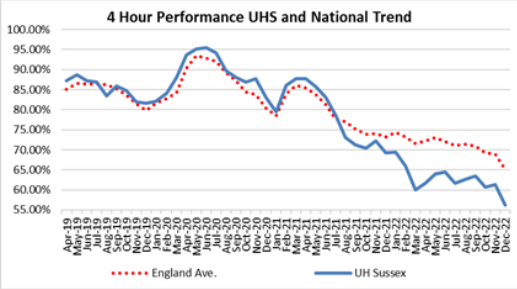
- 54.7% of patients who commenced cancer treatment were treated within 62 days in November. National performance was 61.0%.
- There has been a reduction in over 62 and 104 day prospective waits to November, from 543 Aug-22 to 378 Nov-22 for over 62 day patients, and from 127 patients Aug-22 to 98 in Nov-22 for over 104 week waits. This has increased in December to 462 >62 days, and 100 over 104 days.

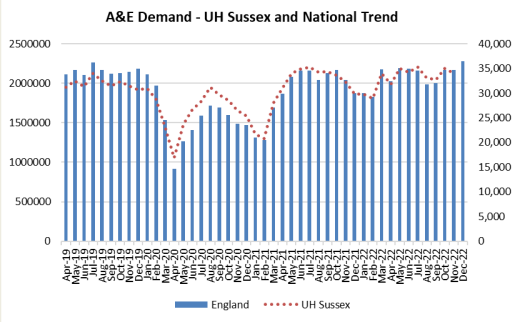


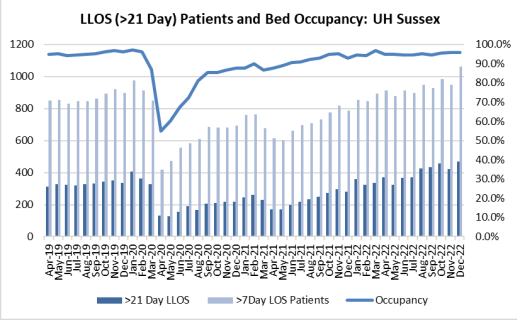
- The Trust had 37.6% of patients waiting more than 6 weeks at the end of December for a diagnostic against a 1% target. This is deterioration of 10.3% relative to Nov-22 position of 27.3%
- The National average for Nov-22 was 26.9%

A&E Performance Summary Q3

University Hospitals Sussex
NHS Foundation Trust







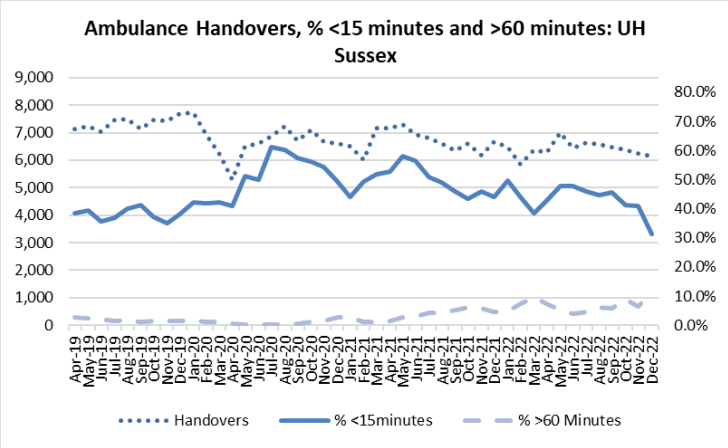
- The Trust treated 59.4% of patients within 4 hours of attending all A&E departments October to December , and 56.2% December 2022. National performance was 65% Dec-22
- To ensure patient safety, the time to triage, treatment and mean waiting times are key areas of focus for the Emergency Department teams. These have been continued to be extremely challenging in Quarter 3 2022.

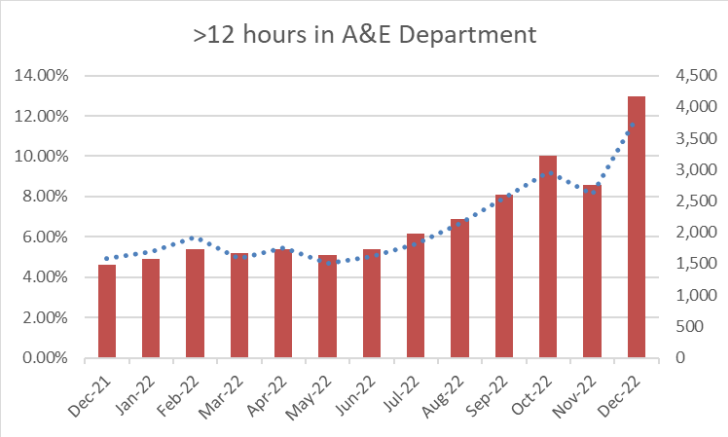
UHSussex	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Time to Triage:	18.9	18.6	22.6	29.1	25.3	21.3	22.2	23.7	21.3	23.2	24.4	23.7	27.8
Time to Treatment:	102.5	99.2	114.8	143.0	130.4	128.1	134.1	142.2	137.5	131.7	142.5	137.9	148.1
Mean Waiting Time:	275.0	280.7	296.3	332.9	319.8	306.4	316.6	332.4	347.3	343.8	373.4	360.5	432.3

- There are high levels of emergency demand but flow is made more complex and delayed by the ‘red/green’ pathway split within ED and the hospitals and this is made more challenging each time there is another wave of covid. The main driver for long wait times is the inability to create flow out of the Emergency Departments and admit patients in a timely manner.
- The Trust is working with system partners whilst simultaneously looking at internal processes to balance the discharge profile against the A&E demand. This includes working on morning discharges as well as working to increase weekend discharges with the aim to decompress Monday/Tuesday pressures.
- There have been material increases in the numbers of patients in the Trust’s acute beds who are Long length of stay patients over 21 days, 28% of beds in December-22. A corporate project looking at Length of Stay and how we will work to reduce this has been launched. There are three workstreams in this project to ensure that all aspects of LoS are covered
- The key metrics describe overall Trust performance but there has been material variation by site, although in September-22 all of the Emergency Departments have been challenged. Each site implemented plans for use of super surge capacity to ensure boarding and plus 1 was done safely and in a robust way.

Ambulance Handovers and A&E 12 Hours

University Hospitals Sussex NHS Foundation Trust

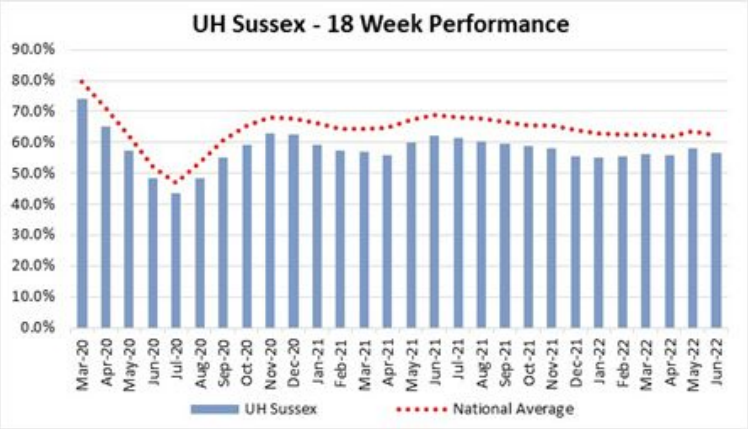


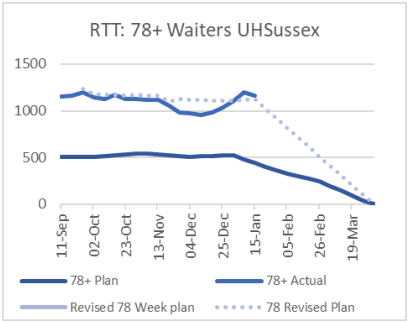


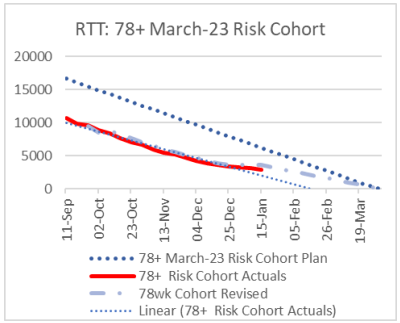
- Over 60 minute handovers in December increased to 726 (11.8%) compared to 392 (6.3%) Nov-22 and compared to 122 (1.6%) in December-19. 307 of the 60 minute plus handovers were at the Royal Sussex County Site and 213 at SRH
- The Trust saw a deterioration to 31.3% of handovers within 15 minutes December-22 , compared to 40.9% November-22, and from September-19 (38.1%). This is variable by site, with 13.7% at RSCH, 23.7% PRH, 42.4% SRH, and 42.8% Worthing
- Patients 12 hours in A&E department increased in December-22 compared to August-22 (11.9% compared to 8.1% November) of attendances. Performance is most challenged at RSCH with 18.9% on average of RSCH attendances in department more than 12 hours in December-22 compared to 17.6% Nov-22.
- Patient safety is a concern for both long ambulance handovers and patients remaining in the department for over 12 hrs. Flow through EDs of admitted patients is a driver of both of these metrics: patients stay longer in the department whilst waiting for a bed and this leads to congestion in the EDs and delays offloads of ambulances.
- Both of these metrics require the flow through the EDs to be increased and for this be maintained through the day.
- The project work on LoS, the safe use of super surge capacity is underway as well as work with system partners to ensure discharge processes are as efficient as possible: these schemes will create capacity on the wards allowing better flow through the ED reducing 12 hr stays and reducing ambulance handover delays

RTT Performance Summary Q3

University Hospitals Sussex
NHS Foundation Trust





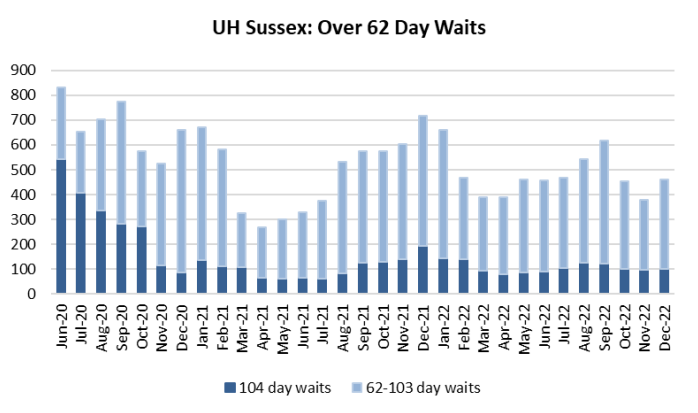


- The Trust has 49.8% of patients waiting longer than the target 18 weeks at the end of Dec-22. National performance was 60.1% November-22.
- There were 1165 78 week breaches 15th January 44 higher than planned recovery
- Progress has been maintained in treating the longest waiting patients, and at the end of Dec-22 there were 15 patients waiting over 104 weeks (compared to 286 December-21), all of which are classified as patient choice, clinical reasons or due to the specialist nature of the pathway.
- The Risk cohort for patients whose 78 week breach date is before the 1st April has reduced to 2873 15th January 696 ahead of the Trust recovery plans.
- The Trust has plans to the manage the majority of the 78 week wait cohort by the end of the financial year. The plans focus on productivity improvements, internal additional capacity, mutual aid across Sussex and the use of the independent sector. Industrial action and emergency pressure have exacerbated risk of achieving this target.
- The waiting list grew by 3386 patients in December to 125,576. The waiting list has grown by 22% since the end Mar-22. This is mirroring the national trend for increasing patients on the waiting list, and illustrates supply is not keeping pace with increased demand.

Cancer Performance Summary Q3

University Hospitals Sussex NHS Foundation Trust

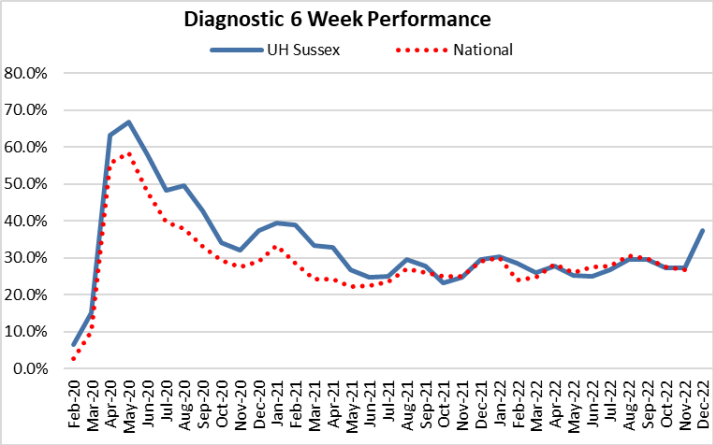
		Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Retrospective Performance	2WW	62.56%	61.71%	73.20%	74.90%	
	2WW - Breast Symptomatic	21.17%	21.05%	24.13%	19.06%	
	31 Day - Surgery	77.78%	67.65%	89.19%	84.44%	
	31 Day - Drug	96.94%	98.15%	99.07%	93.58%	
	31 Day - First	89.95%	91.01%	90.05%	89.73%	
	31 Day - Radiotherapy	68.52%	77.19%	74.29%	71.01%	
	62 Day - GP Refs	55.21%	60.50%	57.32%	54.67%	
	62 Day - Screening	72.73%	64.47%	57.83%	38.46%	
	62 Day - Upgrade	61.32%	62.90%	55.67%	66.06%	
	28 Day FDS	66.79%	62.99%	62.21%	65.38%	
Prospective Waits	Total PTL	5,088	5,231	4,706	4,978	5,104
	*>62 Day Breaches**	543	617	452	378	462
	*>104 Day Breaches**	127	123	99	98	100
	% PTL >62 days	10.7%	11.8%	9.6%	7.6%	9.1%
	% PTL >104 days	2.5%	2.4%	2.1%	2.0%	2.0%

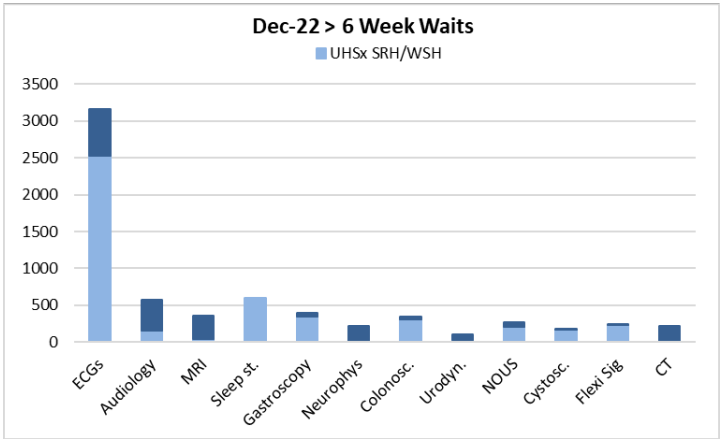


- Cancer 62 day cancer treatment targets were not met in Nov-22 with 54.7% starting treatment in under 62 days. National performance was 61.0%.
- There has been a reduction in over 62 and 104 day prospective waits in November, from 543 Aug-22 to 378 Nov-22 for over 62 day patients, and from 127 patients Aug-22 to 98 in Nov-22 for over 104 week waits. This has increased in December to 462 >62 days, and 100 over 104 days.
- The Trust performance improved by 3.2% to 65.4% Nov-22 for the new 28 Day Faster Diagnosis standard, compared to 69.7% Nationally.
- In agreement with system colleagues a revised trajectory has been developed with the ambition to deliver the requirement of recovering 62 day prospective waits (to Feb-20 levels) and 75% for Faster Diagnosis Standards, by Jan-23.
- Comprehensive action plans by anatomical site are tracked robustly by the cancer divisional leads.

Diagnostic Performance Summary Q3

University Hospitals Sussex NHS Foundation Trust





- UH Sussex achieved 37.6% in December-22 against the diagnostic patients over 6 week target of 1%. This was a significant deterioration of 10.3% relative to November. This compares to 26.9% National performance (Nov-22)
- The waiting list snapshot is as of the 31st December, and reduced due to a drop in demand Christmas week, whilst capacity was also lower due to industrial action and staff and patient availability. This was also compounded by PAS migration and reporting for endoscopy in particular was reduced in December, also leading to growth in waiting list size and shape.
- Imaging, ECGs (Echocardiograms), and Neurophysiology have been most impacted by workforce constraints. High emergency pressures have also resulted in significantly higher demand for imaging services in particular.
- Plans are in place to increase service capacity at Worthing for Echocardiography (ECGs)
- Some areas such as MRI, and gastroscopy have seen significant reductions in 6 week backlog since Mar-22

Summary and Forward Look 22/23

University Hospitals Sussex NHS Foundation Trust

- Performance in Q3 has been significantly challenged, but there has been good progress with mitigation plans that are designed to address the continued pressures.
- Within Emergency care, work has continued with Sussex ICS partners to focus on both alternatives to A&E attendance and efforts with partners to target MRD patients, and LOS for patients not on a complex pathway.
- The elective and cancer recovery plans are well developed and continue into Q4 22/23. Executive weekly scrutiny and system support have meant the Trust are on a strong footing to continue to reduce long waiting patients in 22/23. This enable the potential risks within them to be closely managed and early identification of mitigations to ensure that as many long waiting patients are treated as possible.
- Operational planning for 23/24 has commenced with targets to achieve 76% A&E performance by March-24, eliminate over 65 week waits, reduce over 62 day waits for cancer, and reduce over 6 week diagnostic performance to less than 5%. The Trust is constructing plans to target these areas
- The key risks remains the operational pressures relating to urgent elective and emergency demand, the impact of Covid-19 and the recent industrial action which impact capacity and workforce across all areas of delivery.

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System Oversight Framework

Integrated Performance Report Section

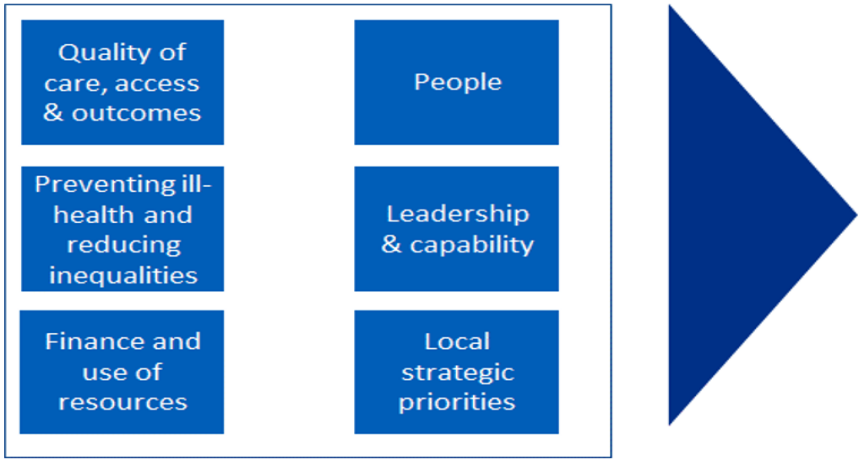
Systems Oversight Framework

University Hospitals Sussex NHS Foundation Trust

The system oversight framework for 2022/23 builds on the 2021/22 framework but takes account of:

- Statutory role of ICBs
- NHSE duty to undertake annual performance assessment of ICBs
- The learning from the implementation of oversight framework during 2021/22
- The revised NHS priorities set out in 2022/23 planning documentation

The oversight framework covers 6 areas, as shown below along with how their measurement is undertaken



- Core quality and planning guidance metrics including headline LTP measures collected at ICB and organisational level
- Additional ICB and organisation metrics required for assurance and assessment
- Metrics to support monitoring of key local priorities
- Strategic and operational plans
- 'Use of Resources' reviews
- Annual report
- Digital maturity

Systems Oversight Framework

University Hospitals Sussex NHS Foundation Trust

The review meetings schedule is agreed between NHSE region, the ICB and each trust. University Hospitals Sussex meetings are bi-monthly alongside regular weekly Winter, Urgent and Emergency Care and Planned Care meetings.

The oversight process follows an ongoing cycle of:

- monitoring ICB and NHS organisation performance and capability under six themes
- identifying the scale and nature of support needs
- co-ordinating support activity (and where necessary formal intervention) so that it is targeted where it is most needed.

System Oversight Framework Q3 Position

University Hospitals Sussex NHS Foundation Trust

Trust's current rating

The Trust's position within the System Oversight Framework for Quarter 3 is Segment 3. The Trust's position for Quarter 4 has yet to be determined but it is likely the Trust will remain in Segment 3.

Implications of this segmentation

- Access to external advice and support with the development of improvement plans will be supported by NHSE/I and the ICS
- The lead for the oversight of the Trust's performance remains with the ICB
- The Trust is in dialogue with the ICB and NHSE on the support available

Actions being taken to move from segment 3

The move to segment 2 will be contingent on delivery of the its operational delivery and financial plan along with the improvements required by the CQC

System Oversight Framework – Actions and Recommendations

University Hospitals Sussex NHS Foundation Trust

There are no actions required of the Board

The Board is asked to **NOTE** the Trust's segmentation rating remains a 3 for quarter 3 with the rating for quarter 4 yet to be determined but is unlikely to change.

The Board is asked to **NOTE** that the Trust's move to segment 2 will be contingent on delivery of the its operational delivery and financial plan along with the improvements required by the CQC.

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Agenda Item:	14	**Meeting:**	Board	**Meeting Date:**	February 2023
Report Title:	Patient Committee Chair report to Board				
Committee Chair:		Jackie Cassell, Committee Chair			
Author(s):		Jackie Cassell, Committee Chair			
Report previously considered by and date:					
Purpose of the report:					
Information		☐	Assurance	✓	
Review and Discussion		☐	Approval / Agreement	☐	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		☐	Staff confidentiality	☐	
Patient confidentiality		☐	Other exceptional circumstances	☐	
Implications for Trust Strategic Themes and any link to BAF risks					
Patient	✓	Assurances in relation to risk 1.1			
Sustainability	☐				
People	☐				
Quality	☐				
Systems and Partnerships	☐				
Research and Innovation	✓	Assurances in relation to risks 6.1, 6.2 and 6.3			
Link to CQC Domains:					
Safe		☐	Effective	☐	
Caring		✓	Responsive	✓	
Well-led		✓	Use of Resources	☐	
Communication and Consultation:					

Executive Summary:

The Patient Committee met on the 1 November and was quorate as it was attended by two Non-Executive Directors, the Chief Medical Officer, the Chief Governance Officer, the Chief People Officer and the Chief Executive. In attendance were the Director of Patient Experience, the Deputy Director of Engagement and Involvement and the Director for Improvement and Delivery, Assistant Director Patient Experience and Assistant Director of Communications and Engagement and Director of Clinical Research.

This was the first meeting in which the Committee received reports relating to the Research and Innovation domain alongside its routine reports on the Patient domain.

The Committee received its planned items including the Patient True North, Breakthrough, Corporate Project and Strategic Initiative, the quarter 3 patient experience report, the National Maternity Patient Survey results, an update on the friends and family reporting system and reports from the Committee's reporting groups along with the Research and Innovation Steering Group Terms of Reference, Breakthrough Objective project charter. The Committee also considered both the Corporate Risks with a potential patient impact and the BAF risk for which it has assigned oversight.

Patient Experience Feedback

The Committee noted the actions taken in response to patient feedback received during quarter 3 for improving patient experience and was assured these are aligned to those areas within the developed Patient Experience Strategy. The Committee noted the enhanced reporting capabilities within the new Friends and

Family Test (FFT) system and how this offers opportunities to bring a focus to the Trust's improvement actions.

National Maternity Patient Survey report for 2022

The Committee noted the results from the National Maternity Patient Survey report for 2022 relating to a survey of women over 16 who gave birth between the 1st and 28th February. The survey reported an overall a positive level of satisfaction, with 8 from 51 questions being ranked better than the national average, although for several questions the 2022 survey satisfaction was lower than the prior year. These reductions were however less marked than other providers nationally, and no question scored less than the national average. The Committee noted that the improvement plan for the service based on these results would be reported to the Quality Committee as part of the routine suite of information relating to Maternity.

Patient Breakthrough Objective, Strategic Initiative and Corporate Projects

The Committee noted the detailed Committee oversight arrangements for each True North, Breakthrough Objective, Strategic Initiative and Corporate Project and the developments being made to the Strategy Deployment Process with the inclusion of a Hospital Deep Dive which would inform a process for Hospital Strategy Development Reviews.

The Committee in considering the update on the delivery of the Trust's Breakthrough objective for 'Patient', endorsed the work described by the Director of Patient Experience, Engagement and Involvement to develop the Trust's Welcome Standards through engagement with key cohorts of staff. The Committee encouraged drawing on input from Trust receptionists within this co design of these Standards.

The Committee noted that the Patient Breakthrough Objective and its potential for positively impacting on the Patient True North will be considered at the Patient First Steering Group to ensure that Trust's improvement activity remains correctly targeted.

The Committee discussed the Patient First Improvement Strategic Initiative and recognised the significant level of work undertaken across the Trust to mobilise the improvement projects aligned to the Trust's strategy refresh. Through the work presented to the Committee and this report the Committee remained assured that Patient First remains central to the Trust's delivery of improvement.

Research and Innovation

The Committee discussed the work being undertaken in respect of the developing Research and Innovation (R&I) Strategy and the establishment of a Research and Innovation Steering Group which will report to the Committee. Terms of Reference which is to be the mechanism by which the management oversight for the delivery of the R&I True North through the development of and then the delivery of the Trust's R&I strategy. The research lead provided information on the 7 workstreams that underpin the delivery of the R&I strategy. The Committee **NOTED** the work being undertaken to develop the Trust's R&I Strategy and its interlinkage to our partners and their respective strategies.

The Committee **AGREED** the Terms of Reference of the Research and Innovation Steering Group.

Patient Risks and BAF

The Committee reviewed the Trust's key risks with their potential to impact on patient experience and noted those with the highest current score and their alignment to the Patient Strategic Risk which is maintained its score at 16. The Committee noted the work within the Quality Corporate Project will enhance the reporting of risk throughout the organisation through an enhanced focus on the assurance that the established control are operating as intended along with the progress with the mitigating actions and that they will lower the risk.

University Hospitals Sussex
NHS Foundation Trust

Key Recommendation(s):
The Board is asked to **NOTE** the assurances received at the Committee and the actions taken of the Committee within its terms of reference. The Board is asked to **NOTE** both Committee's review and endorsement of the Research and Innovation Breakthrough Project charter. The Board is asked to **NOTE** the Committee's approval of a revision to the Committee's terms of reference to reflect the Committee's allocated oversight for Research and Innovation. The Board is asked to **NOTE** the outcome of the Committees review of BAF risks 1.1, 6.1, 6.2 and 6.3 and that the Committee's view is that these risks are fairly represented and therefore these risk scores were recommended to Board.

University Hospitals Sussex NHS Foundation Trust

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
Patient Committee	**1 November 2022**	**Jackie Cassell Committee chair**	yes ✓	no ☐

Declarations of Interest Made

There were no declarations of interest made

Assurances received at the Committee meeting

Patient True North, Breakthrough Objective, Strategic Initiative and Corporate Project

The Committee **RECEIVED** updates on the Patient True North, Breakthrough Objective, Strategic Initiative and Corporate Project aligned to this Committee.

Patient True North – To have 95% or more of patients, rating FFT surveys as good or very good

2022/23 Quarter 3 Patient Experience Report

The Committee **RECEIVED** the quarter 3 report on the patient experience feedback and the actions taken as a result of this feedback. The Director of Experience, Engagement and Involvement provided the Committee with information on the key areas being flagged within the Friends and Family Test responses by area, A&E, Outpatients, Inpatients and Maternity along with feedback provided from patients through complaints and PALS aligned to the clinical operating model. The Committee **NOTED** that the analysis undertaken in respect of the themes from these sources of feedback, reflecting that waiting specifically on site for treatment, the environment for waiting within the emergency department, communication and discharge all are areas for action within the Patient Experience Strategy. The Committee also **NOTED** that the Friends and Family Test (FFT) satisfaction results outweighed the level of negative comments.

The Director of Experience, Engagement and Involvement provided an update on the developing divisional dashboards which take from the FFT data and show the key themes from both the positive and learning comments. The Committee **NOTED** the enhanced information this provides to the divisions and the opportunity it provides to give focus to improvements for specific patient groups, and welcomed the emergence of metrics that can enable tracking of delivery on Patient Experience.

The Committee discussed the Trust's complaint response times and the learning opportunities presented from this source of feedback. The Committee recognised the strength of the Trust's process and how this supported the drive for delivery of timely responses, while encouraging ongoing efforts to identify further improvements in the process. The Committee **NOTED** the update from the Director of Experience, Engagement and Involvement that the quality of the responses has correctly been focused on and balanced with speed, and that increasing levels of positive replies are being received from complainants in respect of their compliant response.

The Committee **NOTED** the enhanced reporting of performance against the delivery in quarter 3 against the Trust's 2022/23 priorities for improving patient experience and was **ASSURED** these are aligned to those areas within the developed Patient Experience Strategy.

The Committee was updated on the identified good practice reflected in the plaudits received which is shared widely so others can replicate these actions. The Committee **NOTED** the update from the Director of

Experience, Engagement and Involvement and was **ASSURED** that the Trust remains committed to listening to all feedback and acting where improvements are required.

The Committee **RECEIVED** a report from the Director of Patient Experience, Engagement and Involvement on the capabilities of the Trust's new friends and family test system and the plans supporting its deployment. The Committee **NOTED** the enhanced trend and dashboard information this system provides over that available within the previous system. The Committee discussed and **AGREED** the potential the new system has to provide information on responder characteristics which would help the Trust to focus improvements. It also encouraged ongoing engagement with the provider to further optimise the usability of the patient interface over time.

2022 Maternity Patient Survey

The Committee **RECEIVED** the Maternity Patient Survey report for 2022 relating to a national survey of maternity services for each Trust where there had been at least 300 live births during the year. Women over 16 who gave birth between the 1st and 28th February where surveyed for their views on the service. The Committee **NOTED** the results, in the context that responses rates to national surveys are relatively low, that the survey reported an overall a positive level of satisfaction, with 8 from 51 questions being ranked better than the national average although for several questions the 2022 survey rates were lower than the prior year. These reductions were however less marked than other providers nationally, and no question scored less than the national average. The Committee emphasised the importance of drawing on other sources of intelligence on patient experience for maternity patients from black and other ethnic minority groups, a small number and not separately analysed in this survey.

The Committee **NOTED** this update that that the developed improvement actions from this survey will be overseen by the Quality Committee.

Patient Breakthrough Objective - Reduction in negative comments in FFT surveys that relate to waiting experience

The Committee **RECEIVED** the update on the delivery of the Trust's Breakthrough objective for 'Patient', this being the area where improvement action has the potential to have the largest positive impact on the True North. The Director of Patient Experience and Engagement gave an update on the on work being undertaken within A&E and Trust wide on waiting, recognising waiting is being addressed within other Patient First projects. This Breakthrough Objective is focusing on improving the feedback in respect to communication and staff attitude. The work being undertaken on the Welcome Standards aligned to the patient experience strategy taking the best practice from various service sectors. The Committee **ENDORSED** the approach of co-design of the Welcome Standards through engagement with key cohorts of staff. The Committee encouraged drawing on the input from Trust receptionists in the development of these Standards. The Committee **NOTED** that this Breakthrough Objective and its potential for positively impacting on the Patient True North and whether it should be refined will be further considered at the Patient First Steering Group.

The Committee **NOTED** this update.

Patient Strategic Initiative – Patient First Improvement Project

The Committee **RECEIVED** the update on the delivery of the Strategic Initiative for which oversight is provided by this Committee, the Patient First Improvement Programme from the Director of Improvement and Delivery. The Director of Delivery and Improvement tookthe meeting through the delivery of the Strategy Deployment Process with the inclusion of a Hospital Strategy Deep Dive which will be used to frame a Hospital Strategy Deployment Review. The Committee **NOTED** that the work continues to improve the levels of PFIS maturity. The Committee **NOTED** that the mobilisation of all the improvement projects, with the planned exception of the patient access transformation corporate project which is not scheduled to commence until later in quarter 4, had taken place successfully into the winter despite pressures. The Committee **NOTED** that the delivery of each of the improvement projects themselves is overseen by the respective oversight Board Committee.

The Committee **NOTED** that Patient First will be the methodology by which the benefits from the use of the Louisa Martindale building, and that this will be reported through the Systems and Partnership Committee which oversees that Strategic Initiative.

The Committee **NOTED** the intention to develop the Patient Strategic Initiative project charter on the Patient Frist Improvement Programme based on the feedback and reflection from the launch of the revised strategic priorities along with the developing Strategy Deployment Reviews.

The Committee **NOTED** this update and was **ASSURED** from the update that Patient First remains central to the Trust and its delivery of improvement.

Research and Innovation True North, Breakthrough Objective

The Committee **RECEIVED** updates on the Research and Innovation (R&I) True North, Breakthrough Objective, newly assigned to this Committee for oversight.

The Committee **RECEIVED** the Research and Innovation Steering Group Terms of Reference which is to be the mechanism by which the management oversight for the delivery of the R&I True North, through the development of and subsequent delivery of the Trust's R&I strategy. The Clinical Research Lead provided information on the seven workstreams that underpin the delivery of the R&I strategy. The Committee **NOTED** the work being undertaken to develop the Trust's R&I Strategy and its interlinkage to our partners and their respective strategies.

The Committee **AGREED** the Terms of Reference of this reporting group covering this domain, subject to additional representation of Nursing, Midwifery and Allied Health Professionals.

Research and Innovation Breakthrough Objective - To increase patient recruitment to NIHR Portfolio studies in the next 12 months

The Clinical Research Lead presented the R&I Breakthrough Objective performance recognising that currently the only available metric supporting this area is participation in Portfolio studies, informing the Committee that work is being undertaken to enhance the completeness and timeliness of this data. The Committee **NOTED** the activity undertaken to identify specialities with potential for significant growth and the work to mitigate the risks to this objective noting their alignment to the newly recorded BAF risks in this domain.

The Committee discussed and **ENDORSED** the project charter which supports the Breakthrough Objective.

ICS and System Collaborations

The Committee **RECEIVED** an update from the Chief Executive on the work with the system, noting the development of specific workstreams which the Trust is actively engaging in to support the drive for system wide and place based improvements for patients.

Reporting Groups

The Committee **RECEIVED** a report from the Chair of the Patent Experience and Engagement Group meeting, the Director of Experience, Engagement, and Involvement in respect of the meetings that took place since the Committee's last meeting. The report provided an update on the activity of the group at these meetings with the Committee **NOTING** the alignment of this Group's work with the Patient Experience Strategy improvement projects. The Director of Experience, Engagement, and Involvement informed the Committee on the work of the Group and that both the internal and external attendance at the Group remained positive and supported the Group to have a focus for its work and had allowed it to consider the Trust's Dementia and Delirium Strategy

The Committee **NOTED** that the Quality Governance Steering Group (QGSG) provides a formal detailed report to the Quality Committee but has a dual reporting line to this Committee. The Committee **NOTED** that there were no items referred to this Committee.

Risk and BAF

The Committee **RECEIVED** and discussed the Risk Register report which provided information in respect of those risks with a potential patient impact.

Across both of the Patient and Quality domains there are 42 risks for quarter 3, that have been raised that have the potential to have an impact on Quality and or Patient Experience, and which have been identified with a post-mitigation score of above 12. Of these risks there are two risks identified with a current risk score of 25, 8 risks scoring 20, and 32 risks scoring 16. There are 16 risks scoring 15. There has been a reduction in the number of risks scoring 16 in this quarter, but an increase to 2 of those risks scoring 25 (both were scored 20 in the previous quarter). The highest scoring risks relate to: -

- Waits within the ED Corridor
- Extended placement of and delay in the treatment of adults, children and young people with mental health needs onto acute wards
- Emergency Department capacity to meet demands leading to patients waiting in crowded areas leading to long waits.
- Workforce pressures and staff vacancies impacting on the ability to meet patient experience
- Availability of equipment or access to resources.
- Increased cancellations due to limited resources leading to long waits
- The Trust's ability to meet patient dignity with high levels of occupancy.

The Committee recognised the interlinkages of these risks to those where the quality, people and systems and partnerships committees have oversight.

The Committee **NOTED** the work within the Quality Corporate Project will enhance the reporting of risk throughout the organisation through an enhanced focus on the need to achieve assurance that the established control are operating as intended along with the progress with the mitigating actions and that they will lower the risk

The Committee had a discussion on the BAF and the respective risks it has assigned oversight, this being risks 1.1, 6.1, 6.2 and 6.3. The Committee **AGREED** given both the direct review of the BAF and the supporting corporate risk report that the current scores for these BAF risks were fairly stated as well as being supported by the information received within the meeting.

Committee Terms of Reference review

The Committee reviewed a revised Terms of Reference reflecting that this Committee had been allocated oversight of the Trust's Research and Innovation activities which had previously sat with the Quality Committee. The Committee recognised that the oversight of this area may be short term as the Trust's R&I strategy and supporting plans develop then the Board is committed to considering the establishment of a separate Board Committee. The Committee **APPROVED** the revisions to its Terms of Reference.

Actions taken by the Committee within its Terms of Reference

The Committee **ENDORSED** the Trust's Research and Innovation Breakthrough Project charter.

The Committee **AGREED** the Terms of Reference of the Research and Innovation Steering Group.

The Committee **AGREED** to recommend the quarter 4 scores for BAF risks 1.1, 6.1, 6.2 and 6.3 to the Board.

The Committee **APPROVED** the revisions to its Terms of Reference.

University Hospitals Sussex NHS Foundation Trust

Items to come back to Committee (Items the Committee keeping an eye on outside its routine business cycle)	
The Committee did not identify any specific matters outside its normal business cycle to come to its next meeting.	
Items referred to the Board or another Committee for decision or action	
Item	**Referred to**
The Committee following a detailed discussion agreed to **RECOMMEND** to the Board that risks 1.1, 6.1, 6.2 and 6.3 within the BAF for which it has oversight are fairly represented.	Board Feb 2023

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	15	**Meeting:**	Board	**Meeting Date:**	February 2022
Report Title:	Quality Committee Chair report to Board				
Committee Chair:		Lucy Bloem, Committee Non Executive Chair			
Author(s):		Lucy Bloem, Committee Non Executive Chair			
Report previously considered by and date:					
Purpose of the report:					
Information		✓	Assurance	✓	
Review and Discussion		☐	Approval / Agreement	☐	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		☐	Staff confidentiality	☐	
Patient confidentiality		☐	Other exceptional circumstances	☐	
Implications for Trust Strategic Themes and any link to BAF risks					
Patient	✓	Links to risk 1.1			
Sustainability	☐				
People	☐				
Quality	✓	Assurances in relation to risk 4.1 and 4.2			
Systems and Partnerships	☐				
Research and Innovation	☐				
Link to CQC Domains:					
Safe		✓	Effective	✓	
Caring		✓	Responsive	✓	
Well-led		✓	Use of Resources	☐	
Communication and Consultation:					

Executive Summary:

The Quality Committee has met monthly in order to meet the national requirement to review maternity performance and therefore this report covers November, December and January 2023. All meetings were quorate, attended by at least two Non-Executive Directors and two executives. In attendance at the meetings were a number of the Trust Directors including, the Trust's Medical Director, along with Director of Midwifery and the Director of Infection Prevention and Control (the latter was represented by their Assistant Director (IPC) at the November meeting) and the Director of Patient Safety and Learning was present in November and December.

At each of the meetings the Committee received its planned items including the reports on the respective Patient First Trust Norths, Breakthrough Objectives, Strategic Initiatives and Corporate Projects, the developing quality scorecard, the perinatal quality surveillance dashboards, Maternity Clinical Negligence Scheme for Trusts, and reports from the Committee's reporting group: Quality Governance Steering Group (QGSG). The only exceptions were in the January meeting when due to operational pressures and absence meant reports covering Clinical Harm Reviews, Infection Prevention and Control Board Assurance Framework, and Venous Thromboembolism (VTE) incident review were deferred.

The Committee received reports over the quarter on a number of areas including: the Sentinel Stroke National Audit Programme (SSNAP), Learning from Deaths Q3, Safeguarding Q2, Infection Prevention and Control Q2, Mental Health Strategy development, and the Trust's Serious Incident and Duty of Candour reports for Q2. The Committee also considered both the Corporate Risks with a potential quality impact at each of its meetings and the Board Assurance Framework (BAF) risks for which it has assigned oversight at its meeting on 24 January.

The Committee, in considering the **Quality Scorecard,** noted the continuing improvement in the data completeness and the narrative that enabled a rich discussion by the Committee. The Committee note at the January meeting an increase in falls that triangulated with the increased bed stays during periods of exceptional demand in December 2022 and an increase in pressure damage.

Through the scorecard the Committee has been tracking the **Neck of Femur** outcomes and noted that Worthing standardised mortality ratio had increased but are now falling but SRH rates are rising and the Committee asked for a review to be undertaken against the national hip fracture database recommendations on governance in the Annual Report.

The Committee noted that rolling crude mortality continues to rise monthly and the Trust Standardised Hospital Mortality Indicator exceeds the scorecard target, with higher SHMI values at by PRH and RSCH sites. Investigations are ongoing with HED (Healthcare evaluation unit at Birmingham University) to determine the cause of this, and a report is expected in the next quarter.

The Committee noted the findings of the **external mortality coding review** into the Trust's clinical coding processes. They supported the hypothesis that shallower coding had missed circumstances that would have impacted the mortality data. The external review assured the accuracy of coding at WH and SRH and outlined recommendations to secure a greater depth to the coding across the Trust.

The Committee received a further update on the risks to **Clinical Outcomes and Effectiveness** due to the capacity and restructure and the action plan that is in place including the appointment of a lead for the team but the Board are advised of the gap in assurance reflected in the Board Assurance Framework while acknowledging there was work ongoing to address this.

In respect of the **perinatal quality surveillance (PQS)** dashboards the Committee noted the enhanced oversight these have brought to the Committee. At each meeting, the Trust's overall and site specific perinatal mortality rates were compared to the national rate. The Committee noted the Trust's overall perinatal mortality rate was above the national target. The Committee noted that the neonatal provision at Brighton (RSCH) means considerably higher risk cases are received which has an impact on outcomes compared to national benchmarks. The risk of staffing levels in RSCH and PRH due to high vacancy and sickness rates and theatre requirement in RSCH were discussed.

The Committee received an update on the **Maternity Safety Support Programme** and noted the recommendations for investment in leadership in areas of the service linked to Workforce; Leadership; Governance; Training; Culture and Clinical Pathways, and a business case was under discussion. As Chair and Maternity NED Safety Champion I have reviewed the evidence supporting the **CNST** submission and was able to confirm this to the ICB.

The Committee welcomed the new Learning from Deaths manager who presented the Quarter 3 **Learning from Deaths report** and noted continued differences across sites in respect of systems and processes used. The committee was **ASSURED** that 98% of deaths in UHSussex were scrutinised by a Medical Examiner and that cases were referred for Structed Judgement Reviews. The Committee noted that there is currently no moderation of SJR's across UH Sussex but recruitment is imminent that would help to support this across the Trust's four sites. It was also noted that SJR reviewer numbers on the RSCH and PRH sites are not yet at the desired level.

The Committee reviewed numbers of Serious Incidents and noted 0 Never Events in the quarter.

The Committee reviewed and approved the Trust's **Mental Health Strategy,** noting the considerable engagement with system partners and agreed this supported the Trust's ambition to improve the quality of services for this cohort of patients. The strategy is recommended for approval by the Board and appended to this report.

The Committee was assured by the update to the committee on the Trust's **Children and Adults Safeguarding** together with the Quarter 2 report. The Committee noted the report highlighted significant increases in activity and workforce pressures and continued referrals of mental health related cases and detainments. The Committee noted full representation by partners and the Integrated Commissioning Board (ICB) at the Q2 Safeguarding meeting at which the University Hospitals Sussex received positive feedback.

The Committee discussed and reviewed the action plans that have been developed for Maternity, Surgery RSCH and ED RSCH resulting from **CQC** inspections noting how the plans have been developed.
General Surgery had recently become a corporate project and has made a strong start encouraged by the level of engagement across the service with this project. The Committee scrutinised progress and received updates on red RAG rated items and confirmed that indeed progress had been made and their status should be recorded 'in progress'.

The Committee received countermeasure summary updates against the new Quality Breakthrough Objectives (harms reductions), Corporate Projects (General Surgery and Quality Governance Effectiveness). The Committee noted the updates and were reassured that these are aligned to the Trust's strategic priorities refresh for 2022/23 – 2023/24.

The Committee reviewed the **Trust's key risks** with the potential to impact on quality and noted that two risks had escalated to 25, the highest possible risk score, relating to RSCH ED pressure and child mental health. There are eight risks scoring 20, which includes 2 new risks relating to paediatric staffing and in-patient mental health care over quarter 2. Reflecting on these risks the committee has asked for an update on Mental Health in the next quarter.

The Committee had a discussion on the **BAF** and the respective risks it has assigned oversight, this being risks 4.1 and 4.2. The Committee reflected on the information received during the meetings in respect these risks along with the update provided post the review by the Audit Committee. The Committee supported the increase of 4.2 to 20 and after some discussion agreed to retain 4.1 at 16.

Key Recommendation(s):

The Board is asked to **NOTE** the assurances received at the Committee and the actions taken of the Committee within its terms of reference.

The Board is asked to **NOTE** the Committee's recommendation in respect of BAF risks 4.1 and 4.2 for which it has oversight, that the scores for start of quarter 3 are fairly represented.

The Committee **RECOMMEND** the Mental Health Strategy for approval.

The Committee **RECOMMEND** Quarter 3 learning from deaths report to the Board

NHS
University Hospitals Sussex
NHS Foundation Trust

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Dates	Chair	Quorate	
			yes	no
Quality Committee	**29 November 2022, 20 December 2022 and 24 January 2022**	**Lucy Bloem**	✓	☐

Declarations of Interest Made

There were no declarations of interest made

Assurances received at the Committee meeting

Quality Dashboard

At each of the three meetings the Committee **RECEIVED** the Trust's quality dashboard with a performance overview across each of the dimensions of Patient Experience, Patient Safety, Clinical Outcomes and Effectiveness and Mortality. The Committee **NOTED** the continued progress on development of the dashboard while work continues to include appropriate quality assured metrics.

At each meeting the Medical Director took the Committee through the Quality scorecard narrative in respect of the dashboard segments covering the domains of mortality, clinical outcomes and effectiveness, patient safety and patient experience. Between November and November reports, there were consistent data flows into the quality scorecard and gaps in data continued to reduce. The Committee continues to anticipate the further improvement to the dashboard through the introduction of Power BI. After triangulation of issues with high scoring risks, the Committee requested that Mental Health metrics are explored for future reporting through the scorecard.

The Committee at each meeting discussed the key elements within Patient Experience. Complaints remaining high, predominantly due to long waits. The Committee asked for assurance that data in the scorecard is tested for its alignment to the Friends and Family Test data as the richness of data from the now whole-Trust FFT system had been acknowledged. The Committee **NOTED** that the patient experience data did not show the decline in positive feedback that might had been expected given the extraordinary waiting times and pressures experienced in December.

The Committee discussed the key elements relating to Patient Safety trends in incident learning as well as the Trust's performance in the associated processes around incidents including the timeliness of incident investigation and adherence to duty of candour. The Committee **NOTED** the supporting report through the Reduction in Harms breakthrough objective that showed higher numbers of moderate and severe incidents in the winter months correlating with the Trusts deteriorated performance, particularly around patients waiting in the community for surgery and patients in hospital waiting for beds. Associated with the review of the mortality data, the Committee invited an update from a review of fractured neck of femur patient outcomes.

The Committee **NOTED** within the scorecard reported progress around Clinical Outcomes and Effectiveness with for SRH and WG measures of compliance with NICE guidance the range of national clinical audits, local clinical audits, National Confidential Enquiries and Stroke audits (SSNAP) as well as the arrangements within the team. The Committee **NOTED** that all clinical effectiveness support processes had continued to face significant resource and capacity pressures due to a period of restructure coinciding with considerable vacancies. The Committee **NOTED** positive recruitment progress to key leadership and roles within the team but confirmed the resource gap on associated assurance processes remain a risk on the Corporate Risk Register and Board Assurance Framework.

Maternity

At each meeting the Committee **RECEIVED** reports in respect of the Trust's Perinatal Quality Surveillance Reports & Dashboards for all four of its maternity units, which included the Ockenden data sets within the current dashboards. The Committee considered each of the dashboards across each of the domains of; learning from any deaths or incidents where the medical Director cross referred to the information within the incident and learning from deaths reports; training which had continued to show good compliance levels; and the voice of the patient for which the information in respect of the Trust's friends and family rates and resultant actions are reported to the Patient Committee. The Committee **NOTED** the information within the reports and the associated dashboards. At the November meeting, the Committee asked that obstetric staffing issues, neonatal risks and associated challenges indicated within related media interest, are reflected in future summary reports.

Through receipt of reports the Committee was **ASSURED** that the Maternity Directorate continue to report neonatal deaths and engages with the Healthcare Safety Investigation Branch (HSIB) as required.

Patient First Trust North, Breakthrough Objective Strategic Initiative and Corporate Project

The Committee **RECEIVED** reports linked to the Trust's delivery of the new Quality True Norths, Breakthrough Objective, and Strategic Initiatives.

Reducing Harm

At the November and December meetings the Director of Patient Safety and Learning provided an update on the True North in relation to harms, this was presented by the Chief Nurse in January. In **RECEIVING** these reports the Committee reflected on the processes for the management of incidents and through the updates at each meeting was **ASSURED** over the Trust's continuing focus on learning through the information provided and the Trust's processes to support families through the investigation process.

At each of the meetings, the Committee **RECEIVED** through the updates from the Director of Patient Safety and Learning on the associated breakthrough objective aligned to the True North on Harm. The Committee was updated on the data analysis undertaken to determine the key priorities for reducing the level of harm whilst maintaining a strong reporting culture. The Committee was **ASSURED** over the operation of the patient safety group and the preparations to implement the Patient Safety Investigation and Reporting Framework from April 2023. The Committee **NOTED** the updates and at the January meeting asked for the triangulation of issues associated with the rise in falls on the Quality Scorecard to be reported back to the Committee and for the information to be provided to the Board through the integrated performance report.

Learning from Deaths

The Committee **RECEIVED** the **Learning From Deaths reports from quarter 3** for 2022/23. The Committee welcomed the new Learning from Deaths manager who presented the report and **NOTED** continued differences across sites in respect of systems and processes used. These differences impact the level of consideration and feedback from the reviews undertaken through the medical examiner and structured judgement review (SJR) processes. While there was considerable variation between sites and examples of poor care there had also been excellent care examples including end of life care arrangements and there had been good governance in the process of reporting and for learning. The Committee was **ASSURED** over the process applied at WH and SRH and the drive for the identification of learning and its cascading across the Trust through the Trust's medical examiner reviews leading then to Structured Judgement Reviews as required and cross referencing with the Serious Incident reporting and review arrangements to ensure that these processes are aligned and linked together.

The Committee **NOTED** that there is some difference in the depth of information across the four sites linked to the resource available. The Committee **NOTED** the recruitment of medical examiners with appointments imminent that would help to standardise arrangements supporting the oversight and review of deaths across

the Trust's four sites though it was **NOTED** that SJR reviewer numbers on the RSCH and PRH sites are not yet at the desired level.

The Committee awaits a review of deaths of any patients with Learning Disabilities at RSCH and PRH for the previous 12 months.

Mortality

At the November, December and January meetings of the Committee the Medical Director (Quality and Governance) took the committee through the True North on Mortality, whilst the True North metric is for crude mortality the Committee **NOTED** that the Trust also tracks both Hospitalised Standardized Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) performance. Following the case note review of the data highlighted in my last report that suggested a coding issue as a cause for an apparent rising trend in SHMI, the Committee received updates against the action plan describing work and received an external coding Audit which had reported preliminarily to the meeting in November and finally in January.

The Committee **RECEIVED** at its January meeting the final report in respect of the external mortality coding review that had included fuller detail in respect of the PRH outlying data. The main findings from the preliminary report received in November remained unchanged and the Committee noted the **ASSURANCE** this report provides. The Committee **NOTED** the confirmation that changes made during covid which brought challenge into the coding process, and whilst the accuracy of coding remained, the depth of coding from discharge summaries only is less.

The Committee **NOTED** the new Breakthrough Objective around the Deteriorating Patient mobilised from September 2022 and the associated countermeasure summary that commenced at the January meeting providing clarity of the problem statement, supported by the introduction of Power BI, would enable particular focus on the improvements to be made in this area.

Quality Priority Projects

The Committee **RECEIVED** countermeasure summary updates against the new Quality Breakthrough Objectives (harms reductions), Corporate Projects (General Surgery and Quality Governance Effectiveness) as well as the Strategic Initiative (Clinical Strategy). The Committee **NOTED** the updates and confirmed that this are aligned to the Trust's strategic priorities refresh for 2022/23 – 2023/24.

The Committee **NOTED** Surgery's report showing positive progress through strong engagement from clinicians. The Committee also received positive **ASSURANCE** from a visit from Health Education England in January had provided largely positive feedback on the experience of foundation trainees. Work toward the standardisation in the approach to handovers was **NOTED**.
The Committee **NOTED** the detailed update on actions taken in respect of the Surgery Corporate Project and the level of engagement across the service with this project.

Clinical Negligence Scheme For Trusts (CNST) Maternity Incentive Scheme

In each of the meetings the Committee **NOTED** progress against CNST year 4 preparations for submission of evidence in January 2023. The Committee **NOTED** that the Trust's internal auditors, BDO, had been engaged to review the process of evidence capture prior to submission and had provided an initial positive conclusion on the Trust's processes and they have confirmed the Trust's identified risk. Two safety standards had been assessed by the Trust as requiring further work to achieve compliance by the year end, BDO have confirmed that there are no other areas of concern. At the January meeting, the Committee **NOTED** the extensive work and oversight towards achieving full compliance. Due to an administrative error it was reported that just one

of the 155 criteria was not met. The Committee **NOTED** that the deficient aspect of mortality data capture had no bearing on patient safety or quality of care and discussions would take place with NHS Resolution to seek their condonation. The submission was under discussion with the Integrated Care Board and the recommended submission with confirmation of ICB support would be submitted to Trust Board.

Mental Health

The Committee **RECEIVED** at its meetings in November and January updates on the developing Mental Health Strategy and **ENDORSED** the Final Draft Strategy for Board approval. The Committee **NOTED** the extensive engagement in developing the strategy that included mental health service users and the Sussex Partnership NHS Foundation Trust as well as Trust staff. The Strategy and summary of engagement are attached at Appendix 1. The Committee **NOTED** the linkage of this work to the Trust's ambition for this cohort of patients and how the Strategy was aligned to the Patient First Domains where improvements will be realised through the developing implementation plan for this Strategy. The Committee asked that in respect of oversight of this strategy, further work should be considered to add a subset of metrics into the Quality Dashboard.

Safeguarding

At the meeting in January the Committee **RECEIVED** the quarterly reports for Adults' and Children's Safeguarding activity. The Committee **NOTED** that the Integrated Safeguarding Strategy Committee meetings gained assurance that all safeguarding commitments and responsibilities for both adults and children are met by overseeing the work of the Safeguarding Adults Operational Group and Safeguarding Children Operational Group. The Committee was **ASSURED** that the Trust was fully engaged with the necessary meetings both internally and those external meetings, including the meetings with the Integrated Care Board system partners, and **NOTED** the considerable work that had ensured all requirements on reporting safeguarding were met.

The Committee **RECEIVED** and **NOTED** the Trust's Adult Safeguarding quarter 2 report which highlighted the work undertaken by the Trust's Adults Safeguarding team in respect to its commitment and responsibilities in maintaining the safety and protection of vulnerable adults at risk of abuse and neglect with the principle that every person should be able to live a life that is free from harm and abuse.

The Committee **RECEIVED** and **NOTED** the Children's Safeguarding quarter 2 report that drew out the details of how the Trust responds to the statutory requirements, national guidance and progress against the priorities for 2022 – 2023.

The Committee **NOTED** the further update provided by the deputy chief nurse in respect of the national changes in respect of liberty and protection standards. The Committee **NOTED** the Trust's engagement with the system and national reviews being undertaken. The Committee **NOTED** that there was nothing referred from the Safeguarding Committees seeking support or action from the Committee and that further quarterly updates are scheduled in line with the Committee's cycle of business.

Infection Prevention and Control (IPC)

The Q2 Infection Prevention and Control report was received in November. The Committee was due to receive the Infection Prevention and Control Board Assurance Framework report at its meeting in January however this item was deferred to the February meeting.

Care Quality Commission

The Committee **RECEIVED** updates from the Chief Nurse and Chief Medical Officer through a tracking report showing the delivery of the actions from recent inspections including Maternity and the ED improvement plan. The General Surgery Corporate Project was presented as a separate item and covered those actions arising from the RSCH Surgery inspection. The Committee **NOTED** reporting of action progress takes place at the NHS Sussex Integrated Care Board Quality Review Meetings.

The Committee **NOTED** that further mitigating actions to address pressures raised in my previous report are contingent on building developments overseen by the Systems and Partnerships Committee.

At the January meeting, the Committee **NOTED** that the reports from the 2022 inspections including well led were still awaited.

Policies and Procedures

In November, the Committee sought assurance in regard to the new boarding process within Trust hospitals to support Emergency Departments. The Committee asked to receive assurance that a written policy outlines the processes, particularly in relation to maximising early discharge, and environmental risks in is progress and would be presented to a future Committee and Trust Board for further oversight.

Committee Reporting groups

At each meeting in November, December and January the Committee **RECEIVED** an update from the Chief Medical Officer on work of the Quality Governance Steering Group (QGSG) at its preceding meetings detailed within the formal report provided to the Committee. The Chief Medical Officer confirmed that the agenda of the QGSG continued to be aligned to the work of this Committee and the key quality risks. The Committee **NOTED** the review of divisional risks scoring 12 or above had been undertaken by divisions.
The Committee **NOTED** at the January meeting an issue of the support personnel coverage dedicated to Quality Governance in each division and asked for an update to be provided.

In December, the Committee **NOTED** the matter discussed at QGSG relating to challenges within Pharmacy affecting the Women and Children division and asked for confirmation from the Chief Pharmacist to the March meeting of the Committee whether the associated delays extended to other divisions.

The Committee welcomed the positive engagement from Divisions with the group and the evidence of live risk register management. The Committee **NOTED** plans to change the meeting scheduling for QGSG to support formalised onward reporting.

Risk and BAF oversight

The Committee **RECEIVED** and discussed the Corporate Risk Register report at each meeting which provided information in respect of those corporate risks with a potential quality impact. Within the January meeting the Committee considered the risks recorded in December 2022 across the quality domains which have been identified with a post-mitigation score of 12 or above. The Committee gave greater consideration of the identified risks which had a current risk score of 20 or above, noting there has been a further increase from the prior reporting period. These highest scored risks continue to be those as summarised below:

- Risks 15, 44, and 53 describe risks due to operational pressures seeing patients waiting in the ED corridor, poor nursing cover due to high levels of nursing vacancies and an inability to provide consistent nursing & medical cover for escalation/outliers and crowding within ED
- Risks 70, 120, 121 and 252 describe risks in respect of the management of young people requiring inpatient care for mental health problems and risks relating to delays in assessment, treatment, and the ongoing management of patients with mental health needs.
- Risk 74, describes risks due to reduced levels of HCAs placing extra demands on the nursing workforce
- Risks 420 and 1119 relating to reduced staffing levels impacting on patients in paediatric nursing and radiology patient respectively.

Risks 44 and 120 had increased to 25, the highest risk score. Review of other high scoring risks (16+) had identified similar themes with operational pressures leading to delays for referral to treatments as well as a further risks theme around aging equipment in pathology. The Committee **NOTED** that the Divisional use of the Risk Register had been maturing with the introduction of DatixIQ but the Committee concurred with the request of the Audit Committee that future risk reports must demonstrate further detail on risk mitigation.

The Committee had a fulsome discussion on the BAF and the respective risks for which it has been assigned oversight, these being risks 4.1, which remain at 16, and 4.2. which the Committee considered had been correctly increased to 20, this quarter. The Committee reflected on the information received during the meeting in respect of these risks along with the updates provided post the review by the Audit Committee. The Committee **AGREED** given both the direct review of the BAF and the supporting corporate risk report that the current score for BAF risks 4.1 and 4.2 were fairly stated as well as being supported by the information received within the meeting. The committee asked that further narrative is added to risk 4.1 in explaining the gap in assurance arising from the limited clinical effectiveness team resource. The Committee noted these risks would remain under active review given the operational and workforce pressures facing the Trust.

Actions taken by the Committee within its Terms of Reference

The Committee **AGREED** to recommend the risk score for BAF risks 4.1 and 4.2 to the Board for the start of quarter 4.

The Committee received the Adult Safeguarding and Child Safeguarding Quarterly Reports

The Committee reviewed the Mental Health Strategy and **AGREED** to recommend this to the Board for approval.

The Committee **NOTED** the Learning from Deaths report Q3 and recommended this to the Board.

Items to come back to Committee (Items the Committee is keeping an eye on outside its routine business cycle)

The Committee asked for the triangulation of issues associated with the rise in falls on the Quality Scorecard to be reported back to the Committee and for the information to be provided to the Board through the integrated performance report

The Chief Pharmacist was asked to provide an update on the reported challenges within Pharmacy affecting the Women and Children division and the Committee asked for confirmation at their March meeting whether the associated delays extended to other divisions.

The Committee asked for the development of suitable metrics for quality scorecard to reflect the quality of care to patients with Mental Health conditions within the Trust's care. The Committee also asked for a proposal for providing the Committee with visibility of Guardian of Safeworking and Freedom to Speak Up key metrics to ensure valid oversight and assurance.

The Committee asked to include within its cycle of business a report in relation to risks arising in the radiology service.

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

Item	Referred to
The Committee following a detailed discussion agreed to **RECOMMEND** to the Board that risks 4.1 and risk 4.2 within the BAF for which it has oversight are fairly represented.	Board Feb 2023

The Committee received the Draft Mental Health Strategy and **RECOMMEND** its approval to the Board.	Board Feb 2023
The Committee **RECOMMEND** Quarter 3 learning from deaths report to the Board	Board Feb 2023

NHS
University Hospitals Sussex
NHS Foundation Trust

Mental Health Strategy
2023-2028

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Forward

Myself and our Trust Board at University Hospitals Sussex NHS Foundation Trust are highly committed to ensuring that mental health care is an integral part of the work we do. As such, I am pleased to present our Mental Health Strategy. This sets out our vision for how we will improve the care we deliver to our patients who have mental health needs for both adults, children, young people and their carers. It also sets out how we can best support the emotional wellbeing of our staff.

The Trust is experiencing a significant growth in demand from patients experiencing mental health issues. Taking this into account, our strategy will enable us to deliver the best possible outcomes for all our patients. It will focus on the steps we need to take to consistently provide excellent care within safe, therapeutic environments.

I know that our staff work incredibly hard to provide compassionate care, often in difficult circumstances. The strategy will ensure that staff are provided with the necessary training and support to enable them to feel equipped to deliver this care.

The strategy will also support our collaborative work with system partners to improve the access to mental health care our patients need, when they need it, particularly at a time of crisis. It will also help us to support joined efforts with system partners, to ensure delivery of the right care, in the right place, at the right time across mental health and acute services.

The development of our strategy is founded upon our 'True North' approach. This is the term we use to describe our overarching goal of constantly improving standards of patient care, utilising our Patient First improvement methodology. To support the delivery of this strategy, our Board will provide ongoing oversight of the care our patients with mental health needs receive.

George Findlay
Chief Executive

Purpose

The purpose of this document is to set out the five year Mental Health Strategy for our acute Trust for adults, children and young people and their carers. The Strategy sets out our aims and ambitions through the Trust's Patient First approach. Patient First is our integrated framework and model for improvement and defines the organisation's vision, strategy, and goals.

Working collaboratively with our staff, patients and system partners, this strategy will enable the Trust to work towards achieving the ambitions set out in the NHS Long Term Plan, as well as responding to CQC's Assessment of mental health services in acute trusts programme and other key national guidance.

Context

In the context of the COVID-19 pandemic, the Trust has seen a significant growth in demand from adults, children and young people experiencing mental health issues, with large numbers of patients presenting in crisis to acute care. Patients are often experiencing long waits in the Emergency Departments and paediatric wards for Mental Health provision. Our Trust is not always fully equipped to meet these patients' needs. In particular, our Emergency Departments are not currently designed to safely care for patients with complex mental health needs, either from an environmental or a staffing perspective. In this context unfortunately there have been serious incidents. This strategy incorporates the learning from these.

The Trust also takes account of the needs of our wider population. The age profile of many of the communities we serve is significantly older than that of the rest of England, whilst this is a considerable asset for our communities, it also means we have higher rates of people with dementia. The strategy provides an opportunity to further enhance our work with people who have dementia that require our acute care. The Strategy also provides an opportunity to work collaboratively with our partners to help address health inequalities.

Scope

Taking this context into account, the strategy will seek to improve the provision of our acute care for:

- Children and young people with psychological needs and mental illness and their carers.
- People with severe and enduring mental health problems that need to access acute care including for physical health screening as well as their carers.
- People with dementia and those patients with delirium and/or needing cognitive assessment or screening and their carers.
- Patients with alcohol dependence, substance misuse or homelessness issues who also have serious physical and mental health comorbidities and their carers.
- People with alcohol related brain injury and their carers.
- Patients accessing maternity services.
- Patients who could benefit from psychological support to better manage or alleviate their physical health issues, as well as those with medically unexplained symptoms.

The strategy also takes into account the needs of people who have ADHD, Autistic Spectrum, intellectual (learning) disability, people with Special Educational Needs (SEND) and neurodevelopmental disorders, and who are also experiencing mental distress. We will be particularly mindful of this in our implementation.

System working

Effective partnership working across systems is at the heart of national guidance, and the Trust has worked closely with our partners to develop the strategy and has been a collaboration of effort by members of the Mental Health Quality and Strategy Group (MHQSG).

Our Population

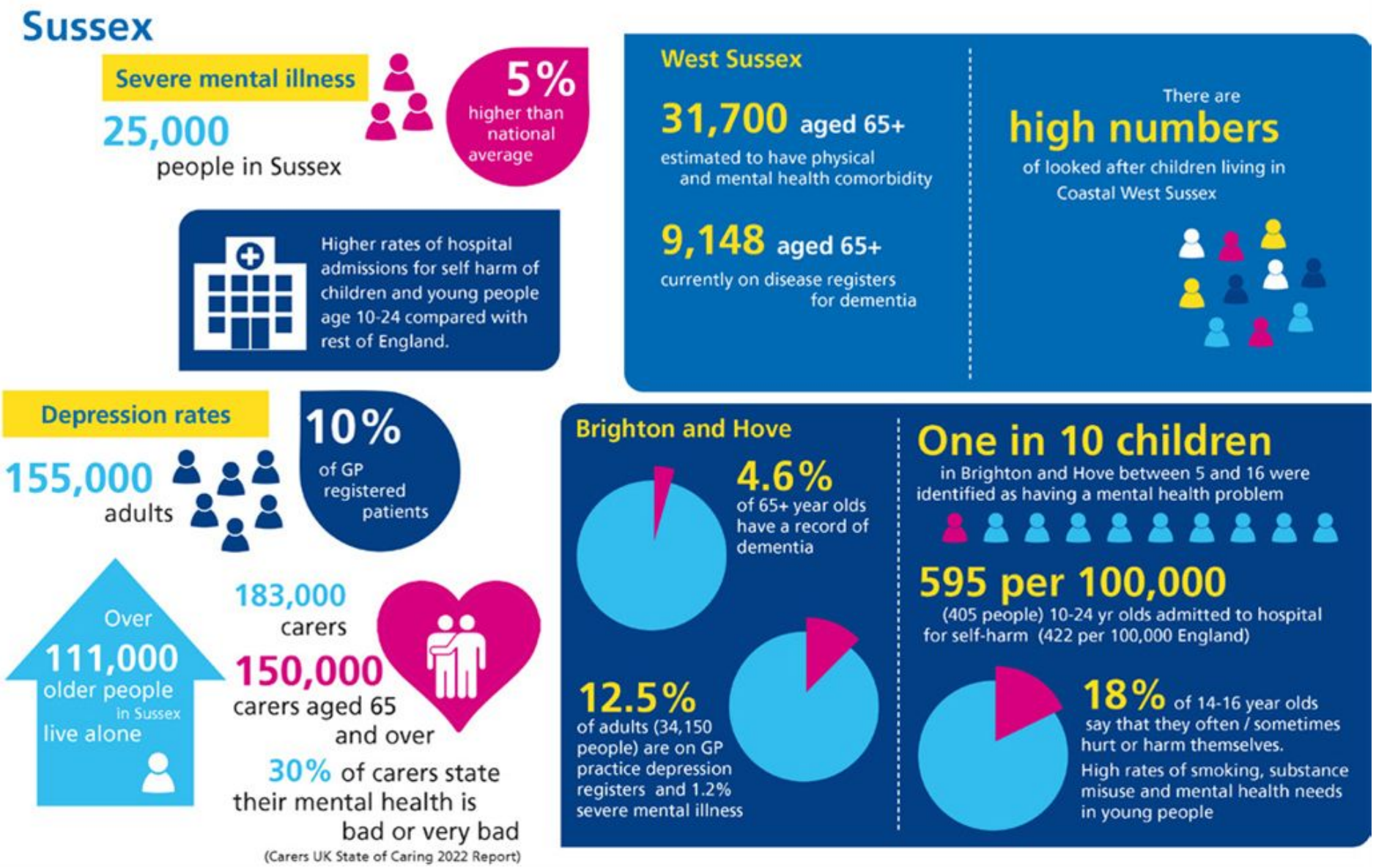
Our Mental Health Strategy is based on an understanding of the changing demographics and diverse needs of our local population including the inequalities in health outcomes they experience. Our Mental Health Strategy will help to ensure that we are best placed to meet the changing needs of the population we serve.

Our Trust provides acute services for approximately a million people living within the district and borough areas of Chichester, Mid Sussex, Arun, Adur and Worthing, as well as residents of Brighton and Hove and the Lewes area. We also provide specialised and tertiary services to patients across a larger geographical footprint including Horsham, Crawley and East Sussex.

Our population spans both urban and rural communities and is highly diverse in terms of age, ethnicity, religion, deprivation and health. Our older population across much of the areas we serve is set to grow significantly over the next 5 years. In contrast, the population of Brighton and Hove has a younger age structure and presents key health challenges around mental health, alcohol and drug misuse, with one of the highest suicide rates in the country. There are also an estimated 144 rough sleepers, which is the highest outside of London. These trends reflect Brighton's large areas of urban deprivation with some wards amongst the 10% most deprived in the UK.

The Trust has experienced significant growth in demand for our services across all our patient groups. This is illustrated in appendix 1.

Mental Health Strategy Data: Population Sussex



Our Trust

Our Trust was formed in April 2021, bringing together Western Sussex Hospitals NHS Foundation Trust (WSHFT) and Brighton and Sussex University Hospitals (BSUH). Our Trust operates five acute hospitals (Royal Sussex County Hospital – RSCH, Princess Royal Hospital – PRH, St. Richard's Hospital, Worthing Hospital and Southlands Hospital). We also deliver multiple services in other satellite and community settings, employing over 16,000 people. The Trust operates within the Sussex Health and Care Partnership Integrated Care System and works closely with partner health and social care organisations across Sussex and in each of the three localities or 'places' which are based on Local Authority boundaries: Brighton and Hove, East Sussex and West Sussex.

The Trust is responsible for all district general acute services for Brighton and Hove, West and Mid Sussex and parts of East Sussex. It is also responsible for specialised and tertiary services across Sussex and the South East including neurosciences, arterial vascular surgery, neonatology, paediatrics, cardiac, cancer, renal, infectious diseases and HIV medicine.

Our Mental Health Provision

The existing model of care across our Trust is based on in-reach using Mental Health Liaison Teams from Sussex Partnership NHS Foundation Trust (SPFT) who are a specialist NHS organisation providing mental health and learning disability services to people living in Sussex.

Within each acute site there are Adult Mental Health Liaison teams (MHLTs), Older Persons Mental Health (OPMH), Child and Adolescent Mental Health Services (CAMHS). The community based Perinatal Mental Health Teams also provide in reach services. The availability and staffing models of these teams varies considerably across the Trust. There is scarce provision of psychological services. Various Service Level Agreements, including some training components, formalise this provision.

Patients in the Trust waiting a mental health assessment, a voluntary placement in a mental health hospital or when detained under the MHA may require additional specialist nursing which is difficult to source. The mental health needs of our patients with chronic conditions often goes unmet. The current provision of MHLTs falls considerable short of those recommended in the Psychiatric Liaison Accreditation Network (PLAN).

National Context

This strategy takes into account national guidance.
The key considerations have been:

The NHS Long Term Plan

The Trust in collaboration with partners, will support the key goals of the Long Term Plan, including:

- The development of services in the community and hospitals, talking therapies and mental health liaison teams, to provide the right level of care for hundreds of thousands more people with common or severe mental illnesses.
- Expanding specialist mental health care for mothers during and following pregnancy, with mental health assessments offered to partners so they can be signposted to services for support if they need it.
- Working towards 100% coverage of 24/7 crisis provision for children and young people by 2023/24 (NHS Mental Health Implementation Plan 2019/20 – 2023/24).

CQC National Report

The Trust is drawing on the findings of the CQC Assessment of mental health services in acute trusts. This found that:

- People faced barriers in accessing help at a time of crisis. A lack of availability of 24/7 community crisis services meant patients were often left with no other option than to attend the Emergency Department.
- Acute trust boards did not always see mental health care as part of the overall provision of care. Boards often lacked oversight of how people with mental health needs were cared for while in hospitals.
- In emergency departments, patients whose mental health conditions put them at a high risk of harm towards themselves or others were not always provided with a safe, therapeutic environment.
- Staff in acute hospitals were often not clear about the Mental Health Act and the legal process for detaining someone in hospital.
- Staff felt unsupported and unprepared to meet the mental health needs of their patients. Mental health training for staff varied across the acute hospital trusts.

The report recommended that systems and acute providers should undertake:

- System-wide changes to improve the planning and commissioning of services, and ensure that patients have access to the physical and mental health care they need, when they need it.
- Trust-level changes to improve care for patients with mental health needs while in acute hospitals. For example, ensuring there is better provision and governance of mental health care within trusts.
- Support for staff. This includes training for staff that gives them the skills and confidence to meet people's mental health needs, as well as support for staff wellbeing.

Treat as One

Published by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD), this report makes recommendations relating to: patients who present with known co-existing mental health conditions; expectations of general hospital staff in the management of mental health conditions; and documentation for psychiatric liaison staff.

PLAN (Psychiatric Liaison Accreditation Network)

This is a quality improvement and accreditation network who have defined service standards for Liaison Psychiatry services. This provides a template for the commissioning of these services.

Developing the Strategy

The strategy has been a collaboration of effort from the members of the Mental Health Quality and Strategy Group. It has been developed taking into account national guidance and is based on patient, carer and staff experience and feedback. It has also been informed by a joint clinical summit held by the Trust with system partners.

The strategy will improve the care provided to patients in a stepwise and equitable fashion across the Trust to deliver exemplary care based on national and international guidance and best practice over the next 5 years.

Patients, Public and Staff Insights

When developing the strategy, we have reflected on what patients, the public and staff have told us about our services and what is important to them when accessing acute care. Patients report that they sometimes experience stigma when in our care and that they have heard themselves being talked about and felt they were responded to in terms of "not you again", "they shouldn't be here". When complaints and concerns data is analysed from an inequalities perspective across the Trust for 2021 – 22, the most prevalent protective characteristic raised in concerns relates to mental ill health. As such our patient voice tells us that improving the care of patients with mental ill health is a priority.

User feedback sought specifically to inform the development of this strategy from adults and young people also highlighted the importance of getting the basics right, for example, listening to patients and appreciating that people are individuals with highly diverse needs, rather than making assumptions. Feedback also showed that patients can sometimes feel that staff do not take their concerns about their physical health sufficiently seriously and that this is over shadowed by their mental health diagnosis. The importance of care planning was highlighted, so that staff know how to support patients and manage their needs that is informed by those who know the patient best. It was also raised that their could be a benefit in exploring the use of peer support for people attending our Emergency Department when in mental distress, and that this could improve patient experience and support enhanced communication between staff and patients.

Staff from across the system have noted that they see patients deteriorating both within the acute setting when they are having prolonged stays.

Furthermore, the environment in our emergency departments is also not designed to meet the needs of people in acute mental health crisis resulting in poor patient experience and a lack of privacy to have conversations with patients. This is reflected in Friends and Family Test (FFT) data which demonstrates that after waiting time; waiting conditions and environment are the most prevalent reasons for a negative experience. Patients tell us they want to feel safe while they wait, with challenging behaviour in waiting environments a particular concern.

Staff including our security team have been deeply affected when patients have left our facilities whilst waiting for care and have come to harm, and also when their help has been required to safely handle young people for sedation.

Staff across our Trust highlight that they need improved training to deliver care to people with mental health issues.

When implementing this strategy, the Trust will ensure that changes to services are co-produced with patients, families and carers so they address the concerns raised about stigma, safety and effectiveness of care.

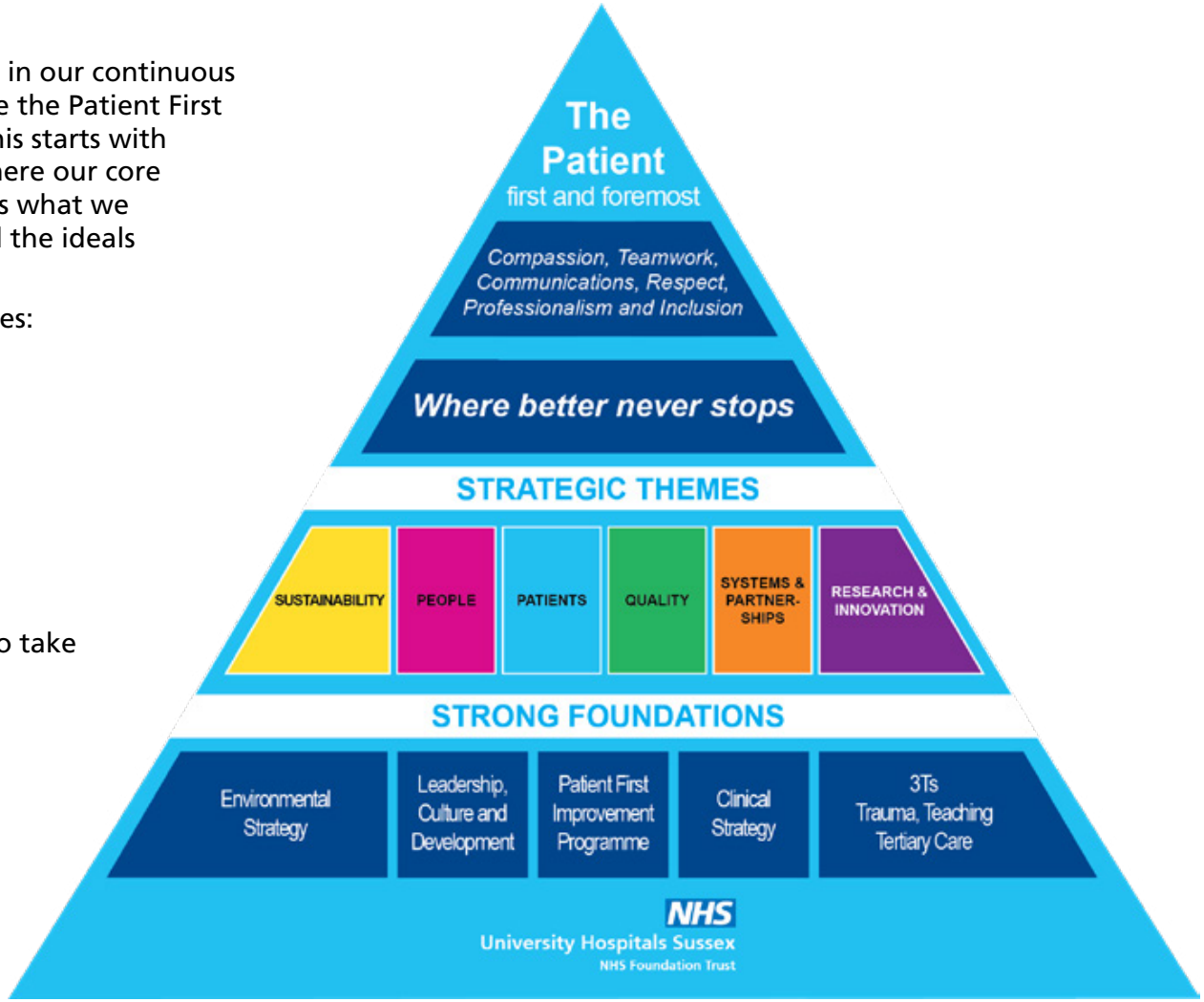
Our True North Goals

Our Mental Health Strategy is firmly embedded in our continuous improvement approach of 'Patient First'. We use the Patient First Triangle to explain how our approach works. This starts with our purpose, mission and values of our Trust where our core focus is the patient first and foremost, as well as what we strive to achieve 'excellent care, every time' and the ideals that guide everything we do.

Integral to our approach are our strategic themes:

- Patient Experience;
- Quality;
- Our People;
- Sustainability;
- Systems and Partnerships;
- Research and Innovation.

The Strategy will describe the actions we plan to take to improve our delivery of care for people with mental health needs.



The Patient First Triangle

Principles

The following set of principles framed within our six True North Domains have been developed with partners and patients to underpin our strategy:

Table 1: Principles

True North	Principle
Patient Experience	• Ensure equal parity between mental health and physical health care, and reduce stigma for our patients who have mental health needs and require our services. • Keep children and young people at the centre of all our decision making. • Take into account the needs of those people who regularly care for another person. • Support our patients in a way that takes account of diverse needs and promotes inclusivity.
Quality	• Provide integrated, holistic care, addressing the mental and physical health needs of all our patients. • Ensure equality and legal rights are upheld under the law. • Maintain safety and safeguarding responsibilities by appropriately assessing risks and supporting where necessary.
Our People	• Our Trust Board sees mental health care as an integral part of our overall provision of care with governance structures supporting Trust Board oversight of delivery of mental health care within our hospitals. • Enhance the mental health and wellbeing of our staff across the organisation.
Sustainability	• Ensure that each of our hospital sites is equipped to deal with the varied needs of the population they serve.
System and Partnerships	• Promote partnership working with other providers, commissioners and the Voluntary and Community Sector to provide joined up, holistic provision. • Work collaboratively with system partners to help address health inequalities for those people with Mental Health needs. • Ensure joint working arrangements are in place to support collaboration, understanding and learning from incidents across all our patient groups including with adult as well as children and adolescent teams.
Research and Innovation	• Patients are able to access and benefit from research and innovation.

The Strategy will also drive our wider Trust values of compassion, communication, teamwork, respect, professionalism, and inclusion

Focus on Children and Young People

One of the key principles of our strategy is to keep children and young people with mental health and psychological needs at the centre of all our decision making. Throughout this strategy our aims relate equally to adults, children and young people. Here though, we summarise the actions we intend to take that are particularly relevant to children and young people, to underline the importance of our commitment. We will ensure that:

Table 2: Focus on Children and Young People

True North	Principle
Patient Experience	• Meeting the mental health and psychological needs of our children and young people is fundamental to the care we deliver. • All children and young people are cared for in a supportive and respectful manner. • We work collaboratively with parent carers involving families in the planning and development of care and treatment.
Quality	• We respond effectively to the growing need from children and young people who are at risk of self harm or suicide, as well as for those children and young people with eating disorders. • Careplanning is used to ensure that staff are informed about the best options for treatment and care especially in an emergency.
Our People	• Our staff are given the support and training to provide optimal patient care for our children and young people, taking account of their diverse needs.
Sustainability	• All children and young people are cared for in a safe and therapeutic environment, both within our Emergency Departments and inpatient areas
System and Partnerships	• We work collaboratively with our system partners, in particular West Sussex County Council and Brighton and Hove City Council Children's Services, as well as SPFTs Children and Adolescent Mental Health Services to deliver joined up responsive care that puts children and young people at the centre. • Learning from series incidents is widely disseminated and acted upon. • As part of this collaborative working, we will support the implementation of FOUNDATIONS FOR OUR FUTURE Sussex Children and Young Peoples' Emotional Wellbeing and Mental Health Strategy 2022 – 2027
Research and Innovation	• The care that children and young people receive is informed by research and innovation

The implementation plan for our Mental Health Strategy will apply to delivery of care for children and young people, as well as adults. There will however, be a separate work stream established to measure and review the progress against the plans, utilising the Children and Young People Improvement Board to oversee and drive the developments. The implementation will also take into account the principles within the NHS national guidance: *Supporting children and young people (CYP) with mental health needs in acute paediatric settings: A framework for systems.*

Focus on Adults with Dementia and Delirium

One of the key aims of our strategy is to ensure that we provide excellent care for our patients who have dementia and delirium, and work collaboratively and supportively with their families, friends and carers. The key strategic priorities for this are:

Table 3: Focus on Adults with Dementia and Delirium

True North	Principle
Patient Experience	• Completion of the 'This is me/knowing me' document in 24 hours of a hospital stay. • Partnership working with family, friends and carers to promote co-production of care and services. • Individualised approach to our outpatient areas. • A reduction in inpatient bed moves with a particular focus on night moves.
Quality	• Consistent dementia care across the hospital sites. • Individualised care planning with the right profession leading on care. • Advanced care planning at a stage when the person with dementia is able to make choices. • We robustly identify those patients who are experiencing delirium to inform optimal treatment and appropriate care planning.
Our People	• Staff provide skilled management of behaviour and psychological symptoms of dementia and delirium. • Staff are equipped to have honest conversations about the progression of the person's dementia, with staff feeling confident and competent about advanced planning and end of life discussions. • Ward staff are trained to understand the complexities of discharge planning for people with dementia. • Undertake a rigorous training analysis of each site. • Recruitment drive to enable the provision of dementia ambassadors in every ward and outpatient area. • Specific training for staff who provide enhanced care for people living with dementia or delirium. • Regular dementia and delirium conferences. • Psychological support to staff as they support families through the dying and bereavement process. • Support systems in place for staff after distressing incidents.

Continued...

Focus on Adults with Dementia and Delirium cont...

True North	Principle
Sustainability	• To work collaboratively with Facilities, Estates and Capital to follow dementia friendly approach to environmental changes to ensure continued compliance.
System and Partnerships	• A clear pathway into our specialist dementia wards at the RSCH and PRH where there are complex needs around patients' dementia and delirium. • A clear pathway for our specialist older person's wards that will have a focus on dementia and delirium. • Discharge planning commenced on admission in collaboration with the person living with dementia or delirium and their family, friends and carers. • People with dementia discharged with dignity with their needs clearly communicated. • Promote understanding and partnership working with our community partners and voluntary organisations. • Collaborative work with the palliative care team.
Research and Innovation	• Patients benefit from research and innovation.

Patient Experience

Overarching aim:

Our aim is ensure that all our patients (Adults, Children and Young People) and their carers benefit from integrated, holistic care, addressing mental and physical health needs. Patient experience will be enhanced by ensuring that all patients are cared for in a supportive and respectful manner, in a safe and therapeutic environment, both within our Emergency Departments and inpatient areas.

How to achieve this:

We aim to achieve this by ensuring that all patient facing staff have the necessary knowledge, skills and confidence to enable them to deliver inclusive and compassionate care to support the physical and mental wellbeing of all our patients, reducing stigma that some patients describe.

This will also take into account the diverse needs of our patients including those relating to age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, gender or sexual orientation. It will also take into account health inequalities, and the work that our ICB is undertaking to address this, particularly for the 20% most deprived of our population, as well as patient groups specifically targeted, such as maternity care.

We will work with our partners to ensure joined up care that reduces wait times.

We will also work with our Capital and Estates teams to plan for how the environment in our Emergency Departments and inpatient areas can better meet the needs of our patients and promote privacy and dignity and help all our patients feel safe.

We will place increased emphasis on the needs of those people who regularly care for another person, including young carers, ensuring that our staff are able to recognise those who have caring responsibilities, supporting them to access additional support if needed, including registering as a carer with local Voluntary and Community Services, if they wish to do so.

We will also explore whether and how peer support could be beneficial to further support our patients in mental distress.

Quality

Overarching aim:

Our aim is to provide high quality, safe care for all our patients that takes into account their mental and physical health needs and reflects national best practice.

How to achieve this:

We will achieve this working with our partners, patients and staff to develop and implement a detailed joint mental health improvement plan. This will incorporate actions required to:

- Ensure holistic, psychologically informed care of all patients, understanding where there are gaps in our current service offer and how these can be addressed.
- Achieve nationally recognised quality standards including Core 24 and PLAN standards for Mental Health Liaison, by first benchmarking our existing service provision against these national standards, identifying service gaps and assessing the varying levels of risk this generates and prioritise immediate actions to bring all service standards to a level of minimum safety.
- Respond to the needs of our population, taking account of the rising prevalence of mental health problems in children and young people, urban deprivation and high rates of dementia, taking account of health inequalities.
- Further enhance the work we do to prevent self-harm and suicide.

- Reduce violence and aggression.
- Safely and effectively respond to patients experiencing drug and alcohol misuse and/or homelessness issues.
- Ensure safe delivery of medical care for patients with psychological problems and psychiatric illness.
- Ensure that detained patients are cared for in accommodation that consistently provides patients with essential food drink, medicines and communication with friends and family.
- Improve the safety of paediatric patients who are awaiting specialised mental health placements.
- Improve our approach to those patients experiencing delirium and/or needing cognitive assessment or screening.

Continued….

Quality

- Ensure robust governance arrangements are in place that: oversee the improvement plan; ensure mental health risks are regularly reviewed; and that learning from serious incidents and HSIB investigations (Healthcare Safety Investigation Branch) are embedded across our Health and Care system, with mental health frequently considered by our Trust Board.
- Refresh and invigorate the Trust policy relating to the use of the Mental Health Act, Mental Capacity Act and the Liberty Protection Safeguards, ensuring that staff have the knowledge and expertise to carry out their duties as required, and are supported by robust administrative processes.
- Our policies related to Mental Health such as the Observation Policy, the Restraint Policy and the Missing Person's policy will be established and integrated into practice as quickly as possible.
- Enhance our midwifery provision by: enabling our midwives to feel more equipped to respond to the mental health needs of patients; improving the birth trauma pathway; and facilitating greater specialist mental health midwifery input into team meetings etc..
- Develop our emotional and psychological responses to trauma/ trauma-informed care for all our patients as needed.
- Build on elements of good practice already in place for high intensity users of emergency departments, many of whom have comorbid physical and mental health issues, substance misuse, homelessness and other social determinants of health.
- We identify, celebrate and disseminate good practice across our Trust, such as the approach developing for high intensity users at the RSCH.

High Intensity Users – RSCH

The Emergency Department (ED) at the RSCH has a structured approach to support high intensity users. Coordinated by one of our ED consultants, the approach identifies patients who frequently attend. Patients can often attend recurrently as a consequence of medically unexplained symptoms, or due to complex mental health, substance, alcohol or social issues.

A collaborative approach with our partners including mental health, homeless, and drug and alcohol teams helps to ensure that there is coordinated support in place for our patients. For those patients that have medically unexplained symptoms, previous investigations and findings are collated and summarised so that they are easily accessible to the ED staff. For some patients, a plan will be developed to enable staff to provide joined up, optimal care and support.

Where appropriate, the approach supports patients to access help and advice in a more structured manner in the community rather than attending ED. If they do still need to attend our ED, it enables staff to deliver optimal care, responsive to their specific needs. This has the additional benefit that it reduces time in ED for the patient and avoids unnecessary investigations, contributing to a safe environment for all our patients.

Our People

Overarching aims:

Our dual aims are to ensure that:

- **Our staff have the knowledge, skills and experience to provide integrated, holistic care that supports the physical and mental health needs of all our patients** (the focus of this section).
- The emotional and mental health of all our staff is improved.

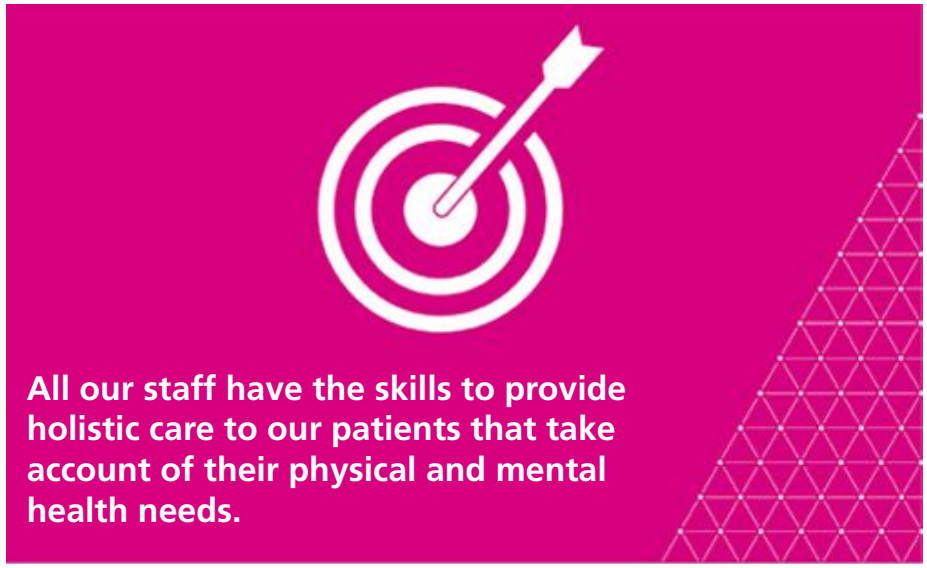
How to achieve this:

Collaborative joined up leadership across our system will be fundamental to achieve these dual aims. This will include implementation of a mental health leadership structure at each of our Hospital sites, that will engage local enthusiasts with the improvement programme.

We will also develop and implement a costed mental health training and supervision plan. This will enable staff teams to have the necessary knowledge, skills and confidence to meet people's mental health needs.

To develop this plan, detailed training analysis will be undertaken focusing on ensuring:

- Staff understand their role in providing holistic and joined up physical and mental health care, without stigma.



- Staff are trained in identifying and responding to self harm and suicide risk, including ligature awareness and provision of a safe environment.
- Staff across the Trust receive training in de-escalation and conflict resolution.
- Training takes account of the different population needs and service provision at each hospital site.
- Training incorporates new policy as this is developed e.g. relating to missing patients.
- Staff understand their role in ensuring the we provide care that is compliant with Mental Health and Mental Capacity legislation.
- Learning from serious incidents is incorporated in to the training.
- Staff know how to look after their own wellbeing and access support, particularly when working with patients who have complex mental health needs.
- Delivery takes account of the PLAN requirements for the liaison service to provide a proportion of this training.

Our People

We will also assess our existing provision of staffing against national guidance and prioritise action. This will include working with our system partners to review the service level agreements, for example in relation to our liaison services and our Older People Mental Health services, with joint recruitment initiatives taken forward.

We will work with our commissions to consider the access to Neuropsychiatry in Sussex which is currently not available.

Overarching aim:

Focusing on:

- **The emotional and mental health of all our staff is improved.**

How to achieve this:

There is a plan developed to provide structured supervision for our staff to support them to care for those patients with complex mental health issues to enable them to further develop their skills and build emotional resilience.

All staff are able to access reflective practice groups to help them feel more able to care for patients supportive manner.

Our Trust will also build on and promote the initiatives already in place to support the wellbeing of our staff including:

- Agree a Health & Wellbeing Plan.
- Ensure equity of access taking a health inequality lens.
- Better align capacity with need, through partnership with BSUH & Love Your Hospital Charities.
- Take steps to promote a healthy future workforce through a focus on prevention – via leadership, culture, management practices, and the wider determinates of health.
- Provide support to our staff members who have unpaid caring responsibilities outside of work, promoting the use of our Carers Passport and colleagues as carer groups.

Sustainability

Overarching aim:

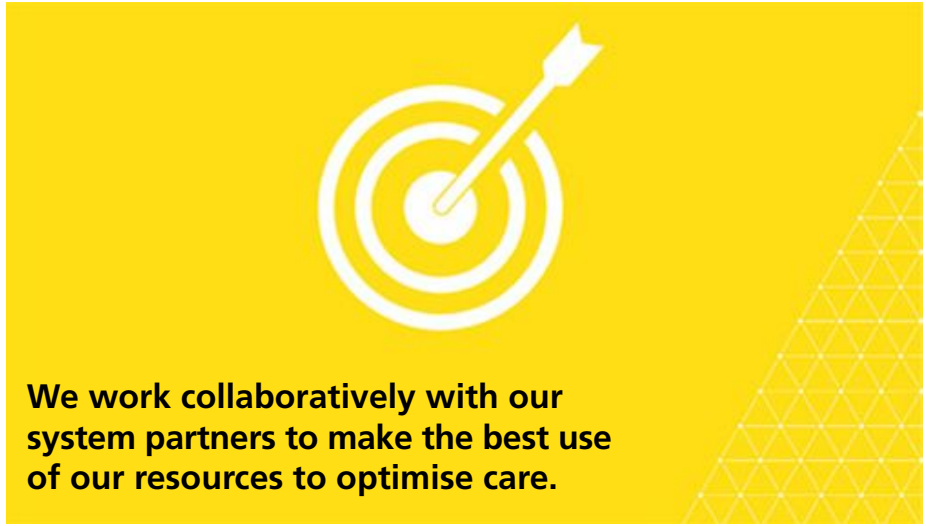
Our aim is to work collaboratively across our system to make the best use of our resources to deliver excellent, joined up care for our patients taking account of both their mental and physical health needs.

How to achieve this:

To achieve this, the Senior leadership across our system will ensure maximum utilisation of resources and prevent unnecessary service duplication. A review of the resources and funding available will be undertaken to gain greater clarity on funding gaps, how these could be addressed and opportunities for joint funding initiatives across partner organisations.

Joined up investment plans will be developed within the available financial resources that look to ensure:

- Safe and therapeutic provision of care– in both emergency departments and inpatient wards that also take account of PLAN staffing requirements.
- Sustainable provision of Registered Mental Health Nurses (RMNs) at our acute Trust.
- Spaces to assess and care for patients physical and mental health needs both in the Emergency Department and inpatient wards that supports their privacy.



- Sufficient office space with access to IT to support the effective work of the Mental Health Liaison teams.
- IT systems that support joint working across our Trust and between different organisations to help manage risk and optimise care.

Systems and Partnerships

Overarching aim:

The aim is to provide joined up physical and mental health provision across our system, that is timely and easy for patients to navigate, and supports effective multi-disciplinary care.

How to achieve this:

In order to achieve this goal, we will work with our partners to ensure that:

- System-wide changes improve the planning and commissioning of services, and ensure that patients have access to the physical and mental health care they need, when they need it, including opportunities for patients to transfer quickly to specialist provision as needed.
- Support effective partnership working between our Trust and other service providers through a renewed Mental Health Service Level Agreement.
- Work collaboratively with the wider Voluntary and Community Services to provide joined up care.
- Support effective partnership working with carers, through identification, access to support and enabling contingency planning.
- The improvement plan takes into account the significant increase in need for mental health provision within our services, both within our Emergency department, paediatric services and inpatient care.
- Staff have access to careplans when working with patients in crisis so as to inform how best to provide support.
- For our patients with the most complex mental health needs, there is a meeting within 24 hours of admission to plan for the treatment and care.

- There is standardisation of documentation and activity records across the Trust. To allow sharing of patient information across organisations, to prioritise actions and monitor improvement.
- Development of pathway improvements across partner organisations in specific areas such as self harm and swallowing razor blades.
- Further explore with primary care and SPFT whether there are opportunities to better support the physical health of inpatients in mental health units.

While the primary focus of this strategy relates to the provision of care within our Trust, the success of this strategy will rest on the partnership working with our wider health and care system, and our Voluntary and Community Services.

Research and Innovation

Overarching aim:

The aim is to ensure that all patients and carers are able to benefit from research and innovation.

How to achieve this:

We want to make this happen by ensuring that:

- There are opportunities for our patients and staff to participate in research should they wish to.
- Staff feel able to make evidenced based improvements and are supported to do so through our Patient First continuous improvement methodology.
- We take full advantage of our partnerships with Universities in Sussex to improve the care of our patients.
- We work collaboratively with the Sussex Health Research Partnership and National Institute for Health and Care Research, to widen opportunities for participation in research and ensure we deliver research informed care.
- We plan to build greater collaboration around designing, delivering and learning from research with partners, particularly with SPFT, for example, around dementia, staff wellbeing and training.

Governance and Next Steps

Overarching aim:

The implementation of our strategy will be underpinned with robust governance arrangements already in place, supported by and strengthened through the joint governance within our system partners.

How to achieve this:

We will achieve this by ensuring that:

- The Mental Health Strategy and Quality Group (MHSQG) will be responsible for the delivery of this strategy and will maintain an oversight of all matters related to the quality and safety of Mental Health patients within our Trust.
- The Mental Health leadership structure at each acute site will include executive and non-executive leads, Medical and Nursing leadership that will oversee the implementation of various working streams as directed by the MHSQG. These Mental Health leaders will work closely across Acute sites and with local and national experts to develop integrated governance arrangements with partners, mandatory training programmes for our staff, establish safe and therapeutic environments to support the care of patients with mental health disorders and ensure that our staff well-being is promoted.
- Our Trust Board promotes parity of esteem between physical and mental health care provision across the Trust .
- Joint governance is strengthened, with the MHSQG group chaired by the medical director and working to an agreed Terms of Reference that include all age groups with senior representation from our Trust and system partners.
- Joint governance incorporates the routine review of incidents and implements the learning.
- Clear governance processes for administering the Mental Health Act (in conjunction with the relevant system partners).

Next steps:

In order to ensure robust implementation of the strategy, a detailed plan will be developed that sets out the actions required for each True North domain, with clear priorities and KPIs. Whilst there will be an overarching implementation, there will be separate work streams for Adults, Adults with Dementia, and for Children and Young People.

The implementation will be monitored by the Mental Health Strategy and Quality Group, with oversight from the Quality Committee. The joint representation on the Mental Health Strategy and Quality Group will ensure a joined up approach across system partners is taken.

The implementation plan will ensure that changes to services are coproduced with patients, families and carers so they the address the concerns raised about stigma, safety and effectiveness of care.

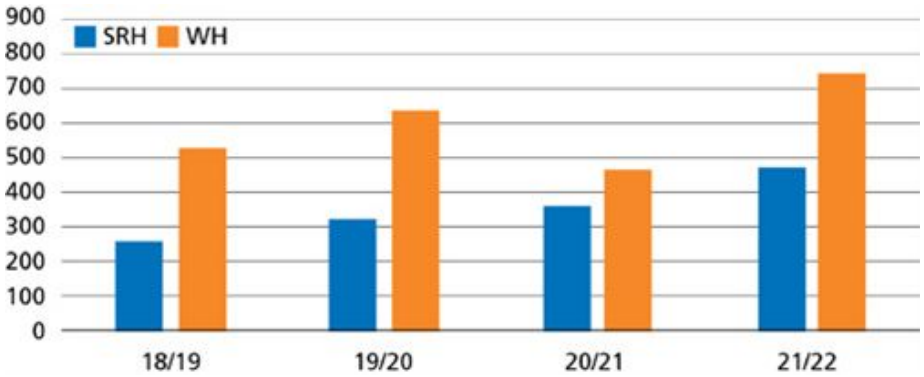
In this way, we will be able to ensure that mental health care is an integral part of the work we do with the Trust.

Appendix 1

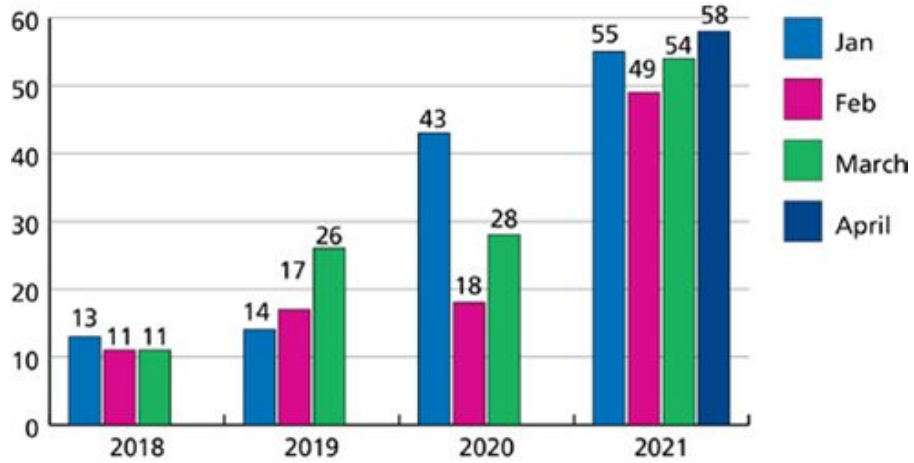
Our Patient Need – Children and Young People

Demand for our services from children and young people with psychological and mental health needs is growing significantly. This is demonstrated in the following graphs:

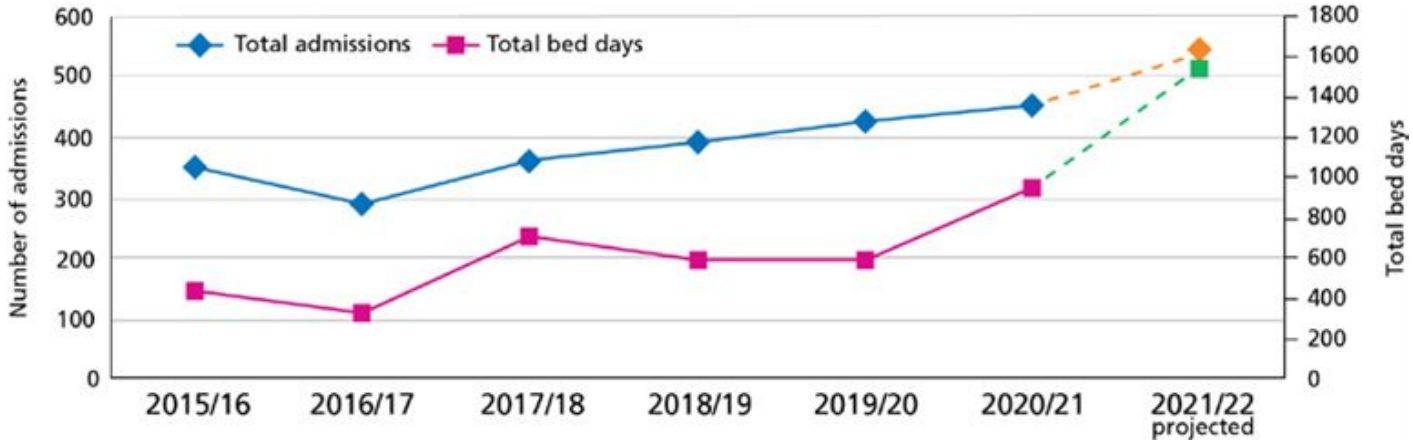
Graph 1: UHSussex - West safeguarding concerns and referrals for children with mental/emotional health, self harm or eating disorder problems



Graph 2: RACH self-harm figures Jan-April 2018-2021



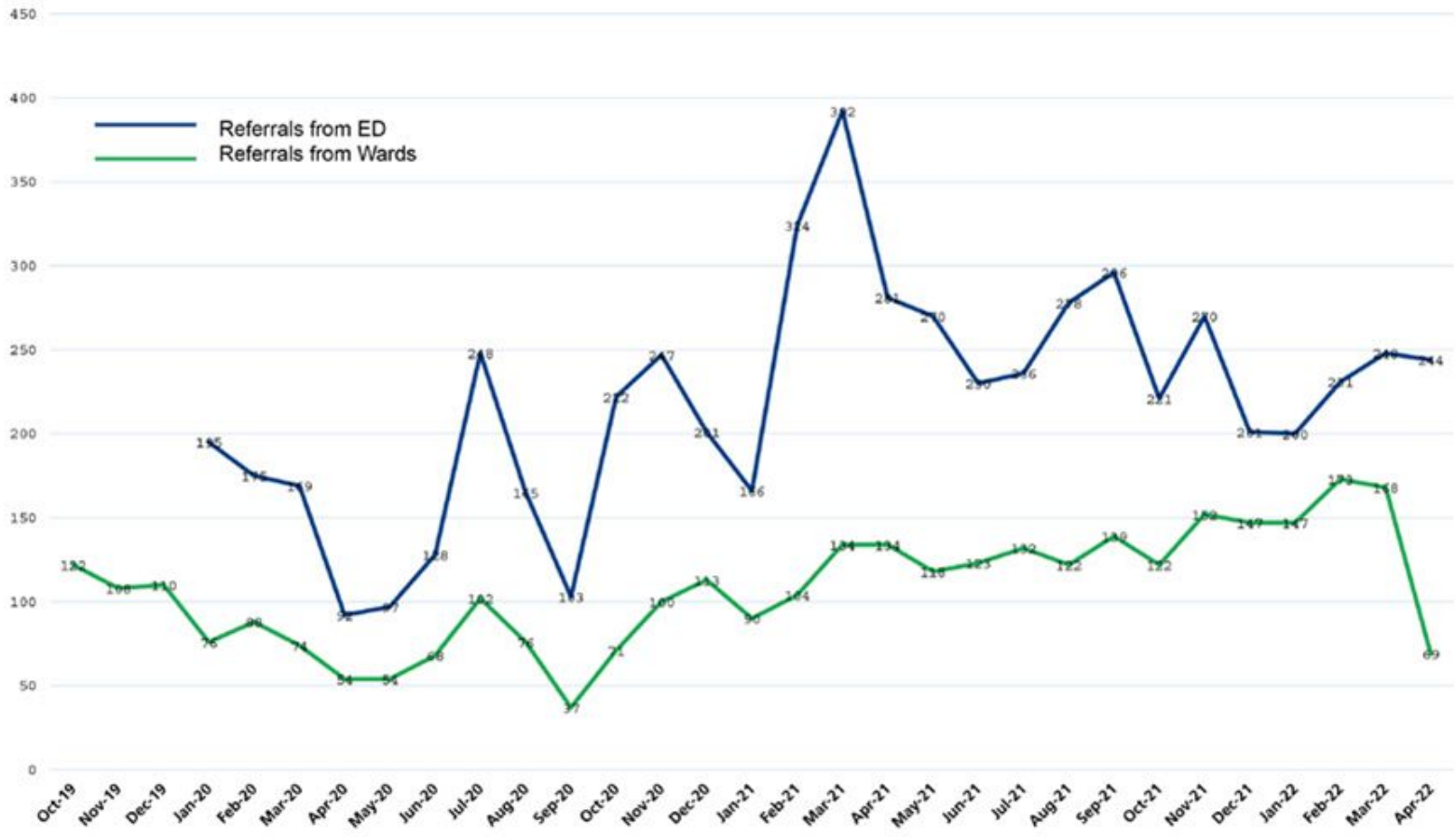
Graph 3: Admissions and total bed days for children with mental health illness



Our Patient Need - Adults

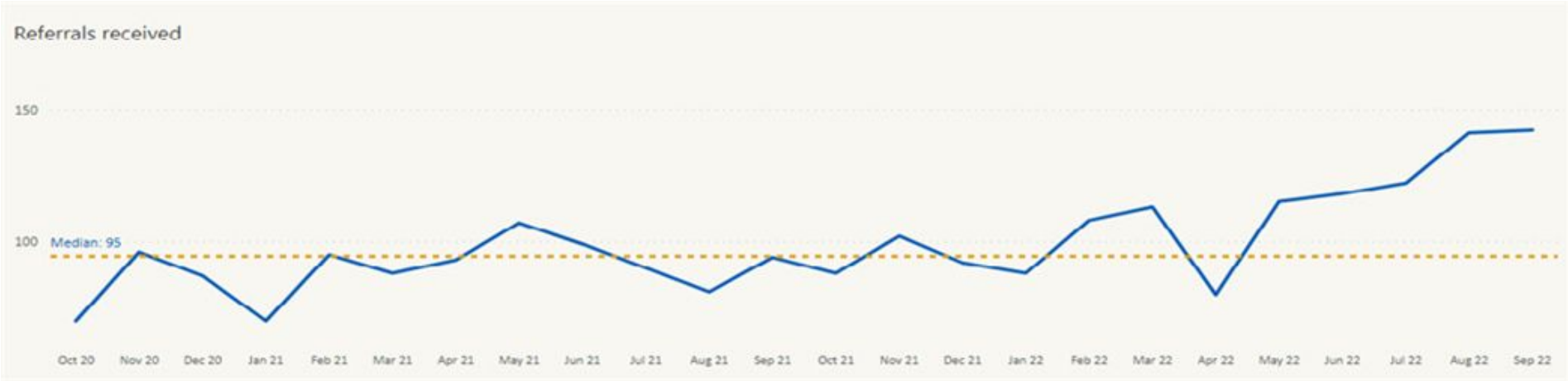
Demand for our services adults with psychological and mental health needs is also growing significantly. This is demonstrated in the following graphs:

Graph 4: Mental Health Liaison Team - Contacts/Referrals - October 2019 to April 2022 – Worthing



Our Patient Need - Adults

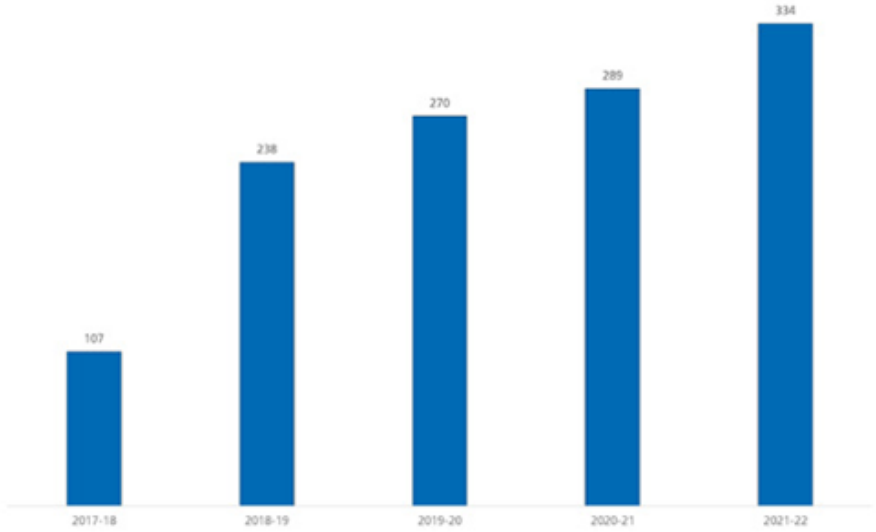
Graph 5: Mental Health Liaison Team - referrals received October 20 - September 22 - St Richard's



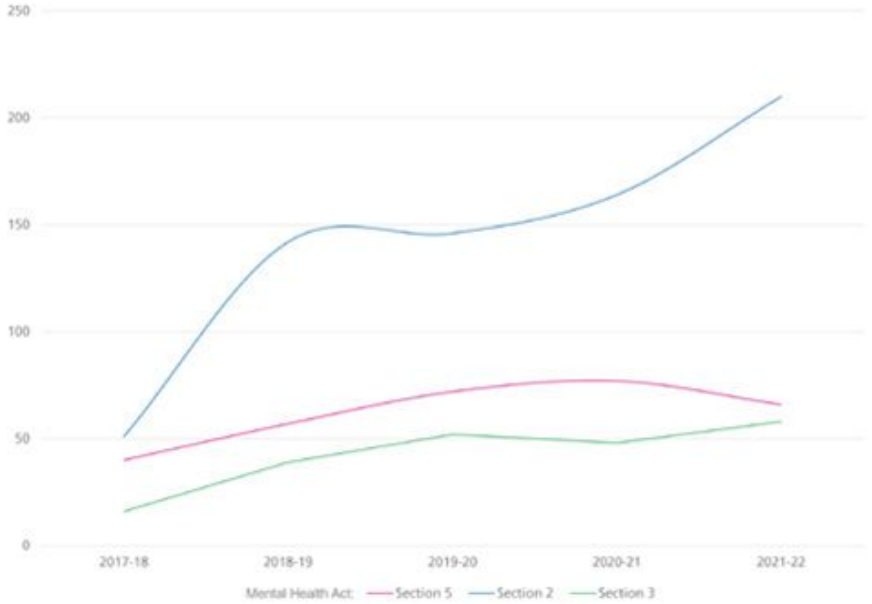
Graph 6: Mental Health Liaison Team - referrals received October 20 - September 22 - Royal Sussex County Hospital

Our Patient Need - Adults

Graph 7: Total detentions to University Hospitals Sussex: 2017-2022



Graph 8: Breakdown of detention type: University Hospitals Sussex, 2017-2022



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Mental health Strategy Summary of engagement

Jan 22

Summary of engagement

Whom/ Organisation	When	Summary of Feedback
Mental Health Quality and Strategy Group + joint clinical summit		Reviewed and shaped the content
Took account of what patients have already told us		Analysis of complaints data to gain insight that highlights that improving the care of patients with mental ill health is a priority.
Chief Medical Officer - SPFT	Sept 22	Suicide prevention, on going co-design with patients, carers and families, physical support in MH hospitals
Children's Mental and Emotional Health Team West Sussex County Council	Sept 22	Incorporate FOUNDATIONS FOR OUR FUTURE Sussex Children and Young Peoples' Emotional Wellbeing and Mental Health Strategy 2022 – 2027
ED Consultant – approach to High Intensity users	Oct 22	Detailed good practice approach in ED
West Sussex Parents and Carers Forum	Nov 22	Include carers and family members specifically in the scope. Weave this throughout the strategy, e.g. treating parents, carers and family members with respect Increase emphasis on health inequalities Highlight overlaps with SEND Look for opportunities to improve the estate at Blue Finn to ensure a therapeutic environment for all patients, taking account different needs. How do we embed voices as we implement? Rowan is happy to support the implementation.
UHSx Dementia leads	Dec 22	Incorporated principles for Dementia and delirium
CAMHS	Dec 22	Importance of ongoing engagement with Children and Young People
Carers Support West Sussex	Jan 22	Include carers in the scope throughout the strategy, carer engagement as the strategy is implemented, promote carer identification, registering as carers and contingency planning. Re-establish Carers as Colleagues across the all main sites
SPFT Adult user engagement session with 5 users	Jan 22	Addressing stigma Getting the basics right e.g. treating people with diverse needs as individuals Not allowing a diagnosis of mental heath to overshadow their physical health issues. Importance of peer support
SPFT Children and Young people engagement session	Jan 22	Staff taking to people a respectful manner. Improved understanding of the interaction between physical and mental health. Joint working with other hospital trusts. Care planning and contingency planning so that appropriate care and support is provided in an emergency. Understand how patients could benefit from R&I who may only have a brief attendance
Adult Operations West Sussex County Council	Jan 22	Building resilience of staff, supervision of staff, emotional wellbeing of staff, taking into account the needs of people who have neuro-diversity
Adult Social Care – Brighton and Hove	Jan 22	Reviewed summary version and highlighted the impact of people with delirium being discharged to long term placements as thought to have dementia.
Research and Innovation – SFPT	Jan 22	Work collaboratively on R&I for clear areas of overlap, e.g.: dementia, staff wellbeing, and staff training. Thinking about three areas of designing, participation and learning from Research

Whom/ Organisation	When	Summary of Feedback
Turning Tides	Jan 23	Suggested we include: • Specific reference to homelessness and mental health, including improving discharge planning for homeless people • Include substance misuse along with alcohol dependency • Link to the SHCP Mental Health and Homeless Strategy and wider ICB Strategy • Increase reference to collaborative working with the Voluntary and Community Sector • Importance of proactively supporting patients who are frequent attenders • Wider system and partnership issues, including lack of mental health beds, resulting in delays in MHA assessments and increased risk within the acute hospitals

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	16	**Meeting:**	Board	**Meeting Date:**	February 2023
Report Title:	People Committee Chair report to Board				
Committee Chair:		Patrick Boyle, Committee Non-Executive Chair			
Author(s):		Patrick Boyle, Committee Non-Executive Chair			
Report previously considered by					
Purpose of the report:					
Information		✓	Assurance	✓	
Review and Discussion		☐	Approval / Agreement	☐	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		☐	Staff confidentiality	☐	
Patient confidentiality		☐	Other exceptional circumstances	☐	
Implications for Trust Strategic Themes and any link to BAF risks					
Patient	☐				
Sustainability	☐				
People	✓	Assurances in relation to risks 3.1 – 3.4			
Quality	☐				
Systems and Partnerships	✓				
Research and Innovation	☐				
Link to CQC Domains:					
Safe		✓	Effective	✓	
Caring		✓	Responsive	✓	
Well-led		✓	Use of Resources	☐	
Communication and Consultation:					

Executive Summary:

The People Committee met on 25 January 2023 and was quorate as it was attended by three Non-Executive Directors, the Chairman as well as the Chief People Officer, the Chief Operating Officer and Chief Executive. In attendance were the Director of Human Resource Management, the Director of Integrated Education, the Director of Workforce Planning and Deployment, Director of Medical Education, the Associate Director for Leadership, OD and Engagement. The Guardian of Safe Working Hours for Worthing and St Richards joined the meeting for their respective element of meeting.

The Committee received its planned items including the reports on the respective Patient First Trust North, Breakthrough Objective, Strategic Initiative and Corporate Project; the GMC staff survey report; a presentation in respect of Cancer showing the corporate project oversight for people improvements; updates on health and wellbeing, leadership, culture and development, Employee Relations; the Medical Workforce Systems review; workforce scorecard (KPIs), an update on the activity of the Freedom to Speak up Guardian as well as reports from the Guardian of Safe Working Hours. The Committee that staff survey data for 2022 would be published after February 2023.

The Committee in receiving the reports from the Guardian of Safe Working Hours noted the differential oversight at Royal Sussex County and Princess Royal with their reduction in administrative support to that provided at both Worthing and St Richards. The Committee has sought updates on the urgent need to progress the filling of the Guardian position covering Royal Sussex County and Princess Royal to ensure that exception reporting is acted on to support the Junior Doctors in having confidence their voice is heard. At the January meeting, the Committee were advised that these recruitment activities had not yet been successful. The Committee was assured by the update from the Guardian of Safe working that the exceptions are reviewed and acted upon in a timely way and that there is a strong process for encouraging reporting to

enable the staff to be remunerated where excess hours have been worked. The Committee was also assured that the Junior Doctor forum was active and they had welcomed the attendance from the Chief Medical Officer.

The Committee through the receipt of the report in respect of the 2022 General Medical Council Survey Report by the Director of Medical Education noted the high-level response rate achieved. The Committee noted the actions taken where improvements opportunities were identified. The Committee was assured by the update that all significant concerns were reviewed, and detailed responses were provided to Health Education England in respect of action taken or being taken to address the concerns raised. At the January meeting the Committee was assured by the HE-KSS responses to the Trust Submission, that the 2022 GMC survey has resulted in no additions to the Trust Master Action Plan for either RSCH/PRH or SRH/WSH.

The Committee considered the countermeasure summaries against the new People Breakthrough Objective in respect of Staff Voice that counts, increasing the percentage of staff who are confident that the organisation would address concerns if raised. The Committee, having reference to the associated Board Assurance Framework risks, had a detailed discussion on the types of training and support required for line managers. The Committee noted that following suggestion from the acting Freedom to Speak Up guardian, a Toolkit had been developed to support staff feeling able to speak up in their work area and ensuring a common recognition of the dialogue taking place. The Committee was assured from the updates from both the Chief Operating Officer and the Chief Executive that this breakthrough objective is built into divisional patient first methodology which will support its achievement.

The Committee received at the January meeting an update from the Cancer division that outlined the workforce challenges and opportunities in their services that reflected considerable multi-professional diversity. The Committee noted that the Cancer division had sought to deploy the approach of staff listening events that had been pioneered to considerable success by the Maternity departments.

The Committee reviewed the developed workforce dashboard and welcomed the enhanced commentary provided within the report against each of the scorecard domains. The Committee noted the continuing operational demand pressure on staff and the impact this is having on the Trust's levels of compliance with its targets for staff training and appraisals as well as the wider people strategic risks of recruitment and retention. The Committee noted that the apparent increase in vacancies in the scorecard data was attributed to the addition of new bed establishments into budgets and was assured that recruiting activity had continued to be positive.

The Committee reviewed and discussed the gender pay gap report and the suggested actions based on the information. The Committee endorsed the report for Board approval at their next public meeting and agreed to recommend publication on the Trust website by 30 March 2023 as per National submission requirements.

The Committee reviewed the Trust's key risks with the potential to impact on people and noted those with the highest current scores align to the People Strategic Risks which have maintained their scores of 16 with risk 3.3 scoring 20.

The Committee acknowledged an increased volume of business and formal reporting linked to the Committee's areas of focus and agreed to meet as a formal Committee twice a quarter from February, outside of the strategy deployment review meetings.

Key Recommendation(s):

The Board is asked to **NOTE** the assurances received at the Committee and the actions taken of the Committee within its terms of reference.

The Board is asked to **NOTE** that the Committee considered, with reflection on continued pressures on staff and time to fully recruit to leadership posts and agreed the risk scores for BAF risks 3.1 to 3.4 are fairly stated for quarter 3.

The Board is invited to **APPROVE** the Gender Pay Gap report and agree to publication on the Website

University Hospitals Sussex
NHS Foundation Trust

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	No
People Committee	**25 January 2023**	**Patrick Boyle**	✓	☐

Declarations of Interest Made

There were no declarations of interest made

Assurances received at the Committee meeting

Patient First Trust North, Breakthrough Objective Strategic Initiative and Corporate Project

True North

The Committee **RECEIVED** updates on the delivery of the respective True North, Breakthrough Objective, Strategic Initiative and Corporate Project.

The Committee **RECEIVED** a spotlight report from the Cancer leadership on the key workforce issues faced by the Division and **NOTED** the arrangements to mitigate those. The report confirmed successful recruitment to their Clinical Operating Model and, while Nursing roles had been fully recruited, there was pressure on all cancer specialties around medical workforce, particularly Breast cancer specialist consultants. The Committee considered the risks raised and **NOTED** Advanced Clinical Practitioners recruitment and retention is dependent on the academic pathway. The Committee was **ASSURED** by the division's workforce scrutiny across a very varied multi-professional workforce group.

Examples of redesign were described including Haematology at night arrangements with a reduction on reliance on agency staffing. The Committee praised the service's 90% statutory and mandatory training and appraisal compliance and acknowledged the division's recognition of the significance of new or refurbished clinical environments in attracting and retaining staff (e.g. the WH Amberley Day unit and the future plans for a new Sussex Cancer Centre due to open in the 3Ts Stage 2 development in 2026). The Committee **NOTED** the Cancer Division's arrangements for engaging with staff and that they had learned from the Midwifery exemplar of staff listening events as well as forging a divisional identity through visible leadership and conducting gemba with purpose. The Committee NOTED the learning from the Divisions reports of the destabilising impact on morale and staff retention from the multiple premises moves enforced as a result of the pandemic.

The Committee **RECEIVED** an update report on the actions it has taken as a result of identified learning from employee relations feedback. The Committee encouraged a continued focus on assurance that the strategic risks are mitigated and would consider a future planned use of internal audit. Informal data e.g. on resolved issues is now captured from 1 January 2023 to quantify those matters mitigated from becoming formal cases.

Data is aligned to the True North areas and the Committee **NOTED** that Quarter 3 numbers of formal employment tribunals were consistent with previous periods and upcoming matters for Employment Tribunal were not considered to represent a significant risk to the Trust.

Management of sickness absence continued to be cause of concern and sickness absence had increased considerably in quarter 3, evenly split between short term and long term sickness absences. The Committee **NOTED** work was continuing to better equip staff and managers to avert and manage staff sickness in a clear but compassionate manner with HR support; both advisory business support as well as project support with education to line managers in key areas such as recognition of reasonable adjustments.

The Committee also noted the work continued around the development of performance measures to allow the HR department to track the timeliness of their support to deal with matters raised. The Committee were **ASSURED** that data for both formal and informal matters brought through the organisation is analysed by protected characteristics. The Committee asked for future deep dive activities to be scheduled around on

sickness management and were informed that a Structured Deployment Review approach had been applied with a completed A3 including both analysis by protected characteristic and recognised financial impact.

The Committee **RECEIVED** an update on the 2022 General Medical Council Survey Report providing the responses to the Trust's submission to 16 KSS domains (62 programmes. The recent HEE visit showed considerable progress and acknowledged the connection with the significant General Surgery Corporate Project. There were no additions to the master action plan and the areas visited had showed considerable improvement. At the January meeting the Committee was **ASSURED** by the HE-KSS responses to the Trust Submission, that the 2022 GMC survey has resulted in no additions to the Trust Master Action Plan for either RSCH/PRH or SRH/WSH.

Breakthrough Objective

The Committee **NOTED** the developing project plan to deliver this objective and its linkage to the wider people initiatives. The Committee **RECEIVED** the Breakthrough Objective project charter in respect of Staff Voice that counts, increasing the percentage of staff who are confident that the organisation would address concerns if raised. The Committee **NOTED** progress on embedding the supporting arrangements around leadership development and included training line managers to support their staff to feel heard when concerns or disagreements are raised.

Pulse data on 4 months of data had shown a slight decline in the quarter and was particularly low in December. The Committee **NOTED** significant focus on corporate actions given operational challenges in January 2023. Dates for Divisional meetings had been set for March 2023. The Committee **NOTED** that insights from the acting Freedom to Speak Up Guardian were shared with the Chief People Officer and included the suggestion that managers had in some cases been unsure how to respond to matters raised with them. The Committee **NOTED** a toolkit for managers had been developed.

The Committee acknowledged the key risk to the breakthrough objective is the impact of operational pressures and that it would be critical to ensure valid data can be provided. The Committee **NOTED** support had been given by the Kaizen team and BI colleagues. The Committee **NOTED** the organisational importance of daily improvement huddles following patient first methodology as the primary means for engaging with staff rather than reliance on corporate communications. The Committee was **ASSURED** from the updates from the Chief Operating Officer and the Chief Executive that this breakthrough objective is built into the divisional strategy deployment review meetings through the Trust patient first methodology with staff voice and **NOTED** the pulse data was represented as either a driver metric or watch metric in all Divisions.

Strategic Initiative

The Committee **RECEIVED** an update on Strategic Initiative in respect of Leadership, Culture, and Development from the Associate Director for Leadership, OD and Engagement. The Committee **NOTED** the activity being undertaken with an update on the Annual Equality Plan.

Cost of Living Support

The Committee **RECEIVED** an update on the approaches that the Trust sought to deliver to support with cost-of-living pressures and the support from the Trust's Charity had been welcomed in enabling Crisis support hardship grants to commence have started and claims had been received for which the Committee were keen to see demographic and protected characteristic analysis at a future meeting. The Committee were advised that the Trust had a list of 40-50 potential initiatives and may revisit other areas again in light of changing circumstances. The Committee was keen to hear learning from the process including the experience of claimants and acknowledged that the staff who could be anticipated to be at greatest risk of hardship might often be in roles hardest to reach through traditional corporate communications about available support

arrangements. The Committee NOTED the varied means by which the grants and other initiatives can be promoted.

Gender Pay Gap report

The Committee **NOTED** the Annual Gender Pay Gap report showing 1% discrepancy between women and men's pay. There was detailed discussion of the issues involved, primarily around the factors associated with Clinical Excellence Award payments and the Committee **NOTED** the work outlined to support women applicants in an effort to address the imbalance. It was acknowledged that aspects of the Clinical Excellence Award that carried a risk of prolonging the effects of historic inequity were outside of the Trust's control. The Chief People Officer advised that Gender Pay Gap information will be published on the Trust Website subject to Board approval.

Applications for clinical excellence awards were acknowledged to be the drivers for the difference and required work to further mitigate the factors that can lead to the differences in this area, e.g. helping female applicants to apply. The Committee welcomed the commencement of the Trust's new Equalities lead together with data analyst supported the suggested actions. The Committee **ENDORSED** the report for Board approval which is appended to this report.

Annual Equality Plan - deferred

The Committee noted that the Annual Equality Plan would be presented to the February meeting.

Staff vaccinations

The Committee **NOTED** the update on the Staff vaccination programme in respect of Flu and Covid.
The Committee **RECEIVED** the vaccine report as at January 2023 and noted a slight decline in vaccination status at Covid 54% and flu 47.7% acknowledging this is the most conservative indication of uptake based on ESR data and the Trust is seeking confirmation from staff who accessed vaccinations elsewhere that the Trust has not yet recorded,

Corporate Project

The Committee **RECEIVED** the countermeasure summary for the established people corporate project relating to medical workforce systems and **NOTED** a business case pending imminent approval to support the project and help to realised projected benefits.

Committee Activity

People Scorecard

The Committee **NOTED** the developed workforce dashboard and welcomed the enhanced commentary provided within the report against each of the scorecard domains. Through the update provided by the Chief People Officer the Committee **NOTED** the Trust's performance across the core metrics of recruitment, retention, appraisals, training, and engagement, it was highlighted by the Director of HR that a Recruitment deep dive is currently in progress relating to budget management which would be presented at the February meeting The Committee **NOTED** the detailed commentary continued to be provided as requested previously and that this will aid the reporting to the Board within the integrated performance report.

The Committee **NOTED** the continuing operational demand pressure on staff and the impact this is having on the Trust's levels of compliance with its targets for staff training and appraisals.

At the January meeting Committee noted that the apparent increase in vacancy factor in the scorecard data was attributed to the addition of new bed establishments into budgets and not a shortfall in recruiting activity nor particular staff retention issues. The Committee noted caution on the suitability of the global Trust vacancy factor and associated benchmarking in the identification of areas for particular focus which would instead use specific analysis supporting reports on the business cycle schedule. The Committee **NOTED** that Healthcare assistant roles remained an area of focus and recruiting 60-65 per month continued and Band 5 staff nurse recruitment had been addressed through overseas recruitment and successful newly qualified nurse arrangements.

The Committee **NOTED** the scorecard highlighted the sickness rate increase concerns discussed within the True North reporting.

Freedom to Speak Up

The Committee **NOTED** the report prepared by the Chief People Officer in respect of the Trust's Freedom to Speak up Guardian (FTSU) activities. The Committee was **ASSURED** that a substantive Guardian is due to start and also that the mailbox for the acting FTSU Guardian is appropriately monitored during any periods of absence.

Guardian of Safeworking

The Committee **RECEIVED** the reports in respect of the Guardian of Safeworking Hours activity across for Q3 2022/23 for all four principal sites of the Trust. The Committee **NOTED** the formal process available to the Junior doctors to raise exceptions and that the level of these exception reports remains comparable to the prior periods in 2021/22. The Committee was **ASSURED** by the update from the Guardian of Safeworking that all exceptions are reviewed and acted upon in a timely way and that there is a strong process for encouraging reporting to enable the staff to be remunerated where excess hours have been worked. The Committee **NOTED** positive engagement in the junior doctor forum with hotseat attendances. The Committee **NOTED** differential oversight at RSCH and PRH with their reduction in administrative support and **NOTED** the update provided by the Chief People Officer in respect to the actions taken to reinstate the provision of this administration support as the recruitment of a further Guardian is progressed. In the meantime the exception reports had all been considered and processed appropriately. The Committee **NOTED** that the recruitment of the Guardian remains underway by the Chief Medical Officer supported by the Chief People Officer and further efforts are under consideration to attract applicants following unsuccessful approaches to date.

The Committee **NOTED** the considerable increase in exception reporting and immediate safety concerns and the reference to the extraordinary workforce pressures as well as reports that the impact of the new rate card for additional junior doctor shifts had made shifts harder to fill and had led to increased pressure on junior doctors in post to work additional hours. The Committee heard from the Chief Executive and Chief Operating Officer who advised that the period of extraordinary demand and bed flow issues had led to particular ward challenges leading to rota pressure from patients spread outside the specialty. Executives had acknowledged there is a need to look at whether rotas are fit for purpose and clarity of escalation issues.

Reporting Groups

The Committee **RECEIVED** an update from the Corporate Directors leading the respective reporting groups namely the Diversity Matters Steering Group, that was about to reconvene following a period of operational pressure; Integrated Education Committee for which the Director of Integrated Education confirmed that a reinitiated meeting of the group was imminent; the Joint negotiation and consultation committee and the Nursing and Midwifery workforce group, both of which had continued to meet regularly and had been especially supportive for maintaining communicating through industrial action

Sussex Integrated Care Board and System Collaboration

The Chief People Officer provided an update on the meetings of Chief People Officers from the Trusts in the Sussex ICS. The Committee NOTED progress in development of a Sussex ICS People Workforce plan, an ICS Workforce level plan and a consolidated People Plan. The Committee NOTED an update on an ICS disinvestment for which the Trusts would need to consider funding at a local level and the advice from the Chief People Officer that the usage of service by Trust staff had seemed disproportionately low which may suggest UH Sussex staff are accessing alternative local arrangements meaning a case for continuation would need careful consideration.

Risk

The Committee **RECEIVED** and discussed the Corporate Risk Register report which provided information in respect of those corporate risks with a potential people impact.

Across each of the people domain the Committee's attention was drawn to risks that have been raised that have the potential to impact on our people domain which for quarter 3 have been identified with a post-mitigation score of 12 or above.
The Committee **NOTED** there is still ongoing work to do to ensure all risks are captured at both corporate and Divisional level and reported in a timely way to the relevant Committees which is supported by the ongoing development of risk management systems and processes. The Committee NOTED the report contained a considerable number of new risks from divisions that had been approved by Divisional governance processes and QGSG and while support was proposed to gain greater clarity on some risk descriptions the reoccurring theme is workforce availability and capacity. The Committee also concurred with the request from the Audit Committee that future risk reports should show a greater emphasis on the assurances around the mitigation arrangements being applied.

The Committee had a discussion on the BAF and the respective risks it has assigned oversight, these being risks 3.1 to 3.4. The Committee **AGREED** given both the direct review of the BAF and the supporting corporate risk report that the current score for BAF risks 3.1 to 3.4 were fairly stated and remained at their prior quarter scores of 16 and 20 for risk 3.3 relating to recruitment, retention and development of the Trust's staff. The Committee **AGREED** with these assessments based on the information received within the meeting and these continue to correctly reflect the pressures on the Trust's workforce along with the context of the wider risks impacting on Trust.

Actions taken by the Committee within its Terms of Reference

The Committee **AGREED** to recommend the quarter 4 score for BAF risks 3.1 to 3.4 to the Board.

Items to come back to Committee (Items the Committee keeping an eye on outside its routine business cycle)

The Committee sought demographic and protected characteristic level analysis of Cost of Living Grant applicants and decisions to report to a future meeting of the Committee.

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

Item	Referred to
The Committee recommended to the Board that after careful consideration of the continued pressures facing staff that the risk scores for BAF risks 3.1 to 3.4 are fairly stated for quarter 4.	Board February 2023
The Board is Recommended to approve the annual Gender Pay Gap and agree to publication of the information on the Trust Website	Board February 2023

University Hospitals Sussex
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Agenda Item:	14	**Meeting:**	People Committee	**Meeting Date:**	25 January 2023
Report Title:	Gender Pay Gap Report 2021-22				
Sponsoring Executive Director:	David Grantham, Chief People Officer				
Author(s):	Head of Equalities and Inclusion				
Report previously considered by and date:	n/a				

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

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

Implications for Trust Strategic Themes and any link to BAF risks		
Patient	☐	
Sustainability	☐	
People	✓	Assurance in relation to risk 3.3
Quality	☐	
Systems and Partnerships	☐	
Research and Innovation	☐	

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

Communication and Consultation:

Executive Summary:

The aim of the gender pay gap report is to use transparency as a tool for raising awareness. The report also complies with the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, which came into force on the 31 March 2017.

This is proposed to be the first and the final standalone report for UHSussex. Future reports will be integrated within the annual equality report to allow for more timely analysis, and to allow comparative analysis with data about gender differentials across the entire employee life cycle, and to understand the statistical significance of factors underlying the gaps to better target future actions to address them.

The key headlines in 2022 were:

- Women earned 99p for every £1 that men earned when comparing median hourly pay. Their median hourly pay is 1.2% lower than men's
- Women occupied 64% of the highest paid jobs and 73% of the lowest paid jobs
- Women earned 37p for every £1 that men earn when comparing median bonus pay. Their median bonus pay was 63% lower than men's. This is largely attributable to CEA
- The 2022 median bonus pay gap 63.4% has widened than at either legacy trust in 2021 (BSUH: 58.2%, and WSHT: 60.8%)
- 0.5% of women and 3.2% of men received bonus pay.

Key Recommendation(s):

It is recommended that members review the report and have a discussion about the suggested actions and ENDORSE for Board approval on the 2 February 2023. (National Submission Requirement by 30 March 2023.)

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Gender Pay Gap Report 2021-22

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Introduction

Our gender pay gap (GPG) report 2021-22 shows the difference in average hourly pay and bonus payments between men and women employed by University Hospitals Sussex NHS Foundation report (UHSussex) at the 31 March 2022.

This is the first UHSussex gender pay gap report following the merger between legacy trusts Western Sussex Hospitals NHS Foundation Trust (WSHT) and Brighton and Sussex University Hospitals NHS Trust (BSUH). Both of these predecessor employers published separate gender pay gap reports in 2022.

We report and publish information based upon six calculations in this report:

- Mean gender hourly pay gap
- Median gender hourly pay gap
- Mean bonus gender pay gap
- Median bonus gender pay gap
- Proportion of male and female staff receiving a bonus payment
- Proportion of male and female staff in each of the four equal quartiles

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 has since the 30 March 2018 required most public authorities, including NHS foundation trusts, to publish annually the information in this report to show whether there is a difference in the average pay of male and female employees. For further information please refer to Appendix A: Legislative Background.

GPG statistics

The GPG is an unadjusted indicator. It does not just capture discrimination in the sense of ‘equal pay for equal work’. Statistical significance has not been applied to the data behind the calculations in this report since the particular factors of interest are unclear.

Unadjusted GPG’s at a country level combine three elements[1]: (1) differences in the average characteristics of men and women in our workforce (i.e. factors such as different occupations, economic activities, and average age); and (2) gender pay gaps for the same average characteristics (i.e. ‘unequal pay for equal work’); and (3) the unexplained residual.

This is the final standalone report, with future gender pay gap reporting integrated within publication of the Trust’s annual equality report. This will not only allow us to compare disparities in staff rewards with data for the entire employee life cycle to identify the wider effects on our staff, but also allow us to decompose the unadjusted GPG into the explained and unexplained factors and to filter out sectoral and occupational segregation effects to create an adjusted GPG.

By identifying and interpreting the causes of an adjusted GPG, future policy actions by UHSussex in favour of gender equality will be better targeted.

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[1] Gender pay gaps in the European Union — a statistical analysis — Revision 1, 2021 edition (2021, Eurostat)

This report does not include pay gaps for other protected characteristics or how these intersect. Following the findings of the 'Ethnicity pay gaps: 2019' (ONS, 2020)[2] and the final report of the government's Commission on Race and Ethnic Disparities (CRED, 2021)[3] future reports will include pay gaps for other protected characteristics where statistically possible.

Terminology

The use of the binary categories 'male' and 'female' are set out in regulation. The national NHS electronic staff record (ESR) does not have the facility to record or report upon the pay gap of people with other diverse sex characteristics, or of people with other gender identities. We remain fully committed to improving work equality for the trans, non-binary, and intersex (TNBI) workforce population groups.

The workforce population measured includes all employees using the wider definition of employment under the Equality Act 2010, which covers bank workers and apprentices, and excludes contractors operating through their own personal service companies and agency workers employed by an agency. The definition of 'pay' used includes:

- Basic pay including other allowances
- Fully paid leave, including annual leave, sick leave, maternity, paternity, adoption or parental leave
- Bonus pay (if paid in the pay period): VSM bonus or Clinical Excellence Award (CEA)

The report does not include: overtime pay, waiting list initiatives (WLI), expenses, value of salary sacrifice schemes, benefits in kind, redundancy pay and tax credits.

Purpose

The gender pay gap report shows the difference in average hourly pay and bonus payments between men and women. UHSussex analyses the information to identify any underlying root causes for gender pay gaps and put in place remedial actions to address and mitigate this. The results will be used to assess:

- Levels of gender pay equality
- Balance of male and female employees in each of the four pay quartiles
- The efficacy of talent management and reward

The benefits of reporting gender pay gaps include building a reputation for being known as a fair and progressive employer, attracting a wider pool of recruits, enhancing productivity, and creating a culture committed to tackling gender pay inequality.

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[2] Office for National Statistics (2020) 'Ethnicity pay gaps: 2019. Available at: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/articles/ethnicitypaygapsingreatbritain/2019

[3] CRED (2021) 'Commission on Race and Ethnic Disparities: The Report'. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/974507/20210331_-_CRED_Report_-_FINAL_-_Web_Accessible.pdf

Ordinary Pay Analysis

Mean and median figures give UHSussex a better understanding of our gender pay gap, whilst facilitating comparison with other benchmarks.

Mean and median hourly pay gap by gender

Table 1 below shows the mean and median hourly rates for male and female employees in the Trust and the actual gap in monetary and percentage terms in 2022.

Data from 2021 is shown in Table 2 underneath for reference, where information is split by legacy trusts BSUH and WSHT. However, direct comparisons cannot be drawn here as we are not comparing like for like.

Table 1. 2022 ordinary pay by gender in UHSussex

Gender	Mean	Median	Mean Difference	Median Difference	Mean Pay Gap %	Median Pay Gap %
Female	17.78	16.32	4.00	0.20	18.38	1.20
Male	21.79	16.52				

In UHSussex, women earned 99p for every £1 that men earned when comparing median hourly pay. Their median hourly pay is 1.2% lower than men's. This headline hides the effect of occupational differences, e.g. for doctors.

Table 2. 2021 ordinary pay by gender

Legacy Trust	Gender	Mean	Median	Mean Difference	Median Difference	Mean Pay Gap %	Median Pay Gap %
BSUH	Male	20.51	15.66	3.26	0.00	15.90	0.00
BSUH	Female	17.25	15.66				
WSHT	Male	20.51	15.07	4.06	0.44	19.79	2.91
WSHT	Female	16.45	14.63				

Women and men earned the same in 2021 at BSUH when comparing median hourly pay, and in WSHT women earned 97p for every £1 earned by men in 2021.

Proportion of male and female staff in each quartile band

This report ranks the 16,963 employees by rate of pay on the 31 March 2022. The data has been presented in four equal size pay quartiles in Table 3 below.

Data from 2021 is shown in Table 4 underneath for reference, where information is split by legacy trusts BSUH and WSHT. Again, direct comparisons cannot be drawn here as we are not comparing like for like, but 2022 figures are broadly similar to 2021.

Table 3. 2022 Proportion of male and female staff in each quartile band at UHSussex

Quartile	Gender	Number of employees	% of Employees
1	Female	3,070	72.84
1	Male	1,145	27.16
2	Female	3,183	74.75
2	Male	1,075	25.25
3	Female	3,432	80.85

Quartile	Gender	Number of employees	% of Employees
3	Male	813	19.15
4	Female	2,730	64.31
4	Male	1,515	35.69

In UHSussex, women occupied 64% of the highest paid jobs and 73% of the lowest paid jobs.

The largest representation of women (81%) was in the third pay quartile, compared to 73% in the overall employee workforce. Representation of women in the highest paid jobs relative to the 2021 figures for the predecessor organisations was 62% at BSUH and 68% at WSHT.

In UHSussex, men occupied 36% of the highest paid jobs and 27% of the lowest paid jobs, compared to representation of 27% in the workforce overall. The UHSussex workforce has less male representation overall than at BSUH (29%) and more than at WSHT (24%).

Table 4. 2021 Proportion of male and female staff in each quartile band

Legacy Trust	Quartile	Gender	Number of employees	% of Employees
BSUH	1	Male	729	31.6
BSUH	2	Male	646	27.7
BSUH	3	Male	473	20.3
BSUH	4	Male	878	37.8
BSUH	1	Female	1,584	68.4
BSUH	2	Female	1,680	72.3
BSUH	3	Female	1,853	79.7
BSUH	4	Female	1,449	62.2
WSHT	1	Male	471	24.2
WSHT	2	Male	433	22.2
WSHT	3	Male	337	17.3
WSHT	4	Male	617	31.7
WSHT	1	Female	1,474	75.8
WSHT	2	Female	1,513	77.8
WSHT	3	Female	1,610	82.7
WSHT	4	Female	1,331	68.3

Bonus Pay Analysis

Mean and median bonus pay gap by gender

Table 5 includes medical and dental employees who received a Clinical Excellence Award (CEA) and very senior managers (VSM) who received a bonus.

Table 5. 2022 UHSussex mean and median bonus pay gap by gender

Gender	Mean	Median	Mean Difference	Median Difference	Mean Pay Gap %	Median Pay Gap %
Female	8,482.54	3,769.94	7,247.62	6,536.25	46.07	63.42
Male	15,730.16	10,306.19				

5

In UHSussex, women earned 37p for every £1 that men earn when comparing median bonus pay. Their median bonus pay was 63% lower than men's.

Table 6. 2021 mean and median bonus pay gap by gender

Legacy Trust	Gender	Mean	Median	Mean Difference	Median Difference	Mean Pay Gap %	Median Pay gap %
*BSUH	Male	18,177.09	12,993.92	7,346.58	7,565.12	40.42	58.22
*BSUH	Female	10,830.51	5,428.80				
WSHT	Male	11,629.48	7,690.81	5,404.25	4,674.83	46.47	60.78
WSHT	Female	6,225.23	3,015.97				

*Note: BSUH 2021 figures differ marginally compared to last year's report of these figures due to harmonisation of methodologies in calculation to allow for comparability between predecessor organisations.

In 2021 at BSUH, women earned 42p for every £1 men earned in median bonus pay. At WSHT, women earned 39p for every £1 men earned. The 2022 median bonus pay gap 63.4% has widened than at either legacy trust in 2021 (BSUH: 58.2%, and WSHT: 60.8%).

Proportion of males and females receiving a bonus payment

A total of 253 employees received a bonus payment. This is shown in Table 7 split by gender, the percentage of males and females in this group, and the percentage of relevant employees in the workforce. Table 8 shows the same information from the legacy trusts in 2021.

Table 7. 2022 Proportion of males and females receiving bonus pay in UHSussex

Gender	Number of Employees	% of Employees (by gender)	Total Employees	% of Total Employees (by gender)
Female	79	31.23	14,621	0.54
Male	174	68.77	5,419	3.21

In 2022 at UHSussex, 0.5% of the female workforce received a bonus compared to 0.6% in 2021 at both BSUH and WSHT.

Table 8. 2021 Mean and Median bonus pay gap by gender

Legacy Trust	Gender	Number of employees (by gender)	% of Employees	% of Total employees (by gender)
*BSUH	Male	110	70.06*	3.70
*BSUH	Female	47	29.94*	0.65
WSHT	Male	81	65.85	3.59
WSHT	Female	42	34.15	0.60

*Note: BSUH 2021 figures differ marginally compared to last year's report of these figures due to harmonisation of methodologies in calculation to allow for comparability between predecessor organisations.

Publication of data

This report will be submitted to the People Committee and approved at the Trust Board. It will be uploaded to the Trust's website and the government's gender pay reporting service.

Actions to take forward

The key actions to be completed over 2023-24 include:

- We will analyse and understand our gender pay data within directorates or divisions, and by ethnicity and other protected characteristics, and by occupational group, including for doctors and dentists
- We will analyse future gender pay gap data by comparison with gender breakdowns of recruitment, staff survey, flexible working, and staff development data
- We will explore statistical significance methods to help quantify which elements of the GPG and underlying factors had an effect so as to better target policy action
- We will set up a workplace gender equality group to work on developing detailed plans to address the gender pay gaps
- We will look at pay gaps by grade of doctor (including SAS doctors), and by agenda for change pay band for other staff
- We will look at bonus payments for doctors ('clinical excellence awards'), which are a significant factor in the medical gender pay gap. Options for consideration include:
    - Use of appraisal and job planning meetings to encourage applications
    - Divisional level diversity targets for applications
    - Internal publication of successful applications
    - Support for applicants and feedback to unsuccessful applicants
    - Proportionate assessments for LTFT (less than full time) applicants
    - Ensuring sufficient notice for applications around school holidays.

Appendix A: Legislative background

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 requires UHSussex, along with most public authorities, to publish annual prescribed information to show whether there is a difference in the average pay of their male and female employees.

The purpose of the duties is to enable the better performance by the authority of the public sector equality duty imposed by section 149(1) of the Equality Act 2010 (c. 15) that requires public authorities to have due regard, in the exercise of their functions, to specified equality aims.

The gender pay gap is a measurement of the difference between men and women's average earnings. It is not about men and women being paid differently for the same job, which has been prohibited by equal pay legislation since 1975.

The aim of compulsory gender pay gap reporting is to use transparency as a tool for raising awareness, to incentivise employers to analyse the drivers behind their gender pay gap and to explore the extent to which their own policies and practices may have contributed to that gap.

The definition of 'ordinary pay' and the methodology was intended by the government to mirror as closely as possible that used by the Office for National Statistics (ONS) in its Annual Survey of Hours and Earnings, to enable meaningful comparison of the data.

Bonus payments are a significant element of overall remuneration in some occupations. The report allows the UHSussex to scrutinise it's remuneration policies and ensure that our practices for bonuses are fair and transparent.

A key driver of the gender pay gap is that fewer women are employed in senior and higher paid positions. UHSussex is required to report on the number of men and women in each quartile of its pay distribution. This allows the Trust to consider where women are concentrated in terms of their remuneration and whether there are any blockages to their progression.

The information must be published on UHSussex's own website and provided on a digital portal (the 'Gender pay gap service'[4]) maintained by the Secretary of State, within 12 months of the 31 March snapshot date each year.

The requirements for the information to be signed and published are intended to ensure reliability of, and accountability for, the data and to identify for the public record those employers who have complied.

The Equality and Human Rights Commission (EHRC) is responsible for monitoring how public authorities are complying with the specific duties and can take enforcement action. The Commission has powers to issue a compliance notice to a public body that it believes

[4] Gender pay gap service https://gender-pay-gap.service.gov.uk/

has failed to comply with the Regulations, and can apply to the courts for an order requiring compliance (sections 31 and 32 of the Equality Act 2006 (c. 3)). The EHRC has a memorandum of understanding with the Care Quality Commission, including cross-referrals of concerns and joint inquiries.

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Agenda Item:	17	**Meeting:**	Board	**Meeting Date:**	February 2023
Report Title:	Sustainability Committee Chair report to Board				
Committee Chair:		Lizzie Peers, Committee Non Executive Chair			
Author(s):		Lizzie Peers, Committee Non Executive Chair			
Report previously considered by and date:					
Purpose of the report:					
Information		☐	Assurance	✓	
Review and Discussion		☐	Approval / Agreement	☐	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		☐	Staff confidentiality	☐	
Patient confidentiality		☐	Other exceptional circumstances	☐	
Implications for Trust Strategic Themes and any link to BAF risks					
Patient	☐				
Sustainability	✓	Assurances in relation to risks 2.1, 2.2 and 2.3			
People	☐				
Quality	☐				
Systems and Partnerships	☐				
Link to CQC Domains:					
Safe		✓	Effective	✓	
Caring		✓	Responsive	✓	
Well-led		✓	Use of Resources	✓	
Communication and Consultation:					

Executive Summary:

The Sustainability Committee met on the 26 January 2023 and was quorate as it was attended by three Non-Executive Directors, the Chair, the Chief Financial Officer, the Chief Operating Officer, Chief Executive and the Chief Governance Officer. In attendance were the Finance Director, the Director of Capital, the Director of Estates and Facilities, the Commercial Director, the Director for Improvement and Delivery, the Director of IM&T and Managing Director Planned Care.

The Committee received its planned items including the reports on the Sustainability True North, Breakthrough Objective, Strategic Initiative (environmental sustainability) and Corporate Project (estates strategy and master planning), along with a comprehensive report on the Trust's Financial Performance with a 2022/23 year end road map, the 2023/24 financial planning framework, the Efficiency Programme, the Capital Programme, an IM&T update, an update on the Commercial team activities including procurement, an ICS finance update and a risk paper and the Board Assurance Framework.

The Committee had an extended discussion on the Trust's current highly challenged financial position, forecast year end outturn and the financial planning framework for 2023/24. The Committee recognised the significant risk within the forecast and based on this the Committee agreed that the relevant BAF risk scores have been correctly increased.

The Committee noted the challenges within the delivery of the Trust's capital programme and noted the assurance given by the Director of Capital that the Trust will deliver its programme by the year end, noting there will be rephrasing of some of the schemes. The Committee noted the breath of schemes delivered benefits for our patients and our staff across all hospital sites.

The Committee noted the current level of delivery of the year's efficiency, recognsing the programme for quarter 3 has delivery 97% of its plan. The Committee noted the risks within the delivery of the final quarter and its linkage to the elevated BAF risks. The Committee noted the positive level of engagement from the divisions in respect of determining the 2023/24 plan.

The Committee received the planned updates on the Sustainability Breakthrough Objective (Productivity), Strategic Initiative (Environmental Sustainability) and the Corporate Project (Estates Strategy and Master planning). The Committee noted the level of delivery and the continued successful work being undertaken to deliver and share the work in respect of the Trust's Green Plan. The Committee reflected on the inter-relationship with the reporting on the productivity breakthrough objective and the oversight of workforce productivity provided within the People Committee.

In the reports provided by the Director of IM&T on the Trust's major IT programmes, the Committee noted the progress being made and the risks within IT and was assured by the Director of IM&T that these are being managed.

The Committee received an update from the Commercial Director on the activities of the commercial directorate over the last quarter. The Director provided an update on the development of the procurement and commercial strategies and the Committee noted that these will shape the future reporting to this Committee.

The Committee reviewed the quarter 3 Sustainability Risk Paper and agreed the identified significant risks detailed with a current score of 12 and above were reflective of the Trust and consistent with the papers discussed in the meeting. In reviewing this report and the other reports presented to the Committee the Committee agreed that the BAF risks it has oversight of were fairly stated, noting that BAF risks 2.1 and 2.2 were increased to 20 with risk 2.3 reduced based on reports presented to the Audit Committee on actions to improve the systems of internal financial control.

Key Recommendation(s):

The Board is asked to **NOTE** the assurances received at the Committee and the actions taken of the Committee within its terms of reference.

The Board is asked to **NOTE** the Committee recommendation that the BAF risks 2.1, 2.2 and 2.3, for which it has oversight, are fairly represented.

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COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Sustainability Committee	**26 January 2023**	**Lizzie Peers**	✓	☐

Declarations of Interest Made

There were no declarations of interest made

Assurances received at the Committee meeting

Patient First Trust North, Breakthrough Objective, Strategic Initiative and Corporate Projects

Financial position, year-end forecast and 2023/24 financial planning

The Committee **RECEIVED** an update from the Chief Financial Officer and Finance Director on the financial performance of the Trust at Quarter 3 and **NOTED** that the Trust remains adverse to its plan. The Committee **NOTED** the internal and external drivers of this position, including the delivery of elective recovery through a higher level of use of outsourcing and insourcing; urgent care demands requiring a continuation of the use of escalation beds being supported by agency staff and inflationary pressures. The importance of achieving the expected benefits from business case investments was also discussed.

The Committee **NOTED** the actions being taken and those that underpin the mid case and best case forecasts in the financial roadmap to year end. The Committee **NOTED** the assumptions within the forecast options and that a number of actions having been taken since the last meeting. These included the funding of the winter plan through delegated budgets, the establishment of regular oversight meetings with the divisions and a focus on opportunities to increase internal productivity.

The Committee **RECEIVED** an update on the planning process for 2023/24, with the divisions working on their bottom up budget development which is then aligned to top down financial planning. The Committee **NOTED** that the final guidance remains outstanding but the developing plan is based on the best assumptions available to the Trust.

The Committee considered the heightened degree of risk within the 2022/23 roadmap delivery with the challenge of continued operational pressures from emergency activity and the increase in the use of escalation beds along with the significant risk for the 2023/24 financial forecast. Based on these reports the Committee **AGREED** these supported an increase to the Trust BAF risks score from 16 to that of 20 for the relevant sustainability strategic risks (BAF risks 2.1 and 2.2). The Committee **NOTED** that further discussions will be held with the Board as the Trust develops its draft 2023/24 annual plan and outstanding guidance is received alongside the work being undertaken to determine the activity and workforce forecast plans for 2023/24.

The Committee reflected on the financial framework and the expectations within this of productivity improvements and the interlinkage of the work on the productivity Breakthrough Objective with areas assured through other Board Committees such as People (turnover, recruit, retain, sickness management, e deployment, rostering, job planning, agency spend and international recruitment benefits realisation) and Systems and Partnerships (activity, length of stay reduction, emergency demand management) .

Productivity Breakthrough Objective

The Committee discussed the productivity breakthrough objective. The Committee **RECEIVED** an update from the Managing Director for Planned Care and Cancer on the work of the project. Whilst data analysis

continues, the data has already been used and fed into the divisional activity plans supporting potential for efficiency improvements within the non-elective and elective activity pathways. The Managing Director for Planned Care and Cancer provided an update on each of the workstreams, covering Theatres, Outpatients and Speciality elective pathways as well as the ICB productivity workstream. The data for each area indicates clear opportunities for improvements with some improvements already achieved. The Committee was **ASSURED** from this update that a focus on the control oversight arrangements and the work being done on data analysis and quality will help the Trust monitor its delivery within the revised financial regime for 2023/24. The Committee **NOTED** the progress made, the further work needed, the associated risks and the importance of increasing activity to the deliver the 2023/24 annual plan. The Committee **NOTED** that the developing patient access transformation corporate project reporting to Systems and Partnerships will also support the overall productivity gain within outpatients.

Strategic Initiative - Environmental Sustainability

There was an update on the Strategic Initiative - Environmental Sustainability provided by the Deputy Director of Facilities and Estates. The Committee **NOTED** the delivery of the planned interventions to reduce the Trust's carbon reductions. The update confirmed that the Trust's delivery remains on track across the 28 identified schemes developed to achieve the 57% carbon reduction to 2025. The Committee **NOTED** the continuing success of the Trust in securing external sources of funds to progress its determined schemes at an increased pace. The Committee **NOTED** the Environment Sustainability Steering Group met to review past successes within the delivered projects, plan schemes for 2023/24 and for the promotion of environmental week in February which will provide an opportunity to provide feedback on the current success and those next schemes. The Committee **NOTED** that with the opening of escalation areas and other estates activity the carbon footprint has now increased but the Deputy Director provided information on new schemes that will allow this to be mitigated especially focusing on reuse. The Committee was **ASSURED** over the Trust's engagement with the ICS own green plans.

Corporate Project - Estates Strategy and Master Planning

The Director of Capital presented an update on the Estates Strategy and Master Planning corporate project. The Committee **NOTED** the established core group to shape the project delivery and to ensure this action is aligned to the Trust's key priorities encapsulated within the clinical strategy, supports the green plan through carbon reduction and the corporate and clinical activity expectations. The Committee **NOTED** the update and the engagement being undertaken ahead of the launch of project and its scope especially with the Divisions.

Efficiency Programme

The Committee **RECEIVED** the quarter 3 Efficiency Programme Report from the Director for Improvement and Delivery. Through the update provided by the Director the Committee **NOTED** the successful delivery of 97% of the plan for quarter 3 alongside the degree of risk within the overall programme delivery especially during quarter 4.

The Director for Improvement and Delivery advised that there is strong engagement with the divisional leaders in respect of the establishing the 2023/24 programme. The Committee were assured that there continues to be a well-tested and robust system for delivery of efficiencies.

Capital Plan

The Committee **RECEIVED** the Q3 update against the Trust's 2022/23 capital plan and the Director of Capital informed the Committee on the Trust's capital prioritisation process. The Committee **NOTED** that the level of over programming within the capital programme is being managed as usual through re-prioritisation and the Director informed the meeting of his confidence in meeting the year end position. The Committee **NOTED** the breadth of schemes supported by the Capital Programme and **NOTED** the patient and staff benefits these schemes bring.

The Committee were **ASSURED** by the update from the Director of Capital over the work undertaken to secure the planned hand over of 3Ts phase one at the end of January 2023, noting the risks associated with this.

IM&T Programme update

The Committee **RECEIVED** the quarter 3 IM&T Programme Report on the wide-ranging Trust's IM&T programme of work. The Committee **NOTED** the update provided by the Director of IM&T on the main IM&T work being undertaken over the last quarter and those scheduled for the remaining quarter focusing on infrastructure and platform replacement. The Committee discussed the PAS implementation and the benefits this will bring. The report also provided data showing the performance of the IT department itself which confirmed the teams continue to perform well.

Commercial Activities Update

The Commercial Director provided an update on the activities of the commercial directorate over the last quarter. The Committee **NOTED** the Q3 activities around the Sussex Pathway Network, and the wider retail strategy. The Director provided an update on the development of the procurement and commercial strategies which will shape the future reporting to this Committee. The Committee **NOTED** the update.

ICS

The Committee **RECEIVED** an update from the Chief Financial Officer on the ICS Finance Leadership Group during quarter 3 which had focused on the year end forecast along with the developing the 2023/24 annual plans.

The Committee **NOTED** the system risks and how they align to those reflected in the reports provided at the meeting today and these align to the elevated scores for the BAF risks 2.1 and 2.2.

Risk

The Committee **REVIEWED** the quarter 3 Sustainability Risk Paper on the programme risks which may impact the delivery of the Sustainability True North along with the overarching risks from the respective Strategic Initiative and Corporate Project. The Committee considered this report alongside the respective discussions on risk within the respective Committee items. The Committee **AGREED** the risk paper summary and through the respective discussions **NOTED** the key risks and their linkage to the Committee's oversight of three BAF strategic risks.

The Committee **REVIEWED** the BAF risks it has oversight for, and **AGREED**, having regard to both the BAF summary and the Committees consideration of the risks considered during the meeting, that the quarter four score for risks 2.1 and 2.2 increases were fairly stated and that risk 2.3 was correctly reduced linked to the reporting provided directly at the Audit Committee.

Actions taken by the Committee within its Terms of Reference

The Committee **AGREED** to recommend the quarter 3 score for BAF risks 2.1 to 2.3 to the Board, noting the changes to these risk scores in this quarter.

Items to come back to Committee (Items the Committee keeping an eye on outside its routine business cycle)

The Committee noted that important inter-dependency between the productivity improvement Breakthrough Objective, and actions overseen by the People Committee in respect of workforce and by the Systems and Partnerships Committee and would consider what cross reporting may be beneficial at this Committee.

The return on investment and benefits realised from investments made will be reported back to future Committees.

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Items referred to the Board or another Committee for decision or action	
Item	**Referred to**
The Committee recommended to the Board for review the financial year end road map and the associated BAF risk scores.	To Board February 2023

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Agenda Item:	18	**Meeting:**	Board	**Meeting Date:**	February 2023
Report Title:	Systems and Partnerships Committee Chair report to Board				
Committee Chair:		Bindesh Shah, Committee Non Executive Chair			
Author(s):		Bindesh Shah, Committee Non Executive Chair			
Report previously considered by and date:					
Purpose of the report:					
Information		☐	Assurance		✓
Review and Discussion		☐	Approval / Agreement		☐
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		☐	Staff confidentiality		☐
Patient confidentiality		☐	Other exceptional circumstances		☐
Implications for Trust Strategic Themes and any link to BAF risks					
Patient	☐				
Sustainability	☐				
People	☐				
Quality	☐				
Systems and Partnerships	✓	Assurances in relation to risks 5.1, 5.2 and 5.3			
Research and Innovation	☐				
Link to CQC Domains:					
Safe		✓	Effective		✓
Caring		✓	Responsive		✓
Well-led		✓	Use of Resources		✓
Communication and Consultation:					
Executive Summary:					

The Systems and Partnerships Committee met on 26 January 2023 and was quorate as it was attended by three Non-Executive Directors, the Trust Chair, the Chief Executive, the Chief Operating Officer, the Chief Financial Officer, and the Chief Governance Officer. In attendance was the Director of Strategy and Planning, the Managing Director for Planned Care and Cancer, the Managing Director of Urgent and Emergency Care and the Director of Improvement and Efficiency

The Committee received its planned items including the Q3 report on the Trust's performance against the key constitutional standards, reports on the respective counter measure summaries from the Systems and Partnerships Strategic Initiative, the 3Ts development; and new Corporate Projects namely, Reducing Length of Stay and Community Diagnostic Centres. Further items provided updates on the Trust's work within the ICS, Systems and Partnerships key risks and the Board Assurance Framework.

The Chief Operating Officer and Managing Director for Planned Care and Cancer updated the Committee on the challenges impacting on the Trust's operational performance noting the interlinkage between the activity reports and the reports provided at the People Committee on workforce pressures and the reports provided to the Sustainability Committee in respect of productivity challenges. Based on this the Committee agreed the Systems and Partnership strategic risks were correctly reflecting these, noting that risk 5.3 remains at a score of 20.

The Committee recognised the significant benefit that 3Ts will bring to patients and staff and through the reports received, were assured on the progress tightly overseen by the programme governance as the Trust took handover of the Louisa Martindale Building in November and December in line with the agreed

programme. The committee noted further programme work progressing well with the scrutiny of the Sustainability Committee on capital works. Pre-occupation activities are delivering in line with programme plans and discussed the focus for the clinical and operational readiness team in the next period. The Committee discussed and noted the increased stakeholder engagement will be pursued including with the New Hospitals Programme Operational readiness team and system partners including the ICB. The Committee asked for an updated External Communications plan to come back to the next meeting. The Committee also noted continued focus on plans to ensure the expected benefits from the move are realised and any problems identified early and addressed quickly.

The Committee reviewed and discussed the Business Planning arrangements for 2023/24 and noted the considerable challenge of meeting the NHS National objectives in the planning guidance in the context of the extremely difficult environment generally and particularly those challenges facing the Trust.

The Committee received assurance of the Trust's Emergency Preparedness Resilience and Response arrangements that had returned a substantially compliant rating endorsed and validated by the NHS Sussex EPRR Team through a detailed review process. The Committee noted the further improvement work to take place ahead of the 2023 inspection that included lock-down at PRH and RSCH sites, evacuation plans, enhanced business continuity incident plans from divisions and the on-call policy needed to be consistent across Trust sites. The Committee noted the Emergency Preparedness Resilience and Response Annual Report 2022 and recommended its approval to the Board.

The Committee reviewed the quarter 3 Systems and Partnership Risk Paper and noted the risks detailed with a current score of 12 were reflective of the Trust. The Committee noted the reduction in risks scoring 12 or above given the successful progress with the 3Ts stage one programme but noted the associated recruitment risk on mobilisation. In reviewing this report and the other reports presented to the Committee, the Committee agreed that the BAF risks it has oversight of were fairly stated and was assured that with the maintained system collaboration through a period of particular challenge risk 5.1 had been appropriately reduced in score from 16 at the beginning of the year to its target score of 8.

Key Recommendation(s):

The Board is asked to **NOTE** the assurances received at the Committee and the actions taken of the Committee within its terms of reference.

The Board is asked to **NOTE** the outcome of the Committees review of BAF risks 5.1, 5.2 and 5.3 that the Committee's view is that these risks are fairly represented noting the Committee recognised that the Board review and discussion of the winter plan may change some of these risk scores. Risk 5.1 had been reduced to it's target risk score in light of the apparent improvement of system working.

The Board is asked to **APPROVE** the EPRR Annual Report 2022. The Board is invited to **NOTE** the positive assurance from the Trust's EPRR function assessed as substantially compliance, externally validated by the NHS Sussex EPRR team.

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COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Systems and Partnerships Committee	**26th January 2023**	**Bindesh Shah**	✓	☐

Declarations of Interest Made

There were no declarations of interest made

Assurances received at the Committee meeting

Constitution performance report

The Committee **RECEIVED** an update on constitutional performance for quarter three including the performance against the Trust's systems and partnership true norths and breakthrough objectives for emergency and planned care for the most recent period.

The Committee **NOTED** the Trust has continued to focus on recovery against Constitutional NHS access targets. However, the Committee **NOTED** there had been a considerable worsening of demand pressure on hospital flow and challenged performance against all the key measures for urgent and emergency care, particularly in the Month of December across all hospitals in Sussex. The Committee **NOTED** that similar challenges had been observed nationally and that the early figures from January had indicated that particular causes of increased presentations, Covid and Flu and general levels of acuity had since reduced. The Committee **NOTED** the work to capitalise on the improving position using the learning from the Prism visits and reducing Covid restrictions on the environment along with the support and focus from the Hospital Director / Hospital Director of Nursing teams on each site for which reports had indicated early benefits.

All parts of the Sussex ICS are continuing to experience significant pressures and there have remained very high numbers of Medically Ready for Discharge (MRD) patients within all the Trust's hospitals and across the wider system. Flow through the hospital is constrained due to increased length of stay, increased acuity compared to pre-pandemic levels and community constraints. The compound effect was that A&E departments become heavily congested, predominantly with minor A&E patients, leading to increased delays and fewer patients seen within the 4 hours standard. The Committee **NOTED** the close system working during the Critical Incident declared and were advised by the Chief Operating Officer that System Partners including the Community Trust and Social Care had a shared recognition of the daily patient numbers and MRD that would enable optimal flow on each site.

The Committee **NOTED** Trust's continued focus for elective recovery to ensure no patients wait over 78 weeks for elective RTT treatment or 104 days for Cancer treatment. While Elective recovery had progressed well with improvements observed in the constitutional standards and reductions in those patients waiting the longest for completion of their clinical pathway, industrial action had led to a growth of waiting lists and followed a pattern observed nationally. The Committee **NOTED** that, while the cohort of patients at most risk of their treatment wait breaching the 78 week target had continued to reduce, cancelled activity during the industrial action in December had eroded the contingency headroom. The Committee **NOTED** work to improve booked appointments by end of March. The Committee **NOTED** that Cancer lists represented an area of required focus on pathways and with system partners supporting the most effective referral behaviours.

The Managing Director for Planned Care and Cancer informed the Committee that within the remaining cohort of patients waiting 78 weeks there is an increasing level of treatment complexity which is bringing increased risk to achieve the set milestones. The Committee **NOTED** that the Trust's diagnostic performance remained under significant pressure from the emergency operational demands.

The Committee **NOTED** the interlinkage between the activity reports received at this Committee the reports at the People Committee on workforce pressures and the reports at the Sustainability Committee in respect of productivity challenges and financial implications of the risk cohort on the 78 week waiting list. Based on this, the Committee **AGREED** the Systems and Partnership strategic risks were correctly reflecting these noting that risk 5.3 on the BAF remains at a score of 20.

Breakthrough Objective

The Committee **NOTED** the Countermeasure Summary report against the refreshed Systems and Partnerships Breakthrough Objective in respect of the median hour of discharge. The Committee **RECEIVED** an update from the Chief Operating Officer who reported considerable progress during Q3 in mobilising the project with top contributing units engaged with frequently and reported a clear effect of visible leadership and Hospital Director supervision activities.

3Ts Strategic Initiative

The Committee **RECEIVED** updates on the Trust 3Ts hospital development Strategic Initiative from the Director of Improvement and Delivery. The Committee **NOTED** The Trust took handover of the Louisa Martindale Building in November and December in line with the agreed programme; the car park and systems will be handed over in January which will complete the handover to the Trust. The contracted capital works will also complete at the end of January. A new programme is required from January onwards to confirm completion of building defect resolution and post completion works and the Committee **NOTED** a detailed capital report is provided to the Sustainability Committee. The Committee **NOTED** Pre-occupation activities are in progress and are delivering in line with programme plans. The focus for the clinical and operational readiness team in the next period. The Committee discussed and **NOTED** the increased stakeholder engagement will be pursued including with the New Hospitals Programme Operational readiness team and system partners including the ICB. The Committee was **ASSURED** over the oversight of the move recognising the continued focus from frequent Steering Group meetings.

The Committee also **NOTED** continued progress toward developing a decommissioning plan concurrent with mobilisation in the new Louisa Martindale building and the 100 day post handover plan to ensure the expected benefits from the move are realised and any problems identified early and addressed quickly.

The Committee noted the programme risks and through the report and associated discussion was **ASSURED** over the alignment of the risk mitigations, the tracking of their delivery and that these are subject to regular review by their assigned risk owners. The Committee had a detailed discussion around the contemplation of post-occupation phase risks and acknowledged that Facilities and Estates have a major role in the pre-occupation phase.

Systems and Partnerships Corporate projects

The Committee **RECEIVED** the countermeasure summaries against the previously agreed project charters for the Systems and Partnerships Corporate Projects: Reducing Length of Stay and Community Diagnostic Centres. The Committee **NOTED** the update from the Chief Operating Officer, Medical Director for Planned Care and Cancer and the Director of Strategy and Planning on the progress and the work undertaken during the period through the established workstreams. The Committee **NOTED** the Patient Access Transformation project is phased to commence towards the end of 2022/23 and once launched then it will flow to this Committee at the start of 2023/24.

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ICS and Systems Collaborations

The Committee **NOTED** the Business Planning arrangements for 2023 / 24 and the very difficult environment for the NHS generally and particularly those challenges facing the Trust. The Committee **NOTED** the approach proposed for business planning reflects this context, particularly with regard to any potential service changes. The Committee **NOTED** the National Objectives and that a high number of key actions of which have the potential to impact on the Trust and that that these requirements would represent considerable challenge. The Committee **NOTED** these actions had been captured and are being reviewed internally to ensure they are covered within the Trust's Operational Plan. The Committee **NOTED** that business planning activities within the Trust had commenced with work to identify the extent of gaps between capacity and demand, how this will be closed and would be followed by a focus on productivity
improvements and pathway changes. The Committee **NOTED** that known service changes, such as the move to Louisa Martindale building (formerly 3Ts phase 1), and the opening of the Southlands CDC, will be factored into the process

The Committee **NOTED** the Business Planning Governance through which the final submission to NHS Sussex, and the Trust's own Operational Plan will require the agreement of the Trust Board. The Committee **NOTED** The development of the plan will be overseen by the Executive Director Business Planning Steering Group, chaired by the Chief Governance Officer and the Business Planning Development Group (chaired by the Director of Strategy and Planning) will support the development of the plan. The Committee **NOTED** that at ICB level, the existing CEO and COO groups will be responsible for ensuring wider system sign off of the plan. There was a discussion of the extent to which System partners are engaged with discussion of any identified capacity and demand imbalance and **NOTED** that there are System Level Senior Responsible Officers. The Committee heard from the Chief Executive that the Trust would take care to ensure a credible road map in advance of any ambition commitments.

Clinical Operating Model deep dive

The Chief Operating Officer provided the Committee with presentation on the implementation of the new clinical operating model (COM), including development, leadership appointments, and proposals to review effectiveness of leadership structures and opportunities for development and evolution of the model.
The Committee discussed how operational and Corporate Divisions overlap and **NOTED** that at the point of review of the COM the Chief Operating Officer would seek to articulate the matrix working and to report on the work required to effect this.

Emergency Preparedness, Resilience and Response

The Managing Director of Urgent and Emergency Care provided an update on the assurance process for the Trust's EPRR arrangements. The Committee was **ASSURED** that as a direct result of the Emergency Preparedness, Resilience and Response team working extensively with NHS Sussex, the EPRR Assurance Process for the Trust returned a **substantially compliant** rating which was endorsed and validated by the NHS Sussex EPRR Team. The requirements for assurance had been considerably enhanced post pandemic and the Committee acknowledged the significant achievement of the rating. The Committee **NOTED** the
Key Recommendations that included action plans ensure that all EPRR Assurance advisories are completed prior to the 2023 Assurance process; to continue to work with Lockdown Planning Group to progress the Lockdown Plan for UHSussex sites at RSCH, RACH and PRH; to continue to work with Fire and Estates and Facilities to progress the Shelter and Evacuation Plan for UHSussex Brighton and PRH sites for completion by August 2023l; continue to review and update all EPRR Polices and Emergency Plans as appropriate and merge any outstanding legacy emergency plans and to review Business Continuity Service Level plans and Business Impact Assessment templates and processes

Risk and BAF

The Committee **RECEIVED** and discussed the quarter 3 System and Partnership Risk Paper on the programme risks which may impact the delivery of the Systems and Partnership True Norths along with the overarching risks from the respective Strategic Initiative and Corporate Projects.

The Committee considered this report alongside the respective discussions on risk within the respective Committee items.

Actions taken by the Committee within its Terms of Reference

The Committee **AGREED** to recommend the quarter 3 scores for BAF risks 5.1 to 5.3 to the Board

The Committee **AGREED** the EPRR Annual Report and agreed to commend it to the Board. The Committee also **NOTED** the substantial compliance assessment of the Trust's EPRR arrangements in 2022 validated by NHS Sussex.

The Committee **NOTED** updates against the Constitutional standards as well as the Systems and Partnerships Breakthrough Objective (Median Hour of Discharge), Strategic Initiative (3Ts) and Corporate Projects (Reducing Length of Stay, Community Diagnostic Centres) and **NOTED** the progress made and identified risks.

Items to come back to Committee (Items the Committee keeping an eye on outside its routine business cycle)

The Committee asked for the external communications plan for the Louisa Martindale building opening to come back to the next meeting

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

Item	Referred to
The Committee **RECOMMEND** to the Board that the risks within the BAF for which it has oversight are fairly represented.	To Board February 2023
The Committee **RECOMMEND** that the Board note and approve the Trust Emergency Preparedness Resilience and Response Annual Report which documents the substantial compliance assessment of the Trust's EPRR arrangements in 2022 that had been validated by NHS Sussex.	To Board February 2023

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Agenda Item:	18.1	**Meeting:**	**Systems & Partnerships Committee**	**Meeting Date:**	26 January 2023
Report Title:	**Emergency Preparedness, Resilience and Response Annual Report 2022**				
Sponsoring Executive Director:	Siobhan Murray – Managing Director				
Author(s):	Mark Stevens - Emergency Planning and Business Continuity Manager				
Report previously considered by and date:					

Purpose of the report:			
Information	✓	Assurance	✓
Review and Discussion	✓	Approval / Agreement	✓
Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	☐	Staff confidentiality	☐
Patient confidentiality	☐	Other exceptional circumstances	☐

Implications for Trust Strategic Themes and any link to BAF risks		
Patient	✓	
Sustainability	✓	
People	✓	
Quality	✓	
Systems and Partnerships	✓	

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

Communication and Consultation:

This report provides detail on the Trust's preparedness to respond to emergencies in order to meet the requirements of the Civil Contingencies Act (2004) and the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework and has been written by the Emergency Planning and Business Continuity Manager (West) in consultation with the Head of Resilience (East).

Executive Summary:

This report details work undertaken over the last year by the EPRR team to ensure the Trusts readiness and resilience in response to any type of disruption or emergency event which may impact upon service delivery and covers the following key areas:

- Risks
- Assurance
- Policies and Plans
- Business Continuity
- Training and Exercising

Key Recommendation(s):

As a direct result of the Emergency Preparedness, Resilience and Response team working extensively with NHS Sussex, the EPRR Assurance Process for UHSussex returned a substantially compliant rating which was endorsed and validated by the NHS Sussex EPRR Team with recognition of the Trust EPRR team for the work undertaken in the Assurance process to attain this rating and develop a comprehensive action plan going forward.

The requirements for assurance were considerably enhanced post pandemic so to achieve this rating was a significant achievement.

Key Recommendations:

- To work through the updated EPRR Work stream for 2023 to ensure that all EPRR Assurance advisories are completed prior to the 2023 Assurance.
- Continue to work with Lockdown Planning Group to progress the Lockdown Plan for UHSussex East sites. Due to delays moving forward with the infrastructure work that needs to be completed this piece of work has been pushed back but meetings have now been scheduled - completion by August 2023
- Continue to work with Fire and Estates and Facilities to progress the Shelter and Evacuation Plan for UHSussex Brighton and PRH sites for completion by August 2023
- Continue to review and update all EPRR Polices and Emergency Plans as appropriate and merge any outstanding legacy emergency plans.
- Review Business Continuity Service Level plans and Business Impact Assessment templates/processes with a view to merging / aligning the processes into one.
- Continue to work with the M365 team to create an EPRR TEAMs account and migrate all relevant EPRR shared folders / files to that account for future filing and ease of access.
- Also continue to work with the M365 team to create a Trust shared folder on TEAMs to enable all staff to access EPRR emergency and business continuity plans remotely as required.

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Copies of the following reports/documents mentioned in the main report can be made available if required:

- EPRR Annual Assurance spreadsheet
- UHSussex Core Standards Assurance slides (LHRP Exec Report)
- UHSussex EPRR Work Stream 2023

The Committee/Board are asked to NOTE the contents of and APPROVE this Emergency Preparedness, Resilience and Response annual report.

University Hospitals Sussex
NHS Foundation Trust

To: **Systems & Partnerships Committee**

Date: 26th Jan 2023

From: Mark Stevens - Emergency Planning and Business Continuity Manager

Agenda Item: 18

EMERGENCY PREPAREDNESS, RESILIENCE and RESPONSE ANNUAL REPORT 2022

1. INTRODUCTION

1.1. The Civil Contingencies Act 2004 outlines a single framework for civil protection in the United Kingdom. The Act establishes a clear set of roles and responsibilities for those involved in emergency preparedness and response at a local level.

1.2. Under the Civil Contingencies Act 2004, NHS organisations and providers of NHS funded care must show that they can plan for and deal with a wide range of incidents and emergencies that could affect health or patient care. This programme of work is referred to as Emergency Preparedness, Resilience and Response (EPRR).

1.3 University Hospitals Sussex NHS Foundation Trust (UHSussex) is classed as a Category One responder under the Civil Contingencies Act 2004 and is obliged to respond in the event of a civil emergency, which threatens serious damage to human welfare in a place in the United Kingdom and is subject to the following civil protection duties:

- Assess the risk of emergencies occurring and use this knowledge to inform contingency planning.
- Ensure emergency plans and business continuity management arrangements are in place.
- Communicate with the public to ensure they are warned, informed and advised in the event of an emergency.
- Share information and cooperate with other local responders to enhance coordination and efficiency.

1.4 The NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework provides national guidance for emergency preparedness which enables the Trust to ensure effective arrangements are in place to deliver appropriate care to patients affected during an emergency.

1.5 The NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) are the minimum standards which NHS organisations and providers of NHS funded care must meet to ensure they are able to respond to a wide range of incident and emergencies that could affect health or patient care.

2 RECOMMENDATIONS

2.1 The Committee/Board are asked to NOTE the contents of and endorse this **Emergency Preparedness, Resilience and Response** annual report.

3. CONTEXT

3.1 This report provides detail on the Trust's preparedness to respond to emergencies in order to meet the requirements of the Civil Contingencies Act (2004) and the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework.

3.2 This report details work undertaken over the last year to ensure the Trusts readiness and resilience in response to any type of disruption or emergency event which may impact upon service delivery and covers the following key areas:

- Risks
- Assurance
- Policies and Plans
- Business Continuity
- Training and Exercising

4. MAIN REPORT

4.1 Risk

4.1. 1 Risk management is covered within the Civil Contingencies Act 2004 and is the first step in the emergency planning and business continuity process. It ensures that local responders make plans that are sound and proportionate to risks.

4.1.2 Following the merger an Emergency Preparedness, Resilience and Response Corporate Risk has been drafted on SHE and lists all Trust Emergency Planning and Business Continuity risks in line with risks identified on the National Risk Register and Local Community Risk Register in collaboration with NHS Sussex and Sussex Resilience Forum.

4.1.3 UHSussex is represented by the EPRR Team on both the Sussex Resilience Forum Risk Group and the Local Health Resilience Partnership Risk Task and Finish Group. The EPRR team are also members of the UHSussex Health and Safety Committee.

4.1.4 All Emergency Planning and Business Continuity Risks have now been reviewed and updated and entered on the new IQ Datix system.

4.1.5 All Emergency Planning and Business Continuity risks are linked to the Sussex Local Resilience Forum Community Risk Register (CRR) and the Local Health Resilience Partnership (LHRP) risk register; all have been reviewed and updated on a regular basis during the year and in response to any specific events or changes.

4.1.6 Current Emergency Planning and Business Continuity risks on Datix are:

- Pandemic Influenza or other new and emergency pandemic
- Multiple or Mass Casualty Incident
- Incident involving CBRN or Hazardous material
- Adverse Weather
- Evacuation
- Lockdown
- Business Continuity – service disruption affecting critical services

4.2 **Assurance**

4.2.1 The minimum requirements which commissioners and providers of NHS funded services must meet are set out in the NHS England core standards for Emergency Preparedness, Resilience and Response. The accountable emergency officer in each organisation is responsible for ensuring these standards are met.

4.2.2 As a direct result of the Emergency Preparedness, Resilience and Response team working extensively with NHS Sussex, the EPRR Assurance Process for UHSussex returned a substantially compliant rating which was endorsed and validated by the NHS Sussex EPRR Team with recognition of the Trust EPRR team for the work undertaken in the Assurance process to attain this rating and develop a comprehensive action plan going forward. The requirements for assurance were considerably enhanced post pandemic so to achieve this rating was a significant achievement.

4.2.3 Out of the total of 64 Core Standards which are relevant to Acute Trusts, the Trust was fully compliant with 57 of the standards with the remaining 7 being partially compliant as detailed below:

- CS14 Countermeasures
- CS16 Evacuation and Shelter
- CS17 Lockdown
- CS50 Business Continuity Management monitoring and evaluation

- CS51 Business Continuity Audit
- CS52 Business Continuity Management Continuous Improvement Process
- CS58 Decontamination capability 24/7

4.2.4 In the annual Assurance report to the Local Health Resilience Partnership Executive Group the Trust presented the following summary:

Top three findings:

- EPRR Assurance post-merger – substantially compliant rating.

- EPRR Policies – The Trust has reviewed and updated all EPRR Polices following the merger and have separate and comprehensive polices for EPRR, Business Continuity Management and Lockdown, each being intrinsically linked with each other and appropriate emergency plans.

- EPRR Risks – the EPRR team has reviewed all the legacy EPRR Risks, created an overarching Corporate EPRR risk transferring all EPRR risks to the Trust RL Datix IQ incident and risk management system, with all risks being reviewed at the Health and Safety Committee with any issues/risks escalated as necessary.

Top three issues identified:

- Shelter and Evacuation - Shelter and Evacuation Plan has been reviewed in line with the current NHSE Guidance issued in Oct 2021. This is the first draft and requires further work with regards to the Brighton and PRH sites

- Lockdown - Lockdown Policy has been reviewed and updated for UHSussex. UHSussex does not currently have a Lockdown Plan for the Brighton and PRH sites.

- On Call Policy – Currently the on-call mechanisms are not consistent across the Trust, and this is a priority workstream and is in progress following the development and implementation of the new Clinical Operating Model. A new Trust ‘On Call Policy’ and documentation which clearly defines the roles and responsibilities and required core skill set and competencies required for these roles with appropriate training programmes will be completed by quarter 1.

Key actions to deliver improvement:

- EPRR Work Stream for 2022/23 currently being reviewed to include key areas of focus from EPRR Assurance and time frames for completion
- Evacuation and Shelter planning group and Lockdown planning group to further progress the review of the plans for whole of UHSussex and implementation for Brighton and PRH sites.
- On Call Policy to be developed

2.2.4 Although the UHSussex EPRR team has worked hard with NHS Sussex EPRR to retain a substantially compliant rating for the 2022 Assurance, it was noted that there are a number of advisories and a number of partially compliant standards which have been added to the EPRR Workstream for 2023 to ensure that these are addressed prior to the 2023 Assurance process. A detailed work plan has been established to deliver the work in good time for the next assessment.

4.3 Policies and Plans

4.3.1 The Trust has a mature suite of legacy policies and plans to deal with EPRR Issues and specifically Critical, Business Continuity and Major Incidents as defined by the NHS England Emergency Preparedness Resilience and Response (EPRR) Framework.

4.3.2 All EPRR policies and plans have been reviewed and updated to ensure that they are current and conform to current guidance and legislation and are relevant to UHSussex.

4.3.3 The progressive implementation of the new Clinical Operating Model and the impact on the Command and Control process in the Trust resulted in legacy command and control plans continuing to be used in 2022, although each plan was reviewed and updated and operationally tested through BCI/Critical Incidents. A new combined plan will be produced as part of the on call policy workstream so a clear Trust wide command and control process will be in place.

4.4 Business Continuity

4.4.1 Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity procedures continue to be embedded in the Trust with clear and comprehensive separate EPRR and Business Continuity Management policies which provide a clear division between policy and operational plans.

4.4.2 The following documents have been reviewed and updated and approved for UHSussex:

- Business Continuity Management Policy
- Corporate Level Critical Activities
- Trust Business Continuity Plan

4.4.3 As detailed in Section 4.2.3 Assurance, a number of core standards were rated as partially compliant, three of which focussed on business continuity:

- CS50 Business Continuity Management monitoring and evaluation
- CS51 Business Continuity Audit
- CS52 Business Continuity Management Continuous Improvement Process

4.4.4 Staff awareness with regards to Business Continuity has increased as individual departmental business continuity service level plans have been reviewed in preparation for planned service/IT upgrades and activation of specific business continuity processes.

4.4.5 There have also been a number of declared business continuity incidents throughout the year which has helped raise staff awareness and identified any areas of concern which need to be addressed.

4.4.6 It is the responsibility of the individual department to update their individual business continuity service level plans and notify the Emergency Preparedness, Resilience and Response team when documents have been updated. However, due to exceptional operational pressures and changes associated with the new operational structures, some departments have further work to complete their plans following merger and has been added to the EPRR Workstream for 2023 to ensure that these are addressed.

4.4.7 The EPRR team has been focusing on departments specifically affected by planned move into the 3T's in February 2023 and assisting those departments in updating their departmental service level plans.

4.5 Training and Exercising

4.5.1 The EPRR Team continue to provide training when identified for Director on Call, On Call Manager and Loggists where necessary on a 1:2:1 with individuals with classroom-based courses now being planned and phased in.

4.5.2 All EPRR training courses are being reviewed and updated with the intention that elements of these will be added as e-learning courses on IRIS.

4.5.3 The level of formal training exercises in 2021/22 has been compromised due to operational pressures and structural changes including many new roles/new postholders, however the following exercises have been held with constructive debriefs and lessons learnt identified:

- Exercise Cytokine - Infection Prevention and Control Viral haemorrhagic fever exercise
- Exercise Absturz – Crisis Communications Exercise

4.5.4 Operational pressures and various BCI/Critical incidents have offered many opportunities to test BCI processes and operational control processes and many staff have participated in these, and lessons learnt will be factored into BCI plans and the future command and control updates. A move to more standard operating practice across the Trust sites will be a feature of the refreshed plans going forward.

4.5.5 The NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework requires NHS Providers to undertake a number of specific emergency planning and business continuity exercises and these requirements have been detailed in the EPRR Workstream for 2023.

4.5.6 Formal training attendances and exercises had dropped in 2021/22 compared with pre pandemic levels but as the new operational structures are in place this is being addressed rapidly and is part of the 2023 work programme.

5 NEXT STEPS AND RECOMMENDATIONS

5.1.1 Key Recommendations:

- To work through the updated EPRR Work stream for 2023 to ensure that all EPRR Assurance advisories are completed prior to the 2023 Assurance.

- Continue to work with Lockdown Planning Group to progress the Lockdown Plan for UHSussex East sites. Due to delays moving forward with the infrastructure work that needs to be completed this piece of work has been pushed back but meetings have now been scheduled - completion by August 2023

- Continue to work with Fire and Estates and Facilities to progress the Shelter and Evacuation Plan for UHSussex Brighton and PRH sites for completion by August 2023

- Continue to review and update all EPRR Polices and Emergency Plans as appropriate and merge any outstanding legacy emergency plans.

- Review Business Continuity Service Level plans and Business Impact Assessment templates/processes with a view to merging / aligning the processes into one.

- Continue to work with the M365 team to create an EPRR TEAMs account and migrate all relevant EPRR shared folders / files to that account for future filing and ease of access.

- Also continue to work with the M365 team to create a Trust shared folder on TEAMs to enable all staff to access EPRR emergency and business continuity plans remotely as required.

Mark Stevens
Emergency Planning and Business
Continuity Manager

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	19	**Meeting:**	Board	**Meeting Date:**	February 2023
Report Title:	Audit Committee Chair report to Board				
Committee Chair:		David Curley, Non-Executive Director and Committee Chair			
Author(s):		David Curley, Non-Executive Director and Committee Chair			
Report previously considered by and date:					

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

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

Implications for Trust Strategic Themes and any link to BAF risks		
Patient	✓	The work of Internal Audit and Counter Fraud provided assurance in respect of various elements of the Trusts' the systems of internal control relied upon in managing a number of BAF risks. The Internal Audit plan is aligned to the BAF, therefore their assurance is linked to the strategic risks facing the Trust.
Sustainability	✓	
People	✓	
Quality	✓	
Systems and Partnerships	✓	
Research and Innovation	✓	

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

Communication and Consultation:

Executive Summary:

The Audit Committee met on the 17 January 2023 and was quorate as it was attended by five Non-Executive Directors. In attendance was the Chief Financial Officer, the Trust's Director of Finance, the Trust's Commercial Director, and the Company Secretary along with the Trust's Internal and External Auditors and Local Counter Fraud team members. The Trust's Chief Medical Officer also attended to present a report on the Trust's IG and Caldicott Guardian arrangements.

The Committee received its planned items with the focus being on receiving the reports in relation to work undertaken by Internal Audit and Counter Fraud during Quarter 3 of 2022/23. The Committee also received its scheduled reports in relation to tender waivers, losses and special payments, the report from the interim Health and Safety Committee chair on the activity of that Committee, a report on the improvements made in relation to pay issues for some staff and a report on the Trust's declaration of interests' processes. The Committee received the Trust BAF and a report on the process enhancements to the reporting of compliance against the Trust's risk management policy.

The Committee noted the developments made to the BAF reporting structure especially those in relation to the provision of information in respect of assurance received during the quarter and a summary of the delivery of the planned actions. The Committee discussed how further improvements being planned in respect of the tracking of the impact of actions taken and planned will have on the ability of the Trust to achieve their target scores. The Committee noted the changes in risk from quarter 3 to the start of quarter 4 and that these would be subject to review at the respective Committee meetings the following week. The Committee did note that one of the quality risks, risk 4.1 had not increased although it may have been expected to have increased in line with the increase in risk 4.2 but that this would be subject to review at the Quality Committee prior to a recommendation being made to the Board. The Committee agreed to devote more time the BAF and

supporting highly scored risk report at future Committee and that it would be beneficial to have more executive attendance for this item.

Through the reports the Committee was assured that the Trust's system of internal control, including its systems of internal financial control where positive opinions were received from Internal Audit, systems for preventing fraud, information governance and processes covering business conduct where functioning adequately and where improvement actions had been identified then appropriate improvement actions were being taken.

The Committee referred those actions where updates had not been provided or the original implementation date have been exceeded to the respective Board Committees to secure assurance this lack of progress did not pose a significant risk.

The Committee approved the Trust's accounting policies for 2022/23 and the continuation of the production of the Trust's financial statements on a group model incorporating Pharm@Sea and the Charities.

Key Recommendation(s):

The Board is asked to **NOTE** the assurances received at the Committee, the actions taken by the Committee in accordance with its terms of reference and the referrals made to other Committees for scrutiny of delayed actions in respect of agreed Internal Audit recommendation and the risks these may pose.

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COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Audit Committee	**17 January 2023**	**David Curley**	✓	☐

Declarations of Interest Made

There were no declarations of interest made

Assurances received at the Committee meeting

Risk Register and BAF reports

The Committee **RECEIVED** the latest risk report providing information on the Trust risks scoring over 15, and of these the Committee noted that there were eight risks scoring 20 and increase of two from the last report. The report showed the mapping of these risks to the relevant patient first domains and thus which Committee would provide the oversight of these risks and their actions. The Committee **RECEIVED** information on the progress with the Trust risk register alignment programme and **NOTED** this project would provide enhanced reporting over the Corporate and Operational compliance with the Trust Risk Management Policy.

The Committee **RECEIVED** the Quarter 4 BAF, noting that this information is to be subject to review by each of the Board Committee's in their meetings next week. The Committee noted that the BAF included the strategic risks in respect of the research and innovation domain. The Committee **NOTED** the enhancements made to the report structure especially those in relation to the provision of information in respect of assurance received during the quarter and a summary of the delivery of the planned actions. The Committee discussed how further improvements in respect of the tracking of the impact of actions taken and planned will have on the ability of the Trust to achieve their target scores.

The Committee **RECEIVED** reports directly supporting the reduction in risk 2.3 in relation to the Trust's systems of internal control from Internal Audit, the Commercial Director, the Finance Director and the Director of Workforce Planning and Development. Based on these updates the Committee agreed that risk 2.3 was correctly scored. The Committee **NOTED** the changes in risk from quarter 3 to the start of quarter 4 and that these would be subject to review at the respective Committee meetings the following week. The Committee did note that one of the quality risks, risk 4.1 had not increased although it may have been expected to have increased in line with the increase in risk 4.2 but that this would be subject to review at the Quality Committee prior to a recommendation being made to the Board.

The Committee **ENDORSED** having these items earlier on the meeting agenda had been beneficial but would welcome more time on the agenda being devoted to these items and reflected on the benefit for at least these items of having wider Executive Director attendance. and that having a high-level executive summary showing changes and associated actions would assist the Committee focus its attention and cross reference to sources of assurance available to the Trust to determine if seeking further 3rd party assurance from Internal Audit may be beneficial.

Internal Audit activity

The Committee **RECEIVED** the Internal Audit progress report incorporating the management action plans for the work undertaken since the last meeting against the 2022/23 internal audit plan. The Committee **NOTED** the plan had been developed to continue to use the Internal Audit resources to assist the Trust to make improvements. The original plan contained a degree of flexible resource to deal with changing or emerging matters.

The Committee considered the positive Internal Audit opinion in respect of Trust's Key Financial Systems and the Internal Audit positive conclusions in respect of the Trusts processes for making its CNST declaration

along with the nationally mandated review of Financial Sustainability where the Internal Audit conclusions were again positive. The Committee **NOTED** the positive outcome of the Key Financial Systems and Financial Sustainability Internal Audit and agreed these supported the reduction in the BAF risk 2.3.

The Committee **RECEIVED** the Internal Audit follow up review which provided information in respect of actions completed. This gave **ASSURANCE** over the delivery of agreed actions and in respect of those not yet completed that the revised timescales were reasonable. Internal Audit reflected that there had been an improvement in the level of engagement with the action owners however, there remained a smaller number of areas where enhanced engagement is required. The Finance Director confirmed that within the codified roles and responsibilities that all changes to agreed dates are to be agreed by the relevant review Executive Director and their comment would then be included in the report to this Committee. The Committee **AGREED** to refer those actions where updates had not been provided or the original implementation date have been exceeded to the respective Board Committees to secure assurance this lack of progress did not pose a significant risk.

Local Counter Fraud

The Committee **RECEIVED** the Local Counter Fraud progress report for Quarter 3 2022/23. This report provided information in respect of their proactive work undertaken, fraud awareness raising work with Trust staff aligned to the National Fraud Awareness week for the NHS alongside specific training to various cohorts of staff to maintain their fraud awareness. The Committee was also updated in response to reported concerns.

The Committee was **ASSURED** by the updates provided by the Local Counter Fraud Specialists on their work during the quarter that there were no significant fraud risks which Trust needed to be actioned urgently within the Trust.

External Audit

The Committee **RECEIVED** a report from the external auditors on their work planning for the 2022/23 audit, with a plan to bring the detailed audit plan to the next Committee meeting.

External Audit provided information on their processes to deliver both the financial statements and mandated value for money opinions. The Director of Finance provided information on the working relationships between the Trust and the Auditors. The Committee was **ASSURED** that the Trust's strong processes would continue and that through this process the Trust and the External Auditors are well positioned for the delivery of the 2022/23 audit.

Accounting Policies

The Director of Finance updated the Committee on the development of the Trust's Accounting Policies, identifying the changes the IFRS16 and that these are based on the Government Accounting Manual. The Committee reviewed the Trust's Accounting Policies and **AGREED** these for 2022/23

The Committee also **AGREED** to continue to consolidate the accounts of Pharm@Sea and the Charities into the Trust's financial statements for 2022/23.

Losses and Special Payment Report and Tender Waiver Report

The Committee **RECEIVED** the Trust's Losses and Special Payments registers. The Trust's Director of Finance provided information on those cases in Quarter 3 alongside the overall position for the preceding year, noting that the levels of these cases in quarter 3 remain consistent with those in prior year. The Commercial Director updated the Committee on the continuing work by the procurement teams with the divisions which supports the continued reduction in the number of waivers required, noting for Quarter 3 the numbers continued to be within the trajectory for a reduction to be achieved for the year 2022/23. The

Committee, through these reports, was **ASSURED** over the underlying processes applied to manage Trust resources.

Information Governance and Caldicott Guardian Update

The Committee received **ASSURANCE** from the Chief Medical Officer though the report in respect of information governance oversight and activity during quarter 2 of 2022/23. The Committee was provided information on the Trust's assessment against the Data Security and Protection Toolkit standards noting that the Trust's self-assessment will be subject to an Internal Audit within the next quarter. The Committee **NOTED** that whilst there had been a number of reportable incidents there had been none that required reporting to the Information Commissioner. The Committee was also informed of the Trust's level of compliance with Subject Access Request despite the high level of requests being made. The Chief Medical Officer confirmed that the Trust's systems of internal control within the area of Information Governance supports him in the undertake the role of the Trust's Caldicott Guardian. The Committee **NOTED** the level of assurance this report provided over the system of control across the area of information governance.

Audit Committee Reporting Group – Health and Safety

The Committee received **ASSURANCE** from the Health and Safety Committee Chair's report from its meeting in November 2022. The Committee noted that work continues to schedule the Health and Safety Committee meetings to have the full quarters data available to the Committee and thus enhance the assurance this report provides to the Audit Committee. The report from the Committee Chair confirmed the Trust has effective oversight of the Trust's H&S key risks and requirements, especially the Trust's compliance with those in relation to RIDDOR.

The report also provided the Committee on the active management of the Health and Safety risk assessments. The Committee **NOTED** that the report had been adjusted to provide more detail on where the oversight of risks occurs and confirmed this additional information enabled the Committee to better assess the level of and timeliness of the assurances being reported within the Chair's report.

Declaration of Interest Report

The Committee **RECEIVED** a report from the Company Secretary on the application of the Trust's declaration of interests' processes. The Committee **NOTED** the level of declarations made at this point in the year is at a higher level that this time during the same period last year and this provided confidence over the application of the Trust's policy.

Actions taken by the Committee within its Terms of Reference

The Committee approved the Trust's accounting policies for 2022/23 and the continuation of the production of the Trust's financial statements on a group model incorporating Pharm@Sea and the Charities.

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

There were no items considered at this meeting requiring specific reports to come back to the next meeting as all items where action was requested are scheduled for the next meeting. However, the Committee discussed further reporting enhancements in respect of the tracking of the impact of actions against the BAF risk target scores and the linkages of key risks to the BAF.

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

Item	Referred to
The Committee requested that the respective Board Committees are provided information on the outstanding Internal Audit recommendations in respect of reviews in their area.	Various Committees at their

The Committee requested that the Executive Team consider broadening the Executive attendance at the meeting to allow fuller discussions to be held on risk and internal control outside the financial arena.	January meetings Executive team

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Agenda Item:	20	**Meeting:**	Trust Board in Public	**Meeting Date:**	February 2023
Report Title:	Charitable Funds Committee Chair report				
Committee Chair:	Lizzie Peers, Non-Executive Director				
Author(s):	Lizzie Peers, Non-Executive Director				
Report previously considered by and date:					

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

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

Implications for Trust Strategic Themes and any link to BAF risks		
Patient	✓	The Charities' activities underpin the Trust's strategic themes.
Sustainability	✓	
People	✓	
Quality	✓	
Systems and Partnerships	✓	
Research and Innovation	✓	

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

Communication and Consultation:

Executive Summary:

The Charitable Funds Committee met on the 10 January 2023 and was quorate as it was attended by four Non-Executive Directors, the Chief People Officer, the Chief Financial Officer and Chief Governance Officer. In attendance was the Interim Charity Director for both BSUH and Love Your Hospital (LYH) Charities and other members of the Trust's finance and Charity's teams. The meeting was reconvened on the 12 January to conclude its scheduled business, the reconvened meeting was attended by 2 Non-Executive Directors, the Chief People Officer, the Chief Governance Officer and the Interim Charity Director making the reconvened meeting quorate.

The Committee received the operational and financial reports for month 8, the developing 2023-25 Charity Strategy and Operational Plan for 2023/24 and a series of funding requests supporting enhanced patient experience through accelerated investment in additional equipment and facilities.

Key Recommendation(s):

The Board is asked to **NOTE** the activity of the Committee and the assurances received over the stewardship of the funds.

The Board is also asked to **NOTE** the decisions taken by the Committee within its delegated authority to agree the alignment of the respective authorised signatories for both Charities and to support the funding proposals that exceeded the Committee's delegated authority.

The Board is asked to **NOTE** that the Committee is recommending to the Trustees the 2023-25 Charity Strategy and 2023-24 Charity Operational Budget and plan.

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COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Charitable Funds Committee	**10 January 2023 and 12 January 2023**	**Lizzie Peers**	✓	☐

Declarations of Interest Made

There were no declarations of interest made.

Assurances received at the Committee meeting

Charity Strategy, Spending & Operation Plan 2023 -25

The Committee **RECEIVED** a report detailing the Charities' strategic priorities for the next two years (2023 – 2025) and the operating plan and budget for the forthcoming year 2023/24 and considered the four strategic priorities and **ENDORSED** these recognising these remain valid and support the merger to be enacted on 1 April 2023.

The Committee received an update on a suite of developing default metrics that each funding request will need to select from to help demonstrate public/patient benefit. The Committee **ENDORSED** the introduction of outcome metrics as their use aligns with the Committee's requirement to have grant funding outcomes included in each request and will allow regular reporting to the Committee on delivered outcomes and an annual impact report.

The Committee **AGREED** to recommend the final Strategy and Operational Plan and Budget to the Trustees of Charity.

BSUH and LYH Charities Operational Reports for the period October to December 2022

The Committee was **ASSURED** there had been no identified regulatory or compliance issues with the operation of both Charities.

The Committee was **ASSURED** over the oversight of the funds within each of the Charities through the report from the Charities finance team.

The Committee was **ASSURED** that both Charities were operating within their respective objectives through the receipt of the respective performance reports from the Interim Charity Director for both Charities. The operations update included the performance scorecard that provided a progress update for both BSUH and LYH Charities along with a review of the Charities' risk register and mitigations.

The Committee **NOTED** the delivery against the developed Charity spending plan.

BSUH and LYH Charities Operational Reports for Month 8 (to 30 November 2022)

The Committee **RECEIVED** the report from the Associate Director of Finance which provided assurance over the compliance with the charities' reserves policy and **NOTED** that the level of expenditure remains within the level of donations provided.

The Committee **RECEIVED** information on the performance of the Charities investments noting that fuller information is planned at the next meeting. The Committee **AGREED** to the proposal to align the Charities signatories for both the LYH and BSUH investments.

Charity Bids

The Committee **ENDORSED** the work being recommended by the Executives to enhance the quality of the bid requests, as had been discussed at prior Committee meetings. This would include securing greater and earlier Executive and Director engagement in the development of the bids, clear statements of the measurable outcome benefits and explicit confirmation of compliance with all the required internal governance processes.

The Committee considered a number of bids and assessed these against the expected public/patient benefits and recognised the enhancements made to the quality of bid paperwork. It **RECOMMENDED** these bids to the Trustees for final approval.

Actions taken by the Committee within its Terms of Reference

The Committee **RECOMMENDED** a number of the funding bids presented

The Committee **APPROVED** the updates to the Charities authorised investment signatory lists

Items to come back to Committee / Group (Items Committee / Group keeping an eye on)

The Committee **AGREED** to secure a further update from the investment manager on the future forecast for the market and requested the finance team provide information on actions that could be taken to minimise investment risk and secure maximum interest for monies held in bank accounts whilst safeguarding those funds.

The Committee **AGREED** to review the Charities' risk appetite in line with the market forecast update from the investment manager for both Charities and the bank interest paper.

The Committee **AGREED** to consider the establishment of specific meetings focusing on the consideration of the bids being made for Charitable Funds.

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

Item	
The Board is also asked to **NOTE** ▪ the work of the Charity and the support provided by our donors to enhance patient experiences as well as staff wellbeing; ▪ the decisions taken in respect of approvals for the use of funds; ▪ the assurances received in respect of the stewardship of the donated funds; and ▪ the recommendation of the developing Charity Strategy and Operational Budget to the Trustees.	

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Agenda Item:	21	**Meeting:**	Board	**Meeting Date:**	February 2023
Report Title:	2022/23 Quarter 4 BAF and Corporate Risk Report				
Sponsoring Executive Director:	Chief Governance Officer				
Author(s):	Company Secretary				
Report previously considered by and date:	The Trust's BAF and Corporate Risks have been considered by each of the Trust's allocated oversight committees in January.				
Purpose of the report:					
Information	☐	Assurance	✓		
Review and Discussion	✓	Approval / Agreement	✓		
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	☐	Staff confidentiality	☐		
Patient confidentiality	☐	Other exceptional circumstances	☐		
Implications for Trust Strategic Themes and any link to BAF risks					
Patient	✓	The report covers each BAF risk			
Sustainability	✓				
Our People	✓				
Quality	✓				
Systems and Partnerships	✓				
Research and Development	✓				
Link to CQC Domains:					
Safe	✓	Effective	✓		
Caring	✓	Responsive	✓		
Well-led	✓	Use of Resources	✓		
Communication and Consultation:					
[3]					

Executive Summary:

1 Introduction

With the development of the Research and Innovation domain the Trust's BAF has been adjusted and now includes 16 strategic risks, three more than in the previous quarter. The BAF has also been refreshed to reflect the outcome of the Trust's strategic priority refresh reported to the Board in November 2022.

Each risk has been assessed against the Trust's risk appetite when setting their target score, and each segment of the BAF continues to have a lead executive and lead oversight committee.

For each segment of the BAF the respective lead executive has considered their risks along with the supporting highly scored and corporate risks when determining the quarter 4 score.

The quarter 4 BAF elements are to be considered by the respective Board Committees at their meetings in January 2023.

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2 BAF Summary

The table below overleaf shows by risk, their current score and their target risk score. The table shows pictorially the movement in risk between the current score for Q4 and Q3, Q2 and Q1. (⟷ No change, ↑ an increase in risk and ↓ a decrease in risk)

BAF: Strategic Objectives and Strategic Risks (Key: I = Impact L = Likelihood T = Total)	Risk Scores														
	2022/23 Q1			2022/23 Q2			2022/23 Q3			2022/23 Q4			Target		
	I	L	T	I	L	T	I	L	T	I	L	T	I	L	T
1. Patient *(Oversight provided by the Patient Committee)*															
1.1 We are unable to deliver or demonstrate a continuous and sustained improvement in patient experience resulting in adverse reputational impact and poor patient outcomes	4	4	16 ⟷	4	4	16 ⟷	4	4	16 ⟷	4	4	16 ⟷	3	2	6
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***					
2. Sustainability *(Oversight provided by the Sustainability Committee)*															
2.1 We are unable to align or invest in our workforce, finance, estate and IM&T infrastructure effectively to support operational resilience, deliver our strategic and operational plans and improve care for patients	4	4	16 ⟷	4	4	16 ⟷	4	4	16 ⟷	4	5	20 ↑	4	2	8
Assessed strength of control	***Operating as intended***			***Operating as intended***			***Operating as intended***			***Operating as intended***					
2.2 We cannot deliver ongoing efficiencies and flex our resources in an agile way resulting in an increasing or unmanaged deficit and inefficient, unaffordable and unsustainable services.	4	4	16 ⟷	4	4	16 ⟷	4	4	16 ⟷	4	5	20 ↑	4	2	8
Assessed strength of control	***Operating as intended***			***Operating as intended***			***Operating as intended***			***Operating as intended***					
2.3 We are unable to meet high standards of financial stewardship meaning we cannot sustain compliance with our statutory financial duties	4	3	12 ⟷	4	3	12 ⟷	4	4	16 ↑	4	3	12 ↓	4	2	8

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Assessed strength of control	***Operating as intended***			***Operating as intended***			***Operating as intended***			***Operating as intended***															
3. People ***(Oversight provided by the People Committee)***																									
3.1 We are unable to develop and sustain the leadership and organisational capability and capacity to lead on-going performance improvement and build a high performing organisation	4	4	**16** ↑	4	4	**16** ↔	4	4	**16** ↔	4	4	**16** ↔	4	2	**8**										
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***															
3.2 We are unable to effect cultural change and involve and engage staff in a way that leads to continuous improvements in patient experience, patient outcomes, and staff morale and wellbeing	4	4	**16** ↑	4	4	**16** ↔	4	4	**16** ↔	4	4	**16** ↔	4	2	**8**										
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***															
3.3 We are unable to meet our workforce requirements through the effective recruitment, development, training and retention of *sufficient* staff adversely impacting on patient experience and the safety, quality and sustainability of our services	4	5	**20** ↔	4	5	**20** ↔	4	5	**20** ↔	4	5	**20** ↔	3	2	**6**										
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***															
3.4 We are unable to consistently meet the health, safety and wellbeing needs of our staff as we recover and restore services in line with CV-19 restrictions	4	4	**16** ↔	4	4	**16** ↔	4	4	**16** ↔	4	4	**16** ↔	4	2	**8**										
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***															
4. Quality ***(Oversight provided by the Quality Committee)***																									
4.1 We are unable to deliver safe and harm free care to reduce non-covid mortality.	4	4	**16** ↔	4	4	**16** ↔	4	4	**16** ↔	4	4	**16** ↔	3	2	**6**										
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***															

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4.2 We are unable to deliver service improvements and improve safety, care quality and outcomes for our patients or demonstrate that our services are clinically effective and demonstrate our consistent compliance with regulatory requirements or clinical standards.	4	4	16 ↔	4	4	16 ↔	4	4	16 ↔	4	5	20 ↑	3	2	6
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***					
5. Systems and Partnerships *(Oversight provided by the Systems and Partnerships Committee)*															
5.1 We are unable to develop and maintain collaborative relationships with partner organisations based on shared aims, objectives, and timescales leading to an adverse impact on our ability to operate efficiently and effectively within our health economy	4	4	16 ↔	4	3	12 ↓	4	3	12 ↔	4	2	8 ↓	4	2	8
Assessed strength of control	***Operating as intended***			***Operating as intended***			***Operating as intended***			***Operating as intended***					
5.2 We are unable to define and deliver the strategic intentions, plans and optimal configuration that will enable our services to be sustainable, leading to an adverse impact on their future viability.	4	4	16 ↔	4	4	16 ↔	4	4	16 ↔	4	4	16 ↔	4	2	8
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***					
5.3 We are unable to deliver and demonstrate consistent compliance with operational and NHS constitutional standards resulting in an adverse impact on patient care and financial penalties and the Trust's reputation.	4	5	20 ↔	4	5	20 ↔	4	5	20 ↔	4	5	20 ↔	4	2	8
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***					
6. Research and Innovation (Oversight provided by the Patient Committee)															
6.1 We are unable to harness its research capabilities thus not being able to meets is stated ambition as high-class										4	4	16	3	2	6

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research organisation thus impacting on the Trust's ability to attract and retain staff							
Assessed strength of control		***Some weaknesses***					
6.2 We are unable to secure protected research and innovation time within individual job plans of our clinical and support workforce to meet the Trust R&I ambition		4	4	**16**	3	3	**9**
Assessed strength of control		***Some weaknesses***					
6.3 We lack a fit for purpose Clinical Research Facility (CRF) and clinical research space across Trust hospital sites to support the delivery of the R&I True North ambition.		4	4	**16**	3	2	**6**
Assessed strength of control		***Some weaknesses***					

3 The Quarter 4 BAF summary

3.1 Risk scoring

Following review at the end of quarter 3 the Executives have agreed that all risks except risk 5.1 continue to exceed their target score. Risk 5.1 has seen a reduction to its target score given the continued maturity of the processes for system working.

For the start of quarter 4 three risks have had their score increased to 20, these being risks 2.1 and 2.2 relating to sustainability and risk 4.2 relating to quality, noting that the increase in the quality risk score is reflective of workforce and performance risks. As described in the next section for these risks the level of assurance reflected in the BAF is current and covered all aspects of the expected assurances documented within the BAF.

Two risks, one relating to People (risk 3.3) and one relating to systems and partnerships (performance risk 5.3) remain at 20.

The risk score for risk 2.3 has reduced in line with that expected and reported to both the Audit Committee and Sustainability Committee it would do following the delivery of the actions following the review into the issues that led to the non-payment of some staff, this would be expected to reduce further to its target score as the divisions deliver their plans.

The BAF for quarter 4 includes the three new risks relating to research and innovation with the assurance over these risks being reported to the Patient Committee, the Committee assigned to have initial oversight of this True North domain.

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3.2 Assurance Confidence Levels

The Assurance Framework reflects both the level of assurance and the timeliness of this assurance, with the date the planned assurance was either received or is expected.

For *Patient* the assurance received match those expected and each has been received within the last month so is timely giving a high level of confidence for over the score at 16. These assurances have as their source a mix of management, executive and external provided (through FFT) thus strengthening the confidence level of the assurances. These assurances are considered at the Patient Committee but for those relating to FFT and the delivery of the patient experience strategy by the Governors within their Patient Experience and Engagement Committee.

For *Sustainability* the assurance received match those expected and each has been received within the last month noting that there is a mix of management and executive assurance along with external assurance from Internal Audit. The timeliness and breadth of assurance gives a high level of confidence for over the scores and supports the increase of risk 2.1 and risk 2.2 to 20 (in line with risks described to the Board) and the reduction of risk 2.3 to 12 (in line with the assurances provided to the last Audit Committee and Sustainability Committee. The BAF records that a further reduction in this risk score to its target score of 8 is dependent on the receipt of the planed assurances over divisional delivery of the control totals as will be recorded within the financial reports and efficiency delivery reports to the sustainability committee.

For *People* a number of the key sources of assurance were reported to the January Committee with routine assurance reported to the last Committee meeting in January (December performance information). The assurance is therefore reasonably timely. In recognition of the level of risk within this domain and the pervasive nature of these risks on the other domains the frequency of the formal People Committee meetings has been increased from 4 to 8 a year, this will see formal meetings in both February and March which will allow the BAF to reflect more timely assurance in support of the current scores across quarter 4 and into 2023/24. The Executive view of the assurances recorded supports no change to any of the people scores leaving risk 3.3 scored at 20 with the other three people risks all scored at 16

For *Quality* the assurance received broadly matched those expected but with the notable exception of clinical effectiveness assurance. Information on the risks and the plans to address these have been reported to the Quality Committee. External assurance in respect of the Trust's clinical coding processes has been provided through an interim report on this work with the final report expected for the next Committee meeting in January. The current score for risk 4.2 has been increased reflecting the inter linkage of this risk and those relating to workforce and performance impacting on the Trust's ability to deliver its improvements in clinical quality at the pace it desires and the need for enhanced assurance in respect to the Trust's processes for sustained high quality outcomes.

For *Systems and Partnerships* the assurance received match those expected noting that a number of assurances have been provided directly to the Board in respect of system working alongside the routine reporting on performance both that the Committee and the Committee SDR meetings. The score for risk 5.1 has been reduced to its target score of 8 with the other scores remaining at the quarter 3 sore for 16 and 30 respectively for risks 5.2.and 5.3.

For *Research and Innovation* the BAF records the opening score for each of these three risks. The listed sources of assurance are planned to be overseen through the respective Research Strategy Group which

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will support the flow of assurance to the Patient Committee during with the first reporting occurring at the Patient meeting in January 2023.

Assurance Confidence

As reported to the Audit Committee in response to their request for greater clarity over the levels of assurance received a visual grading system will be added to the BAF reflecting a grading of High to Poor where High would signify that those assurance planned have all been received and they cover the range of assurance from management, executive and external parties and where Poor would signify either missing assurance or a mix of positive and negative assurance in respect of the designed control environment.

Example of how the assurance confidence grading could be visualised is below

BAF: Strategic Objectives and Strategic Risks (Key: I = Impact L = Likelihood T = Total)	**Risk Scores**						
	2022/23 Q4			**Assurance confidence**	**Target**		
	I	**L**	**T**		**I**	**L**	**T**
1. Patient *(Oversight provided by the Patient Committee)*							
1.2 We are unable to deliver or demonstrate a continuous and sustained improvement in patient experience resulting in adverse reputational impact and poor patient outcomes	4	4	16	High	3	2	6

4 Committee review

Each of the respective Board Committee's received reports aligned to the BAF risks allowing each Committee to consider the appropriateness of the current score.

Each Committee within their meetings in January endorsed the opening quarter 4 risk scoring

5 Supporting Key Risks

Each Committee at their meetings in January considered the respective key risks with the potential to impact on the Committee's relevant patient first domain. These included consideration of the risks in relation to the domain's True North, Breakthrough Objective, Strategic Initiative and Corporate Project along with a consideration of the highly scored risks within datix (noting that the highly scored risks within Datix are included within a separate report).

There are also a number of organisational (enduring risks) in overseen by the Health and Safety Committee which include Fire, Estates, EPRR, along with specific specifics such as radiology protection, waste management which are reported directly to the Audit Committee. The majority of these Health and

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Safety risks have a current score close to or at their target scores, with any significantly elevated included within Datix.

Below is a table of the Key Risks, from each of the Patient First Thematic Board Committees to the Board. The key risks are mapped to their identified themes and to the BAF risks by patient first domain.

BAF	Corporate Themes	Key Risks
Patient		
1.1 We are unable to deliver or demonstrate a continuous and sustained improvement in patient experience resulting in adverse reputational impact and poor patient outcomes	Management of young people requiring inpatient care for mental health problems Risk of harm to staff and patients by violent and aggressive patients in ED Failure to meet access target (4 and 12 hour target) and impact on patient experience A&E RSCH Cohort area is a poorly designed place in which to look after patients which has the potential to impact on patient experience	Levels of nursing vacancies and an inability to provide consistent nursing & medical cover for escalation/outliers if bed capacity full. Management of adults, young people and children requiring inpatient care for mental health problems A&E RSCH Cohort Area Increase in RTT waiting times. Inability to consistently access equipment or resources resulting in waits for treatment.
Sustainability		
2.1 We are unable to align or invest in our workforce, finance, estate and IM&T infrastructure effectively to support operational resilience, deliver our strategic and operational plans and improve care for patients 2.2 We cannot deliver ongoing efficiencies and flex our resources in an agile way resulting in an increasing or unmanaged deficit and inefficient, unaffordable and unsustainable services. 2.3 We are unable to meet high standards of financial stewardship meaning we cannot sustain compliance with our statutory financial duties	Operational pressures including Covid-19 pandemic and workforce constraints are impacting on operational costs and productivity. These, alongside organisational capacity and a financial framework are adding further risk to delivery of financial targets, a required step-up in elective capacity and delivery of a challenging efficiency programme. The financial framework for capital funding and allocations significantly reduces flexibility within the capital programme. This, alongside the high number of complex projects to be delivered presents a significant capacity challenge within the	Capital Developments Cyber Security Financial performance

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	capital projects team to deliver the programme. There risk for cybersecurity, which is an on-going and known risk requiring continuous oversight.	
People		
3.1 We are unable to develop and sustain the leadership and organisational capability and capacity to lead on-going performance improvement and build a high performing organisation 3.2 We are unable to effect cultural change and involve and engage staff in a way that leads to continuous improvements in patient experience, patient outcomes, and staff morale and wellbeing 3.3 We are unable to meet our workforce requirements through the effective recruitment, development, training and retention of *sufficient* staff adversely impacting on patient experience and the safety, quality and sustainability of our services 3.4 We are unable to consistently meet the health, safety and wellbeing needs of our staff as we recover and restore services in line with CV-19 restrictions	The stretch on staffing and their morale and wellbeing. These pressures are not unique to UHSussex but nevertheless pose a significant risk to delivery. Operational pressures including Covid-19 pandemic and workforce constraints are impacting on people, patient safety and trust operational costs and productivity. The general pressure on staffing of being able to sustain the levels of workforce needed, particularly at times of stretch (escalation beds, extra RTT activity etc)	Risk of insufficient medical staff Insufficient numbers of registered nurses and health care nurses Staff sickness Health and wellbeing Staff stretch and patient experience
Quality		
4.1 We are unable to deliver safe and harm free care to reduce non-covid mortality. 4.2 We are unable to deliver service improvements and improve safety, care quality and outcomes for our patients or demonstrate that our services are clinically effective and	Operational pressures including Covid-19 and flu, acute system pressures, escalation wards and staffing, referral to treatment delay and workforce constraints are all impacting on the delivery of the quality and safety of patient care.	Levels nursing cover due to high levels of nursing vacancies and an inability to provide consistent nursing & medical cover for escalation/outliers if bed capacity full.

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demonstrate our consistent compliance with regulatory requirements or clinical standards	Risk of harm to staff and patients by violent and aggressive patients in ED Patient profile, frailty, mental health, delays to specialist placement (in particular child and adolescent mental health), long waits for pre-hospital assessment (ambulance transfers) reduced care in community and social care placement and primary care capacity.	Management of young people requiring inpatient care for mental health problems A&E RSCH Cohort Area is a poorly designed Increase in RTT waiting times Inability to consistently access equipment or resources resulting in waits for treatment.
Systems and Partnerships		
5.1 We are unable to develop and maintain collaborative relationships with partner organisations based on shared aims, objectives, and timescales leading to an adverse impact on our ability to operate efficiently and effectively within our health economy 5.2 We are unable to define and deliver the strategic intentions, plans and optimal configuration that will enable our services to be sustainable, leading to an adverse impact on their future viability. 5.3 We are unable to deliver and demonstrate consistent compliance with operational and NHS constitutional standards resulting in an adverse impact on patient care and financial penalties and the Trust's reputation.	Operational pressures including Covid-19 pandemic, increased system demand and delays, and workforce constraints are impacting on all operational capacity and workstreams including delivery of constitutional targets, and indirectly potential risks to the objectives of 3Ts, and the new corporate projects – reducing length of stay and transforming patient access. Specific capacity constraints in operational services (including workforce impacts) which are driving the overall increase in the elective waiting times across a wide range of services, and the resulting reliance on Independent Sector capacity to deliver the plan to have no patient waiting more than 78 weeks for treatment.	Delivery of the Recovery and Restoration programme. Capacity constraints leading to Increase in RTT waiting times Service Demands
Research and Innovation		
6.1 We are unable to harness its research capabilities thus not being able to meets is stated ambition as high-class research organisation thus impacting on the Trust's ability to attract and retain staff	The Trust is not able to achieve its ambition within the area of research to realise the full potential of patient benefit.	Lack of dedicated time to pursue research Lack of dedicated research space

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6.2 We are unable to secure protected research and innovation time within individual job plans of our clinical and support workforce to meet the Trust R&I ambition 6.3 We lack a fit for purpose Clinical Research Facility (CRF) and clinical research space across Trust hospital sites to support the delivery of the R&I True North ambition.		

7 Conclusion

The BAF continues to record the timely receipt of the planned assurances with a mix of management and executive assurance provided for most risks but for those relating to sustainability and quality (mortality) these also include assurances from external sources, internal audit and an external coding audit.

The respective Board Committees continue to oversee their allocated strategic (BAF) key risks aligned to their patient first domain.

It should also be noted that for 2023/24 as the Trust refines its annual plan in support of the developing ICS strategy then the Trust's strategic risks will be adjusted within the BAF.

Key Recommendation(s):

The Board is asked to **AGREE** the BAF risk scores for the start if quarter 4 noting that each score was reviewed by the respective oversight Committee who agreed with their score.

The Board is asked to **NOTE** that the BAF will be subject to a review as the Trust's develops its 2023/24 annual plan.

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Agenda Item:	22	**Meeting:**	Board	**Meeting Date:**	2 February 2023
Report Title:	CQC Action plans compliance report				
Sponsoring Executive Director:	Dr Maggie Davies, Chief Nursing Officer				
Author(s):	Amanda Feest, CQC Registration and Compliance Manager				
Report previously considered by and date:	The detail behind this summary report was considered at the Quality Committee at its meeting on the 24 January 2023				
Purpose of the report:					
Information	✓		Assurance	✓	
Review and Discussion	☐		Approval / Agreement	☐	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	☐		Staff confidentiality	☐	
Patient confidentiality	☐		Other exceptional circumstances	☐	
Link to Trust Strategic Themes:					
Patient Care	✓		Sustainability	☐	
Our People	☐		Quality	✓	
Systems and Partnerships	☐				

Implications for Trust Strategic Themes and any link to BAF risk	
Patient	✓
Sustainability	☐
Our People	✓
Quality	✓
Systems and Partnerships	☐
Research and Innovation	☐

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

Communication and Consultation:

Dissemination of any actions or escalation by the membership of the committee.

Executive Summary:

This report provides an update on the status of the actions being taken following the CQC inspections as listed below:

- Royal Sussex County Hospital unannounced inspection on 26th September 2021 to Surgery (main theatres) and Maternity (Inpatient services) and re-inspection on 26th & 27th April 2022
- Princess Royal Hospital unannounced visit to Maternity (Inpatient services) in October 2021 and re-inspection on 26th April 2022
- Worthing Hospital, Maternity (Inpatient services) on the 26th & 27th April 2022
- St. Richards Hospital, Maternity (Inpatient Services) on the 26th and 27th April 2022
- Royal Sussex County Hospital, Urgent and Emergency Services on 26th & 27th April 2022
- Royal Sussex County Hosptial, Gastro-Intenstinal Surgery and cancer Care – unnanounced inspection on 15th August 2022

The content of the report summarises the CQC 'Must do' and 'Should do' actions listed on published CQC inspection reports with the division's current status of compliance to these; for the purpose of ongoing awareness of the Board.

Key Recommendation(s):

The Board is asked to note the reported status of the divisional action plans.

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1.0 Introduction

Further to the Care Quality Commission (CQC) inspections to our Maternity Inpatient Services (Trust-wide), Surgery services at The Royal Sussex County Hospital (RSCH), our Emergency Department at RSCH and the Upper Gastro-Intestinal Surgery and cancer Care services at RSCH, the CQC have published report findings including necessary actions that the Trust 'Must do' to comply with its legal obligations.

Alongside of these are the provision of 'Should do' actions. These are noted as the Trust "*not seen to be doing something required by a regulation, but it would be deemed disproportionate for the CQC to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services".*

1.2 Compliance report to Quality Committee

To maintain central oversight, the CQC compliance team will request monthly submissions of the divisional action plans via the divisional triumvirate, copying in the associated hospital directors, hospital directors of nursing and the executive team.

The action plans include the CQC 'must do' and 'should do' actions, identified gaps in controls or assurance with risks associated to these, a brief narrative where actions are outstanding and planned dates for action closure. The action plans will be RAG rated as follows:

Actions on track or completed	Actions partially complete or plan in place with date for completion	Awaiting action plan

2.0 UHSussex Action plans

2.1 Surgery RSCH action plan 2021-2022:

'Must do' action – RSCH Surgery 2021	Date raised	RAG Status	Due date for completion (if applicable)
The trust must improve the culture and ensure all staff are actively encouraged to raise concerns and in particular clinicians are engaged and encouraged to collaborate in improving the quality of care. Regulation 12 (1) (2i)	December 2021	**Actions partially complete or plan in place with date for completion**	April 2023
The trust must ensure that managers have the required skills, knowledge & experience to lead the service. Regulation 18 (b)	December 2021	**Actions partially complete or plan in place**	April 2023

'Must do' action – RSCH Surgery 2021	Date raised	RAG Status	Due date for completion (if applicable)
		with date for completion	
Delays - The service must ensure that patients receive surgery when they need it and do not experience delays, placing patients at the risk of deterioration and harm. Regulation 12 (2)(a) and Regulation 12 (2)(b)	December 2021	-------	See Must do list 2022 actions
The service must ensure all risks are escalated as appropriate and documented on the relevant risk register. Regulation 17 (2)(b)	December 2021	**Actions partially complete or plan in place with date for completion**	April 2023
The service must ensure their governance processes link with all staff to provide a safe service. Regulation 17	December 2021	**Actions partially complete or plan in place with date for completion**	subject to review
The trust must operate effective governance systems to ensure compliance with all relevant sections as set out in Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 17(1)	December 2021	**Actions on track or completed**	N/A
The trust must ensure staff complete their mandatory training and each module meets their compliance targets. Regulation 12 (2)©	December 2021	**Actions on track or completed**	N/A
The trust must ensure it improves its management of risk and issues and ensure they can plan effectively to tackle patient safety issues. Regulation 17(1)	December 2021	**Actions on track or completed**	N/A
The trust must ensure leaders at all levels are supported and leadership improves at all levels across the hospital. Regulation 18 (2)	December 2021	**Actions on track or completed**	N/A
The trust must improve staffing levels to maintain safe staffing levels. Regulation 18 (1)	December 2021	**Actions on track or completed**	N/A
The trust must ensure regular checks on lifesaving equipment are undertaken. Regulation 12 (2) (b, e)	December 2021	**Actions on track or completed**	N/A
The trust must ensure all staff follow the trust's infection control policy and national guidelines in relation to infection prevention and control. Regulation 12 (2)(h)	December 2021	**Actions on track or completed**	N/A
The trust must ensure that all incidents' investigations are completed in a timely way to allow opportunity for action on learning to be shared and action taken swiftly. Regulation 17 (2) (b)	December 2021	**Actions on track or completed**	N/A
			N/A

‘Must do’ action – RSCH Surgery 2021	Date raised	RAG Status	Due date for completion (if applicable)
The trust must ensure it improves its management of risk and issues and ensure they can plan effectively to tackle patient safety issues. Regulation 17(1)	December 2021	**Actions on track or completed**	
The service must ensure that staff working in theatres have the qualifications, competence, skills and experience to keep patients safe. Regulation 12 (2) ©	December 2021	**Actions on track or completed**	N/A
The service must ensure all staff follow the trust’s infection control policy. Regulation 12 (2)(h)	December 2021	**Actions on track or completed**	N/A
The service must ensure it takes staff’s concerns seriously and takes demonstrable action to address their concerns. Regulation 17 (2)(b)	December 2021	**Actions on track or completed**	N/A
The service must undertake scheduled audits and take action to address poor performance in order to monitor the safety and quality of the service. Regulation 17 (2)(b)	December 2021	**Actions on track or completed**	N/A
The service must ensure it improves flow in the hospital and theatres to reduce the time patients spend in the recovery unit waiting for a bed in the hospital. Regulation 12(1)	December 2021	**Actions on track or completed**	N/A
The service must ensure it has suitable facilities to care for patients requiring high dependency or intensive care. Regulation 12 (2)(b)	December 2021	**Actions on track or completed**	N/A
The service must ensure nurse staffing levels meets the needs of patients and national guidelines. Regulation 18 (1)	December 2021	**Actions on track or completed**	N/A
The service must not care for patients with high dependency needs in recovery without an appropriate standard operating procedure and risk assessments. Regulation 17(2)(b)	December 2021	**Actions on track or completed**	N/A
The service must ensure that all rooms display the maximum safe occupancy. Regulation 12 (2)(h)	December 2021	**Actions on track or completed**	N/A
The service must ensure patients experiencing prolonged periods of time in recover have their privacy and dignity maintained. Regulation 17(2) (a)	December 2021	**Actions on track or completed**	N/A

RSCH Surgery Action plan 2021:

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'Should do' action – RSCH Surgery 2021	Date raised	RAG Status	Due date for completion (if applicable)
Staff Meetings: The trust should consider restarting regular formal staff meetings to improve staff engagement.	December 2021	**Actions on track or completed**	N/A
CPD: The service should ensure it provides continuous professional development to all staff. Regulation 18 (2)(b)	December 2021	**Actions partially complete or plan in place with date for completion**	See 2022 action plan
Theatres and Recovery action plan: The service should continue to complete and review the action plan developed for theatres and recovery.	December 2021	**Actions partially complete or plan in place with date for completion**	June 2023
Storage in Theatre: The service should consider how it improves the storage space and facilities within main theatres.	December 2021	**Actions partially complete or plan in place with date for completion**	June 2023
Exec & Clinical Leader Comms: The service should consider how it improves communication and decision making between the senior executive team and clinical leaders within the surgery division.	December 2021	**Actions partially complete or plan in place with date for completion**	Awaiting date
Strategy and Vision: The service should consider reviewing the strategy and vision of the service to ensure it still fits the service needs.	December 2021	**Actions partially complete or plan in place with date for completion**	Awaiting outcome of last review
Protected Training Time: The service should consider how to ringfence time for teaching and training for theatre and recovery staff.	December 2021	**Actions on track or completed**	N/A
Audit meetings: The service should consider how to recommence theatre and recovery unit meetings and ensure these follow a set format, include who has attended and discuss key issues.	December 2021	**Actions on track or completed**	N/A
Culture and Views: The service should consider the views of staff with regards to culture and take appropriate action.	December 2021	**Actions on track or completed**	N/A

‘Should do’ action – RSCH Surgery 2021	Date raised	RAG Status	Due date for completion (if applicable)
Incident Themes: The service should ensure action is taken regarding identified themes to resolve concerns. Regulation 17 (2)	December 2021	**Actions on track or completed**	N/A

RSCH Surgery Action plan 2022

‘Must do’ action – RSCH Surgery 2022	Date raised	RAG Status	Due date for completion (if applicable)
The trust must monitor the risk of harm and outcomes for patients who experience cancellations of surgery. Regulation 12 (2) (a) (b)	July 2022	**Actions partially complete or plan in place with date for completion**	Awaiting outcome of latest review
The service must ensure that there is enough staff with the right skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Regulation 18 (1)	July 2022	**Actions partially complete or plan in place with date for completion**	April 2023
STAM: The service must ensure staff complete their mandatory training and each module meets their compliance targets. Regulation 12 (2) (c)	July 2022	**Actions partially complete or plan in place with date for completion**	April 2023
Delays: The service must ensure that patients receive surgery when they need it and do not experience delays, placing patients at risk of deterioration and harm. Regulation 12 (2) (a) and Regulation 12 (2) (b)	July 2022	**Actions partially complete or plan in place with date for completion**	April 2023
Recovery Flow: The service must ensure it improves flow in the hospital and theatres to reduce the time patients spend in the recovery unit waiting for a bed in the hospital. Regulation 12 (1)	July 2022	**Actions on track or completed**	N/A
HDU/ ITU: The service must ensure it has suitable facilities to care for patients requiring high dependency or intensive care. Regulation 12 (2) (b)	July 2022	**Actions on track or completed**	N/A
Theatre Training: The service must ensure that staff working in theatres and recovery have the qualifications,	July 2022		N/A

competence, skills and experience to keep patients safe. Regulation 12 (2) (c)		**Actions on track or completed**	

RSCH Action plan 2022

'Should do' action – RSCH Surgery 2022	**Date raised**	**RAG Status**	**Due date for completion (if applicable)**
Governance Process: The trust should monitor the governance processes of all surgical disciplines to ensure they are able to assess, monitor and improve the quality and safety of the service. Regulation 17 (2) (a)	July 2022	**Actions partially complete or plan in place with date for completion**	June 2023
CPD: The service should ensure it provides continuous professional development to all staff. Regulation 18 (2) (b)	July 2022	**Actions partially complete or plan in place with date for completion**	June 2023
WHO Audits Theatres: The service should ensure all parts of the with World Health Organisations (WHO) '5 Steps to safer surgery' checklist process are adhered and monitored to ensure compliance. Regulation 17 (2) (f)	July 2022	**Actions partially complete or plan in place with date for completion**	April 2023
There service should consider a staffing levels and skill mix review to ensure it is able to adapt and respond to the changing needs and circumstances of the people using the service. Regulation 18 (1)	July 2022	**Actions partially complete or plan in place with date for completion**	Ongoing

2.2 Maternity RSCH action plan – January 2023

'Must do' action – RSCH Maternity	**Date raised**	**RAG Status**	**Due date for completion (if applicable)**
The trust must ensure the maternity triage RAG ratings recorded in the electronic patient record. (Regulation 12 (1) (2)	July 2022	**Actions partially complete or plan in place with date for completion**	BSOTS 28/02/2023 Tendable training 31/01/2023
The trust must ensure regular checks on lifesaving equipment are undertaken. (Regulation 12: (2) (b, e).	July 2022	**Actions partially complete or plan in place with date for completion**	28/02/2023

‘Should do’ action – RSCH Maternity	Date raised	RAG Status	Due date for completion (if applicable)
The trust should ensure the temperature of clinical rooms where medicines and intravenous are stored is monitored daily and remains under 25 degrees centigrade (Regulation 12)	July 2022	**Actions on track or completed**	N/A

2.3 Maternity PRH action plan – January 2023

‘Must do’ action – PRH Maternity	Date raised	RAG Status	Due date for completion (if applicable)
The trust must improve staffing levels to maintain safe staffing levels. (Regulation 18 (1))	July 2022	**Actions partially complete or plan in place with date for completion**	To be reviewed 28/02/2023.

‘Should do’ action – PRH Maternity	Date raised	RAG Status	Due date for completion (if applicable)
The trust should ensure the implementation of a systematic approach for risk assessing women in triage is continued to be embedded.	July 2022	**Actions partially complete or plan in place with date for completion**	28/02/2023
The trust should ensure that regular checks on lifesaving equipment are undertaken.	July 2022	**Actions partially complete or plan in place with date for completion**	28/02/2023
The trust should ensure that carbon monoxide screening is undertaken.	July 2022	**Actions partially complete or plan in place with date for completion**	TBC

2.4 Maternity WTG action plan

'Must do' action – WTG Maternity	Date raised	RAG Status	Due date for completion (if applicable)
The service must ensure it continues to monitor regular checks on resuscitaires to limit the risk of any gaps in the daily checks. (Regulation 12 (2) (b, e)	July 2022	**Actions partially complete or plan in place with date for completion**	31/01/2023

'Should do' action – WTG Maternity	Date raised	RAG Status	Due date for completion (if applicable)
The Trust should ensure the maternity telephone triage services are delivered by experienced midwives. (Regulation 12 (1) (2) (a, b)	July 2022	**Actions partially complete or plan in place with date for completion**	Est 31/03/2023
The service should ensure that it continues to monitor cardiotocographs (CTG) documentation to embed accurate documentation of CTG readings and accurately categorise their findings. (Regulation 12 (a)	July 2022	**Actions on track or completed**	N/A
The trust should ensure that simulated pool evacuation training is completed as a priority for all staff caring for women in labour. (Regulation 12 (1) (2) (a, b)	July 2022	**Actions partially complete or plan in place with date for completion**	31/03/2023
The service should ensure it maintains securely an accurate, complete, and contemporaneous record in respect of each service user (Regulation 17(C)	July 2022	**Actions partially complete or plan in place with date for completion**	Est 30/09/2023
The service should ensure that the divisional risk register continues to be update on a regular basis and that it includes clear time frames for completion. (Regulation 17(C)).	July 2022	**Actions on track or completed**	N/A
The trust should consider updating the job description for the band 5 nurses working on the maternity ward to reflect their remit and ensure clear boundaries between midwifery and nursing care.	September 2022	**Actions partially complete or plan in place with date for completion**	Est 31/03/2023

'Should do' action – WTG Maternity	Date raised	RAG Status	Due date for completion (if applicable)
The trust should consider increasing the working hours of the fetal wellbeing midwife to make sure outcomes of audits can be followed up and improved.	September 2022	**Actions partially complete or plan in place with date for completion**	Q1 2023/24
The trust should consider implementing annual medicines management competency training. So that they are confident all staff administering medication to mothers and babies are doing so safely.	September 2022	**Actions partially complete or plan in place with date for completion**	To be reviewed on a Trust wide basis.
The trust should consider using MEOWS observations charts as soon as a woman arrives for care.	July 2022	**Actions on track or completed**	N/A
The trust should consider identifying a designated area to safely and appropriately triage women who call the unit unexpectedly.	August 2022	**Actions partially complete or plan in place with date for completion**	23/01/2023

2.5 Maternity SRH action plan

'Must do' action – SRH Maternity	Date raised	RAG Status	Due date for completion (if applicable)
The trust must ensure regular checks on lifesaving equipment are undertaken. (Regulation 12: (2) (b, e).	June 2022	**Actions on track or completed**	N/A

'Should do' action – SRH Maternity	Date raised	RAG Status	Due date for completion (if applicable)
The trust should ensure that training for emergency evacuation from birthing pools is booked for staff to ensure they are up to date a soon as possible. (Regulation 12)	July 2022	**Actions partially complete or plan in place with date for completion**	31/03/2023
The trust should ensure consistency with the use of the birth-rate plus tool and escalation policies to ensure safe staffing numbers. (Regulation 17)	July 2022	**Actions partially complete or plan in place with date for completion**	31/03/2023

‘Should do’ action – SRH Maternity	Date raised	RAG Status	Due date for completion (if applicable)
The trust should continue to embed the new triage tool and ensure all records are updated when women contact the service.	June 2022	**Actions partially complete or plan in place with date for completion**	31/03/2023

2.6 Emergency Department RSCH action plan

‘Must do’ action – ED RSCH	Date raised	RAG Status	Due date for completion (if applicable)
The trust must ensure that action is taken to improve the environment of the emergency department to ensure it is suitable for its use and protects patients' privacy and dignity. (Regulation 15)	August 2022	**Actions partially complete or plan in place with date for completion**	TBC
The trust must ensure that all areas of the department can be cleaned effectively. (Regulation 12)	August 2022	**Actions on track or completed**	N/A
The trust must ensure that staff complete appropriate lifesaving training. (Regulation 12)	August 2022	**Actions partially complete or plan in place with date for completion**	TBC
The trust must ensure that staff complete required safeguarding training. (Regulation 12)	August 2022	**Actions partially complete or plan in place with date for completion**	TBC
The trust must ensure all patients are cared for in designated patient areas. (Regulation 12)	August 2022	**Actions partially complete or plan in place with date for completion**	TBC
The trust must make sure patients with mental health illnesses accommodated in the emergency department receive care and treatment from staff who have the relevant skills and experience. (Regulation 12)	August 2022	**Actions partially complete or plan in place with date for completion**	TBC

‘Should do’ action – ED RSCH	Date raised	RAG Status	Due date for completion (if applicable)
The trust should ensure that staff compliance with mandatory training meets the trust target. (Regulation 12(2)	August 2022	**Actions on Track or completed**	N/A

'Should do' action – ED RSCH	Date raised	RAG Status	Due date for completion (if applicable)
The trust should ensure that completion of staff appraisals meets the trust target. (Regulation 18(2)	August 2022	**Actions partially complete or plan in place with date for completion**	**31/12/2023**
The trust should ensure the practice of open notes trolleys in the department does not pose a risk to patient confidentiality.	August 2022	**Actions partially complete or plan in place with date for completion**	TBC
The trust should consider improving the environment to meet the needs of people living with dementia.	August 2022	**Actions on track or completed**	N/A
The trust should consider introducing a structured approach to share learning form incidents.	August 2022	**Actions on track or completed**	N/A
The trust should consider improving the facilities for relatives.	August 2022	**Actions on track or completed**	N/A

2.7 RSCH Surgery, Upper Gastro-Intestinal action plan

This action plan will be submitted to the Quality Committee for reporting in 2023. The list of 'Must do' actions from the inspection report of November 2022 are noted below.

'Must do' action – RSCH, Surgery Upper GI	Date raised	RAG Status	Due date for completion (where applicable)
The Trust must ensure that there is a robust governance and risk arrangements to provide assurance that the upper gastrointestinal service is safe, effective and well led. (Regulation 17)	November 2022	**Partially completed**	Phase 1 - June 2023 Phase 2 – December 2023
The Trust must ensure there are enough numbers of appropriately trained and competent upper gastrointestinal consultants working in the service in line with the "NHS standard contract for cancer: oesophageal and gastric (adult) section B Part 1 service specifications." (Regulation 18)	November 2022	**Action complete**	**N/A**
The Trust must ensure there is enough Cancer Nurse Specialist resources to support the upper gastrointestinal service. (Regulation 18)	November 2022	**Action complete**	**N/A**
The Trust must ensure that there are enough numbers of competent staff to provide out of hours emergency cover. (Regulation 18)	November 2022	**Action complete**	**N/A**

University Hospitals Sussex NHS Foundation Trust

'Must do' action – RSCH, Surgery Upper GI	Date raised	RAG Status	Due date for completion (where applicable)
The Trust must ensure that all upper gastrointestinal multidisciplinary team (MDT) meetings are held in line with "NHS England and Improvement Streamlining Multi-Disciplinary Team Meetings" guidance. (Regulation 12)	November 2022	**Partially completed**	TBC
The Trust must ensure that patient records are legible and easily available to all staff providing care and treatment. (Regulation 17)	November 2022	**Partially completed**	TBC
The Trust must ensure that patient records and details are not accessible to unauthorised persons. (Regulation 17)	November 2022	**Action complete**	Ongoing monitoring
The Trust must ensure morbidity and mortality meetings are carried out in accordance with national guidance. (Regulation 17)	November 2022	**Partially completed**	June 2023
The Trust must ensure they consistently use audits to measure quality and improve services. (Regulation 17)	November 2022	**Partially complete**	June 2023
The Trust must ensure leaders and managers have protected time to effectively carry out their role. (Regulation 18)	November 2022	**Partially complete**	June 2023

Agenda Item:	23	**Meeting:**	Trust Board – Private	**Meeting Date:**	02 February 2023
Report Title:	UHSussex – CNST Year 4 Submission – ICB Approval				
Sponsoring Executive Director:	Dr Maggie Davies, Chief Nurse				
Author(s):	Emma Chambers, Director of Midwifery Dr Tim Taylor, Chief of Service Hugh Jolley, Director of Operations Cathy Stone, Associate Chief Nurse Delivery Support – James Weller				
Report previously considered by and date:	UHSussex – CNST Year 4 Submission – January 2023				

Purpose of the report:			
Information	✓	Assurance	✓
Review and Discussion	✓	Approval / Agreement	✓
Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	☐	Staff confidentiality	☐
Patient confidentiality	☐	Other exceptional circumstances	☐

Implications for Trust Strategic Themes and any link to BAF risks		
Patient	✓	
Sustainability	✓	
People	☐	
Quality	✓	
Systems and Partnerships	☐	

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

Communication and Consultation:

This paper has been prepared for the Trust Board to inform them of ICB support and approval of UHSussex Year 4 CNST Safety Action Standards as per NHS Resolution guidance. At January Trust Board, a comprehensive paper was presented which included the year 4 declaration, the Board approved this submission. In line with current NHSR guidance this paper is to confirm support and approval by NHS Sussex (ICB) which confirmed support and approval of the Trust's submission during a joint meeting with the ICB and the Trust held on 24th January.

Summary:

Requirement

The CNST scheme supports the delivery of safer maternity care through an incentive element to trust contributions to the CNST. The scheme, developed in partnership with the national maternity safety champions, Dr Matthew Jolly and Professor Jacqueline Dunkley-Bent OBE, rewards trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services.

Approval of Year 4 CNST UHSussex declaration by ICB

The Trust completed a comprehensive review of the planned declaration at January Board meeting and approved submission.

As per NHSR guidance, this paper today formally confirms ICB support and approval of the declaration as presented in January. Support and sign off was confirmed during a meeting held with the CEO of the ICB on 24th January. This meeting referenced a review of Trust papers and

acknowledged evidence catalogue and BDO audit made in support of the year 4 declaration. ICB to provide confirmation of this support via formal correspondence and inclusion of ICB signatures on the NHSR declaration template.

During the ICB meeting delivery of all standards, with the exception of Safety Action One was noted. The ICB supported the Trusts position including support for a request of NHSR to consider the minimal impact of an administrative error and given no impact to safety of patients request to release the full CNST rebate.

Given approval by ICB, the Trust has submitted the declaration to ensure submission of paperwork is completed by midday Thursday 2nd February.

Key Recommendation(s):

Members of the Board are asked to:

- to note the ICB support and approval of the year 4 submission for records.
- to note declaration has been submitted as per approved declaration at January Board Meeting.
- to note that the Trust will submit a formal request to NHSR to review the case in relation to minimal impact of administrative error and consider full release of CNST rebate for year 4.
- A post submission review will commence including any planning for any newly published guidance (as available).

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Agenda Item:	24	**Meeting:**	Board	**Meeting Date:**	2 February 2023
Report Title:	**Company Secretary Report**				
Committee Chair:			Glen Palethorpe, Company Secretary		
Author(s):			Glen Palethorpe, Company Secretary		
Report previously considered by and date:			*The learning from deaths appendix has been considered at the January Quality Committee*		

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

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

Implications for Trust Strategic Themes and any link to BAF risks		
Patient	☐	
Sustainability	☐	
People	☐	
Quality	☐	
Systems and Partnerships	☐	

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

Communication and Consultation:

Executive Summary:

This report provides the Board with an update, including matters for which the Trust has complied with NHS I or other regulatory requirements.

Learning from Deaths reports 2022/23 quarter 3 – Appendix 1

The Trust is required to receive reports on learning from deaths. The Board is reminded that the detail of these reports are scrutinised by the Quality Committee, with the report for quarter 3 considered at the meeting on the 24 January 2023. At that meeting the Committee was updated on the progress being made to standardise the processes across all four sites with plans to increase the level of scrutiny for the outcomes of SJRs and medical examiner office reviews. The reports highlight the Trust's processes for learning from the review of deaths to utilise the learning to improve the Trust's processes. The outcome of this learning manifests itself within the Trust's mortality indices; these are tracked within the routine report to the Board as part of the Integrated Performance Report.

2021/22 LYH and BSUH Charities Annual Reports

The Board acting as corporate trustees for both LYH and BSUH Charities approved the annual report for both Charities, these have been submitted to the Charity Commission and placed on the Trust's website at

http://www.uhsussex.nhs.uk/charity/about/

Both annual reports detail the generous support given by our communities and highlight some of the amazing individual and group fundraising activities undertaken along with key highlights on how those donations have made a difference to our patients and staff.

Key Recommendation(s):

The Board is recommended to

- **NOTE** the Trust's learning from deaths reports for quarter 3 of 2022/23 and note the learning identified from the structured judgement review process, recognising the detail of this work is subject to scrutiny and oversight at the Quality Committee.
- **NOTE** that the submission and publication of the Charities Annual Reports

Appendix 1

Agenda Item:		**Meeting:**	Board	**Meeting Date:**	2 Feb 2023
Report Title:	Learning from Deaths Q3 2022/23 University Hospitals Sussex NHS Foundation Trust				
Sponsoring Executive Director:	Rob Haigh – interim Chief Medical Officer				
Author(s):	Kim Bailey – Mortality & Learning from Deaths Manager Tim Taylor - Medical Director for Governance and Quality assurance				
Report previously considered by and date:	Quality Committee on 24 January 2023				
Purpose of the report:					
Information		✓	Assurance		✓
Review and Discussion		✓	Approval / Agreement		☐
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		☐	Staff confidentiality		☐
Patient confidentiality		☐	Other exceptional circumstances		☐
Link to Trust Strategic Themes:					
Patient Care		✓	Sustainability		☐
Our People		☐	Quality		✓
Systems and Partnerships		☐			
Any implications for:					
Quality	Learning and quality improvement from the review of deaths				
Financial	Nil				
Workforce	Training requirements and time for individuals to undertake and respond to learning				
Link to CQC Domains:					
Safe		✓	Effective		✓
Caring		✓	Responsive		✓
Well-led		☐	Use of Resources		☐
Communication and Consultation:					
A plan for communication is being developed					
Executive Summary:					
The purpose of the report is to provide an update of the progress in the implementation of the structured approach for reviewing the deaths of patients to provide assurance on care and identify areas where it could have been improved. This report also aims to provide assurance on progress on alignment of the LfD programs across the four sites.					
Key Recommendation(s):					
The Board is asked to **NOTE** the report and that its contents have been considered by the Quality Committee.					

Appendix 1

Learning from Deaths/Mortality review Report - Quarter 3 2022/23 University Hospitals Sussex NHS Foundation Trust (UHSx)

1. Purpose

1.1 The purpose of reviews and investigations of deaths is to improve understanding and learning of mortality and end of life care at a system wide level, local level and individual level. Through aligning all of Universities Hospitals Sussex Mortality processes, services can share best practice and excellence in care; address barriers that impact service delivery and identify themes that support developing a more responsive and proactive organisation to deliver increased personalised patient centred care and experience when nearing or reaching the end of their life.

1.2 This report aims to provide assurance of the continued ongoing work that seeks to increase efficacy of the Learning from Deaths (LfD) and Learning Disabilities Mortality Review (LeDeR) in adherence to the National Quality Board guidance on Learning from Deaths (2017).

2. Background

2.1 The National Quality Board's National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on identifying, reporting, investigating and learning from deaths in care (March 2017) set out key requirements to ensure organisations effectively respond to and learn from patient deaths.

2.2 Acute trusts in England were initially asked to set up Medical Examiner (ME) offices to focus on the certification and to provide scrutiny of all deaths that occur in their own organisation on a non-statutory basis. In February 2021, the government published "Integration and innovation: Working together to improve health and social care for all", the white paper which includes provisions for medical examiners to be put on a statutory footing.

2.3 ME offices across UHSussex are now fully implemented to allow for the scrutiny all in hospital non coronial deaths. The role of the ME is currently being extended to include all out of hospital non-coronial deaths. Implementation of this phase is now underway and a programme of work to develop systems and processes is in place. This programme of works is supported by the Mortality & Learning from Deaths Manager, the current Medical Examiner Officers and Lead Medical Examiners.

3. Governance

3.1 The Chief Medical Officer is the responsible executive for Learning from Deaths.

3.2 The End of Life Care and Mortality Board (EOLM) is an aligned clinical governance forum covering all Universities Hospitals Sussex NHS Foundation Trust sites including Royal Sussex County Hospital/Princess Royal Hospital (RSCH/PRH) and the Worthing General Hospital/St Richards Hospital (WGH/SRH.

3.3 Weekly mortality panel meetings continue for WGH and SRH deaths, chaired by Medical Director for Governance and Quality assurance. A programme to implement weekly panel meetings is currently being developed for RSCH/PRH.

3.4 The mortality panel reports to the End of Life Care and Mortality Board, the Clinical Outcomes and Effectiveness Group (COEG) and by exception to the Quality Governance Steering Group (QGSG).

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4. Process

4.1 Structured Judgement Review (SJR) methodology is a standardised, non-rigid, case notes review methodology blending traditional, clinical judgement based, review methods with a standard format. The trained reviewers make quality and safety judgements over phases of care, make explicit written comments about care for each phase, and score care for each phase. These aspects are then applied to the overall care received. This process is structured and replicable examining both interventions and holistic care giving reviewers a rich data set of information.

4.2 SJR also allows the identification and feedback of good care in the same detail as 'problematic' care, enabling learning from excellence and examples of high-quality care.

4.3 The process regarding SJR currently differs across the four hospital sites of University Hospitals Sussex NHS Foundation Trust (UHSussex). For the RSCH and PRH sites - SJRs are completed on an electronic form within PANDA (patient information and management system populated by the patient access system) which is also used to alert the Divisional Quality and Safety Managers (DQSM) to those cases requiring an SJR. The DQSM allocates each case to a trained mortality reviewer to complete and share any findings for learning. For SRH and WGH - SJRs are completed on a word document with outcome scores and learning themes populated onto an excel spreadsheet for recording and reporting purposes.

4.4 Deaths requiring review are triangulated via the Serious Incident Review Group (SIRG), Complaints, Medical Examiner office, Medico-legal Department, Learning Disabilities Team, or in response to risk adjusted mortality statistics.

4.5 Any deaths identified as potentially resulting from failures in care are recorded on the DATIXRL® incident reporting system and considered by SIRG for Serious Incident (SI) investigation.

4.6 Deaths of patients with learning disabilities (LD) are referred to the Learning from Life and Death Reviews previously Learning Disabilities Mortality Review (LeDeR) Programme for independent care pathway review but also undergo local SJR, to ensure timely scrutiny and learning from the inpatient hospital admission, which is then shared to assist LeDeR to complete their review.

5. Involving Families / Carers

5.1 All non-coronial deaths across UHSussex are reviewed by the Medical Examiner (ME) office. An ME or Medical Examiner Officer (MEO) speaks with the nominated family/carers of the deceased to discuss and explain the Medical Certificate of Cause of Death (MCCD) and to ascertain any concerns regarding care. If concerns are raised either by the family or following ME scrutiny of the case, the ME refers the case for SJR.

Appendix 1

University Hospitals Sussex NHS Foundation Trust

Activity Report for Quarter 3 2022/23 (October, November and December 2022)

6. Workstream Highlights

6.1 LfD and Alignment of the LfD programmes

- The Mortality & Learning from Deaths Manager commenced in post in November 2022.
- Action plans and workstreams are currently being developed to support alignment of the programmes.
- The Medical Examiners Office has welcomed interim leadership and management from the Mortality & Learning from Deaths Manager enabling a programme of recruitment, increased collaborative working and aligned processes.
- Resource constraints have constrained the implementation of mortality panel review of SJR activity for RSCH and PRH although there is cross UHXs representation at the WGH/SRH panel. Administrative support has been a limiting factor.
- Recruitment of a full time LfD administrator commenced in December 2022. This will support the provision of mortality review panels for SJR activity across UHSx.
- A review of SJR reviewer activity is currently being conducted to ensure protected time is applied to the SJR process across all UHSussex.
- It is anticipated that there will be recruitment of mortality reviewers from RSCH and PRH in Q4
- Full engagement with the lead Medical Examiners and Medical Examiner Officers across all UHSussex.
- Systems requirement meetings with the ME teams, Panda development and the LfD Manager have established a programme of works to support development of the Mortality and LfD alignment objectives.
- Further work is being carried out to identify if there are ways of aligning Panda with Datix workstreams.

6.2 Medical Examiners Office

- Recruitment of two Lead Medical Examiner Officers commenced in December 2022.
- Recruitment of 6 wte Medical Examiner Officers commenced in December 2022.
- Significant reduction of unnecessary referrals made to WSCC coroner since the introduction of ME service in late 2020.
    - NFA=No further Action: significant reduction in 2021 and 2022 (194 and 202) compared to 2019 and 2020 (493 and 459).
    - Previously all deaths that involved falls and operations were referred to the coroner. This impacted on the time it took for a doctor to make the referral and created a delay in the MCCD being available for the family to register their loved ones death.
- 12 Plaudits completed by MEOs at RSCH/PRH
- 487 calls to NOK at RSCH/PRH
- 355 discussions with clinical team at RSCH/PRH
- MEO's improved LD awareness with local teams, including; ensuring easy read resources available in department and increased liaison with LD team.
- Redesign of data capture form in line with NHS England reporting requirements.

Appendix 1

7. Mortality Reviews

7.1 **Total deaths:** Table 1 highlights the total number of deaths in UHSx during Quarter 3 was 1059. (Q1 total was 1038, Q2 total was 975)

Table 1: Number of hospital deaths by setting and site

Table 1	SRH		WGH		RSCH		PRH		UHSx	
	Inpatient Deaths*	ED Deaths*	Inpatient Deaths*	ED Deaths*	Inpatient Deaths	ED Deaths	Inpatient Deaths	ED Deaths	Inpatient Deaths	ED Deaths
Oct	96	5	104	8	110	10	46	5	356	28
Nov	69	8	95	10	81	14	32	1	277	33
Dec	104	3	128	11	101	13	39	2	372	29
Total	**269**	**16**	**327**	**29**	**292**	**37**	**117**	**8**	**1005**	**90**

*Data reconciliation is currently underway following changes to patient administration systems. Data may require updating in once reconciliation is complete in February 2023.

7.2 Table 2 details the total number of out of hospital deaths within 30 days of discharge for quarter 2 (Jul - Sep 22), the latest data available:

Table 2: Number of adult inpatients who died with 30 days of being discharged* by site of discharge (Q2 2022-23)

Table 2	SRH	WGH	RSCH	PRH	UHXs
July	32	33	27	24	116
August	31	38	36	14	119
September	40	36	23	23	122
Total	**103**	**107**	**86**	**61**	**357**

* Data Source SHMI Module HEDS and includes out of hospital deaths

7.3 **Hospital onset healthcare associated Covid-19**

Table 3: Details where Covid-19 appeared on the MCCD where a hospital onset probable or definite healthcare associated Covid-19 was identified (Q1 total was 15, Q2 total was 14)

Table 3	SRH	WGH	RSCH	PRH	UHXs
Oct	4	2	0	2	8
Nov	1	4	1	1	7
Dec	3*	3	2	1	9
Total	**8***	**9**	**3**	**4**	**24**

*2 deaths awaiting coroner outcome, figure may increase by 2.

7.4 In accordance with national guidance, all probable or definite hospital onset healthcare associated Covid-19 infection deaths where Covid-19 appears on the MCCD, are reported, and investigated as patient safety incidents. This includes a patient safety investigation to identify learning, as well as the completion of Duty of Candour (Regulation 20).

Appendix 1

8. Medical Examiner's Office

8.1 Medical Examiner scrutiny

Table 4: Percentage of deaths scrutinised by ME

Table 4	SRH	WGH	RSCH	PRH	UHXs
October	100%	100%	96.55%	97.78%	98.58%
November	100%	100%	95.59%	100%	98.90%
December	100%	98.60%	96.97%	92.13%	97%
Total	**100%**	**99.53%**	**96.37%**	**97%**	**98%**

8.2 **Referral to Coroner**

Table 5: Number of deaths per hospital site, referred to the coroner (Q1 total was 267, Q2 total was 227)

Table 5	SRH	WGH	RSCH	PRH	UHXs
October	15	13	42	7	77
November	8	14	38	7	67
December	13	17	29	9	68
Total	**36**	**44**	**109**	**24**	**213**

8.3 **Investigated by Coroner**

Table 6: Number of deaths per hospital site investigated by the coroner's office

Table 6	SRH	WGH	RSCH	PRH	UHXs
October	10	6	23	3	42
November	6	11	26	3	46
December	9	4	13	3	29
Total	**25**	**21**	**62**	**9**	**117**

8.4 **Deaths referred for structured Judgement review (SJR)**

Table 7: Number of deaths per site referred for SJR following ME scrutiny. (Q1 total was 92, Q2 total 81)

Table 7	SRH	WGH	RSCH	PRH	UHXs
October	9	10	11	3	33
November	10	9	12	0	31
December	7	9	12	4	32
Total	**26**	**28**	**35**	**7**	**96**

Appendix 1

9. Learning from deaths

9.1 **SJRs** completed

Table 8: Details the number of SJRs undertaken in the quarter* (Q1 total was 83, Q2 was 72)

Table 8	SRH	WGH	RSCH	PRH	UHXs
October	2	1	2	0	5
November	3	2	7	2	14
December	4	2	4	3	13
Total	**9**	**5**	**13**	**5**	**32**

* Note: Some of the SJRs are completed for patient deaths during previous quarters.

Table 8a: Number of SJRs reviewed by the Mortality Panel. (WGH and SRH SJR process includes a panel of reviewers and the Mortality & Learning from Deaths Manager. The panel reviews all completed SJR's with a score of 1 or 2).

Table 8	SRH	WGH	UHXs
October	2	1	3
November	3	2*	5
December	4	2	6
Total	**9**	**5**	**14**

*Death was reviewed at panel but not signed off and sent for Investigation (SI).

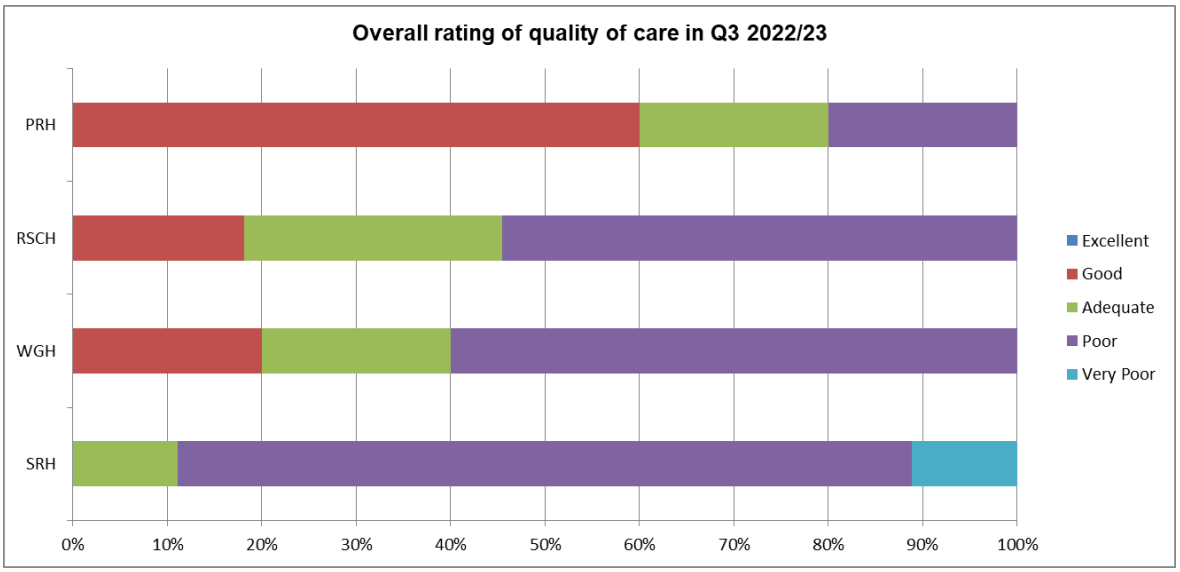
SJR outcome scores

Table 9: Details the overall outcome score of initial SJR per site completed during Quarter 3 2022/23

Table 9	SRH	WGH	RSCH	PRH
Excellent	0	0	0	0
Good	0	1	2	3
Adequate	1	1	3	1
Poor	7	3*	6	1
Very Poor	1	0	0	0
Total	**9**	**5**	**11**	**5**

Appendix 1

Graph 1: Details the outcome scores of initial SJR on all four sites, completed during Quarter 3 2022/23



A Mortality panel is currently being developed to support moderating the outcome scores of reviews along with increased protected time for reviewers at RSCH and PRH sites. It is anticipated, with an applied standard methodology across UHSussex, variation in the application of outcome scores will be reduced.

Increasing the number of mortality reviewers is currently being reviewed to ensure adequate numbers of reviewers are available at RSCH and PRH and protected time to support weekly Mortality Panels to review SJRs (with an outcome score of 1 or 2).

Development and integration of electronic case notes and a shared electronic SJR process will support increased opportunities for cross site working.

10. Patients with a Learning Disability (LD)

10.1 SJRs and learning disability (LD) flagged patients

The Mortality & LfD team are continuing to work with the LeDeR teams and reviewers to address system and process barriers. Included in the Learning from Deaths programme of works is to develop a robust process for reviewing deaths where a patient has a learning disability. Recruitment of a full time LfD administrator is currently underway and it is anticipated that the position will commence in March 2023.

A review is currently planned to ensure that all LD deaths from the last year have received appropriate scrutiny with a local SJR and have been referred to the LeDer program.

Table 10: Details the number of inpatient deaths with a LD and referred for an SJR during Quarter 3 2022/23

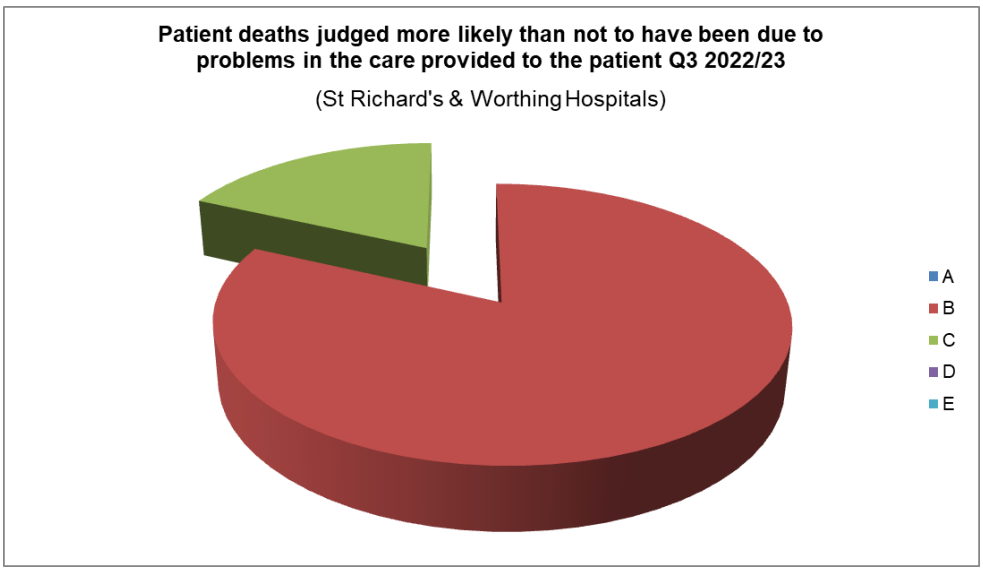
Table 10	SRH	WGH	RSCH/ PRH	UHXs
October	0	0	2	2
November	2	3	0	5
December	0	3	6	9
Total	**2**	**6**	**8**	**16**

10.2 Eight patients with a LD were identified as having died as an inpatient across the WGH/SRH sites with ME office scrutiny and SJR referral. The Learning from Life and Death Reviews programme were notified of all cases.

11. Mortality panel outcomes (SRH and WGH only)

11.1 In the absence of a mortality panel at RSCH/PRH, an outcome assessment is not currently made on completed SJRs at those sites. Mortality panels will commence in April 2023 aligning this part of the learning from deaths process across all sites of UHSx.

Graph 2:
Details of patient deaths during Q3 2022/23 judged to be more likely than not to have been due to problems in the care provided to the patient.
N.B. three deaths have not been classified.



11.2 An additional rating system is adopted by the Mortality Panel for SJRs at SRH and WGH.

A. The review group concluded that there were no issues with care Identified up to the point that the patient died
B. The review group identified care issues which they consider would have made no difference to the outcome for the patient
C. The review group identified care issues which they consider may have made a difference to the outcome for the patient

D. The review group identified care issues which they consider were likely to have made a difference to the outcome for the patient
E. Further information required

12. Learning from deaths themes

12.1 Care identified as poor or very poor

- Long hospital stays due to unavailable care in the community leading to deconditioning along with a
- Missed opportunity for safeguarding referral.
- Inappropriate discharge with lack of palliative care input
- and no referral until prompted by the patient's family: in addition, end of life pain management was not optimised until the patient's family intervened.
- Anticoagulation issues, particularly recording correctly on EPMA
- Identification of patients for thromboprophylaxis was raised as a concern following an SJR.

12.2 Care identified as adequate

- The need for senior input into all decisions to suspend VTE prophylaxis and the importance of ensuring patient compliance with wearing prescribed surgical stockings.
- Patients presenting in ED with hip pain and raised inflammatory markers require decision to admit for treatment.
- Recognition of the deteriorating patient
- The need for improved acute clerking

12.3 Care identified as good or excellent

SJRs are requested when a concern is raised regarding care. Current resources restrict reviewers to conducting SJRs only for patients where a concern in care is identified through ME scrutiny or a member of the clinical teams.

Alignment of the Medical Examiners Office and Learning from Deaths programmes across all UHSussex will include a single electronic point for recording all deaths. Completion of the alignment will enable thematic analysis to support learning from excellence as well as learning where improvements are required.

12.4 All SJRs where care is assessed as poor or very poor and likely to have made a difference to the outcome for the patient are presented to the serious incident review group (SIRG) for consideration under the patient safety investigation framework.

13. Conclusion

A great deal of progress is currently being made to align the four sites' Mortality processes including increasing SJR reviewers at RSCH/PRH; recruitment of administration support; increasing the number of MEOs across all sites and recruiting two Lead MEOs.

The additional resource aims to support mitigating some of the current bottlenecks associated with aligning the Mortality and Learning from Deaths programmes. Once implemented, streamlined processes will provide greater collaboration with clinical teams as well as shared learning opportunities for ward level and divisional level quality improvement plans; improved audit and reporting process.