University Hospitals Sussex
NHS Foundation Trust

Meeting of the Board of Directors

10.00 to 14:00 on Thursday 05 May 2022

Virtual MS Teams

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 31 March 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	Presentation	Andy Heeps
		INTEGRATED PERFORMANCE REPORT		
6.	10.30	**Patient** To receive and agree any necessary actions *After this section the Chair of the Patient Committee will be invited to provide their report included at item 11* To receive assurance from Committee and recommendations from the Committee	Enclosure	Maggie Davies
7.	10.45	**Quality** To receive and agree any necessary actions *After this section the Chair of the Quality Committee will be invited to provide their reports included at item 12* To receive assurance from Committee and recommendations from the Committee	Enclosure	Maggie Davies Charlotte Hopkins
8.	11.05	**People** To receive and agree any necessary actions	Enclosure	David Grantham

		At this point the Chair of the People Committee will be invited to provide their report included at item 13 To receive assurance from Committee and recommendations from the Committee		
9.	11.20	**Sustainability** To receive and agree any necessary actions *After this section the Chair of the Sustainability Committee will be invited to provide their report included at item 14* To receive assurance from Committee and recommendations from the Committee	Enclosure	Karen Geoghegan
10.	11.40	**Systems and Partnerships** To receive and agree any necessary actions *After this section the Chair of the Systems and Partnerships Committee will be invited to provide their report included at item 15* To receive assurance from Committee and recommendations from the Committee	Enclosure	Ellis Pullinger
		ASSURANCE REPORTS FROM COMMITTEES		
11.	12.00	**Report from Patient Committee** - **from the meeting held on the 26 April 2022** To receive assurance from Committee and recommendations from the Committee	Enclosure	Jackie Cassell
12.	12.05	**Report from Quality Committee** - **from the meeting held on the 26 April 2022** To receive assurance from Committee and recommendations from the Committee	Enclosure	Lucy Bloem
13.	12.10	**Report from People Committee** - **from the meeting held on the 27 April 2022** To receive assurance from Committee and recommendations from the Committee	Enclosure	Patrick Boyle
14.	12.15	**Report from Sustainability Committee** - **from the meeting held on the 28 April 2022** To receive assurance from Committee and recommendations from the Committee	Enclosure	Lizzie Peers
15.	12.20	**Report from Systems and Partnerships Committee** - **from the meeting held on the 28 April 2022** To receive assurance from Committee and recommendations from the Committee	Enclosure	Patrick Boyle
16.	12.25	**Report from Audit Committee** - **from the meeting held on the 14 April 2022 including** - ***NHSI Licence Self-Certifications (recommended by the Committee for approval)***	Enclosure	Jon Furmston

		To receive assurance from Committee and recommendations from the Committee		
17.	12.35	**Report from Charitable Funds Committee from the meeting held on the 12 April 2022** To receive assurance from Committee and recommendations from the Committee	Enclosure	Lizzie Peers
18.	12.45	**Board Assurance Framework and Corporate Risk Register highlight report** To approve	Enclosure	Darren Grayson / Glen Palethorpe
		QUALITY		
19.	12.55	**CQC Update and Trust response to the warning notice** To note	Enclosure	Darren Grayson / Maggie Davies
		SYSTEMS & PARTNERSHIPS		
20.	13.05	**UHSussex Operational Plan 2022/2023** To note	Enclosure	Ellis Pullinger
		WELL LED & COMPLIANCE		
21.	13.20	**Company Secretary Report** To approve	Enclosure	Glen Palethorpe
		OTHER		
22.	13.30	**Any Other Business** To receive and action	Verbal	Alan McCarthy
23.	13.40	**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
24.	14.00	**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 August 2022.	Verbal	Alan McCarthy
		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*		

Minutes

University Hospitals Sussex
NHS Foundation Trust

Minutes of the Board of Directors meeting held in Public at 13.30 on Thursday 31 March 2022, held virtually via Microsoft Teams Live Broadcast.

Present:

Alan McCarthy MBE DL	Trust Chairman
Dame Marianne Griffiths	Chief Executive
Joanna Crane	Non-Executive Director
Jon Furmston	Non-Executive Director
Lizzie Peers	Non-Executive Director
Patrick Boyle	Non-Executive Director
Jackie Cassell	Non-Executive Director
Claire Keatinge	Non-Executive Director
Lucy Bloem	Non-Executive Director
Lillian Philip*	Associate Non-Executive Director
Karen Geoghegan	Chief Financial Officer
Pete Landstrom	Chief Delivery and Strategy Officer
Dr Maggie Davies	Chief Nurse
David Grantham	Chief People Officer
Charlotte Hopkins	Chief Medical Officer
Dr Andy Heeps	Deputy Chief Executive
Darren Grayson	Chief Governance Officer

*Non-voting member of the Board

In Attendance:

Emma Chambers	Director of Midwifery
Ellis Pullinger	Chief Operating Officer designate
Glen Palethorpe	Company Secretary
Tamsin James	Board and Committee Administrator
Tanya Humphrys	Board and Committee Administrator

TB/03/22/1 WELCOME AND APOLOGIES FOR ABSENCE **ACTION**

1.1 The Chairman welcomed all those present to the meeting and began by sharing the news that Dame Marianne Griffiths was leaving the Trust as Chief Executive on the 1st April 2022 and this meeting today would be her last Board meeting.

1.2 Alan went on to advise that the Chief Delivery & Strategy Officer, Pete Landstrom, was also leaving the Trust today.

1.3 The Board shared their thanks to both Marianne and Pete and wished them all the best for the future.

1.4 There were no apologies for absence received for the meeting.

TB/03/22/2 DECLARATIONS OF INTERESTS

2.1 There were no other interests declared.

TB/03/22/3 MINUTES OF THE MEETING HELD ON 03 FEBRUARY 2022

3.1 The Board received the minutes of the meeting held on 03 February 2022.

3.2 The minutes of the meeting held on 03 February 2022 were **APPROVED** as a correct record.

TB/03/22/4 CHIEF EXECUTIVE REPORT

4.1 Dame Marianne Griffiths introduced the Chief Executive's report.

4.2 Marianne advised the Board that the numbers of patients in critical care beds had significantly reduced which was positive, however prevalence within the younger population in the community was increasing which is being reflected in the increasing hospital numbers.

4.3 Marianne explained that in addition to Covid pressures affecting patients and staff alike, the Trust continues to experience high demand for its servcies especially those seeking urgent care through our A&E department and continued challenges around delayed discharges with substantial numbers of patients that are medically ready for discharge (MRDs) impacting on the Trust's use of these beds.

4.4 Marianne extended her thanks to all the staff who have continued to work tirelessly throughout the pandemic and continue to provide high levels of care to patients through such challenging times. In addition, Marianne stated that the 23rd March 2022 was a National Day of Reflection, marking two years since the first lockdown due to Covid, and staff reflections were being shared on the UHSussex website these highlight the Trust's workforce inspiring tales of courage, dedication and teamwork throughout the first year of the pandemic.

4.5 Marianne went on to highlight that the Trust's Patient First STAR Awards would be taking place again on the 25th May 2022 following a two-year break due to the pandemic. 1200 nominations have been received covering all sites and specialties; and Marianne shared her pride and thanked all staff, patients and members of the public who had taken the time to submit a nomination, recognising the efforts of a fantastic and hardworking workforce.

4.6 Marianne highlighted some organisational changes:

- Dr George Findlay will be returning to the Trust as Chief Executive Officer on the 1 June 2022.
- Dr Andy Heeps as interim Chief Executive from 1 April 2022 until the 1 June 2022.
- Ellis Pullinger has joined and will be taking the role of Interim Chief Operating Officer from 1 April 2022
- Darren Grayson has joined as Chief Governance Officer.

4.7 Marianne concluded the update by stating that it had been a considerable honour and privilege to have served the Trust over her 14-year period, praising all colleagues across the Trust. Marianne was positive that the Trust would be guided brilliantly under the leadership of Dr Andy Heeps, and Dr George Findlay, who will continue to build on the Restoration and Recovery activities of the Trust whilst continuing to guide the Trust through the pandemic.

4.8 The Chair extended his thanks again to Marianne and echoed the comments regarding the Trust's outstanding workforce.

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

TB/03/22/5 MATERNITY SERVICES ASSURANCE REPORT

5.1 Maggie Davies welcomed Emma Chambers as Director of Midwifery in order to provide the Board with the Maternity Services Assurance Report.

5.2 Emma advised that the purpose of the report was to share an updated position in respect of the on-going progress required to achieve compliance with regard to the first Ockenden report and the Morecambe Bay investigation recommendations, and progress with the Trust's overall workforce improvement plan.

5.3 The Ockenden Report, was first published in December 2020 following a review of maternity services at Shrewsbury and Telford NHS Trust, whereby Seven Immediate and Essential Actions (IEAs) were required which included 12 clinical priorities. The Trust's most recent review presented to the LMNS, the Regional Chief Midwife and the National Maternity Improvement Advisor in March 2022, reflected significant delivery against these immediate and essential actions, the outcome being the Trust was either compliant or partially compliant with all 7 IEAs.

5.4 Emma went on to explain that in addition to the 7 IEAs, an additional 49 recommendations were made within the Ockenden report, resulting in NHSEI developing a self-assessment tool to support the recommendations. Following scrutiny led by LMNS the Trust has demonstrated a positive progression towards full compliance. Emma took the Board through the Trust's further actions and advised that the assurance over these being delivered will be further supported by NHSEI Ockenden insight visits over the next few months where the actions will be further assessed.

5.5 Emma outlined the Morecambe Bay requirements, a report that was published in 2015 following an independent Investigation that was commissioned by the Secretary of State for Health to examine concerns raised by the occurrence of serious incidents, including the deaths of mothers and babies in maternity services, provided by what became the University Hospitals of Morecambe Bay NHS Foundation Trust.

5.6 Emma outlined that the Morecambe Bay report highlighted 44 recommendations in total, 18 of which were for provider organisations to complete, the remaining actions were owned by the Department of Health, regulatory bodies and other national stakeholders. Emma highlighted that the Trust is compliant with 11 of the recommendations and the delivery of the remaining 7 are under regular scrutiny within the CQC action plan monitoring.

5.7 Emma outlined the Trust's significant Maternity Services workforce issues, recognising this correlates with National workforce shortages as well as long and short term sickness rates, largely due to Covid; annual leave; an increase in retirements, and an increase in ongoing requests to reduce working hours. Whilst these areas continue to be very challenging, the Trust is reducing the impact of these by actively recruiting additional workforce both regionally and nationally following the introduction of recruitment and retention initiatives.

5.8 Emma advised that the BirthRate+ assessment of the Trust's midwifery and support worker workforce requirements is underway and the Trust will be triangulating this with regional support to ensure the governance and management structures are sufficiently robust.

5.9 Emma outlined the formulation of the Maternity improvement Plan which would have oversight at the newly formed Maternity Board to enable clear evidence and validation of the Trust's safe, effective, and passionate Maternity services.

5.10 Emma concluded by sharing her sincere thanks to all members of the Maternity workforce for their ongoing hard work and determination to provide high quality safe care, and wellbeing support across the division, during this operationally difficult time.

5.11 The Chair thanked Emma Chambers for the update and welcomed an update from the Chair of the Quality Committee, Joanna Crane.

5.12 Joanna Crane shared her thanks to Emma, Maggie Davies and the wider Maternity workforce, for their ongoing work and commitment to providing support to this comprehensive area of work.

5.13 Joanna stated that the governance relating to areas of compliance and non-compliance is in place, which is overseen at Quality Committee, and explained that the Trust continues to focus on its workforce wellbeing, the provision of continuity of carer and safer staffing deployment as it continues to deliver outstanding care through these troubling times.

5.14 Lucy Bloem thanked Emma for the update and provided the Board with additional assurance that the Maternity Improvement Plan will continue to provide accurate oversight and assurance in evidencing the compliance actions plans. Emma added that new ways of working would complement improvement in this area of work through the introduction of twice daily Consultant rounds which is part of revised job planning which is audited through the Allocate e-rostering system

5.15 In relation to Continuity of Carer (CoC) Emma explained that within the Ockenden report it had been recommended to pause this element, which will be subject to a national review. Emma went on to praise the CoC teams based at RSCH who remain a pivotal support to the workforce in these areas.

5.16 Andy Heeps thanked Emma for her support since joining the Trust and went on to reflect the number of reports relating to Morecambe Bay and Ockenden whilst adding that the Trust must continue to focus on high quality Maternity Services while underpinning the requirements of these reports.

5.17 Andy went on to acknowledge that the Continuity of Carer team based at RSCH are excellent and risk assessments relating to the pausing of this element of work must be undertaken in the best interest of our Patients.

5.18 **ACTION: The Board shared their thanks to the Maternity workforce and asked that their well wishes are passed on to every member following the meeting.** **MD**

5.19 The Chair confirmed that Lucy Bloem would be stepping up as Chair of the Quality Committee from April 2022 following the retirement of Joanna Crane later this year.

5.20 The Board **APPROVED** the report as a balanced view and assessment, supported by the work of the Quality Committee.

TB/03/22/6 SAFER STAFFING REPORT

6.1 Maggie Davies presented the Safer Staffing Report in the absence of Cathy Stone, Associate Director of Nursing.

6.2 Maggie advised that the purpose of this report is to provide the Trust Board with a review of ward staffing establishment levels across UHSussex, as directed by the National Quality Board (NQB).

6.3 Maggie stated that information in relation to the Maternity staffing establishment was not included within the report as the comprehensive birth rate+ review reported previously is ongoing and its outcome was planned to be reported to the Maternity Board at a later date.

6.4 Maggie explained that Cathy Stone has led the Trust's establishment reviews with support from Heads of Nursing and the Patient and Quality teams, focusing on 35 clinical areas across Worthing and St Richards, and 47 across RSCH and PRH in quarter 3, noting that these have taken place during the pandemic. The establishment review outcome information was then triangulated against the patient experience and safety outcomes (metrics including Serious Incidents (SI), Never Events (NE), Tissue Viability (TV), outcomes of falls and complaints to provide context to the Board as to the levels of establishment lower than the national expectation. The Board was informed that the quality indicator information had not identified adverse outcomes for patients in the areas where the establishment was lower than expected.

6.5 The report recommended that all Trusts start recording Care Hours per Patient Day (CHPPD) which is a single, consistent metric of nursing and health care support workers deployment on inpatient wards and units. Maggie stated that the two legacy Trusts collect the data in different ways which will be addressed within the full rollout of the Allocate (e-Rostering system) in the East.

6.6 Maggie went on to advise on the focus of vacancies and recruitment recognising the importance of the NHS Five Year Forward view recruitment and retention plan. The plan highlights that there should be no more than 5% registered nurse (RN) vacancies by October 2021 which is subject to significant improvement across the Trust following campaigns to recruit oversees workforce and attracting student nurses from the Trust's University campuses.

6.7 Maggie added that across the general acute bed base the greater majority of the ward establishments were in line with national expectation when measured against previous criteria. In the adult areas the nurse to patient ratio across a 24-hour period was less or equal to 1 RN to 8 patients Those areas where the establishment was lower than this ratio were wards located on the west of the organisation. The Board was updated that whilst this ratio was lower when those areas quality metrics were considered there was no deviation of the Quality metrics noted.

6.8 Maggie stated that the Royal Alexandra Children's Hospital and the West Paediatric department are under significant operational pressure currently following additional inpatient care capacity demands and these areas dealing with patients with complex mental health requirements. The Trust continues to manage the staffing shortfalls through the use of additional bank, agency and temporary staff. Whilst vacancies remain a concern, a recruitment business case is underway to alleviate the additional pressures on the workforce.

6.9 The Board **NOTED** the recommendations within the report.

TB/03/22/7 USE OF THE COMPANY SEAL

7.1 Glen Palethorpe provided an update on the use of the Company Seal and stated that it is a requirement of the Trust Standing Orders that a register of sealing is maintained, its use is affixed in the presence of two senior employees duly authorised by the Chief Executive and that the use of the Common Seal is reported to the Trust Board.

7.2 There were 13 uses of the seals within the year; a number of the which were 're-seals' of contracts following the merger of the two former legacy Trusts WSHFT and BSUH to the newly merged UHSussex Trust.

7.3 The Board **NOTED** the report.

TB/03/22/8 ANY OTHER BUSINESS

8.1 There were no further items discussed.

TB/03/22/9 QUESTIONS FROM MEMBERS OF THE PUBLIC

9.1 There were no questions received from members of the public in advance of the meeting.

TB/03/22/10 DATE OF NEXT MEETING

10.1 The Chair formally closed the meeting

10.2 It was noted that the next meeting in public of the Board of Directors is scheduled to take place at **10.00** on **Thursday 05 May 2022**.

Tamsin James
Board & Committee Administrator
31 March 2022

Signed as a correct record of the meeting

……. Chair

..…… Date

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	5	**Meeting:**	Trust Board	**Meeting Date:**	05 May 2022
Report Title:	Chief Executive's Report				
Sponsoring Executive Director:		Andy Heeps, Interim Chief Executive			
Author(s):		Andy Heeps, Interim 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 an overview of 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: 05 May 2022

From: Interim Chief Executive – Andy Heeps

Agenda Item: 5

CHIEF EXECUTIVE BOARD REPORT

1. INTRODUCTION

1.1. On 1 April 2022 we wished a fond farewell to Dame Marianne Griffiths DBE who has retired after nearly 14 years as chief executive of University Hospitals Sussex NHS Foundation Trust (UHSussex) and our predecessor organisations. I first met Marianne in my previous organisation, North Middlesex University Hospital, where we adopted the UHSussex Patient First approach to continuous improvement to empower our staff to accelerate quality improvement.

1.2. From our first meeting, I was hugely impressed with Marianne's passion for improvement and her steadfast commitment to always putting patients first. To work alongside her over the past nine months, first as managing director and then deputy chief executive, was a privilege. Dame Marianne has helped forge a spirit of innovation and enterprise in our hospitals locally that is now being emulated all around the NHS.

1.3. To follow in her footprints and to serve as interim chief executive of UHSussex is an honour. On 1 June, Dr George Findlay will take up his new appointment as our CEO. George is a familiar face to many, having previously been the trust's deputy chief executive and chief medical officer.

1.4. Both George and I are passionate advocates of our Patient First programme and the strategic focus it provides for the improvement of our services under five key themes: Patients, Quality, Our People, Sustainability, and Systems and Partnerships. Throughout these board papers there are many examples of this. Here, in the chief executive's report, I will also share a few highlights as well as my reflections on recent key achievements and issues related to each theme.

2. PATIENTS

2.1. We strive to deliver an excellent experience to all our patients, whether they're attending A&E as an emergency, receiving care as an inpatient, or seeing our specialists as an Outpatient and for a diagnostic procedure. The past few months have continued to be very challenging and as I have been visiting teams in all our hospitals I am incredibly proud of the concerted efforts I see every day being made staff to put our patients first and provide the best care possible for them.

2.2. While a sense of normality returned to wider society, the effects of the pandemic continued to be felt very strongly in our hospitals. Demand for all our patient services has remained very high. Our emergency departments have been experiencing unprecedented numbers of patients when our

hospitals were already operating at their capacity. Additionally, a late wave of the Covid Omicron BA.2 variant in March saw the number of patients we were caring for with Covid peak at more than 300 for the first time since the previous winter.

2.3. Understandably, against the backdrop of such extraordinary circumstances and with many of our staff also absent due to Covid, we did see an impact on our patient satisfaction scores. We set ourselves a high standard for patient experience, with a Patient First target of 95% of patients rating their experience of our care 'Good' or 'Very Good' via the Friends and Family Test. Over the recent period, this slipped to around 92%. We are now making concerted efforts to address this with a particular focus on the most challenged areas such as our emergency departments.

2.4. Fortunately, in more recent weeks, we have seen a significant reduction in the number of patients with Covid as well as small drop in demand for emergency care. I am confident that these factors, in combination with an improvement in staff sickness and the change of season, will see patient experience return to the levels we pride ourselves on achieving in normal times.

3. QUALITY

3.1. Our Patient First ambition (or True North) for Quality is that zero harm occurs to our patients when in our care. Unfortunately, patient falls, pressure ulcers and infections are historically commonplace in hospitals, but this is of course unacceptable, and we are committed to doing all we can to eliminate such harms. We also have a target to reduce 'low' and 'moderate' harms and I am proud to highlight that despite the extraordinary pressures mentioned above, our staff have continued to reduce such harms. This is a superb achievement and I want to publicly acknowledge it and thank colleagues here.

3.2. Another key measure of the quality of care we provide is mortality. We continue to make good progress in reducing our crude mortality score, while our Hospital Standardised Mortality Rate (HSMR) for the most recent month available puts us in the 'very low' range and demonstrates that we are performing better than the majority of other hospital trusts. We continue to review all indicators of mortality to support our improvement work.

3.3. There are of course many other measures of quality, but our Patient First focus and success on reducing patient harm and mortality should provide patients with strong confidence that from UHSussex they can expect high quality safe care.

3.4. Our leading contribution to national and local research also supports our Quality agenda and in March we were one of only ten trust's taking part in a new nationwide Cov-Boost study designed to help us keep ahead of any new Covid wave. The annual Brighton Marathon on 10 April once again presented us with an opportunity to participate in world-leading research into life-threatening hypothermia and heat illness in marathon runners. Nearly 100 volunteers took part in the study, run by UHSussex doctors Todd Leckie and Luke Hodgson in partnership with the Brighton Marathon Research Group (BMRG).

4. OUR PEOPLE

4.1. Evidence collated over many years demonstrates that quality of care is better in organisations where staff feel involved, listened to and empowered. Our Patient First aim is therefore to have the best staff engagement rates in the NHS. Last Autumn, more than 8,000 UHSussex completed the annual NHS staff survey - 49% participation rate that was 3% above the national average,

which is really positive. The results published in March showed that we scored on track with our peers across the country – with a decrease in overall scores.

4.2. In general, our scores were just below the average across the NHS. This is reflective of the ongoing pressures Covid has created on our services and people, and the significant organisational change we have been undergoing as a new trust. However, we are continually trying to find ways to increase our support for staff, from staffing levels to regular opportunities for reflection and decompression, to new wellbeing hubs and mental health first aiders.

4.3. Despite the challenges of the past two years, feedback from our staff also reinforced our values-focused culture. For example, questions that assessed if "we are compassionate and inclusive" ranked UHSussex as top performing. This is really encouraging, and demonstrates how we support one another, particularly in the difficult times.

4.4. Our values of compassion, communication, teamwork, respect, professionalism and inclusion are also self-evident in the many ways our staff make headline outside of work. For example, scores of UHSussex staff volunteered to run the Brighton Marathon Medical Centre to support the 9,000 runners pounding the streets of the city on 10 April. It was my first ever experience of the event and as I talked to the many medical volunteers that we provide, along with others from the medical school and St John Ambulance, I realised this event would not go ahead without their contribution.

4.5. In recent weeks, our people have also been making headlines all over the world. For example, the Gambia has become the first country in the world to have a nationwide virtual fracture clinic, using a system first developed by UHSussex doctors. Meanwhile, A&E nurse Christopher Smith is part of a team aiming to become the first people to climb and ski the tallest mountain on each of the seven continents to raise awareness of climate change. And intensive care consultant Mike Margason is taking part in the Patrouille des Glaciers Route, an international ski-mountaineering challenge to raise awareness and funds for the support of critical care nurses, doctors and others traumatised by their experiences of Covid.

4.6. Our staff are our greatest asset and I cannot overstate how hard they have worked throughout the pandemic under unprecedented and extremely testing circumstances. The publication *of Our Covid Story* at www.uhsussexcovidstory.org.uk on the National Day of Reflection (23 March) helped demonstrate through first-hand accounts from our staff how impactful, and sometimes traumatising the Covid health emergency has proved for our staff. I would encourage everyone to take some time to read their reflections and experience the feelings they have expressed through art, poetry, and music.

4.7. You can also watch a recording of a complimentary public event we hosted on 26 April when deputy chief medical officer Dr Rob Haigh shared his Covid story and took the time to answer questions from our members and supporters about how our hospitals and staff have risen to the challenge of the pandemic.

5. SYSTEMS & PARTNERSHIPS

5.1. Our priority for Systems and Partnerships is to reduce waiting times for patients, both for urgent care and planned procedures. The pause in elective procedures at the onset of the pandemic in 2020 has caused waiting lists to grow nationwide to unacceptable lengths. Locally, we are doing

all we can to increase the number of patients we are seeing, despite ongoing and important infection control protocols that reduce capacity at the very time we want to treat more people.

5.2. I wish to thank all our staff working additional hours and helping us innovate and provide services in new ways to address our waiting lists. Throughout the pandemic, we have continued to see patients with the most urgent needs, such as new cancer referrals and those requiring urgent procedures, in a timely way. I am pleased to report that we have also made excellent progress seeing patients who have been waiting the longest, but we remain acutely aware that many more are waiting to see us.

5.3. Addressing waiting lists will be a long-term priority for the whole NHS and unfortunately it will take a number of years to return to pre-pandemic levels. This is why it is great to see our new hospital development in Brighton making such good progress towards its opening this time next year. More than 40 wards and departments will transfer into the 3Ts Stage One building, significantly increasing our capacity at a crucial time. I was fortunate to visit some of the completed areas recently and they are simply first-class. I know our ward patients, in particular, will enjoy the extraordinary sea views from the Kemptown location.

5.4. As the opening draws ever nearer, we are asking people to help inform what shops and food and drink facilities they would like to see in the new hospital building. To complete our short survey, and to find out more about 3Ts, please visit www.uhsussex.nhs.uk/about/hospital-redevelopment/.

6. SUSTAINABILITY

6.1. Our Patient First financial goal was to break even at the end of 2021/22 and I am delighted to confirm we exceeded this by delivering a small surplus. This was helped by our successful recovery of patient services that helped us access additional national recovery fund money, that supported our overall financial position.

6.2. In terms of environmental sustainability and following the publication of our UHSussex Patient First, Planet First green plan in February, our carbon reduction programme is gathering pace. Ten workstreams have been established to focus on areas such as decarbonising our supply cain, reducing energy and water consumption, promoting sustainable travel and reducing our use resources, including medical gases that exacerbate climate change.

6.3. In March, we focused on green travel and highlighted the many initiatives and incentive schemes we support that encourage our staff to walk, cycle or use public transport to get to and from work. These include discounted bicycle, e-bike and electric vehicles, public transport discounts and investment in new facilities for cyclists, such as secure storage areas. We are also supporting the development of the Sussex Health and Care Partnership green plan and by working in step with our all our partners locally we can prevent thousands of tonnes of harmful emissions in Sussex and help improve the health and environment of everyone living here.

7. INTERESTED TO FIND OUT MORE?

7.1. 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 us @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 your 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. You can be part of the UHSussex family too. Visit www.uhsussex.nhs.uk/join-us - thank you.

8. RECOMMENDATIONS

8.1. The Board is asked to **NOTE** the Chief Executive Report for May 2022.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	6-10	**Meeting:**	Trust Board	**Meeting Date:**	05 May 2022
Report Title:	**Integrated Performance Report – Quarter 4 2021/22**				
Sponsoring Executive Directors:	Andy Heeps, Charlotte Hopkins, Maggie Davies, Ellis Pullinger, Karen Geoghegan and David Grantham				
Author(s):	Andy Heeps, Charlotte Hopkins, Maggie Davies, Ellis Pullinger, Karen Geoghegan and David Grantham				
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:

Executive Summary:

Attached is the Trust's integrated performance report for quarter 4 of 2021/22.

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.

NHS
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NHS Foundation Trust

Integrated Performance Report

May 2022

Contents

University Hospitals Sussex
NHS Foundation Trust

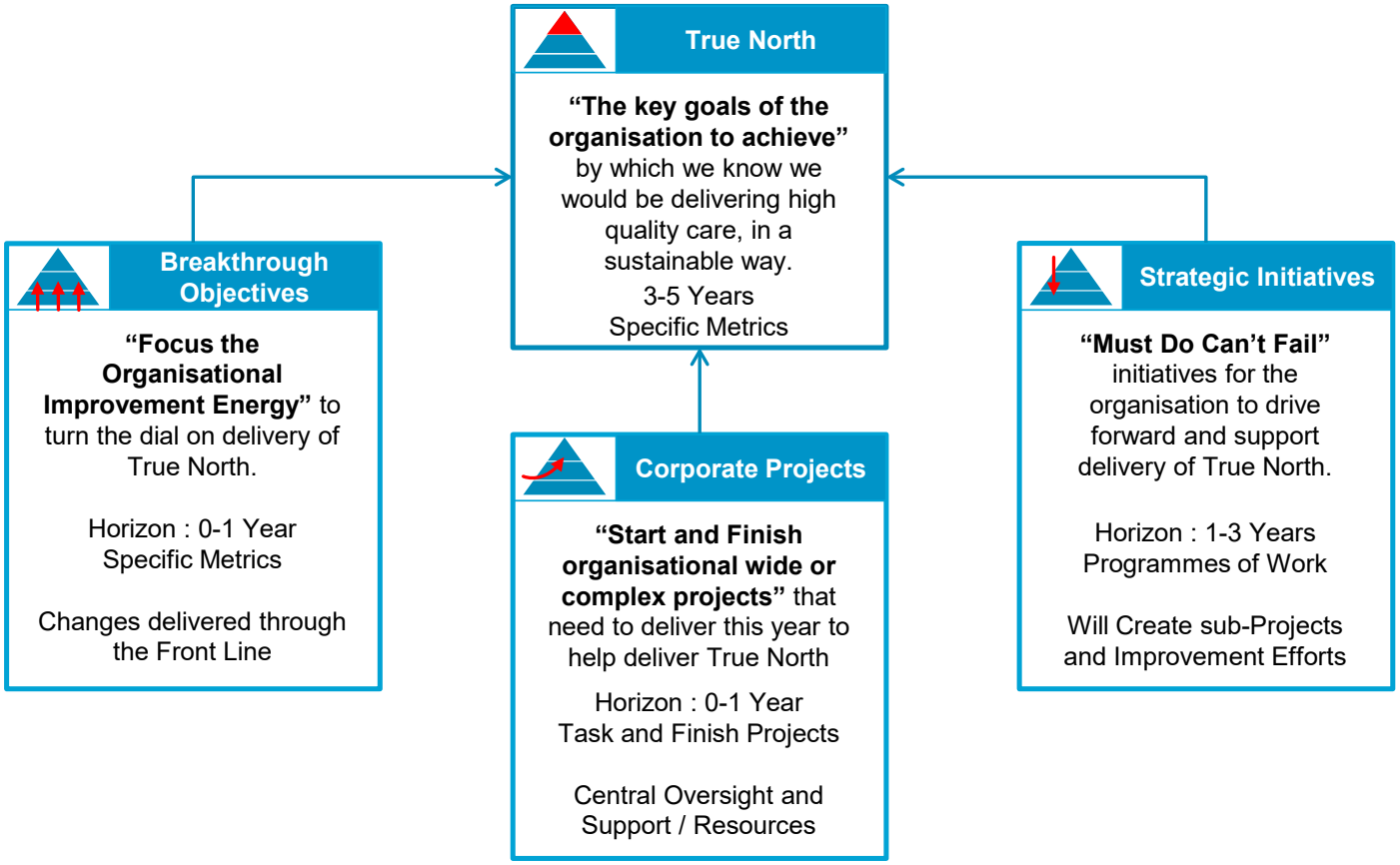
Structure of the report

Patient First Strategy Deployment Framework
Patient First True Norths
Patient First Reports

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

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 have 95% or more of patients rating FFT surveys as Very Good or Good

Sustainability

Financial Sustainability:

To deliver the Trust's financial plan

People

Staff Engagement:

To be within the top quartile of acute Trusts for the National staff engagement score

Quality

Mortality:
To achieve a 10% reduction in the crude mortality rate

Harm:
To reduce the number of all harms categorised as 'low' or 'moderate' by 10%

Systems & Partnerships

Planned Care:
To have no patients waiting in excess of 40 weeks on an RTT pathway to be seen and treated

Emergency Care:
To achieve 95% of patients are treated within 4 hours in Emergency Care services

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Patient

Integrated Performance Report Section

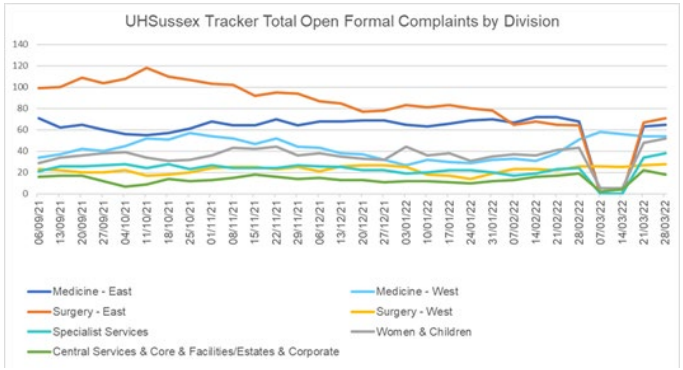
Patient: Key performance headlines

University Hospitals Sussex NHS Foundation Trust

- Based on FFT data, the significant majority of patients are satisfied that they have a good or better experience, however the average across all touchpoints is lower than the trust target of 95%, and satisfaction levels are reducing
- Satisfaction is on par with national average for maternity and inpatient services, above average for outpatients but lower for ED. In March 2022 the lowest satisfaction across all trust sites was SRH ED.
- A new survey provider for all sites is being procured and services will be encouraged to increase survey uptake.
- There are increased numbers of concerns -an increase of 57% since Q2. Whilst numbers of open complaints have reduced overall, with surgery open complaints cases halved since October, to achieve this and ensure quality responses, timescales have extended resulting in reduced compliance with the local target of 65% of cases being resolved in 25 days.
- As such, the data for quarter 4 presents a deteriorating 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.
- Insights: Themes in negative patient feedback continue to relate to waiting (on site and for treatment), clinical treatment, communication and staff behaviours. Waiting is the priority change programme under the breakthrough objective programme.

Complaints	Currently open 7/4/22		New Jan 22		New Feb 22		New Mar 22		Closed in 25 days (target 65%)*	
	W	E	W	E	W	E	W	E	W	E
	100	232	41	77	52	67	42	89	74%	36%

PALS	New Jan 22		New Feb 22		New Mar 22		New Total UHS for Q4	Compliments	
	W	E	W	E	W	E		W	E
	385	460	474	465	583	535	2,902	201	308



FFT	ED response rates*		ED satisfaction rates*		Inpatient response rates*		Inpatient satisfaction*		Maternity response rates*		Maternity satisfaction*		Outpatient: response rates*		Outpatient: satisfaction*	
	W	E	W	E	W	E	W	E	W	E	W	E	W	E	W	E
	11.6%	18.1%	74.4%	79.3%	11.3%	25.0%	97.8%	91.3%	19.7%	24.2%	91.7%	94.4%	NA	NA	98.5%	92.4%
Nat Ave 01/22			81%				94%				94%				93%	

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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 %.

2) Safer staffing

2) Infection Prevention and Control

HEDLines Indicator Dashboard: March2022 (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
HSMR (12 mth rolling) HES Inpatients (Mar 2022)	92.83 (Feb 2021 - Jan 2022)	93.64 (Jan 2021 - Dec 2021)	-0.81 ↓	92.59	99.40	Very low (>99.8%)
HSMR (monthly) HES Inpatients (Mar 2022)	94.60 (Jan 2022)	96.94 (Dec 2021)	-2.34 ↓	112.21	99.95	Within expected range
HSMR - Weekday mortality (12 mth rolling) HES Inpatients (Mar 2022)	92.91 (Feb 2021 - Jan 2022)	93.82 (Jan 2021 - Dec 2021)	-0.91 ↓	91.02	97.76	Very low (>99.8%)
HSMR - Weekend mortality (12 mth rolling) HES Inpatients (Mar 2022)	92.58 (Feb 2021 - Jan 2022)	93.13 (Jan 2021 - Dec 2021)	-0.55 ↓	97.14	104.37	Low (>95%)
HSMR - Without adjustment for specialist palliative care (12 mth rolling) HES Inpatients (Mar 2022)	101.47 (Feb 2021 - Jan 2022)	103.45 (Jan 2021 - Dec 2021)	-1.98 ↓	95.73	99.26	Within expected range
SHMI (12 mth rolling) HES Inpatients, HES-ONS Linked Mortality Datasets (Mar 2022)	109.76 (Jan 2021 - Dec 2021)	109.07 (Dec 2020 - Nov 2021)	0.69 ↑	98.53	101.77	Within expected range
SHMI (monthly) HES Inpatients, HES-ONS Linked Mortality Datasets (Mar 2022)	110.89 (Dec 2021)	117.39 (Nov 2021)	-6.50 ↓	102.09	101.48	Within expected range
Crude in-hospital mortality rate (12 mth rolling) HES Inpatients and HES-ONS Linked Mortality Datasets (Mar 2022)	1.45% (Feb 2021 - Jan 2022)	1.54% (Jan 2021 - Dec 2021)	-0.09 ↓	1.38%	1.33%	
Crude mortality rate (12 mth rolling) HES Inpatients and HES-ONS Linked Mortality Datasets (Mar 2022)	3.04% (Feb 2021 - Jan 2022)	3.28% (Jan 2021 - Dec 2021)	-0.24 ↓	2.91%	2.78%	
Crude mortality rate (monthly) HES Inpatients and HES-ONS Linked Mortality Datasets (Mar 2022)	2.27% (Jan 2022)	2.91% (Dec 2021)	-0.64 ↓	2.24%	2.14%	

Mortality Metrics

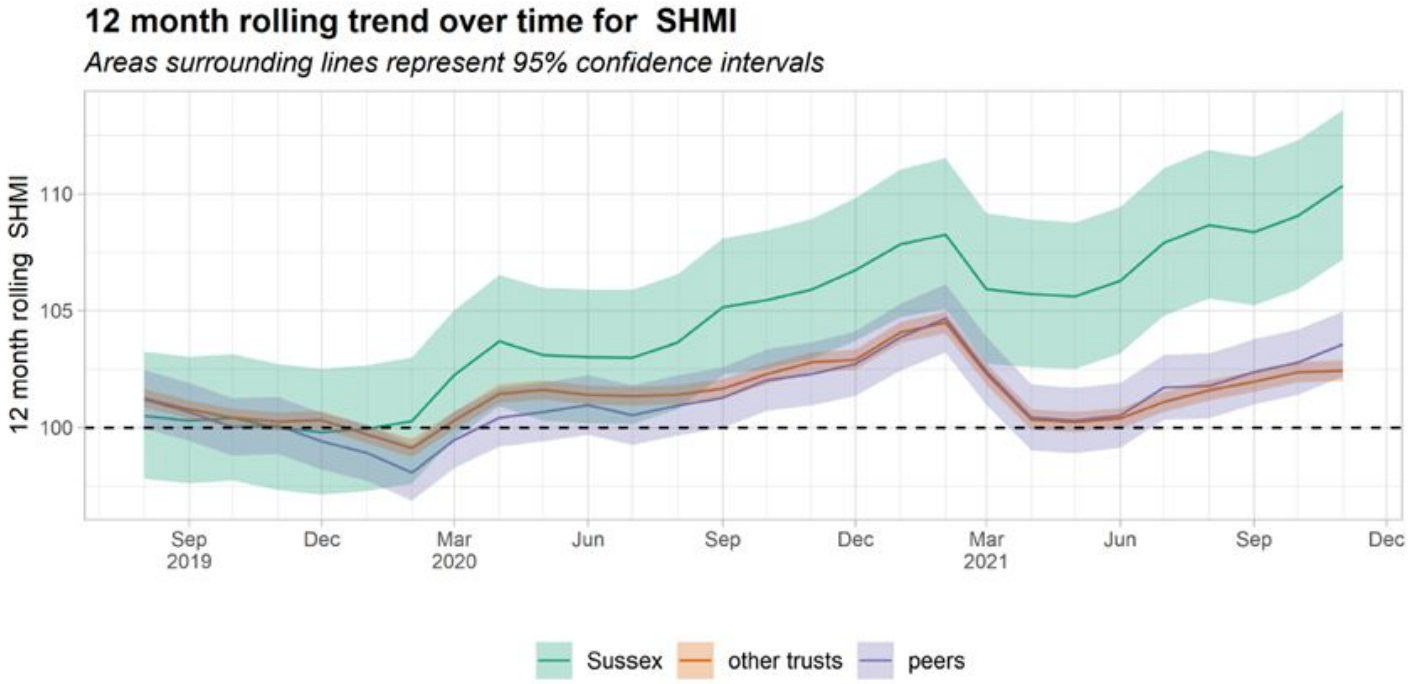
University Hospitals Sussex
NHS Foundation Trust

The UHSx crude 12 month rolling mortality rate is 3.04% and in month for March was 3.51%. These are within the confidence limits and below the previous months values.

The UHSx rolling 12 month HSMR is 92.83. This is in the ‘very low’ range with an in month value for January of 94.6 that lies in the ‘as expected’ range.

SHMI

University Hospitals Sussex
NHS Foundation Trust



The UHSx 12 month rolling SHMI including December 2021 is 109.76 and in the ‘as expected’ range although there is a rising trend and the SHMI is higher than other trusts and the peer group.

SHMI

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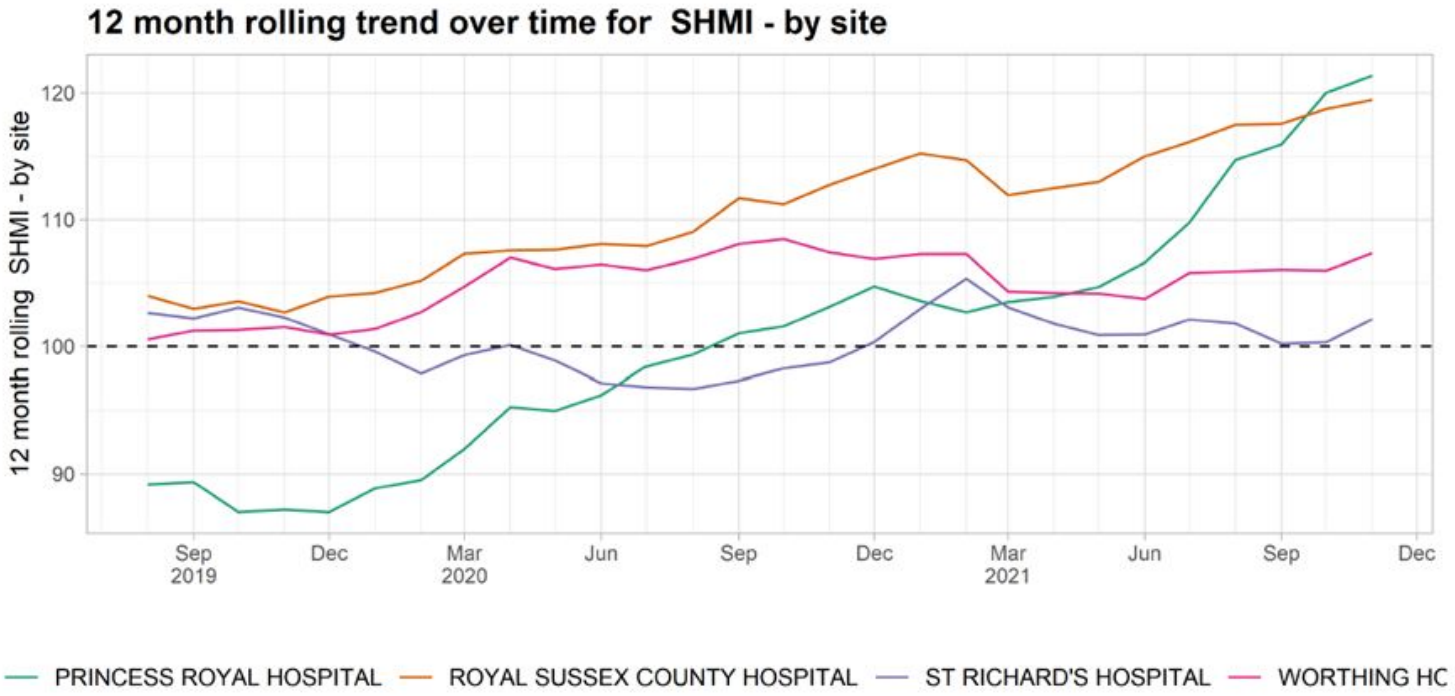
NHS Foundation Trust



There is significant variation for SHMI between the 4 sites. The highest values are seen on the RSCH and PRH sites with a high SHMI for deaths within 30 days of discharge on the PRH site. However the lower numbers of deaths on the PRH site can be a cause of significant statistical variation.

Depth of Coding

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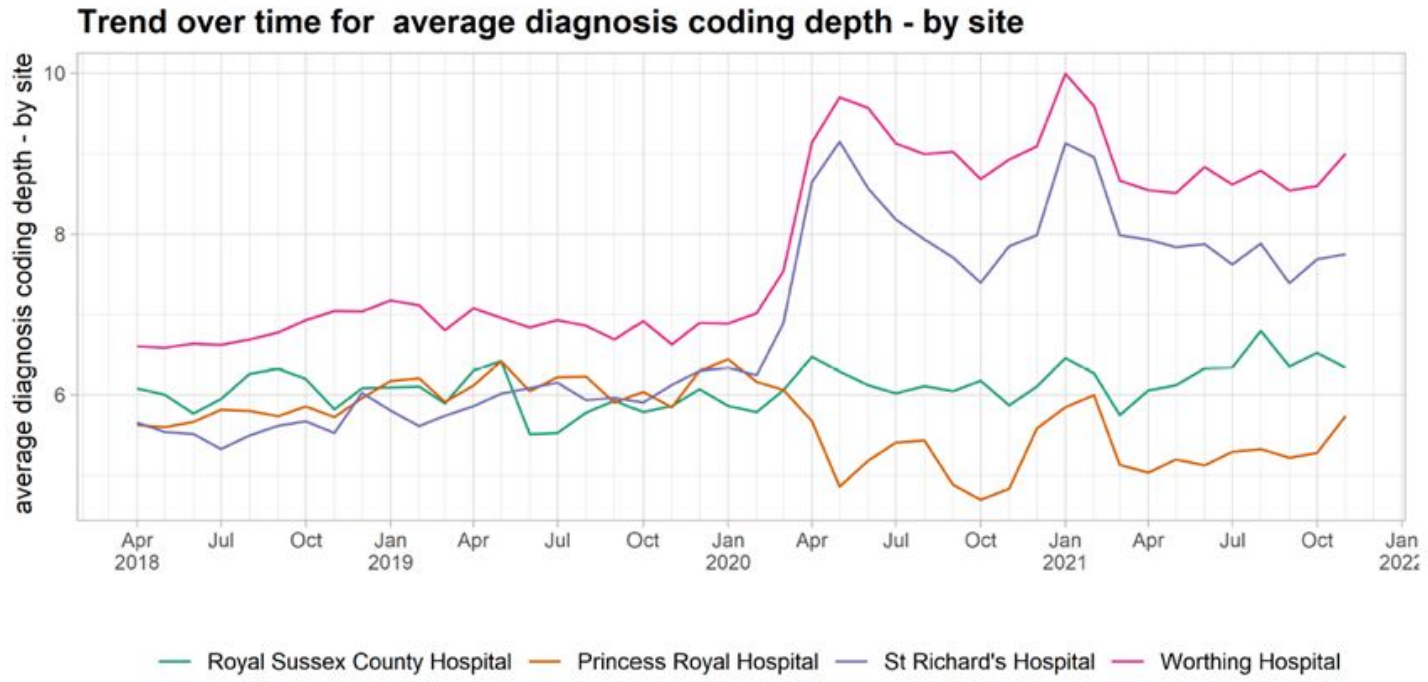


The drivers for the rising SHMI have been investigated with the support of HED and concluded that coding depth is a major driver. There are significant differences in coding depth between sites. A case note audit has corroborated the findings of the analysis.

Action Plan

University Hospitals Sussex NHS Foundation Trust

Action Plan	Lead	For completion	Status
S/L working group for diagnostics	CMO	March 2022	Completed
Regular analytical reporting from HED	CMO	Feb	Completed
Monthly coding & mortality dashboard	Medical Director	Feb	Completed
Review of pneumonia, sepsis and palliative care coding	Medical Director	March	Completed
Audit of OOH PRH deaths	CoS Medicine (E)	April	Completed
Coding & mortality summit	CMO	May	
Review of coding QA	Medical Director	May	
Establish monthly coding improvement group	Medical Director	May	

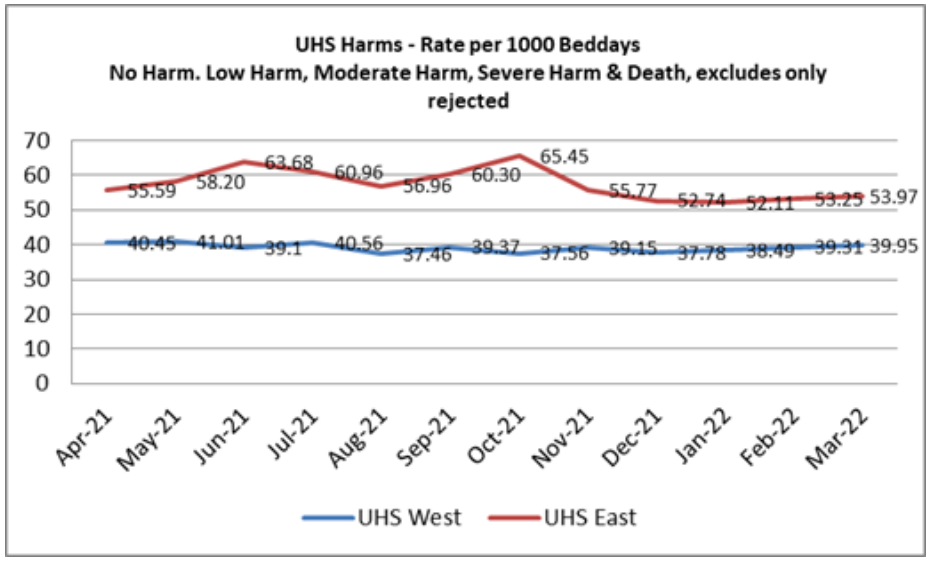
Patient Safety

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 10%.

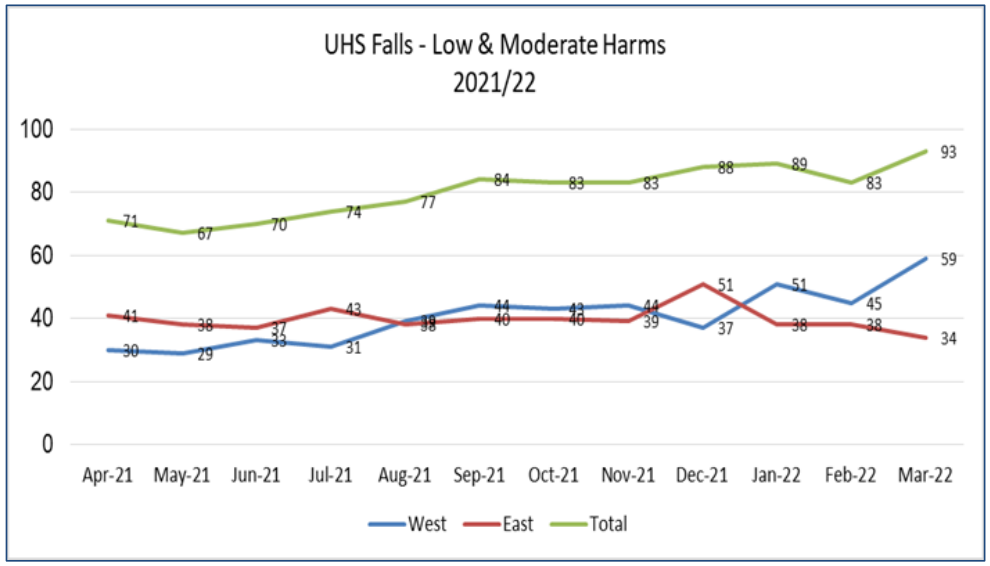
The reduction per 1000 occupied bed days is detailed in Figure 1.



Site variables are due to

- Differences in reporting culture
- Incidents versus 'issues'
- Staffing capacity to report
- Multiple 'categories' on incident reporting system leading to double reporting/duplication
- Demographic IPC reporting
- Outdated version of DATIX – now implementing RLDATIX IQ (Go Live Q1)

Avoidable Harm– Key Metrics: Falls



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West: 223 reported falls; falls rate per 1000 bed day March 2022 = 7.4; (rolling 12 month average 5.31)Trust Rate 6.69

East: 128 reported falls; falls rate per 1000 bed days March 2022 = 5.73; (rolling 12 month average 4.08) Trust Rate 6.69

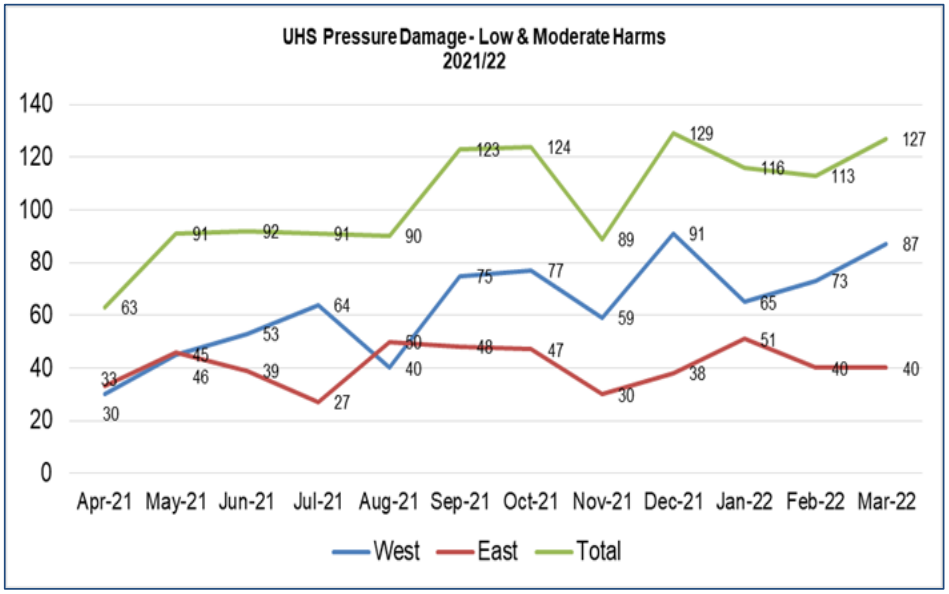
Performance:

Increased number of patients medically fit for discharge
Upward trend (declining picture) continues in overall reported falls and falls rate across sites. West continuing to experience significant challenge.
Admission wards, particularly Worthing EF continue to be areas with highest falls – with flow and acuity impacting greatly.
Increase in harm levels this month across the Trust:
Staffing pressures continue to be very challenged, with additional ward areas open and significant COVID related staff sickness.
High number of red (COVID) areas. The requirement for COVID precautions has led to challenges with completing required assessments and maintaining Baywatch.
Complexity and frailty of pts is of significant note.
Post Falls Care is being closely monitored as has been identified as key area of risk. (post falls observations, delay in medical review and radiology noted in reviews completed this month).

Improvement Actions:

After Action Reviews (AAR) undertaken for all serious falls. Aligned weekly reporting and cross Trust learning now shared at monthly Harm Free Care Group.
Trust A3 updated – Driver wards confirmed to date include: Buck, Erringham, Birdham, Chilgrove, AAU level 5 Level 11 west, Twineham – HFC nurse weekly standard work commencing to support these teams.
Radiology improvement group in west- there is ongoing challenge with prioritising inpatient falls for scans – review of fracture neck of femur pathway underway. Audit of east radiology wait times undertaken - to be reported in April.
Work underway to align Post Falls care protocols - to be presented to next HFC Group for approval.
Environment audit tool now finalised for use (to prioritise escalation areas), 'do not use in shower' stickers for bathroom equipment cascaded
New HCA 'prepare to care' programme in East (aligning with existing programme in West)

Avoidable Harm– Key Metrics: Pressure Damage



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STOP THE PRESSURE.

West: Pressure Ulcer Rate in March 2022= 1.56 patients with Cat 2 and above ulcers per 1000 bed days, rolling average = 1.22 (Trust rate = 1.22)

East: Pressure Ulcer Rate in March 2022= 2.02 patients with Cat 2 and above ulcers per 1000 bed days, rolling average = 1.62 (Trust Rate = 1.22)

Performance:

- Continued high number of patients with reported hospital acquired Cat 2 ulcers, reflecting the ongoing pressures and presenting frailty of patients. Rate has reduced (improved) compared to February.
- Whilst number of reported pts with cat 2 and above ulcers is higher in west, the rate is much lower than the east due to west having greater occupied bed days.
- TV team cover remains a significant challenge.
- Sacral and moisture related ulcers a key theme.
- Heel deep tissue injuries also remains an area of focus.
- High number of reported 'present on admission'(POA) ulcers in west reflects the impact of system pressures on care provision at home and waits for ambulance transfer – leading to underlying skin damage on arrival with higher risk of further deterioration when in hospital.
- POA reporting in west is double that of east with cat 1 and moisture damage also reported in higher numbers.
- East underreporting Cat 1- will be resolved with new RL DATIX IQ incident reporting standards.

Improvement Actions:

- Unified Pressure ulcer policy in development to provide clarity and consistency of reporting and investigation approaches across sites. Work to understand differences in reporting activity underway
- Full review and panel process for severe ulcers, aligned weekly reporting and cross Trust learning now shared at monthly Harm Free Care Group
- Breakthrough wards now confirmed as: Twineham, Level 9A, Castle, Ashling, Boxgrove.
- ITU (SRH) undertaking moisture management improvement project
- TVNs implementing ward based bitesize teaching programme in medicine (east) and targeted wards (west). MASD and heel assessment key topics. HCA *Prepare to Care* programmes aligned.
- Additional seat cushions and APMs in place to ensure adequate cover for escalation areas that have been opened.
- Successful Moisture Associated Skin Damage (MASD) events in March. MASD pathways updated and launched in month.
- Trial of non – concordance tool continues.
- Roll out of Evolve photography project(West) progressing

Incident Management and Learning

Improvement trajectory:
Investigation, review and closure of all no/low harm incidents (within 20 working days) March= 80% reduction in open incidents

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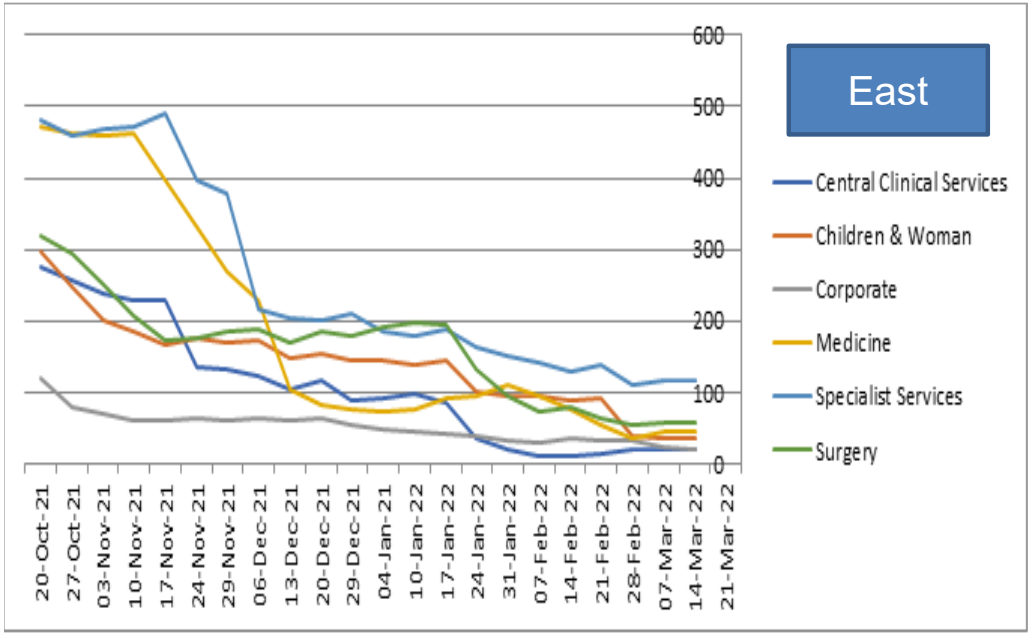
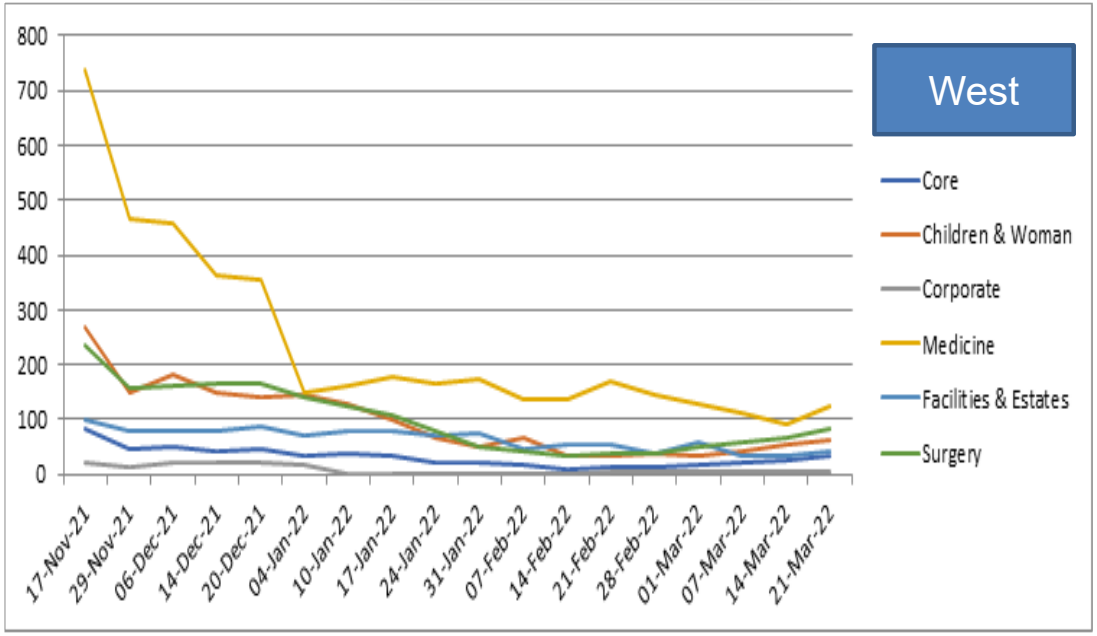
HPA
HARMED PATIENTS ALLIANCE

- Staff feedback
- Thematic learning via governance forums and safety huddles
- Patient Story (working with patients/families)
- Harmed Patient Pathway/Standards (AvMA) working with 3 families
- Regulation 20 Duty of Candour 100% compliance Q3





Improvement actions (harm reduction)

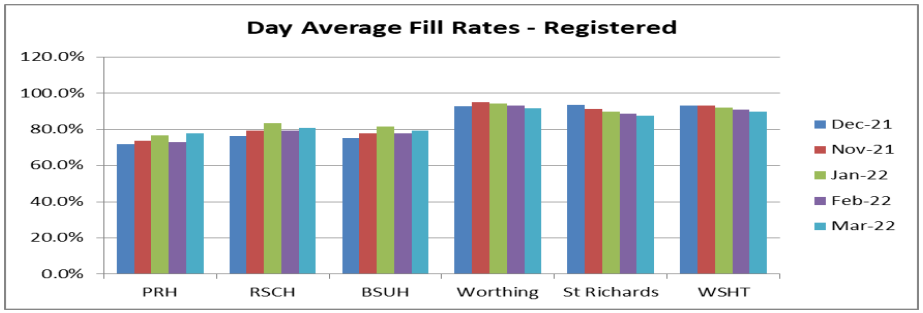
University Hospitals Sussex NHS Foundation Trust

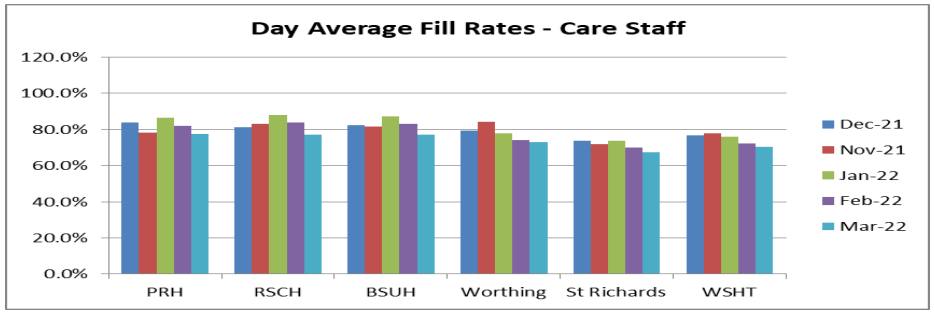
- Analysis of all reported patient safety incidents (site, division, service, ward) continues month on month.
- Implementing RLDATIX IQ risk and incident management and assurance system Q1/2.
- Targeted focus on reduction of low/moderate harms (falls and pressure damage) Falls and pressure damage are noted as top 2 themes in reported harms (moderate/low).
- Post pandemic, learning identified that factors such advanced age and frailty, sex, ethnicity and weight are strong predictors of adverse outcomes, harms and mortality for older people hospitalised because of acute illness.
- 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.

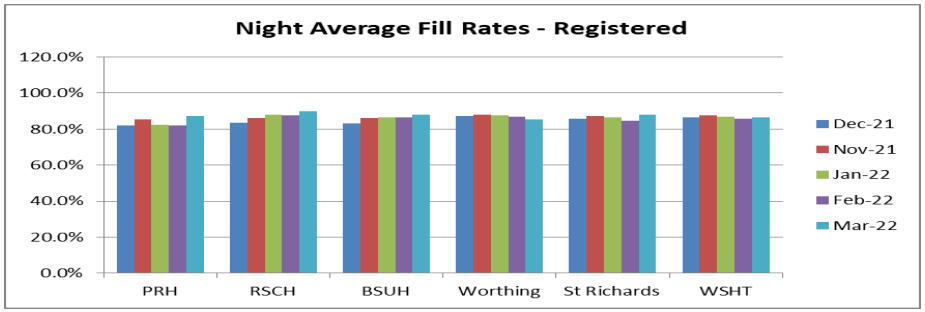
Safer Staffing

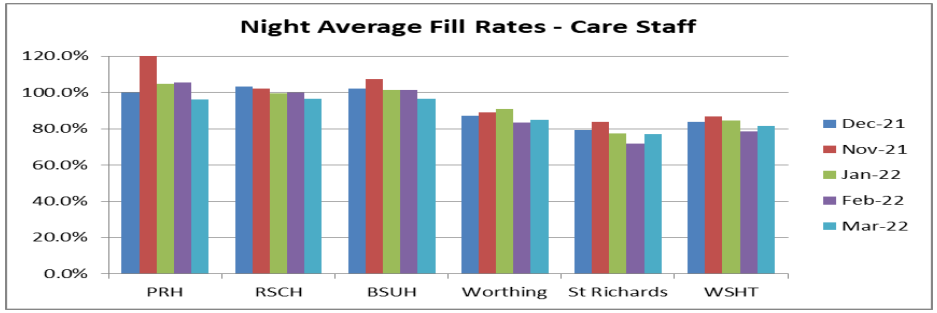
- The data indicates that there has been a decrease in the overall fill rates for both Registered and Unregistered staff across UHSussex during February 2022.
- The high number of staff absence, particularly COVID -19 related sickness have impacted our fill rates. In addition, the Trust had to open additional areas to support the increasing demand for hospital beds.
- 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.
- The Trust has seen an increase in bank shifts uptake following the introduction of the bonus scheme in December 2021, the challenge remained to align with the high levels of staff sickness.
- Although the fill rates have decreased during February 2021, the Trust overall Care Hours Per Patient Day (CHPPD) is 8.0 which is consistent with the national median.
- Recruitment is on going on a regular basis both domestically and internationally.

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



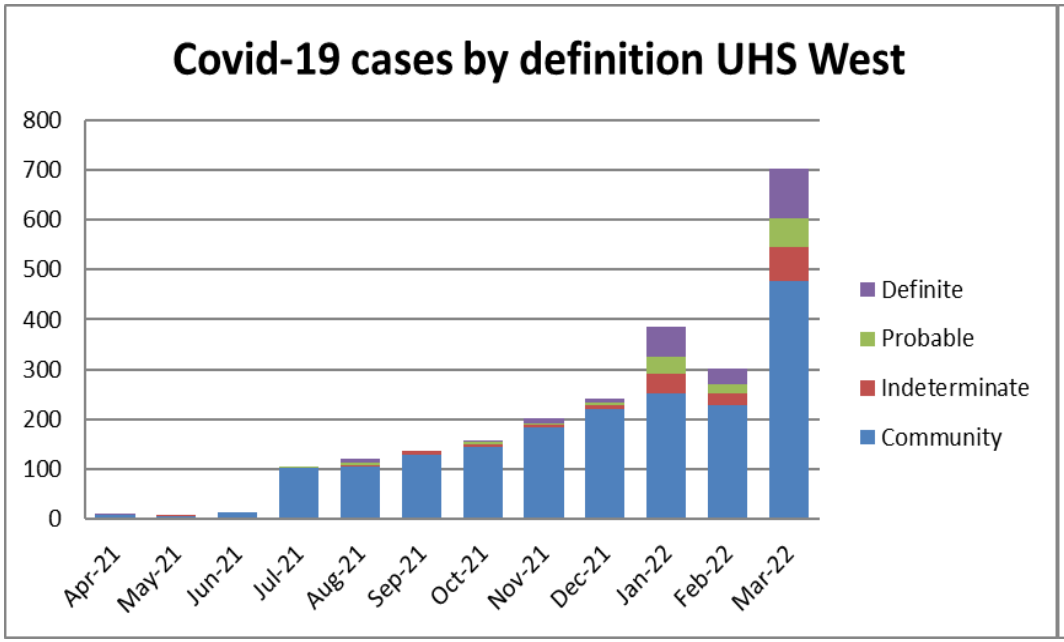


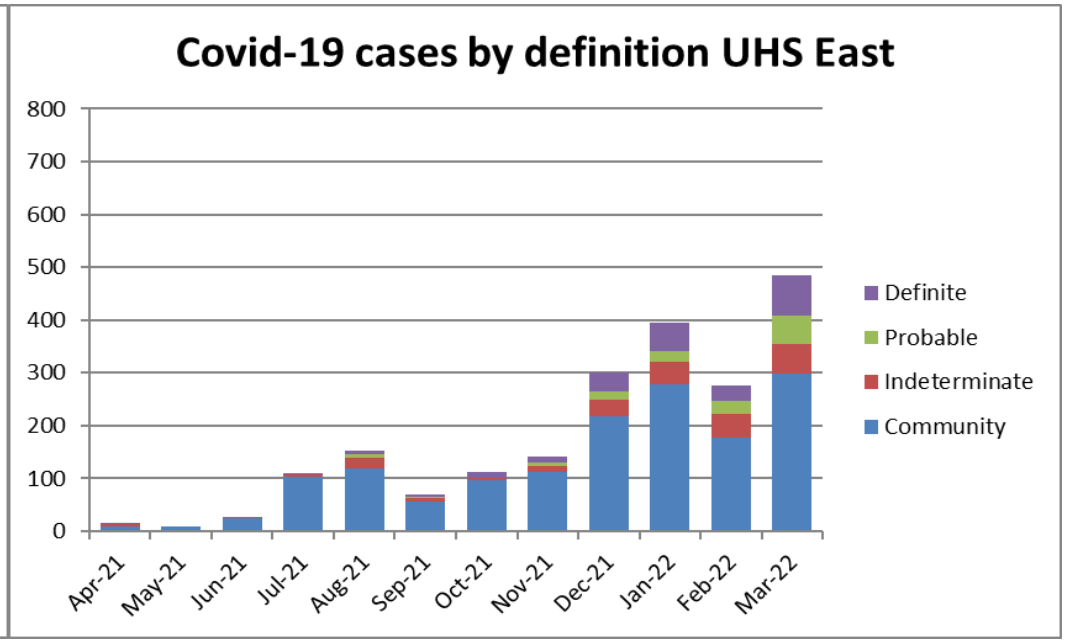




	DAY										NIGHT									
	Fill Rate - Registered					Fill Rate - Care Staff					Fill Rate - Registered					Fill Rate - Care Staff				
	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
PRH	73.9%	72.0%	76.7%	73.1%	77.8%	78.2%	84.0%	86.4%	82.1%	77.3%	85.2%	81.9%	82.4%	81.9%	87.3%	121.1%	99.9%	104.8%	105.6%	96.0%
RSCH	79.2%	76.5%	83.3%	79.2%	81.0%	83.2%	81.4%	88.0%	83.7%	77.1%	86.2%	83.4%	87.9%	87.7%	89.9%	102.3%	103.4%	99.6%	99.8%	96.6%
BSUH	***77.7%***	***75.3%***	***81.4%***	***77.8%***	***79.4%***	***81.5%***	***82.2%***	***87.4%***	***83.2%***	***77.0%***	***85.9%***	***83.0%***	***86.4%***	***86.4%***	***87.9%***	***107.6%***	***102.3%***	***101.4%***	***101.4%***	***96.6%***
Worthing	95.1%	93.0%	94.2%	93.2%	91.8%	84.4%	79.5%	77.9%	74.2%	73.0%	88.1%	87.3%	87.5%	87.0%	85.4%	89.2%	87.4%	91.0%	83.5%	85.0%
St Richards	91.4%	93.5%	89.9%	88.9%	87.5%	71.9%	73.5%	73.6%	70.2%	67.5%	87.3%	85.6%	86.3%	84.6%	88.1%	84.0%	79.5%	77.3%	72.0%	77.3%
WSHT	***93.2%***	***93.2%***	***92.0%***	***91.0%***	***89.7%***	***78.0%***	***76.7%***	***75.8%***	***72.2%***	***70.5%***	***87.7%***	***86.5%***	***86.9%***	***85.8%***	***86.6%***	***86.8%***	***83.9%***	***84.7%***	***78.5%***	***81.8%***
UHSussex	**85.0%**	**81.9%**	**85.6%**	**82.7%**	**83.7%**	**79.7%**	**79.8%**	**81.6%**	**78.3%**	**73.8%**	**86.7%**	**84.3%**	**86.2%**	**85.6%**	**87.4%**	**97.3%**	**94.5%**	**93.9%**	**91.4%**	**89.8%**

Infection Prevention and Control – COVID-19





Infection Prevention and Control COVID - 19

- The Omicron variant which caused cases to soar nationally has continued and while case numbers dipped towards the end of January, they before increased again with the rise of the Omicron BA.2 variant.
- Omicron continues to be (for most vaccinated people) a milder disease and has not translated into as many ITU admissions or deaths. However we have seen a small increase in patients requiring ITU admission.
- Omicron is challenging as many people remain asymptomatic. In some cases the index cannot be identified immediately; patients are screened on admission and at days 3, 5 and 7, but by the time the result is known they may have exposed other patients.
- There have been a total of 106 outbreaks since October 2021
- 48 outbreaks in the East, of which 33 have been since January 2022 (Omicron)
- 58 outbreaks on the West, with 52 since January 2022.
- Numbers peaked in March 2022 with Omicron BA.2
- There has been significant bed pressures caused by the need to isolate cohorts of patients if they are exposed to another patient who tests positive.
- Most cases originated from the community

Infection Prevention and Control COVID - 19

University Hospitals Sussex NHS Foundation Trust

- Visiting has been maintained as much possible
- Changes in national guidelines were made in early January 2022 to reduce isolation times for positive patients.
- UHS has also reduced isolation time for exposed patients after wider discussion with colleagues in other hospitals in the South East.
- Staff are encouraged to undertake twice weekly lateral flow testing
- The removal of the national mandate for masks has resulted in some challenging behaviours from visitors to the site who do not appreciate the need for continued mask adherence in the hospital setting.
- It is recognised that airborne transmission plays a role in infection. The trust has several areas of old estate which have poor ventilation; and while efforts have been made to avoid using these areas, this is not always possible. Mitigation has been attempted with the use of air scrubbing devices, which HEPA filter the air to reduce airborne transmission.
- The IPC team have been working closely with Estates to secure machines and advise correct placement to support with ventilation issues in our older buildings.

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People

Integrated Performance Report Section

Focus of this section

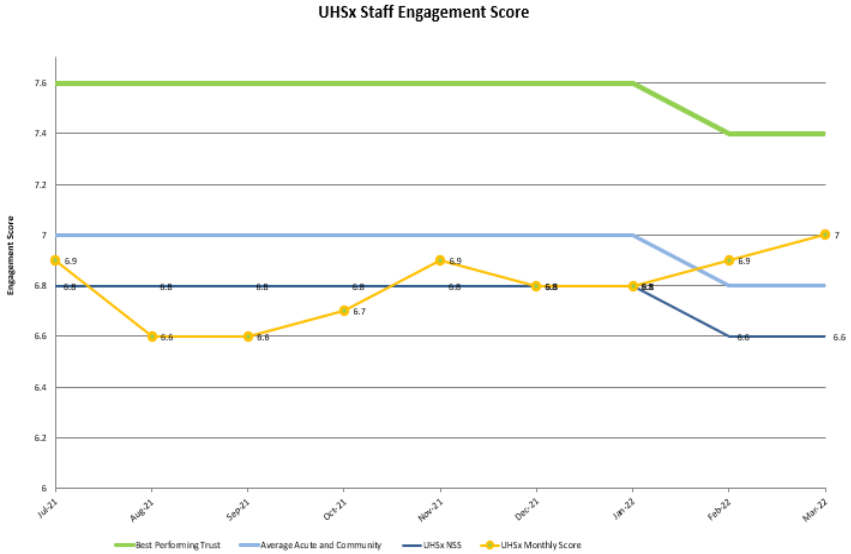
University Hospitals Sussex NHS Foundation Trust

- True North - Performance against Staff Engagement Target
- Breakthrough Objective – Becoming the best place to work
- People Strategic Initiative – Leadership, Culture, Development
- People Corporate Project – Electronic Workforce Deployment
- People Key Performance Indicators – Data 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 (engagement measures and staff survey results):



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.1	5.6	6.5	5.7	5.0	5.8	6.5	6.6	5.5
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	8,050	8,023	7,970	8,006	7,564	7,969	8,025	8,057	8,058

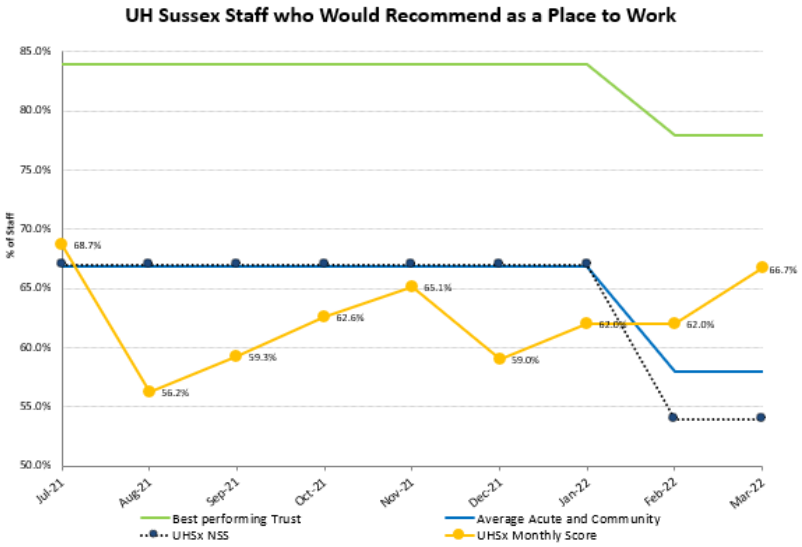
The following pages summarise progress against the People Breakthrough Objective, Strategic Initiative and Corporate Project - which are all intended to improve our staff engagement score. Delivery assurance of our plans is reported through our People Committee and the SDR process.

People Breakthrough Objective

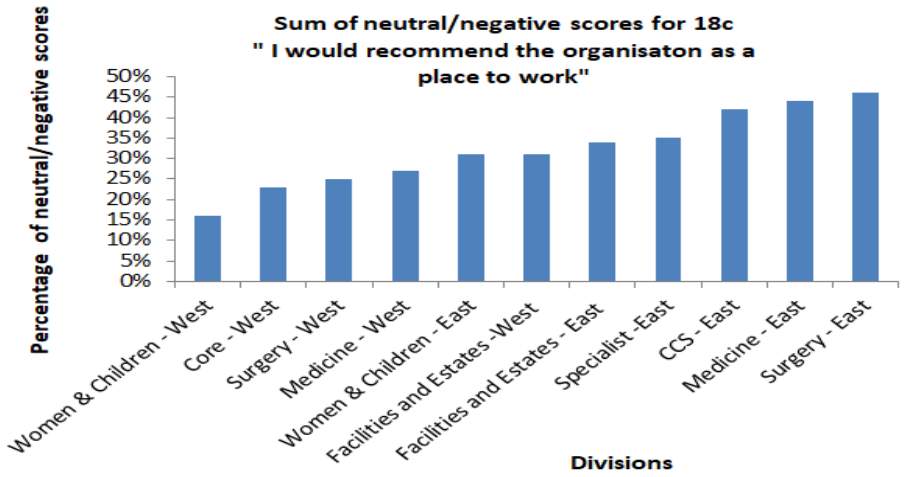
University Hospitals Sussex NHS Foundation Trust

Working with Divisions using PFIS to increase staff recommending the organisation as a place to work

Historic Trend Data / Current Status



Stratified Data



Work is taking place in all Divisions involving staff and activities will be reviewed and informed by lastest staff survey results and reviewed at the People Committee. Work will transition to the new Divisions under the Clinical Operating Model.

People Strategic Initiative

University Hospitals Sussex NHS Foundation Trust

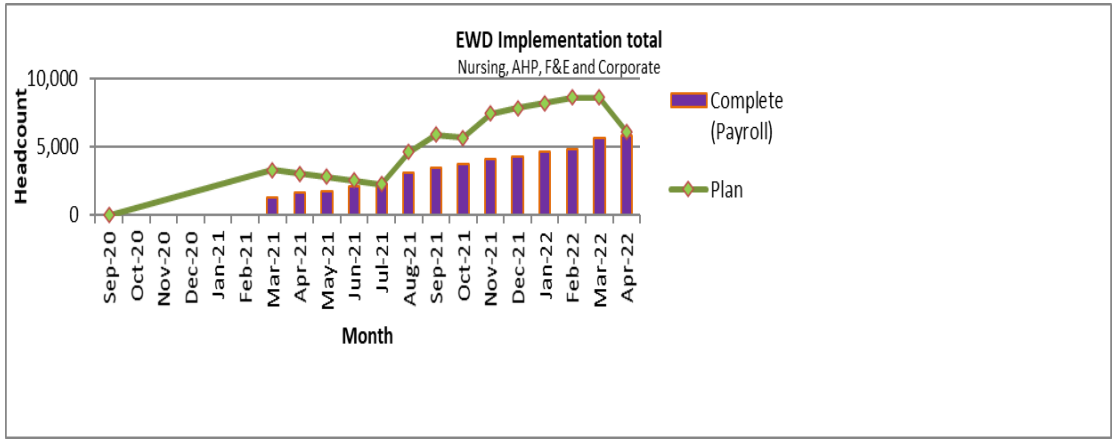
April 2022 Summary Position:

- The SI has been developed under three key workstreams, focussing on long-term strategic and OD focused pieces of work, requiring delivery over more than 1 year. These workstreams are (a) Health and Wellbeing, (b) Leadership Skills and (c) Integrated Education.
- Project charters have been developed for each of these workstreams but continue to be adjusted with lead SROs through a series of meetings, which will include agreement of key deliverables and top level timelines to ensure the detailed plans to drive forward these workstreams in 22-23. These will be informed by most recent staff survey results. Steering groups for each have been established:
  - Health and wellbeing steering group
  - Education Board (Integrated Education steering group)
  - Leadership development steering group
- There is ongoing discussion on an EDI specific fourth workstream working with the Diversity Matters steering group and others.

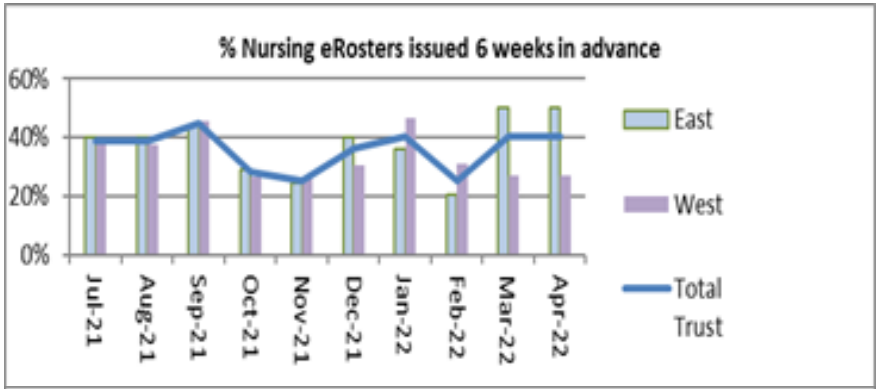
RAG	Workstream	Comments/Key Risks
	Governance	Continued refresh of programme governance underway, including working with Exec Lead and SROs re the setting of workstream deliverables through individual workstream charters. SROs currently reviewing charters for key deliverables and top level timelines. A programme risk register has been completed to identify any programme risks. The Leadership Steering group is now established to ensure governance around this workstream. The H&W steering group is up and running and the Education Board. Key risks are the organisational capacity to deliver the LCD programme alongside business as usual pressures and staff sickness.
	Leadership Skills	**Workstream Lead – Nick Groves** Key actions: • 'Voice of the Customer' survey of all staff 8a and above required to identify the training leaders would like to see in a leadership curriculum completed and reported. • Responses with themes identified informing programme of work and future leadership offerings. Discussed at Leadership Steering Group alongside priorities for action. • Individual workstream charter to be reviewed and ratified to support onward development of project plans. • Steering Group meetings arranged for 2022. • Leadership programmes and commissioning scoped.
	Health & Wellbeing	**Workstream Lead – Abbi Denyer** • Individual workstream charter being reviewed. • Improved use of data to understand pressures and areas for improvement, to establish an evidence base to take forward initiatives and be able to measure improvement outcomes. Data gathered for H&W strategy review. • Focus on the need to raise awareness and responsibility for self and others health and wellbeing • Continue to develop models to support flexible working • Support for winter and keeping well • Use of wellbeing steering group to support integration of interventions • First meetings of H&W steering group held • Review of MH support underway • Assessment against NHS wellbeing framework underway (gap analysis)
	Integrated Education & Development	**Workstream Lead – Martyn Clark** Review project charter, timelines and key deliverables. On-going work on drafting the UHSX Trust Integrated Education and Development Strategy. Key aims: 1. To develop and publish a UHSussex Integrated Learning & Development Strategy, to both deliver and raise standards of education and learning 2. Develop a robust system to regularly review training needs Exec paper on initial design and focus for integrated education has been considered and discussion with HEE as a stakeholder also taken place. Some delay in establishing IE steering group (Education Board) due to operational pressures now started. TOR drafted.

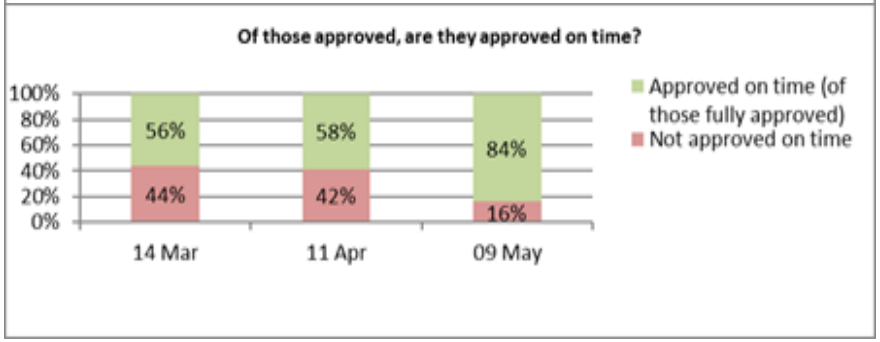
People Corporate Project: Electronic Workforce Deployment (EWD)

Replacing multiple electronic workforce systems and reducing reliance on non-automated processes to ensure effective deployment of the substantive and bank workforce to ensure quality and safety and improve operational workforce reporting. 2021-22 delivery impacted by Covid. 2022-23 is the final year of implementation which is on-track againts the adjusted plan.



		Mar-22	Feb-22
Nursing, AHP & Other Clinical on HealthRoster			
	Trust	8289	8050
Non Clinical on HealthRoster			
	Trust	3856	3566
Nursing eRosters issued 6 weeks in advance	East	32	32
	West	13	13
	Trust	45	45





People scorecard

Headlines

16,024 WTE posts
14,781 WTE in post
1,242 vacancy (7.8%)

Sickness 4.2% (5.2% in month)
Turnover 8.6%

Appraisal (non-medical) 72%

STAM 86.2% (ave)

More people joined than left in last 12 months except in July 2021 (net gain in year 766 WTE)

Latest staff engagement 7.0%
Recommendation 66.7%

People Committee Scorecard - UHSx — **March 2022**

	Key Performance Indicator	Target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Trend
	True North - Engagement		7.1	7.4	7.2	6.9	6.6	6.6	6.7	6.9	6.8	6.8	6.9	7.0	
	Breakthrough - Place to work (included in some of the surveys)		84.02%	79.72%	77.5%	68.7%	56.2%	59.3%	62.6%	65.1%	59.0%	62.0%	62.3%	66.7%	
	Survey Responses		2,505	2,488	2,038	633	268	586	415	461	384	509	487	394	
Workforce Capacity	FTE - Budgeted		15,916.00	15,915.64	15,880.63	15,878.60	15,909.50	15,984.96	16,017.54	16,021.05	16,053.74	16,059.52	16,040.39	16,024.63	
	FTE - Substantive contracted		14,468.75	14,420.36	14,406.04	14,456.34	14,866.65	14,613.69	14,658.54	14,645.01	14,683.37	14,736.02	14,728.95	14,781.80	
	FTE - Substantive contracted variance from Budget		1,447.25	1,495.28	1,474.59	1,422.26	1,042.85	1,371.27	1,359.00	1,376.04	1,370.37	1,323.50	1,311.44	1,242.83	
	Vacancy Factor (Substantive contracted FTE)		9.09%	9.40%	9.29%	8.96%	6.55%	8.58%	8.48%	8.59%	8.54%	8.24%	8.18%	7.76%	
	Spend - Bank as a % of total staffing		7.39%	10.51%	6.81%	7.92%	7.70%	5.43%	7.02%	7.60%	8.78%	10.20%	8.43%	5.52%	
	Spend - Agency as a % of total staffing		3.43%	3.05%	2.85%	3.46%	3.44%	2.86%	3.10%	3.28%	3.18%	3.10%	3.14%	3.42%	
	Substantive Headcount		16,419	16,435	16,452	16,377	16,479	16,508	16,521	16,618	16,586	16,628	16,649	16,682	
Workforce Efficiency	Absence - Sickness (12 month)		3.87%	3.81%	3.81%	3.82%	3.90%	3.92%	4.00%	4.04%	4.10%	4.12%	4.21%		
	Absence - Sickness in month		2.87%	3.48%	3.90%	4.09%	4.44%	4.13%	4.98%	4.66%	4.70%	4.72%	5.16%		
	Absence - Maternity in month		2.01%	2.14%	2.14%	2.10%	2.13%	2.13%	2.07%	1.99%	2.00%	2.00%	1.95%		
	Absence - Special, Study & Other Leave in month		7.20%	7.28%	7.67%	8.33%	7.81%	8.08%	8.44%	8.36%	8.59%	9.09%	8.85%		
	Absence - Total in month		12.08%	12.90%	13.70%	14.52%	14.38%	14.35%	15.49%	15.01%	15.29%	15.80%	15.96%		
	Sickness - Short Term (< 28 days)		1.40%	1.73%	1.87%	1.99%	2.08%	1.97%	2.54%	2.42%	2.24%	2.48%	2.51%		
	Sickness - Long Term (>= 28 days)		1.47%	1.74%	2.03%	2.10%	2.36%	2.17%	2.44%	2.24%	2.46%	2.24%	2.66%		
	Sickness - Stress in month		0.65%	0.85%	0.98%	1.04%	1.13%	0.96%	1.07%	1.03%	0.91%	0.87%	1.05%		
	Sickness - Gastro Intestinal in month		0.21%	0.31%	0.32%	0.31%	0.34%	0.34%	0.34%	0.32%	0.33%	0.27%	0.40%		
	Sickness - Other Musculoskeletal in month		0.34%	0.46%	0.48%	0.43%	0.49%	0.38%	0.44%	0.41%	0.44%	0.37%	0.52%		
	Sickness - Cough, Cold & Flu in month		0.16%	0.16%	0.16%	0.20%	0.22%	0.35%	0.76%	0.70%	0.72%	0.46%	0.48%		
	Sickness - Back in month		0.19%	0.22%	0.27%	0.25%	0.27%	0.27%	0.22%	0.20%	0.16%	0.13%	0.21%		
	Episodes - New sickness episodes in month		1,889	2,077	2,251	2,372	2,382	2,541	3,442	3,133	2,932	2,630	2,604		
	Episodes - On-going sickness episodes in month		506	536	542	666	688	676	793	682	801	867	841		
	Episodes - Total sickness episodes in month		2,395	2,613	2,793	3,038	3,070	3,217	4,235	3,815	3,733	3,497	3,445		
	Maternity - Number of staff on maternity leave		399	430	424	410	423	413	412	392	396	401	392		
	Turnover - Trust (12 month)		9.84%	9.81%	9.80%	9.59%	9.37%	8.87%	8.71%	8.56%	8.58%	8.64%	8.59%	8.57%	
	Turnover - Medical & Dental (12 month)		17.44%	17.56%	15.65%	14.07%	14.06%	14.06%	13.94%	13.60%	13.59%	13.22%	13.09%	13.17%	
	Turnover - Nursing & Midwifery (12 month)		8.93%	8.89%	8.92%	8.59%	7.98%	7.44%	7.03%	6.49%	6.31%	6.17%	6.04%	5.73%	
	Turnover - Scientific, Therapeutic & Technical (12 Month)		9.64%	9.31%	9.31%	9.31%	8.88%	8.24%	8.45%	8.57%	8.57%	8.85%	9.17%	8.92%	
	Turnover - Admin, Clerical & Estates (12 months)		8.69%	8.73%	9.05%	9.15%	9.31%	9.11%	9.07%	9.43%	9.56%	9.88%	9.83%	10.09%	
	Turnover - Support Staffing (12 months)		10.68%	10.70%	10.73%	10.61%	10.65%	9.66%	9.51%	9.10%	9.32%	9.36%	9.23%	9.43%	
	Stability %		89.16%	89.07%	88.79%	92.14%	88.34%	88.38%	88.09%	87.86%	87.14%	87.07%	86.72%	86.49%	
Training and Development	% of appraisals up to date (excl Medical staff)	90%	81.74%	82.84%	81.70%	80.04%	79.96%	77.51%	74.71%	75.20%	75.00%	74.60%	75.44%	72.19%	
	STAM Weighted Average	90%	82.81%	83.34%	84.24%	83.81%	83.64%	82.74%	82.63%	82.30%	82.64%	84.20%	84.53%	86.19%	
	% In Date - Fire	90%	83.46%	85.10%	84.27%	82.32%	82.41%	80.31%	79.78%	79.47%	80.00%	82.45%	82.89%	84.91%	
	% In Date - Infection Control (Role Specific)	90%	82.48%	84.38%	83.73%	81.54%	81.45%	79.67%	79.64%	79.34%	79.94%	82.38%	83.11%	84.84%	
	% In Date - Back Training (Role Specific)	90%	80.53%	69.06%	71.12%	73.23%	74.38%	75.19%	75.92%	76.18%	76.88%	78.40%	78.34%	81.28%	
	% In Date - Child Protection (Role Specific)	90%	87.62%	88.60%	87.92%	87.46%	86.71%	86.03%	86.08%	85.19%	85.47%	86.65%	87.24%	88.65%	
	% In Date - Information Governance	90%	80.61%	82.68%	82.08%	80.25%	80.19%	78.06%	76.88%	77.49%	78.13%	80.07%	80.95%	82.61%	
	% In Date - Adult Protection	90%	84.90%	86.93%	87.64%	88.46%	88.62%	88.44%	88.75%	88.27%	88.41%	89.39%	89.07%	90.91%	
	% in Date - Equality & Diversity	90%	89.54%	90.98%	90.83%	90.46%	89.52%	88.80%	88.54%	88.06%	88.48%	89.72%	89.59%	91.71%	
	% in Date - Health & Safety	90%	87.20%	89.35%	94.74%	94.37%	94.25%	93.87%	93.87%	93.52%	93.51%	93.26%	93.00%	93.21%	
	% in Date - Resus	90%	62.12%	67.53%	71.37%	72.22%	70.89%	70.01%	69.91%	68.57%	68.14%	70.97%	72.42%	73.26%	
Capacity	Starters	-	185	130	151	121	576	251	249	210	137	191	200	170	
	Leavers	-	122	95	105	129	438	140	173	100	118	122	118	145	
COVID	Absence		169	59	89	274	244	157	169	170	308	456	329	415	
	Vaccination % First Dose		89.5%	89.6%	89.6%	89.6%	89.6%	89.6%	89.6%	89.6%	89.6%	89.6%	89.6%	89.6%	
	Vaccination % Second Dose		84.1%	86.2%	86.2%	86.2%	86.2%	86.2%	86.2%	86.2%	86.2%	86.2%	86.2%	86.2%	
	Clinically Extremely Vulnerable		115	10	11	9	10	12	12	11	7	10	10	11	

People scorecard commentary

University Hospitals Sussex
NHS Foundation Trust

Current Performance	Response / Actions Planned
Turnover • The March UHSussex Turnover rate (external leavers) stood at 8.57%, this represents a 1.4 % point reduction since March 2021 (9.97%). • The UHSussex East Turnover rate (external leavers) in March stood at 8.81%. There has been a month on month reduction over the previous 12 month period having stood at 11.93% in March 2021. • The UH West Turnover rate (external leavers) for March stood at 8.28%. The average over the previous 12 month period is 7.70%.	• New style appraisal has been launched to encourage career conversations/development. • Turnover is currently relatively stable. • Rotas are issued 6 weeks in advance to support work/life balance and improved retention, this is monitored via the EWD steering group. • COM implementation should further improve stability of leadership, structure and reporting lines.
Sickness Absence • The one month Sickness Absence rate was 5.16% and the 12 month rate 4.21%. • The UHSussex East in month Sickness Absence rate was 5.88%. The average in month absence over the previous 12 month period is 4.83%. The 12 month Sickness Absence rate stands at 4.83%. Although there has been a gradual rise over the previous 7 months (from 4.55% in June 21) the rate is below that seen in March 2021 (4.88%). The current in month absence split is 2.97% Short Term and 2.91% Long Term (28 days or more). • The UHSussex West in month rate was 4.31%. The average in month absence is 3.47% over the previous 12 month period. The 12 month Sickness Absence rate is 3.47%. There has been a month on month increase since May 2021 when the rate stood at 2.84%. The current in month absence split is 1.96% Short Term and 2.35% Long Term (28 days or more).	• The lowest in month sickness rate in the East Clinical areas is Women and Children at 4.84% with Medicine the highest at 7.03%. Overall though, Facilities and Estates is the highest area at 11.4% In terms of staff groups , Ancillary is the highest at 11.79% and unregistered nursing remains high at 9.88%. • The ER Team are focusing on the management of long term sickness which may have lapsed during the pandemic and also providing proactive, ad hoc training and support in hotspot areas. • The Medicine Division in the West is an area of focus with the top ten areas for absence receiving specific support with management, although the highest in month sickness rate for West clinical areas was in Women and Children's at 4.57% showing a 1.33% increase from the previous month. F&E remains the highest division in the West at 6.84%. F&E East have undertaken a review of their existing A3 sickness action plan to identify further improvement actions. • The health and well being team continues to ensure that psychological support is available to all staff and for specific teams as required whilst ensuring there are resources available for staff and managers to access. • The health and wellbeing strategy is being reviewed against NHS best practice advice.

People scorecard commentary

University Hospitals Sussex NHS Foundation Trust

Current Performance	Response / Actions planned
Appraisal • The March UHSussex (non medical) Appraisal rate stood at 72.19%. • The UHSussex East (non medical) Appraisal rate for March stood at 65.96%. In comparison, the March 2021 rate was 72.84%. • In UHSussex West the (non medical) Appraisal rate for March was 79.48% whilst the previous 12 month average stood at 82.73%.	• Non-Medical Appraisal compliance increased slightly from 74.6% (January 2022) to 75.4% (February 2022). • No Division is meeting 90% compliance target. Best performance: Women & Children West at 88.9%. HRBPs working with Division's on their action plans to improve. • New Development Appraisal (form, guidance) introduced. Publicised via Leaders' Briefing, intranet story, HR Business Partner flagging to Divisional Management Team. • New SurveyMonkey appraisee survey will follow to test how the new documentation is landing. • Short Q&A Video in development. • Working to embed an understanding/appreciation of the value of well-conducted appraisal into upcoming Management & Leadership Development programmes.
STAM • The UHSussex STAM compliance rate stood at 86.19% for March. The average over the previous 12 month period is 83.48%. • The UHSussex East Trust STAM compliance rate stood at 88.15%. • The UHSussex West Trust STAM compliance rate stood at 84.03%.	• March 2022 – all staff continue to be encouraged to complete outstanding STAM requirement • All STAM subjects have increased compliance with three subjects now green and only one still red across the Trust. • Focus is currently on our CQC areas to drive up compliance particularly in f2f subjects – Resus and Moving & Handling • Reporting stepped up and targeted communications will continue and a need to focus on link with appraisal work as compliance should be assessed at point of appraisal. • Plans to move to single system and therefore standardised approach to STAM being finalised with view to have go-live with COM implementation
Vacancy • The March UHSussex Vacancy Rate stood at 7.76% having seen a gradual reduction over the previous 6 month period from 8.58% in September 2021. • In March the UHSussex East Vacancy Rate stood at 6.28%. There has been a 2.09% point reduction from March 2021 when the rate was 8.37%. There are currently 540.67 FTE vacancies across East. • The March UHSussex West Vacancy Rate figure stood at 9.47% which represents a 1.33% point increase from the same position in March 2021 when the rate was 8.14%. There are currently 702.16 FTE vacancies across West.	• International nurse recruitment business case being finalised for an additional 450 nurses. • Workforce modelling presented to the board as part of the operational planning assurance process. • New to health induction and training developed by the Practice Development team allowing a focused approach to new health HCA recruitment. • New recruitment campaigns launched to support the new clinical operating model. • Focused approach to recruiting staff nurses in the specialist division. • Successful clinical fellow recruitment in the East. • Adverts out for key senior COM posts including Managing Directors, Divisional Directors of Operations and Divisional Chief Nurses. • Interims recruited for COO and Hospital Site Director for Brighton.

People risks and forward look

University Hospitals Sussex NHS Foundation Trust

- Q4 was challenging for staff and the burden of managing the ongoing demands of the pandemic, recovery, increased demand and, increasingly, the general pressures reflected in the wider economy (inflation etc). This was reflected in staff survey results. The principle people risks (as discussed at the People Committee) remain around:
  - Mainatining sufficient staffing for the levels of activity / demand experienced
  - Covid absence
  - Future vaccination (flu and Covid)
  - Health and wellbeing of staff
  - Staff stretch and the impact of that on their and patients experience

- Q1 of 2022-23 provides opportunity to re-focus and re-invigorate current programmes of work and re-prioritise. The staff survey results help inform this. The reorganisation of people functions and recruitment into teams will help unlock benefits of merger. As reported in the SDR the BO, SI and CP continue to progress. Key areas to strengthen are the Trusts support for wider culture change, building on and around its Patient First Improvement System and improving staff feedback.

NHS
University Hospitals Sussex
NHS Foundation Trust

Sustainability

Integrated Performance Report Section

Sustainability Summary

University Hospitals Sussex NHS Foundation Trust

- Throughout 2021/22, the Trust has operated under two interim financial frameworks, with block funding arrangements continuing; although with an increased efficiency requirement and a significant change in income recovery for elective activity.
- The intention of the framework, for individual organisations within the Sussex ICS, was to deliver a breakeven position; whilst restoring services and delivering financial targets.
- The Trust's True North domain for sustainability is 'living within our means providing high quality services through optimising the use of resources' which is measured through the metric of delivering the Trust's Financial Plan.
- At the end of March 2022 the Trust delivered:
  - Surplus of £123k; exceeding the breakeven target.
  - Capital expenditure of £150.2m.
  - £22.6m of efficiencies.

Sustainability True North – Financial Plan

University Hospitals Sussex NHS Foundation Trust

- The delivery of the Trust's financial plan is measured through:
  - I&E Performance: achieving the agreed I&E plan;
  - Cash: maintaining sufficient cash balances;
  - Capital: achieving the agreed capital plan; and
  - Efficiency: achieving the required efficiency programme.

- The Trust ended the year with I&E performance being £123k above the breakeven plan. Included within this position are non-recurrent income allocations the Trust secured including: ERF (£32.6m), ERF+ (£12.9m), TIF (£4.2m), Capacity Funding Grant (£3.5m) & COVID (£39m & £7m testing & vaccinations).

- The year-end cash balance of £113m was £39m more than planned due to higher opening cash balances, the unwinding of block arrangements and the timing of payments.

- The 2021/22 capital expenditure of £150m, is £72m on 3T's and £78m on operational capital schemes.

- The Trust delivered £22.6m of efficiencies, against a planned target of £24.4m. Tactical schemes over-delivered, but the plan was impacted by operational pressures impeding delivery of productivity schemes during the first half of the financial year.

Sustainability Key Metrics

University Hospitals Sussex
NHS Foundation Trust

			G
I&E £k	**YTD Plan**	**YTD Actual**	**Variance**
Income	(1,315,032)	(1,350,135)	35,103
Operating Costs	1,291,561	1,350,906	(59,345)
Finance Costs	20,981	20,950	31
Performance Adjustments	2,490	(21,844)	24,334
Overall performance	0	(123)	123

The Trust delivered a £123k surplus for the 2021/22 financial year and achieved the requirement to breakeven.

			G
Cash £k	**YTD Plan**	**YTD Actual**	**Variance**
	74,250	113,313	39,063

The Trust finished the year a healthy cash balance, which will enable the Trust to discharge liabilities as they arise in 2022/23.

			G
Capital £k	**YTD Plan**	**YTD Actual**	**Variance**
3T's Scheme	72,438	72,438	0
Operational Schemes:			
Internally Funded	47,440	47,373	67
Externally Funded	39,345	30,345	9,000
Overall performance	159,223	150,156	9,067

The capital expenditure was £9m below plan with agreement from NHSE/I to defer the funding into 2022/23.

			A
Efficiency £k	**YTD Plan**	**YTD Actual**	**Variance**
	24,405	22,585	(1,820)

The Trust delivered 93% of the planned efficiencies in the year to March 2022.

Operational pressures on the Trust impacted on the delivery of the efficiency schemes in the later parts of the financial year.

Sustainability-Financial Plan 2022/23

University Hospitals Sussex NHS Foundation Trust

- The 2022/23 financial plan has been developed based on the modelling assumptions set out in the draft planning guidance and associated consultations which were circulated on 24th December 2021 by NHSE/I. The intent being to return to more recognisable contracting arrangements, with a move away from interim block arrangements.

- The basis of allocations for 2022/23 is as follows:

  - 2021/22 H2 baseline and top-up funding has been annualised.
  - Recurrent adjustments have been made for maternity and growth of 4.1%; net of a general efficiency requirement of 1.66%.
  - Risk of 'clawback' if activity plans are not delivered in 75% of tariff
  - Covid-19 funding reduced by 57%

- The Trust has submitted a plan of £12.55m deficit, which solely relates to excess inflation. Consideration of further support for this is being sought by the Trust and Sussex ICS, from NHSE/I.

- Included within the 2022/23 Trust plan are:

  - £37m - to support 100% to 104.6% activity performance.
  - £6m - income to support operational pressures

- To deliver the £12.5m deficit plan requires the Trust to deliver £44m efficiency savings (3.7% of Trust income)

- The Trust has submitted a Capital plan totalling £116m.

Sustainability - Actions & Recommendations

University Hospitals Sussex NHS Foundation Trust

There are no actions required of the Board.

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

- The Trust delivered a £123k surplus for the 2021/22 financial year; exceeding the breakeven target.
- The financial framework for the 2022/23 plan; and the further work that is in progress in relation to developing capacity plans for elective activity delivery and maturity of efficiency schemes.
- Detailed financial performance information has been shared with Sustainability Committee; who continue to provide oversight on behalf of the Board.

NHS
University Hospitals Sussex
NHS Foundation Trust

Systems & Partnerships

Integrated Performance Report Section

Systems & Partnerships Summary Q4

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 4 2021/22 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.

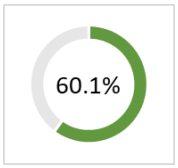
- Despite these operational pressures, there has been continued delivery of the plans to address long waiting RTT and Cancer patients to achieve the national 104 week/day targets.

Performance Summary March-22 , Q4

University Hospitals Sussex NHS Foundation Trust

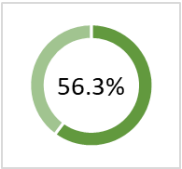
True North and NHS Constitutional Targets

A&E



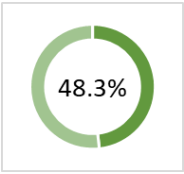
- Overall the combined Trust treated 60.1% of patients within 4 hours of attending all A&E departments Mar-22, and 64.9% Quarter 4. UHS West achieved 53.5% Mar-22 and 62.1% Q4 whilst UHS East achieved 65.9% Mar-22 and 67.4% Q4. National performance also deteriorated and was 71.6% Mar-22 and 73.1% Q4.
- There was continued 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.

RTT



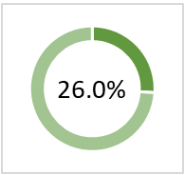
- The combined Trust has 56.3% of patients waiting longer than the target 18 weeks at the end of Mar-22. UHS West achieved 56.7% and UHS East achieved 55.8%. National performance was 62.6% February-22.
- The total number of patients waiting for elective treatment at the Trust is 103,085, of whom 90 were waiting over 104 weeks at the end of March. Despite operational pressures the 104 week patient numbers have continued to decrease in accordance with our aim to have no patients waiting over 104 weeks.

CANCER



- Overall 48.3% of patients who commenced cancer treatment were treated within 62 days in February. UHS West was 47.9% and UHS East achieved 48.8%. National performance was 62.1%.
- There has been a marked decrease in over 62 and 104 day prospective waits in March, from 719 Dec-21 to 389 for over 62 day patients, and from 192 patients Dec-21 to 95 patients March-22 for over 104 week waits

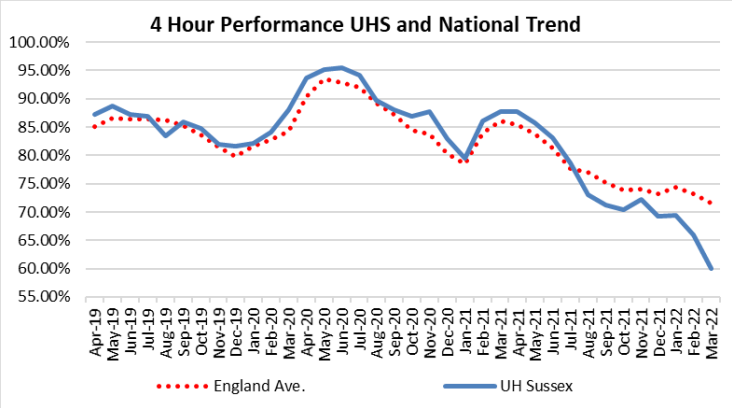
DIAGNOSTICS

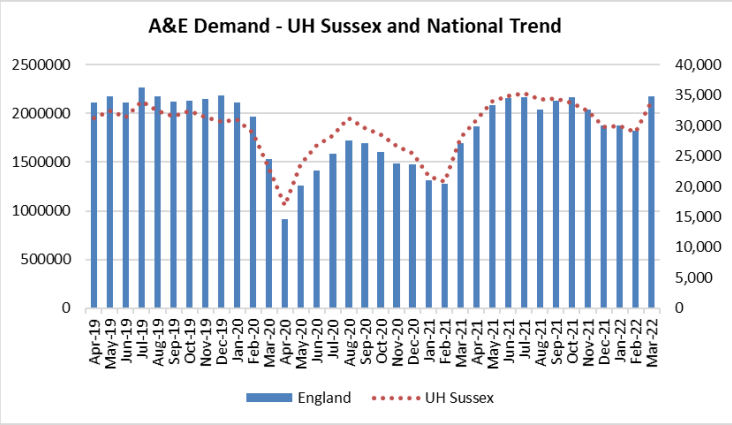


- Overall the combined Trust had 26.0% of patients waiting more than 6 weeks for a diagnostic against a 1% target. UHS West achieved 30.6% and UHS East achieved 19.3%. This is an improvement of 3.5% relative to Dec-21 position of 29.5%
- The National average for February-22 was 24.0%

A&E Performance Summary Q4

University Hospitals Sussex
NHS Foundation Trust





- A&E 4hr performance was 60.1% Mar-21 and 74.0% YTD, and was -11.5% below the national 4hr performance of 71.6% March-22 with a greater and sustained decline in performance than seen nationally over the last 8 months.

- 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 severely impacted Quarter 4 and particularly March-22.

UHSussex	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Time to Triage:	15.8	17.7	18.8	21.9	21.5	22.9	23.6	21.7	18.9	18.6	22.6	29.1
Time to Treatment:	83.6	91.4	99.8	109.5	113.0	115.8	109.8	106.6	102.5	99.2	114.8	143.0
Mean Waiting Time:	199.3	203.9	210.3	230.6	254.4	261.7	271.4	273.0	275.0	280.7	296.3	332.9

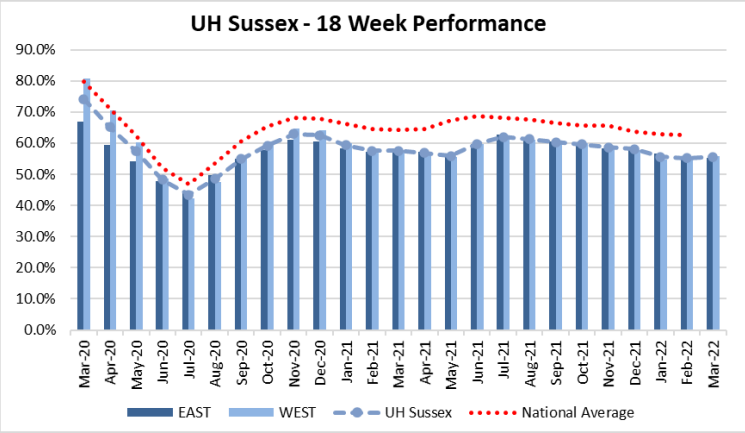
- Whilst there has continued to be high levels of emergency demand, complicated by the continued ‘red/green’ pathway split within both the emergency departments and wider hospitals, the main driver for the challenges has been the inability to create flow out of the Emergency Departments and admit patients in a timely manner.

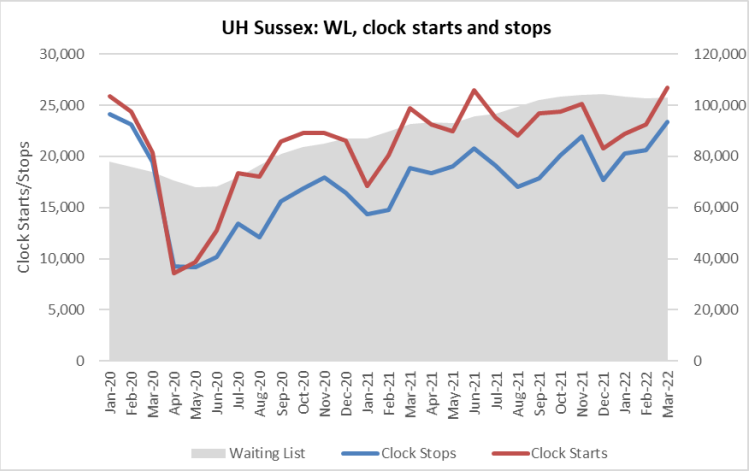
- There have been material increases in the numbers of patients in the Trust’s acute beds who are Medically Ready for Discharge to other care settings, and these were at the highest ever recorded levels for the Trust and wider health system in Q4.

- Whilst the key metrics describe overall Trust performance, there has been material variation by site, although in March-22 all of the Emergency Departments have been under significant pressure.

RTT Performance Summary Q4

University Hospitals Sussex
NHS Foundation Trust

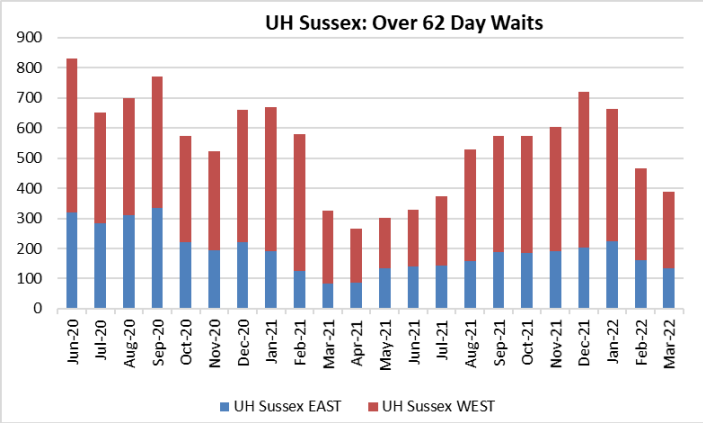


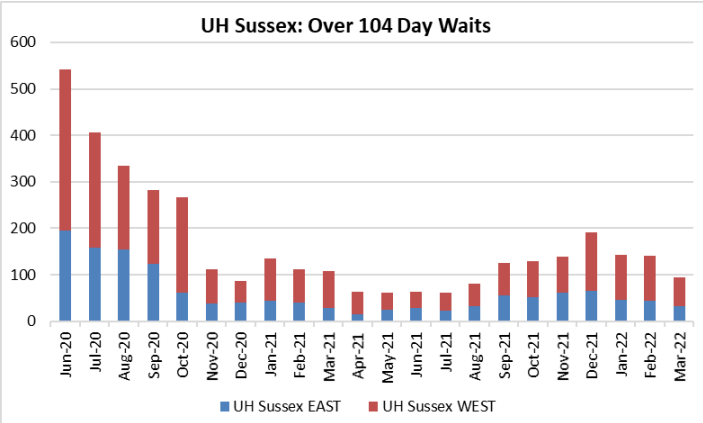


- RTT 18 weeks performance was 56.3% March-22, and there were 6369 patients waiting over 52 weeks, compared to 7031 end Dec-21, an improvement of -662 but fractionally above (+60 higher) than the Trust's forecast recovery trajectory for end March-22
- Despite the operational pressures, good progress has continued to be made treating the longest waiting patients, and at the end of March-22 there were 90 patients waiting over 104 weeks (compared to 286 December-21).
- The Trust has comprehensive plans supported by use of the Independent Sector and the cohort of patients requiring treatment by the end of March (who would otherwise wait longer than 104 weeks) reduced from 1835 patients at the end September-21 to 90 by the end March-22.
- There were 26,746 RTT clock starts in March, whilst the Trust commenced 23,335 definitive treatments. This has led to the waiting list at the end March being 103,085 patients compared to 104,496 Dec-21, and 102,178 Sep-21. This means over the last 4-6 months there has been a better balance of supply and demand in terms of elective restoration and patients being added to the waiting list for treatment.

Cancer Performance Summary Q4

University Hospitals Sussex NHS Foundation Trust





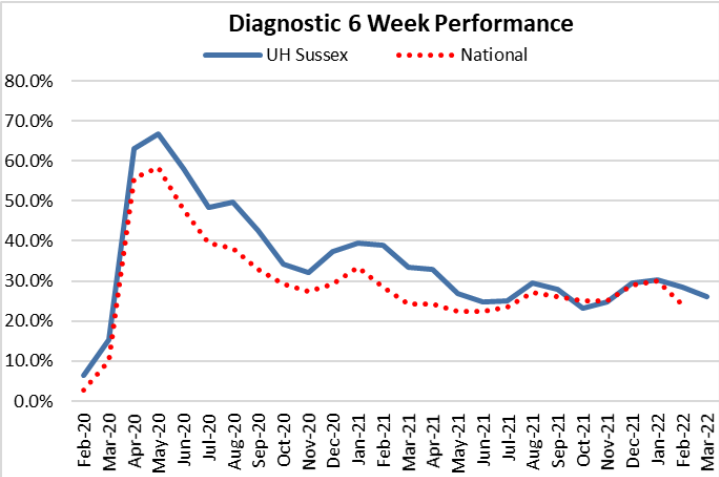
- Cancer 62 day cancer treatment targets were not met in February-22 with 48.3% starting treatment in under 62 days. UHS West was 47.9% and UHS East achieved 48.75%. National performance was 62.1%.

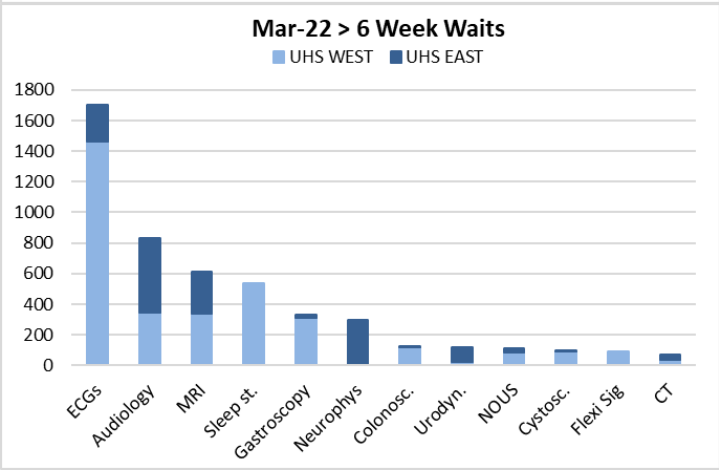
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
62 Day - GP Refs	68.09%	65.35%	69.60%	68.57%	63.36%	61.57%	60.30%	58.99%	57.14%	51.90%	48.27%	
28 Day FDS	70.69%	72.82%	72.10%	67.35%	66.00%	63.58%	65.53%	62.10%	60.26%	57.98%	67.32%	
>62 Day Breaches	267	301	329	372	529	574	573	605	719	662	466	389
>104 Day Breaches	64	62	63	62	82	125	130	138	192	143	141	95

- At the end of March the Trust had 389 patients waiting > 62 days for cancer treatment compared to 719 Dec-21. There were 95 patient waiting > 104 days compared to 192 Dec-21.
- The numbers of patients potentially waiting over 104 days increased in December, particularly in UHSussex West, whereas UHSussex has continued to improve week on week over the last month.
- The Trust performance has worsened against the new 28 Day Faster Diagnosis Standard in Quarter 4, with performance at 67.3% February-22 due to capacity constraints particularly in the skin anatomical site. National performance was 74.1% February-22
- The key driver for this has been the significant increases in cancer referrals over the last quarter, with volumes +10.8% above 2019 levels UHSussex East, and +22% UHSussex West.

Diagnostic Performance Summary Q3

University Hospitals Sussex NHS Foundation Trust





- UHSussex diagnostic performance against the 6 week target improved March-22 with 26.0% of patients waiting longer than 6 weeks for a diagnostic at the end of March compared to 29.5% December-21. National performance was 24.0% (February-22)
- Performance was most challenged in the West with 30.6% of patients waiting longer than 6 weeks for a diagnostic at the end of March, a 4.5% improvement from Dec-21. This continued under-performance as a result of the impact of emergency pressures and Covid-19 with both workforce constraints in key specialist diagnostic areas, and the impact of having to utilise areas such as Endoscopy and Cardiac Physiology to support inpatient surge capacity.
- 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.
- Positively, as some of the surge areas have been able to be de-escalated over the Winter period, clinical areas have been able to restart and increase diagnostic activity. In addition plans are continuing to expand capacity with Independent Sector and community diagnostic centres to support clearance of the backlogs.
- Some areas such as endoscopy and non-obstetric ultrasound have seen significant improvement in quarter 4.

Summary and Forward Look 22/23

University Hospitals Sussex NHS Foundation Trust

- Although Q4 has been significantly challenged, there has been good progress in progressing a number of the Trust plans 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 in April the Trust has ‘gone live’ with additional UTC capacity which will enable increased clinical capacity in the departments to treat patients attending.
- Similarly there have been multi-agency focused discharge improvement efforts to try and reduce the numbers of patients who can be discharged to other care settings (MRD patients)
- The elective and cancer recovery plans are well developed and continue into Q1 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.
- The key risk remains the operational pressures relating to emergency demand and the impact of Covid-19 on the capacity and workforce across all areas of delivery.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	11	**Meeting:**	Board	**Meeting Date:**	5 May 2022
Report Title:	Patient Committee Chair report to Board				
Committee Chair:		Jackie Cassell, Committee Non Executive Chair			
Author(s):		Jackie Cassell, 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	✓	Assurances in relation to risk 1.1			
Sustainability	☐				
People	☐				
Quality	☐				
Systems and Partnerships	☐				
Link to CQC Domains:					
Safe		☐	Effective	☐	
Caring		✓	Responsive	✓	
Well-led		✓	Use of Resources	☐	
Communication and Consultation:					

Executive Summary:

The Patient Committee met on the 26 April and was quorate as it was attended by three Non-Executive Directors, the Trust Chairman, the Chief Executive, and the Chief People Officer. In attendance were the Director of Experience, Engagement and Involvement and the Director of Communications and Engagement.

The Committee received its planned items including the reports on the respective Patient First Trust North, Breakthrough and Strategic Initiative, the quarter 4 patient experience report, the outcome from the national patient survey within maternity and the developing patient experience strategy. The Committee also considered both the Corporate Risks with a potential patient impact and the BAF risk for which it has assigned oversight.

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 Committee following a detailed discussion of the BAF and its review of the Corporate Risks with a patient dimension **AGREED** to recommend to the Board that BAF risk 1.1 for which it has oversight is fairly represented.

University Hospitals Sussex
NHS Foundation Trust

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
Patient Committee	**26 April 2022**	**Jackie Cassell**	yes	no
			✓	☐

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

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

The Committee **RECEIVED** the quarter 4 report on the patient experience feedback and the actions taken as a result of this feedback. The Committee **NOTED** that the Trust reports for 2022/23 will provide data grouped by site. The Committee **NOTED** that the response rates remain variable by site, noting that the majority of patents are recording they are satisfied, but satisfaction levels are reducing. The Committee was updated on the identified good practice which is shared widely so others can replicate. However, during the same quarter, the number of concerns raised has increased by some 57% over those levels of concerns raised in Q2 of 2021/22. The Committee **NOTED** the report by the Director of Experience, Engagement and Involvement and the data indicating the key themes where patient experience could be improved, the main themes are linked to "waits" (waiting for appointments and waiting on arrival) further themes identified are linked to treatment and staff behaviours and communication. 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 **NOTED** the 2022/23 quarter 1 priorities for improving patient experience and was **ASSURED** these are aligned to those areas which will make a key difference for our patients. The Committee asked that within future reports these include, for assurance purposes, the detail on what specific changes were made and how they were delivered, in addition to information on how those process changes will be supported to not degrade over time.

The Committee in discussing the patient experience report **NOTED** the Trust's engagement with the My Planned Care national platform that provides information on wating times to patients, but also includes information to enable patients to be supported whilst wating. This includes information for patients to reduce the risk of their physical health deconditioning as well as maintaining their mental wellbeing. The Committee recognised the platform supports wider health promotion and **ENDORSED** the work of the Trust in engaging with the ICS who are leading on the development of the local content within this platform to support the waiting well national and the ICS local initiatives.

The Committee **RECEIVED** an update from the Director of Experience, Engagement and Involvement on the developing 2022-25 Patient Experience Strategy which incorporated the initial feedback from the Committee members in response to the strategy on a page document taken at the last meeting. The Committee **NOTED** how the voice of the patient is driving the strategy formulation. The Committee was updated on the strategy priorities and the developing measurable outcome metrics which for these priorities. The Committee **NOTED** the timeline for the Strategy development and the opportunity for the Committee's further engagement during quarters 1 and 2 of 2022/23.

The Committee **RECEIVED** a report on the outcome of the National Patient Survey within Maternity which took place in 2021, across all four maternity units. The Committee noted that this survey was undertaken for the two legacy Trusts and therefore the outcomes are reported under the former Trusts. The Director of Experience, Engagement and Involvement informed the Committee that the response rates of our patients where strong and then drew out the highlights from the feedback provided and the developed actions. The Chief Executive reminded the Committee that the developing maternity board will oversee the delivery of these actions and the reporting from this operational board to this Committee has yet to be codified. The Committee was **ASSURED** that the patient voice reflected in the survey results was being used to drive the improvement action plan.

The Committee **RECEIVED** the update on the delivery of the Trust's Breakthrough objective for 'Patient', this being the area where improvement actions will have the largest positive impact on the True North. The Committee was updated on the data analysis undertaken to determine the key priorities for improving the experience of those patients waiting. The data analysis has highlighted the key issue is the time patients wait at key points within their adult emergency department journey. The Committee **NOTED** that this data is being integrated with the operational work to bring the patient experience lens to the patient journey process improvement work. The Committee **ENDORSED** that the key to improved patient experience is better communication throughout the whole journey which needs to run alongside the process improvements. The Committee **NOTED** this update and recognised that further information on the outcome of these actions will flow through the strategy deployment reports to the next meeting.

The Committee **RECEIVED** the end of year update on the delivery of the Patient First Improvement Programme Strategic Initiative from the Chief Executive on behalf of the Director for Delivery and Improvement. The Committee **NOTED** the work undertaken within this initiative across 2021/22 recognising the delivery of the Strategic Projects and Corporate Projects is reported through each of the Board Committees. The Committee was taken through the strategy deployment implementation actions planned for the initial quarters of 2022/23 and how these link to the drive to improve the respective divisional maturity levels. The patient first maturity assessments have seen across 21/22 some 16 units move to the level 4 maturity level and whilst lower than the original plan this move has been supported by a positive shift from those within level 1 progressing though to level 2 and those within that level progressing to level 3. The Committee **NOTED** this progress recognising that that this work remains supported by divisions in spite of the operational challenges they have faced across the year. The Committee **AGREED** the key risk to this initiative is the impact of operational pressures on the divisions impacting on their ability to support the programme at the desired rate by the respective divisions and the Trust as a whole.

The Committee **RECEIVED** an update on the Committee's assigned Corporate Project from the Chief Executive focusing on ensuring the learning and improvement from the recent CQC inspection is cascaded across the Trust. The Committee **NOTED** that an update has been provided in other forums and **NOTED** that an update will come to the Board on the 5 May 2022.

ICS and System Collaborations

With the apologies received at today's meeting, this item was scheduled for the next meeting of the Committee.

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. The report provided an update on the activity of the group at its meetings on the 18 January, 15 February and 15 March 2022. The Committee **NOTED** the work of the Committee and the reports it had discussed reflecting that the majority of these feed into the reports at this Committee including the patient experience quarterly report and the breakthrough objective update. The Committee **NOTED** that the Group referred no specific items for support

The Committee **NOTED** that the Quality Governance Steering Group had reported formally to the Quality Committee on the 26 April and within that report there were no items referred to this Committee. The Director

of Experience, Engagement and Involvement reflected that the last QGSG meeting had maintained its focus on the Darzi quality dimensions and is enabling the embedding of quality governance within divisional leadership.

Risk

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

Across each of the patient and quality domains there are 73 risks that have been raised that have the potential to impact on patient experience which for quarter 4 have been identified with a post-mitigation score of 12 or above. Five of these identified risks are identified with a current risk score of 20, these being:

- 651 and 1887 – A high quality patient experience is at risk due to poor 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.
- 1307 – Management of young people requiring inpatient care for mental health problems is inadequate causing them to stay within the acute setting which is detrimental to their experience.
- 1527 – 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
- 2392 – There is a risk to patient experience due to an increase in RTT waiting times.

The Committee recognised the interlinkages of these risks to those with the quality and people.

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

Terms of Reference

The Committee **RECEIVED** a report from the Company Secretary on the review of the Committee's Terms of Reference after its first year of operation. The Committee **AGREED** that only minor changes were required as the current Terms of Reference correctly reflected the activity of the Committee to achieve its stated purpose. The Committee **AGREED** that the supporting Committee cycle of business adequately supports the basis for the agenda planning for the meetings across 2022/23.

Actions taken by the Committee within its Terms of Reference

The Committee **APPROVED** the minor revisions to the Patient Committee Terms of Reference.

The Committee **AGREED** to recommend the quarter 4 score for BAF risk 1.1 to the Board.

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

The Committee sought further information on the Outpatients corporate project.

The Committee asked if the patient voice in respect of the Children's ED could be weaved into later updates to the Committee

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 risk 1.1 within the BAF for which it has oversight is fairly represented.	To Board 5 May 2022

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	12	**Meeting:**	Board	**Meeting Date:**	5 May 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	☐				
Link to CQC Domains:					
Safe		✓	Effective	✓	
Caring		✓	Responsive	✓	
Well-led		✓	Use of Resources	☐	
Communication and Consultation:					

Executive Summary:

The Quality Committee met on the 26 April 2022 and was quorate as it was attended by three Non-Executive Directors, the Chairman, the Chief Medical Officer, the Chief Nurse for part of the meeting, the Chief People Officer and the Chief Governance Officer. In attendance were the Trust's Medical Director for the west and the Director of Patient Safety along with Director of Midwifery.

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 maternity scorecards including the national Ockenden report metrics, reports covering SIs and the respective learning and the duty of candour audit outcomes, the learning from deaths report, the report from the Committee's respective reporting group. The Committee also considered both the Corporate Risks with a potential quality impact and the BAF risk for which it has assigned oversight.

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 in respect of BAF risks 4.1 and 4.2 for which it has oversight, that the scores for start of quarter 4 are fairly represented.

University Hospitals Sussex
NHS Foundation Trust

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
Quality Committee	**26 April 2022**	**Lucy Bloem**	yes	no
			✓	☐

Declarations of Interest Made

There were no declarations of interest made

Assurances received at the Committee meeting

Quality Dashboard

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 to development of the dashboard and recognise further work is still be to be done fully populate it. The Medical Director took the Committee through the performance overviews in respect of the dashboard segments covering the domains of mortality, clinical outcomes and effectiveness, patient safety and patient experience. The Committee discussed the key elements within Patient Experience relating to increasing levels of dissatisfaction due to increased waits. Within Patient Safety with increases in MRDs this is adding to the potential for harm, noting we undertaken and reported later in the meeting a series of harm reviews. Mortality there is an ongoing review of the SHMI for any learning on the rising trend, noting that the overall UHSussex SHMI is within the expected range. In respect of Clinical Outcomes and Effectiveness the Committee discussed the level of oversight NICE guidance and the Trust's processes to perform the initial assessment of their relevance, noting that not all guidance is relevant to every provider and then the processes for auditing the Trust's compliance with the guidance. The Committee **ENDORSED** the developing dashboard and is supporting the discussion at the Committee. The Committee **ENDORSED** the use of RAG rating to guide the linkage to the performance overview text. The Committee **AGREED** that a specific agenda item on clinical effectiveness will be added to the cycle of business for this Committee.

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

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

The Director of Patient Safety and Learning provided an update on the True North in relation to harms and the supporting Q3 Serious Incident Report. The Committee in **RECEIVING** these reports in respect of the learning being drawn from reported incidents within quarter 3 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.. The Director of Patient Safety and Learning provided detailed information in respect of the outcome of the learning applied in the area of the glaucoma pathway and was through the detailed update was **ASSURED** on the Trust's processes for ensuring learning is followed through with process redesign.

The Committee **RECEIVED** the Q3 Duty of Candour Audit report and **NOTED** the processes applied to audit the data within the report through the update provided by the Director of Patient Safety and Learning. The Committee was **ASSURED** over the Trust's compliance with the duty of candour.

The Committee **RECEIVED** an update 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 **NOTED** this update and recognised that further information on the outcome of these actions routinely flow through the strategy deployment updates provided to the Committee.

The Committee considered the processes of learning against the low and no harm incidents especially within the category of medication incidents. The Committee **NOTED** the review undertaken at QGSG and their recommendation (see the section below in respect of reporting groups) that the Committee receive the report the Group saw at its meeting on 25 April to provide the Committee with the level of assurance it is seeking in respect of medicines safety.

The Medical Director west 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 allowing the Trust to have a three dimensional view of mortality. The Committee was updated on the work undertaken in respect of the rising SHMI levels although the aggregated UHSussex SHMI remains within the expected range. The Trust's action plan was considered, and the Medical Director **ASSURED** the Committee that the initial diagnostic review of the data and a detailed case note review into 34 patients identifies a coding issue as the cause from the rising trend in SHMI. The Committee **ENDORSED** the further line of assurance being obtained from an external review of the patient coding processes.

Supporting the Mortality True North the Committee **RECEIVED** a report and update from the Medical Director on the Trust's harm review process. The update provided information on the developed governance processes. The report provided information on the review outcomes and the actions taken to address the learning identified from the reviews. The Medical Director gave examples of improvements made to the processes for those waiting, where a number of clinical specialities have applied their learning to streamline their processes to reduce time at the pathway wating points. This work complements the Trust's work to aid patients to waiting well. The Committee **NOTED** that the review's identified themes that will go through the harm review group and then progress for wider dissemination at QGSG securing Divisional engagement. The Committee **NOTED** that the Medical Director and the Director of Patient Safety and Learning are working to ensure the link between the harm review group and the patient safety group is effective. The Committee **ASKED** that for future reports considering ambulance handover delays that the context of waits at 15 and 30 mins is included. The committee **NOTED** that a targeted approach to clinical harm reviews on >12hr Emergency Department waits and ambulance handover delays > 60minutes. The Committee thanked the Medical Director for the work in developing this report.

The Committee **RECEIVED** the Trust's learning from deaths report for quarter 4 of 2021/22 noting that whilst the report was for the whole Trust the information offers analyses across the hospital sites of St Richards, Worthing and Southlands and Royal Sussex County and Princess Royal. Through the presentation of this report by the Medical Director the Committee was **ASSURED** over the progress made with undertaking structured judgement reviews where initial medical examiner investigation recommended that this process be applied to seek out learning and **NOTED** there had been an increased level of poor care identified and **ENDORSED** the Medical Director's action to establish a Trust wide mortality panel to accelerate the learning. The Committee **NOTED** the identified themes which included improvements in relation to inter hospital transfers and the use of treatment escalation plans. The Committee **NOTED** the work planned to extend the numbers of SJRs being undertaken especially within the east.

The Chief Medical Officer provided an update on the work being undertaken in respect of the Strategic Initiative in relation to the Trust's clinical strategy. The Committee **NOTED** that the progress made with the development of the ambition and service mission statements which continue. There has been a recent meeting of the clinical strategy steering group which is seeking to engage this work in respect of linking this to the health inequalities. The Committee NOTED the key risk to the delivery of this initiative is capacity and maintaining the momentum given the competing demands on the division's resources.

The Committee **RECEIVED** an update on the Trust's CQC action plan by the Chief Nurse, recognising that within the Patient Committee meeting complementary assurance will be provided over the developed improvement programme that supports this work. The Chief Nurse confirmed that future updates will provide

assurance that the actions taken have been sustained along with the Trust's actions against the workforce improvements required by April. The Committee **NOTED** this update.

Maternity

The Committee **RECEIVED** a report on the Sussex Perinatal Quality Surveillance Model from the Director of Midwifery. The Director of Midwifery updated the Committee on the Trust's current level of compliance with this model, including the appointment of NED and Executive Maternity Service champions. The Committee **APPROVED** the application of this model NOTING this is supported by the decision made at Board to receive for 2022/23 a revised maternity performance dashboard.

The Committee **RECEIVED** reports in respect of the Trust's Maternity 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, with the Trust's Medical Director west providing information 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 seen an improved position in respect of staff undertaking their training; and the voice of the patient where the Committee was reminded that 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. The Committee was updated by the Medical Director in respect of the Internal Audit review of the maternity dashboard compilation process. The auditors identified that a consistent data definition needed to be developed and applied to the whole data set for 2021/22. The Medical Director confirmed that the codified indicator definitions have been applied consistently across each month's data within these dashboards. The Medical Director and Director of Midwifery provided information on the revised internal check processes now applied within the service to oversee the data quality supporting these dashboards. The Committee **NOTED** that the revised dashboard will be subject a further internal audit review to provided further assurance that the lessons from the work on the current dashboards is carried forward to the revised dashboard. The Committee **AGREED** these dashboards be presented to Board. The Committee was informed that the timing of the maternity dashboard data flow from the Service to the Committee is under review and the outcome will be reported to the next meeting. The Committee **AGREED** to raise with the Board that it endorses the Executive focus on Business Information and data quality and that enhanced BI support be provided to the Maternity Service.

The Committee **NOTED** the Trust's engagement with the Sussex Local Maternity and Neonatal System which sees a series of site visits being undertake across each of the maternity units. These visits are part of the scheduled and planed programme.

Quality account

The Committee **RECEIVED** the initial draft of the Trust's quality account for 2021/22 and was informed that the draft went to QGSG the day before (25 April) as part of drafting processes. The Committee members **AGREED** to provide comments on this initial draft by the 3 May NOTING then that the draft will be circulated for wider comment including securing those of the Governors prior to its submission to the Board in June for approval and publication.

Reporting groups

The Committee **RECEIVED** an update from the Chief Medical Officer on work of the Quality Governance Steering Group (QGSG) at its March meeting detailed within the formal report provided to the Committee The Chief Medical Officer also provided an update on the QGSG meeting that took place on the 25 April and confirmed that the agenda of the QGSG is aligned to the work of this Committee and the key quality risks. The Committee **NOTED** there were no matters which the Group was seeking Committee support or action. The Committee **AGREED** with the recommendation from the Group that an update is provided on medicine management based on the report received at its April meeting and the level of positive assurance this

provided. The Committee asked that QGSG continue with its supporting oversight of divisional key quality risks paying particular attention to the divisions oversight of action being taken to manage and mitigate the longest risks on the risk register.

Risk

The Committee **RECEIVED** and discussed the Corporate Risk Register report which provided information in respect of those corporate risks with a potential patient impact. The Committee sought further information on the period of risk review.

Across each of the patient and quality domains there are 73 risks that have been raised that have the potential to impact on patient experience which for quarter 4 have been identified with a post-mitigation score of 12 or above. Five of these identified risks are identified with a current risk score of 20, these being:

- 651 and 1887 – There is an increased risk of harm due to poor 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.
- 1307 – Management of young people requiring inpatient care for mental health problems is inadequate causing them to stay within the acute setting increases the potential for patient safety risk.
- 1527 – A&E RSCH Cohort Area is a poorly designed place in which to look after patients which has the potential to impact on the care for those patients waiting in this area.
- 2392 – There is a risk to of the patient's health deteriorating due to an increase in RTT waiting times.

The Committee recognised the interlinkages of the quality risks with those within the people and patient domains.

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 meeting in respect of the clinical harm outcomes and noted this process is reflected within the BAF for risk 4.1. 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 but asked that the there is a review of the BAF risk 4.1 during quarter 1 in light of the reports received at Committee.

Terms of Reference

The Committee **RECEIVED** a report from the Company Secretary on the review of the Committee's Terms of Reference after its first year of operation. The Committee **AGREED** that only minor changes were required as the Terms of Reference correctly reflected the activity of the Committee to achieve its stated purpose but that there would now be no less than 10 meetings a year. The Committee **AGREED** the draft provided, subject to the addition of the regular Infection, Prevention and Control reports. The Committee **AGREED** that the supporting Committee cycle of business with the addition of matters including medicines management adequately supports the basis for the agenda planning for the meetings across 2022/23.

Actions taken by the Committee within its Terms of Reference

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

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

The Committee **AGREED** the actions being taken in respect of the Maternity dashboard were appropriate.

The Committee **APPROVED** the Perinatal Quality Surveillance Operating Model and Maternity Surveillance Summaries and Dashboards.

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Items to come back to Committee (Items the Committee keeping an eye on outside its routine business cycle)	
The Committee asked that an item on clinical effectiveness be added to the cycle of business for this Committee, this would cover information on NICE oversight. The Committee agreed to receive the update provided on Medicines Management taken at the Quality Governance Steering Group in April 2022. The Committee sought an update at its next meeting in respect to the timing of the maternity dashboard data flow from the Service to the Committee. The Committee asked that for future reports considering ambulance handover delays that the context of waits at 15 and 30 mins is added alongside the 60 minute wait data.	
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 risk 4.1 and risk 4.2 within the BAF for which it has oversight are fairly represented. The Committee asked the Board to note the support of the Quality Committee for the enhancement of the BI support to the Maternity Service.	To Board 5 May 2022

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	13	**Meeting:**	Board	**Meeting Date:**	5 May 2022
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 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	✓	Assurances in relation to risks 3.1 – 3.4			
Quality	☐				
Systems and Partnerships	☐				
Link to CQC Domains:					
Safe		✓	Effective	✓	
Caring		✓	Responsive	✓	
Well-led		✓	Use of Resources	☐	
Communication and Consultation:					

Executive Summary:

The People Committee met on the 27 April 2022 and was quorate as it was attended by three Non-Executive Directors, the Chief People Officer and the Chief Financial Officer along with the Chief Governance Officer and Chief Operating Officer for the opening hour of the meeting. In attendance were the Director of Integrated Education, the Director of Workforce Planning and Deployment, Director of Medical Education, the Nursing Director and senior members of the HR and Wellbeing team.

The Committee received its planned items including the reports on the respective Patient First Trust North, Breakthrough Objective, Strategic Initiative and Corporate Project, Staff Survey results, a report in respect of the Trust's work to address violence and aggression against staff, the maternity listening event outcomes, the health and wellbeing strategy update, leadership, culture and development, and electronic workforce deployment, workforce KPIs, and an update from the Freedom to Speak up Guardian. The Committee also received an update on the work of the ICS people committee.

The Committee also considered both the Corporate Risks with a potential people impact and the BAF risks for which it has assigned oversight.

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 after careful consideration of the continued pressures facing staff agreed the risk scores for BAF risks 3.1 to 3.4 are fairly stated for quarter 4.

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COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
People Committee	**27 April 2022**	**Patrick Boyle**	yes	no
			✓	☐

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

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

The Chief People Officer provided a report on the outcome of the Staff Survey which supports the Trust's True North in respect of staff engagement. The Committee **DISCUSSED** the analysis of staff survey outputs across the 7 national people promises and 2 wider themes of engagement and morale. The Chief People Officer confirmed that the survey results whilst seeing the Trust consistently above the worst performing Trust in each category the Trust is not in the upper quartile for any of the questions. The Committee considered the question responses considering the prior legacy Trust results across the two themes of engagement and morale. The Committee also received information on the local questions added to the survey. These questions were added to assist the Trust to understand its strategy deployment. The Committee agreed these provided valuable insight to enable there to be targeted improvement. The Chief People Officer updated the Committee on the process for sharing the results within the Trust and the work to develop both local and Trust wide improvement actions. The Committee **ENDORSED** the areas for the improvement actions and **NOTED** that many of these areas are aligned to the reports presented to the Committee and that this reporting will enable the Committee to efficiently consider the delivery of these actions. The Chief People Officer informed the Committee that the data will be analysed by the new clinical operating model to allow them to have this as a base line position by which to measure improvement. The Committee **ENDORSED** this approach and that it will aid with the tracking of the delivery of improvement actions through the next survey which will occur in the late summer / early autumn of 2022.

The Committee **RECEIVED** a report on creating a culture of safety looking at violence and aggression suffered by our staff. This area and the actions being taken support the Trust's Breakthrough Objectives to increase the number of staff recommending the Trust as a place to work. The Committee **NOTED** the developing national violence prevention and reduction standard and that the work within this area is linked to one of the priority areas for the ICS people committee. The Committee **NOTED** the workstreams to deliver the standard within people and quality dimensions. The Committee discussed the linkage of work being undertaken in respect to improving patient experience which will enable the Trust to engage with patients seeking to reduce anxiety through enhanced communication which should reduce stress felt by patients as they enter our services that should then see a reduction in their frustrations as they wait.

The Committee **RECEIVED** a report introduced by the Chief People Officer providing the outcome of the Maternity Listening events. The Committee **NOTED** the actions developed from the feedback structured under key themes of; recruitment, retention, education, training career pathways and career progressing as well as wellbeing, inclusion and communication. The Committee **ENDORSED** the approach of using learning events which has been applied within Maternity being utilised within other services and teams to actively engage staff

to shape the improvements as a way of supporting the delivery of the People Breakthrough Objective. The Committee **AGREED** that as the areas of improvement are identified then clarity of the resultant action and their delivery timeframes needed to be provided recognising that for some suggested areas the Trust may not be able to progress them and in these cases feedback is needed to ensure expectations are clear.

The Committee **RECEIVED** the Health Wellbeing Strategy update and **NOTED** that a Trust assessment has been undertaken in respect of the achievement of the 7 elements of the national NHS Health and Wellbeing Framework with this assessment then having been used to develop the Trust's strategy. The Committee **ENDORSED** the five principles of leadership; prevention and self care; interventions; support; and data & metrics that unpin the strategy. The Committee **NOTED** the strategy development next steps with a view to have this developed during May 2022. The Committee discussed the systems for the capturing of data to enable the Trust to be able to judge the delivery of strategy and recognised these processes as being pivotal to the Committees ability to judge the success of the Strategy.

The Committee **RECEIVED** an update on Strategic Initiative in respect of Leadership, Culture, and Development from the Director of the Integrated Education. The Committee **NOTED** that the integrated education oversight group is to meet in early May which will then report to this Committee on the actions planned within integrated education. The Committee was updated on Statutory and Mandatory Training performance and was updated on the work being undertaken to have one learning management system across the Trust and to have this integrated to ESR which will support ease of access and more timely recording of training. The Committee **NOTED** that the national trainee survey is being undertaken at this time and the Trust expects to receive the outcome of this by the end of July or early August. Based on the update provided the Committee was **NOTED** the actions being taken to provide reports to the Committee on the delivery of the integrated education board and that forum's oversight of educational risks.

In respect of the Corporate Project, Electronic Workforce Deployment, the Director of Workforce Planning and Development presented an update on this project and informed the Committee that the project charter for the electronic medical workforce deployment is in progress. The Committee **NOTED** the update on the project risks and their mitigations through a rephasing of elements of this work.

Committee Activity

The Committee **NOTED** the developed workforce dashboard. 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. The Committee **NOTED** the enhanced commentary provided as requested at the previous meeting and that this will flow into the Board integrated performance report. The Committee **NOTED** the pressure on staff and the impact this is having on the Trust's levels of compliance with its targets for staff training and appraisals. The Committee asked about the developing workforce scorecard. The Chief People Officer confirmed that this is in progress and an active discussion is being held as the quality scorecard metrics have now been developed to reduce duplication. The Committee **ASKED** that information is provided on the workforce scorecard at its next meeting.

The Committee **RECEIVED** an update from the Chief People Officer in respect of the Trust's Freedom to Speak up Guardian activities, as the Guardian was on leave for the meeting. The Committee sought for future reports that there is consistency of reporting going forward.

Reporting Groups

The Chief People Officer provided the Committee with an update on the respective Committee reporting groups. The Committee **NOTED** that these Groups had not met since the last meeting. The Chief People Officer provided an update on the role the People Steering Group will play in co-ordinating the oversight of information flowing from the various formally established sub groups to the Committee. The Committee **NOTED** the Steering Group's in support of the regularising the reporting from the respective groups to this Committee. The Committee **NOTED** the Chief People Officer's assurance that the groups will start to provide

formal reports to the Committee over the forthcoming year. The Committee **ENDORSED** the Terms of Reference of the Leadership Steering Group.

ICS Update

The Committee **RECEIVED** an update from the Chief People Officer on work being undertaken within the ICS and that the respective Chef People Officers across the ICS who continue to progress collaborative projects. The Committee **NOTED** the Trust's continued engagement with such projects where collaboration would bring benefits to our staff including occupation health provision.

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 seven risks that have been raised that have the potential to impact on our people domain which for quarter 4 have been identified with a post-mitigation score of 12 or above. These being:

- Payroll (current score of 15)
- Risk of insufficient medical staff (current score 12)
- Insufficient numbers of registered nurses and health care nurses (current 12)
- Covid absence (current score 12)
- Future vaccination (flu and Covid) (current score 12)
- Health and wellbeing (current score 16)
- Staff stretch and patient experience (current score 16)

The Committee recognised the interlinkages of these risks to those with the quality and patient experience.

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 as well as being supported by the information received within the meeting continue to correctly reflect the pressures on the Trust's workforce along with the context of the wider risks impacting on Trust and the workforce

Terms of Reference

The Committee **RECEIVED** a report from the Company Secretary on the review of the Committee's Terms of Reference after its first year of operation. The Committee **AGREED** that only minor changes were required as the current Terms of Reference correctly reflected the activity of the Committee to achieve its stated purpose. The Committee NOTED these may change if the reporting from the Freedom to Speak up Guardian changes to the Quality Committee but that this would be subject to a view to be taken at Board. The Committee **AGREED** that the supporting Committee cycle of business adequately supports the basis for the agenda planning for the meetings across 2022/23.

Actions taken by the Committee within its Terms of Reference

The Committee **APPROVED** the minor revisions to the 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** that information on the workforce scorecard metrics is provided at its next meeting. The Committee **SOUGHT** formal reports from each of the Committee reporting groups for its next meeting.	
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.	To Board 5 May 2022

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	14	**Meeting:**	Board	**Meeting Date:**	5 May 2022
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 28 April 2022 and was quorate as it was attended by two Non-Executive Directors, the Chair, the Chief Financial Officer, the Chief People Officer, the Chief Operating Officer, the Chief Medical Officer and the Chief Governance Officer. In attendance were the Finance Director, the Director of Capital, the Director of Estates and Facilities and the Commercial Director. Alongside these the Director for Improvement and Delivery attended for their item.

The Committee received its planned items including the reports on the Sustainability True North, Breakthrough Objective, Strategic Initiative and Corporate Project, along with updates on the Trust's Financial Performance, the Efficiency Programme, the Capital Programme, an IM&T update, an update on the 2022/23 Financial Planning Framework, the Sustainability risks and the Board Assurance Framework.

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. However the Committee recommended that the Board note the increased risk to the development of the Trust's efficiency programme should the PMO's conflicting priorities not be resolved.

The Committee recommended to the Board that the digital strategy is prioritised for a Board discussion

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COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Sustainability Committee	**28 April 2022**	**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 and Strategic Initiative

The Committee **RECEIVED** an update on the financial performance of the Trust and **NOTED** that the Trust was achieving its financial control total of breakeven for quarter 4, with a small surplus £123k. The Committee was **ASSURED** through their review of the Finance Report for quarter 4 and the supporting scorecard alongside the engagement from the Trust Finance Director, on the actions undertaken to deliver the Trust's overall year end breakeven position, year-end cash position and the delivery of the revised capital plan for the year. The Committee was **ASSURED** through the paper and the discussions with the Chief Financial Officer and Trust Finance Director that the risks reported are fairly stated. The Committee **NOTED** the linkage between this report and the quarter 4 Efficiency Report and the quarter 4 Capital Programme Report. The Committee discussed the financial corporate risk register and through the update from the Trust's Finance Director was **ASSURED** over the actions being taken to mitigate these through 2022/23.

The Committee **RECEIVED** updates on the delivery of the Sustainability Breakthrough Objective - Premium Spend Reduction. The Committee **NOTED** the update provided by the Trust Finance Director including the analysis undertaken of the top contributors and the developed improvement actions to support the reduction in the use of agency spend. The Committee **NOTED** that given the changing environment in respect of workforce nationally the Trust is engaging with the ICS to work on the development of new roles. The Committee **NOTED** that there is a scheduled review within this area for May 2022 to be presented to the next Committee SDR meeting

There was an update on the Strategic Initiative - Environmental Sustainability provided by the Director of Facilities and Estates. The Committee **NOTED** that clinical leads have been appointed and will support the clinical leadership and ambassadorial role these roles bring to the development and delivery of the developing initiatives. The Committee **NOTED** that the Trust has secured a 37% carbon reduction already with 33 identified schemes developed to achieve the 57% carbon reduction to 2025 – 26. The Committee **NOTED** that detailed PIDs and QIAs have been developed and tracked through the developed carbon improvement tracker which provides effective oversight of this at the Environmental Sustainability Steering Group and this Committee.

The Committee discussed the initiative risk register and through the update from the Trust's Director of Facilities and Estates was **ASSURED** over the actions being taken to mitigate these. The Committee **NOTED** the Trust is driving this area as part of our engagement with the ICS to ensure the Trust's momentum is not lost.

In respect of the Corporate Project – PAS Implementation, the Committee was **ASSURED** from the feedback provided by the Chief Medical Officer on behalf of the Director of IM&T that the project remains on

track and the realigned system launch within the Emergency Department took place with a successful deployment. The Committee **NOTED** that the project continues to be well supported by both strong levels of clinical and operational engagement.

Use of Resources

The Committee **RECEIVED** a quarter 4 Trust's Capital Programme Report. This report was submitted from the Trust's Capital Investment Group. The Committee was **ASSURED** by the Director of Capital over the work of the Trust to deliver the programme recognising the level of delivery of the schemes especially those where funding was provided to the Trust late. The Committee **NOTED** the positive phasing of funding from 2021/22 into 2022/23 which will see early investment into our estate and equipment.

The Committee **RECEIVED** the Trust's 2022/23 capital plan and the Director of Capital informed the Committee on the Trust's capital prioritisation process to develop the plan. There remains an over programme risk with a plan to have a further prioritisation stage to take place next month. The Director of Capital highlighted the key schemes within the Plan, covering developments across all the Trust's sites and across each of the Trust's Divisions. The Director of Capital reminded the Committee that with the carry forward of developed schemes this will mean that the delivery of the programme will commence early which will aid programme delivery. The Committee **NOTED** the contribution that the planned capital schemes will contribute to the Trust reduction in its carbon footprint. The Committee through the presentation of the report and discussion with the Director of Capital was **ASSURED** over the designed mitigations for the identified risks but recognised the supply chain risks our main contractors and the process for prioritisation and re-prioritisation of projects to ensure that programme spend is maintained.

The Committee **RECEIVED** the quarter 4 Efficiency Programme Report from the Director for Improvement and Delivery on the delivery of the Trust's efficiency programme for the year 2021/23 and **NOTED** the effort made by the Divisions and the Trust to secure the level of achievement of 93% of the initial target set given the continuing Covid challenges, this level of delivery was supported by the Trust's programme management office. Through the update provided by the Director for Improvement and Delivery the Committee was **ASSURED** over the divisional engagement and remains in a good place for the delivery of the 2022/23 programme on a recurring basis.

The Committee **NOTED** the progress being made on the development of the 2022/23 Efficiency Programme, noting that this is less developed than that seen in prior years. The Committee through the presentation of the report and discussion with the Director for Improvement and Delivery was **ASSURED** over the actions being taken to identify a more mature plan during May, noting that £20m of schemes are already matured with clear PIDs developed. A further £11m of schemes are in development split between schemes which have been identified but for which a PID is to be developed to detail the timing and value of the identified efficiency and areas where data is showing there may be a potential to improve, but they need more work. The Committee **NOTED** that a more matured efficiency plan is to be presented to the next meeting. The Committee **AGREED** with the Chief Financial Officers' comment, that key to the plan to deliver the overall 3.7% efficiency programme this year, will be the development of productivity and transformational schemes, and the Trust is establishing a process to track these efficiency gains and report this information through to the respective Board Committees. The Committee through the presentation of the report and discussion with the Director for Improvement and Delivery **NOTED** the identified risks to the development and then delivery of the 2022/23 efficiency programme. These being the continued operational pressures on the divisions; competing programme office priorities preventing the team being able focus on the efficiency work; and the need to engage with new interim staff appointments within the developed clinical operating model in order to support these staff to engage with the Trust's efficiency methodology and processes. The Committee **AGREED** that pivotal to the development and delivery of the 2022/23 efficiency programme is the plan to have conflicting PMO priorities removed therefore allowing them to apply their skills to what is a key area of activity for the Trust.

The Committee **RECEIVED** the quarter 4 IM&T Programme Report on the wide-ranging Trust's IM&T programme of work. The Committee was taken through main IM&T work being undertaken over the next quarter focusing on infrastructure and platform replacement alongside data showing the performance of the

IT department itself. The Committee discussed the opportunities that IM&T can support within the Trust's productivity improvement. The Committee **AGREED** to raise with the Board the need for the Digital Strategy discussion to take place early in 2022/23.

The Commercial Director provided an update on the activities of the newly formed commercial directorate. The Committee welcomed this first report from the director and **NOTED** the breadth of the work being delivered through this directorate and the developing commercial infrastructure of the Trust. The Committee **NOTED** specifically the work on the Trust's Retail Strategy and the opportunity provided at the Waves Restaurant to both support staff's expressed wishes in respect of the catering offer but also to align this to the Trust environmental strategy through locally sourced and delivered catering. The Committee **NOTED** that the restarting nationally of procurement benchmarking information and was **ASSURED** by the Commercial Director that reporting of these comparisons and the Trust's position and any improvement actions will be flow through to the Committee within this activity report.

ICS

The Committee **RECEIVED** a report on the development of the Trust's 2022/23 financial plan following the initial report to the Board at the end of the prior week (22 April 2022). The Committee was remined that key to the plan is the delivery of 19/20 activity within the 19/20 cost base to secure additional funding. The Trust's Finance Director informed the Committee of the outcome of the discussions with the ICS which sees the Trust's deficit plan of some £12.55m relating to excess inflationary costs. The Committee **NOTED** that the 2022/23 annual plan will be submitted to Board on 5 May 2022. The Committee through the presentation of the report by the Chief Financial Officer and Trust Finance Director was **ASSURED** over the Trust's plans to address the identified risks to the delivery of this financial plan and the developed mitigations. The Committee **NOTED** the consistency between this report and the reports received at the Committee in respect of the 2022/23 capital programme and the 2022/23 efficiency programme. The Committee **NOTED** the risks the regime change brings and that there remained uncertainty for the Trust and the ICS especially in the receipt and allocation of system received Elective Services Recovery Funds and the requirement for collaborative actions in respect of Medically Ready for Discharge patient management. The Committee noted this impacts the BAF risks 2.1 and 2.2 and sees those remain elevated. The Committee **NOTED** that a 2022/23 Financial Plan will be presented to the Board for their approval.

The Committee **RECEIVED** an update from the Chief Financial Officer on the work of the ICS Finance Leadership Group of the ICS in April 2022. The Committee **NOTED** this work and how it linked to the prior report at the Committee in respect of the 2022/23 planning and the areas the group would focus on, including the need for transparency of the efficiency and productive system measurement, capital planning and the capital scheme prioritisation framework at an ICS level for years 2 and 3.

Risk

The Committee **REVIEWED** the quarter 4 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 that there are 20 risks with a current score of 12 or above and there is 1 risk with an impact of 5 but scoring below 12 covering the areas of sustainability true north, operational pressures and productivity, capital and IM&T. Five of these identified risks are identified with a current risk score of over 12, these relating to Payroll, Cyber Security and Capital Developments

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, 2.2 and 2.3 were fairly stated.

Terms of Reference

The Committee **RECEIVED** a report from the Company Secretary on the review of the Committee's Terms of Reference after its first year of operation. The Committee **AGREED** that only minor changes were required as the current Terms of Reference correctly reflected the activity of the Committee to achieve its stated purpose. The Committee **AGREED** that the supporting Committee cycle of business adequately supports the basis for the agenda planning for the meetings across 2022/23, recognising that as the Committee agendas are set between the Committee Chair and Chief Financial Officer.

Actions taken by the Committee within its Terms of Reference

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

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

The Committee **AGREED** to recommend to the Board the Trust's Capital Plan for 2022/23

The Committee **AGREED.** within its delegation, the Trust's programme for medical devices

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

The Committee recognised that within its current matters arsing that a deep dive in respect of the drivers for the continued overspend on medial premia is scheduled to come to its SDR meeting in May.

The Committee noted that the matured efficiency programme for 2022/23 will form part of the scheduled efficiency report at its next Committee meeting at the end of quarter one.

The Committee asked that further information is brought within the reports to the Committee on productivity improvements.

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

Item	Referred to
The Committee recommended to the Board that the risks within the BAF for which it has oversight are fairly represented. The Committee recommended to the Board that the digital strategy is prioritised for a Board discussion. The Committee recommended that the Board note the increased risk to the development of the Trust's efficiency programme should the PMO's conflicting priorities not be resolved.	To Board 5 May 2022

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	15	**Meeting:**	Board	**Meeting Date:**	5 May 2022
Report Title:	Systems and Partnerships 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 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			
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 the 27 April 2022 and was quorate as it was attended by three Non-Executive Directors, the Trust Chair, the Chief Financial Officer, the Chief Operating Officer, the Chief People Officer and the Chief Governance Officer. In attendance was the Director of Strategy and Planning, with the Programme Director for the urgent care recovery programme in attendance for his item in the agenda in respect of Urgent and Emergency care performance improvement.

The Committee received its planned items including the Q4 report on the key reports on the respective the Systems and Partnerships Trust North, Breakthrough Objectives, Strategic Initiatives and Corporate Projects, along with updates on the Trust's work within the ICS, and the Board Assurance Framework.

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 5.1, 5.2 and 5.3, for which it has oversight, with the increase in risk 5.1 are fairly represented.

University Hospitals Sussex
NHS Foundation Trust

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Systems and Partnerships Committee	**28 April 2022**	**Patrick Boyle**	✓	☐

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 four including the performance against the Trust's systems and partnership true norths and breakthrough objectives for emergency and planned care for Q4. The Committee **NOTED** the Trust continued to focus on reducing the patients waiting the longest, those over 104 weeks for elective RTT treatment and that for this cohort of patients the Trust was delivering its trajectory to have no patients wating over 104 weeks by June 2022. The Chief Operating Officer also confirmed that the Trust is also delivering against its trajectory to eliminate patients awaiting over 104 days for Cancer Treatment. The Committee **NOTED** the update from the Quality Committee chair that there is a programme of clinical harm reviews that are undertaken for patients with excessive waits and the outcome of those reviews is reported to Quality Committee. The Committee asked that for future reporting to this Committee that the outcomes of the harm review work is triangulated against the Trust's reported performance bringing into the report the qualitative aspect of patients waiting. The Committee also **NOTED** the reported performance against the diagnostic standard improved marginally in March but was still adverse to national performance average.

The Committee **RECEIVED** a more detailed update in respect of the Trust's Urgent and Emergency Care Recovery Plan from the Programme Director for the urgent care recovery programme. The Committee **NOTED** that the Urgent Treatment Centre (UTC) at the Royal Sussex County Hospital was showing good activity levels within its first weeks of operation. The Programme Director updated the Committee on the recovery plan itself and that its development was structured around four key areas, these being to have zero 60 min ambulance handover delays; zero 12 hour patient delays within ED for admitted pathways; to secure a 25% – 35% increase in UTC streaming; and increasing pathway zero discharges and those before noon Early. The Committee **NOTED** the established measurable improvement metrics captured within the tactical scorecard which is shared both internally and with our system partners. The Committee was **ASSURED** by the presentation of this report by the Programme Director that the improvement plan was developed utilising the Trust's patient first improvement methodology. The Committee **NOTED** that a series of qualitative outcomes are being developed to triangulate with the quantitative outcomes and that this information will be reported to future meetings. The Committee **AGREED** to receive within its regular updates', information on the delivery of these planned actions along with the improvement metrics.

In respect of the delivery against the suite of performance measure the Chief Operating Officer informed the Committee that a broader performance dashboard would be presented to the next formal committee meeting. The Committee **AGREED** with this action reflecting that having a developed relevant dashboard presented regularly to the Board Committee was an action agreed within the Committee effectiveness review.

The Committee **RECEIVED** updates on the Trust 3Ts hospital development Strategic Initiative from the Chief Financial Officer as the executive lead for this initiative. The Committee **NOTED** that the 3Ts Strategic

Initiative has transitioned into focusing on the operational readiness. The established 3Ts clinical and operations leaders are supporting with the engagement of this phase. The Committee **NOTED** the early priorities of the established steering group and the associated workstreams. The Committee noted the programme risk register 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 **NOTED** that a number of these risks linked to those presented also to the Sustainability Committee in respect of the complex capital funding arrangements for the stages of the 3T build.

The Committee **RECEIVED** updates on the delivery of the respective Corporate Projects, in respect of M&A and Restoration and Recovery. In respect of the M&A project the Committee **NOTED** the review of the activity undertaken across the year, covering the aspects of quality governance alignment, workforce integration, the development of the corporate operating and clinical operating models, recognising that the clinical operating model deployment is planned for July 2022. The Committee **NOTED** the plan to ensure over the first quarter of 2022/23 that these processes are embedded into the Trust's business as usual processes allowing this project to be closed. The Committee recognised that whilst some of these areas such as quality governance and the clinical operating model will continue to see development work continue across the year. The Committee **AGREED** that the merger benefits realisation tracking process has been aligned to the Trust's delivery of a number of its True Norths and individual projects. The Committee **NOTED** that the Restoration and Recovery report complemented the discussions held within the update on the Systems and Partnership True Norths.

The Committee **AGREED** that the Trust's ability to improve its productively including the deployment of its workforce would be key to the delivery of its 2022/23 plan. The Committee **ASKED** that within future reports to this Committee that a focus on productively is provided complementing the discussion at the Sustainability Committee about the potential for the development of a productivity performance tracker.

ICS and Systems Collaborations

The Committee **NOTED** that the Sussex Acute Collaborative Network meeting in April was postposed but the Trust continues to engage with the system partners in the development and delivery of actions to enhance acute collaboration for the benefit of the patients of Sussex.

The Committee **RECEIVED** an update on the Trust's work with Queen Victoria Hospital NHS Foundation Trust and **NOTED** the plan for the remobilisation of the development of the Full Business Case in conjunction with QVH. The Committee **NOTED** the breadth of work supporting the development of the Full Business Case including the development of the Post Transaction Integrated Plan, the undertaking of the Due Diligence and the drafting of the transaction agreement itself. The Committee **NOTED** that the outline workstream deadlines to enable a transaction to be delivered for 1 April 2023.

Risk

The Committee **NOTED** that within a number of the reports taken at the Committee there had been a discussion in respect of the overarching risks from the respective Strategic Initiative and Corporate Projects along with the areas of risk in respect of performance delivery. The Committee **ASKED** that for the next meeting the summary report on risk drawing together the key corporate, highly scored divisional risks that have the potential to impact on the systems and partnership domain along with the overarching Strategic Initiative and Corporate Projects risks be reinstated as the Committee found the report to the last meeting beneficial in framing its review of the BAF

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 5.1, 5.2 and 5.3 were fairly stated

Terms of Reference

The Committee **RECEIVED** a report from the Company Secretary on the review of the Committee's Terms of Reference after its first year of operation. The Committee **AGREED** that only minor changes were required as the current Terms of Reference correctly reflected the activity of the Committee to achieve its stated purpose. The Committee **AGREED** that the supporting Committee cycle of business adequately supports the basis for the agenda planning for the meetings across 2022/23.
Actions taken by the Committee within its Terms of Reference
The Committee **APPROVED** the minor revisions to the Terms of Reference. The Committee **AGREED** to recommend the quarter 4 score for BAF risks 5.1 to 5.3 to the Board
Items to come back to Committee (Items the Committee keeping an eye on outside its routine business cycle)
The Committee asked that the consolidated risk report be reinstated for the next meeting The Committee also asked that within future reports to this Committee they include a focus on productively is provided
Items referred to the Board or another Committee for decision or action

Item	Referred to
The Committee recommended to the Board that the risks within the BAF for which it has oversight are fairly represented.	To Board 5 May 2022

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	16	**Meeting:**	Board	**Meeting Date:**	5 May 2022
Report Title:	Audit Committee Chair report to Board				
Committee Chair:		Jon Furmston, Non-Executive Director and Committee Chair			
Author(s):		Jon Furmston, 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	✓				
Link to CQC Domains:					
Safe		☐	Effective	✓	
Caring		☐	Responsive	☐	
Well-led		✓	Use of Resources	✓	
Communication and Consultation:					

Executive Summary:

The Audit Committee met on the 14 April 2022 and was quorate as it was attended by five Non-Executive Directors. In attendance was the Chief Financial Officer, the Chief Executive, the Trust's Finance Director, 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 Director of IT and the Trust's Medical Director attended to provide an update on the respective internal audit reports where they were lead directors. The Director of IM&T also provided an update on the Trust's actions to manage cyber security risks.

The Committee received its planned items with the focus being on receiving the reports in relation to work undertaken by Internal Audit, Counter Fraud during Quarter 4 of 2021/22, the Trust's draft Annual Governance Statement, the Trust's assessment of compliance with the NHS I Provider Licence and declaration of interests processes. The Committee received and approved the Internal Audit and LCFS plans for 2022/23. The Committee also received its scheduled reports in relation to tender waivers, losses and special payments and the report from the interim Health and Safety Committee chair on the activity of that Committee. The Committee also received information in relation to the Trust's financial statements and that they will be prepared on a going concern basis.

Through these reports the Committee received assurance over various aspects of the Trust's system of internal control, including its systems of internal financial control, systems for preventing fraud, information governance and processes of business conduct. The Committee was also assured that identified actions were being dealt with and that any delays in the delivery of agreed actions are to be addressed by the next Committee meeting.

Key Recommendation(s):

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

The Board is also asked to **NOTE** the Audit Committee's endorsement of the draft 2021/22 Annual Governance Statement being incorporated into the 2021/22 Annual Report for External Audit.

The Board is asked to **APPROVE** the Trust's assessment of compliance with its Provider Licence based on the recommendation of the Audit Committee.

University Hospitals Sussex NHS Foundation Trust

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Audit Committee	**14 April 2022**	**Jon Furmston**	✓	☐

Declarations of Interest Made

There were no declarations of interest made

Assurances received at the Committee meeting

Internal Audit activity

The Committee **RECEIVED** the Internal Audit progress report incorporating the management action plans for the work undertaken since the last meeting for UHSussex. The Committee **NOTED** the continued use of Internal Audit resources to assist the Trust to make improvements and was **ASSURED** over the agreed actions in respect of the reviews covering Data Quality (Maternity), the Trust's Data Security Protection Toolkit, IT post implementation and Disability Confident work.

The Disability Confident Internal Audit report was included for reference at this meeting as it was discussed in detail at the Committee's last meeting where assurance was provided by the Chief People Officer on the actions being taken.

The IT post-merger implementation was an area where Internal Audit were proactively used to look at the Trust's processes following the merger. Internal Audit provided a complimentary conclusion on the Trust's processes. The advisory recommendations were agreed by the Director of IM&T as adding value to the Trust's processes. The Audit Committee on receipt of the action plan and the update provided by the Director of IM&T was **ASSURED** that the actions to be enacted will deliver the enhancements identified within the advisory review.

The Internal Audit review of the Trust's Data Security Protection Toolkit assessment provided a high level of confidence that the Trust's submission is correctly stated. The Committee **NOTED** this assurance and the continued confidence it provided over the Trust's processes for data security and information governance compliance which support statements made within the Trust's Annual Governance Statement.

Data Quality within maternity reporting, this was a further area where given the development of the respective dashboards Internal Audit was asked to proactively review these processes. This work recognised the developing nature of the codification of the data definitions for the developed dashboards. The Medical Director provided a detailed update on the actions taken in respect of this audit and that these will track through the future dashboards. The Audit Committee was **ASSURED** over these actions and **AGREED** that a planned follow up audit be scheduled as the respective dashboards are planned to be further adjusted in 2022/23 as part of their planned development following the Trust's own review of their content and the feedback from the LMNS. The Committee asked that the proactive of use of Internal Audit to continue to test the Trust's data quality processes be considered by the executives in respect of the use of the currently unallocated Internal Resource within the approved plan.

The Committee **RECEIVED** an update on the Trust's activities in respect of the cyber security risks from the Trust's Director of IM&T who holds the position of the Trust's Senior Information Risk Owner. The detailed update of the activity undertaken by the IT Department, in respect of device and system security, access controls, local systems oversight and staff awareness programmes provided **ASSURANCE** over the Trust's actions and their positive impact on managing these risks.

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 they all had revised timescales and that these were considered by Internal Audit noting that those did not raise any significant uncontrolled risk.

Draft Head of Internal Audit Opinion

The Committee **RECEIVED** the draft Internal Audit Head of Internal Audit Opinion for 2021/22 which provided an overall positive opinion and noted that he majority of audits provided moderate assurance including the key audits of key financial systems. Internal Audit concluded that through their work on key audits including key financial systems that in the areas of core assurance the Trust continues to perform strongly. The Committee **NOTED** that this opinion is to be reflected within the Trust's Annual Governance Statement.

2022/23 Internal Audit Plan

The Committee **RECEIVED** the 2022/23 Internal Audit plan which was aligned to Trust's BAF and the mandated areas of Internal Audit activity to enable the delivery of an annual Head of Internal Audit Opinion. The Committee **AGREED** the initial 2022/23 plan and **NOTED** there remained a continued focus on the use of Internal Audit resource to review areas where activity would accelerate improvement and that the plan contains some flexibility should emergent issues arise where Internal Audit support / review would be beneficial.

Local Counter Fraud

The Committee **RECEIVED** the Local Counter Fraud annual report which provided information in respect of their proactive work undertaken, fraud awareness raising work and the work in response to any reporting concerns. The update from the Trust LCFS on the assessment of the Trust's processes against the national counter fraud functional standards provided an overall Green rating, with those areas where enhancements can be made flowing through the 2022/23 work programme. The Committee received **ASSURANCE** from the update provided by the Local Counter Fraud Specialists on their work during the year that there were no significant fraud risks which Trust needed to be actioned urgently within the Trust.

The Committee **RECEIVED** and **APPROVED** the Local Counter Fraud annual work plan for 2022/23.

External Audit

The Committee **RECEIVED** both a report including sector updates and the external auditors plan. The External Audit partner took the Committee through the external audit risks and the activity they plan to undertake, noting that some work had already been undertaken in these areas. The Committee **NOTED** that the review undertaken by External Audit had not identified any local risks of significant weakness that would require audit work over and above the mandated risks required to be covered by external audit in respect of the Trust's financial statements. The Committee discussed the external auditors work in allowing them to issue their value for money conclusion and their plan for that work to be delivered and concluded at the same time as the work on the Trust's overall opinion. The Committee **APPROVED** this plan.

2021/22 Annual Accounts

The Committee **RECEIVED** an update from Trust's Finance Director on the Trust's annual accounts preparation work. The Committee **NOTED** that the external auditors interim audit had progressed in line with the plan recognising that the required stock takes had been undertaken by External Audit. The Committee was **ASSURED** by the update provided and the commentary of the External Auditors that the Trust has a robust plan to deliver its financial statements and is geared up to support their Audit to meet the required submission timescales.

The Committee **RECEIVED** a report on Management's Going Concern Assessment. The Trust's Finance Director took the Committee through the rationale supporting the assessment that the Trust's financial

statements should be prepared on a going concern basis. The Committee discussed this assertion, with the Chair of Sustainability Committee confirming the assertions made were consistent with the information presented to that Committee. The Committee **APPROVED** that the Trust's financial statements should be prepared on the going concern based.

Losses and Special Payment Report

The Committee **RECEIVED** the Trust's Losses and Special Payments registers. The Trust Finance Director provided information on those cases since the last meeting and the overall position for the year, noting that the levels of these were lower than those of last year. The Committee **RECEIVED** the tender waiver report for quarter 4 and the cumulative position for the year. The Commercial Director updated the Committee on the work that had been undertaken with the procurement teams and the divisions which supported the reduced in 21/22 of the number of waivers required. The Committee, through these reports, was **ASSURED** over the underlying processes applied to manage Trust resources.

Audit Committee Reporting Group – Health and Safety

The Committee received **ASSURANCE** from the Health and Safety Committee Chair's report from its meeting in January 2022 supported by a verbal update from the Committee Chair on the activity of the meeting held 12 April which meant the formal report was not able to be shared at this meeting. The Committee asked that the scheduling of these meetings be reviewed to ensure they allow for a more timely flow of information to this 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.

Annual Governance Statement

The Committee **RECEIVED** the Trust's draft Annual Governance Statement. The Company Secretary took the Committee through its construction and confirmed its compliance with the FT Annual Reporting Manual Requirements. The Committee **AGREED** subject to a small number of observations that this draft statement be included within the Trust's draft annual report which is to be submitted for External Audit review and opinion in May 2022.

FT Provider Licence – annual declarations

The Committee **RECEIVED** a report from the Trust's Company Secretary in respect of the Trust's declarations against the Trust's Provider Licence. The Committee considered the assertions made and based on their review **RECOMMENDED** this declaration to the Board for approval indicating compliance with each of the licence requirements.

Declarations of Interest Annual Report

The Committee **RECEIVED** a report from the Trust's Company Secretary in respect of the application of the Trust's declarations of interest policy and was **ASSURED** over the application of these processes given the high level of responses made thus far this year. The Committee **NOTED** that from the review of those returned, that there have been no areas of potential conflict identified.

Actions taken by the Committee within its Terms of Reference

The Committee **AGREED** the Internal Audit, External Audit and Local Counter Fraud Plans for 2022/23

The Committee **AGREED** the draft Annual Governance Statement subject to the comments provided by the Committee be included within the Trust's draft Annual Report as it is submitted for audit review.

The Committee **AGREED** that the Trust should prepare its financial statements for 2021/22 on a going concern basis.

Items to come back to Committee (Items Committee keeping an eye on)	
The outcome of the executive review of the unallocated Internal Audit resources within the approved plan be brought back to a future meeting through the regular Internal Audit plan progress updates	
Items referred to the Board or another Committee for decision or action	
Item	**Referred to**
The Committee recommended to the Board for their approval the Trust's assertions of compliance with its Provider Licence.	The Board

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	16.1	**Meeting:**	Trust Board	**Meeting Date:**	05 May 2022
Report Title:	NHS Improvement Provider Licence self-certifications for 2021/22				
Sponsoring Executive Director:	Darren Grayson – Chief Governance Officer				
Author(s):	Glen Palethorpe – Company Secretary				
Report previously considered by and date:					

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

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

Implications for Trust Strategic Themes and any link to BAF risks		
Patient	✓	The provider licence covers all aspects of the Trust's delivery.
Sustainability	✓	
People	✓	
Quality	✓	
Systems and Partnerships	✓	

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

Communication and Consultation:

Executive Summary:

Each Foundation Trust is required annually to make an assessment of its compliance with its NHS I Provider Licence.

NHS I have not considered the Trust to be in breach of its Licence and the Trust has not entered into any undertakings in respect of its Licence. Within the NHS System Oversight Framework the Trust is judged to be in segment 2 with segments 3 and 4 indicating the potential for of for a Trust to be in breach of its Licence.

The Trust is declaring compliance with the Licence conditions noting the conditions stipulated within the licence are the minimum requirements expected of Foundation Trusts.

The actual return does not allow in all cases for supporting narrative to be included, therefore the Trust has prepared a short supporting report to aid the public in understanding the basis for the Trust's declared position of compliance.

Key Recommendation(s):

The Board is asked to review the draft of the Trust's assessment of its compliance with the NHS I licence and approve that the Trust is complaint with its provider licence conditions.

University Hospitals Sussex
NHS Foundation Trust

Provider Licence – Self Certifications for 2021/22

Introduction

The Trust each year undertakes an assessment against each of the NHS Improvement Provider Licence requirements. These declarations are once approved placed on the Trust's website.

Certifications

There three declarations required.

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

Declaration 2 - this relates to NHS Provider Licence General Condition FT4 – Corporate Governance

Declaration 3 - relating to the Training for Governors.

Declaration 1

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

The Board is required to confirm it is compliant with the following certification or explain why it cannot certify itself as compliant.

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

UHSussex does not have any conditions placed on its Licence and has not entered into any formal undertakings with NHS Improvement. The Trust was judged to be in segment 2 within the NHS system oversight framework where segments 3 & 4 indicate a significant risk or actual breech of the Licence.

The Trust has received a warning notice from the CQC following an inspection of Maternity services (across all sites) and Surgery at the Royal Sussex County Hospital site. Whilst the inspection was in respect of certain CQC domains one of the domains assessed was well led, this saw a significant reduction in the assigned ratings to requires improvement / inadequate.

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The Trust has provided an improvement plan to the CQC with initial feedback being that the plan addresses all the requirements of the warning notice. The Trust will provide detailed assurance to the CQC by the 29 April 2022 and anticipates that the services subject to the warning notice will be reinspected in April.

Whilst actions are needed to deliver the identified improvements the Trust through its reporting to the established oversight committee and to its Quality Committee and Board has been provided assurance that the plan will be delivered.

Based on the above it is recommended that the Board can confirm its compliance.

Continuity of Service condition 7 – Availability of Resources

The Trust does not have any Commissioner Requested Services; *therefore, this declaration is not required.*

Declaration 2

Condition FT4 - Corporate Governance Statement

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

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

The Trust has established its strategic intentions and has an established set of processes through its Board, Committees, Management and Divisional structures and processes where the monitoring of its strategic deployment takes place and is assured.

Each of the Board Committees have terms of reference agreed by the Board.. Each ToR includes details of their delegated responsibilities for scrutinising and assurance the Board on mandated governance reports and statements. As part of the development of these ToRs they were subject to both internal and external review as to their adequacy with the external review conducted by KPMG confirming their adequacy and effectiveness.

The Audit Committee membership is drawn from the respective Board Committee Chairs facilitating the ability to cross refer between committees matters where the

tracking of improvements in internal control have been identified by Internal Audit, External Audit, Counter Fraud or Management.

Within the development of the Trust's corporate operating model the lines of accountability were assigned to the respective Executive Directors and for each Committee there are assigned Executive Director committee leads.

As part of the merger the Trust's constitution was confirmed to be compliant with the NHS Act.

There are known areas where improvements are required, a number of these were flagged within the post transaction implementation plan, especially the integration of the Trust's quality governance arrangements. These improvements are tracked through the Trust's Merger and Acquisition oversight group.

The Trust's internal auditors have not identified any significant weaknesses within the Trust's internal financial control and the BAF risk 2.3 shows this risk at 12, with a likelihood of 3.

Based on the above it is recommended that the Board can confirm its compliance.

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

During the latest Covid 19 level 4 incident the Executive Team enhanced its reporting and information exchange with the NEDsso that there was a shared appreciation and understanding of the emerging risks and their planned mitigations.

Whilst the Board has overall responsibility for ensuring it complies with revised guidance from NHS Improvement the Trust takes an active role within the ICS both at an Executive Level but also through reporting to each Committee that allows it to horizon scan for likely changes.

Based on the above it is recommended that the Board can confirm its compliance.

3) The Board is satisfied that the Trust implements:
(a) Effective board and committee structures;
(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
(c) Clear reporting lines and accountabilities throughout its organisation.

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The Board has established a set of committees aligned to the Trust's strategic domains along with the mandated committees (Audit, Remuneration & Appointments and Charitable Funds). The planned review of their respective effectiveness is underway and will report to the Board and the Audit Committee.

There are clear lines of reporting for each Committee which include each Committee Chair providing a report to the Board after each of their respective meetings.

At the end of each Committee meeting there is a standing agenda item that allows for items to be cross referred to the most appropriate oversight committee enabling matters that cross committees to be more holistically considered.

Within the development of the Trust's corporate operating model the lines of accountability were assigned to the respective Executive Directors noting that for each Committee there are assigned Executive Director committee leads.

Based on the above it is recommended that the Board can confirm its compliance.

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

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

Through reports to the Board directly and through its Committee structure assurance has been provided on the Trust's efficient and economic operation, the lead committees with oversight are the Sustainability and People Committees.

Whilst there have been numerous changes to the NHSEI financial frameworks the Trust will achieve its financial plan and break even (subject to audit) and it will deliver a substantial proportion of its the efficiency programme.

The Systems and Partnerships Committee has a lead role for the oversight of operational performance and whilst the Trust recognises the significant risks within this area, the Board is sighted on the respective operational performance plans.

The Quality Committee is the lead Committee for providing assurance to the Board on the Trust's compliance with health care standards. Noting that for a number of areas, such as maternity and the CQC improvement plan these are also reported in detail to the Board.

The Board receives and reviews the BAF at each of its scheduled meetings, this review is supported by the prior consideration of the BAF segments within each responsible Committee. There has been a gap in the reporting of supporting corporate risks to the respective Committees.

The Board meets following Committee meetings allowing the Board to receive timely assurance to complement the Executive reporting against the Trust's strategy deployment within their Integrated Performance Report.

The Board's cycle of business ensures that it receives all mandated reports allowing it to meet its obligations in respect of its required declarations. The Committee workplans link to these requirements allowing the Board to receive greater depth of commentary at its meetings.

Based on the above it is recommended that the Board can confirm its compliance.

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

(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;
(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality

of care;
(e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
(f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

The Board Remuneration and Appointments Committee has received regular updates on the Executive, Corporate Director and Clinical Operating Model structures including the rationale for any changes. All changes have been endorsed by the Committee.

In respect of the Non Executives the Council of Governors Appointment and Remuneration Committee received information on the NED skills and were actively involved in the development of the person specification and their subsequent recruitment.

In respect of the quality of care then there are clear executive and committee accountabilities for their oversight.

The Board both directly and through its Committee structures ensures that a focus is maintained on the delivery of safe services. Reporting of the delivery against the Trust's stated quality priorities is provided through the Trust SDR processes and Integrated Performance Report.

Whilst the Trust has a number of CQC improvement actions their delivery is tracked by the Quality Committee.

Based on the above it is recommended that the Board can confirm its compliance.

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

The Trust has an established process that ensures that all Board Members are "fit and proper" persons. This process has been applied to Board appointments made in the year. An annual review of all Board Members' continuation as fit and proper persons will be reported to the Audit Committee at the end of the year. The Board and its Committees through the receipt of Workforce reports have oversight of the actions being taken to mitigate the workforce risks in relation to recruitment and retention complemented and the Board's review of workforce BAF risks.

There is scheduled reporting to the Board on the Trust's compliance with the nursing safer staffing levels and the revalidation of its nursing and medical workforce.

All transformation schemes are subject to a detailed quality impact assessment and this rigor includes those schemes which include any workforce reduction and through this process the Board is assured that the Trust retains an appropriately qualified workforce to deliver its services.

The Board Remuneration and Appointments Committee has received regular updates on the Executive, Corporate Director and Clinical Operating Model structures including the rationale for any changes. All changes have been endorsed by the Committee.

The Trust has reviewed and relaunched its Patient First director development programme.

Based on the above it is recommended that the Board can confirm its compliance.

Declaration 3

Training of Governors

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

The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

As part the merger planning work was undertaken with the support of the Governors to assess the Governor Training Programme. The revised programme and enhanced Governor Induction Handbook have been used to support all new governors elected during 2021/22.

The Governor training programme is supplemented by information workshops / briefings where information on Trust and NHS developments are discussed. Also, at the Council of Governors meetings, a presentation is made by a Non-Executive Director on their role and work of their Committee thus allowing Governors knowledge over the governance of the Trust to be enhanced.

The Chair and Chief Executive regularly meet with the Governors and no issues over their training have been raised during this year.

Based on the above it is recommended that the Board can confirm its compliance.

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Conditions G6 and CoS7

University Hospitals Sussex NHS Foundation Trust *Insert name of organisation*

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates **2021/2022** Please complete the explanatory information in cell E36

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

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

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.		Please Respond

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		Please Respond

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The Trust does not have amy continuty of services conditions within its licence.

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

Signature		**Signature**	
Name	Alan McCarthy	**Name**	Andy Heeps
Capacity	Trust Chair	**Capacity**	Chief Executive
Date	05 May 2022	**Date**	05 May 2022

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

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

University Hospitals Sussex NHS Foundation Trust *Insert name of organisation*

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration" Financial Year to which self-certification relates: **2021/2022** Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Board is assured over its systems of corporate governnce from the work of the Audit Committee, its Internal and External Auditors and their opinions received during the year. The Board's view as to its governance processes is also reflected within the Trust's Annual Governance Statement. #REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Chief Financial Officer and Trust Board Secretary has made the Board, Audit Committee and Executives aware of monitor guidance and any impact / improvements to be made within Trust systems as a result. Also during the period where the Trust is delivering the Covid-19 challenges then the established Gold structure ensures the Executives and NEDs are updated on any governance guidance changes. The Trust through its processes ensured that apprpirate focus was maintained by the Board and Committees during the year. #REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	These processes were referred to and their effectiveness was considered by the Accounting Officer when drafting the Trust's Annual Governance Statement with this description then considered by the Audit Committee as it endorsed the AGS for submission to the Auditors. Respective Committee reporting to the Board is operating effectively as evidenced by the regular reports to the Board from each Committee Chair. #REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	The Board both directly and through its Committee structure has been assured that the Trust's designed systems of internal control have been operating effectively and as intended over the year. Where issues have arisen during the year, for example in respect of operational performance, timely actions have been implement to improve these areas. The Trust will achieve its financial plan and break even (subject to audit) and it will deliver a substantial proportion of its the efficiency programme. The Audit Committee has recommended based on the information it has received that the Trust can prepare its financial statements on a going concern basis. Assurance is obtained as to the quality of the data supporting the Trust's performance reporting through the annual internal audit work programm and management reviews. The Board has received regular assurance over the delivery of the Trust's control total and efficiency plan. Key risks and associated assurance have been reported to the Board during the year through receipt and review of the Trust's Board Assurance Framework. #REF!
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	There is clear leadership and accountability for the delivery of high quality and safe services within the Trust. This is detailed with the Trust's Annual Report and the statements contained therein. The Board both directly and through its Committee structures ensures that a focus is maintained on the delivery of quality services. The Trust's quality priorities continue to be set having regard to feedback from our patients, carers , the Governors and other stakeholders with regular reporting of the delivery against these priorities provided to the Board and the Council of Governors and to our Commissioners. The effectiveness of these processes was again considered by the Accounting Officer in drafting the Annual Governance Statement which in turn was subject to consideration by the Audit Committee prior to its submission to the Auditors and inclusion within the Annual Report. #REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Trust has established a process that ensures that all Board Members are "fit and proper" persons. This process has been applied to Board appointments made in the year. An annual review of all Board Members continuation as fit and proper persons has been undertaken and reported to the Audit Committee at the end of the year. The Board and its Committees through its receipt of Workforce reports has been assured over the actions being taken to manage the workforce risks in relation to recruitment and retention complimented and the Board's review of people BAF risks. Regular reporting is also provided to the Board on the Trust's compliance with the nursing safer staffing levels and the revalidation of its nursing and medical workforce. All transformation schemes are subject to a detailed quality impact assessment and this rigor includes those schemes which include any workforce reduction and through this process the Board is assured that the Trust retains an appropriately qualified workforce to deliver its services. The Trust has a number of established Executive and Senior Management development programmes and these activities are designed to support and strengthen the personnel on the Board, those reporting to the Board and those within the rest of the Trust. #REF!

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

Signature _____ **Name** Alan McCarthy

Signature _____ **Name** Andy Heeps

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

A

Please Respond

Worksheet "Training of governors" | **Financial Year to which self-certification relates** | **2021/2022** | Please Respond

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed	OK

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

Signature		**Signature**	
Name	Alan McCarthy	**Name**	Andy Heeps
Capacity	Trust Chair	**Capacity**	Chief Executive
Date	05 May 2022	**Date**	05 May 2022

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	17	**Meeting:**	Trust Board in Public	**Meeting Date:**	May 2022
Report Title:	Charitable Funds Committee Chair report to Board				
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	✓	

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 12 April 2022 and was quorate as it was attended by three Non-Executive Directors, the Associate Non Executive, the Trust Chair, the Chief Financial Officer and the Chief People Officer. In attendance was the Interim Charity Director for both BSUH and LYH Charities and other members of the Trust's Finance and Charity's teams.

The Committee received its planned items in respect of the two Charities, BSUH and LYH including information on the use of the Charity's respective funds since the last meeting, fundraising activities undertaken as well as information on the charity's performance and the stewardship of the donated funds.

The Committee also approved a series of 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 **NOTED** the decisions taken by the Committee within its delegated authority.

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COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Charitable Funds Committee	**12 April 2022**	**Lizzie Peers**	✓	☐

Declarations of Interest Made

There were no declarations of interest made

Assurances received at the Committee meeting

The Committee received updates on the activity of the BSUH Charity and LYH Charity for the Q4 period, this included information on the use of donated monies for items that enhanced the patient's experience of our services along with support for staff wellbeing and was **ASSURED** that both charities were focused on activities that supported both patient benefits and staff wellbeing.

The Committee was **ASSURED** that both Charities were operating within their respective objectives through the receipt of Q4 performance reports from the Charity Director for both Charities.

The Committee was **ASSURED** over the oversight of the funds through the report from the Charities finance team.

The Committee **APPROVED** bids for use of charitable funds recognising the patient and public benefit of these bids. The included

- The provision of an OCT machine for use in the Sussex Eye Hospital;
- The provision of a further Resuscitaire machine for SRH neonatal unit;
- Support with the Macmillan Information and Support Services refurbishment; and
- The provision of an ultrasound scanner within the Brighton HIV, Sexual Health and Contraception service, noting that the Brighton League of Friends provided matched funding for this item
  The provision of an Ultrasound machine for Breast Care services, noting that the majority of funding for this item was made by a Charity Partner Butterflies.

Actions taken by the Committee within its Terms of Reference

The Committee approved a number of fund bids recognising their patient benefits

Items to come back to Committee / Group (Items Committee / Group keeping an eye on)

The Committee agreed to receive an update from the Charities investment managers

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

Item	Referred to
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; and • the assurances received in respect of the stewardship of the donated funds	

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	18	**Meeting:**	Board	**Meeting Date:**	May 2022
Report Title:	2021/22 Quarter 4 BAF and Corporate Risk Report				
Sponsoring Executive Director:	Chief Executive				
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 April.				
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	✓				
Link to CQC Domains:					
Safe		✓	Effective	✓	
Caring		✓	Responsive	✓	
Well-led		✓	Use of Resources	✓	
Communication and Consultation:					
[3]					

Executive Summary:

Introduction

The Trust identified 13 strategic risks at the start of 2021/22, each risk being assessed against the Trust's risk appetite when setting their target score. 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 and proposed a risk score for Q4.

The closing quarter 4 BAF was considered by the respective Board Committees in April 2022 which then recommended their respective BAF risk scores to the Board who agreed these were fairly stated.

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, Q3 and Q2 and Q2 and Q1.
(⟷ No change, ↑ an increase in risk and ↓ a decrease in risk)

University Hospitals Sussex
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BAF: Strategic Objectives and Strategic Risks (Key: I = Impact L = Likelihood T = Total)	Risk Scores														
	Q1			Q2			Q3			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	3	4	12	3	4	12 ↔	4	4	16 ↑	4	4	16 ↔	3	2	6
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	4	16 ↔	4	2	8
2.2 We cannot deliver ongoing efficiencies and flex our resources in an agile way resulting in an increasing or unmanaged deficit and inefficient, unaffordable and unsustainable services.	4	4	16	4	4	16 ↔	4	4	16 ↔	4	4	16 ↔	4	2	8
2.3 We are unable to meet high standards of financial stewardship meaning we cannot sustain compliance with our statutory financial duties	4	4	16	4	3	12 ↓	4	3	12 ↔	4	3	12 ↔	4	2	8
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	3	12	4	3	12 ↔	4	3	12 ↔	4	4	16 ↑	4	2	8
3.2 We are unable to effect cultural change and involve and engage staff in a way that	4	3	12	4	3	12 ↔	4	3	12 ↔	4	4	16 ↑	4	2	8

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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	**12**	3	5	**15** ↑	4	5	**20** ↑	4	5	**20** ↔	3	2	**6**
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**
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.	3	4	**12**	3	4	**12** ↔	4	4	**16** ↑	4	4	**16** ↔	3	2	**6**
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.	3	3	**9**	3	4	**12** ↑	4	4	**16** ↑	4	4	**16** ↔	3	2	**6**
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	3	**12**	4	3	**12** ↔	4	4	**16** ↑	4	4	**16** ↔	4	2	**8**

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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
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

Quarter 4 summary

Following review at the end of quarter 4 the Executives this have agreed that the all risks exceed their target score and that for 12 of the 13 risks their scores reflect these as significant.

The BAF reflects that the Trust's highest risks scoring 20 are risk 5.3 relating to the delivery of consistent compliance with the constitutional standards and risk, 3.3 relating to workforce. The BAF reflects an increase in risks scoring 16 for quarter 4 being the people risks 3.1 and 3.2.

Supporting Key Risks

Each Committee at their meetings in April 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 for Systems and Partnerships the datix information was not presented). The Committees used this information to consider their potential to change the Trust's BAF score.

See below for the mapping of the Key Risks, through their identified themes to the BAF risks by patient first domain (note the key risk descriptions vary in detail whilst the Datix harmonisation programme continues)

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	Levels of nursing vacancies and an inability to provide consistent nursing & medical cover for escalation/outliers if bed capacity full. Management of young people requiring inpatient care for mental health problems

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	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	A&E RSCH Cohort Area Increase in RTT waiting times.
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 new 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. Current construction market conditions, supply chain constraints are creating an elevated risk to the capital programme at this stage. A further Executive-led prioritisation of service development schemes in May will further reduce the level of over-programming and mitigate some delivery risks of the capital programme. There is an increased level of risk for cybersecurity. This is an on-going and known risk requiring continuous oversight.	Capital Developments Cyber Security
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	The stretch on staffing and their morale and wellbeing. These pressures are not unique to UHSussex but nevertheless pose a significant risk to delivery.	Risk of insufficient medical staff Insufficient numbers of registered nurses and health care nurses Covid absence

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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	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)	Future vaccination (flu and Covid) 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 demonstrate our consistent compliance with regulatory requirements or clinical standards	Operational pressures including Covid-19 pandemic, 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. Staff sickness during COVID Omicron wave. 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.	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. 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
Systems and Partnerships *		

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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 Recovery and Restoration programmes 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 minimum National requirements for elective care	Delivery of the Recovery and Restoration programme. Capacity constraints leading to Increase in RTT waiting times Service Demands

* *For systems and partnerships the key themes and specific risks are predominantly drawn from the report at the start of Q4.*

Conclusion

All the Committees noted that their review of the risk information presented along with the reports they received directly at the meetings in April confirmed the BAF risks were for quarter 4 reasonably scored.

Key Recommendation(s):

The Board is asked to consider the Q4 risk scores in light of the changing environment the Trust is operating within recognising that these scores have been reviewed by the respective oversight committees and their recommendations to the Board that the scores are fairly represented.

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Agenda Item:	19	**Meeting:**	Board	**Meeting Date:**	5 May 2022
Report Title:	CQC update				
Sponsoring Executive Director:			Darren Grayson – Director of Governance		
Author(s):					
Report previously considered by and date:			Updates have been provided to the Board, Patient and Quality Committees alongside the updates provided to the oversight meeting		

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	✓	Link to risk 1.1
Sustainability	☐	
People	✓	Link to risks 3.1 – 3.4
Quality	✓	Link to risk 4.1 – 4.2
Systems and Partnerships	☐	

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

Communication and Consultation:

The information contained in the report has been reported previously to the Board, Patient and Quality Committees alongside the updates provided to the oversight meeting. The Maternity Service and Surgery (East) teams have been actively engaged on the provision of the information and improvement delivery.

Executive Summary:

The attached paper provides the Board with an overview of the process applied to respond to the CQC Warning Notice.

The Trust expects initial feedback from the CQC's recent re-inspection of Maternity and Surgery at RSCH and an update will be provided to the Board in the meeting on the 5 May 2022.

Key Recommendation(s):

Detail what the Board is required to **NOTE** that the Trust has continued with its developed processes to respond to the CQC Warning Notice. The Board is also asked to NOTE that the Trust has made its final response to the Warning Notice by the 29 April and has been re-inspected in the areas of Maternity and Surgery at the RSCH.

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CQC Update

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Executive Summary

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The Trust is in the final stages of preparation of its response to the Warning Notice issued following the unannounced inspection of surgical services at the Royal Sussex County Hospital (RSCH) and maternity services trust-wide. Part of this including preparing these services for reinspection expected week commencing 25th April 2022.

Trust-wide maternity services and surgical services at RSCH were reinspected on 26th and 27th April respectively and at the same time there was a unannounced comprehensive inspection of the Emergency Department at the RSCH. These inspections included interviews with frontline staff and Executives and we awaiting a Provider Information Request (PIR). Informal feedback will be provided to the Trust Chief Executive and Chief Nursing Officer on 3rd May 2022.

Focus in the last week of April, is on preparation of the formal response to the Warning Notice, which includes collation of extensive evidence files and also responding to the PIR within 10 days of receipt.

The Executive Team will continue its usual relationship management with the CQC and ICS and will consider how the operational management of CQC compliance is achieved.

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Background and current workstreams

BACKGROUND

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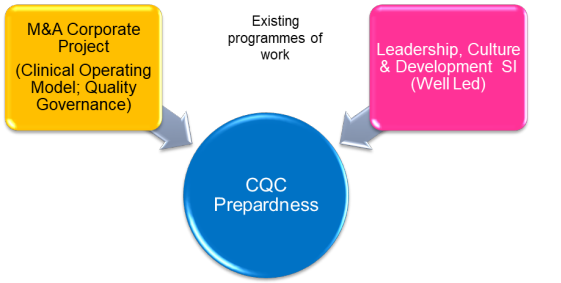
CQC Preparedness Corporate Project

- In July 2021, the Trust was given notice that the CQC would complete a full inspection of UHSussex during 21/22, within the first 12 months of merger. This was due to CQC learnings from previous mergers that there is a potential destabilising effect that may impact Trust safety performance
- Work commenced on the scoping of programme milestones and resources required, with an expectation of maximising synergy between workstreams, alongside use of our BAU processes and PFIS tools.
- The programme was closely aligned to both M&A and LCD corporate projects




CareQuality Commission

CQC Representations
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

For the attention of the Chief Executive
University Hospitals Sussex NHS Foundation Trust
Worthing Hospital
Lyndhurst Road
Worthing
West Sussex
BN11 2DH

22 October 2021

Served by email

The Care Quality Commission
The Health and Social Care Act 2008
SECTION 29A WARNING NOTICE:
Provider: University Hospitals Sussex NHS Foundation Trust

Regulated activities: Surgical procedures and Maternity and midwifery services

Our reference: RGP1-11850142539
Account number: RYR

Dear University Hospitals Sussex NHS Foundation Trust,

This notice is served under Section 29A of the Health and Social Care Act 2008.

This warning notice serves to notify you that the Care Quality Commission has formed the view that the quality of health care provided by University Hospitals Sussex NHS Foundation Trust for the regulated activities above requires significant improvement:

The Commission has formed its view on the basis of its findings in respect of the healthcare being delivered in accordance with:

the Regulated Activity Surgical procedures at the location identified below:

Royal Sussex County Hospital
Eastern Road
Brighton
BN2 5BE

And the Regulated Activity Maternity and midwifery services at the locations identified below:

CQC Unannounced Inspection

- At the end of September 2021, an unannounced inspection took place, focussed on Maternity (all sites) and Surgery (RSCH).
- During this inspection, the CQC identified six areas that required significant improvements, and issued a Warning Notice dated 22nd October 2021. A summary is included in the following slide
- Full Inspection Reports were issued December 21, containing ‘must do, should do’ improvements that the Trust is also required to progress in a timely way. A reminder on the themes captured by the CQC is included as Appendix A.

WARNING NOTICE REQUIREMENTS

University Hospitals Sussex NHS Foundation Trust

- There were six themes identified in the CQC Warning Notice, four requiring improvements by 3rd December, with two for 29th April 2022.
- Under the four themes that required improvement by 3rd December, 17 specific items required a response.
- The Trust responded to the CQC on 6th December, providing a full 'you said, we did' update against the 17 improvement actions. The CQC later confirmed that the submitted action plan (focussed on 3rd December improvements) evidenced significant improvement.
- There were five outstanding actions from 3rd December which either had not made significant improvement or the Trust was not confident that they were sufficiently embedded. In February 2022, the Trust confirmed successful closure of four of the outstanding actions, with only Maternity Triage requiring a longer period to embed.
- A further 29 separate items require improvement by 29th April 2022 (across 22 subjects) and, together with Maternity Triage, form the focus of the final formal response to the CQC at the end of April. The Trust will also confirm the original improvements from December/January continue to be embedded.

3rd December 2021

- Safe Storage and administration of medicines in Maternity
- Safe, secure and contemporaneous medical records in Maternity
- Infection prevention and control in Surgery at RSCH
- Assessing and responding to risk

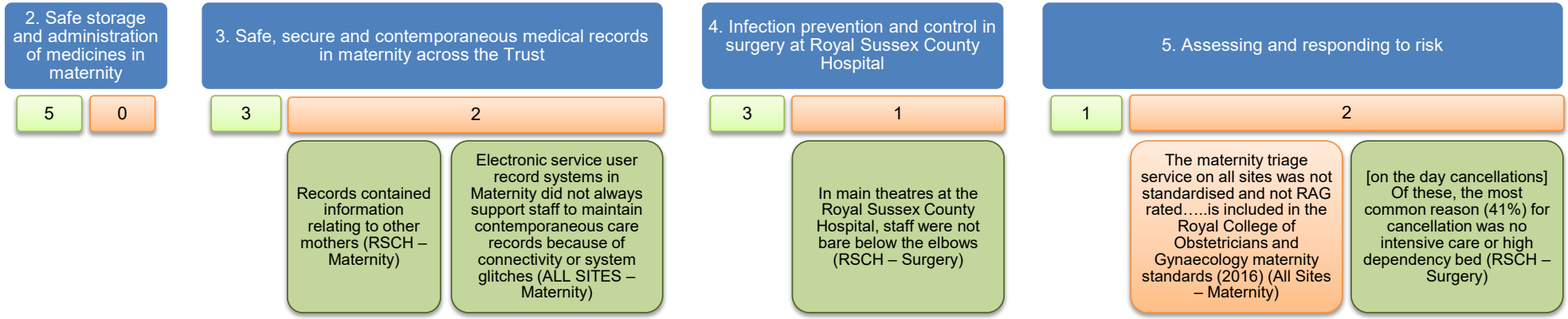
29th April 2022

- Lack of sufficient numbers of trained staff to deliver safe services
- Good governance

WARNING NOTICE - DECEMBER RESPONSE

University Hospitals Sussex
NHS Foundation Trust

In December 21, The Trust confirmed that 12 of the 17 actions had been completed, and that clear action plans were in place for the remaining 5. The graphic below shows the five items that remained in progress.



The Trust received confirmation from the CQC that the submitted action plan (focussed on 3rd December improvements) demonstrated significant improvement. It also recognised the work that has gone into producing the action plan and to ensure all the actions are embedded by the timeframes set out in the warning notice.

In January, the Trust confirmed to the CQC that further compliance has been achieved on four of the remaining five items, with just Maternity Triage RAG process requiring additional time to complete and embed.

A series of ICS Oversight Meetings took place in January – March 2022, to provide additional oversight on the remaining work in progress, primarily Section 1 Workforce and Section 6 Governance.

CQC Current Workstreams

University Hospitals Sussex NHS Foundation Trust

There are three main pieces of work are being progressed - two are priority actions that are delivered under this programme, and the final one requires delivery over a longer timescale:-

REINSPECTION PREPARATION
The CQC have confirmed they will return to site prior to 29th April, re-visiting the areas previously inspected to assess progress against required improvements

Reinspection anticipated on 26th April 2022
Reinspection Areas: Maternity West, Maternity East, RSCH Surgery

WARNING NOTICE
The CQC gave notice to the Trust in October 21 of a number of essential improvements that needed to be implemented by end April

Final improvements are required to be evidenced by 29th April 2022, and a formal response provided

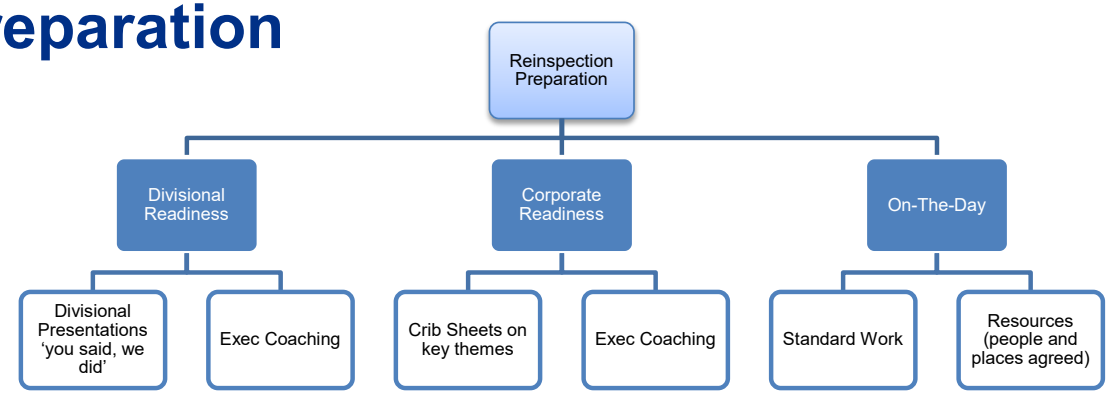
MUST DO SHOULD DO
Within the CQC Inspection Reports, there are a number of must do and should be improvements that need to be taken forward by the Trust

As part of normal CQC relationship management, a number of must do and should do improvements were identified that need progression and completion in a reasonable time period under BAU

These workstreams require immediate progression and are described in more detail in the following slides

This will be progressed through BAU CQC Relationship Management team

Reinspection Preparation



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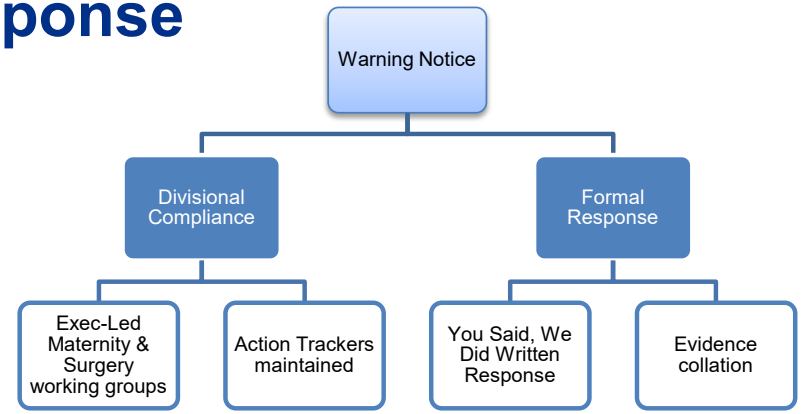
Divisional Readiness	Corporate Readiness	On-The-Day
DIVISIONAL PRESENTATIONS Divisions have been provided a template, and asked to describe structure, scale, improvements undertaken, challenges and opportunities, and including key achievements and best practice To be used to help prepare staff, and then shared with CQC as part of inspection visit	CRIB SHEETS Topics have been identified that would benefit from dissemination of formal briefing notes. Corporate Directors and Exec leads have been tasked to prepare reference sheets that describe remedial actions, current KPIs and how we will continue to embed improved performance. Topics include Ockenden, complaints, STAM, Appraisal, theatres culture, risk, incidents, clinical audits, local clinical guidelines, Clinical Operating Model, MSSW, vacancies and workforce	STANDARD WORK Capturing best practice from the September unannounced visit, standard work has been developed to include on-the day timings, communication groups, and standard templates,
EXEC COACHING Coaching, led by Chief Governance Officer, has taken place with Divisions and Corporate leads during w/e 8th April, to support with preparation for CQC questions and responses. A further round of coaching sessions is planned for w/e 22th April (unless CQC visit takes place that week)		RESOURCES Briefings have taken place with key members of staff, with deputies identified where possible. Room locations for control room and CQC bases have been reserved .

Warning Notice Response



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Divisional Compliance	Formal Response
WORKING GROUPS From early March, twice-weekly working groups have been taking place to ensure progress against required improvements. Exec-Led (Maternity – CNO, Surgery – CMO), with divisional triumvirates alongside corporate leads meet to review status by exception, unblock and progress. These groups also provide escalation feedback up into the weekly Executive Huddle meeting, alongside PMO project managers and senior team that have been assigned to support.	YOU SAID, WE DID – RESPONSE The formal response will build in the original 3 December communication, which provided narrative and performance against each required improvement. For improvements that were delivered 3rd December, an update will be provided that shows how these have been embedded, maintained and/or require further refinements. For improvements due 29th April, a similar template has been developed to enable to Trust to articulate the improvement actions delivered, together with any additional planned improvement s
ACTION TRACKERS These trackers have taken the improvement requirements from the warning notice, and describe the required performance, how improvements will be measure and monitored, and the status of closed and outstanding actions. A RAG rating is also maintained, to show current and anticipated compliance to required improvement.	EVIDENCE COLLATION Alongside the action trackers Divisions have bene asked to supply evidence of both performance and tools/processes in place. This will be used to supplement the formal written response.

Formal Response Structure

University Hospitals Sussex NHS Foundation Trust

1. Covering Letter

Need to agree handling of any areas of non-compliance that may remain

Suggested Content/Structure of letter:

- Explain format and content of response
- Describe methods undertaken to enable improvements
- By Division, summarise journey from September 21 to April 22 and highlight key areas of success
- Describe areas where continued improvement will be taking place

2. Update to 3rd December required improvements

17 items were required to be significantly improved by 3rd December

- 6th December Response to CQC
  - 12
  - 5
- 31st January Response to Oversight
  - 16
  - 1
- Anticipated 29th April response
  - 17

3. Response to 29th April required improvements (x3) + executive summaries

22 items require significant improvement by 29th April (which results in 29 service-specific responses)

- Maternity West
  - 4 - Workforce
  - 2 - Good Governance
- Maternity East
  - 5 - Workforce
  - 4 - Good Governance
- Surgery East
  - 9 - Workforce
  - 5 - Good Governance

Current Position

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LAST WEEK

Crib Sheets
- Reference Sheets have been created across key themes

Divisional Presentations
- Draft presentations were reviewed by Executive Team 19/4
- Further review in 2nd round of Coaching Sessions w/e 22/4
- Presentations progressed

Executive Coaching
- Initial sessions held w/e 8/4
- Final sessions held w/e 22/4, including:-
  - Maternity West
  - Maternity East
  - Surgery East
  - HR
  - Quality Governance

On The Day Readiness
- Briefings taken place with key personnel
- Standard work shared
- WhatsApp group for initial notification as well as CQC Control Room established

Extraordinary Board
- Discussion on CQC reinspection and formal warning notice response
- Agreement for Execs to execute response as agreed, and issued to Public/Private Board for information 5th May

THIS WEEK

Monday 25th	Tuesday 26th	Wednesday 27th	Thursday 28th	Friday 29th
Finalise approach to Warning Notice response & covering letter; approve divisional presentations	CQC Reinspection (anticipated)	Finalisation of KPIs and approval of evidence submissions	Final Draft of Formal Response to Warning Notice & Covering Letter	Issue of Formal Response to Warning Notice & Covering Letter
Exec Meeting 4.30pm	CQC On Site (tbc)	Exec-Led Divisional Meetings	CGO working with PMO	

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Next Steps

Next Steps

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- Submit formal response 29th April 2022 including Executive quality assurance of all supporting evidence
- Response to Provider Information Request within 10 days following receipt of request
- Informal feedback to Chief Executive and Chief Nursing Officer 3rd May 2022
- Agree ongoing support to Maternity and Surgery Divisions to support continued improvement to achieve Trust standards and / or embed operational changes
- Agree onward scope for the CQC Preparedness (UHSx Improvement Programme) Corporate Project

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Agenda Item:	20	**Meeting:**	Trust Board	**Meeting Date:**	05 May 2022
Report Title:	Planning submission 2022/23				
Sponsoring Executive Director:	Darren Grayson, Chief Governance Officer				
Author(s):	Oliver Phillips, Director of Strategy and Planning				
Report previously considered by and date:					

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

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

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:

The 2022/23 Planning round and submission is led by the Sussex Health and Care Partnership, and has been coordinated across the Sussex area. Board seminars to discuss and review the submission have been held on 11th March 2022 and 22nd April 2022.

Executive Summary:

The attached slides provide a summary position of the Trust's 2022/23 planning submission as part of the Sussex Health and Care Partnership plans, which were submitted to NHSEI for approval on 28th April. The key elements of note are:

- Plans to eliminate 104 week waiters have progressed well and this will be maintained in 2022/23, as will the plans to achieve the key cancer targets. An activity plan has been modelled to deliver the national ask of zero 78 week waiters by March 2023. This activity volume to deliver the ask is above the initial requirement to reach 104% of the 19/20 baseline activity.
- System-wide plans have been developed to improve the responsiveness of urgent and emergency care, including the reduction of 12-hour waits in A&E
- The Trust has a number of submissions for central funding to support our plans, including a proposed £15m CDC development at Southlands and the £30m High Volume Low Complexity (HVLC) day-case and endoscopy programme at PRH
- The risks to the delivery of the plan are provided in the paper, including the potential for further disruption due to COVID.
- The commitment to providing further activity in order to meet the 78 week target has exacerbated the financial risk within the plan.

- Financial projections confirm a core gap of £57m, for which an efficiency programme of £44m has been identified. This leaves a residual £12.55m which relates to excess inflation above funded levels.

Key Recommendation(s):

The Board is required to NOTE the submission of the activity, performance, workforce and finance elements of the 22/23 Annual Plan, and the risks associated with delivery of these plans

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22/23 Planning – Updated Submission Overview

Trust Board

5th May 2022

Planning Context and Background

University Hospitals Sussex NHS Foundation Trust

- The ICS rather than the Trust are required to submit a narrative plan which addresses objectives in the planning guidance, informed by discussions with Providers and other stakeholders
- The focus of the submission for Acute Providers is to achieve the following:
  - Deliver significantly more elective care to tackle the elective backlog
  - Improve the responsiveness of urgent and emergency care and community care
  - Continue to develop our approach to population health management, prevent ill-health and address health inequalities
  - Exploit the potential of digital technologies to transform the delivery of care and patient outcomes
  - Invest in our workforce
  - Make the most effective use of our resources to transform the delivery of care and patient outcomes
- As part of technical planning the Trust makes its own triangulated submissions for the following areas to the ICS for collation:
  - Activity
  - Performance
  - Workforce
  - Finance
- Two separate Board seminars (11th March and 22nd April) have taken place to review the Trust's submission
- The ICS will submit the final plan on 28th April

Executive Summary – Key Issues

University Hospitals Sussex NHS Foundation Trust

- Plans to eliminate 104 week waiters have progressed well and this will be maintained in 2022/23, as will the plans to achieve the key cancer targets. An activity plan has been modelled to deliver the national ask of zero 78 week waiters by March 2023. This activity volume to deliver the ask is above the initial requirement to reach 104% of the 19/20 baseline activity.
- System-wide plans have been developed to improve the responsiveness of urgent and emergency care, including the reduction of 12-hour waits in A&E
- The Trust has a number of submissions for central funding to support our plans in the medium term, including a proposed £15m CDC development at Southlands and the £30m High Volume Low Complexity (HVLC) day-case and endoscopy programme at PRH
- The risks to the delivery of the plan are provided in the paper, including the potential for further disruption due to COVID.
- Financial projections confirm a core gap of £57m, for which an efficiency programme of £44m has been identified. This leaves a residual gap of £12.55m which relates to excess inflation above funded levels.

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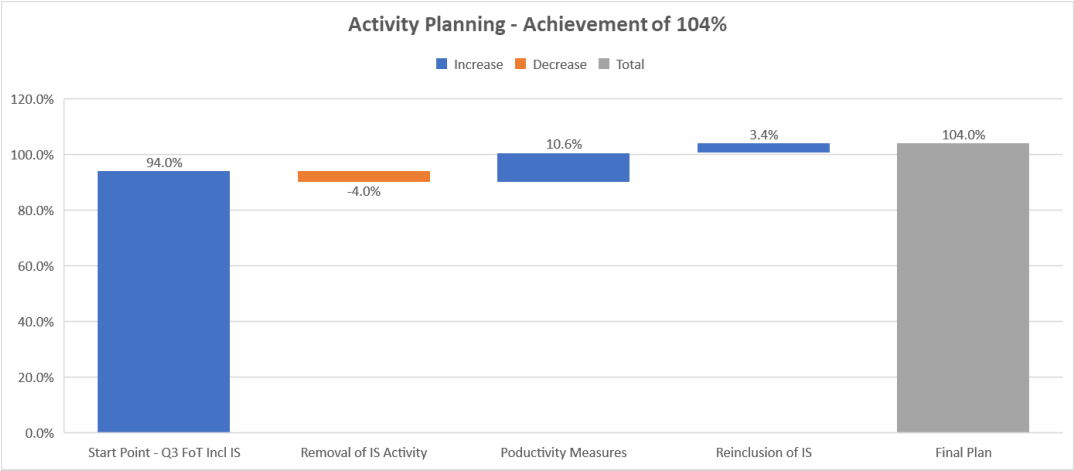
Activity and Performance

Activity Planning for 22/23

University Hospitals Sussex
NHS Foundation Trust

- Achievement of 104% of 19/20 baseline activity target is based on the following methodology:
  - The start point for the activity forecast was based on Quarter 3 outturn (including all Independent Sector activity)
  - Independent Sector activity above 19/20 outturn was initially removed
  - The impact of productivity measures was incorporated
  - The Independent sector activity above 19/20 baseline was added back to be included in the activity forecast total
- This has been supplemented by a bottom up exercise with the clinical divisions to assess capacity at a service and Point of Delivery level to ensure all productivity opportunities are captured.



Summary of performance targets

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Target	Proposed Submission	Risks and Issues
Deliver 104% of activity baseline	Compliant	Requires delivery of the productivity measures and access to IS capacity
Eliminate 104 week waiters by July 2022	Compliant	To achieve and maintain the target will require continued use of IS
Eliminate 78 week waiters by March 2023	Compliant	Requires delivery of the productivity measures and access to IS capacity
Reduction/elimination of 52 week waiters by 2023	Compliant with national guidance	The focus on elimination of 78 and 104 week waiters will deliver the national target, although the proposal will not achieve the Sussex ICS ambition
Cancer – 62 day and Faster Diagnosis standards	Compliant	Significant progress made during 22/23 forecast to continue. Key risk is potential to increased referrals following suppressed demand during COVID
Diagnostics – 120% of activity baseline	Compliant at system level	High level of confidence in delivering proposed 10% increase. Risk at system level if CDCs do not delivery forecast activity
Outpatients – 25% reduction in follow ups	Non-compliant	Reduction of 25% not achievable given need to tackle waiting list backlog. Further work will be undertaken on pathway redesign to improve position
Outpatients – Patient Initiated Follow ups	Non-Compliant	The Trust anticipates a step up in PIFU pathways in 22/23, but does not yet have plans to deliver the full 5% requirement
Outpatients – Advice and Guidance	Compliant (at ICS Level)	A continuation of current level including ICS other acute and non-acute contracts will achieve this aim.

RTT 78 Weeks

University Hospitals Sussex
NHS Foundation Trust

- As per the national target the expectation of the ICS for Sussex is to achieve zero patients waiting more than 78 weeks for treatment or outcome by March 2023.
- Modelling has been undertaken to assess the impact of the delivery activity levels at 104% of the 19/20 baseline on waiting list size and waiting times.
- Based on the current modelling delivering 104% activity to does not clear the 78 week risk cohort entirely.
- In order to clear the entire 78 week risk cohort activity would need to exceed 104% as follows:

Activity Volume 22/23 Total	Percentage of 19/20 Baseline	Forecast 78 week wait position at March 2023
588,019	104%	4218
592,237	104.7%	0

- The Trust is working with the operational divisions to review any further opportunities for efficiency and productivity improvements in order to achieve this, however the 104% activity levels are already predicated on significant gains in this area

Urgent and emergency care

University Hospitals Sussex NHS Foundation Trust

- The Trust has been working with system partners to develop a plan to improve the responsiveness of urgent and emergency care. This includes
  - Improvements in admission avoidance pathways to prevent unnecessary admissions
  - Continuing to develop the Sussex mode for integrated care, including the development of Urgent Treatment Centres in Brighton and St. Richard's
  - Delivery against the Hospital Discharge Programme plan across Health, Local Authorities, and the voluntary sector
- A UHSussex improvement plan has been agreed with partners, focusing on improving flow in key areas, including
  - Improving pathways and flow via the UTC, reducing demand on our A&E services
  - Reducing ambulance handover delays, aimed at eliminating all over one-hour ambulance waits
  - Improvements to same day emergency care – increasing the availability of non-Emergency Department urgent pathways to avoid admissions
  - Ensuring better flow through earlier discharge of patients during the day

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Workforce

Workforce Modelling & Bridge

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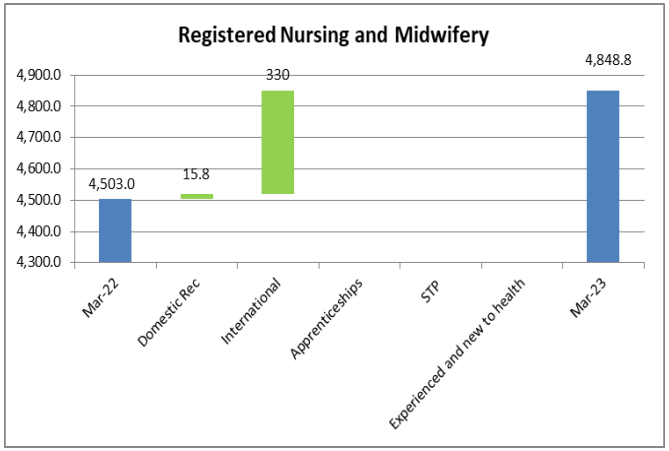

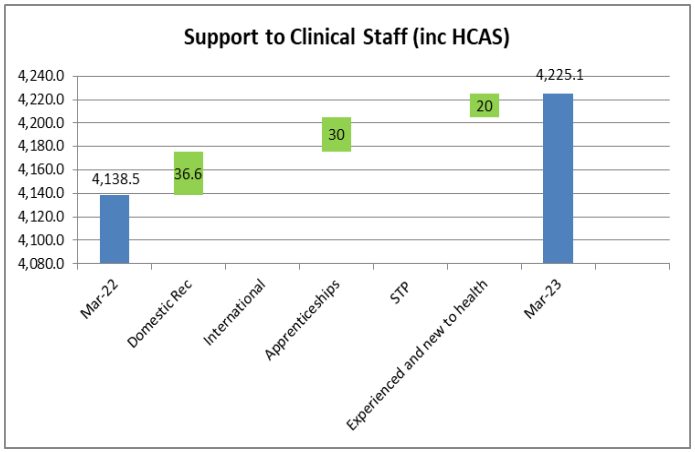

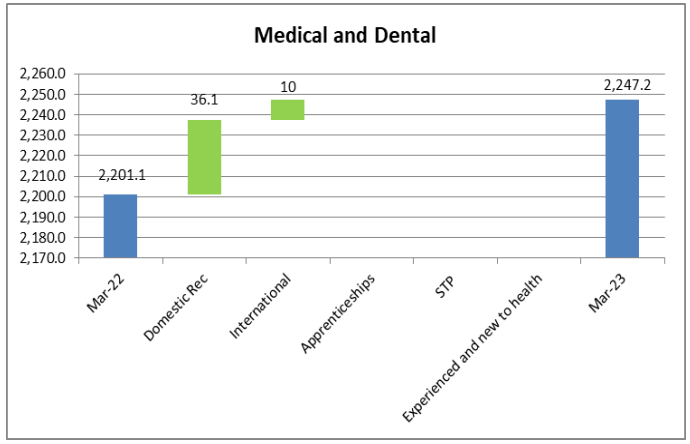

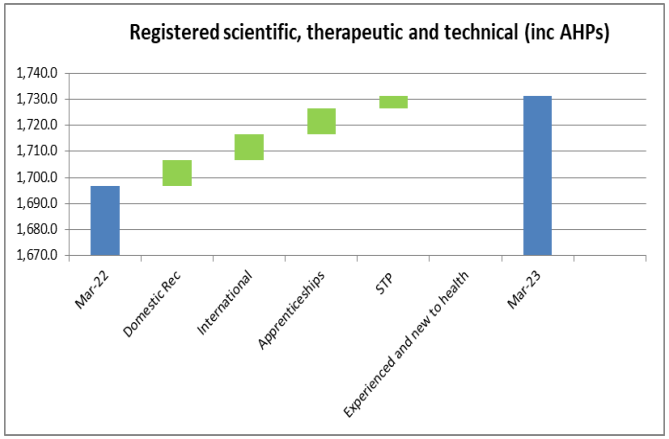

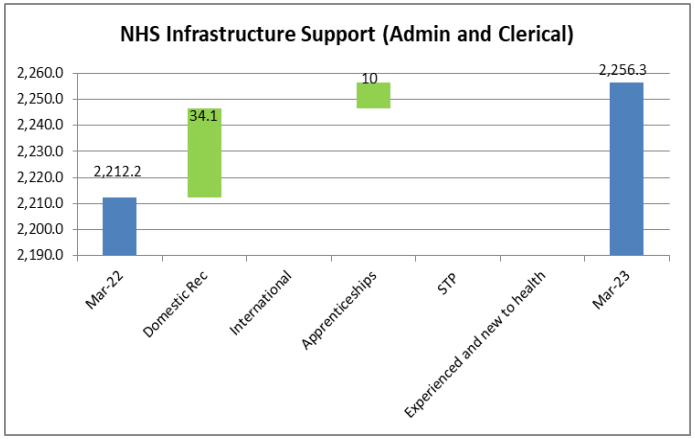

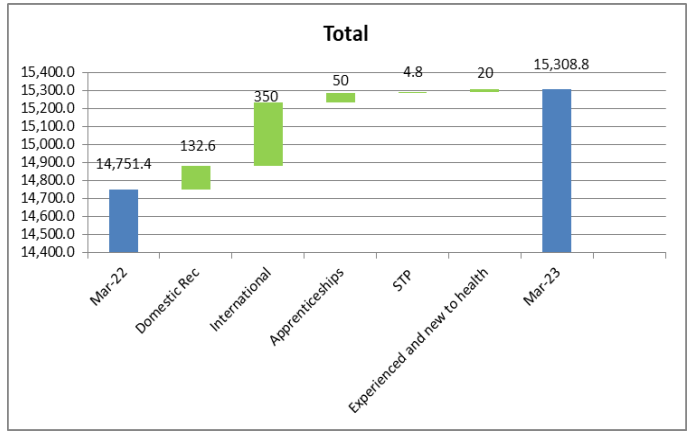

Workforce Planning

University Hospitals Sussex NHS Foundation Trust

Modelling & Bridge

• Establishment growth is modelled at 1.5%.
• Staff in post growth modelled at 2% (covering the increase in demand of 1.5% and an additional 0.5% efficiency in recruitment for all areas with the exception of nursing where staff in post is expected to grow at 7.7%). The strong position for registered nurses is due to a comprehensive international nurse campaign (c450 nurses joining in calendar year 2022).
• Over establishment of nurses does not take into account any changes in nursing establishment relating to 3Ts, establishment review and assumes stable turnover.
• Turnover is expected to remain stable across the Trust at 8.5% resulting in a net growth of staff in post WTE of 557.40.
• 40 midwives (Ockenden) and 15 additional medics in Medicine are factored into establishment baseline figure at March 2022.
• Based on recruitment, turnover and planned attraction campaigns, modelling suggests that the Trust should have a healthy c5% vacancy by March 2023.
• The organisation has a relatively stable workforce and clear trajectories for registered nurse recruitment.
• Modelling is based on the Trust being in a position to fully exploit a range of recruitment sources including sourcing internationally for nursing, medical and AHP.
• Apprenticeships for HCA and a targeted campaign for those new to health feature prominently in plans as does our ability to further develop a strong local employer brand specifically for admin and professional support roles.

What are the risks?

• The availability of locally educated qualified nurses remains a challenge, however, this is being mitigated by a robust international nurse recruitment campaign.
• Covid related absence (self-isolation, sickness, staff with caring responsibilities/childcare) has remained an issue and is closely managed operationally.
• Increased establishment for registered band 6 midwives and the Trust's ability to successfully attract candidates into new posts is a risk. This is being mitigated by recruitment incentives, changes to process to proactively interview and prioritise pre-employment screening, developing a recruitment film and the use of registered nurses to provide support whilst posts are being filled.
• Healthcare Assistant local labour market and retention for this group of staff.
• Challenges regarding recruiting to A&E consultant and registrar level in the West. Training gaps in surgery East at registrar level (mitigated by clinical fellow posts). High consultant recruitment (c34 posts), although this is being actively managed. Challenges with delivering consultant recruitment (AACs) due to panel capacity/availability and forward planning (changes have been made with the agreement of the Chair regarding AAC panel composition to in part mitigate).
• The extent that the Trust can attract and retain local talent for admin roles and a potential for turnover to increase post covid for all staff groups.
• High cost area in Brighton and historic challenges retaining staff at the Country site, mitigated by career development and a focus on leadership and culture.

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Finance

Purpose

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The purpose of this slide-deck is to provide further details of the financial plan component of the Trust's 2022/23 Strategic Operating Plan.

- 2022/23 Planning Context
- 2022/23 Planning Methodology & Assumptions
- Financial Plan
- Capital Plan
- Financial Risks, Mitigations and Next Steps

2022/23 Planning Context

University Hospitals Sussex NHS Foundation Trust

- NHSEI have advised that a multi-year funding settlement has been agreed for 22/23 – 24/25 (Spending Review settlement). Key messages are:
  - Efficiency requirements will continue to increase further into 2022/23
  - Elective Activity needs to increase above the levels delivered in 2019/20 and there will be an incentives scheme, ESRF to recognise costs incurred in delivering this activity.
    - *There will also be penalties applied if baseline plans are not met.*
  - COVID funding will decrease annually and be removed entirely by the end of the 3 year period
  - The 2022/23 Financial Plan has been constructed through modelling the assumptions set out in the draft guidance and System allocations envelope received at the end of December.

2022/23 Planning Methodology and Assumptions

University Hospitals Sussex NHS Foundation Trust

In line with prior years, the approach to the development of the financial plan is a two-fold process:

- Top-down - development of the draft core gap to inform the Trust's affordability envelope, including the efficiency expectation based on the application of a series of national and local assumptions
- Bottom-up - development of granular level plans to enable triangulation of activity, income, expenditure and efficiency plans

Top-down financial planning

- Breakeven Financial Performance
- FOT as at month 9
- Adjusted for:
  - Non-recurrent impacts
  - Full-year effects
- Tariff impacts:
  - Inflation
  - Efficiency
- Statutory & Mandatory pressures
- Service Developments
- = Core Gap
- Which informs the efficiency Requirement

Bottom-up budget-setting

- Principles:
  - Realistic
  - Transparency
  - Ownership
- Activity
- Income
- Pay
- Non-pay
- Non-operational
- Cost drivers
- Service Developments
- Efficiency plans

Financial Plan

University Hospitals Sussex
NHS Foundation Trust

	Financial Plan (pre mitigations) 2022/23 £m	Mitigating actions 2022/23 £m	Opening Financial Plan **2022/23** £m
Income from patient care activities	1,195.00	2.12	1,197.12
Other Operating Income	100.83	1.98	102.81
Total Income	**1,295.83**	**4.10**	**1,299.93**
Pay	(864.37)	24.18	(840.19)
Non-Pay	(465.57)	16.12	(449.45)
Operating Expenditure	**(1,329.95)**	**40.30**	**(1,289.65)**
Finance Costs	(21.10)		(21.10)
Donated Asset Adjustment	(1.73)		(1.73)
Net (surplus)/ deficit	**(56.95)**	**44.40**	**(12.55)**

- The Trust will receive £1.3bn of income in 2022/23 to manage delivery of all hospital services and activities. This income includes up to £37m to support recovery of elective services activity.
- The key drivers of the £57m deficit, prior to mitigations, are: £22m (57%) decrease in COVID income, increased non elective activity and excess inflationary pressures.
- Efficiency schemes of £44.4m are being developed to mitigate a number of the pressures identified. The residual deficit of £12.55m relates to excess inflation above funded levels.
- The Trust has submitted a deficit plan of £12.55m to NHSE/I. Consideration of further support for excess inflation is being sought by the Trust and Sussex ICS, from NHSE/I.

Capital Plan 2022/23

University Hospitals Sussex NHS Foundation Trust

Source of Funds		Application of Funds	
Strategic capital funding sources (secured)	£000s	**Strategic capital expenditure**	£000s
PDC 3Ts	26,233	PDC 3Ts	26,233
Total strategic capital funding (secured)	**26,233**	Total strategic capital expenditure	**26,233**
Operational capital funding sources		**Operational capital expenditure**	
Depreciation	40,293	Deferred schemes	18,830
Less capital loan repayments	(4,740)	Medical devices	9,000
Surplus brought forward as per PFR return	16,053	Service developments	9,776
		Estates infrastructure	8,000
		IM&T	6,000
Total operational capital funding	**51,606**	Total operational capital expenditure	**51,606**
PDC ED Floor RSCH	*9,000*	*PDC ED Floor RSCH*	*9,000*
Daycase & Endoscopy HVLC (PRH)	12,000	Daycase & Endoscopy HVLC (PRH)	12,000
PDC Ringfenced Funding Sources (Secured)	**21,000**	PDC Ringfenced Funding Sources (Secured)	**21,000**
Surplus brought forward as per PFR return	851	PFI Lifecycle	851
Charitable funds	680	Charitably funded schemes	680
PFI & Charitable funding	**1,531**	PFI & Charitable expenditure	**1,531**
Total capital funding	**100,370**	Total capital expenditure	**100,370**
PDC Southlands CDC	*10,000*	*PDC Southlands CDC*	*10,000*
Leases	*5,527*	*Leases*	*5,527*
PDC Ringfenced Funding Sources (awaiting final confirmation)	**15,527**	PDC Ringfenced Funding Sources (awaiting final confirmation)	**15,527**
Capital submission - Final Plan	**115,897**	Capital submission - Final Plan	**115,897**
Additional Capital commitments requiring confirmation			
3Ts stage 2/3 (pre contract service agreement)	*8,653*	*3Ts stage 2/3 (pre contract service agreement)*	*8,653*
Charitable funds	*3,274*	*Charitable funds*	*3,274*
Total funding requiring confirmation	***11,927***	*Total expenditure requiring confirmation*	***11,927***
Leases - transfer incentive IFRS16	*(5,527)*	*Leases - transfer incentive IFRS16*	*(5,527)*
Indicative 2022/23 Capital Funding	**122,297**	Indicative 2022/23 Capital Expenditure	**122,297**

- The 2022/23 Capital Plan is £116m.
- Operational Capital allocations have been made on a three year basis to the ICS. The Trust's allocation for year 1 has been agreed; years 2 and 3 remain outstanding.
- Oversight and scrutiny of the plan is via the executive-led Capital Investment Group & 3Ts Programme Board, with the assurance route to the Board via the Sustainability Committee.

Financial Risks, Mitigations & Next Steps

University Hospitals Sussex NHS Foundation Trust

Elective Performance within funded envelope:
- Risk that the Trust is unable to recover to 100% of 19/20 activity levels within funded allocation, significant reliance on insourcing and outsourcing in 2020/21 & 2021/22.

Elective Productivity:
- Risk that the Trust is unable to deliver required productivity improvements included in the plan, with IPC regulations only starting to ease during Q1 of 22/23.

COVID-19:
- Risk that there remains the uncertainty regarding COVID and the impact of any new variants on both staff availability and cancellation of activity, reducing funding could compounded these issues:

Utilities price rises :
- Risk that the Trust does not have the ability to mitigate the pressures from the significant Utilities above inflation price increases.

Medical Ready for Discharge Patients (MRDs):
- Risk that without collaborative action to manage MRD's, there will be significant impacts on patient flow and hospital capacity, which is likely to affect delivery of elective activity.

Efficiency Programme:
- Risk that the Trust does not have the capacity to deliver the level of efficiency required in addition to managing Elective Restoration & Recovery in a continuing COVID environment.

Next Steps:
- Further testing of activity plans to asses requirements to achieve 104% activity recovery and agreement of System strategy to manage long waiters.

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Risks and Mitigations

Risks and Mitigations

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Risks	Impact	Mitigations
Disruption due to further COVID waves results in poor flow of patients through the system	Capacity for delivering elective care is reduced due to high MFD patients and IPC guidance	Maximise use of capacity away from acute sites, including Southlands, LVH, and the Independent sector
Sickness due to COVID reduces staff availability	Capacity for elective care is reduced as available staff are prioritised for urgent and emergency care	Maximise use of the Independent Sector to deliver elective activity, plus international recruitment
The Independent Sector cannot provide the additional capacity required	We are unable to achieve the 104/78 week targets due to lack of additional capacity	Early discussions with IS to secure required levels of capacity throughout the year
The Trust does not receive the financial support required to deliver the targets	We are unable to open additional capacity or outsource activity to the IS, leading to a failure to deliver targets	Continued negotiation with ICS to ensure that plans are fully funded.
We are unable to fully staff our clinical areas due to high levels of vacancies	We are unable treat sufficient patients to achieve our targets	A range of workforce measures including a larger international recruitment programme
Demand for elective and non-elective care exceeds our expectations	Caring for urgent elective and emergency cases displaces non-urgent patients leading to a failure to achieve 104/78 week targets	Work closely with primary care and other stakeholders to manage demand, preventing referral/admission to the Trust where appropriate
Preparation for the opening of 3Ts disrupts capacity	We do not make full use of the current capacity available, risking achievement of targets	Further development of the clear transition plan for 3Ts to ensure focus on in year delivery can remain

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	21	**Meeting:**	Board	**Meeting Date:**	5 May 2022
Report Title:	**Company Secretary Report**				
Committee Chair:		Glen Palethorpe, Company Secretary			
Author(s):		Glen Palethorpe, Company Secretary			
Report previously considered by and date:					
Purpose of the report:					
Information		✓	Assurance	✓	
Review and Discussion		☐	Approval / Agreement	☐	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		☐	Staff confidentiality	☐	
Patient confidentiality		☐	Other exceptional circumstances	☐	
Implications for Trust Strategic Themes and any link to BAF risks					
Patient	☐				
Sustainability	☐				
People	☐				
Quality	✓	Learning from Deaths links to BAF risks 4.1 and 4.2			
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 a NHS l or other regulatory requirements. This report does not seek to duplicate matters that are subject to separate agenda items at today's meeting.

Learning from Deaths reports 2021/22 quarter 4 – Appendix 1

The Trust is required to receive reports on learning from deaths. The Board is reminded that the detail of this report is scrutinised by the Quality Committee especially in respect of the Trust's processes for learning from the review of deaths. The focus for learning is to improve the Trust's processes. The outcome of this learning manifests itself in the Trust's mortality indices; these are tracked within the routine report to the Board as part of the Integrated Performance Report.

The Quality Committee received and reviewed this report at its meeting on the 26 April 2022 and noting the one report covers Royal Sussex County, Princess Royal, St Richards and Worthing Hospitals.

Committee Terms of Reference – Appendices 2 - 6

Each of the Board five thematic assurance committees of Patient, Quality, People, Sustainability and Systems & Partnerships, having completed their annual cycle of meeting undertook a review of their terms of reference. All Committees agreed their current Terms of Reference supported the Committee's purpose and for the majority of these Committees there were only minor changes to reflect changes in membership and director attendance and to ensure the all matters from the business cycle of the Committee were explicitly referenced in the Terms of Reference. The Quality Committee on reviewing its terms of reference agreed to increase the

frequency of these meetings to not less than 10 meetings a year. All these revised terms of reference are attached at appendix 2 – 6 to this report.

The Board is asked to **RATIFY** these approved Terms of Reference.

Membership Elections

We have a small number of publicly elected governors whose terms of office end on the 30 June 2022. These cover the constituencies of Adur, Arun and Worthing. The election process commenced in early April with voting taking place between 23 May and 14 June, with declaration of the results on 15 June 2022.

There were three virtual public drop-in sessions held during April to provide more information on the role of the governor and the election process for those who were considering standing for election.

ELECTION STAGE	Timetable
Notice of Poll published	Friday, 20 May 2022
Voting packs despatched	Monday, 23 May 2022
Close of election	Tuesday, 14 Jun 2022
Declaration of results	**Wednesday, 15 Jun 2022**

Key Recommendation(s):

The Board is recommended to

RATIFY these approved Terms of Reference, relating to Patient, Quality, People, Sustainability and Systems & Partnerships Committees.

NOTE the Trust's learning from deaths report 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 scheduled round of governor elections will seek to return successful candidates in early June 2022.

Appendix 1

University Hospitals Sussex NHS Foundation Trust

Agenda Item:	21.1	**Meeting:**	Trust Board	**Meeting Date:**	May 2022
Report Title:	Learning from Deaths Q4 2021/22 University Hospitals Sussex NHS Foundation Trust				
Sponsoring Executive Director:	Charlotte Hopkins - Chief Medical Officer				
Author(s):	Mary Evans – Learning from Deaths Manager (Worthing and St. Richards Hospitals) Mark Renshaw - Head of Quality Improvement Alison Young – Head of Quality Improvement Tim Taylor - Medical Director for Governance and Quality assurance				
Report previously considered by and date:	Quality Committee 26.04.2022				
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 briefing is to update the board 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.					
Key Recommendation(s):					
The Board is asked to NOTE the report..					

Appendix 1

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Learning from Deaths Mortality Report Quarter 4 2021/22 as at 05/04/2022 for University Hospitals Sussex NHS Foundation Trust (UHSussex)

1. Purpose

1.1 The purpose of reviews and investigations of deaths is to improve understanding and learning about problems and processes in healthcare associated with mortality, share best practice, identify themes and address deficiencies in processes and patient care.

1.2 This report is presented to the Trust Board as assurance of the 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. During 2021/22, the role of these offices is being extended to include all non-coronial deaths, wherever they occur. Implementation of this next phase to include all non-coronial community deaths will take place incrementally, to allow time for capacity and processes to be put in place. ME offices across UHSussex are now fully implemented and currently scrutinise all in hospital non coronial deaths.

3. Governance

3.1. The Chief Medical Officer is the responsible executive for Learning from Deaths.

3.2. Pre-merger, the Medical Director for Royal Sussex County Hospital (RSCH) and Princess Royal Hospital (PRH) chaired the Trust Mortality Review Group. The Medical Director for Worthing (WGH) and St Richard's hospitals (SRH) chaired the weekly mortality panel. Post-merger the weekly panel meetings continue for WGH and SRH deaths, chaired by Medical Director for Governance and Quality assurance.

3.3 Pre-merger, the Medical Director for WGH and SRH chaired the quarterly End of Life (EOL) and Mortality Board. Post-merger, the EOL and Mortality Board have merged across the trust and is chaired by the Medical Director for Governance and Quality assurance

3.4. In the revised governance structure, the weekly mortality panel will report to the Clinical Outcomes and Effectiveness Group (COEG) and by exception to the Quality Governance Steering Group (QGSG), as will the EOL and Mortality Board.

Appendix 1

University Hospitals Sussex NHS Foundation Trust

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 safety and quality 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 and spread 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 Royal Sussex County Hospital (RSCH) and Princess Royal Hospital (PRH) sites - SJRs are completed on an electronic form within PANDA (the Trust's electronic patient information system). PANDA 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 reviewer (multidisciplinary) to complete and share any findings for learning. All consultants can submit and review SJRs on PANDA. The 'assessment of problems in healthcare' section of the SJR records quantitative data on the nature of the problem type and whether this resulted in harm to the patient. For SRH and WGH - SJRs are completed on a word document. The outcome scores and learning themes are populated using excel spreadsheets until an electronic system is available (Datix IQ Mortality Module).

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 DATIX RL® 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. LeDeR was originally introduced in 2015 in response to significant ongoing concerns about the likelihood of premature deaths of people with learning disabilities. From 1 June 2021, the name was changed and the processes were updated, as a result of a review of the previous process during 2019/20. There is evidence from both before and during the Covid-19 pandemic that deaths for people with disabilities and autistic people are higher than they should be, and that people die earlier than ought to be the case.

5. Involving Families / Carers

5.1 All non-coronial deaths across UHSussex are reviewed by the 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.

6. Mortality Reviews

6.1 Total deaths

Table 1: Details the number of adult inpatient deaths for quarter 4 2021/22 per month, per hospital site

Table 1	SRH	WGH	RSCH	PRH
January	104	96	102	33
February	67	93	98	32
March	76	108	81	37
Total	**247**	**297**	**281**	**102**

6.2 Covid-19 related deaths

Table 2: Details the number of deaths where Covid-19 appeared on the MCCD for quarter 4, 2021/22 per month, per hospital site

Table 2	SRH	WGH	RSCH*	PRH*
January	10	12	16	3
February	5	3	12	14
March	8	4*	12	8
Total	**23**	**19**	**40**	**25**

* Numbers for RSCH and PRH are deaths within 28 days of a positive Covid-19 death
** Inquest pending for 1 additional case so MCCD unknown at time of writing this report

All the deaths where Covid-19 appeared on the MCCD, that occurred in WGH and SRH underwent ME scrutiny as per current practice and were only escalated to SJR if the criteria for referral was met. Eight such cases were escalated to SJR for quarter 4 2021/22.

6.3 Hospital onset healthcare associated Covid-19

National Health Service England and NHS Improvement (2020) published identified categories re data collection to assist with monitoring of in-hospital transmission of Covid-19. The three categories were identified as:

- **Category 1** = Hospital onset indeterminate healthcare-associated – first positive specimen date 3-7 days after admission to Trust.
- **Category 2** = Hospital onset probable healthcare-associated – first positive specimen date 8-14 days after admission to Trust.
- **Category 3** = Hospital onset definite healthcare-associated – first positive specimen date 15 or more days after admission to Trust.

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Table 3: Details the number of deaths for quarter 4 2021/22 where Covid-19 appeared on the MCCD where a hospital onset probable or definite healthcare associated Covid-19 was identified.

Table 3	SRH	WGH	RSCH	PRH
January	4 (2 x cat 2, 2 x cat 3)	2 (1 x cat 2, 1 x cat 3)	4	1
February	1 (cat 2)	1 (cat 3)	2	8
March	2 (2 x cat 2)	2 (2 x cat 3)	4	0
Total	**7**	**5**	**10**	**9**

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).

7. Mortality reviews

7.1 Medical Examiner Office

Table 4: Details the number of deaths per hospital site, per month during quarter 4 2021/22, which underwent ME scrutiny. N.B these numbers include deaths that occurred in the Emergency Departments

Table 4	SRH	WGH	RSCH	PRH
January	106	108	99	32
February	69	96	95	32
March	79	110	81	27
Total	**254**	**314**	**275**	**101**

At RSCH and PRH 98% of the deaths in quarter 4 2021/22 were reviewed by a Medical Examiner, and of these an SJR was requested in the deaths of 31 patients.

Table 5: Details the number of deaths per hospital site, per month during quarter 4 2021/22, that were referred to the coroners

Table 5	SRH	WGH	RSCH*	PRH*
January	24	20		
February	18	16		
March	12	22		
Total	**32**	**58**		

*Data not available

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Table 6: Details the number of deaths per hospital site, per month during quarter 4 2021/22, where a conversation was held with the nominated person.

Table 6	SRH	WGH	RSCH	PRH
January	93	82	77	26
February	53	77	52	19
March	71	72	69	20
Total	**217**	**231**	**198**	**65**

Graph 1: Details the percentage of deaths that underwent ME scrutiny, per hospital site where a conversation was held with the nominated person

Graph 1

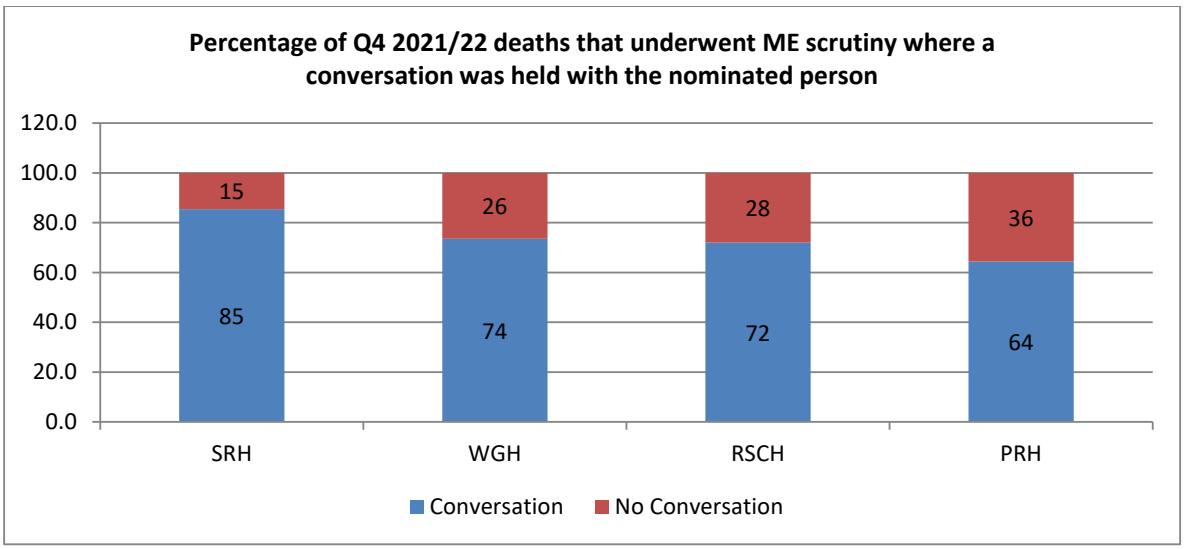

Table 7: Details the number of quarter 4, 2021/22 deaths per hospital site, per month where the nominated person raised a concern upon discussion with ME office

Table 7	SRH	WGH	RSCH	PRH
January	16	10	7	3
February	10	9	8	4
March	10	19	12	2
Total	**36**	**38**	**27**	**9**

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Graph 2: Details the percentage of quarter 4, 2021/22 deaths per hospital site where the nominated person raised a concern upon discussion with ME office

Graph 2

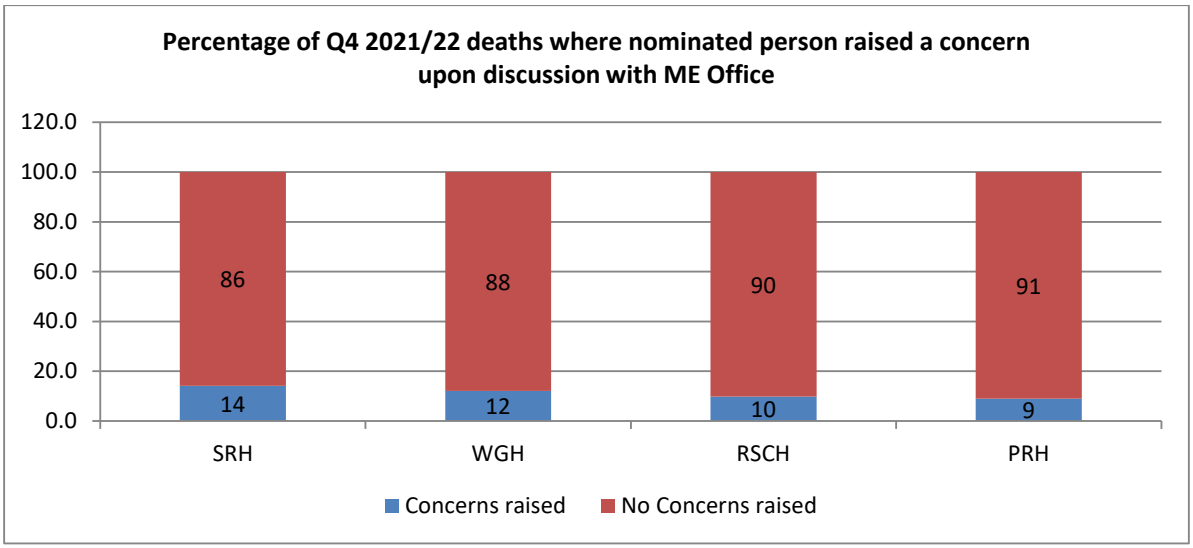

Table 8: Details the number of quarter 4, 2021/22 deaths per month, per hospital site where the nominated person provided positive feedback upon discussion with ME office

Table 8	SRH	WGH	RSCH*	PRH*
January	3	0		
February	1	6		
March	8	4		
Total	**12**	**10**		

* Data not collected

Table 9: Details the number of quarter 4, 2021/22 deaths per month, per site where learning was identified and feedback to clinicians in real time

Table 9	SRH	WGH	RSCH*	PRH*
January	19	17		
February	12	11		
March	9	15		
Total	**40**	**43**		

* Data not collected

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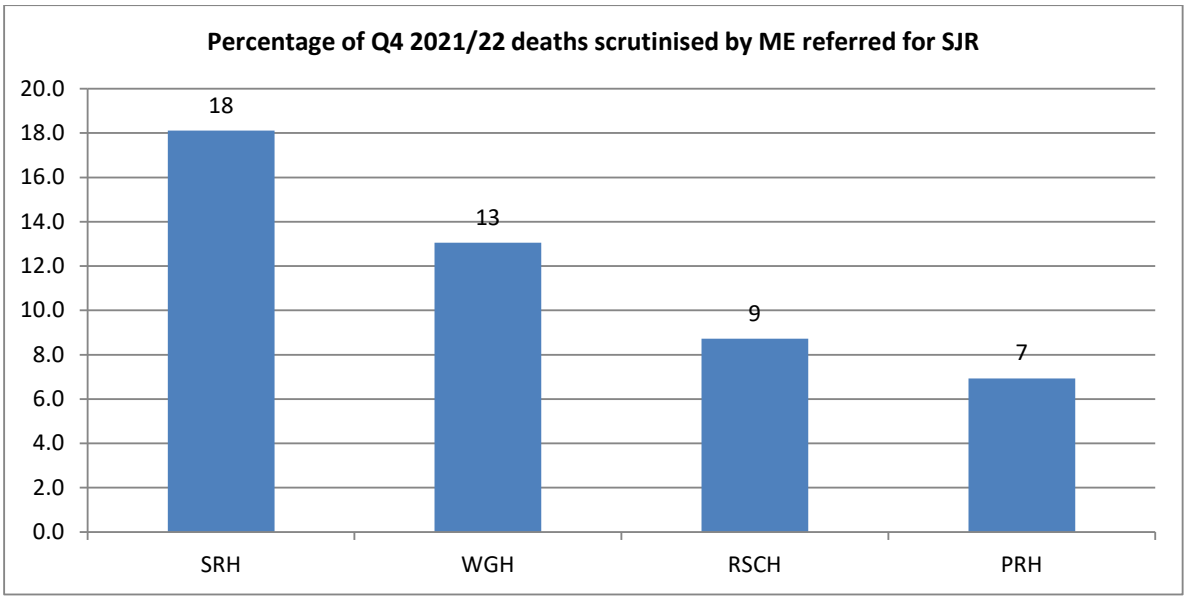
Table 10: Details the number of quarter 4, 2021/22 deaths per month, per site referred for SJR following ME scrutiny.

Table 10	SRH	WGH	RSCH	PRH
January	15	13	5	5
February	20	11	10	2
March	11	17	9	0
Total	**46**	**41**	**24**	**7**

Graph 3: Details the percentage of quarter 4 2021/22 deaths referred for SJR following ME scrutiny, per hospital site

Graph 3



7.2 Structured Judgement Reviews

Table 11: Details the overall outcome score of initial SJR on all four sites, completed during quarter 4 2021/22

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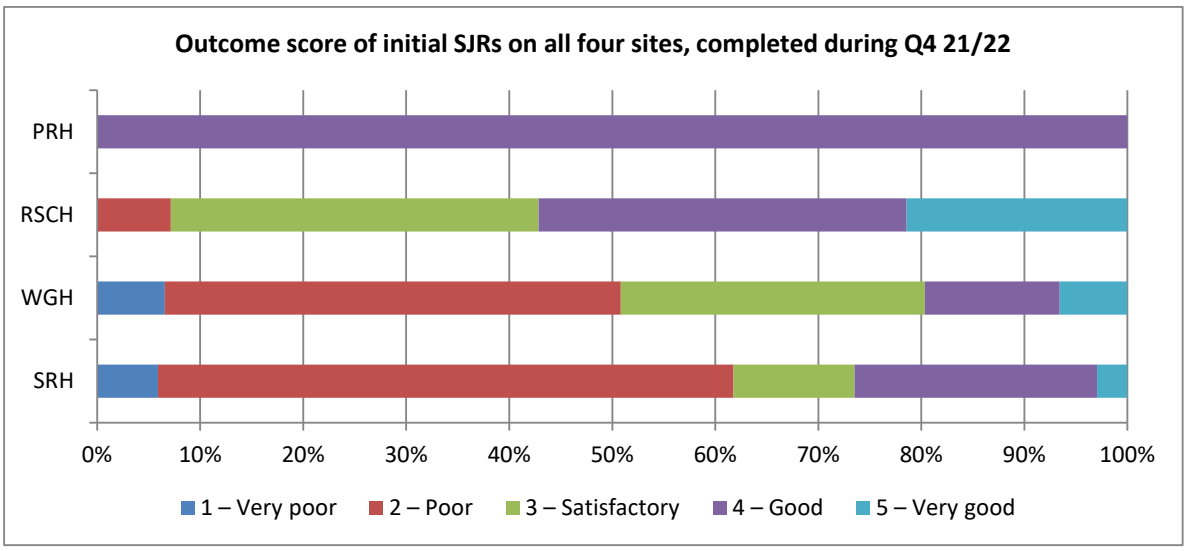
Table 11

Overall outcome score	SRH	WGH	RSCH	PRH
1 – Very poor	2	4	0	0
2 – Poor	19	27	1	0
3 – Satisfactory	4	18	5	0
4 – Good	8	8	5	2
5 – Very good	1	4	3	0
Total	**34**	**61**	**14**	**2**

Graph 4: Details the outcome scores of initial SJR on all four sites, completed during quarter 4 2021/22

Graph 4



For deaths occurring at SRH and WGH, the proportion of 'very poor' and 'poor' care being identified following SJR, as per SJR methodology, has increased. This increase appears to be mainly as a result of the introduction of a robust Medical Examiner system as only cases where problems in care have been identified (which may have affected the patient outcome or would provide a greater opportunity for wider learning) in addition to those where there were mandated reasons for referrals are escalated to SJR. It may also be because of the extreme operational pressures that all the services have continued to experience as a result of the pandemic. This means that there are fewer cases for all Divisions where the overall care has been judged as 'good' or 'excellent' following SJR. For cases where 'excellent' care or feedback is identified via the ME office (through discussion with the relatives or case note scrutiny), the clinicians and teams received positive feedback from the ME office in real time. For deaths scrutinised during quarter 4 2021/22 this occurred in 22 cases (↓4%). Cases where there was some learning but the ME office did not feel an SJR would provide any further value were also fed back in real time to the clinical teams or the Divisional Morbidity and Mortality (M & M) leads, for them to discuss in the appropriate governance forum. This involved 83 cases (↑15%) of cases scrutinised by a ME for quarter 4, 2021/22).

The overall quality of care was evaluated as poor in one SJR undertaken on a patient treated at RSCH. The reviewer noted an unfortunate lack of documented senior clinical leadership / decision making documented in the medical notes, resulting in ambiguity for nursing staff and the out of hours medical teams. These concerns were escalated via Datix. The review also noted that the patients syringe pump had been displaced although it was unclear whether it had been originally sited correctly.

7.3 Mortality reviews for people with a Learning Disability (LD) quarter 4 2021/22

Table 12: Details the number of deaths of patients with a LD during quarter 4 2021/22

Table 12	SRH	WGH	RSCH	PRH
January	0	2	0	1
February	1	1	0	0
March	0	1	1	0
Total	**1**	**4**	**1**	**1**

For SRH and WGH for quarter 4 2021/22, five patients with a LD were identified as having died, and had their care scrutinised by the ME and were referred on for SJR, as per policy. The Learning from Life and Death Reviews programme was notified of all cases, within the agreed timeframe. Four out of the five cases (80%), have completed the mortality review process having had SJRs completed +/- mortality panel discussion, and all the relevant documents have been uploaded to either the LeDeR record and / or sent to the Sussex Learning from Lives and Deaths (LeDeR) programme lead. All four deaths were identified as being NOT more likely than not due to problems in care. 1 case had an overall outcome score of 4, 2 cases scored 3 and 1 case scored 2. The case that scored 2 was investigated as a patient safety incident.

The completed reviews are received via the Sussex Learning from Lives and Deaths (LeDeR) programme lead by the Learning from Deaths Manager for deaths occurring at SRH and WGH. This includes feedback, identified learning, and recommendations as well as positive action points. In the last quarter, six completed LeDeR external reviews were received. The feedback is then shared at the Learning Disabilities Strategy Group and with the Divisions The identified learning and recommendations from these reviews is then scrutinised at the LeDeR Action Review Group (LARG) who initiate, facilitate and monitor the required quality improvement work streams.

Two patients with LD were identified during quarter 4 2021/22, one at RSCH and one at PRH. One of the SJRs has been completed and overall, the care was assessed as adequate.

8. Mortality Panel Outcomes (SRH and WGH only)

During quarter 4 2021/22 a total of 43 (↑) cases (patients who died at SRH and WGH) were discussed at the weekly mortality panel meetings. These involved 9 cases from deaths that occurred in quarter 4 2020/21, 11 cases from quarter 3 2021/22, 12 cases from quarter 2 2021/22 and 11 cases from quarter 1 2021/22.

Graph 5: Details outcome scores for all cases discussed at mortality panel meetings that took place within quarter 4 2021/22.

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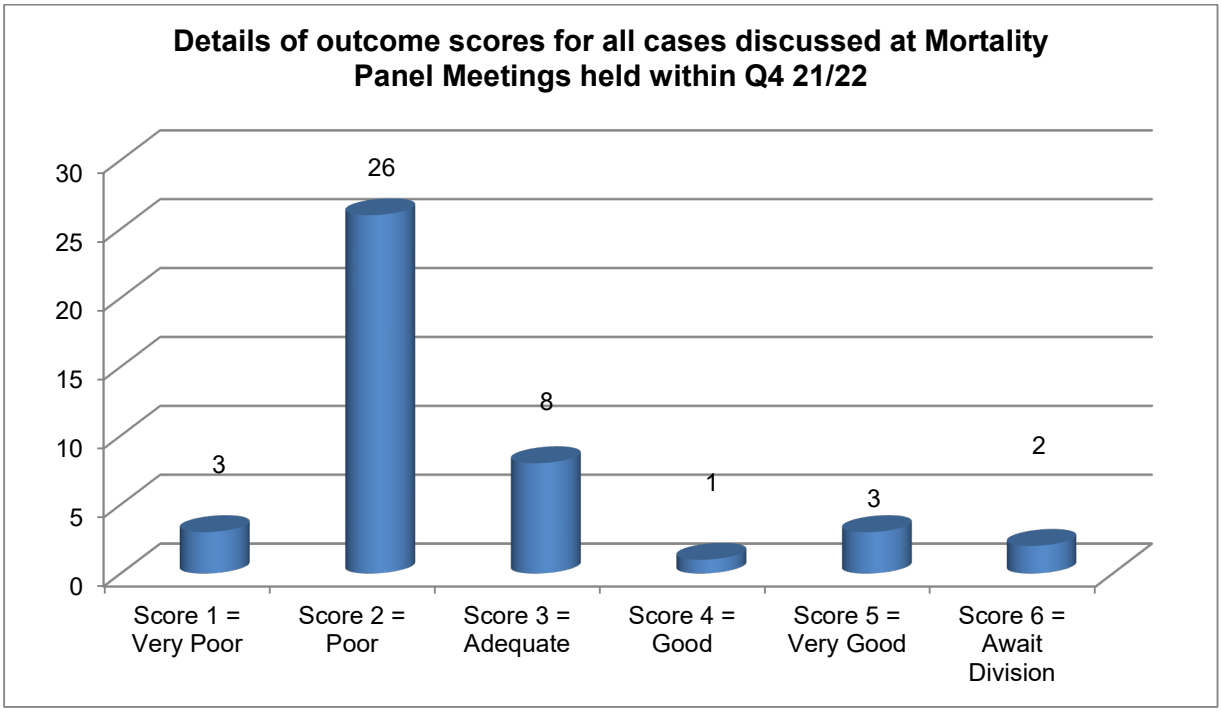
Graph 5



As of July 2021, an alternative avoidability rating system was adopted by the mortality panel for patients that died at SRH and WGH. This new rating system, not only gives the mortality panel wider scope when considering the effect that care issues may have had on the outcome of the patient, but it also uses language that is more considerate for the Divisions when feedback is given. The avoidability ratings are as follows.

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

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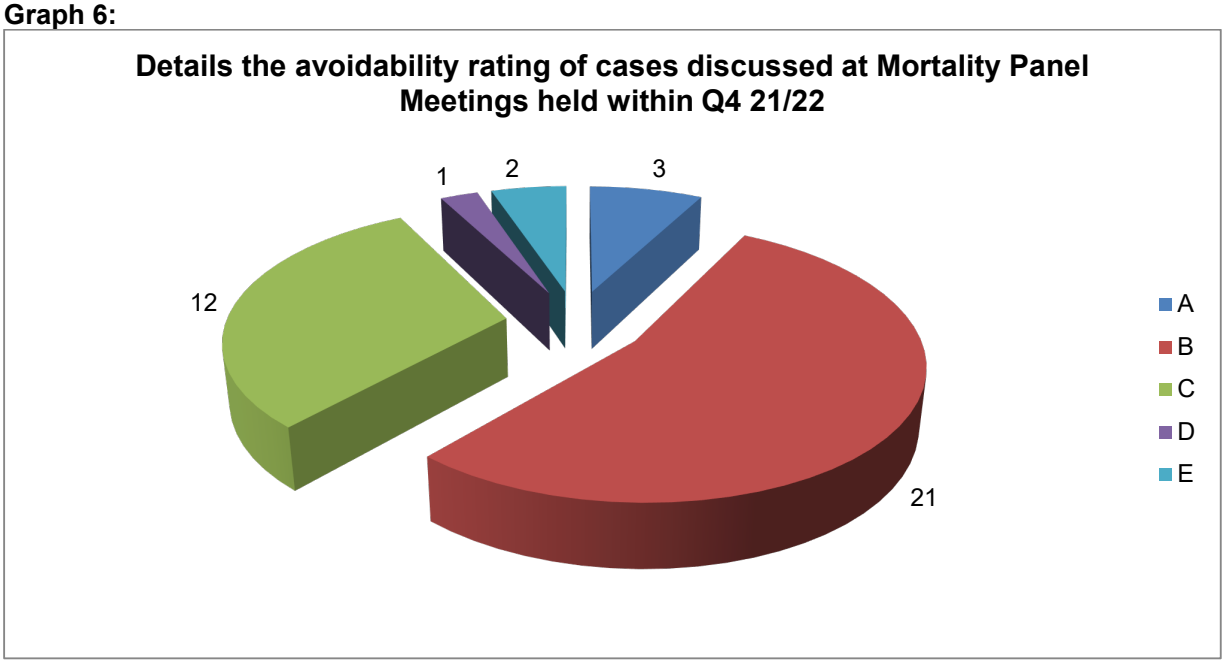
Graph 6: Details the avoidability rating of cases discussed at Mortality Panel Meetings held within quarter 4 2021/22

Graph 6:



Of the cases that were discussed at the weekly mortality panel where a final outcome score was determined *(n=41),* the review group identified one case where care issues were considered likely to have made a difference to the outcome for the patient (D). This case involved a patient who was admitted for elective hip surgery. He had known alcoholic liver disease. The risk of hepatic and renal decompensation was not recognised pre or post operatively. An RLDatix® incident report has been submitted for divisional investigation, learning and quality improvements. A further case where care issues were likely to have made a difference to the outcome of the patient was escalated at the Serious Incident Review Group meeting following SJR, and reviewed at the Venous Thromboembolism (VTE) panel and was subsequently reported as a serious incident. This involved a patient who had a delay in the prescription of VTE thromboprophylaxis post elective surgery and died of a pulmonary embolism.

Two cases are awaiting further information and/or investigation from the Divisions. This information will then be fed back to the mortality panel meeting and an outcome score will be determined.

9. Mortality Review Outcomes (RSCH and PRH)

Some of the learning from the SJR's undertaken at RSCH and PRH include problems with delays that include:

- Delayed diagnosis
- Delayed discharge
- Delayed Treatment Escalation Plans
- Delayed senior review
- Delay in involving palliative care

Other concerns identified includes an extended stay in the Emergency Department for a patient in the last hours of life, a crisis admission for a patient wanting to die at home and a prolonged admission because of nosocomial infections (covid-19 and norovirus).

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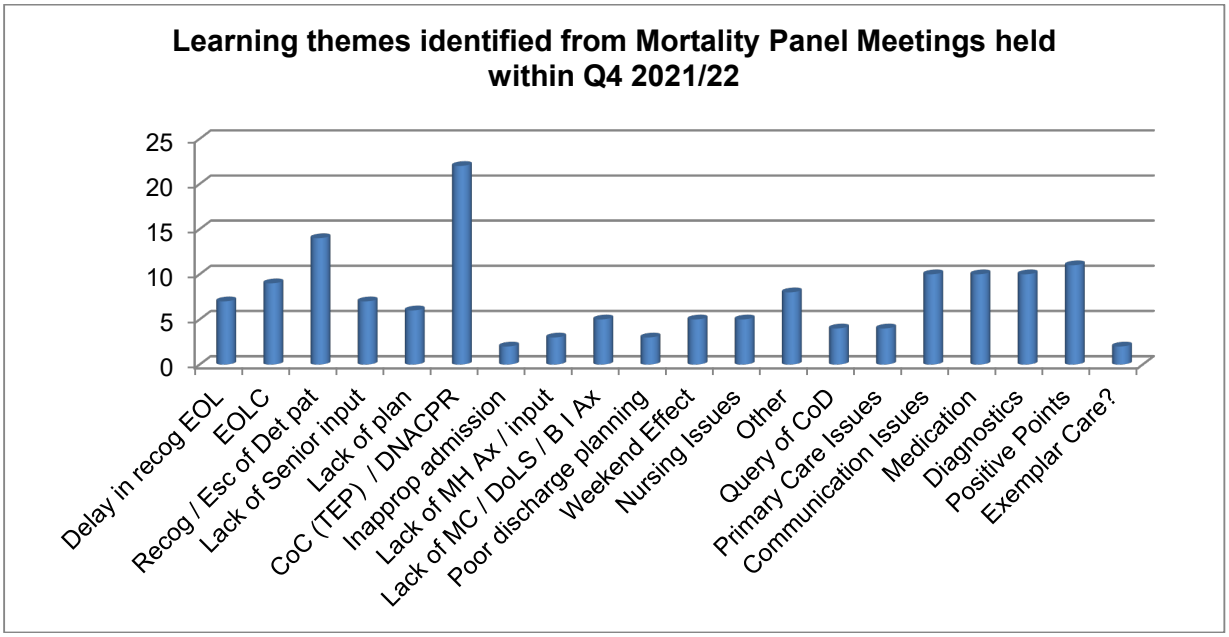
10. Learning from deaths themes quarter 4 2021/22 (SRH and WGH)

Graph 7: Details learning themes identified from mortality panel meetings that took place within quarter 4 2021/22, SRH and WGH only.

Graph 7



See Appendix 1 for Glossary of Terms

Table 13: Details where 'other' learning identified that does not fit into any specific category

Table 13

Learning identified as "other"
ITU Juniors declined a patient without discussion with Consultant.
Delayed MDT
Quality of care on escalation ward
Delay in NG Tube & Surgery
Thresholds for Neurosurgery varied according to tertiary centre
Collar not applied? on purpose - but not documented or? in error. Unrealistic advice from neuro re collar for 6/52 in pt with dementia
Not cared for holistically during previous admission
#NoF pathway not triggered

The top three themes identified at mortality panel meetings throughout quarter 4 2021/22 for WGH and SRH are:

10.1 Ceilings of care (Treatment Escalation Plan (TEP)) and DNACPR

The underutilisation of DNACPR and TEP forms remains a consistent learning theme. Issues identified when these documents were not used included:

- Delayed end of life care
- Inappropriate medical interventions including resuscitation
- Expectations for clinical teams, the patient and family members not being clearly communicated has led to additional stress and upset for all concerned

10.2 Lack of recognition or escalation of the deteriorating patient

Issues identified in contributing to the late recognition and escalation of deteriorating patients included aspects of both medical and nursing care and comprised of:

- Management and monitoring of fluid balance
- Delayed recognition and treatment of Acute kidney Injury (AKI)
- Weekend effect

10.3 Positive points

For quarter 4 2021/22, following feedback from the Divisions at WGH and SRH, the mortality panel have focused on particularly good elements of care as well as identifying areas of care where improvements are required. It can be the case that although the overall care has been graded as satisfactory or less, there are elements within the care pathway that have been of a high standard.

Table 14: Details 'Positive points' that were identified at mortality panel

Table 14

Learning Identified as 'Positive Points'
MH issues no barrier to care patient received
A&E Nurse escalating patients care needs
Exemplar Care
Good nursing documentation & support of the family
Excellent input from A&E, Dr, Dietician, PD Nurse
Good initial care in ED and during the perioperative phase

For these cases plaudits were sent to the relevant clinicians and teams on behalf of the mortality panel.

10.4 Learning from deaths recommendations quarter 4 2021/22 (RSCH and PRH)

The themes emerging from the completed SJR's at RSCH and PRH include:

- Better communications both when transferring patients between hospitals and in understanding and listening to patient's needs
- Improving continuity of care and decision making
- Better involvement of other teams including, care of the elderly, palliative care and the Learning Disabilities team
- Expanding the use of Treatment Escalation Plans
- Identify training needs on the acute floor around syringe drivers and practical management of symptom control

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11. Current capacity and future sustainability of robust mortality review processes

11.1 The activity of the mortality reviewers undertaking SJRs is constrained by their clinical commitments. Following episodes of business continuity related to capacity, demand and because of the Corona virus pandemic, SJR activity reduced causing a backlog of cases requiring review. A recovery plan remains ongoing to assist in managing the SJR backlog for SRH and WGH.

11.2 In the past 12 months at RSCH and PRH, 82 SJRs were requested (63 at RSCH and 19 at PRH). Currently 55 SJR requests from 2021 deaths are outstanding (67%), this includes one LeDeR review. At SRH and WGH 349 SJRs were requested (2 were withdrawn from the programme; one was declared as a Serious Incident and the other was investigated fully as a moderate harm patient safety incident). Out of the remaining 347 cases, 61 SJR requests are outstanding (18%). Additionally, at the time of writing this report, 13 cases are awaiting a second review and 45 cases are awaiting a mortality panel discussion

11.3 The facilitation of the learning from deaths programme is different across the four hospital sites. At SRH and WGH mortality processes are supported by a dedicated learning from deaths manager and has remained within the clinical effectiveness portfolio. A clinically diverse group of six medical consultants use four hours as mortality reviewers within their weekly job plans to complete structured judgement reviews and attend the weekly mortality panel.

11.4 At RSCH and PRH, the mortality processes were facilitated by a palliative care consultant and the palliative care lead nurse with the support of the patient safety team. A group of medical consultants with special interests for mortality reviewing/learning form deaths complete SJRs according to local referral and clinical triggers via M&M reviews. Post – merger, the mortality review processes sits within clinical effectiveness across UHSussex, currently with no additional resources.

11.5 The ME offices intention across UHSussex is to scrutinise every adult inpatient death. The first phase of community roll out which includes the review of all West Sussex inpatient hospice deaths by the end of quarter 4 2021/22, has commenced. To date, the deaths for one of the two hospices within West Sussex are being reviewed by the ME service at WGH and SRH. Additionally, during quarter 4 2021/22, two MEs from within primary care have been appointed to support the next phase of the community roll out , which is to pilot the review of community based deaths, within West Sussex, by the end of quarter 1 2022/23.

11.5 Currently SRH and WGH have no automated system for recording SJR requests, outcomes and activity whilst RSCH and PRH do use an automated system (PANDA). Subsequently analysing joint activity and outcomes is challenging. The plan is for SRH and WGH to pilot the Datix Cloud IQ® Mortality Module as a potential first step for unifying approaches across UHSussex.

12. Conclusions

- Ongoing recruitment of both Medical Examiners and Medical Examiner Officers will be required to sustain the current level of inpatient mortality reviews as well as to fully extend the Medical Examiner service to include all community deaths.
- Post-merger implementation plans towards aligning the learning from deaths processes across UHSussex to continue, with a view to increase activity at RSCH and PRH.

- Joint working between Medical Examiner office, learning from deaths team, bereavement team and speciality M and M leads to develop the Datix Cloud IQ® Mortality Module to continue – project initially launched October 2020 for SRH and WGH. This was then on hold awaiting post-merger implementation plans. The project re-launched September 2021, following recruitment of dedicated project manager. Work on the mortality module was due to re commence March 2022 but is currently on 'pause'.

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Table 15: Details actions in response to learning themes from mortality panel meeting outcomes and the mortality review process

Colour	Status
	Due
	Open
	Open on track
	Closed/complete

QUARTER	SUBJECT	ACTION	LEAD	UPDATE	RAG rating
Q2 20/21	Missed / delayed diagnosis of chest pains	Launch of HSIB report on pulmonary embolism published and includes direct experience from UHSussex. Recommendations to include increased use of simulation and human factors training. Implementation plan will be required.	TT	Ongoing	
All	Varied response from divisions with regards learning from mortality panel feedback/actions	Internal audit	TT/ME	Completed	
		Update Learning from Deaths Policy – to include divisional/speciality M&M leads roles and responsibilities	AY	Completed	
		Scope divisional/speciality mortality leads & M & M meetings	ME	Ongoing	
		Design Datix Cloud IQ® mortality module	ME/AY	Ongoing	
		Use of DatixRL® incident module (interim solution)	ME	Ongoing	
		Present case and learning theme at Triangulation group monthly	ME/AY	Ongoing	
All	Recognition and escalation of deteriorating patients	Merged deteriorating patient group for UHS (commenced May 2021)	AY	Ongoing	
		Implementation of blood gas results incorporation into main results systems & use of ↑lactate as marker for deteriorating patient on Patientrack	TT/LH	Ongoing	
All	Issues around Ceilings of Care / Treatment Escalation Plans / DNACPR	Targeted educational sessions with Capsticks on DNACPR and mental capacity complete.	TT	Completed	
		Across UHSussex task and finish group underway for implementation of TEP and RESPECT tool.	TT	Ongoing	

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QUARTER	SUBJECT	ACTION	LEAD	UPDATE	RAG rating
All	Delay in recognising EoLC	Successful palliative care business case to extend service - consultants appointed at both sites. Nursing cover 7 days across site	TT	Completed	
		Merged UHSussex End of Life and Mortality Board (commenced June '21)	TT	Ongoing	
		Patient comfort observations on Patientrack	TT	Ongoing	
All	Backlog of SJRs/cases awaiting mortality panel	Workshop to discuss benchmarking for reviewers re activity and streamlining process.	TT/ME	Completed	
		Pilot of streamlined review process (one review prior to mortality panel if reviewer considers appropriate)	TT/ME	Completed	
		Review job plans of reviewers – with option of half PA	TT	Ongoing	
		Plan additional and/or extended mortality panels	TT/ME	Ongoing	
From Q1 21/22	Align mortality review process across UHSussex, with a view to increase activity at RSCH & PRH	Newly appointed Medical Director for Governance and Quality assurance	TT	Completed	
		Cross site working to scope and align all elements of the mortality review process including reporting	TT/AY/ ME	Ongoing	
		Merged Learning from Deaths Policy	AY/ME	Ongoing	

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Glossary of terms:
Delay in recog EoL - Delay in recognising patient was approaching End of Life

EOLC – Issues with the End of Life Care the patient received

Rec / Esc of det pat – Lack of recognition or escalation of the deteriorating patient

Lack of senior input – Lack of input from senior doctors

Lack of plan – Lack of treatment plan for the patient

CoC (TEP) / DNACPR – Ceilings of Care and/or Treatment Escalation Plan were not discussed or completed and/or lack of Do Not Attempt Cardio-Pulmonary Resuscitation documentation or discussion

Inapprop admission – Inappropriate admission to hospital

Lack of MH Ax / input – Lack of documented Mental Health Assessment or input from Mental Health Specialists

Lack of MC / DoLS / BI Ax – Lack of documentation regarding Mental Capacity / Deprivation of Liberties / Best Interests discussions/assessments

Poor discharge planning – Poor discharge planning

Weekend Effect – Patient care may have been compromised due insufficient clinical review at the weekend or over a Bank Holiday

Nursing Issues – Issues with nursing care identified

Any other – See separate table below

Query of CoD – There is a query over the accuracy of the Cause of Death as stated on the Medical Certificate of Cause of Death.

Primary Care Issues – Where issues with Primary Care were identified

Communication – Where poor communication between staff, teams or with the family has been identified

Medication – Where delays or errors in prescribing/administering drugs; drug errors or omissions identified.

Diagnostics – Where delays or errors in completing/reporting/actioning diagnostic tests identified.

Positive Points – Where examples of good care / processes / communication had been identified

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QUALITY COMMITTEE

TERMS OF REFERENCE

1.00 PURPOSE

1.01 The purpose of the Quality Committee is to support the Trust in achieving its quality strategic objective; "We will deliver safe, high quality clinical services and demonstrate they achieve optimal clinical outcomes and deliver best practice for our patients whilst ensuring we meet regulatory standards."

1.02 The Quality Committee will do this through;

- Providing input and recommendations to the Board for the development of the Quality Strategy and Clinical Framework and Strategy, ensuring there is alignment between the two;
- Assisting the Board in its oversight of achievement of the True North Targets, breakthrough objectives and strategic initiatives pertaining to the Quality domain;
- Ensuring robust clinical governance structures, systems and processes are in place across all services and in line with national, regional and commissioning requirements;
- Driving a culture of learning and continuous improvement across the organisation;
- Obtaining assurance that the quality strategy is being implemented; and
- Review of soft intelligence, narrative and data relating to the NHS Quality Assurance Framework and Darzi principles of quality (patient and family experience, patient safety and clinical effectiveness) to enable integrated quality performance reporting to the Board.

2.00 MEMBERSHIP AND ATTENDANCE AT MEETINGS

2.01 The membership of the Committee shall be:

- Chair: a nominated non-executive Director
- Three further nominated non-executive Directors
- Chief Medical Officer (Lead Executive for the Committee)
- Chief Nurse (Alternate Lead Executive for the Committee)
- Chief Governance Officer

2.02 The Trust Chair shall propose which non-executive Directors will be most suitable for nomination as Chair and members of the Committee. The Trust Board shall approve the appointment of the Committee Chair and members, based on the Chair's recommendations.

2.03 In the absence of the Committee Chair one of the remaining non-executive members present shall elect themselves to chair the meeting.

2.04 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of meetings. The Committee secretary will maintain a register of attendance which will be published in the Trust's annual report.

2.05 All members of the Committee shall receive training and development support before joining the Committee and on a continuing basis to ensure their effectiveness as members, supported by a performance assessment process, as agreed by the Board of Directors.

2.06 Core Corporate Directors attendees will be those who are presenting reports to the Committee but are not voting members of the Committee. These will include:

- Medical Directors
- Director of Clinical Effectiveness
- Director of Research and Innovation
- Director of Patient Safety and Learning
- Director of Patient Experience, Involvement and Engagement
- Associate Director of Infection Prevention and Control
- Director of Nursing
- Director of Midwifery
- Director of OD and Leadership
- Patient Safety Champions

2.07 Any member of the Board of Directors shall have the right to attend any meeting of the Committee by prior agreement with the Chair.

2.08 The executive members of the Committee may exceptionally send a deputy to the meeting, but the deputy will not have voting rights at the meeting. Those who are in attendance may exceptionally send a deputy to the meeting.

2.09 Other Trust managers and clinicians may be invited to attend for particular items on the Agenda that relate to areas of risk or operation for which they are responsible.

2.10 The Company Secretary or their nominee shall act as Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

3.00 ROLES AND RESPONSIBILITIES

DELEGATED AUTHORITY

3.01 The Committee shall have the delegated authority to act on behalf of the Board of Directors in accordance with the Constitution, Standing Orders, Standing Financial Instructions, and Scheme of Delegation. The limit of such delegated authority is

restricted to the areas outlined in the Duties of the Committee and subject to the rules on reporting, both as defined below.

3.02 The Committee is empowered to investigate any activity within its Terms of Reference, and to seek any information it requires from staff, who are required to co-operate with the Committee in the conduct of its enquiries.

3.03 The Committee should challenge and ensure the robustness of information provided.

3.04 The Committee is authorised by the Board of Directors to obtain independent legal and professional advice and to secure the attendance of external personnel with relevant experience and expertise, should it consider this necessary. All such advice should be arranged in consultation with the Company Secretary.

RESPONSIBILITIES

True North

3.05 Within the Trust's strategic framework, the Trust's True North is defined as putting the patient first and foremost so all improvements ultimately benefit the people the Trust serves. This Committee will therefore operate within that framework, following agreement of the strategy and plans prioritised and agreed by the Board.

3.06 In support of the True North strategy development the Committee will work to ensure the Trust develops and maintains appropriate annual plans which aligns to the Quality domain True North goals, breakthrough objectives, strategic initiatives and corporate projects and make relevant recommendations to the Board for approval.

3.07 Through discharge of the objectives below the Committee will support the Trust's progress towards achieving its True North goals and overseeing improvement plans when required.

Breakthrough Objectives

3.08 To receive confirmation from the Board an annual basis the cascade of the relevant Breakthrough Objectives which are to be held to account by the Committee.

3.09 To obtain assurance that the Breakthrough Objectives, which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, challenging management and escalating to the Board when required.

Strategic initiatives

3.10 To receive confirmation from the Board an annual basis of the Strategic Initiatives for which delivery is being held to account by the Committee.

3.11 To provide assurance that the Strategic Initiatives, which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, challenging management and escalating to the Board when required.

Corporate Projects

3.12 To receive confirmation from the Board an annual basis of the Corporate Projects for which delivery is being held to account by the Committee.

3.13 To provide assurance that the Corporate Projects, which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, challenging management and escalating to the Board when required.

Statutory requirements

3.14 Review the annual quality report.

External reviews

3.15 The Quality Committee shall receive assurance from other significant assurance functions, both internal and external to the organisation, on its review of the findings and consider the implications to the organisation. These will include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors.

3.16 To monitor the Trust's responses to all relevant external assessment reports and the progress of their implementation, including the reports of the Care Quality Commission.

3.17 To receive exception reporting from sub-groups regarding the CQC's insight report in respect of any potential changes to the Trust's quality risk profile.

Safe

3.18 To obtain assurance that there are effective systems and processes in place which embed learning from incidents and near misses in a way that reduces risk thereby improving outcome measures and quality of care.

3.19 To receive a summary reports, using a standard template, which includes identification of areas of concern and escalations from the Committee's determined sub-groups.

3.20 To receive triangulated reports and review the themes, trends, management, and improvements relating to serious incidents, 'never' events, post-mortem reports, medico-legal cases and to seek assurance that remedial action plans are being implemented and learning is embedded and shared across the organisation. Assurance to be obtained through incident reports, Learning from Deaths, HSMR Action plan, Duty of Candour audits and Patient safety reports.

3.21 Review and monitor Quality Impact Assessments (QIA) relating to Efficiency and Transformation programmes to gain assurance that there will be no unforeseen detrimental impact on quality of care for patients.

3.22 Obtain assurance that the Trust is compliant with the Mental Health Act and its associated Code of Practice and the Mental Capacity Act.

3.23 Obtain assurance that robust safeguarding structures, systems and processes are in place to safeguard children and young people and vulnerable adults.

3.24 To consider reports from the Committee's reporting groups, e.g. Safeguarding, in the context of quality risks and assurances over the Trust's system of internal control as reflected within the BAF.

3.25 Review the annual infection prevention and control report.

3.26 Obtain assurance over the safe delivery of the Trust's children's services

3.27 Obtain assurance over the Trust's maternity services including receipt of reports from the Executive Maternity Champion and the relevant maternity safety and performance dashboards

3.28 Obtain assurance over the safe delivery of the Trust's Palliative and End of Life Care Services

3.29 Obtain assurance over the safe delivery of the Trust's Resuscitation services

3.30 Obtain assurance over the safe delivery of the Trust's Dementia strategy

3.31 To receive of relevant reports from national bodies in relation the standards or practice of clinical care.

Effective

3.32 To ensure there is a comprehensive clinical audit programme in place to support and apply evidence-based practice, implement clinical standards and guidelines, and drive quality improvement, including through approving and monitoring progress against the Clinical Audit Strategy.

3.33 In response to requests from the Board, or where appropriate as decided by the Committee, monitor the implementation of action/improvement plans in respect of quality of care, particularly in relation to incidents and similar issues.

3.34 To maintain oversight of research and innovation activity, ensuring that it is well governed and is focused on and delivers improvement in respect of the Trust's clinical quality priorities.

Well-led

3.35 To receive and consider the Trust's clinical governance and risk management reports and agree recommendations on actions for improvement.

3.36 To monitor and obtain assurance as to the effectiveness of the processes, systems and structures for good clinical governance at the Trust, and to seek their continuous improvement.

3.37 To consider reports from Service Governance Reviews, to ensure that the reviews are effective and that actions arising from them are addressed in a timely and appropriate manner.

3.38 To ensure that board assurance framework reflects the assurances for which the committee has oversight, and that risks highlighted are appropriately reflected on the risk registers.

Responsive

3.39 To obtain assurance that clinical recommendations resulting from complaints including those investigated by the Parliamentary and Health Service Ombudsman have been implemented.

ICS and system collaborations

3.40 To receive and review reports from the ICS meetings, Sussex Acute Collaboration Network and Sussex Health and Care Partnership meetings.

Sub-Groups

3.41 To oversee and scrutinise the performance of relevant sub-groups through a range of formal and informal activities.

3.42 The Committee shall approve all sub-groups' terms of reference annually or as recommended otherwise by the Trust Company Secretary.

Risk

3.43 To review regularly the Board Assurance Framework (including through in-depth reviews of specific risks) and the High Level Operational Risks with a significant potential for impact on the Trust's quality risk appetite, and promote continuous quality improvement with regard to the management of quality risk and the control environment throughout the Trust.

4.00 REPORTING AND RELATIONSHIPS

4.01 The Committee shall be accountable to the Board of Directors of the Trust.

4.02 The Committee shall make recommendations to the Board of Directors concerning any issues that require decision or resolution by the Board.

4.03 The Committee shall refer to the Audit Committee, People Committee, Patient Committee, Systems and Partnerships Committee or Sustainability Committee any matters requiring review or decision-making in that forum.

4.04 The Committee shall receive reports from all sub-groups, which set out any matters requiring escalation to the Quality Committee and provide assurance of effective standards and performance in their respective Departments.

4.05 On an annual basis the Committee will provide a self-assessment report to the Board detailing how the Committee has discharged its obligations as set out within its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate. This will form part of the assurances which support the Annual Governance Statement and the Annual report disclosures and will be submitted in the first quarter of the following financial year.

4.06 The Committee Chair shall present a report summarising the proceedings of the meeting at the next Trust Board meeting. This should draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

5.00 CONDUCT OF BUSINESS

5.01 The Committee shall conduct its business in accordance with the Standing Orders of the Trust.

5.02 The Committee shall be deemed quorate if there are at least two non-executive Directors and two executive Directors present, one of whom should be the Lead or Alternate Lead Executive for the Committee, the Chief Medical Officer or Chief Nurse. A quorate meeting shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.

5.03 The Committee shall meet not less than 10 times in each financial year and dates will be set by the end of the previous financial year.

5.04 The Committee will set an annual plan for its work to form part of the Board's Annual Cycle of Business, and report to the Board on its progress.

5.05 In exceptional circumstances where delaying actions or decisions would have a negative impact on the Trust's business, certain items of business requiring an urgent decision, or the taking of the decision itself, may be conducted outside of formal meetings, in line with the requirements set out within the Trust standing orders. This will normally be agreed by the Committee in advance and executed by either: Chair's action, calling an extraordinary meeting or reaching consensus on a decision by e-mail. Any decisions are to be formally ratified the Committee and/or Board at the next meeting.

5.06 The Committee business may be transacted through virtual media (using either teleconference or other collaboration and meeting tools). At the start of each meeting which is taking place without all parties being physically present the Chair shall be responsible for determining that the quoracy arrangements has been achieved and that members can effectively contribute.

5.07 The Committee Chair, with the support of the Company Secretary, is responsible for taking appropriate actions to manage conflicts of interest (perceived and actual) during a meeting. Members conflicted on any items of business on a committee meeting agenda shall declare their conflict and withdraw from discussions and/or the decision-making as required. Conflicted members are not to be counted for quorum.

5.08 The Company Secretary is responsible for preparing the agenda and collating and circulating papers to Committee Members. Papers should be provided not less than five calendar days before the meeting and the agenda and papers should be circulated not less five calendar days before the meeting, to provide sufficient time for due consideration.

5.09 Proceedings and decisions made will be formally recorded by the Company Secretary in the form of minutes and distributed to Committee Members within 10 working days of the meeting.

6.00 TERMS OF REFERENCE

6.01 The Committee shall review its own performance, constitution and terms of reference at least every two years to ensure it is operating at maximum effectiveness. Any proposed changes to the terms of reference should be agreed by the Trust Board.

6.02 It is the Company Secretary's responsibility to make the necessary updates to the terms of reference.

6.03 Approved by Committee April 2022

6.04 Next full review: by March 2025 (recognising that these have been reviewed at the end of the first year of operation of this Committee and will be subject to review during the annual review of Committee effectiveness)

University Hospitals Sussex
NHS Foundation Trust

Appendix - Mandated reports considered by the Committee

Below is a list of the mandated reports the Committee the Committee would receive over the year

- Annual Quality Report
- Annual Mental Health Act Compliance Report
- Adult Safeguarding Annual Report and Quarterly Reports
- Child Safeguarding Annual Report and Quarterly Reports
- Infection Prevention and Control Annual Report
- Learning from Deaths quarterly and annual report
- Annual Incident Report
- Duty of Candour Compliance Report
- External Reviews Report
- CQC Reports
- Annual Complaints Report
- Annual Research and Innovation Report
- Quality Dashboards, covering Maternity and Key Indicators (List)
- Dementia Strategy
- Children & Young People
- Resuscitation
- Palliative and End of Life Care

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PATIENT COMMITTEE

TERMS OF REFERENCE

1.00 PURPOSE

1.01 The purpose of the Patient Committee is to support the Trust in achieving its patient care strategic objective; “We will make delivering excellent care experience for our patients our highest priority.”

1.02 The Patient Committee will do this through;

- Providing input and recommendations to the Board for the development of the Patient First strategy and operational plan, ensuring there is alignment between the two; and
- Assisting the Board in its oversight of achievement of the True North Targets, breakthrough objectives and strategic initiatives pertaining to the Patient Care domain.

2.00 MEMBERSHIP AND ATTENDANCE AT MEETINGS

2.01 The membership of the Committee shall be:

- Chair: a nominated non-executive Director
- Three further nominated non-executive Directors
- Chief Nurse (Lead Executive for the Committee)
- Chief Medical Officer (Alternate Lead Executive for the Committee)
- Chief Operating Officer
- Chief People Officer

2.02 The Trust Chair shall propose which non-executive Directors will be most suitable for nomination as Chair and members of the Committee. The Trust Board shall approve the appointment of the Committee Chair and members, based on the Chair’s recommendations.

2.03 In the absence of the Committee Chair one of the remaining non-executive members present shall elect themselves to chair the meeting.

2.04 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of meetings. The Committee secretary will maintain a register of attendance which will be published in the Trust’s annual report.

2.05 All members of the Committee shall receive training and development support before joining the Committee and on a continuing basis to ensure their effectiveness as members, supported by a performance assessment process, as agreed by the Board of Directors.

2.06 Core Corporate Directors attendees will be those who are presenting reports to the Committee but are not voting members of the Committee. These will include:

- Director of Patient Experience, Involvement and Engagement
- Director of Delivery & Improvement
- Director of Nursing
- Director of Communications and Engagement

2.07 Any member of the Board of Directors shall have the right to attend any meeting of the Committee by prior agreement with the Chair.

2.08 The executive members of the Committee may exceptionally send a deputy to the meeting, but the deputy will not have voting rights at the meeting. Those who are in attendance may exceptionally send a deputy to the meeting.

2.09 Other Trust managers and clinicians may be invited to attend for particular items on the Agenda that relate to areas of risk or operation for which they are responsible.

2.10 The Company Secretary or their nominee shall act as Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

3.00 ROLES AND RESPONSIBILITIES

DELEGATED AUTHORITY

3.01 The Committee shall have the delegated authority to act on behalf of the Board of Directors in accordance with the Constitution, Standing Orders, Standing Financial Instructions, and Scheme of Delegation. The limit of such delegated authority is restricted to the areas outlined in the Duties of the Committee and subject to the rules on reporting, both as defined below.

3.02 The Committee is empowered to investigate any activity within its Terms of Reference, and to seek any information it requires from staff, who are required to co-operate with the Committee in the conduct of its enquiries.

3.03 The Committee should challenge and ensure the robustness of information provided.

3.04 The Committee is authorised by the Board of Directors to obtain independent legal and professional advice and to secure the attendance of external personnel with relevant experience and expertise, should it consider this necessary. All such advice should be arranged in consultation with the Company Secretary.

RESPONSIBILITIES

True North

3.05 Within the Trust's strategic framework, the Trust's True North is defined as putting the patient first and foremost so all improvements ultimately benefit the people the Trust serves. This Committee will therefore operate within that framework, following agreement of the strategy and plans prioritised and agreed by the Board.

3.06 In support of the True North strategy development the Committee will work to ensure the Trust develops and maintains appropriate annual plans which aligns to the Patient domain True North goals, breakthrough objectives, strategic initiatives and corporate projects and make relevant recommendations to the Board for approval.

3.07 Through discharge of the objectives below the Committee will support the Trust's progress towards achieving its True North goals and overseeing improvement plans when required.

Breakthrough Objectives

3.08 To receive confirmation from the Board an annual basis the cascade of the relevant Breakthrough Objectives which are to be held to account by the Committee.

3.09 To obtain assurance that the Breakthrough Objectives, which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, challenging management and escalating to the Board when required.

Strategic initiatives

3.10 To receive confirmation from the Board an annual basis of the Strategic Initiatives for which delivery is being held to account by the Committee.

3.11 To provide assurance that the Strategic Initiatives, which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, challenging management and escalating to the Board when required.

Corporate Projects

3.12 To receive confirmation from the Board an annual basis of the Corporate Projects for which delivery is being held to account by the Committee.

3.13 To provide assurance that the Corporate Projects, which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, challenging management and escalating to the Board when required.

Well led

3.14 Approve and monitor delivery of the Trust's equality delivery system, through review of the Equality Impact Assessments (EIA) so that essential principles of equality are embedded into the culture, behaviour and decision-making process of the organisation to ensure that patient centred decisions are being made.

Safe

3.15 To receive incident reporting which shows the level of harm and near misses, thus providing a robust picture of the quality of care. To oversee investigations into such events and monitor the learning and education plans put in place to prevent such future incidents.

3.16 To link with the People Committee in the oversight of the Trust education and learning plans, in so far as they impact and enhance patient experience.

Caring

3.17 To receive reporting from the Committees established reporting groups and ensure that the patient voice is being used to influence, change and shape practice.

3.18 To approve the Trust's patient and public engagement plans and the patient experience plans/strategy and ensure that these plans are incorporated into the quality and clinical governance teams across the Trust.

3.19 Receive assurance that appropriate safeguarding arrangements are in place and effectively monitored.

3.20 To consider reports from the Customer Relations Team, the Patient Advice & Liaison Service and other sources of feedback (such as Healthwatch) on all formal and informal patient feedback, both positive and negative, and to consider action in respect of matters of concern.

3.21 To consider the results the issues raised and the trends in all patient surveys (including real-time patient feedback systems), of in-patients and out-patients activities (e.g. Inpatient, Cancer, Maternity and ED) and estate surveys such as PLACE that may impact on clinical quality, and to gain assurance of the development of robust improvement plans and the subsequent completion of action taken to address issues raised.

Responsive

3.22 To review the complaints procedure in conjunction with the periodic review of the complaints policy.

3.23 To seek assurance that complaints are managed in a way that promotes a culture of openness, learning and continuous improvement across all divisions.

3.24 To review the themes and trends in complaints and the learning and improvements made relating to complaints raised and trends identified.

3.25 To consider national reports from the Ombudsman, to identify matters of relevance requiring action within the Trust, and to make recommendations to the Board.

3.26 Ensure Trust framework of policies and procedures facilitate compliance with the Duty of Candour regulation.

ICS and system collaborations

3.27 Receive and review reports from the ICS meetings, Sussex Acute Collaboration Network and Sussex Health and Care Partnership meetings.

Risk

3.28 To review regularly the Board Assurance Framework (including through in-depth reviews of specific risks) and the High-Level Operational Risks with a significant potential for impact on the Trust's Patient objectives.

4.00 REPORTING AND RELATIONSHIPS

4.01 The Committee shall be accountable to the Board of Directors of the Trust.

4.02 The Committee shall make recommendations to the Board of Directors concerning any issues that require decision or resolution by the Board.

4.03 The Committee shall refer to the Audit Committee, Quality Committee, People Committee, Systems and Partnerships Committee or Sustainability Committee any matters requiring review or decision-making in that forum.

4.04 The Committee shall receive reports from all sub-groups setting out any matters requiring escalation to the Patient Committee.

4.05 On an annual basis the Committee will provide a self-assessment report to the Board detailing how the Committee has discharged its obligations as set out within its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate. This will form part of the assurances which support the Annual Governance Statement and the Annual report disclosures and will be submitted in the first quarter of the following financial year.

4.06 The Committee Chair shall present a report summarising the proceedings of the meeting at the next Trust Board meeting. This should draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

5.00 CONDUCT OF BUSINESS

5.01 The Committee shall conduct its business in accordance with the Standing Orders of the Trust.

5.02 The Committee shall be deemed quorate if there are at least two non-executive Directors and two executive Directors present, one of whom should be the Lead Executive for the Committee, the Chief Nurse, or Chief Delivery and Strategy Officer as the alternate Lead Executive for the Committee. A quorate meeting shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.

5.03 The Committee shall meet not less than 4 times in each financial year and dates will be set by the end of the previous financial year, noting that in between the quarterly Committee meetings the members of the Committee will hold strategy deployment meetings focusing on the patient True North.

5.04 The Committee will set an annual plan for its work to form part of the Board's Annual Cycle of Business, and report to the Board on its progress.

5.05 In exceptional circumstances where delaying actions or decisions would have a negative impact on the Trust's business, certain items of business requiring an urgent decision, or the taking of the decision itself, may be conducted outside of formal meetings, in line with the requirements set out within the Trust standing orders. This will normally be agreed by the Committee in advance and executed by either: Chair's action, calling an extraordinary meeting or reaching consensus on a decision by e-mail. Any decisions are to be formally ratified the Committee and/or Board at the next meeting.

5.06 The Committee business may be transacted through virtual media (using either teleconference or other collaboration and meeting tools). At the start of each meeting which is taking place without all parties being physically present the Chair shall be

responsible for determining that the quoracy arrangements has been achieved and that members can effectively contribute.

5.07 The Committee Chair, with the support of the Company Secretary, is responsible for taking appropriate actions to manage conflicts of interest (perceived and actual) during a meeting. Members conflicted on any items of business on a committee meeting agenda shall declare their conflict and withdraw from discussions and/or the decision-making as required. Conflicted members are not to be counted for quorum.

5.08 The Company Secretary is responsible for preparing the agenda and collating and circulating papers to Committee Members. Papers should be provided not less than five calendar days before the meeting and the agenda and papers should be circulated not less five calendar days before the meeting, to provide sufficient time for due consideration.

5.09 Proceedings and decisions made will be formally recorded by the Company Secretary in the form of minutes and distributed to Committee Members within 10 working days of the meeting.

6.00 TERMS OF REFERENCE

6.01 The Committee shall review its own performance, constitution and terms of reference at least every two years to ensure it is operating at maximum effectiveness. Any proposed changes to the terms of reference should be agreed by the Trust Board.

6.02 It is the Company Secretary's responsibility to make the necessary updates to the terms of reference.

6.03 Approved by Committee April 2022

6.04 Next full review: by March 2025 (recognising that these have been reviewed at the end of the first year of operation of this Committee and will be subject to review during the annual review of Committee effectiveness)

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Appendix - Mandated reports considered by the Committee

Below is a list of the mandated reports the Committee the Committee would receive over the year

- Patient Survey Reports
- PLACE Reports
- Ombudsman Reports
- HealthWatch Reports
- Annual Patient Experience Report

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PEOPLE COMMITTEE

TERMS OF REFERENCE

1.00 PURPOSE

1.01 The purpose of the People Committee is to support the Trust in achieving its people strategic objective; "We will value and respect all our staff equitably, involve them in decisions about the services they provide and offer the training and development they need to fulfil their roles."

1.02 The People Committee will do this through;

- Provide input and recommendations to the Board for the development of the People Plan; and
- Assisting the Board in its oversight of achievement of the True North Targets, breakthrough objectives and strategic initiatives pertaining to the People domain.

2.00 MEMBERSHIP AND ATTENDANCE AT MEETINGS

2.01 The membership of the Committee shall be:

- Chair: a nominated non-executive Director
- Three further nominated non-executive Directors
- Chief People Officer (Lead Executive for the Committee)
- Chief Operating Officer (Alternate Lead Executive for the Committee)
- Chief Nurse
- Chief Finance Officer

2.02 The Trust Chair shall propose which non-executive Directors will be most suitable for nomination as Chair and members of the Committee. The Trust Board shall approve the appointment of the Committee Chair and members, based on the Chair's recommendations.

2.03 In the absence of the Committee Chair one of the remaining non-executive members present shall elect themselves to chair the meeting.

2.04 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of meetings. The Committee secretary will maintain a register of attendance which will be published in the Trust's annual report.

2.05 All members of the Committee shall receive training and development support before joining the Committee and on a continuing basis to ensure their effectiveness as members, supported by a performance assessment process, as agreed by the Board of Directors.

2.06 Core Corporate Directors attendees will be those who are presenting reports to the Committee but are not voting members of the Committee. These will include:

- Director of HR Management
- Director of Workforce Planning and Deployment
- Director of OD and Leadership
- Director of Integrated Education

2.07 Any member of the Board of Directors shall have the right to attend any meeting of the Committee by prior agreement with the Chair.

2.08 The executive members of the Committee may exceptionally send a deputy to the meeting, but the deputy unless stated will not have voting rights at the meeting. Those who are in attendance may exceptionally send a deputy to the meeting.

2.09 Other Trust managers and clinicians may be invited to attend for particular items on the Agenda that relate to areas of risk or operation for which they are responsible.

2.10 The Company Secretary or their nominee shall act as Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

3.00 ROLES AND RESPONSIBILITIES

DELEGATED AUTHORITY

3.01 The Committee shall have the delegated authority to act on behalf of the Board of Directors in accordance with the Constitution, Standing Orders, Standing Financial Instructions, and Scheme of Delegation. The limit of such delegated authority is restricted to the areas outlined in the Duties of the Committee and subject to the rules on reporting, both as defined below.

3.02 The Committee is empowered to investigate any activity within its Terms of Reference, and to seek any information it requires from staff, who are required to co-operate with the Committee in the conduct of its enquiries.

3.03 The Committee should challenge and ensure the robustness of information provided.

3.04 The Committee is authorised by the Board of Directors to obtain independent legal and professional advice and to secure the attendance of external personnel with relevant experience and expertise, should it consider this necessary. All such advice should be arranged in consultation with the Company Secretary.

RESPONSIBILITIES

True North

3.05 Within the Trust's strategic framework, the Trust's True North is defined as putting the patient first and foremost so all improvements ultimately benefit the people the Trust serves. This Committee will therefore operate within that framework, following agreement of the strategy and plans prioritised and agreed by the Board.

3.06 In support of the True North strategy development the Committee will work to ensure the Trust develops and maintains appropriate annual plans which aligns to the People domain True North goals, breakthrough objectives, strategic initiatives and corporate projects and make relevant recommendations to the Board for approval.

3.07 Through discharge of the objectives below the Committee will support the Trust's progress towards achieving its True North goals and overseeing improvement plans when required.

Breakthrough Objectives

3.08 To receive confirmation from the Board an annual basis the cascade of the relevant Breakthrough Objectives which are to be held to account by the Committee.

3.09 To obtain assurance that the Breakthrough Objectives, which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, challenging management and escalating to the Board when required.

Strategic initiatives

3.10 To receive confirmation from the Board an annual basis of the Strategic Initiatives for which delivery is being held to account by the Committee.

3.11 To provide assurance that the Strategic Initiatives, which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, challenging management and escalating to the Board when required.

Corporate Projects

3.12 To receive confirmation from the Board an annual basis of the Corporate Projects for which delivery is being held to account by the Committee.

3.13 To provide assurance that the Corporate Projects, which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, challenging management and escalating to the Board when required.

People Plan

The Committee has oversight for the development and delivery of the Trust's people plan covering the main areas of

Leadership

3.14 To ensure the Trust develops and effective staff structure and operating model across the enlarged organisation.

3.15 To monitor delivery of staff engagement plans to ensure there are clear communication channels across the enlarged organisation which provide staff with key information during the merger.

3.16 To monitor organisational integration and cultural development, using methods such as pulse surveys and Town Halls, and implement action plans as necessary.

Culture

3.17 To consider reports from the Guardian of Safe Working and Freedom to Speak up Guardian in the context of the Trust's quality, safety and patient experience processes to ensure that there is a genuinely open culture in which all safety concerns raised are highly valued as integral to learning and improvement.

3.18 Consider reports on national and local surveys including the staff survey and GMC survey as they relate to workforce, and to monitor the implementation of action taken to address issues raised.

3.19 To gain assurance that appropriate feedback mechanisms are in place for those raising incidents and that a culture of openness and transparency in respect of incident reporting is encouraged by supporting the Speak Up agenda and receiving reports from the Freedom to Speak up Guardian.

3.20 Receive assurance that clinicians, managers and staff promote and advance equality and diversity, whilst working closely with patients, the public, local communities, voluntary organisations, staff and staff side organisations.

3.21 Receive assurance on the Trust's wellbeing and staff safety initiatives and ensure they support staff retention, development and wellbeing.

3.22 Obtain assurance over the Trust's Security and those raising incidents against violence and aggression

Integrated Education

3.23 To ensure that other education and training-related issues, themes and trends are addressed, to promote high standards of care quality through approval of the education and training strategy and monitoring delivery of the strategy.

3.24 To receive assurance that training and educational opportunities area available and staff are encouraged to participate in local, national, and international safety programmes.

Workforce Transformation

3.25 To monitor all Workforce Transformation programmes, including to obtain assurance that no programme has an unforeseen detrimental impact on workforce or on the performance of the Trust especially in respect of constitutional and key operational metrics; and to make recommendations as necessary to the Board about action required in-year.

3.26 To receive and monitor the Trust's suite of workforce indicators, including Recruitment, Retention / Turnover, Sickness, Appraisals, Training, along with reports relating to the efficient use of the Trust's workforce

Mandated Annual Reporting oversight

3.27 To oversee and monitor progress against national NHS England workforce standards and reporting e.g. Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), NHS England guidance on Whistleblowing and the government introduced Apprenticeship Levy.

3.28 To consider reports from the Trust's Caldicott Guardian and Data Protection Officer where people risks have been identified.

3.29 To review the Trust's Equality and Diversity annual report.

3.30 To review and develop action plan from the Gender Pay Gap Report.

3.31 To review the Trust's Annual People Report.

3.32 To review of the Annual consultant revalidation report.

ICS and system collaborations

3.33 To receive and review reports from the ICS meetings, Sussex Acute Collaboration Network and Sussex Health and Care Partnership meetings.

Risk

3.34 To review regularly the Board Assurance Framework (including through in-depth reviews of specific risks) and the High-Level Operational Risks with a significant potential for impact on the Trust's People objectives.

4.00 REPORTING AND RELATIONSHIPS

4.01 The Committee shall be accountable to the Board of Directors of the Trust.

4.02 The Committee shall make recommendations to the Board of Directors concerning any issues that require decision or resolution by the Board.

4.03 The Committee shall refer to the Audit Committee, Quality Committee, Systems and Partnerships Committee, Patient Committee or Sustainability Committee any matters requiring review or decision-making in that forum.

4.04 The Committee shall receive reports from the Committees sub-groups setting out any matters requiring escalation to the People Committee.

4.05 On an annual basis the Committee will provide a self-assessment report to the Board detailing how the Committee has discharged its obligations as set out within its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate. This will form part of the assurances which support the Annual Governance Statement and the Annual report disclosures and will be submitted in the first quarter of the following financial year.

4.06 The Committee Chair shall present a report summarising the proceedings of the meeting at the next Trust Board meeting. This should draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

5.00 CONDUCT OF BUSINESS

5.01 The Committee shall conduct its business in accordance with the Standing Orders of the Trust.

5.02 The Committee shall be deemed quorate if there are at least two non-executive Directors and two executive Directors present, one of whom should be the Lead Executive for the Committee, the Chief People Officer or the Alternate Lead

Executive for the Committee that being the Chief Culture and Organisation Development Officer. A quorate meeting shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.

5.03 The Committee shall meet not less than 4 times in each financial year and dates will be set by the end of the previous financial year, noting that in between the quarterly Committee meetings the members of the Committee will hold strategy deployment meetings focusing on the patient True North.

5.04 The Committee will set an annual plan for its work to form part of the Board's Annual Cycle of Business, and report to the Board on its progress.

5.05 In exceptional circumstances where delaying actions or decisions would have a negative impact on the Trust's business, certain items of business requiring an urgent decision, or the taking of the decision itself, may be conducted outside of formal meetings, in line with the requirements set out within the Trust standing orders. This will normally be agreed by the Committee in advance and executed by either: Chair's action, calling an extraordinary meeting or reaching consensus on a decision by e-mail. Any decisions are to be formally ratified the Committee and/or Board at the next meeting.

5.06 The Committee business may be transacted through virtual media (using either teleconference or other collaboration and meeting tools). At the start of each meeting which is taking place without all parties being physically present the Chair shall be responsible for determining that the quoracy arrangements has been achieved and that members can effectively contribute.

5.07 The Committee Chair, with the support of the Company Secretary, is responsible for taking appropriate actions to manage conflicts of interest (perceived and actual) during a meeting. Members conflicted on any items of business on a committee meeting agenda shall declare their conflict and withdraw from discussions and/or the decision-making as required. Conflicted members are not to be counted for quorum.

5.08 The Company Secretary is responsible for preparing the agenda and collating and circulating papers to Committee Members. Papers should be provided not less than five calendar days before the meeting and the agenda and papers should be circulated not less five calendar days before the meeting, to provide sufficient time for due consideration.

5.09 Proceedings and decisions made will be formally recorded by the Company Secretary in the form of minutes and distributed to Committee Members within 10 working days of the meeting.

6.00 TERMS OF REFERENCE

6.01 The Committee shall review its own performance, constitution and terms of reference at least every two years to ensure it is operating at maximum effectiveness. Any proposed changes to the terms of reference should be agreed by the Trust Board.

6.02 It is the Company Secretary's responsibility to make the necessary updates to the terms of reference.

6.03 Approved by Committee April 2022

6.04 Next full review: by March 2025 (recognising that these have been reviewed at the end of the first year of operation of this Committee and will be subject to review during the annual review of Committee effectiveness)

University Hospitals Sussex
NHS Foundation Trust

Appendix - Mandated reports considered by the Committee

Below is a list of the mandated reports the Committee the Committee would receive over the year

- Gender Pay Gap Report
- Equality Annual Report
- Workforce Race Equality Standard Annual Report
- Disability Equality Standard Annual Report
- National Staff Survey
- GMC Staff Survey
- Freedom to Speak up Annual Report / Whistleblowing report
- Guardian of Safe Working Annual Report
- Security Management – violence and aggression quarterly report

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SUSTAINABILITY COMMITTEE

TERMS OF REFERENCE

1.00 PURPOSE

1.01 The purpose of the Sustainability Committee is to support the Trust in achieving its sustainability strategic objective; "We will use our resources efficiently and effectively for the benefit of our patients and their care and to ensure our services are clinically, operationally, and financially sustainable."

1.02 The Sustainability Committee will do this through;

- Providing input and recommendations to the Board to enable delivery of the sustainability strategic objectives and the supporting operational plan, ensuring there is alignment between the two;
- Assisting the Board in its oversight of achievement of the Trust North Targets, breakthrough objectives and strategic initiatives pertaining to the Sustainability Domain; and
- Monitoring risks relating to the effective use of resources, including financial performance.

2.00 MEMBERSHIP AND ATTENDANCE AT MEETINGS

2.01 The membership of the Committee shall be:

- Chair: a nominated non-executive Director
- Three further nominated non-executive Directors
- Chief Finance Officer (Lead Executive)
- Chief Delivery and Strategy Officer (Alternate Lead Executive)
- Chief Medical Officer
- Chief Operating Officer
- Chief People Officer

2.02 The Trust Chair shall propose which non-executive Directors will be most suitable for nomination as Chair and members of the Committee. The Trust Board shall approve the appointment of the Committee Chair and members, based on the Chair's recommendations. At least one of the Committee members should have recent and relevant financial experience.

2.03 In the absence of the Committee Chair one of the remaining non-executive members present shall elect themselves to chair the meeting.

2.04 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of meetings. The Committee secretary will maintain a register of attendance which will be published in the Trust's annual report.

2.05 All members of the Committee shall receive training and development support before joining the Committee and on a continuing basis to ensure their effectiveness as members, supported by a performance assessment process, as agreed by the Board of Directors.

2.06 Core Corporate Directors attendees will be those who are presenting reports to the Committee but are not voting members of the Committee. These will include:

- Director of Finance
- Director of Improvement and Delivery
- Director of Workforce, Planning & Deployment
- Director of IM&T
- Director of Capital & Property
- Commercial Director
- Director of Facilities & Estates

2.07 Any member of the Board of Directors shall have the right to attend any meeting of the Committee by prior agreement with the Chair.

2.08 The executive members of the Committee may exceptionally send a deputy to the meeting, but the deputy will not have voting rights at the meeting. Those who are in attendance may exceptionally send a deputy to the meeting.

2.09 Other Trust managers and clinicians may be invited to attend for particular items on the Agenda that relate to areas of risk or operation for which they are responsible.

2.10 The Company Secretary or their nominee shall act as Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

3.00 ROLES AND RESPONSIBILITIES

DELEGATED AUTHORITY

3.01 The Committee shall have the delegated authority to act on behalf of the Board of Directors in accordance with the Constitution, Standing Orders, Standing Financial Instructions, and Scheme of Delegation. The limit of such delegated authority is restricted to the areas outlined in the Duties of the Committee and subject to the rules on reporting, both as defined below.

3.02 The Committee shall have delegated authority to award Contracts and approve Business Cases up to the value delegated to it by the Trust Board.

3.03 The Committee should challenge and ensure the robustness of information provided.

3.04 The Committee is empowered to investigate any activity within its Terms of Reference, and to seek any information it requires from staff, who are required to co-operate with the Committee in the conduct of its enquiries.

3.05 The Committee is authorised by the Board of Directors to obtain independent legal and professional advice and to secure the attendance of external personnel with relevant experience and expertise, should it consider this necessary. All such advice should be arranged in consultation with the Company Secretary.

RESPONSIBILITIES

True North

3.06 Within the Trust's strategic framework, the Trust's True North is defined as putting the patient first and foremost in decision so all improvements ultimately benefit the people the Trust serves. This Committee will therefore operate within that framework, following agreement of the strategy and periodic plans by the Board.

3.07 In support of the True North strategy development the Committee will work to ensure the Trust develops and maintains appropriate annual plans which aligns to the Sustainability domain True North goals, breakthrough objectives, strategic initiatives and corporate projects and make relevant recommendations to the Board for approval.

3.08 Through discharge of the objectives below the Committee will support the Trust's progress towards achieving its True North goals and overseeing improvement plans when required.

Breakthrough objectives

3.09 To receive confirmation from the Board an annual basis of the Breakthrough Objectives which are to be held to account by the Committee.

3.10 To obtain assurance that the Breakthrough Objectives, which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively by receiving reporting, in line with Business Rules, which enables the Committee to oversee delivery, challenge management and escalate to the Board when required.

Strategic initiatives

3.11 To receive confirmation from the Board an annual basis of the Strategic Initiatives for which delivery is being held to account by the Committee.

3.12 To provide assurance that the Strategic Initiatives, which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, challenging management and escalating to the Board when required.

Corporate Projects

3.13 To receive confirmation from the Board an annual basis of the Corporate Projects for which delivery is being held to account by the Committee.

3.14 To provide assurance that the Corporate Projects, which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, challenging management and escalating to the Board when required.

Use of resources

3.15 To obtain assurance over the use of the Trust's resources (physical, workforce and financial) to ensure that they are being used economically, efficiently and effectively, considering as necessary; activity, productivity, sustainability and safety.

3.16 To receive and monitor activity reporting on the use of the Trust physical, workforce and financial resources. This will include effective reporting of service line costs, model hospital and benchmarking to inform unwarranted cost variation, productivity and efficiency opportunities across operational services.

Financial performance

3.17 To review and approve the annual plan and medium-term financial plans.

3.18 To keep the Board updated on any identified regulatory and statutory duties related to financial performance for the Trust and how this impacts delivery against the control total.

3.19 To monitor the Trust's Risk Forecasting against the Financial plan including I&E, Balance Sheet and Cash.

3.20 To monitor and receive assurances over the progress of the Trust's efficiency programme.

3.21 To receive reports setting out any changes to the financial reporting framework and gain an understanding of the risk associated with any changes including any implications on the Trust and how these regulatory changes can be met.

Capital

3.22 To review and approve the Trust's capital programme, including 3Ts build and to monitor progress and risks associated with the delivery of the operational and strategic capital programmes and to escalate to the Board / other relevant committee any significant risks within its delivery.

3.23 To review the estates strategy and Estates masterplan, recommend to the Board, and to monitor progress against and risks associated with the strategy and monitor other estates-related improvement plans.

Information Management and Technology

3.24 To review the IM&T and Digital strategies and recommend to the Board for approval.

3.25 To monitor the implementation of the Trust's IM&T and Digital plans as enablers to Efficiency and Transformation, and to receive regular progress reports to scrutinise delivery and the meeting of key milestones.

Environment

3.26 To review the Environment, Social and Governance activities of the Trust with reference to national requirements and reporting frameworks and the formulated Trust response to those.

3.27 To monitor the implementation of the Trust's Environmental sustainability plans (carbon reduction) and to receive regular progress reports to scrutinise delivery and the meeting of key milestones.

Commercial Activities

3.28 Oversight of commercial activities including Joint Ventures, Business Developments and wholly-owned subsidiaries.

3.29 To review the development and delivery of commercial strategies of the Trust, including partnership arrangements with other organisations.

Procurement

3.30 To review the Trust's procurement strategy and policies on a biennial basis and to make recommendations to the Board.

3.31 To review the effectiveness of the Trust's procurement systems and processes.

Business cases and Significant Investments

3.32 To evaluate and scrutinise the financial viability of business cases (for both revenue and capital spend). This includes receiving recommendations from the Business Scrutiny Panel and TEC, approving business cases and recommending for approval by the Trust Board those in line with Standing Financial Instructions.

ICS and system collaborations

3.33 Receive and review the financial reports for the ICS and any other relevant updates from Sussex Acute Collaboration Network and Sussex Health and Care Partnership meetings.

Risk

3.34 To review regularly the Board Assurance Framework (including through in-depth reviews of specific risks) and the High-Level Operational Risks with a significant potential for impact on the Trust's Sustainability objectives.

4.00 REPORTING AND RELATIONSHIPS

4.01 The Committee shall be accountable to the Board of Directors of the Trust.

4.02 The Committee shall make recommendations to the Board of Directors concerning any issues that require decision or resolution by the Board.

4.03 The Committee shall refer to the Audit Committee, Quality Committee, People Committee, Systems and Partnerships Committee or Patient Committee any matters requiring review or decision-making in that forum.

4.04 The Committee shall receive reports from all sub-groups setting out any matters requiring escalation to the Sustainability Committee.

4.05 On an annual basis the Committee will provide a self-assessment report to the Board detailing how the Committee has discharged its obligations as set out within its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate. This will form part of the assurances which support the Annual Governance Statement and the Annual report disclosures and will be submitted in the first quarter of the following financial year.

4.06 The Committee Chair or Executive lead shall present a report summarising the proceedings of the meeting at the next Trust Board meeting. This should draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

5.00 CONDUCT OF BUSINESS

5.01 The Committee shall conduct its business in accordance with the Standing Orders of the Trust.

5.02 The Committee shall be deemed quorate if there are at least two non-executive Directors and two executive Directors present, one of whom should be the Lead or Alternate Lead Executive for the Committee. A quorate meeting shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.

5.03 The Committee shall meet not less than 4 times in each financial year and dates will be set by the end of the previous financial year, noting that in between the quarterly Committee meetings the members of the Committee will hold strategy deployment meetings focusing on the patient True North.

5.04 The Committee will set an annual plan for its work to form part of the Board's Annual Cycle of Business, and report to the Board on its progress.

5.05 In exceptional circumstances where delaying actions or decisions would have a negative impact on the Trust's business, certain items of business requiring an urgent decision, or the taking of the decision itself, may be conducted outside of formal meetings, in line with the requirements set out within the Trust standing orders. This will normally be agreed by the Committee in advance and executed by either: Chair's action, calling an extraordinary meeting or reaching consensus on a decision by e-mail. Any decisions re to be formally ratified the Committee and/or Board at the next meeting.

5.06 The Committee business may be transacted through virtual media (using either teleconference or other collaboration and meeting tools). At the start of each meeting which is taking place without all parties being physically present the Chair shall be responsible for determining that the quoracy arrangements has been achieved and that members can effectively contribute.

5.07 The Committee Chair, with the support of the Company Secretary, is responsible for taking appropriate actions to manage conflicts of interest (perceived and actual) during a meeting. Members conflicted on any items of business on a committee meeting agenda shall declare their conflict and withdraw from discussions and/or the decision-making as required. Conflicted members are not to be counted for quorum.

5.08 The Company Secretary is responsible for preparing the agenda and collating and circulating papers to Committee Members. Papers should be provided not less than five calendar days before the meeting and the agenda and papers should be circulated not less five calendar days before the meeting, to provide sufficient time for due consideration.

5.09 Proceedings and decisions made will be formally recorded by the Company Secretary in the form of minutes and distributed to Committee Members within 10 working days of the meeting.

6.00 TERMS OF REFERENCE

6.01 The Committee shall review its own performance, constitution and terms of reference at least every two years to ensure it is operating at maximum effectiveness. Any proposed changes to the terms of reference should be agreed by the Trust Board.

6.02 It is the Company Secretary's responsibility to make the necessary updates to the terms of reference.

6.03 Approved by Committee April 2022

6.04 Next full review: by March 2025 (recognising that these have been reviewed at the end of the first year of operation of this Committee and will be subject to review during the annual review of Committee effectiveness)

University Hospitals Sussex
NHS Foundation Trust

Appendix - Mandated reports considered by the Committee

Below is a list of the mandated reports the Committee the Committee would receive over the year

- Capital Programme and Annual Plan
- Annual Financial Plan
- Costing Audit Report
- Environmental Sustainability Annual Report
- IT Strategy
- Subsidiary (Pharm@sea) annual report (prior to AGM)
- Commercial and Procurement Activities Report

University Hospitals Sussex
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SYSTEMS AND PARTNERSHIPS COMMITTEE

TERMS OF REFERENCE

1.00 PURPOSE

1.01 The purpose of the Systems and Partnerships Committee is to support the Trust in achieving its systems and partnerships strategic objective; "We will deliver timely appropriate access to acute care as part of a wider integrated care system."

1.02 The Systems and Partnerships Committee will do this through;

- Providing input and recommendations to the Board to enable delivery of the systems and partnerships objectives and the supporting operational plan to achieve this, ensuring there is alignment between the two;
- Assisting the Board in its oversight of achievement of the True North targets, breakthrough objectives, strategic initiatives, and corporate projects pertaining to the Systems and Partnerships domain;
- Monitoring risks relating to the effective delivery of constitutional access standards; and
- Providing oversight and assurance to relevant major strategic programmes to support the collaboration and partnership development with other partners as part of the wider Integrated Care System priorities.

2.00 MEMBERSHIP AND ATTENDANCE AT MEETINGS

2.01 The membership of the Committee shall be:

- Chair: a nominated non-executive Director
- Three further nominated non-executive Directors
- Chief Operating Officer (Lead Executive)
- Chief Finance Officer (Alternate Lead Executive)
- Chief Delivery and Strategy Officer
- Chief Governance Officer

2.02 The Trust Chair shall propose which non-executive Directors will be most suitable for nomination as Chair and members of the Committee. The Trust Board shall approve the appointment of the Committee Chair and members, based on the Chair's recommendations.

2.03 In the absence of the Committee Chair one of the remaining non-executive members present shall elect themselves to chair the meeting.

2.04 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of meetings. The Committee secretary will maintain a register of attendance which will be published in the Trust's annual report.

2.05 All members of the Committee shall receive training and development support before joining the Committee and on a continuing basis to ensure their effectiveness as members, supported by a performance assessment process, as agreed by the Board of Directors.

2.06 Core Corporate Directors attendees will be those who are presenting reports to the Committee but are not voting members of the Committee. These will include:

- Director of Performance
- Director of Strategy and Planning
- Director of Improvement and Delivery

2.07 Any member of the Board of Directors shall have the right to attend any meeting of the Committee by prior agreement with the Chair.

2.08 The executive members of the Committee may exceptionally send a deputy to the meeting, but the deputy will not have voting rights at the meeting. Those who are in attendance may exceptionally send a deputy to the meeting.

2.09 Other Trust managers and clinicians may be invited to attend for particular items on the Agenda that relate to areas of risk or operation for which they are responsible.

2.10 The Company Secretary or their nominee shall act as Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

3.00 ROLES AND RESPONSIBILITIES

DELEGATED AUTHORITY

3.01 The Committee shall have the delegated authority to act on behalf of the Board of Directors in accordance with the Constitution, Standing Orders, Standing Financial Instructions, and Scheme of Delegation. The limit of such delegated authority is restricted to the areas outlined in the Duties of the Committee and subject to the rules on reporting, both as defined below.

3.02 The Committee is empowered to investigate any activity within its Terms of Reference, and to seek any information it requires from staff, who are required to co-operate with the Committee in the conduct of its enquiries.

3.03 The Committee should challenge and ensure the robustness of information provided.

3.04 The Committee is authorised by the Board of Directors to obtain independent legal and professional advice and to secure the attendance of external personnel with relevant experience and expertise, should it consider this necessary. All such advice should be arranged in consultation with the Company Secretary.

RESPONSIBILITIES

True North

3.05 Within the Trust's strategic framework, the Trust's True North is defined as putting the patient first and foremost so all improvements ultimately benefit the people

the Trust serves. This Committee will therefore operate within that framework, following agreement of the strategy and plans prioritised and agreed by the Board.

3.06 In support of the True North strategy development the Committee will work to ensure the Trust develops and maintains appropriate annual plans which align to the Systems and Partnerships domain True North goals, breakthrough objectives, strategic initiatives and corporate projects and make relevant recommendations to the Board for approval.

3.07 Through discharge of the objectives below the Committee will support the Trust's progress towards achieving its True North goals and overseeing improvement plans when required.

Breakthrough Objectives

3.08 To receive confirmation from the Board an annual basis the cascade of the relevant Breakthrough Objectives which are to be held to account by the Committee.

3.09 To obtain assurance that the Breakthrough Objectives, which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, challenging management and escalating to the Board when required.

Strategic Initiatives

3.10 To receive confirmation from the Board on an annual basis of the Strategic Initiatives for which delivery is being held to account by the Committee.

3.11 To provide assurance that the Strategic Initiatives, which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, challenging management and escalating to the Board when required.

Corporate Projects

3.12 To receive confirmation from the Board on an annual basis of the Corporate Projects for which delivery is being held to account by the Committee.

3.13 To provide assurance that the Corporate Projects, which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, challenging management and escalating to the Board when required.

Delivery of Constitutional Operational and Access Targets

3.14 Review delivery progress and obtain assurance that patient access targets are being delivered (through reviewing performance of A&E, RTT, Cancer and Diagnostics).

3.15 To monitor and receive assurance over the wider suite of relevant operational targets including operational productivity and specific non-constitutional standards.

3.16 To receive reports setting out any changes to the NHSEI Performance Framework and gain an understanding of the risk associated with any changes including any implications for the Trust and how these regulatory changes can be met.

3.17 To review and receive assurance over the data quality systems and processes that supports the Trust's operational performance management and reporting.

Provider Collaboration activity

3.18 Receive and review the collaboration and integration activity for the Trust as part of the developing Integrated Care System, and local Place development.

3.19 Where relevant Receive and review reports from the ICS meetings, Sussex Acute Collaboration Network and Sussex Health and Care Partnership meetings.

3.20 Oversee arrangements for the development of any formal partnership arrangements with other statutory organisations as part of the Trust or ICS agreed strategy.

Emergency Planning and Responsiveness

3.21 To assure and approve the Trust's EPRR arrangements and required operational resilience plans including the Winter Plan.

Sub-Groups

3.22 Oversee and scrutinise the performance of relevant sub-groups through a range of formal and informal activities.

3.23 The Committee shall approve all sub-groups' terms of reference annually or as recommended otherwise by the Trust Company Secretary.

Risk

3.24 To review regularly the Board Assurance Framework (including through in-depth reviews of specific risks) and the High-Level Operational Risks with a significant potential for impact on the Trust's Systems and Partnerships objectives.

4.00 REPORTING AND RELATIONSHIPS

4.01 The Committee shall be accountable to the Board of Directors of the Trust.

4.02 The Committee shall make recommendations to the Board of Directors concerning any issues that require decision or resolution by the Board.

4.03 The Committee shall refer to the Audit Committee, People Committee, Quality Committee, Patient Committee or Sustainability Committee any matters requiring review or decision-making in that forum.

4.04 The Committee shall receive reports from all sub-groups, setting out any matters requiring escalation to the Systems and Partnerships Committee and provide assurance of effective standards and performance in their respective Departments.

4.05 On an annual basis the Committee will provide a self-assessment report to the Board detailing how the Committee has discharged its obligations as set out within its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate. This will form part of the assurances which support the Annual Governance Statement and the Annual report disclosures and will be submitted in the first quarter of the following financial year.

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5.00 CONDUCT OF BUSINESS

5.01 The Committee shall conduct its business in accordance with the Standing Orders of the Trust.

5.02 The Committee shall be deemed quorate if there are at least two non-executive Directors and two executive Directors present, one of whom should be the Lead Executive for the Committee, the Chief Delivery and Strategy Officer or one of the Managing Directors who would be the alternate Lead Executive for this Committee. A quorate meeting shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.

5.03 The Committee shall meet not less than 4 times in each financial year and dates will be set by the end of the previous financial year, noting that in between the quarterly Committee meetings the members of the Committee will hold strategy deployment meetings focusing on the patient True North.

5.04 The Committee will set an annual plan for its work to form part of the Board's Annual Cycle of Business, and report to the Board on its progress.

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6.01 The Committee shall review its own performance, constitution and terms of reference at least every two years to ensure it is operating at maximum effectiveness. Any proposed changes to the terms of reference should be agreed by the Trust Board.

6.02 It is the Company Secretary's responsibility to make the necessary updates to the terms of reference.

6.03 Approved by Committee April 2022

6.04 Next full review: by March 2025 (recognising that these have been reviewed at the end of the first year of operation of this Committee and will be subject to review during the annual review of Committee effectiveness)

University Hospitals Sussex
NHS Foundation Trust

Appendix - Mandated reports considered by the Committee

Below is a list of the mandated reports the Committee the Committee would receive over the year

- Operational Plan
- Annual EPRR Report
- Formal Collaborative Reports