![NHS University Hospitals Sussex NHS Foundation Trust]

Meeting of the Board of Directors

10.00 to 14:30 on Thursday 04 August 2022

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

AGENDA – MEETING IN PUBLIC

1.	10.00	**Welcome and Apologies for Absence** To note	Verbal	Alan McCarthy
		Confirmation of Quoracy To note *A meeting of the Board shall be quorate and shall not commence until it is quorate. Quoracy is defined as meaning that at least half of the Board must be present this being nine Board members. With a minimum of two Executives and two Non-Executive Directors.*	Verbal	Alan McCarthy
2.	10.00	**Declarations of Interests** To note	Verbal	All
3.	10.00	**Minutes of UHSussex Board Meeting held on 05 May 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	George Findlay

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 Rob Haigh

8.	11.05	**People** To receive and agree any necessary actions *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	Enclosure	David Grantham
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	Andy Heeps

ASSURANCE REPORTS FROM COMMITTEES

11.	12.00	**Report from Patient Committee** To receive assurance from Committee and recommendations from the Committee - **from the meetings held on the 26 July 2022 including:** - *Annual Patient Experience Report 2021/22* - *Patient Experience Strategy 2022-2025* To approve for publication on the Trust Website	Enclosure	Claire Keatinge
12.	12.10	**Report from Quality Committee** To receive assurance from Committee and recommendations from the Committee - **from the meeting held on the 24 May, 28 June, and 26 July 2022 including:** - *Infection, Prevention & Control 2021/22 Annual Report* To approve for publication on the Trust Website	To Follow	Lucy Bloem
13.	12.30	**Report from People Committee** To receive assurance from Committee and recommendations from the Committee - **from the meeting held on the 27 July 2022 including:** - *Annual Workforce Race Equality Survey* - *Annual Workforce Disability Survey* To approve for publication on the Trust Website	Enclosure	Claire Keatinge
14.	12.50	**Report from Sustainability Committee** - **from the meeting held on the 28 July 2022** To receive assurance from Committee and recommendations	To Follow	Lizzie Peers

from the Committee

15.	12.55	**Report from Systems and Partnerships Committee** - **from the meeting held on the 28 July 2022** To receive assurance from Committee and recommendations from the Committee	Enclosure	Lizzie Peers
16.	13.00	**Report from Audit Committee** - **from the meeting held on the 19 July 2022 including** - *2021/22 Audit Committee Annual Report to Board* To receive assurance from Committee and recommendations from the Committee	Enclosure	David Curley
17.	13.10	**Report from Charitable Funds Committee** - **from the meeting held on the 12 July 2022** To receive assurance from Committee and recommendations from the Committee	Enclosure	Lizzie Peers
18.	13.20	**Board Assurance Framework and Corporate Risk Register highlight report** To approve	Enclosure	Darren Grayson / Glen Palethorpe

QUALITY

19.	13.30	**CQC Update** To note	Verbal	Maggie Davies / Darren Grayson
20.	13.50	**2021/2022 Annual Medical Appraisal and Revalidation Report** To approve	Enclosure	Rob Haigh

WELL LED & COMPLIANCE

21.	14.00	**System Oversight Framework** To note	Enclosure	Darren Grayson
22.	14.10	**Company Secretary Report** To note	Enclosure	Glen Palethorpe

OTHER

23.	14.15	**Any Other Business** To receive any notified business and action	Verbal	Alan McCarthy
24.	14.20	**Questions from the public** To receive and respond to questions submitted by the public at least 48 hours in advance of the meeting.	Verbal	Alan McCarthy

| 25. | 14.30 | **Date and time of next meeting:** | Verbal | Alan McCarthy |

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 10 November 2022.

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

NHS University Hospitals Sussex NHS Foundation Trust

Minutes of the Board of Directors meeting held in Public at 10.00am on Thursday 05 May 2022, held virtually via Microsoft Teams Live Broadcast.

Present:

Alan McCarthy MBE DL	Chair
Dr Andy Heeps	Interim 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
Karen Geoghegan	Chief Financial Officer
Maggie Davies	Chief Nurse
David Grantham	Chief People Officer
Charlotte Hopkins	Chief Medical Officer
Darren Grayson*	Chief Governance Officer
Ellis Pullinger *	Interim Chief Operating Officer

*Non-voting member of the Board

In Attendance:

Rob Haigh	Medical Director and Deputy Chief Medical Officer
Glen Palethorpe	Company Secretary
Ben Smith	Deputy Company Secretary
Tanya Humphrys	Board and Committee Administrator

			ACTION
TB/05/22/1	**WELCOME AND APOLOGIES FOR ABSENCE**		

1.1 The Chairman welcomed all those present to the meeting and began by noting that this was the first Board meeting in public with Dr Andy Heeps as interim Chief Executive. Alan also welcomed Ellis Pullinger, who was attending his first Board meeting in public as interim Chief Operating Officer.

1.2 There were apologies for absence received from Lillian Philip.

TB/05/22/2 DECLARATIONS OF INTERESTS

2.1 There were no other interests declared.

TB/05/22/3 MINUTES OF THE MEETING HELD ON 31 MARCH 2022

3.1 The Board received the minutes of the meeting held on 31 March 2022.

3.2 The minutes of the meeting held on 31 March 2022 were **APPROVED** as a correct record.

TB/05/22/4 MATTERS ARISING FROM THE MINUTES OF THE PREVIOUS MEETING

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

TB/05/22/5   Chief Executive Report

5.1   Andy Heeps introduced the Chief Executive's Report noting that the report was in a slightly different format to the previous Chief Executive's reports and was structured to provide a detailed update of the last quarter at UHSussex against each of the Trust's patient first domains.

5.2   Andy began by paying tribute to the staff of UHSussex who continue to work under significant amounts of operational pressure and remain incredibly busy, noting that positively the number of patients currently in UHSussex hospitals with Covid had reduced significantly and were now lower than the pre-March peak. Andy explained to the Board that this had resulted in the Trust beginning to deescalate a number of Covid areas which will support with flow through the hospitals.

5.3   Andy advised the Board that for his first Chief Executive Report, he had framed it through the Trusts Patient First programme which sees the Trust putting the patient and their needs at the centre of all that it does.

5.4   In respect of the Trusts Friends and Family Test (FFT) the Trust target is to achieve a 95% rating of good or very good experience at UHSussex, it was noted that the had Trust slipped to 92% during quarter 4. Andy explained that the Trust was committed to improving this with a focus on how long patients are waiting to be seen in A&E with a new target in respect of ambulance waits, with the Trust aiming to have no patient waiting longer than 60 minutes to be admitted to the department from an ambulance. It was noted that this data would be included in the next pack of Board papers in August and was being closely monitored.

5.5   The Board was advised that UHSussex staff remained the Trusts greatest asset and the commitment and dedication throughout the pandemic had been nothing short of phenomenal, Andy noted that thew publication of 'Our Covid Story' on the national day of reflection helped demonstrate through first-hand accounts from our staff how impactful, and sometimes traumatising the Covid health emergency has proved for our staff. Andy added that he encouraged everyone to take some time to read their reflections and experience through the pandemic.

5.6   Andy advised the Board that the Trust had made an incredible effort to reduce the number of patients waiting longer than 2 years for their elective procedures, addressing waiting lists will be a long-term priority for the whole NHS. It was noted that the Trust was also reflecting on the long waiting lists from a health inequalities perspective focussing treatments on those patients that need it the most.

5.7   The Board noted that the Trust had achieved its True North objective to breakeven in the last year, Andy took the opportunity to pay tribute to Chief Financial Officer, Karen Geoghegan and her team on their sterling effort to enable the Trust to achieve this in such challenging circumstances. The accounts are now subject to external audit which is currently underway.

5.8   The Board was advised that the Trust had received an unannounced inspection from the CQC at the end of April, which saw them reinspect the maternity departments on all sites, the Surgery Division at RSCH in addition, they visited the Emergency Department at RSCH. Andy thanked Board colleagues and those teams that supported the inspection, Andy highlighted that the inspectors reflected how welcome they were made to feel with staff being able to speak

about the challenges they experience in an open and honest way as well as the successes.

5.9 Lizzie Peers commented that she had recently had the opportunity to visit a number of wards and was absolutely taken aback by the level of kindness shown by staff not only to the patients but also to one and other.

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

TB/05/22/6   Integrated Performance Report

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

6.2 Andy explained that the Trust had aligned its governance to the patient first, it was noted that the Integrated Performance Report is aligned to the Trust Committees and that the Committee Chairs would be invited to provide their Chairs report after each section of the IPR.

TB/05/22/7   Patient

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

7.2 The Board was advised that 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, it was noted that satisfaction is on par with the national average for maternity and inpatient services, above the national average for outpatients but lower than the national average for the Emergency Department (ED). Maggie explained that a new survey provider for all sites was being procured and services will be encouraged to increase survey uptake, this will also help with making data more comparable across all 4 sites.

7.3 Maggie advised the Board that there had been an increased number of concerns, an increase of 57% since Quarter 2 of 2021/21. Whilst numbers of open complaints had 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.

7.4 In respect of insights from feedback received, it was noted that themes in negative patient feedback continue to relate to waiting both on site and for treatment, clinical treatment, communication and staff behaviours. Maggie explained that the Trust was working to improve comfort for patients waiting in all ED's.

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

7.6 Jackie advised the Board that the Committee had received an update on the Trusts engagement with the 'My Planned Care Initiative' which is an ICS informed project to support patients with remaining well and managing their pain whilst waiting for elective procedures with the aim to enable them to be as well as they can be ahead of a hospital stay.

7.7 The Board was advised that the Committee had discussed at length the Trust's patient first improvement programme which is developing well. The Committee was updated on the preparation for the CQC reinspection and the enormous amount of preparation undertaken alongside the embedding of the improvement work.

7.8 Jackie added that the Committee had also received an early version of Trust patient experience strategy, which is in progress at present with further consideration by the Committee at a future meeting.

7.9 Lizzie Peers commented that members of the Charitable Funds Committee had received a good presentation on patient experience showcasing an inspiring investment request that the Committee will be supporting.

TB/05/22/8 **Quality**

8.1 Charlotte Hopkins updated the Board on the key messages from the Quality section of the report in respect of mortality.

8.2 Charlotte drew the Boards attention to the table on slide 9 which provided an overview of the indicators that the Trust uses to determine if the Trust's mortality figures are within the expected ranges. Charlotte explained that the Trust is within the expected range for these markers with crude mortality being within the normal and very low range in month. It was noted that 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.

8.3 Charlotte advised the Board that the drivers for the rising SHMI had been investigated with the support of Healthcare Evaluation Data, which concluded that coding depth was a major driver. There are significant differences in coding depth between sites. it was noted that a case note audit had corroborated the findings of the analysis.

8.4 Maggie Davies reminded the Board that the second Quality True North for the Trust was zero harm occurring to patients in our care. Maggie explained that there were two areas of particular focus these being falls and pressure damage, it was noted that this was an important area of focus and had been particularly challenging during the pandemic, with long length of stay also having a negative impact as a result of patients deconditioning over time when delayed ahead of their discharge. The Board was advised that the Trust had seen a steady rise in the number of falls however it was noted there was a significant amount of work underway to ensure patients get home in a timely way with quality improvement work also underway.

8.5 In respect of improvement actions for harm reduction Maggie highlighted the following areas:
- 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 during Quarter 1 and 2 2022/23.
- Targeted focus on the reduction of low/moderate harms with falls and pressure damage noted as top 2 themes in reported harms.
- RTT harm reviews indicate the potential for increased low harm reporting, early identification of at risk groups and patient categorisation.

8.6 Maggie went on to draw the Board's attention to slides 20 through to 23 which provided an update on the Trust's current Safer Staffing metrics and Infection Prevention and Control processes, noting that in March 2022 community prevalence of Covid peaked and had a significant impact on the number of patients with Covid in UHSussex.

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

8.8 Lucy began by thanking Joanna Crane, the previous Chair of the Committee for her outstanding chairmanship over the previous years. The Board was advised that the Committee had agreed on a revised format for the operation of the Committee with it now planning to meet a minimum of 10 times across the year.

8.9 The Committee received the Quarter 3 incident report and was assured by the Trust's continuing focus on improvement which saw the impact of learning applied in respect of a newly introduced glaucoma pathway. In addition, the Committee received a report on the Trust's Duty of Candour application in respect of incident reporting noting that this triangulated back through the Serious Incident report.

8.10 Lucy advised the Board that the Committee had received the Maternity Surveillance Dashboards and noted the Internal Audit report and the revised dashboard following their feedback. The Committee discussed the business information challenges in respect of maternity and endorsed Executive focus in this area, particularly given the additional pressure the departments are currently experiencing.

8.11 Patrick Boyle asked if it was anticipated that there would be a Covid peak later in the year and what had the Trust learnt from previous peaks in respect of how to manage these. Maggie commented that the Trust should expect further peaks but assured the Board that the Trust had learnt from both wave one and two of the pandemic and had implemented much of the learning already, with prompt isolation and early detection processes.

8.12 Rob Haigh added that Covid numbers had come down significantly and the JCVI was currently considering the next steps for the autumn vaccine programme. In addition, the delivery of medications for treating patients with Covid had been very successful.

TB/05/22/9   People

9.1 David Grantham presented the People section of the integrated performance report and explained that the Trust's True North for Our People is to be the Top Acute Trust for Staff Engagement. Our Target is to be within the top quartile of acute Trusts for the National staff engagement score.

9.2 The Board was advised that the Trust was beginning to see a slight improvement in respect of staff engagement, David explained that work was underway with the Divisions using the Patient First Improvement System to increase staff recommending UHSussex as a place to work and this improvement work will be reviewed and informed by the latest staff survey results which were received by the Committee in February, this work will transition to the new Divisions under the Clinical Operating Model.

9.3 In respect of the Strategic Initiative, leadership, culture and development David explained that project charters had 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 2022-23. 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

9.4 It was noted that there was an ongoing discussion on an Equality, Diversity and Inclusion specific fourth workstream working with the Diversity Matters Steering Group.

9.5 David drew the Board's attention to the People scorecard noting the key headlines in respect of respective KPIs. Finally, David highlighted to the Board a number of the key risks noting that Quarter 4 had been really 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 remain around:

- Maintaining sufficient staffing for the levels of activity and 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

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

9.7 Patrick advised the Board that the Committee had covered particularly wide ranging agenda focussing on the Patient First Strategic Deployment as highlighted by David the Committee had focussed on the Staff Survey results in particular the local questions added to the survey with the Committee agreeing these provided valuable insight to enable there to be targeted improvement.

9.8 It was noted that the Committee had received a report on creating a culture of safety looking at violence and aggression suffered by our staff. Patrick noted that the Committee discussed if the Trust could reduce the anxiety and stress that patients feel prior to attending the Trust this would likely help reduce the levels of exhibited aggression and violence towards our staff.

9.9 The Committee received an update on the ongoing work in respect of Health and Wellbeing and noted that a Trust assessment that had 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. Patrick noted that this coupled with the new Clinical Operating Model it is hoped will support engagement with staff.

9.10 Lizzie asked how the Trust can make Health and Wellbeing support, more easily accessible for staff and how as Board the impact of that can be measured. David advised that the Trust had learnt from the recent CQC inspections in respect of in-reaching into departments which would enable the Trust to measure the impact of Health & Wellbeing accessibility.

TB/05/22/10   Sustainability

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

10.2   The Board was advised that throughout 2021/22, the Trust had 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. Karen explained that the Trust's True North domain for sustainability was 'living within our means providing high quality services through optimising the use of resources' which was measured through the metric of delivering the Trust's Financial Plan. At the end of March 2022, the Trust delivered a surplus of £123k, exceeding the breakeven target, Capital expenditure of £150.2m and £22.6m of efficiencies.

10.3   Karen explained to the Board that the Trust ended the year with Income & Expenditure performance being £123k above the breakeven plan. Included within this position were non-recurrent income allocations the Trust secured including: Elective Recovery Fund (ERF), ERF+, Targeted Investment Fund (TIF), Capacity Funding Grant and Covid funding. It was noted that 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.

10.4   The 2021/22 capital expenditure of £150m, was £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.

10.5   Karen updated the Board in respect of the Financial Plan for 2022/2023 and explained that 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.

10.6   Karen provided the Board with the basis of allocations for 2022/23:
  ▪ 2021/22 H2 baseline and top-up funding had been annualised.
  ▪ Recurrent adjustments had been made for maternity and growth of 4.1%; net of a general efficiency requirement of 1.66%.
  ▪ The risk of 'clawback' if activity plans are not delivered within 75% of tariff income
  ▪ Covid-19 funding reduced by 57%

10.7   Alan McCarthy congratulated the Trust on a significant achievement and invited the Chair of the Sustainability Committee, Lizzie Peers, to update the Board on their recent meeting and the assurances received in relation to Sustainability.

10.8   Lizzie advised the Board that the Committee had looked back at Quarter 4 and looked forward to 2022/23. Lizzie noted that there was nothing more assuring than actual delivery of the financial plan in the most challenging of circumstances the Trust has ever seen.

10.9 It was noted that the Committee had received a full report on the Capital Plan, in addition to the Efficiency Programme which had delivered 93% of the set planned target. Lizzie commented that this level of efficiency delivery was the result of the committed teams and a finance team with an eye for detail and an incredible level of grip.

10.10 Lizzie advised the Board that the Trust intended to maintain momentum going into 2022/23 and noted multiple exciting investments with a really strong capital plan. It was noted that the Committee had requested that the Digital Strategy be presented to the Board in the coming months.

TB/05/22/11   **Systems & Partnerships**

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

11.2 **A&E**
Overall, the combined Trust treated 60.1% of patients within 4 hours of attending all A&E departments during March 2022, and 64.9% during Quarter 4. National performance also deteriorated and was 71.6% during March 2022 and 73.1% during Quarter 4. 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.

11.3 **RTT**
The Trust had 56.3% of patients waiting longer than the target 18 weeks at the end of March 2022. The total number of patients waiting for elective treatment at the Trust was 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 the Trusts aim to have no patients waiting over 104 weeks.

11.4 **Cancer**
Ellis explained to the Board that overall, 48.3% of patients who commenced cancer treatment were treated within 62 days during February. UHSussex West was 47.9% and UHSussex East achieved 48.8%. National performance was 62.1%. It was noted that there had been a marked decrease in over 62-day and 104-day prospective waits during March.

11.5 **Diagnostics**
Overall, the combined Trust had 26.0% of patients waiting more than 6 weeks for a diagnostic against a 1% target. UHSussex West achieved 30.6% and UHSussex East achieved 19.3%. The Board was advised that this was an improvement of 3.5% relative to the December 2021 position of 29.5%. It was noted that the National average for February 2022 was 24.0%

11.6 Ellis advised the Board that the Trust was focussed on working through the current operational pressures, with focus on reducing the length of ambulance handover which will be included in future Board reports.

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

11.8 Patrick advised the Board that the Committee had heard about the huge amount of work that was underway to tackle the long waiting times and the

significant amount of work in relation to reaching those trajectories, the Committee received an update on performance in Quarter 4 against the constitutional standards, those waiting 104 weeks in particular, Patrick highlighted that achieving this target was dependent on patients being able to and wanting to take up their treatment.

11.9 It was noted that the Committee had received a presentation from Harvey McEnroe, Programme Director for Unscheduled Care. Patrick advised that it was a positive presentation providing oversight and context to the current pressures that the Trust is experiencing in Urgent and Emergency Care, it is hoped that as Covid numbers and staff absences related to Covid start to reduce that this will have a positive impact on patient flow out of ED and through the hospital.

11.10 Patrick explained that the Committee had received a year-end summary of the Merger and Acquisition Corporate Project including a positive discussion in respect of benefits realisation of the merger and sharing those positive benefits across the Trust.

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

TB/05/22/12 **Report from Patient Committee Chair from the meeting on 26 April 2022**

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

TB/05/22/13 **Report from Quality Committee Chair from the meeting on 26 April 2022**

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

TB/05/22/14 **Report from People Committee Chair from the meeting on 27 April 2022**

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

TB/05/22/15 **Report from Sustainability Committee Chair from the meeting on 28 April 2022**

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

TB/05/22/16 **Report from Systems & Partnerships Committee Chair from the meeting on 28 April 2022**

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

TB/05/22/17 **Report from Audit Committee Chair from the meeting on 14 April 2022**

17.1 Jon Furmston, Chair of the Audit Committee, presented the Chairs report from the meeting held on 14 April and drew out the following key points.

17.2 Jon advised the Board that the Committee had received reports on three completed audits, these included the Trust's Data Security Protection Toolkit, IT post implementation of the merger and Data Quality in respect of Maternity.

17.3 The Board was advised that the Trust had asked Internal Audit to proactively review the processes in respect of Data Quality over the Maternity Dashboard reports. Jon explained that this work recognised the developing nature of the codification of the data definitions for the developed dashboards noting that the Trust had overstated figures in some areas. The Medical Director was in attendance and provided the Committee with assurance in relation to the improvement plans in place. It was noted that as part of the 2022/23 Annual Plan, Data Quality would be reviewed to assure the Committee that improvements were embedded.

17.4 Jon advised the Board that the Committee had received an update from the Chief Information Officer in respect of Cyber Security to assure the Committee that the Trust was in a strong and safe position in respect of the Trusts cyber architecture.

17.5 It was noted that the Committee had also received Annual Plans for 2022/23 from the Local Counter Fraud Service and the Internal Auditors, in addition to an updated from the Trusts External Auditors and Trust Director of Finance in respect of preparation for year-end.

17.6 Finally, Jon advised the Board that the Committee had received the Trust's NHSI Provider Licence Annual self-declaration which was recommended by the Committee to the Board for approval, it was noted that the Trust was declaring compliance with the licence conditions noting the conditions stipulated within the licence are the minimum requirements expected of Foundation Trusts

17.7 The Board **NOTED** the Chairs Report from the Audit Committee.

17.8 The Board **APPROVED** the 2021/2022 Provider Licence Certification for submission and Publication on the Trust Website subject to the update to show the CQC reinspection had indeed taken place, noting the outcome was yet to be received.

The Board paused for a five-minute break.

TB/05/22/18 **Report from Charitable Funds Committee Chair from the meeting on 12 April 2022**

18.1 Lizzie Peers, Chair of the Charitable Funds Committee, presented the Chairs report from the meeting held on 12 April and drew out the following key points.

18.2 Lizzie advised the Board that the Committee had looked back over Quarter 4 and were assured by the way in which both Love Your Hospital (LYH) and BSUH Charity funds were being managed.

18.3 It was noted that the Committee had approved a number of bids recognising the public benefit of all those bids presented to the Committee at its meeting.

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

TB/05/22/19 **Board Assurance Framework**

19.1 Darren Grayson presented the Quarter 4 Board Assurance Framework and Corporate Risk Report.

19.2 The Board was advised that the BAF had been reviewed by each of the Committees and was being presented to the Board for approval, it was noted

that the report included a statement in respect of the highest risks from the Trusts Corporate Risk Register for the Board's information.

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

TB/05/22/20 CQC Update and Trust Response to the Warning Notice

20.1 Darren Grayson provided the Board with an update in respect of the Trusts response to the CQC Warning Notice, Darren began by advising the Board that the report had been prepared prior to the reinspection that took place on Tuesday 26 April 2022.

20.2 It was noted that the Trust had been able to respond positively to the Warning Notice and had been able to complete the Provider Information Requests (PIR) requested by the CQC following the recent reinspection. Darren explained that as part of the reinspection the CQC had, in addition, inspected the Emergency Department (ED) at the RSCH site and that the Trust was now awaiting formal feedback of their findings.

20.3 Andy Heeps advised the Board that the Trust had received very high-level verbal feedback from the inspectors who found that staff were very tired but committed to the organisation and providing the very best safe care to UHSussex patients. Andy went on to explain that significant improvements were noted in maternity services with the inspectors noting a palpable difference to their observations 6 months ago. Feedback from staff involved in the inspections reflected that they had found it a more positive experience than the previous inspection.

20.4 Alan McCarthy asked if the Trust had received any initial feedback in respect of the ED inspection. Andy explained that the inspectors had found good multidisciplinary team working and good levels of consultant cover in addition to the departments single clerking process which was noted as good practice. However, the inspectors noted the physical space and the impact this has on patients with flow being made more challenging as a result of red and green pathways due to Covid.

20.5 The Board **NOTED** the update on the CQC and the Trust response to the Warning Notice.

TB/05/22/21 UHSussex Operational Plan 2022/2023

21.1 Darren Grayson introduced the UHSussex Planning Submission for 2022/2023 and advised the Board that the Trust had submitted the plan consistent with discussions held in previous sessions.

21.2 Ellis Pullinger provided the Board with a summary of the key elements of the plan which was submitted as part of the Sussex Health and Care Partnership plans, to NHSEI for approval on 28 April 2022.

21.3 Plans to eliminate 104-week waiters had progressed well and this would be maintained in 2022/23, as would the plans to achieve the key cancer targets. It was noted that an activity plan had 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 2019/20 baseline activity.

21.4 The Board was advised that System-wide plans had been developed to improve the responsiveness of urgent and emergency care, including the reduction of 12-hour waits in A&E

21.5 Ellis explained that the Trust had a number of submissions for central funding to support its plans, including a proposed £15m CDC development at Southlands and the £30m High Volume Low Complexity (HVLC) day-case and endoscopy programme at PRH

21.6 It was noted that the commitment to providing further activity in order to meet the 78-week target had exacerbated the financial risk within the plan.

21.7 The Board was advised that the financial projections confirm a core gap of £57m, for which an efficiency programme of £44m had been identified. This leaves a residual £12.55m which relates to excess inflation above funded levels.

21.8 The Boards attention was drawn to the risks to the delivery of the plan on slide 20 of the presentation which included the potential for further disruption due to COVID.

21.9 The Board **NOTED** the UHSussex Planning Submission for 2022/2023.

TB/05/22/22   Company Secretary Report

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

22.2 The Board was advised that the Trust is required to receive reports on learning from deaths. The Board was reminded that the detail of 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 the report at its meeting on the 26 April 2022 it was noted the one report covers Royal Sussex County, Princess Royal, St Richards and Worthing Hospitals.

22.3 Glen advised the Board that 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.

22.4 Finally, the Board was advised that the process for Governor elections had recently taken place with voting taking place between 23 May and 14 June 2022, with successful candidates expected to be declared on 15 June 2022.

22.5 The Board **NOTED** the Company Secretary Report for Quarter 4 and **RATIFIED** the approved Terms of Reference for the Patient, Quality, People, Sustainability and Systems & Partnerships Committees.

TB/05/22/23   **OTHER BUSINESS**

22.1   The Chair took the opportunity to acknowledge that this would be the last Board meeting in public for two long standing Non-Executive Directors, Jon Furmston and Joanna Crane who have been with the Trust a number of years. Alan added that both Jon and Joanna had made a huge contribution to the Trust and thanked them both on behalf of the Board and wished them a happy retirement.

TB/05/22/24   **Questions from Members of the Public**

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

TB/05/22/25   **Resolution into Board Committee**

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

TB/05/22/26   The Chair formally closed the meeting

TB/05/22/27   **DATE OF NEXT MEETING**

27.1   It was noted that the next meeting of the Board of Directors was scheduled to take place at **10.00** on **Thursday 04 August 2022**.

Tanya Humphrys
Board & Committee Administrator
05 May 2022   Signed as a correct record of the meeting

…………………………………………………. Chair

..………………………………………………… Date

NHS
University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	5	Meeting:	Trust Board	Meeting Date:	05 May 2022
Report Title:	Chief Executive's Report				
Sponsoring Executive Director:		Dr George Findlay, Chief Executive			
Author(s):		Dr George Findlay, Chief Executive			
Report previously considered by and date:					

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

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

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

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

Communication and Consultation:
n/a

Executive Summary:
This report gives the Trust Board an overview of the work of UHSussex over the last quarter.

Key Recommendation(s):
The Board is asked to **NOTE** this report.

To: Trust Board   **Date: August 2022**

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

CHIEF EXECUTIVE BOARD REPORT

1. **INTRODUCTION**

    1.1. Welcome to my first Chief Executive public board report since re-joining the Trust on 1 June 2022. I was very proud to serve as Chief Medical Officer and Deputy Chief Executive of both our predecessor Trusts in Sussex and it has been excellent to return to University Hospitals Sussex NHS Foundation Trust (UHSussex) after a 15-month secondment as Chief Executive of Medway NHS Foundation Trust.

    1.2. I wish to thank Deputy Chief Executive and Chief Operating Officer Dr Andy Heeps for so ably stepping up as the Trust's interim Chief Executive for three months following the retirement of Dame Marianne Griffiths on 1 April 2022. Andy, working alongside the executive team, provided excellent leadership during a busy transition period and I am grateful to inherit all the good work that both continued and was started during this period.

    1.3. For example, this included our Urgent and Emergency Care Improvement programme as well as our Executive Gemba Programme, that ensures the Trust's leaders are regularly visiting frontline teams and seeing first-hand the challenges and achievements of colleagues in the locations where they work.

    1.4. Going to Gemba (being an active leader on the frontline) is a key element of our Patient First philosophy and strategic approach to continuous improvement at UHSussex. For me, it has also proved a superb opportunity to reacquaint myself with teams in all our hospitals, meet both new and old colleagues, and hear how departments and specialties are meeting the ongoing challenges posed by the Covid pandemic, high demand for urgent services and significant backlog of planned care caused by the national lockdowns over the past two-and-a-half years.

    1.5. The pandemic continues to place immense pressure on our people and the NHS more generally. The health and wellbeing of our people is a major concern and area of investment for us. Staff across the board are tired and many have had traumatic experiences during the pandemic. Despite this, I have been hugely impressed with their resilience and steadfast commitment to delivering the very best patient care possible in the face of adversity and unprecedented pressures.

1.6. Key to meeting these challenges is our Patient First programme, that both equips and empowers colleagues with the right skills to innovate and improve care for their patients. It also provides the Trust with a strategy that enables us to focus on the areas where we can make the biggest difference to the communities and patients we serve.

1.7. This board report is formatted to highlight news and key information related to each of our Patient First strategic themes: Patients | Quality | Our People | Systems & Partnerships | Sustainability. Each theme has its own True North, or aspirational vision statement of want we want to be or achieve. Each theme has a breakthrough objective that is one area of dedicated improvement that will deliver the greatest strides towards our True North. And we have related strategic initiatives and corporate projects that deliver systematic improvement and innovation to address key issues.

2. PATIENTS

2.1. We strive to deliver an excellent experience to all our patients, whether they are attending A&E as an emergency, receiving care as an inpatient, or seeing our specialists as an Outpatient or for a diagnostic procedure. Despite the turn of season, the beginning of the summer has continued to be very challenging with winter pressures persisting from Spring and throughout July. As I have been visiting teams in all our hospitals, I am incredibly proud of the concerted efforts I see every day being made by colleagues to put our patients first and provide excellent quality care for them.

2.2. The ongoing effects of the pandemic continue to be felt very strongly in our hospitals. Demand for all our patient services remains very high. Large numbers of patients have required urgent care while our hospitals were already operating at their capacity and with timely discharges delayed by ongoing issues with social care provision, that have also been exacerbated by the pandemic and staffing availability. Additionally, new Covid Omicron BA.4 and BA.5 variants saw the number of patients we were caring for with Covid peak again at nearly 200 in July and the record-breaking heatwave also added yet more pressure to an already stretched local care system in Sussex.

2.3. Against the backdrop of such extraordinary circumstances and with many of our staff also off work 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 'True North' target of 95% of patients rating their experience of our care 'Good' or 'Very Good' in the Friends and Family Test (FFT). Unfortunately, our average FFT satisfaction score has slipped to around 86%.

2.4. Our most challenged areas are our emergency departments, with long waiting times cited as people's biggest concerns. This, however, is a symptom of a broader patient flow problem that is caused by delayed discharges and ongoing capacity issues within the social care sector. We are looking at piloting new discharge wards in two of our hospitals for patients who are medically ready to leave our care but who are waiting for ongoing support services in the community.

2.5. We are also committing to improving the discharge experience of te majority of patients who go straight home without additional care needs by increasing earlier discharges each day, as part of our Systems & Partnerships breakthrough objective.

2.6. Our current lower average FFT score does mask many areas where patients continue to report excellent satisfaction rates. I would like to take this opportunity to commend the teams in the following areas that have been highlighted as FFT star performers: Royal Sussex County Hospital: Brighton General Hospital Dermatology; Courtyard Level 6 and 7, and Trevor Mann Baby Unit | Sussex Eye Hospital: Pickford ward | Princess Royal: Hurstwood Park Surgical Day Case Unit, Ardingly and Horsted Keynes wards | St Richard's Hospital: Apuldram, Bosham, Lavant, Middleton, Selsey and Wittering wards and Surgical Day Case Unit | Worthing: Beeding, Broadwater, Balcombe and Durrington wards.

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.

3.2. 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.

3.3. Another key measure of the quality of care we provide is mortality. Our aim is to reduce crude mortality score by 10%. In June, our crude mortality was 3.45 with a rolling 12-month value of 3.64, putting us in the middle of our peer group with an ambition to have the lowest crude mortality amongst our peers.

3.4. A significant amount of work is taking place to improve the robustness of our data as well as reduce the incidence of mortality. For example, in May, we held a Coding and Mortality Summit to improve data collection and the medical directorate is now hosting a Monthly Coding and Mortality Improvement Group.

3.5. 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.

3.6. Our leading contribution to national and local research also supports our Quality agenda. In May, we announced investing nearly £1 million on new research initiatives. The money will enable more nurses, midwives, therapists and junior doctors to contribute to and develop their own research through fellowships. Research active trusts are also more rewarding places to work and we hope our growing activity in this

area will help us attract and retain talented colleagues. It is also great news for our patients.

3.7. Following our significant contribution in the fight against Covid and creation of the booster vaccines, we are now also seeing non-Covid research increase again. In the past year, the Trust has recruited 3,691 patients into 217 non-Covid-19 studies in disease areas including: Cancer; Cardiovascular Disease; Dermatology; Diabetes; Gastroenterology; Infectious Disease; Haematology; Herpetology; HIV & Sexual Health; Neurology; Ophthalmology; and Children's' Medicine.

4. OUR PEOPLE

4.1. It is well-evidenced 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. Our NHS Staff Survey results – informed by 8,000 members of staff last Autumn – are being used to focus improvement activity where feedback from staff has shown it is needed most.

4.2. The record-breaking 1,300 nominations for our annual staff recognition awards in May demonstrate many colleagues are highly engaged with the Trust and wish to celebrate and congratulate each other's hard work and achievements. Our Patient First STAR Awards was a hugely uplifting occasion, held in person for the first time since before the pandemic. To enjoy some of the spectacle yourself and watch an excellent video that really captures the spirit of the event, visit the news section of our website at https://www.uhsussex.nhs.uk/uhsussex-celebrates-staff-at-patient-first-awards/.

4.3. I wish to publicly congratulate once again all this year's winners and runners up, including our Infection Prevention and Control Team that won *Clinical Team of the Year;* the Workforce Hub that won *Support Service Team of the Year* for their work managing Covid absence, testing and risk assessments; as well as our Estates Team that won the *Governors' Award* for their incredible work getting our hospitals ready for Covid at short notice that included enabling the red and green pathways, repositioning A&E Minors, creating new ward areas and reconfiguring Emergency Departments across all our hospitals.

4.4. Our awards celebrate our Trust values of compassion, communication, teamwork, respect, professionalism and inclusion in a wonderful set-piece event attended by hundreds of staff. But our values are self-evident in the many ways our staff make headlines with their achievements all year round.

4.5. Recent highlights from our www.uhsussex.nhs.uk/news pages include: Paediatric Matron, **Lynne Mould**, who became the Trust's first recipient of the Cavell Star medal after being nominated by her team at the Royal Alexandra Children's Hospital; Worthing Hospital's Castle Ward Manager, **Liane Seymour**, who was awarded a Certificate of Appreciation in recognition of pressure ulcer prevention work; Consultant

Trauma and Orthopaedic Surgeon, Lt Col **Ben Caesar**, 16 Medical Regiment, Royal Army Medical Corps, who walked 11 km in full combat gear through war memorials of Brighton and Hove in support of Armed Forces Day on 25 June; and A&E staff member at The Royal Sussex County and Princess Royal hospitals, **Luke Tester**, who received a Platinum Champions Awards from The Royal Voluntary Service in recognition of the 1,000 hours of volunteering he does each year, on top of his work for the Trust.

4.6. In July, we also held our first UHSussex Medical Education and Trainee Excellence Awards at the AMEX Stadium in Brighton. Overall, 38 awards were made in nine categories to recognise the invaluable contribution of our junior doctors and those who mentor and train them in our hospitals. The overall winner was Academic Foundation Doctor **Ekelemmna Obiejesie** who won both Foundation Doctor of the Year as well as the Sophie Spooner Legacy Cup. Congratulations to Ekelemmna and all the award winners and runners up.

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 three-month pause in elective procedures at the onset of the pandemic in 2020 and disruption of consequent lock-downs 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. Significant work is underway to maximise our capacity and to use the independent sector where possible to reduce waiting times

5.3. Waiting times in our Emergency Departments have also proved unacceptably long for many patients in recent months with admissions delayed because our hospitals are operating either at, or very near, full capacity. Our Systems and Partnerships breakthrough objective is focused on improving hospital capacity earlier in the day at the time it is most needed by patients waiting in ED.

5.4. We also continue to work in partnership and explore new arrangements with our social and community care partners to reduce the large number of patients who are medically ready for discharge but cannot leave hospital due to delays in arranging packages of care outside of our hospitals.

5.5. Our new 3Ts hospital development in Brighton is key to improving capacity as well, providing as it will new tertiary, trauma and teaching facilities for the whole of Sussex. We know that the care environment makes a real difference to the experience of patients and staff which is why it is great to see the progress being made on 3Ts development. I recently visited the Stage 1 Building with other members of the executive team and could see that we will be able to start moving patient services into the new building in early 2023. Some of the wards and outpatient departments are effectively complete, with the rest not far behind.

5.6. The new building will allow us to think differently about how we manage the numerous services moving into it. It will also unlock potential across our wider hospital estate and have a positive influence on our capacity and planning for the Trust as a whole. Please visit www.uhsussex.nhs.uk/about/hospital-redevelopment/ for further information.

6. **SUSTAINABILITY**

6.1. Our Patient First financial goal is to break even at the end of 2022/23. Our current position is not on target, but our cash position is strong and we have improved our efficiency programme, as well as received additional funding to help counter the current inflationary pressures. We do continue to bear additional costs, however, related to ongoing operational pressures, availability of staff, patient flow and capacity issues.

6.2. In terms of environmental sustainability, our carbon reduction programme is performing very well, following the publication of our UHSussex Patient First, Planet First green plan in February. Ten workstreams are delivering 28 projects on areas such as decarbonising our supply cain, reducing energy and water consumption, promoting sustainable travel and reducing our use of resources, including medical gases that exacerbate climate change.

6.3. Our Trust has one of the most progressed staff engagement programmes in the country with more than 450 staff signed up and participating as Green Ambassadors, representing 77% of our departments. In addition to formal projects, numerous working groups such as Green Admin, Green Pharmacy, and Green Cycling Group are working on local carbon saving initiatives and improvements for staff, patients and our environment. Plans for a second annual UHSussex Environment Week are underway for September to promote the activity of our Green Ambassadors, our Environmental Sustainability Strategic Initiative and to recruit more staff and volunteers in support of our goal to become a net zero organisation.

6.4. In June, we focused on the Digital Transformation workstream. The department has an impressive record of making improvements that benefit both patients and staff, as well as the environment. For example, they have saved 40 tonnes of CO_2 a year by redesigning the Trust's data centre and reducing server racks from 40 to just 10. Additionally, nearly two thirds of the IT equipment disposed by the Trust is re-used,

while virtually everything else is recycled, helping to ensure they meet key ISO codes and other international standards.

6.5. Furthermore, new information management services such as the introduction of 'Order Comms' for radiology and pathology referrals; the Electronic Prescription and Medication Administration system trust-wide; and digitisation of scores of other forms and referrals have saved reams of paper usage and other associated environmental printing costs. Additionally, other projects to expand patient-use of the My Health and Care Record app and the introduction of a new medical eNoting service will deliver further savings of carbon emissions in the coming months.

6.6. To find out more about our Patient First Planet First green plan, please visit https://www.uhsussex.nhs.uk/about/greenplan/.

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 August 2022.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	6-10	Meeting:	Trust Board	Meeting Date:	04 August 2022
Report Title:		Integrated Performance Report – Quarter 1 2022/23			
Sponsoring Executive Directors:		George Findlay, Rob Haigh, Maggie Davies, Andy Heeps, Karen Geoghegan and David Grantham			
Author(s):		George Findlay, Rob Haigh, Maggie Davies, Andy Heeps, 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 1 of 2022/23

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

Key Recommendation(s):

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

Contents

Structure of the report

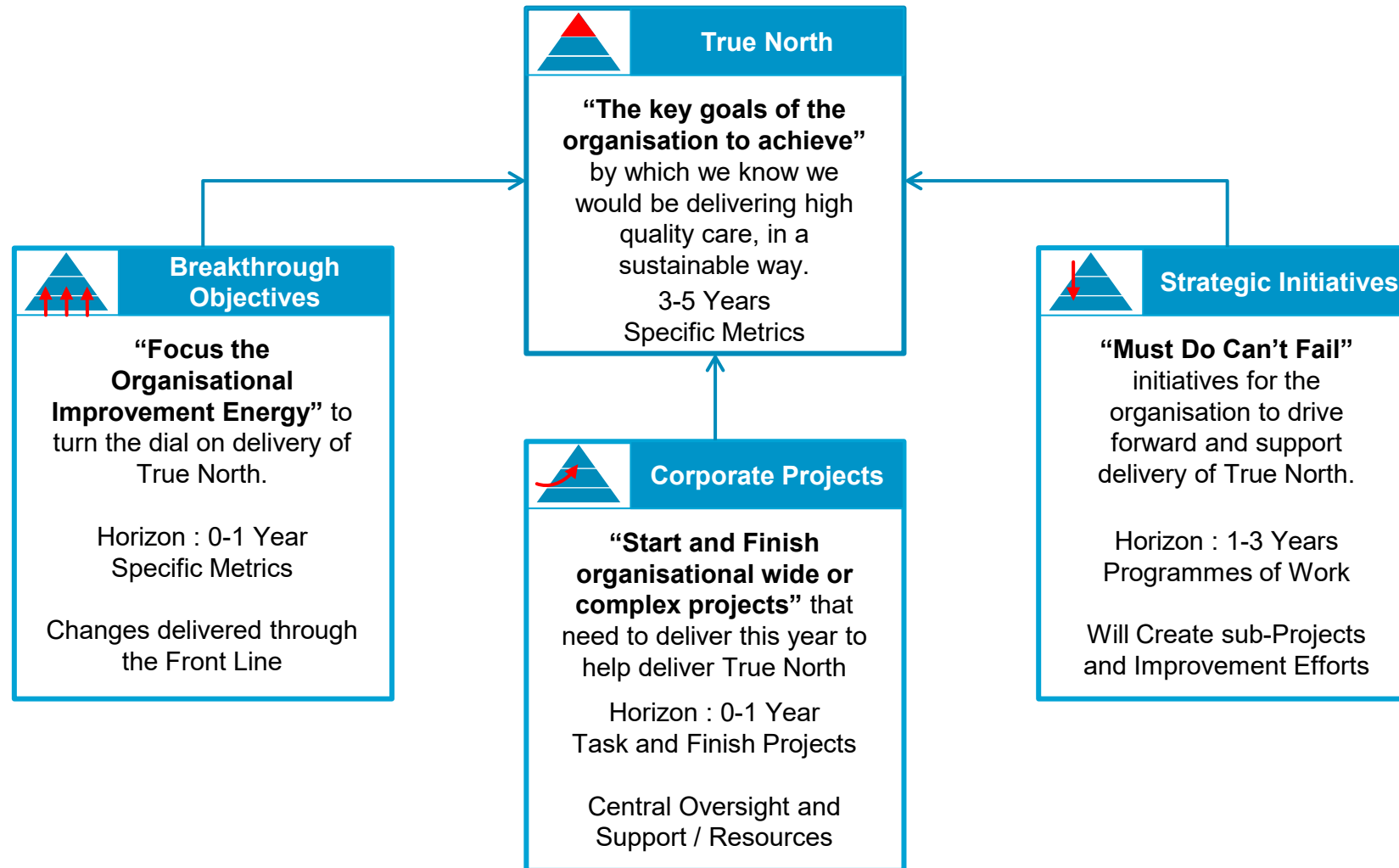Patient First Strategy Deployment Framework
Patient First True Norths
Patient First Reports
- Patient
- Quality
- People
- Systems and Partnership
- Sustainability

Patient First Strategy Deployment Framework
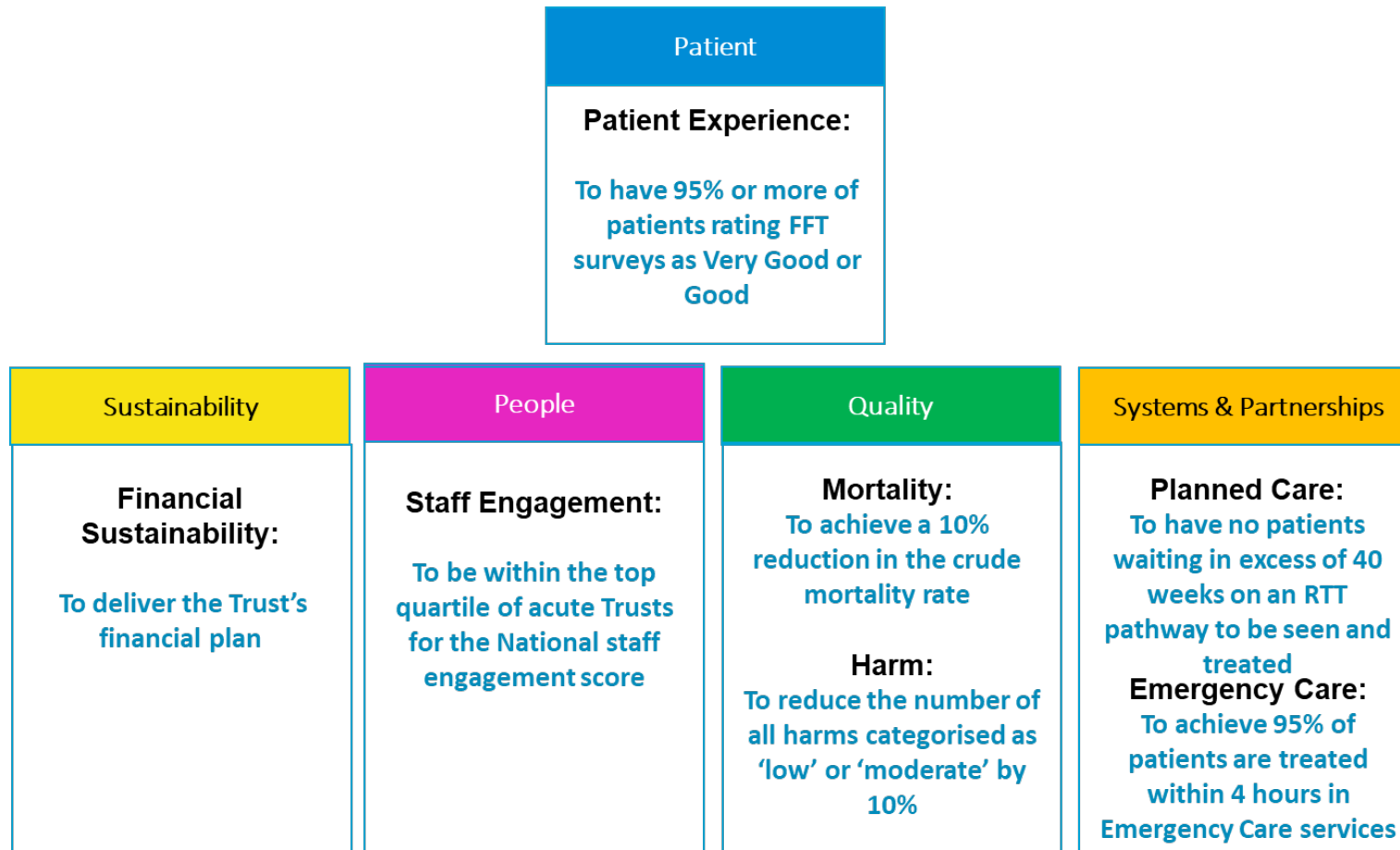
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True North

"The key goals of the organisation to achieve" by which we know we would be delivering high quality care, in a sustainable way.
3-5 Years
Specific Metrics

Breakthrough Objectives

"Focus the Organisational Improvement Energy" to turn the dial on delivery of True North.

Horizon : 0-1 Year
Specific Metrics

Changes delivered through the Front Line

Corporate Projects

"Start and Finish organisational wide or complex projects" that need to deliver this year to help deliver True North

Horizon : 0-1 Year
Task and Finish Projects

Central Oversight and Support / Resources

Strategic Initiatives

"Must Do Can't Fail" initiatives for the organisation to drive forward and support delivery of True North.

Horizon : 1-3 Years
Programmes of Work

Will Create sub-Projects and Improvement Efforts

Patient

Integrated Performance Report
Section

Patient: Key performance headlines

NHS University Hospitals Sussex NHS Foundation Trust

- Based on **Friends and Family Test (FFT) data**, the significant majority of patients are satisfied that they have a good or very good experience of care (average 88%) against a trust ambition of 95%.   This is in line with national averages however it varies between touch-points with satisfaction lowest in A&Es, with satisfaction within the A&Es lowest at SRH.

- The trust received c1000 concerns and complaints every month. Of formal concerns, approximately 55% of all formal complaints being resolved in 25 days (which is the local trust target for response times) for the April to June 2022 period. This varies between divisions due to the numbers of complaint, caseloads and operational pressures reducing responsiveness. Medicine and surgery divisions receive the highest number of complaints.

- **Themes in negative patient feedback** continue to relate to waiting (on site and for treatment), clinical treatment, communication and staff behaviours and discharge. Waiting is the priority change programme under the 'patient' breakthrough objective programme

- **Themes in positive feedback and plaudits** relate to: treatment by staff, characterised by kindness, dedication, efficiency; clarity of explanation and involvement, including of waits and in decision making; attention to basic needs such as refreshments and supplies

Quarterly performance data, April to June 2022

Complaints	Currently open	New April 22	New May 22	June 22	Closed in 25 days (target (65%)
	318	97	110	80	55%
PALS		950	878	888	Total UHS Q1 2716

Key:
True north met
Within 5% of true north target
Below true north target
At or above national average (bold/ italic)

FFT (average satisfaction for Q1 %, rates for June)	ED response rates		ED satisfaction rates						Inpatient response rates		Inpatient satisfaction		Maternity response rates		Maternity satisfaction		Outpatient satisfaction	
	W/SRH	RSCH/PR	W'g	SRH	RSCH	Alex	Eye	PRH	W/SRH	RSCH/PR	W/SRH	RSCH/PR	W/SRH	RSCH/PR	W/SRH	RSCH/PR	W/SRH	RSCH/PR
	5.6	18	73	65	73	*81.5*	*90*	*80*	13	24	*98*	89	23	30	88	92	*98*	*94*
National average			75%								94%				94%		93%	

6

Quality

Integrated Performance Report
Section

Focus of this section

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

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

3) Safer staffing

HEDLines Indicator Dashboard: May 2022 (UHS)
Trust Performance: RYR – University Hospitals Sussex NHS Foundation Trust

Custom Indicator Set: Mortality Summary		Trust Performance			Benchmarking		Position	
Indicator		Current	Previous	Change	Peer	National	Position	
HSMR (12 mth rolling) HES Inpatients (May 2022)		93.93 (Apr 2021 - Mar 2022)	92.24 (Mar 2021 - Feb 2022)	1.69 ↑	92.40	99.78	Very low (>99.8%)	
HSMR (monthly) HES Inpatients (May 2022)		97.51 (Mar 2022)	93.87 (Feb 2022)	3.64 ↑	101.96	99.83	Within expected range	
HSMR - Weekday mortality (12 mth rolling) HES Inpatients (May 2022)		93.94 (Apr 2021 - Mar 2022)	92.27 (Mar 2021 - Feb 2022)	1.67 ↑	90.98	98.32	Low (>95%)	
HSMR - Weekend mortality (12 mth rolling) HES Inpatients (May 2022)		93.91 (Apr 2021 - Mar 2022)	92.15 (Mar 2021 - Feb 2022)	1.76 ↑	96.57	104.21	Within expected range	
HSMR - Without adjustment for specialist palliative care (12 mth rolling) HES Inpatients (May 2022)		102.82 (Apr 2021 - Mar 2022)	100.92 (Mar 2021 - Feb 2022)	1.90 ↑	95.72	99.68	Within expected range	
SHMI (12 mth rolling) HES Inpatients, HES-ONS Linked Mortality Datasets (May 2022)		108.65 (Mar 2021 - Feb 2022)	108.44 (Feb 2021 - Jan 2022)	0.21 ↑	97.69	100.65	Within expected range	
SHMI (monthly) HES Inpatients, HES-ONS Linked Mortality Datasets (May 2022)		105.93 (Feb 2022)	109.70 (Jan 2022)	-3.77 ↓	94.13	101.22	Within expected range	
Crude in-hospital mortality rate (12 mth rolling) HES Inpatients and HES-ONS Linked Mortality Datasets (May 2022)		1.42% (Apr 2021 - Mar 2022)	1.41% (Mar 2021 - Feb 2022)	0.01 ↑	1.31%	1.29%		
Crude mortality rate (12 mth rolling) HES Inpatients and HES-ONS Linked Mortality Datasets (May 2022)		3.00% (Apr 2021 - Mar 2022)	3.14% (Mar 2021 - Feb 2022)	-0.14 ↓	2.81%	2.70%		
Crude mortality rate (monthly) HES Inpatients and HES-ONS Linked Mortality Datasets (May 2022)		1.86% (Mar 2022)	2.51% (Feb 2022)	-0.65 ↓	1.72%	1.66%		

Mortality Metrics

The UHSx crude 12 month rolling mortality rate for emergency admissions is 3.38% and in month for March was 3.91%. These are within the confidence limits and below the previous months values with A stable monthly crude mortality for Q4 with a rising value in preceding quarters.

The UHSx rolling 12 month HSMR is 93.93. This is in the 'very low' range with an in month value for March of 97.51 that lies in the 'as expected' range.

The UHSx SHMI is 108.65 and the rising values seen over the last 18 months appear to have reached a plateaux. This remains within the expected range.

Indicator	Current	Previous	Change
Crude in-hospital mortality rate - Emergency Admissions (12 mth rolling) HES Inpatients and HES-ONS Linked Mortality Datasets (May 2022)	3.38% (Mar 2021 – Feb 2022)	3.31% (Mar 2021 – Feb 2022)	0.07%
Crude in-hospital mortality rate - Emergency Admissions (monthly) HES Inpatients and HES-ONS Linked Mortality Datasets (May 2022)	3.91% (Mar 2022)	3.88% (Feb 2022)	0.03%

CRUDE MORTALITY

Crude mortality rate (excluding COVID) over time
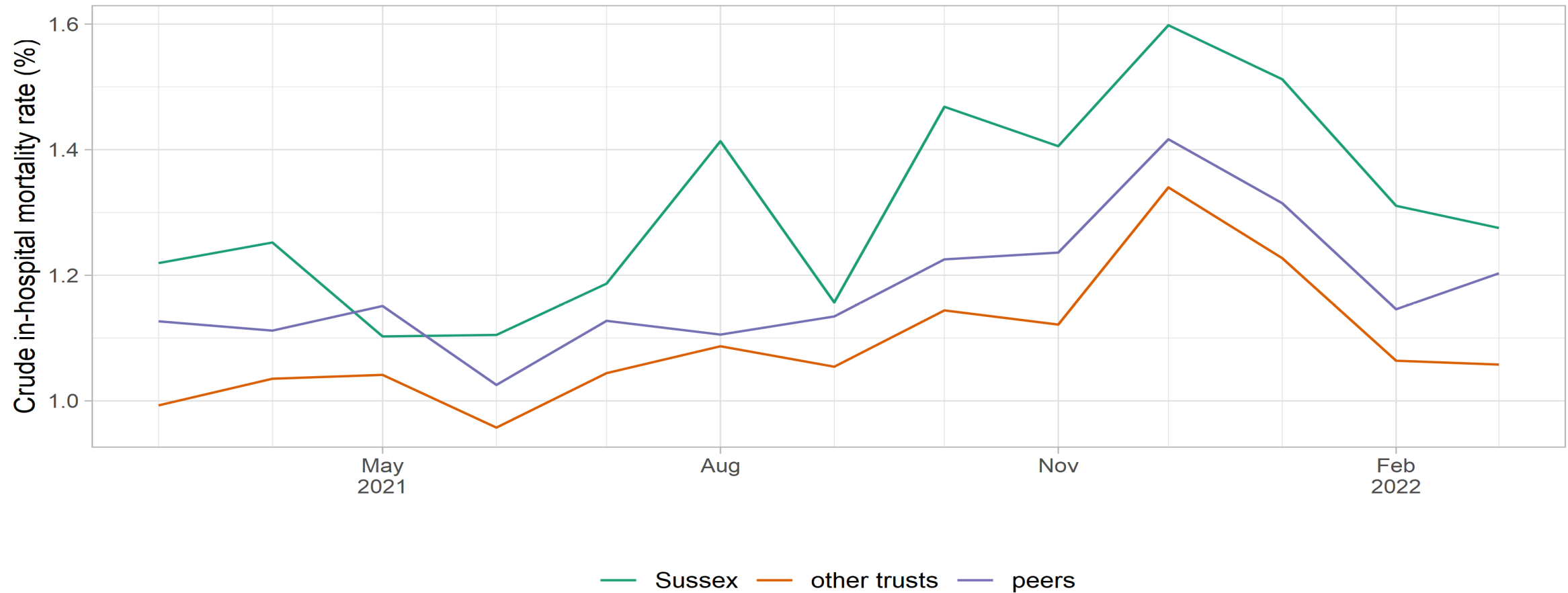
CRUDE MORTALITY

Crude mortality rate (excluding COVID) trend over time - by site

SHMI

12 month rolling trend over time for SHMI
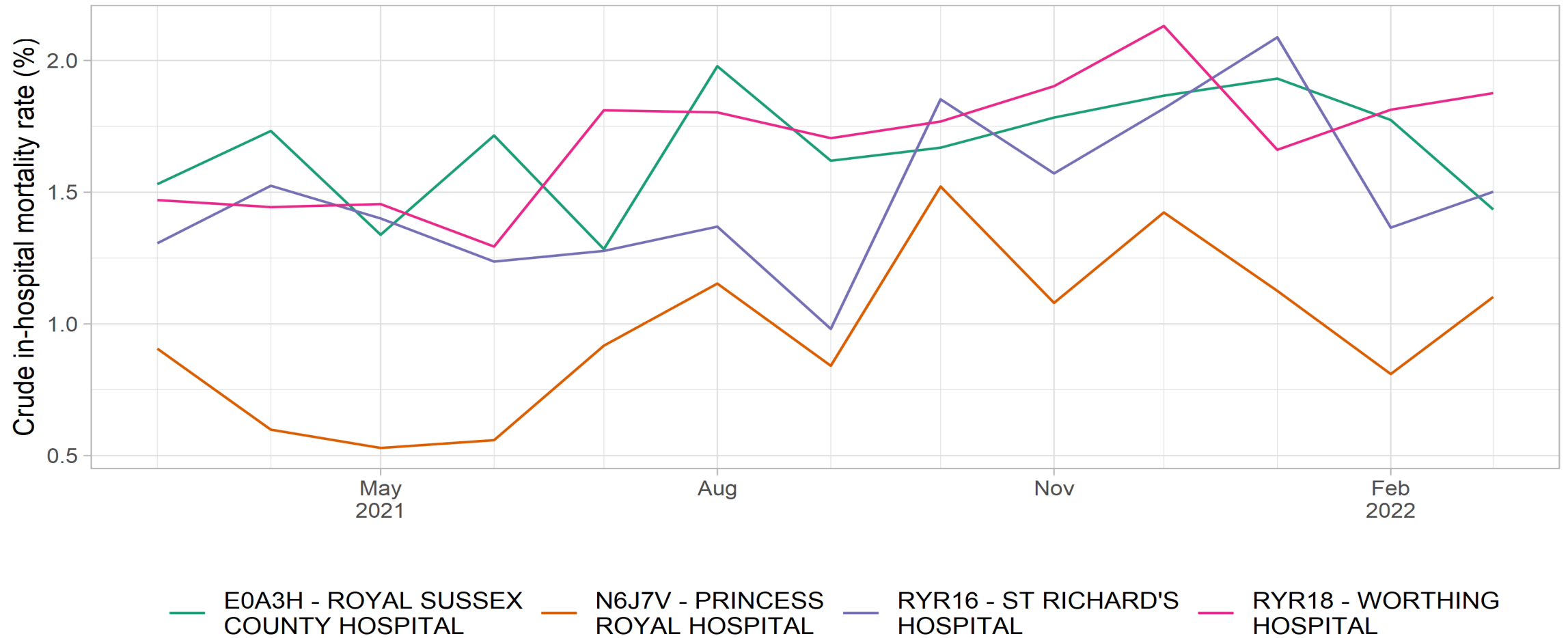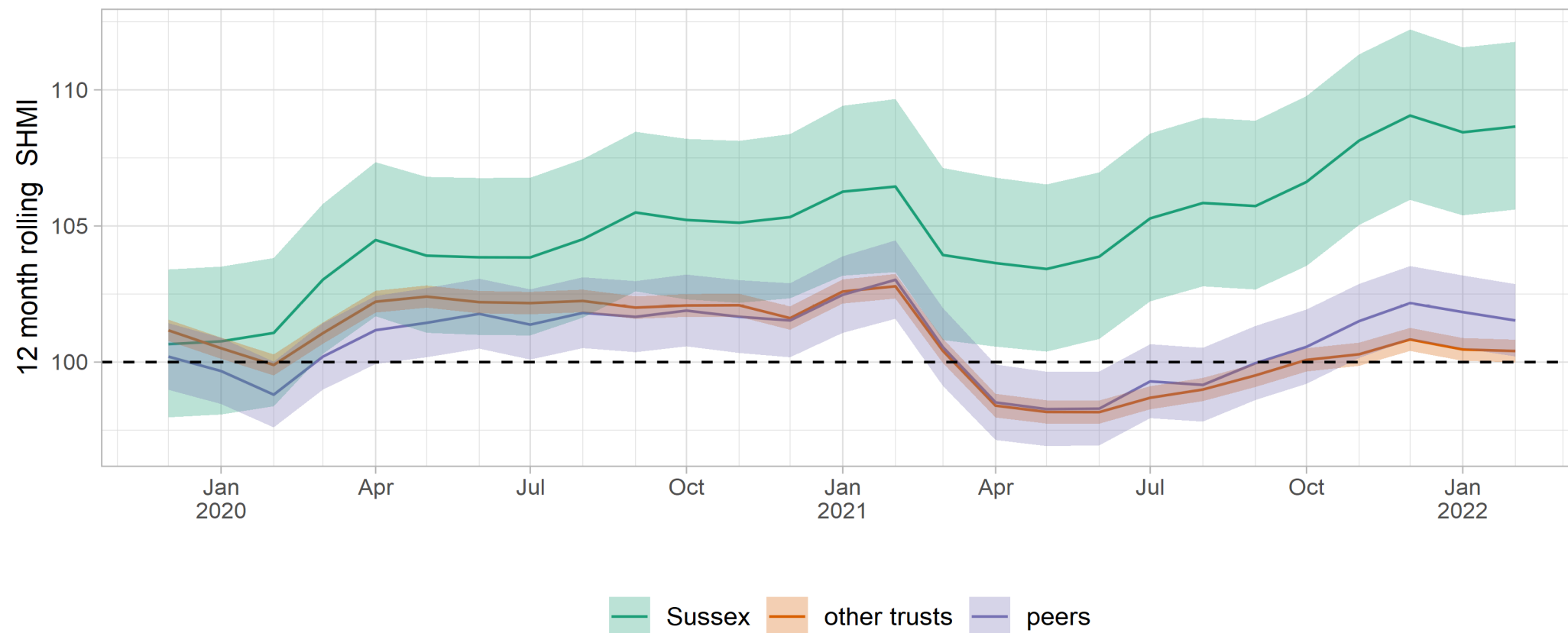
Areas surrounding lines represent 95% confidence intervals

Depth of Coding

Trend over time for average diagnosis coding depth - by site
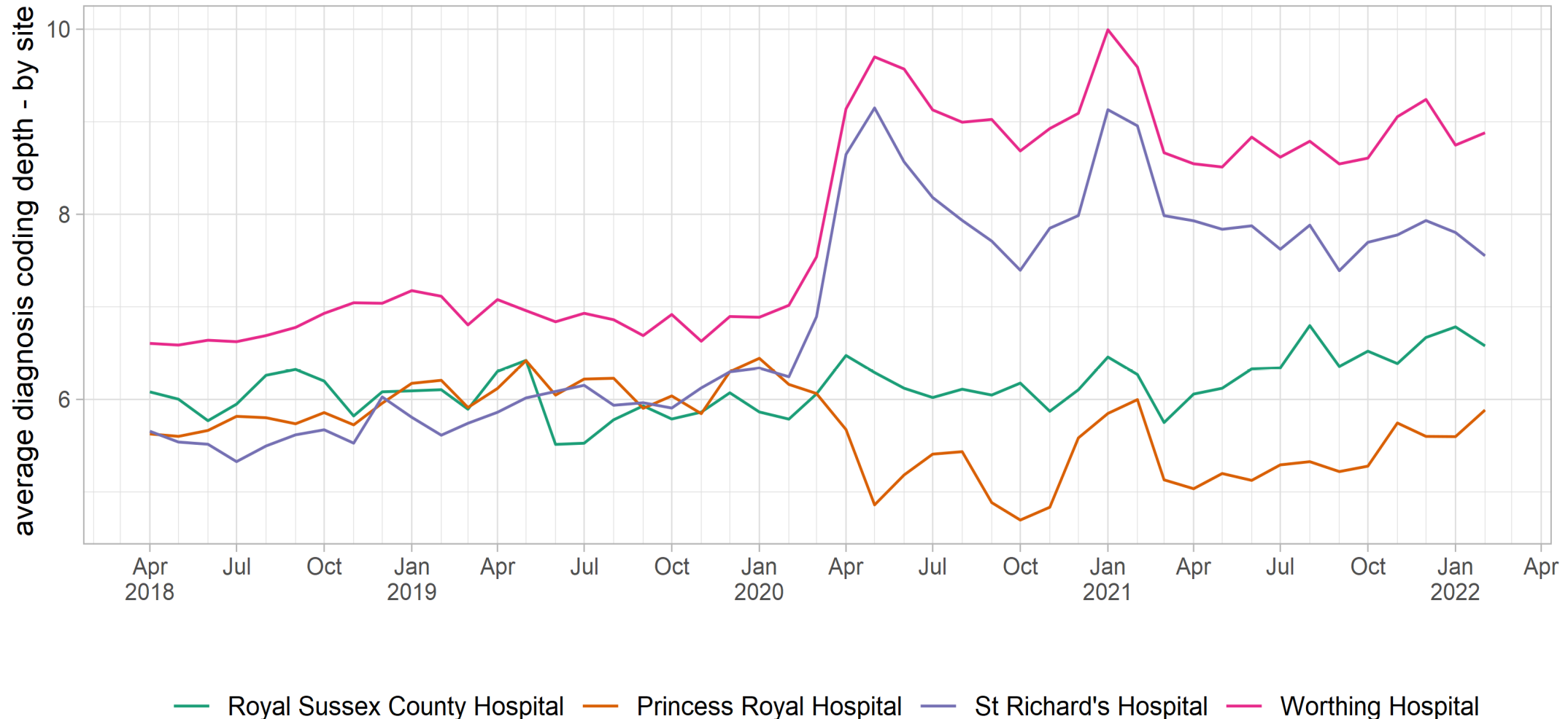
Mortality Summary

In view of the significant variation in coding depth across the organisation and the potential link between the quality of coding and the SHMI; a coding and mortality working group has been established.

An external audit of coding has been commissioned from Monmouth Partners. This will review a sample of 200 clinical records from each of the four acute sites. The coding audit includes urgent care and elective activity. The findings are expected in October 2022.

The coding and mortality group is working to an action plan to improve the quality of mortality data and coding. Examples of actions include strengthening the interface between clinicians and the coders with the development of the link clinician role, the inclusion of training for the medical staff on coding and the clinical record at induction and appropriate case note audits.

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 harms 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%.

For actual harms graded as low, moderate, severe and death the numbers are detailed below. The highest percentage of reported patient safety incidents are graded as no harm (79%).

UHS Approved Harms
Excludes Present on Admission
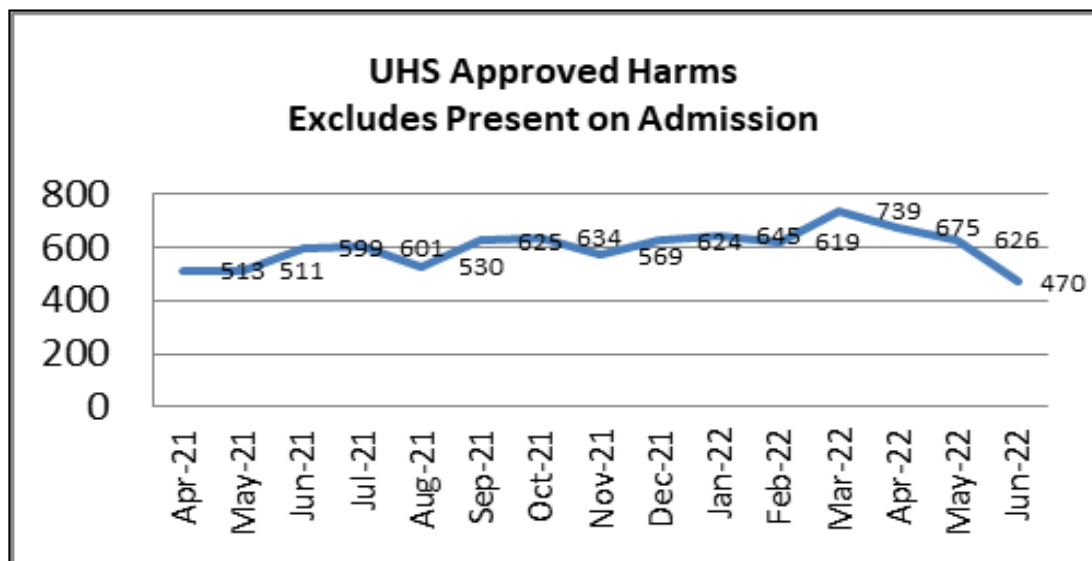
Site variables are due to

➢ 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)

Incident Management and Learning

Improvement trajectory:
Investigation, review and closure of all no/low harm incidents
(within 20 working days) June= 82% reduction in open incidents

- 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
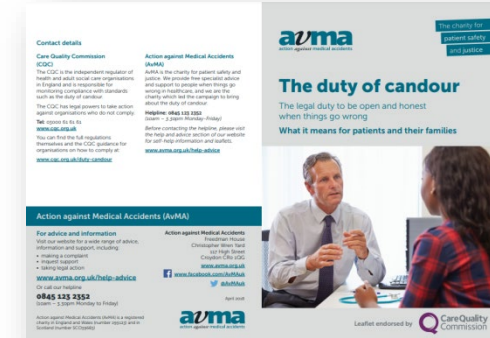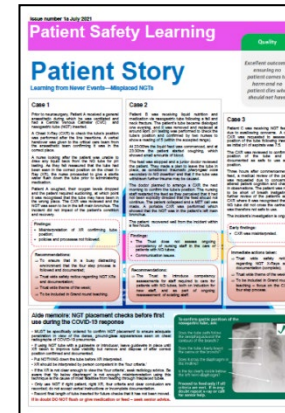
SRH/WH*
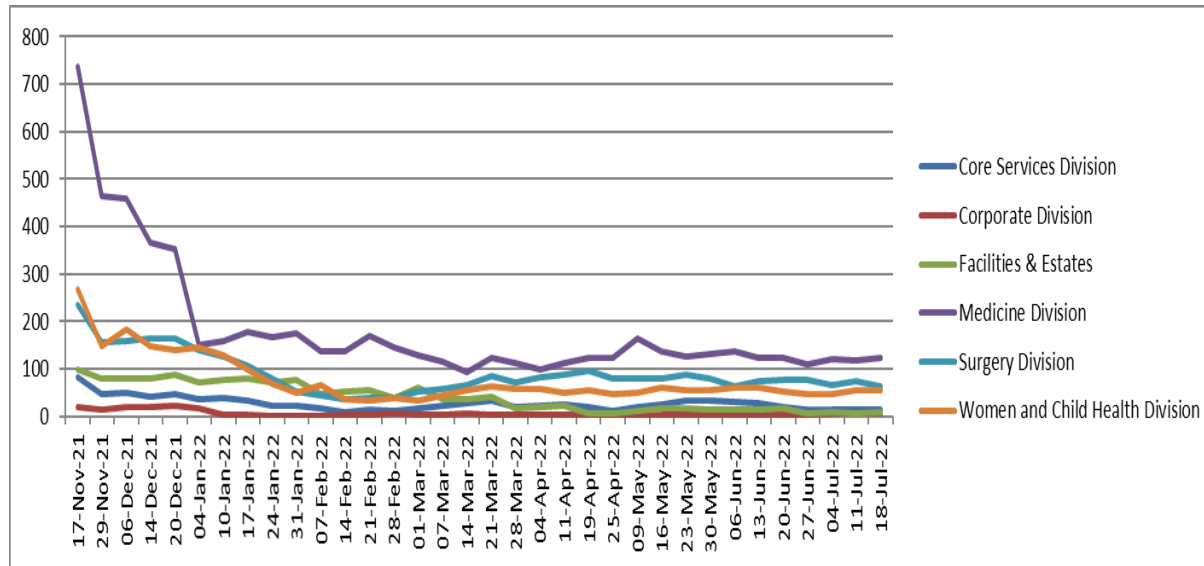
PRH/RSCH
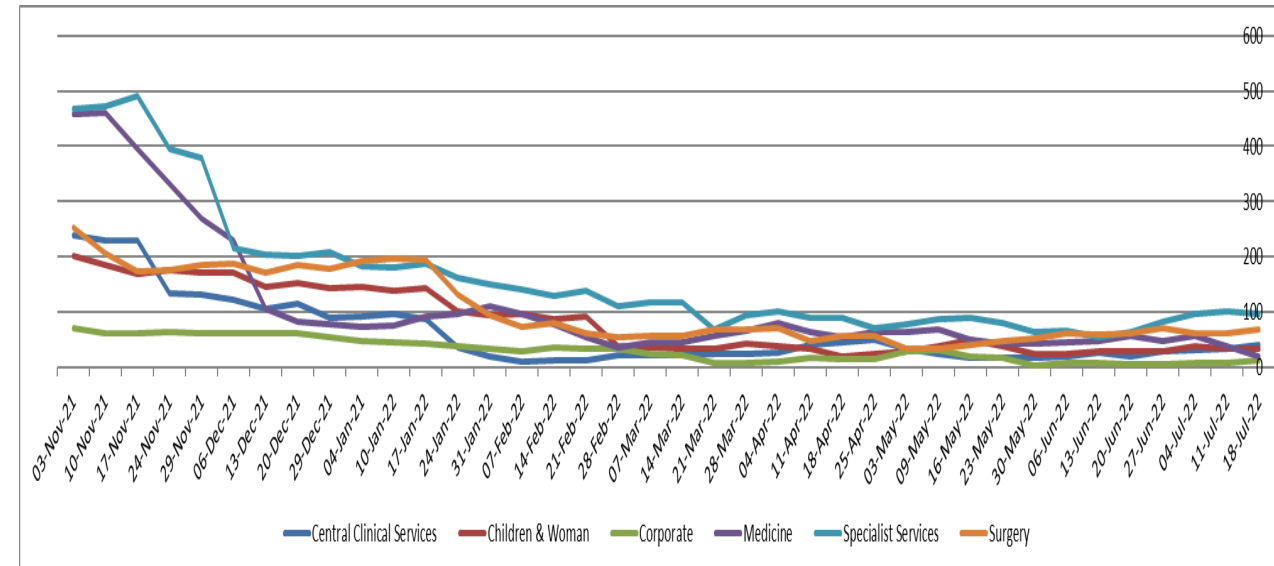
*DCIQ Datix incident module implementation Q3 will align with new divisional COM

Avoidable Harm– Key Metrics: Pressure Damage

Hospital Acquired Pressure Ulcer Tracker - Cat 2 and Above Number of Patients-UHSussex starting 01/04/21

Hospital Acquired Pressure Ulcer Tracker - Cat 2 and Above Per 1,000 Bed Days-UHSussex starting 01/04/21

In June there were 96 patients with reported category 2 and above pressure ulcers = 1.92 per 1000 bed days, (rolling average = 1.67);

Performance/Themes :

- Increased number of patients with reported hospital acquired Cat 2 ulcers, reflecting the ongoing pressures and presenting frailty of patients.
- Number remains on upward trajectory however rate shows little recent variation, although consistently higher than Q1 and 2 2021.
- Medicine (SRH & WH) reporting higher than other divisions reflecting the high numbers of presenting frail patients - on downward(positive) trajectory for the past 3 months.
- TV team cover remains a significant challenge across sites with increasing workload due to high numbers of pts presenting with 'present on admission' ulcers.
- Sacral and moisture related ulcers a key theme.
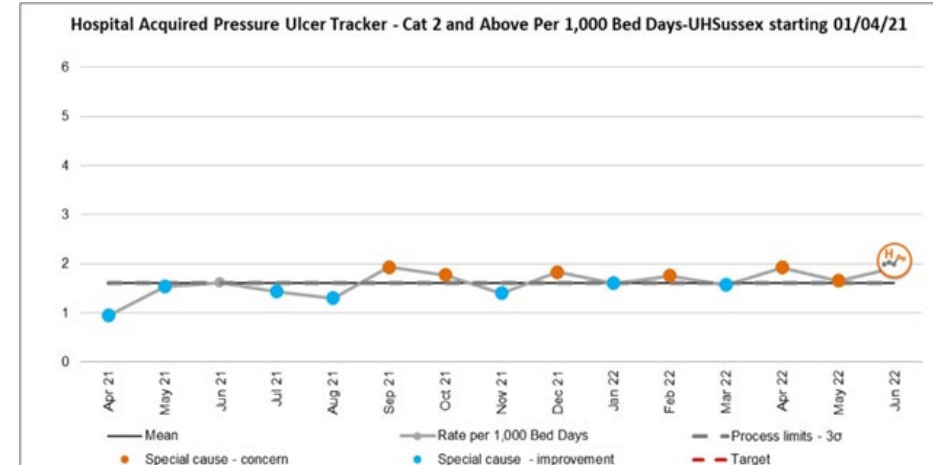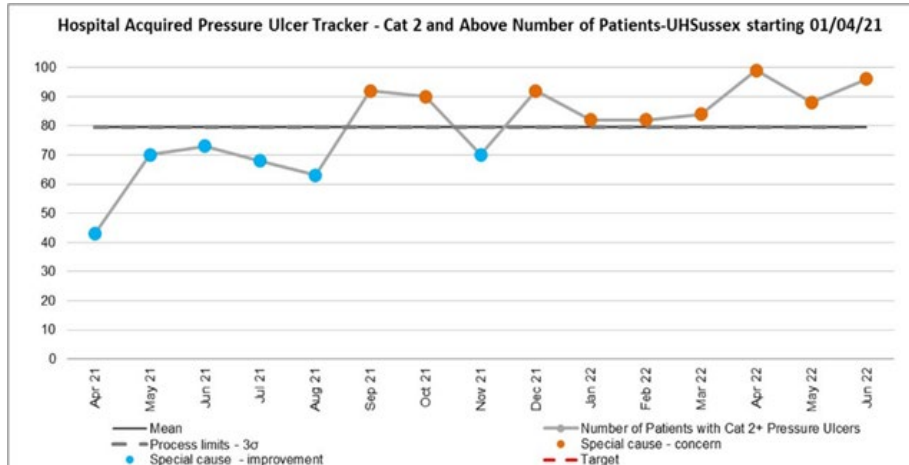- Heel deep tissue injuries also remains an area of focus.
- Provision of skin care products remains a challenge due to national supply issues – alternative products being sourced but this remains an area of risk.

Improvement Actions:

- Breakthrough wards now confirmed as: Twineham, Level 9A, Castle, Ashling, Boxgrove; work underway on A3 plans.
- #NOF pathway review underway at SRH as part of an SI investigation - requiring cross divisional input- (reviewing skin care opportunities from A&E–to-theatre-to-ward).
- TVNs implementing ward based bitesize teaching programme in targeted wards although impacted by recent team sickness
- OSN and HCA Prepare to Care programmes aligned and work underway to design annual update programme for all clinical staff.
- Moisture associated skin damage pathways adjusted to mitigate the challenge of the supply of skin care products.
- Non – concordance tool approved by HFC group.
- Datix IQ project design phase continues, aiming for implementation in Q2. Work to understand and address differences in reporting activity underway.

Avoidable Harm– Key Metrics: Falls

Patient Falls Tracker - Number of Falls-UHSussex starting 01/01/21

Patient Falls Tracker - Per 1,000 Bed Days-UHSussex starting 01/01/21
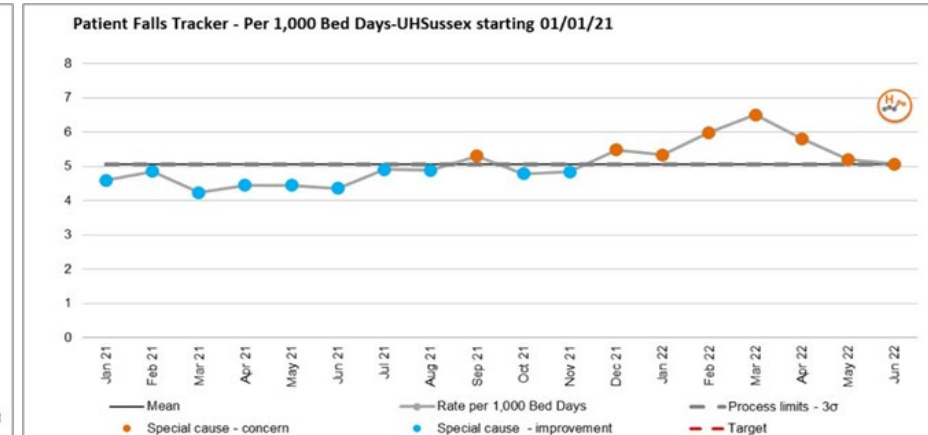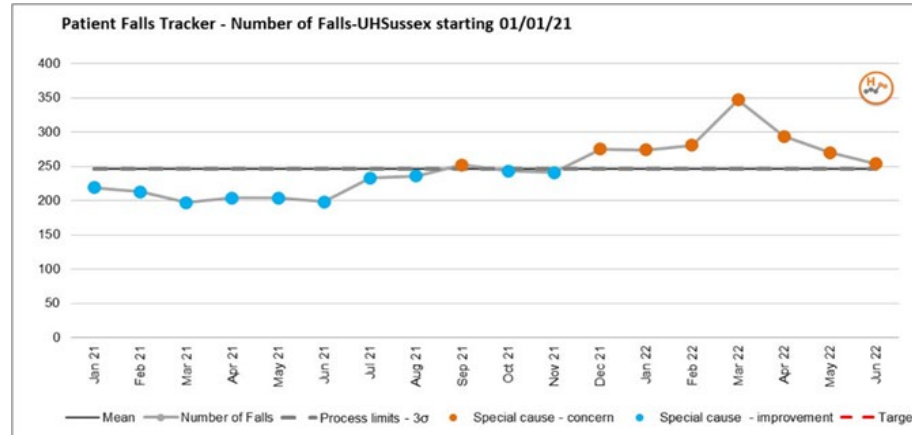
June 2022: 254 reported falls with falls rate per 1000 bed days = 5.07; (rolling 12 month average 5.32)

Performance/ Themes:

- Further (positive) reduction this month with 254 reported falls; 3rd month in row of improvement across all divisions aside from surgery at RSCH and PRH which is showing an upward trajectory over the last 3 months.
- Admission areas across the sites continue to experience highest number of falls.
- There were 6 falls which led to moderate harm and above, (including 2 pts #NOF) with AARs underway for all, supported by HFC nurses.
- Themes identified include staffing impacting observation, Baywatch awareness, and delirium, quality of handover (flow team) and HCA confidence(with high number new starters)
- Ardingly, Newhaven, Courtyard, 8AW and Renal and are all undertaking falls driver improvement programme, working with HFC Nurse to review their data and improvement opportunities.
- W EF, Erringham and Buckingham are also using PFIS framework to identify and monitor their improvement efforts .

Improvement Actions:

- Breakthrough areas at RSCH and PRH focus on pilot of hot debrief and are developing A3 plans.
- Post falls care protocols updated, discussed at HFC group and for cascade across sites; (cascade completed at SRH and Worthing).
- Erringham and Buckingham wards have undertaken staff survey in order to generate improvement ideas; discussed at improvement huddles with ideas shared about ways of working across peer wards; changes underway to ward environment as a result - to enable staff to locate themselves inside the bays at all times (rather than observation from outside)
- Worthing EF and Erringham using falls mapping to try to further understand their opportunities for improvement
- Falls Datix IQ design project work continues with launch aimed for Q2.

Improvement actions (harm reduction)

➢ 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 Q1/2/3.

➢ 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.

Infection Prevention and Control – COVID-19

Covid-19 UHS RSCH and PRH Jan to July 22

■ Hospital onset definite. Day 15 or more
■ Hospital onset probable. Days 8-14 days after admission
■ Hospital Onset indeterminate. Days 3-7 after admission
■ Community Onset. <=2 days after admission

Covid-19 cases by definition UHS West

■ Definite
■ Probable
■ Indeterminate
■ Community
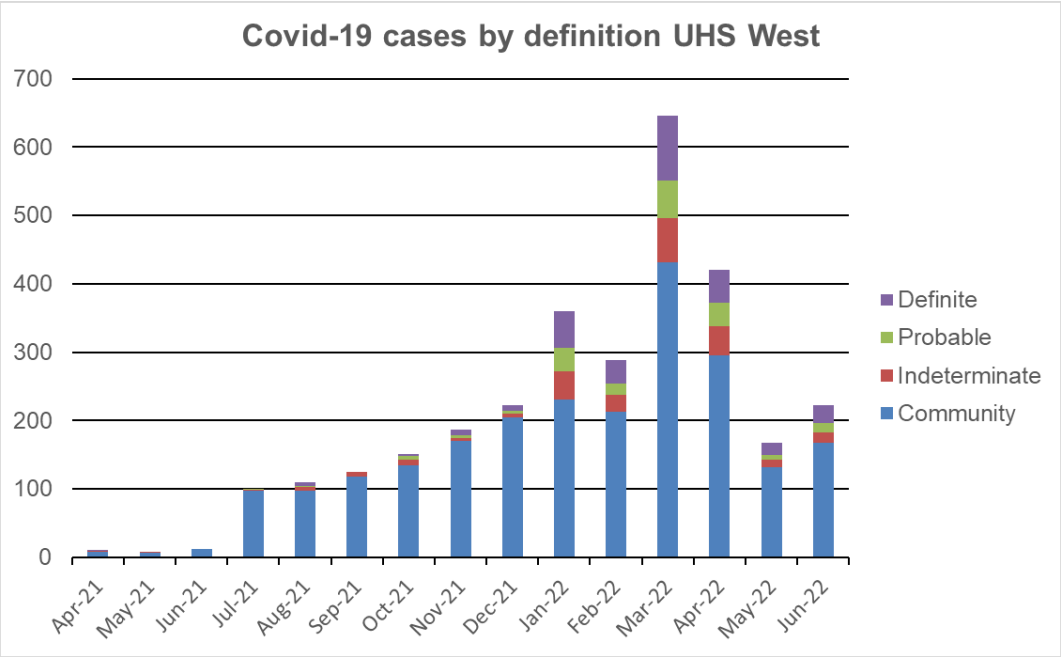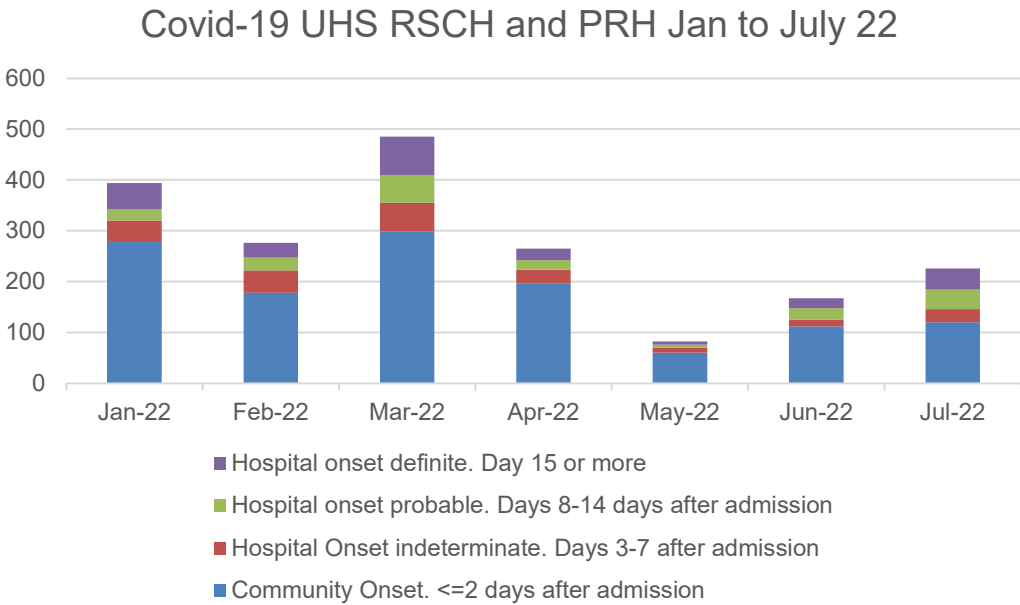
Infection Prevention and Control COVID - 19

► The Omicron variant BA 4 and 5 have caused another wave of cases since the start of June with an increase in positive patients in hospitals. About 2/3 of Covid positive patients have been admitted for other reasons.

► 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 has been significant bed pressures caused by the need to isolate cohorts of patients if they are exposed to another patient who tests positive.

► Case numbers are difficult to monitor as there is now a reliance on LF device tests which are not processed in the labs, and there is no digital results solution.

► Local outbreaks continue to be managed by the IPC Team.

Infection Prevention and Control COVID - 19

- 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 continues to isolate 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 mandate for masks was reintroduced for clinical areas due to the wave of Omicron BA4 and 5.

Mandatory surveillance

- Mandatory surveillance is reported monthly to the UK HAS on MRSA, MSSA, *C.difficile, E.coli, Klebsiella* species and *Pseudomonas aeruginosa*

- The following category definitions are used:

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

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

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

    COCA: Community Onset, Community Associated, acquired within 48 hours of admission to hospital, and no recent admission

- The charts on next slide show data up to June 2022
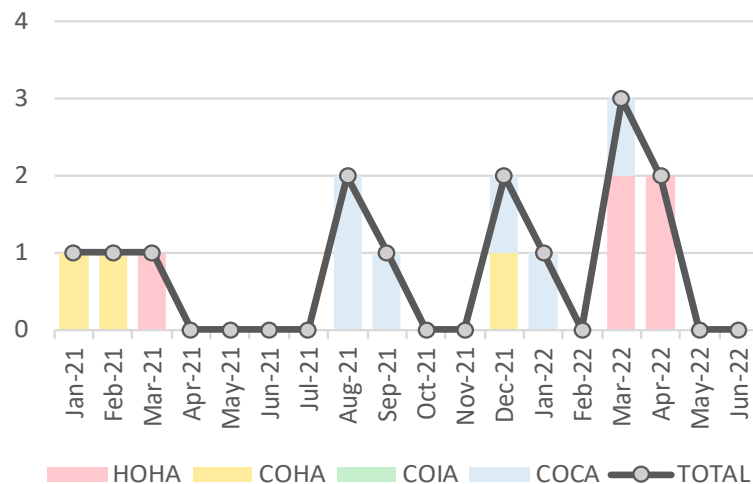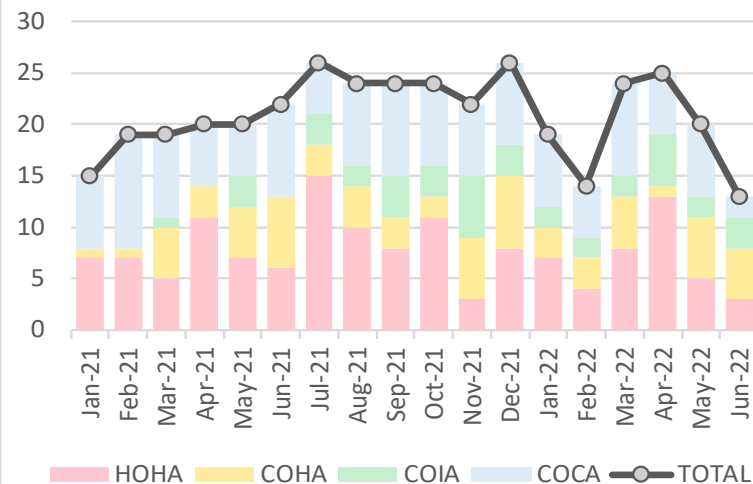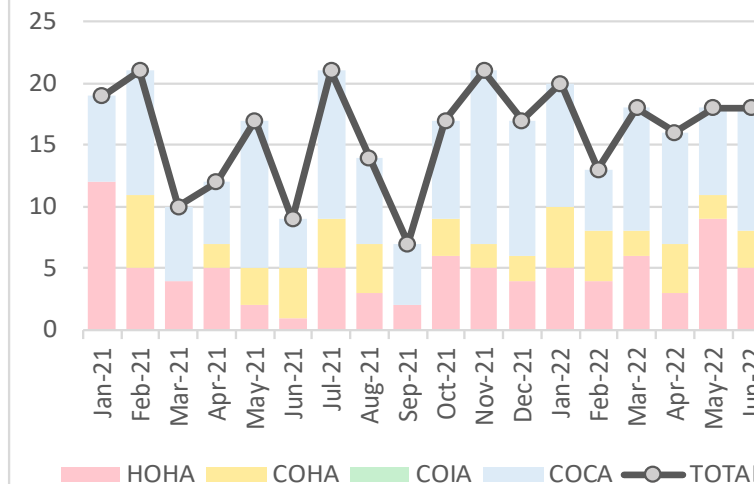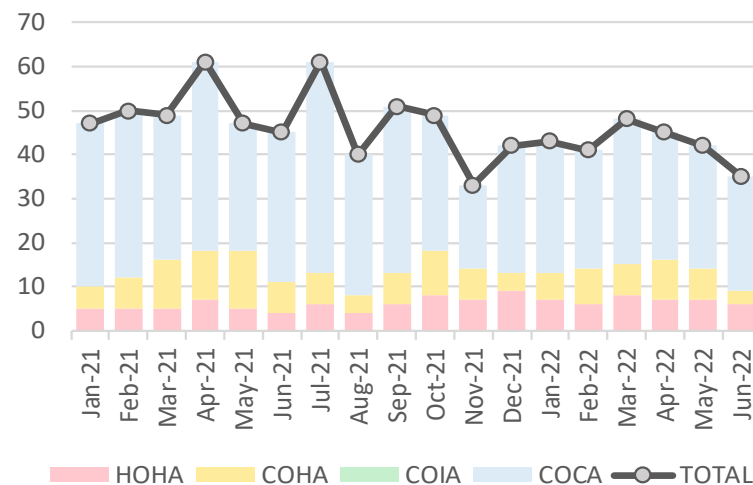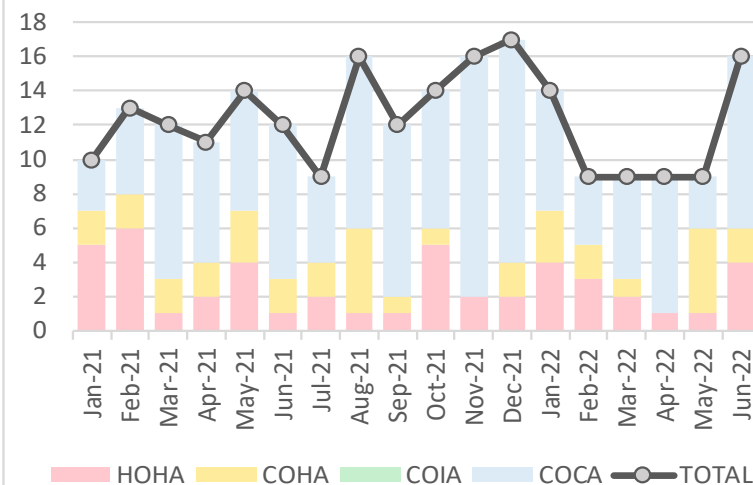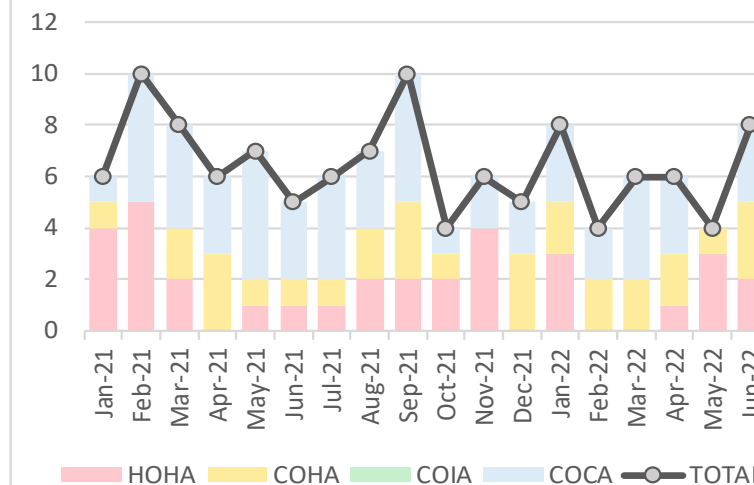
Trust attributable mandatory surveillance data April 2022 to March 2023against trajectory

	Annual Trajectory		Q1	Q2	Q3	Q4	YTD
CDT	1 4 2	Trajectory	35	35	36	36	142
		Actual	31				
		Variance	-4				
E.coli	1 58	Trajectory	40	40	39	39	158
		Actual	28				
		Variance	-12				
Klebsiella	5 4	Trajectory	13	13	14	14	54
		Actual	12				
		Variance	-1				
Pseudomonas	3 8	Trajectory	9	9	10	10	38
		Actual	12				
		Variance	+3				
MRSA	0	Actual	2				
MSSA	n/a	Actual	19				

Safer Staffing

- 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 overall fill rate for PRH and RSCH have improved during the quarter with a significant improvement seen on the day shifts. The CHPPD is 7.84 which is only just below the national average of 8.3 and 8.1 respectively.

- The Safer Care Nursing Tool is currently being piloted on four wards; one on each hospital site with full roll-out in August at PRH. This will ensure timely patient care sensitive information will be available to clinical staff.

- Recruitment is on going on a regular basis both domestically and internationally.

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

Day Average Fill Rates - Registered

Day Average Fill Rates - Care Staff

Night Average Fill Rates - Registered

Night Average Fill Rates - Care Staff

	CHPPD																								
	Registered								Care								Overall								
	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
PRH	3.75	4.42	3.82	4.12	3.95	4.03	4.45	4.23	3.33	3.81	3.76	3.77	3.27	3.58	3.86	3.60	7.07	8.23	7.58	7.90	7.22	7.61	8.31	7.83
RSCH	4.87	5.45	5.15	5.81	5.46	5.62	5.47	5.54	3.31	3.45	3.39	3.66	3.24	3.43	3.28	3.20	8.18	8.90	8.54	9.47	8.69	9.05	8.75	8.75
BSUH	**4.51**	**5.14**	**4.71**	**4.12**	**5.18**	**5.42**	**5.45**	**5.42**	**3.31**	**3.56**	**3.51**	**3.77**	**3.18**	**3.43**	**3.41**	**3.28**	**7.83**	**8.70**	**8.22**	**7.90**	**8.36**	**8.85**	**8.86**	**8.70**
Worthing	3.88	3.97	3.20	3.90		4.15	4.31	4.33	3.03	3.04	2.32	2.80		2.83	2.94	2.88	6.91	7.01	5.51	6.70		6.98	7.25	7.21
St Richards	4.02	4.12	3.41	4.13		4.10	4.12	4.35	2.68	2.56	2.08	2.40		2.36	2.52	2.33	6.70	6.69	5.49	6.54		6.46	6.64	6.68
WSHT	**3.95**	**4.05**	**3.30**	**3.90**		**4.13**	**4.22**	**4.34**	**2.85**	**2.81**	**2.20**	**2.80**		**2.61**	**2.75**	**2.63**	**6.80**	**6.86**	**5.50**	**6.70**		**6.74**	**6.97**	**6.97**
UHSussex	**4.22**	**4.64**	**4.08**	**4.86**		**4.77**	**4.84**	**4.89**	**3.08**	**3.21**	**2.79**	**3.15**		**3.02**	**3.08**	**2.96**	**7.30**	**7.85**	**6.87**	**8.01**		**7.80**	**7.92**	**7.84**

People

Integrated Performance Report Section

Focus of this section

- 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

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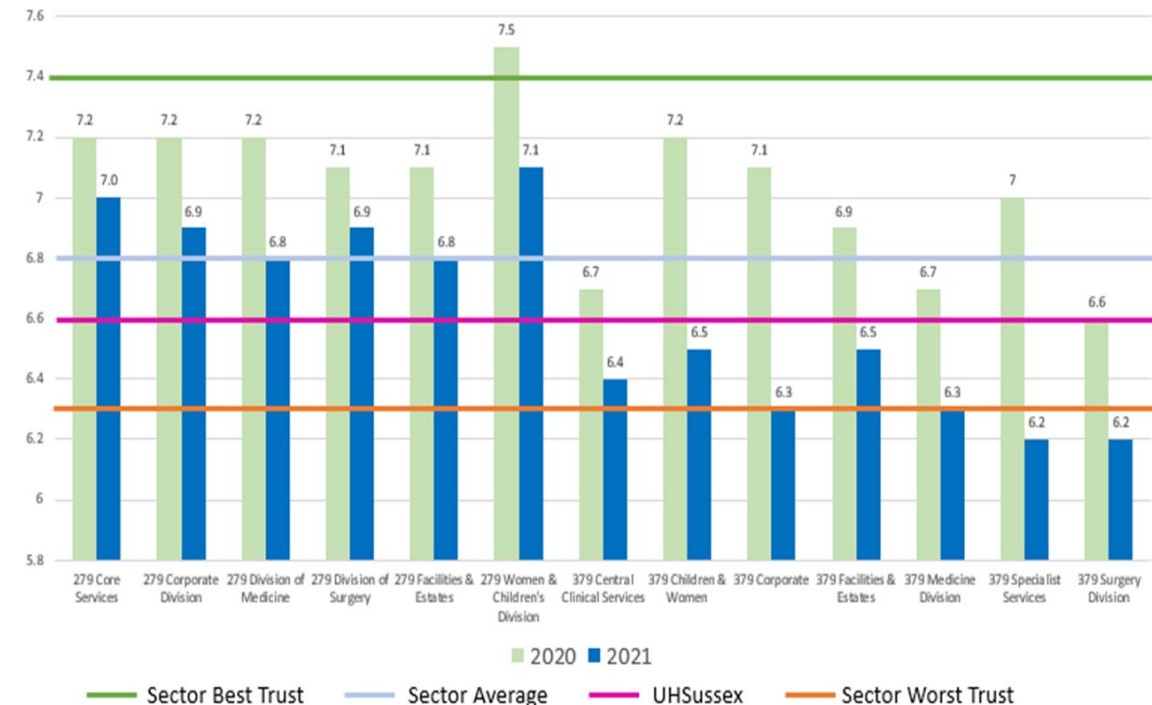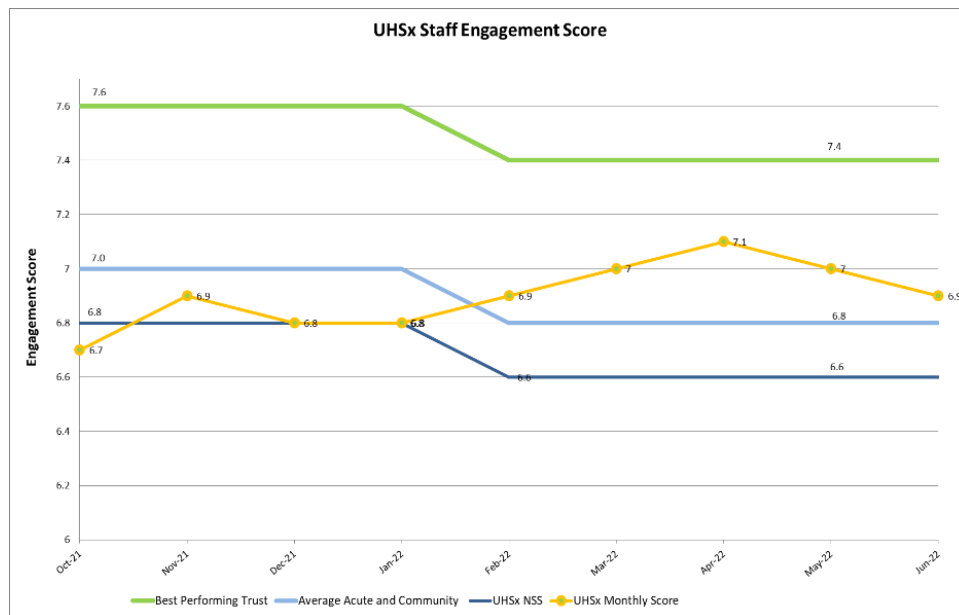
The following pages summarise progress against the People Breakthrough Objective, Strategic Initiative and Corporate Project - which are all intended to improve our staff engagement score. Delivery assurance of our plans is reported through our People Committee and the SDR process.

People Breakthrough Objective

Working with Divisions using PFIS to increase staff recommending the organisation as a place to work
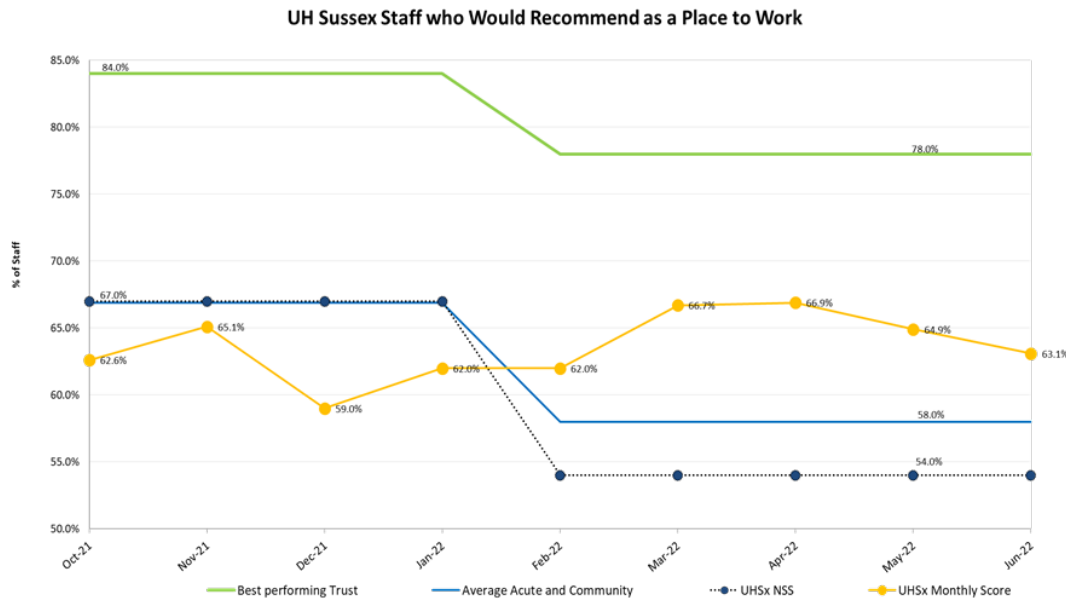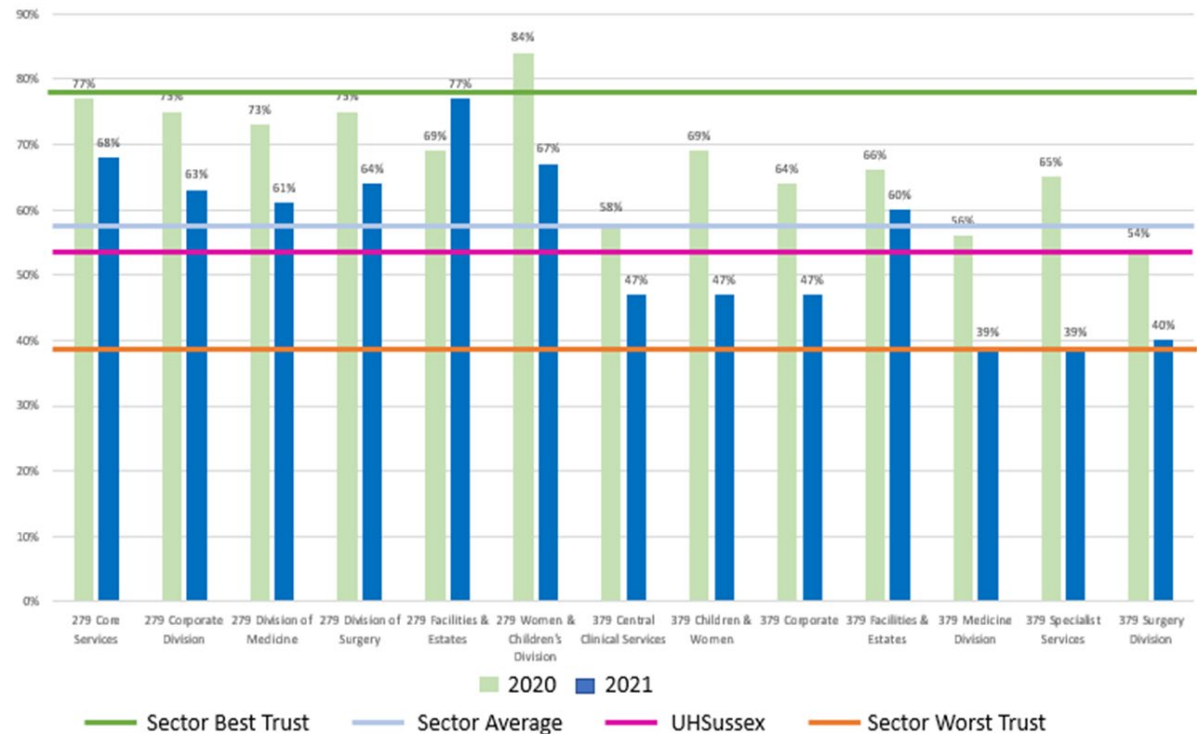
Work is taking place in all Divisions involving staff and activities informed by the lastest staff survey results and reviewed at the People Committee. Work will now transition to the new Divisions under the Clinical Operating Model and the BO is being reviewed.

People Strategic Initiative

July 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 had been developed for each of these workstreams. 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 workstream working with the Diversity Matters steering group and others and a draft EDI strategy is being consulted on.

- The Integrated Education workstream may continue outside the SI from September.

Workstream Current Status Updates

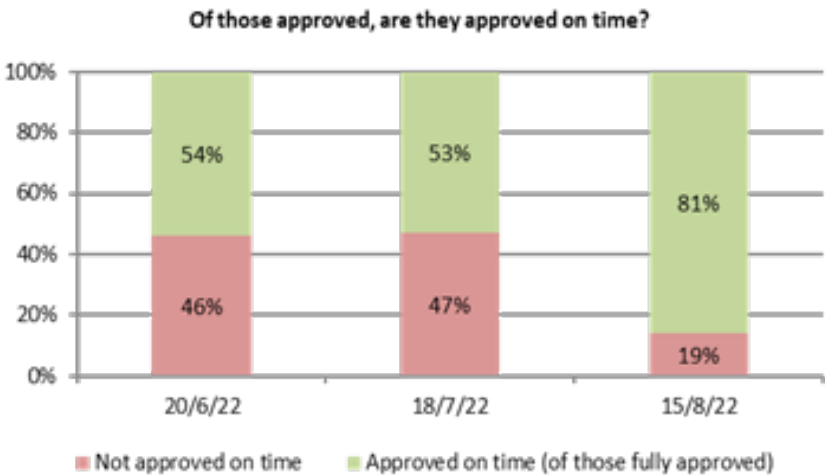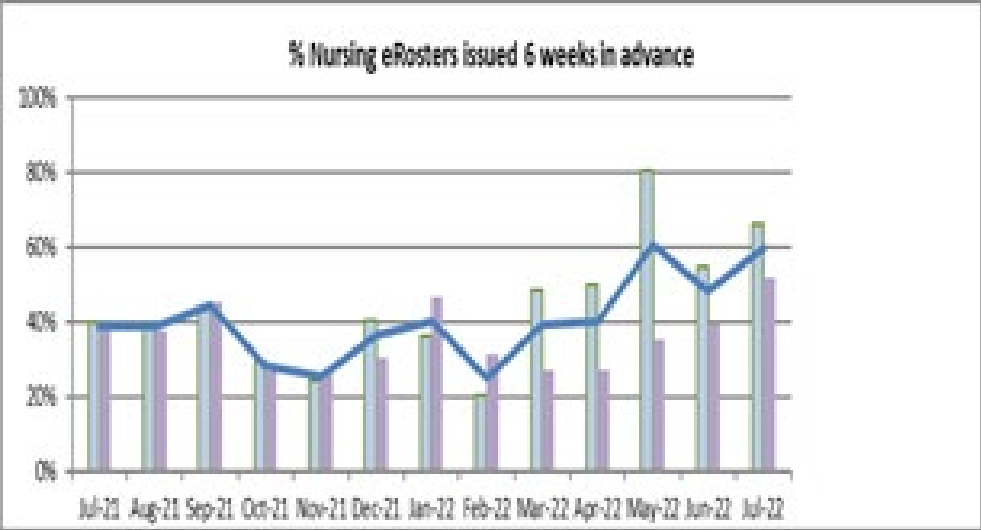| RAG	Workstream	Comments/Key Risks
🟧	Governance	Individual workstream charters have been developed (except EDI). The SRO is currently reviewing key deliverables and top level timelines. A programme risk register has been completed to identify any programme risks and is now being refreshed. Leadership Skills group is now established to ensure governance around this workstream; The H&W group is meeting but requires further support as does EDI. Overarching LCD SI Steering Group to provide full oversight being discussed. Key programme risks are limited capacity and/or resource within BAU Teams to deliver; managing programme interdependencies; LS Procurement Process and the organisational capacity to absorb training commitments/ planned changes.
🟧	Leadership Skills	**Workstream Lead – Nick Groves** Key actions: • Detailed project plans underway • Responses with themes identified informing programme of work and future leadership offerings. • Stakeholder panel meetings/ shortlisting has been scheduled to review ITT for leadership development • Business cases in development Key Risks • Programme resourcing is reliant on one individual who now has overarching SRO responsibility. • ITT process is at risk and potential delay to timeframes for delivery
🟩	Health & Wellbeing	**Workstream Lead – Nick Groves** • New strategy under development • 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. • Continue to develop models to support flexible working • Integrate governance with wider SI • Assessment against NHS wellbeing framework underway (gap analysis) completed and to be shared • Project plan to be developed Key Risks • Steering group to support integration of interventions: Engagement and attendance H&W steering group is limited • Review of MH support report received and being reviewed
🟧	Equality, Diversity and Inclusion	**Workstream Lead – Nick Groves** • Establish leadership and integration within wider EDI work and LCD governance • Develop any charter / A3s for EDI for 22-23 • CQC well led evidence gathering • Project plan to be developed Key Risks • Lack of resource within EDI team to support workstream
🟧	Staff Engagement	**Workstream Lead – Nick Groves** • Establish leadership • Develop charger Key Risk • Lack of resource to initiate project

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.

% Nursing eRosters issued 6 weeks in advance

EWD - Completion: Nursing, AHP, F&E and Corporate

Of those approved, are they approved on time?
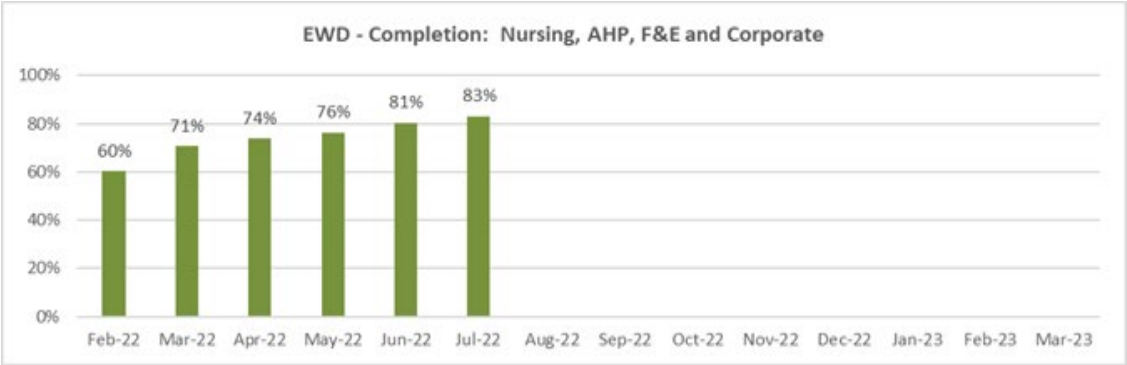
Key stats – people scorecard

- 16,110 WTE posts (+72)
- 14,666 WTE in post (+60)
- 1,444 vacancy (8.97%)
- RN vacancy 6.84%
- HCA vacancy 19.34%

- Sickness 5.08% (4.40% in month)
- Turnover 9.37%

- Appraisal (non-medical) 76.93%
- Consultant 82.47%

- STAM 86.09%

- Latest staff engagement score 6.90%
- Recommendation 63.06%

- Bank utilisation 8.82%
- Agency utilisation 5.42% (up 2.57% from June 2021)

Category	Key Performance Indicator	Target	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Trend
	True North - Engagement		7.4	7.2	6.9	6.6	6.6	6.7	6.9	6.8	6.8	6.9	7.0	7.1	7.0	
	Breakthrough - Place to work (included in some of the surveys)		79.72%	77.45%	68.70%	56.22%	59.27%	62.63%	65.13%	59.02%	62.02%	62.26%	66.67%	67.70%	64.93%	
	Survey Responses		2,058	1,632	633	268	586	415	461	384	509	487	394	377	467	
Workforce Capacity	FTE - Budgeted		15,928.64	15,893.63	15,891.60	15,922.50	15,997.96	16,030.54	16,034.84	16,067.53	16,073.31	16,054.18	16,038.42	16,031.97	16,038.36	
	FTE - Substantive contracted		14,440.13	14,419.91	14,467.63	14,870.46	14,624.98	14,669.56	14,657.42	14,696.39	14,748.13	14,731.54	14,794.27	14,964.53	14,610.57	
	FTE - Substantive contracted variance from Budget		1,488.51	1,473.72	1,423.97	1,052.04	1,372.98	1,360.98	1,377.42	1,371.14	1,325.18	1,322.64	1,244.15	1,067.44	1,427.79	
	Vacancy Factor (Substantive contracted FTE)		9.34%	9.27%	8.96%	6.61%	8.58%	8.49%	8.59%	8.53%	8.24%	8.24%	7.76%	6.66%	8.90%	
	Vacancy Factor HCA Band 2 (Substantive contracted FTE)		6.35%	5.27%	5.17%	7.55%	10.13%	12.85%	14.03%	13.59%	14.96%	15.66%	14.66%	16.29%	17.15%	
	Vacancy Factor Nurse Band 5 (Substantive contracted FTE)		21.44%	20.61%	19.47%	19.80%	18.29%	16.52%	15.18%	13.47%	12.17%	11.59%	10.37%	8.24%	9.91%	
	Spend - Bank as a % of total staffing		10.50%	6.81%	7.95%	7.70%	5.43%	7.02%	7.60%	8.78%	10.21%	8.42%	5.52%	8.38%	7.76%	
	Spend - Agency as a % of total staffing		3.04%	2.85%	3.47%	3.44%	2.86%	3.10%	3.28%	3.17%	3.10%	3.14%	3.42%	3.76%	5.17%	
	Substantive Headcount		16,462	16,470	16,395	16,497	16,525	16,537	16,604	16,604	16,647	16,668	16,701	16,670	16,619	
Workforce Efficiency	Absence - Sickness (12 month)		3.82%	3.81%	3.83%	3.91%	3.93%	4.01%	4.05%	4.10%	4.13%	4.22%	4.34%	4.48%		
	Absence - Sickness in month		3.48%	3.91%	4.10%	4.45%	4.14%	4.99%	4.65%	4.70%	4.72%	5.17%	4.83%	4.63%		
	Absence - Maternity in month		2.14%	2.14%	2.10%	2.13%	2.13%	2.07%	1.99%	2.00%	2.00%	1.94%	1.89%	1.86%		
	Absence - Special, Study & Other Leave in month		7.27%	7.66%	8.33%	7.80%	8.08%	8.44%	8.35%	8.58%	9.08%	8.85%	9.37%	8.58%		
	Absence - Total in month		12.89%	13.71%	14.52%	14.39%	14.34%	15.49%	15.00%	15.28%	15.79%	15.97%	16.09%	15.07%		
	Sickness - Short Term (< 28 days)		1.73%	1.87%	1.99%	2.08%	1.97%	2.55%	2.42%	2.24%	2.48%	2.51%	2.54%	2.34%		
	Sickness - Long Term (>= 28 days)		1.75%	2.04%	2.11%	2.37%	2.17%	2.44%	2.24%	2.45%	2.24%	2.66%	2.29%	2.29%		
	Sickness - Stress in month		0.85%	0.99%	1.05%	1.14%	0.95%	1.07%	1.02%	0.91%	0.87%	1.05%	0.85%	0.93%		
	Sickness - Gastro Intestinal in month		0.31%	0.32%	0.31%	0.34%	0.34%	0.34%	0.32%	0.33%	0.27%	0.40%	0.33%	0.37%		
	Sickness - Other Musculoskeletal in month		0.46%	0.48%	0.43%	0.50%	0.38%	0.43%	0.40%	0.44%	0.37%	0.52%	0.40%	0.36%		
	Sickness - Cough, Cold & Flu in month		0.16%	0.16%	0.20%	0.22%	0.35%	0.76%	0.70%	0.72%	0.46%	0.48%	0.48%	0.46%		
	Sickness - Back in month		0.22%	0.27%	0.25%	0.27%	0.27%	0.22%	0.20%	0.16%	0.13%	0.21%	0.17%	0.17%		
	Episodes - New sickness episodes in month		2,077	2,254	2,374	2,389	2,544	3,448	3,136	2,938	2,635	2,611	3,065	2,670		
	Episodes - On-going sickness episodes in month		537	545	669	692	680	794	682	802	867	842	766	877		
	Episodes - Total sickness episodes in month		2,614	2,799	3,043	3,081	3,224	4,242	3,818	3,740	3,502	3,453	3,831	3,547		
	Maternity - Number of staff on maternity leave		431	425	410	423	414	412	392	396	401	392	370	374		
	Turnover - Trust (12 month)		9.88%	9.91%	9.73%	9.54%	9.05%	8.96%	8.82%	8.86%	9.01%	9.00%	9.06%	9.16%	9.26%	
	Turnover - Medical & Dental (12 month)		17.48%	15.69%	14.12%	14.11%	14.12%	14.12%	13.78%	13.78%	13.42%	13.63%	13.72%	12.70%	12.01%	
	Turnover - Nursing & Midwifery (12 month)		9.00%	9.03%	8.69%	8.11%	7.59%	7.23%	6.68%	6.50%	6.38%	6.27%	6.00%	6.19%	6.26%	
	Turnover - Scientific, Therapeutic & Technical (12 Month)		9.36%	9.36%	9.47%	9.04%	8.40%	8.72%	8.83%	8.84%	9.16%	9.60%	9.39%	9.56%	9.58%	
	Turnover - Admin, Clerical & Estates (12 months)		8.78%	9.12%	9.21%	9.40%	9.22%	9.26%	9.64%	9.84%	10.32%	10.25%	10.60%	10.98%	11.23%	
	Turnover - Support Staffing (12 months)		10.83%	10.96%	10.91%	11.01%	10.06%	9.91%	9.58%	9.83%	9.99%	9.89%	10.24%	10.12%	10.41%	
	Stability %		89.07%	88.79%	92.14%	88.34%	88.4%	88.1%	87.9%	87.1%	87.1%	86.7%	86.5%	85.8%	85.5%	
Training and Development	% of appraisals up to date All Staff (AfC Staff and Consultants Only	90%	78.63%	77.48%	75.79%	75.63%	73.37%	70.78%	71.15%	71.03%	70.58%	71.28%	68.47%	68.88%	73.22%	
	% of appraisals up to date Medical Staff (Consultants Only)	90%	28.92%	28.37%	27.72%	28.54%	27.07%	25.93%	26.06%	28.14%	27.45%	26.72%	28.28%	36.34%	87.53%	
	% of appraisals up to date AfC Staff (excl Medical staff)	90%	82.74%	81.58%	79.83%	79.62%	77.29%	74.61%	75.05%	74.75%	74.30%	75.13%	71.96%	71.00%	72.29%	
	STAM Weighted Average	90%	83.36%	84.25%	83.82%	83.65%	82.76%	82.64%	82.30%	82.63%	84.19%	84.52%	86.19%	85.21%	86.24%	
	% In Date - Fire	90%	85.12%	84.29%	82.33%	82.42%	80.32%	79.77%	79.46%	79.98%	82.43%	82.89%	84.92%	84.55%	85.53%	
	% In Date - Infection Control (Role Specific)	90%	84.40%	83.74%	81.55%	81.46%	79.69%	79.62%	79.33%	79.92%	82.35%	83.10%	84.84%	84.63%	85.35%	
	% In Date - Back Training (Role Specific)	90%	69.11%	71.15%	73.26%	74.40%	75.21%	75.94%	76.20%	76.89%	78.42%	78.36%	81.30%	83.68%	84.62%	
	% In Date - Child Protection (Role Specific)	90%	88.61%	87.92%	87.46%	86.71%	86.04%	86.09%	85.18%	85.45%	86.64%	87.24%	88.65%	82.99%	85.71%	
	% In Date - Information Governance	90%	82.70%	82.09%	80.25%	80.20%	78.07%	76.86%	77.48%	78.11%	80.05%	80.94%	82.61%	82.34%	84.60%	
	% In Date - Adult Protection	90%	86.95%	87.65%	88.48%	88.63%	88.45%	88.76%	88.28%	88.42%	89.40%	89.09%	90.92%	85.62%	87.72%	
	% in Date - Equality & Diversity	90%	91.00%	90.84%	90.46%	89.53%	88.81%	88.55%	88.07%	88.47%	89.72%	89.59%	91.71%	91.77%	91.74%	
	% in Date - Health & Safety	90%	89.36%	94.74%	94.37%	94.26%	93.88%	93.87%	93.53%	93.51%	93.27%	93.00%	93.20%	93.22%	92.61%	
	% in Date - Resus	90%	67.58%	71.41%	72.26%	70.93%	70.05%	69.96%	68.55%	68.13%	70.94%	72.37%	73.22%	74.48%	74.21%	
Capacity	Starters	-	139	170	167	612	287	286	229	139	212	201	190	188	165	
	Leavers	-	101	111	138	456	152	184	107	127	136	127	156	142	109	
COVID*	Absence		59	89	274	244	157	169	170	308	456	329	424	0	97	
	Vaccination % First Dose		89.65%	89.65%	89.65%	89.65%	89.65%	89.65%	89.65%	89.65%	89.65%	89.65%	89.65%	89.65%	89.65%	
	Vaccination % Second Dose		86.23%	86.23%	86.23%	86.23%	86.23%	86.23%	86.23%	86.23%	86.23%	86.23%	86.23%	86.23%	86.23%	
	Clinically Extremely Vulnerable		10	11	9	10	12	12	11	7	10	10	11	0	0	

People scorecard - Commentary

Current Performance	Response / Actions Planned
Turnover • The June UHSussex Turnover rate (external leavers) stood at 9.37%. Although there has been a month on month increase since February 22 (from 9.00%), this figure still sits below the rate seen in June 21 (9.91%). • The UHSussex East Turnover rate (external leavers) in June stood at 9.55%. There has been a 1.74% point reduction over the previous 12 month period from 11.29% in June 2021. The average over the previous 12 month period is 10.03%. • The UH West Turnover rate (external leavers) for June stood at 9.15%. There has been a 1.25% point increase over the previous 12 month period from 7.9% in July 21. The average over the previous 12 month period is 8.19%.	• Work continues regarding rotas being issued 6 weeks in advance to support work/life balance and improved retention, this is monitored via the EWD steering group. • Refreshed governance processes are being developed to support the above i.e. nursing and midwifery workforce steering group, this will also focus on retention and sickness for the nursing workforce group. • Ongoing COM implementation should further improve stability of leadership, structure and reporting lines. New divisional structures were implemented for Surgery RSCH & PRH, Surgery WH & SR and the new Trust-wide Specialist division from 4 July. Further work is underway to implement Trust-wide restructures for Clinical Central Services, Cancer and Children's & Women's divisions. • There is work to monitor the turnover and engage with overseas recruits on ensuring retention of these staff.
Sickness Absence • In May the UHSussex one month Sickness Absence rate was 4.4% and the 12 month rate 5.08%. • The May UHSussex East in month Sickness Absence rate was 4.63% having reduced from the previous 12 month high of 6.03% seen in March 22. The average in month absence over the previous 12 month period is 5.33%. The 12 month Sickness Absence rate is 5.59% which has seen an increase from 4.54% in July 2021. The current in month absence split is 2.02% Short Term and 2.61% Long Term (28 days or more). • The UHSussex West in month Sickness Absence rate for May was 4.13%. This represents a 0.39% point increase from July 21 when the rate stood at 3.74%. The average in month absence over the previous 12 month period is 3.78%. The 12 month Sickness Absence rate is 4.77% which has seen an increase from 2.97% in July 21. The current in month absence split is 1.98% Short Term and 2.15% Long Term (28 days or more).	• National changes to covid sickness arrangements have been announced this month and are being implemented in the Trust. In brief this means that from 7 July 2022 any new sickness absences due to Covid-19 will be treated in the same way as any other sickness absence with no additional sick pay or leave. • From mid June the ER Team have set up a small project team of 2 ER Advisors to focus 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 project is for an initial 3 month period and data at the outset identified 273 LTS cases across the Trust. Linked to the covid changes above the team are identifying all long term covid absence cases and ensuring they are being managed appropriately. • The lowest in month sickness rate in the RSCH/PRH clinical areas is Women and Children at 4.22% with CCS the highest at 4.46%. Overall though, Facilities and Estates is the highest area at 8.42% In terms of staff groups , Additional Clinical Services is the highest at 9.36% and Ancillary remains high at 9.19%. • Data breakdown for SR and WH hospital based divisions and staffing groups are not yet available. • 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.

People scorecard - Commentary

Current Performance	Response / Actions planned

Appraisal
 	
• The June UHSussex (non medical) Appraisal rate stood at 76.93% having risen 4.97% points since March 22 (71.96%). The previous 12 month average is 75.62%.
• The UHSussex East (non medical) Appraisal rate for June stood at 74.66%. In comparison, the July 21 rate was 75.53%.
• In UHSussex the West (non medical) Appraisal rate for June was 79.46%. In comparison, the July 21 rate was 84.71%.
	• Compliance will continue to be a focus at Divisional SDR's
	• The SurveyMonkey appraisee survey is currently live. As at July 2022, 551 staff have completed (c. 18%). Key results:
	    85% agreed they received useful feedback during their appraisal
	    86% agreed their appraisal was a positive experience overall
	    89% felt safe to talk about personal issues if they wished during their appraisal
	    92% agreed that they had the opportunity to discuss all the topics they wanted
	
	• These positive results are not yet fully translating into the NHS Staff Survey appraisal questions.

STAM • The UHSussex STAM compliance rate stood at 86.09% for June. The average over the previous 12 month period is 84.03%. • The UHSussex East STAM compliance rate for June stood at 89.48%. The average over the previous 12 month period is 85.74%. • The UHSussex West STAM compliance rate for June stood at 82.67%. The average over the previous 12 month period is 82.5%.	• June 2022 – all staff continue to be encouraged to complete outstanding STAM requirement as part of the One UH Sussex programme • All STAM subjects have increased compliance across most modules and only one still red across the Trust - Resuscitation although a plan to drive up is in place through providing more in-situ training rather than general groups • Focus is currently on our worst performing areas to drive up compliance particularly with online training at SRH/WGH and f2f at RSCH/PRH • 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. • PRH/RSCH sites have now achieved above 90% compliance in 4/9 modules, 4/9 modules are in the 80%-89% range and 1/9 is below 80% • WGH/SRH sites have not achieved 90% compliance in any modules with 7/9 in the 80%- 89% range and 2/9 are below 80%.
Vacancy • The June UHSussex Vacancy Rate stood at 8.97%. The average over the previous 12 month period is 8.24%. • In June the UHSussex East Vacancy Rate stood at 8.76%, this represents a 0.43% point increase from July 21 when the rate was 8.33%. The average rate over the previous 12 month period is 7.22%. There are currently 756.77 FTE vacancies across East. • The June UHSussex West Vacancy Rate figure stood at 9.2% which represents a 0.51% point reduction from the same position in July 21 when the rate was 9.71%. There are currently 687.71 FTE vacancies across West.	• International nurse recruitment business case has been approved for an additional 300 nurses. • Experienced Head of Resourcing & Talent has been appointed to increase internal resourcing capacity • Appointment of Matron for Nursing Workforce has allowed a strong focus on HCA recruitment. • New resourcing structure confirmed and out to advert for vacant resourcing posts, this will increase administration capacity. • Key roles in new clinical operating model appointed to and work continues with the Chief Operating Officer regarding hospital operations director and site nursing director posts

People risks and forward look

- Q1 & in to Q2 has remained 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). The principle people risks (as discussed at the People Committee) remain around:
  - Mainatining sufficient staffing for the levels of activity / demand being experienced
  - Covid absence
  - Future vaccination (flu and Covid)
  - Health and wellbeing of staff
  - Staff stretch and the impact of that on their and patients' experiences

- Qs 3&4 of 2022-23 provide opportunity to re-focus and re-invigorate current programmes of work and re-prioritise. There is a review of Trust True Norths, including People, and the breakthrough objective and other work to support. 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.

Sustainability

Integrated Performance Report Section

NHS
University Hospitals Sussex
NHS Foundation Trust

Sustainability Summary

- In 2022/23, the Trust is operating under a new financial framework, with block funding arrangements continuing on the basis of H2 2021/22.

- Within funding allocations there has been an increased efficiency requirement applied, reduced funding for COVID and a significant change in income recovery for elective activity.

- The Trust submitted a deficit plan of £12.55m on the 28th April 2022, for 2022/23; this related solely to excess inflation.

- NHSE advised all ICS and Provider organisations of additional funds to be made available to support excess inflation costs and a few other specific pressures, £1.5bn nationally.

- Acceptance of the additional funding was based on an ICS plan to deliver break-even, required all organisations to also break-even.

- UH Sussex received £9.3m to fund excess inflation costs, and identified £3.3m additional efficiencies to allow a balanced plan to be agreed.

- The Trust submitted a break-even plan on the 20th June 2022.

Sustainability True North – Financial Plan

The Trust's True North domain for sustainability for 2022/23 is 'living within our means providing high quality services through optimising the use of resources' which is measured through the metric of delivering the Trust's Financial Plan.

- 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 year-to-date performance as at the end of Q1 is a £4.88m adverse variance to plan.

- Cash balances are £78.9m, which is in line with the Q1 plan.

- The capital expenditure for the year-to-date is £0.07m above plan.

- At the end of Q1 the efficiency programme delivered £5.4m in line with the plan.

Sustainability Key Metrics

			R
I&E £k	**YTD Plan**	**YTD Actual**	**Variance**
Income	(330,086)	(326,520)	(3,566)
Operating Costs	329,074	331,341	(2,267)
Finance Costs	5,375	5,060	315
Performance Adjustments	433	(201)	634
Overall performance	4,796	9,680	(4,884)

Financial performance is £4.88m adverse to plan at the end of Q1. Key drivers are operational pressures in unscheduled care (£3.3m) linked to staff availability, flow and capacity; the net cost of International recruitment (£0.94m) and the risk

			G
Cash £k	**YTD Plan**	**YTD Actual**	**Variance**
	78,766	78,860	94

The cash balance of £78.9m as at the end of Q1 2022 is in line with the plan.

			G
Capital £k	**YTD Plan**	**YTD Actual**	**Variance**
3T's Phase 1	(9,749)	(9,659)	(90)
Operational Schemes:			
Medical Devices Replacement	(382)	(323)	(59)
Service Development	(5,760)	(5,980)	220
Critical Estates Infrastructure	(467)	(461)	(6)
Digital/CDC/Charitable funds	(483)	(490)	7
Overall performance	(16,841)	(16,913)	72

The year-to-date capital expenditure is in line with the plan. Global supply chain delays are a challenge and impacting delivery dates of medical devices purchases. Major programme works are ahead of schedule. 3Ts programme remains on track. The forecast outturn remains on plan.

			G
Efficiency £k	**YTD Plan**	**YTD Actual**	**Variance**
	5,453	5,454	1

The efficiency programme is £47.7m, this is constructed as follows:

• 3% efficiency target for cost reduction and productivity savings - £31.8m.
• Procurement Cost Avoidance efficiencies - £2m.

• Tapered reductions in COVID-19 expenditure - £7.2m.

• Return of non NHS income to 19/20 levels - £6.7m.

The year-to-date efficiency performance of £5.45m is in line with plan.

Sustainability – Risks

- The current level of elective performance is not delivering activity levels in line with the plan, by volume or value. There is a risk of clawback of funding at 75% of the income value of activity below plan.

- The cost to support urgent care demand either through bed escalation capacity, augmenting ED resources or the impacts on elective activity is emerging as a risk from Q1.

- Covid-19 funding made available to the Trust in 2022/23 has been reduced by 57% compared to 2021/22 but Covid-19 remains prevalent and cases have been increasing during Q1.

- Risk that the Trust does not have the capacity to deliver the level of efficiency required in addition to managing Elective Restoration & Recovery whilst urgent care and Covid-19 pressures continue.

- The Trust has received £9.3m of additional funding for inflation making the total inflationary funding equivalent to an inflation level of c. 5.5%. Current rates of inflation are running at 7-10%.

Sustainability - Actions & Recommendations

There are no actions required of the Board.

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

- The year-to-date performance as at the end of Quarter 1 is a £4.88m adverse variance to plan.

- The efficiency programme is £5.45m year-to-date, which is on plan.

- The risks have identified mitigating actions, with Executive level oversight.

- Detailed financial performance information has been shared with Sustainability Committee; who continue to provide oversight on behalf of the Board.

Systems & Partnerships

Integrated Performance Report
Section

Systems & Partnerships Summary Q1

- 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 June-22 , Q1

True North and NHS Constitutional Targets

A&E — 63.4%
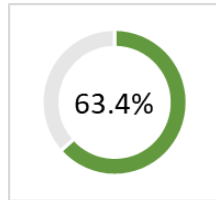
- The Trust treated 63.4% of patients within 4 hours of attending all A&E departments April to June 2022, and 64.5% June 2022. National performance was 72.1% Jun-22 and 72.5% Q1.
- There was renewed pressure on Trust emergency departments in particular with increases in long length of stay patients as a result of constrained flow, exacerbated by the Omicron Covid-19 wave's re-emergence.

RTT — 56.7%
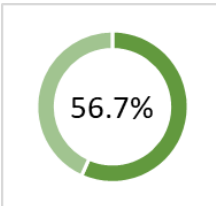
- The Trust has 56.7% of patients waiting longer than the target 18 weeks at the end of Jun-22. National performance was 63.5% May-22.
- The total number of patients waiting for elective treatment at the Trust is 112,029, 27 of which were waiting over 104 weeks, due to patient availability, or specialist complexity. 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 — 57.8%

- 57.8% of patients who commenced cancer treatment were treated within 62 days in May. National performance was 61.5%.
- There has been an increase in over 62 and 104 day prospective waits in June, from 389 Mar-22 to 534 for over 62 day patients, and from 95 patients March-22 to 120 June-22 for over 104 week waits.

DIAGNOSTICS — 25.0%
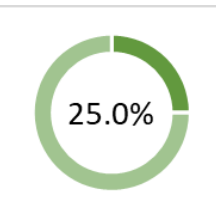
- The Trust had 25.0% of patients waiting more than 6 weeks for a diagnostic against a 1% target. This is an improvement of 1% relative to Mar-22 position of 26.0%
- The National average for May-22 was 26%
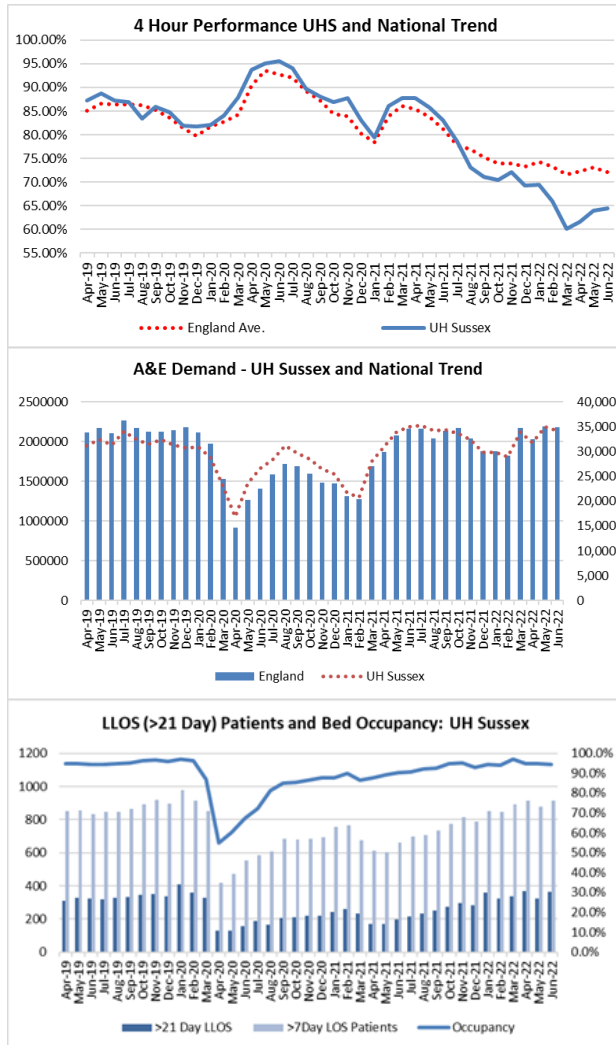
4 Hour Performance UHS and National Trend

A&E Demand - UH Sussex and National Trend

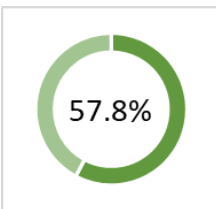

LLOS (>21 Day) Patients and Bed Occupancy: UH Sussex

- The Trust treated 63.4% of patients within 4 hours of attending all A&E departments April to June 2022, and 64.5% June 2022. National performance was 72.1% Jun-22 and 72.5% Q1.

- To ensure patient safety, the time to triage, treatment and mean waiting times are key areas of focus for the Emergency Department teams. These have been continued to be challenging in Quarter 1 2022.

UHSussex	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Time to Triage:	18.8	21.9	21.5	22.9	23.6	21.7	18.9	18.6	22.6	29.1	25.3	21.3	22.2
Time to Treatment:	99.8	109.5	113.0	115.8	109.8	106.6	102.5	99.2	114.8	143.0	130.4	128.1	134.1
Mean Waiting Time:	210.3	230.6	254.4	261.7	271.4	273.0	275.0	280.7	296.3	332.9	319.8	306.4	316.6

- 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.

- The Trust is re-doubling efforts to balance the discharge profile against the A&E demand profile on a daily basis (increasing morning discharges), and on a weekly basis, to rebalance the week-end net admissions versus discharges 'debt' so as to decompress Monday/Tuesday pressures.

- There have been material increases in the numbers of patients in the Trust's acute beds who are Long length of stay patients over 21 days.

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

RTT Performance Summary Q4

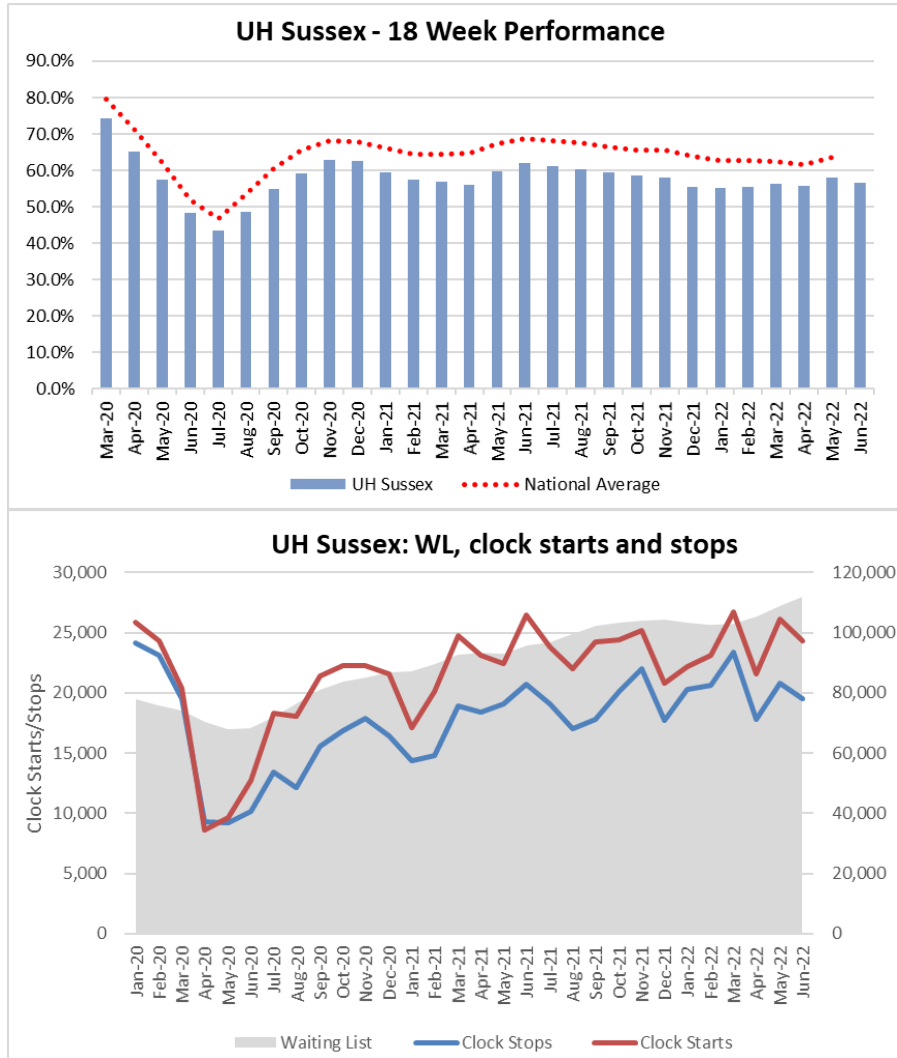UH Sussex - 18 Week Performance

UH Sussex: WL, clock starts and stops

- The Trust has 56.7% of patients waiting longer than the target 18 weeks at the end of Jun-22. National performance was 63.5% May-22.

- There were 7392 52 week breaches end June compared to 6369 at the end of March-22.

- Despite the operational pressures, good progress been made treating the longest waiting patients, and at the end of June-22 there were 27 patients waiting over 104 weeks (compared to 286 December-21), all of which unable to be seen for either patient clinical reasons or due to the specialist nature of the pathway.

- The Trust has comprehensive plans supported by use of the Independent Sector to continue to tackle longest waits (with the aim to eliminate 78 week waits by the end of March-23.

- There were 24,320 clock starts in Jun-22, 1.9% more than June-19. The Trust commenced 19,486 definitive treatments June-22, 5.2% less than June-2019. The waiting list grew by 3184 patients in May to 112,031. The waiting list has grown by 9% since the end March-22. This is mirroring the national trend for increasing patients on the waiting list, and illustrates supply is not keeping pace with increased demand.
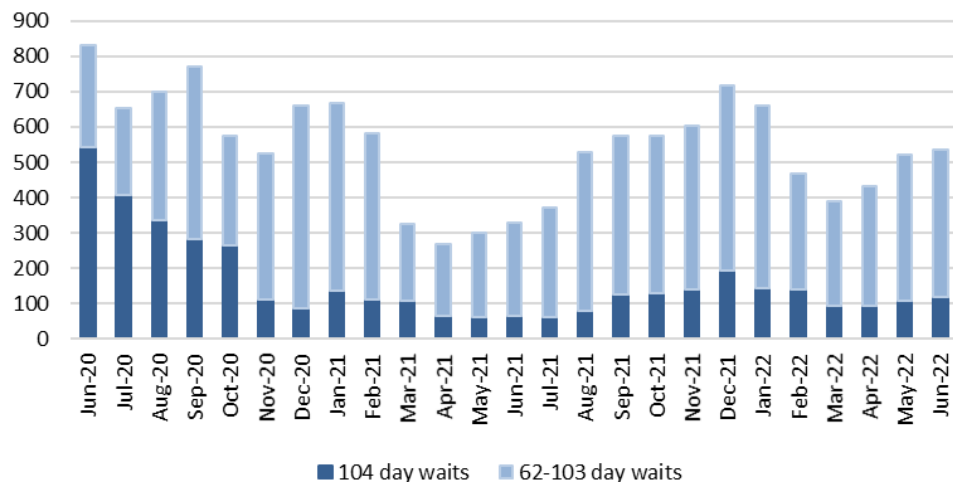
Cancer Performance Summary Q4

	2021/22		2022/23	
Cancer Metric	Feb-22	Mar-22	Apr-22	May-22
2ww	83.04%	80.60%	73.97%	81.48%
2ww Breast	46.24%	26.98%	52.28%	82.83%
31 day surg	96.43%	81.82%	78.13%	70.00%
31 day drug	100.00%	96.23%	100.00%	100.00%
31 Day - First	92.86%	93.41%	93.47%	92.07%
31 Day - Radiotherapy	100.00%	95.00%	97.69%	89.50%
62 Day - GP Refs	48.27%	56.87%	55.43%	57.78%
62 Day - Screening	57.61%	72.28%	90.00%	81.58%
62 Day - Upgrade	72.73%	68.18%	81.03%	66.10%
28 Day FDS	67.3%	69.9%	71.5%	69.8%

- Cancer 62 day cancer treatment targets were not met in May-22 with 57.8% starting treatment in under 62 days. National performance was 61.5%.

- There has been an increase in over 62 and 104 day prospective waits in June, from 389 Mar-22 to 534 for over 62 day patients, and from 95 patients March-22 to 120 June-22 for over 104 week waits.

- The Trust performance has improved against the new 28 Day Faster Diagnosis Standard in Quarter 4, with performance at 69.8% May-22 due to capacity constraints particularly in the skin anatomical site. National performance was 70.8% May-22

- The key driver for this has been the significant increases in cancer referrals over the last quarter, with volumes +8.2% above 2019 levels UHSussex West, and 19.7% UHSussex East.

- The Trust is implementing recovery plans which aim to recover 62 days prospective waits (to Feb-20 levels) and 75% for Faster Diagnosis Standards, by October-22.

UH Sussex: Over 62 Day Waits

104 day waits   62-103 day waits

Diagnostic Performance Summary Q3
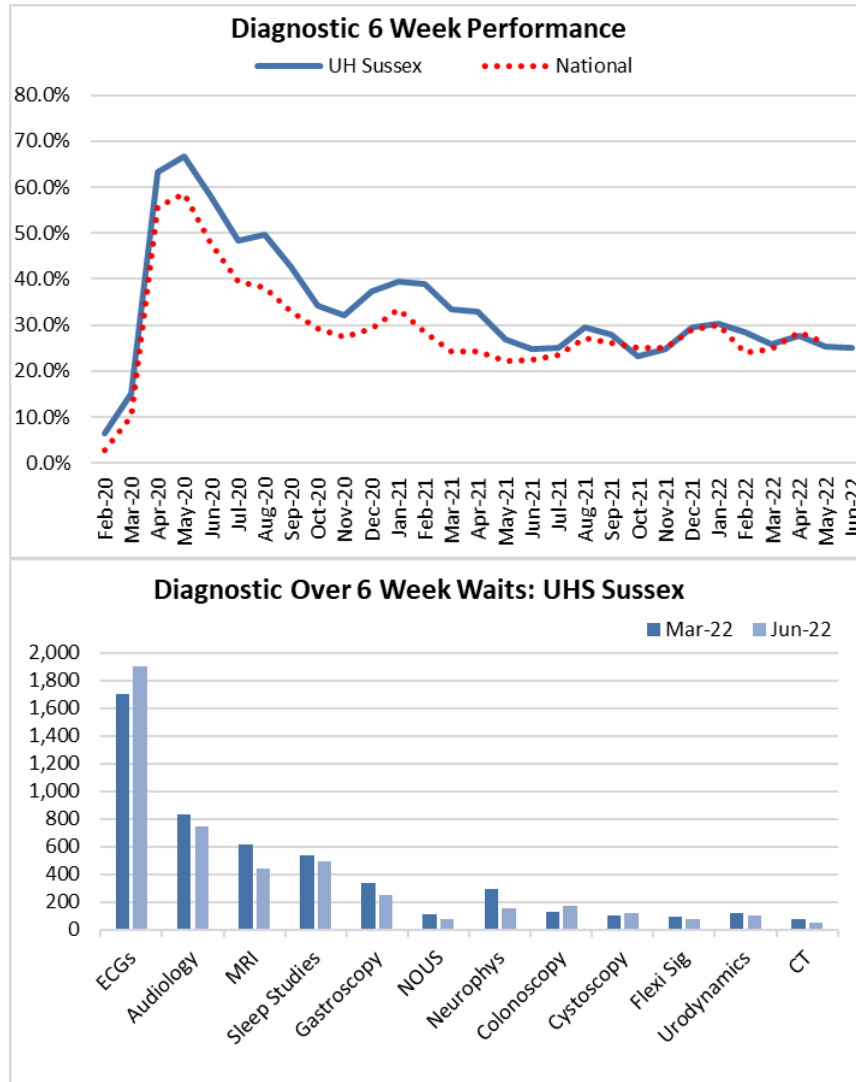
- UHSussex diagnostic performance against the 6 week target improved March-22 with 25.0% of patients waiting longer than 6 weeks for a diagnostic at the end of June compared to 26.0% Mar-22. National performance was 26.0% (May-22)

- Performance was most challenged in the West with 30.6% of patients waiting longer than 6 weeks for a diagnostic at the end of June, the same position as Mar-22. This continued under-performance as a result of 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, 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 MRI, Neurophysiology, and gastroscopy have seen significant reductions in 6 week backlog since Mar-22

Summary and Forward Look 2022/23

- Although Q1 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 the Trust has 'gone live' with additional UTC capacity which will enable increased clinical capacity in the departments to treat patients attending. The Trust is also conducting a pilot in Worthing A&E for booking patients into the UTC.

- The Trust is focussing efforts with partners to target MRD patients, and LOS for patients not on a complex pathway.

- The elective and cancer recovery plans are well developed and continue into Q2 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 urgent elective and emergency demand and the impact of Covid-19 on the capacity and workforce across all areas of delivery.

Agenda Item:	11	Meeting:	Board		Meeting Date:	4 August 2022

Report Title:	Patient Committee Chair report to Board
Committee Chair:	Alan McCarthy / Claire Keatinge acting as Committee Chair
Author(s):	Alan McCarthy / Claire Keatinge acting as Committee Chair
Report previously considered by and date:	

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

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

Implications for Trust Strategic Themes and any link to BAF risks		
Patient	✓	Assurances in relation to risk 1.1
Sustainability	☐	
People	☐	
Quality	☐	
Systems and Partnerships	☐	

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 July and was quorate as it was attended by three Non-Executive Directors, including the Trust Chair, an Associate Non Executive, the Chief Executive, the Chief Nurse, the Chief Medical Officer and the Chief People Officer. In attendance were the Director of Patient Experience, Engagement and Involvement and the Director of Improvement and Efficiency.

The Committee received its planned items including the reports on the respective Patient First True North, Breakthrough, Corporate Project and Strategic Initiative, the quarter 1 patient experience report, the patient experience strategy and the 2021/22 patient experience annual report. The Committee also received an update on the work being undertaken to harness the value of the Trust's patient first methodology in respect of health inequality improvement actions. 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 Board is asked to **ENDORSE** both the 2021/22 Patient Experience Annual Report and the Patient Experience Strategy

The Board is asked to **NOTE** the outcome of the Committees review of BAF risk 1.1 and that the Committee's view is that this risk is fairly represented and therefore this risk score was recommended to Board.

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Patient Committee	26 July 2022	Claire Keatinge on behalf of the Committee chair	✔	☐

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

True North

The Committee **RECEIVED** the patient experience annual report for 2021/22. The Director of Patient Experience, Engagement and Involvement updated the Committee on the Trust's activity in this area across the last year, reminding the Committee that they had within the regular quarterly reports received specific information on this work. The Director of Patient Experience, Engagement and Involvement drew the Committee's attention to the implemented changes within the Patient Experience Team structures, the key achievements that have enhanced patient experience which included the opening the sanctuary spaces for our patients. the offering of packs to patients to support with their discharge. The Director drew attention to examples of applied learning from patient feedback including an enhanced focus on inequalities in areas of dementia, mental health and visual impairment. The Committee **AGREED** the report was a balanced and fair reflection of the prior year and **APPROVED** the Trust's Patient Experience Annual Report for 2021/22 recommending this be provided to the Board for their information and endorsement. (see appendix 1).

The Committee discussed the identified common themes for patient dissatisfaction and recognised through other reports presented to this Committee and the Board that a lot of analysis had been undertaken to develop work to address waiting but that the work on patient communications and the attitude of were areas that the Trust should be also able to improve on. The Committee **AGREED** that through the use of the Trust's patient first methodology the Trust will be able to develop a targeted approach to improve these areas recognising that there are many and different causes of these levels of dissatisfaction. The Committee also reflected on the conduct of some members of the public and their interaction with our patients and staff is another area for attention.

The Committee **RECEIVED** the quarter 1 report on the patient experience feedback and the actions taken as a result of this feedback. The Committee **NOTED** that the Trust report is providing 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 especially in respect of feedback from ED. 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 and the Committee **ENDORSED** the Trust's decision to maintain a response target of responding to at least 65% of complaints within 25 days. The Committee **NOTED** as had been reflected in the prior year annual report the data indicating the key themes where patient experience could be improved, are linked to "waits" (waiting for

appointments and waiting on arrival), 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 delivery against 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.

Breakthrough Objective

The Committee **RECEIVED** the update on the delivery of the Trust's Breakthrough objective for 'Patient', this being the area where improvement action has the potential to have the largest positive impact on the True North. The 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, noting complementary work is dealing with the reduction of waiting time so this activity is about enhancing the environment and the support provided for those waiting. 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 was updated on how this improvement programme links to the Emergency Department Improvement Group. 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.

Strategic Initiative

The Committee **RECEIVED** the update on the delivery of the Patient First Improvement Programme Strategic Initiative from the Director of Improvement and Efficiency. The Committee **NOTED** the work being undertaken to refresh the Trust's developed strategic initiatives and corporate projects along with any revision to the True North breakthrough objectives. The Committee **NOTED** the timeline for this work was to have the strategic filter completed by the end of August with the deployment then following with the divisions in the autumn, noting that the Division continue to undertake the Strategy Deployment reviews against the current agreed improvement metrics. The outcome of the strategic filter will be reported to the next Board meeting. The Committee **NOTED** the level of PFIS maturity was fairly stable within the Trust but that with the planned levels of training completing their courses this will see an increase in level 4 maturity, those areas actively engaged in improvement projects utilising the improvement tools. The Committee **NOTED** the programme governance supporting the oversight and reporting of the programmes of work within each Patient First pillar, with each having a detailed project charter and established reporting into each of the respective Committee. The Committee **NOTED** the update from the Director of Improvement and Efficiency that the Programme Management Officer itself had taken an action to improve its own team's skills with the support of the Director of Patient Experience and Improvement to enable them to better consider and apply the patient experience lens to their work and support of the divisions. The Committee **ENDORSED** this action and recognised the improvement this will bring to their work.

Corporate Project

The Committee **RECEIVED** an update from the Director of Improvement and Efficiency on the Committee's assigned Corporate Project which had been refreshed into a Trust wide improvement programme supporting the launch of the revised clinical operating model. The project had been entitled One UHSussex and within the project there are a number of workstreams designed to aid with the clinical operating model transition. The Committee **NOTED** the update provided on the work undertaken within each workstream and through the update was **ASSURED** over their current status. The Committee **NOTED** the areas aligned to the developed scorecard metrics where further work is needed. The Committee also **NOTED** the degree of complexity contained in this project delivery due to the realignment of the Trust's activity reporting to the revised Clinical Operating Model followed then by the implementation of the new Patient Administration System (PAS) coupled with the levels of interim resources within the Clinical Operating Model. The Committee **NOTED** that the oversight of the PAS implementation is provided through the Sustainability Committee and there reporting to Board had confirmed they were tracking the mitigation of those project risks. The Committee **ENDORSED** the development of this project and the value the attention being given to transition to the new clinical operating model was of significant merit.

Patient Experience Strategy

The Committee **RECEIVED** an update from the Director of Experience, Engagement and Involvement on the developed 2022-25 Patient Experience Strategy which incorporated the initial feedback from the Committee members in response to the strategy on a page document and the wider engagement. The Committee **NOTED** how the voice of the patient has driven the strategy formulation. The Committee was updated on the strategy commitment priorities and the developing measurable outcome metrics set for these priorities.   The Committee **AGREED** the Strategy recommending this be provided to the Board for their information and endorsement. (see appendix 2).

ICS and System Collaborations

The Committee **RECEIVED** a report from the Director of Experience, Engagement and Involvement and the Director of Improvement and Efficiency of in respect of the Trust's developed actions to harness the Trust's Patient First methodology to reduce inequalities risks for our patients. The Committee **NOTED** the developed actions and **ENDORSED** their progress recognising that these action will strengthen the application of a patient lens within the Trust's methodology. The Committee **NOTED** that the focus on addressing inequalities had been referenced within a number of the updates provided to the Committee and is reflected positively within the Trust's developed Patient Experience Strategy. The Committee **NOTED** that the outcome of this work would feature within future reports to 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 meeting on the 17 May 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 and **NOTED** that the structure of these meetings is to change to create time in alternate meetings to allow for the coaching of the divisions with their respective improvement projects on consider the impact and improvement for patient experience.

The Committee **NOTED** that the Quality Governance Steering Group (QGSG) provides a formal detailed report to the Quality Committee but has a dual reporting line to this Committee. The Committee **RECEIVED** a verbal update from the Chief Medical Officer as chair of QGSG that confirmed there were no items referred to this Committee. The Chief Medical Officer reflected that QGSG maintains its focus on the Darzi quality dimensions and is aiding with the development and embedding of quality governance within the divisions

Risk and BAF

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

Across both of the patient and quality domains there are 93 risks for quarter 1, that have been raised that have the potential to have an impact on quality and or patient experience, which have been identified with a post-mitigation score of 12 or above. Of these risks five are identified with a current risk score of 20, these being the same as recorded in the preceding quarter. These highest scoring risks are :-

- 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 where the quality and people committees have oversight.

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.

Actions taken by the Committee within its Terms of Reference

The Committee **APPROVED** the Trust's Patient Experience Annual Report for 2021/22 and **AGREED** to recommend this to Board for their information and endorsement.

The Committee **APPROVED** the Trust's Patient Experience Strategy and **AGREED** to recommend this to Board for their information and endorsement.

The Committee **AGREED** to recommend the quarter 2 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 did not ask for any specific matters come back to the Committee but did reflect that there was merit in the Board being provided with information on what the patient will see from the new Friends and Family Test provider and that for the newly appointed NEDs the provision of information on the Patient First governance architecture would be a beneficial addition to their induction pack.

Items referred to the Board or another Committee for decision or action	
Item	Referred to
The Committee agreed to recommend to the Board both the 2021/22 Patient Experience Annual Report and the Patient Experience Strategy for information and endorsement.	To Board 4 August 2022
The Committee following a discussion and with reference to the reports received and the review of the risk report agreed to recommend to the Board that risk 1.1 within the BAF for which it has oversight is fairly represented.	To Board 4 August 2022

Patient Experience
Annual Report 2021/22

Contents

1. Introduction

The mission of University Hospitals Sussex – what we are striving to achieve – is to provide:

'excellent care every time'

All our efforts to do this put the interests of our patients first and foremost, and are underpinned by our values which were selected by our staff, patients and public:

- ► Compassion

- ► Communication

- ► Teamwork

- ► Respect

- ► Professionalism

- ► Inclusion

A person's experience starts from their very first contact with the health and care system, right through to their last, which may be years after their first treatment, and can include end-of-life care. The NHS Constitution[1] established the principles and values of the NHS in England. The principles guide the NHS in everything it does and principle four states: 'The patient will be at the heart of everything the NHS does'. The NHS has a long-standing commitment to offering high quality patient experience, as described in the NHS Patient Experience Framework and these values and commitments were re-iterated and strengthened in 2018 with the publication of the national Patient Experience Improvement Framework[2]. This offered support to providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

This commitment is also central to the University Hospitals Sussex Patient First Improvement system, in particular the 'patients' pillar. The true north ambition for this pillar is for patients to have a great experience of care every time, as measured by friends and family test with the aim of 95% or more of our patients reporting a good or very good experience.

This annual report describes the progress against the true north ambition as well as the insights and performance of the trust on patient experience for 2021/22.

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[1] [NHS Constitution for England - GOV.UK (www.gov.uk)](#)
[2] [2 NHS England » Patient experience improvement framework](#)

2. Strategic developments and improvements in patient experience
Patient experience as a pillar of quality

Good experience of care, treatment and support is increasingly seen as an essential part of an excellent health and social care service. The NHS has coalesced around the definition of quality set out by Lord Darzi in 2008 that care provided by the NHS will be of a high quality if it is:

- ► Safe
- ► Clinically effective
- ► Delivering a high-quality patient experience.

Quality assurance is a vital component of the trust's quality governance system. This supports a consistent approach to sharing and learning, reducing unwarranted variation, enabling interventions for improvement, ensuring visibility and accountability of actions, encouraging openness about learning and risk, and triangulating information relating to performance, patient and staff feedback and direct observation.

Throughout 2021/22 the Trust has made an unprecedented investment in its infrastructure to support leadership and application of quality in all aspects of the trust's delivery, across the three quality pillars of safety, effectiveness and patient experience. This includes:

- ► Creation of three new corporate director posts for each of the quality pillars
- ► Creation of integrated, trust-wide quality teams
- ► Embedding quality at all levels in the new trust clinical operating model

► Strengthened quality governance through a robust structure of reporting and accountability from the front-line to the trust board.

Improving how we deliver our patient experience functions

For patient experience, 2021/22 has seen a number of changes to strengthen the structures through which the functions are delivered. This includes:

► Consultation and re-structuring of services leading to the creation of integrated patient experience teams, with two distinct but inter-related functions (strategy and operations) with the operational arm including a centralised complaints team aligned to the new clinical operating model and place-based PALS functions
► Rapid deployment of changes in response to burgeoning caseloads and identified backlogs of complaints
► Re-configuration of work to level out caseloads and aid integrated working
► Implementation of weekly data to act as an 'early warning system' for patient experience activity
► Refreshed Patient Experience and Engagement Group (PEEG) forming a core part of the trust's quality governance structures
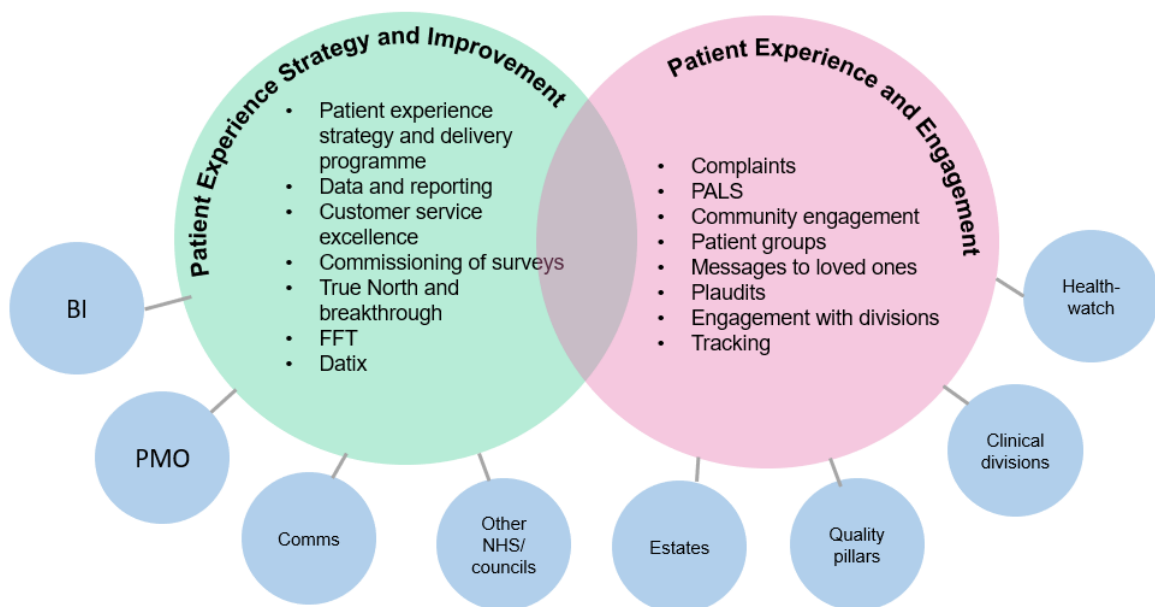
BI (business intelligence); PMO (programme management office)

Achievements in 2021/22

Despite the challenges of the pandemic, more than 90% of patients continue to experience good or very good care. This has been made possible by the progress on improving patient experience in many of the trust's services, a few of which are highlighted here.

Neonatal care

SRH chieved the 'Bliss Baby Charter' demonstrating quality family care

'Pets as therapy' (PAT) dogs have been back on the wards – including May and 'Dog-ter' Scooter

Discharge

A discharge pilot, supported by the Love Your Hospital charity has provided patients with 'comfort packs' clothes and essentials for a safe and comfortable discharge for those in need

Volunteers

Trust volunteers provide exception support to patients, and staff have been going 'bare below the elbow; to provide patient support in ED at RSCH making drinks and providing comfort

Patient education

One example is the TB teams at SRH where staff have been on site to educate patients about their condition

Chaplaincy

New chapel opened at PRH offering a place of sanctuary for patients and staff

Dementia

Trailblazing and promoting the exciting opportunities that working with people with dementia can offer – UHSx is the first trust to offer a degree/ masters module in dementia and other trusts are now following are lead.

Facilities

New facilities including the new operating theatres at PRH

3. True north ambition for patients

True North

Our patient feedback tells us that most of our patients get excellent care each time they use our services – more than 90% of patients report their care as good or very good (Friends and Family test, 2021/22).

During 2021/22 feedback was received from a wide range of sources, including Friends and Family Test (FFT) feedback, national and real time patient surveys and Patient Advice Liaison Service (PALS) concerns and formal complaints. These insights inform the extent to which the true north ambition has been met.

Consistent with the patient first methodology, during 2021/22 a refreshed 'A3' for the patient true north was created, with counter measure summaries produced monthly and shared at the trust and patient committee SDRs each month to report on progress and encourage support and challenge across the trust and its governance.

The trust-wide average FFT satisfaction rate was 91% and as such the true north ambition of 95% was not met. It should be noted that both locally and nationally, collection of FFT data was impacted by the pandemic, with fewer patients accessing services during the covid waves.

<u>Figure a: FFT response rates and satisfaction 2021/22</u>
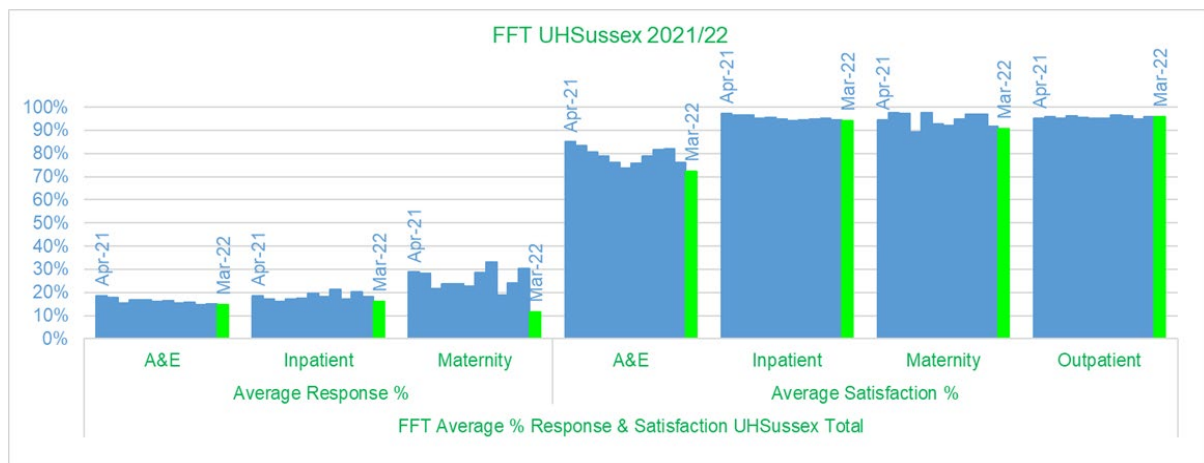
As is demonstrated by the graph above, satisfaction levels varied between touchpoints with satisfaction highest in maternity and outpatients, both of which remained over or close to 95% satisfaction over the year, in line with or exceeding national averages (94% inpatient and maternity, and 93% outpatients). Inpatient satisfaction varies between wards and sites, with satisfaction overall higher at Worthing and St Richards Hospitals (97.5%) than at the Royal County Sussex Hospital (RSCH) and Princess Royal Hospital (PRH) at (91.5%).

Lowest levels of satisfaction were with EDs, with Worthing and St Richards ending 2021/22 with a satisfaction level of 74.4% and RSCH and PRH at 79.3%, below the national average of 81%.

Breakthrough objective

The patient breakthrough objective – the area that if improved will be most effective in shifting the dial towards achievement of the true north ambition – therefore focused on EDs. (Accident and Emergency Departments). When FFT data was analysed, the most prevalent theme in negative comments related to waiting and the % of negative comments relating to this increased from 33% in March 2021 to 51% in October 2021.

Figure b: satisfaction and negative response themes with A&Es
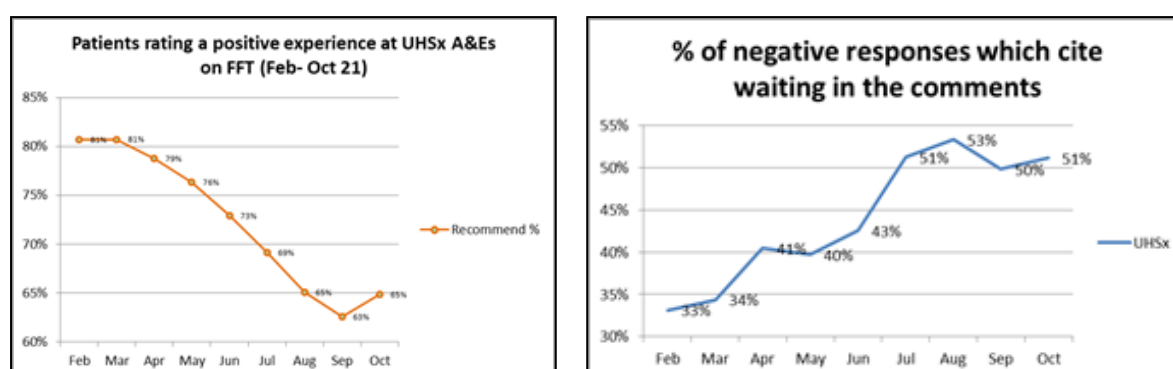
Through the first few months of 2021/22 positive experiences reported by FFT followed a downward trajectory. Prevalent themes within 'waiting' comments include the waiting time, conditions, communication and processes.

Figure c: % negative comments relating to waiting by site and % reporting a positive experience by site
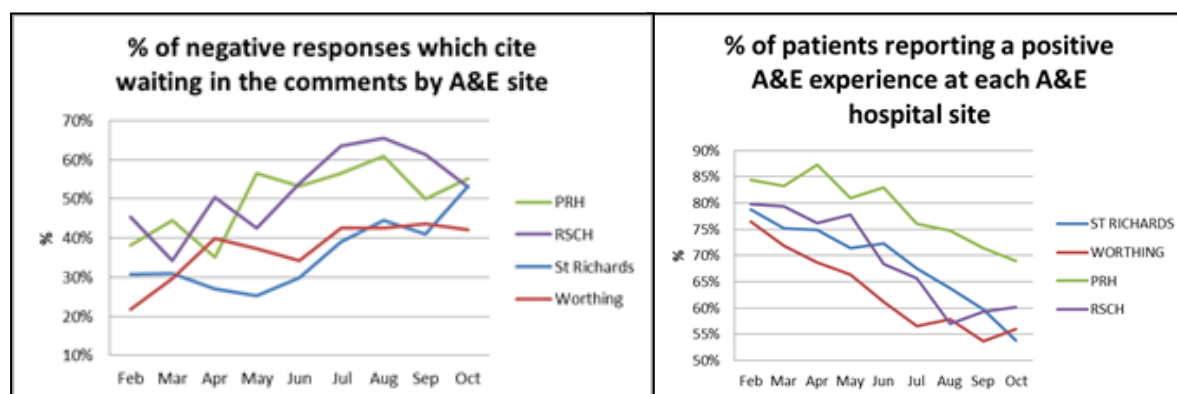
Further analysis of this data identifies the critical customer requirements:

► "I want my wait to be a reasonable and appropriate amount of time"

► "I want to feel safe and comfortable whilst I wait"

► "I want my pain/presenting problem to be manageable whilst I wait"

► "I want to know what is happening throughout my time in A&E"

As such, three priority themes were identified for focus:

► Waiting time

► The experience of waiting

► Communication

Figure d: breakdown by % of negative comments relating to waiting by sub-theme

Theme	RSCH	PRH	SRH	Worthing
Waiting time	52%	59%	53%	55%
Waiting conditions	25%	13%	14%	14%
Waiting circumstances	8%	8%	8%	8%
Communication	5%	6%	8%	6%
Total	90%	86%	83%	83%

With regard to waiting time, the key patient waiting points at A&E are:

► Waiting time from 'check-in' to triage and triage to being seen – this varies between sites.

► Time to triage has increased throughout 2021 at all sites with the exception of PRH. Waiting time from triage to being seen is also showing an upward trend at all sites.

Figure e: waiting times in A&Es by site
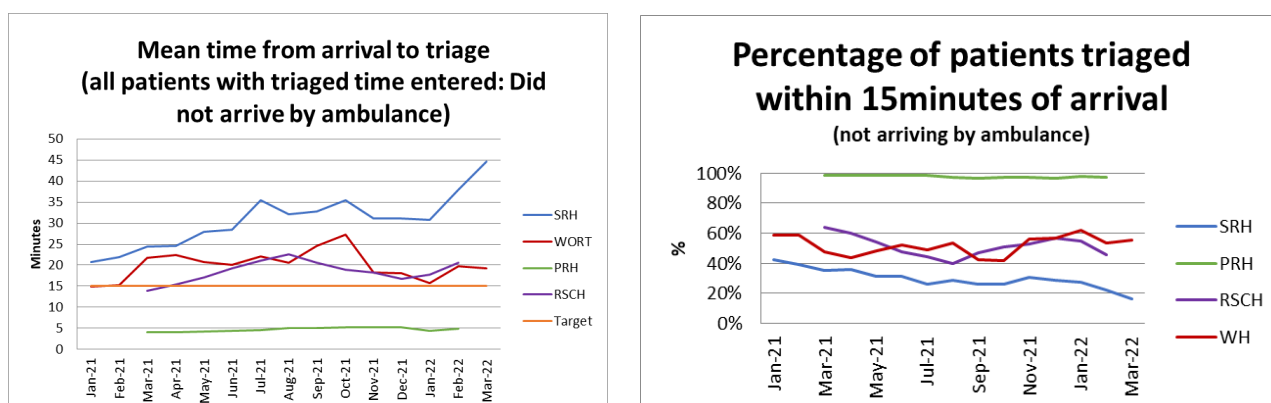
Reducing waiting times is a breakthrough objective under the Strategy and Partnerships pillar, and due to the impact of the pandemic and increases in demand for emergency care, the position became more challenging through 2021 which the urgent and emergency care board continue to respond to. As such, the patient breakthrough objective has focused on the experience of waiting to influence the patient true north objective.

To better understand waiting experience and communication in November and December 2021 walk throughs (also known as gembas) of all four A&Es were undertaken, following the patient journey, engaging patients and identifying opportunities for improving the patient experience of the wait (see figure f).

Figure f: ED gembas of the patient journey - insights
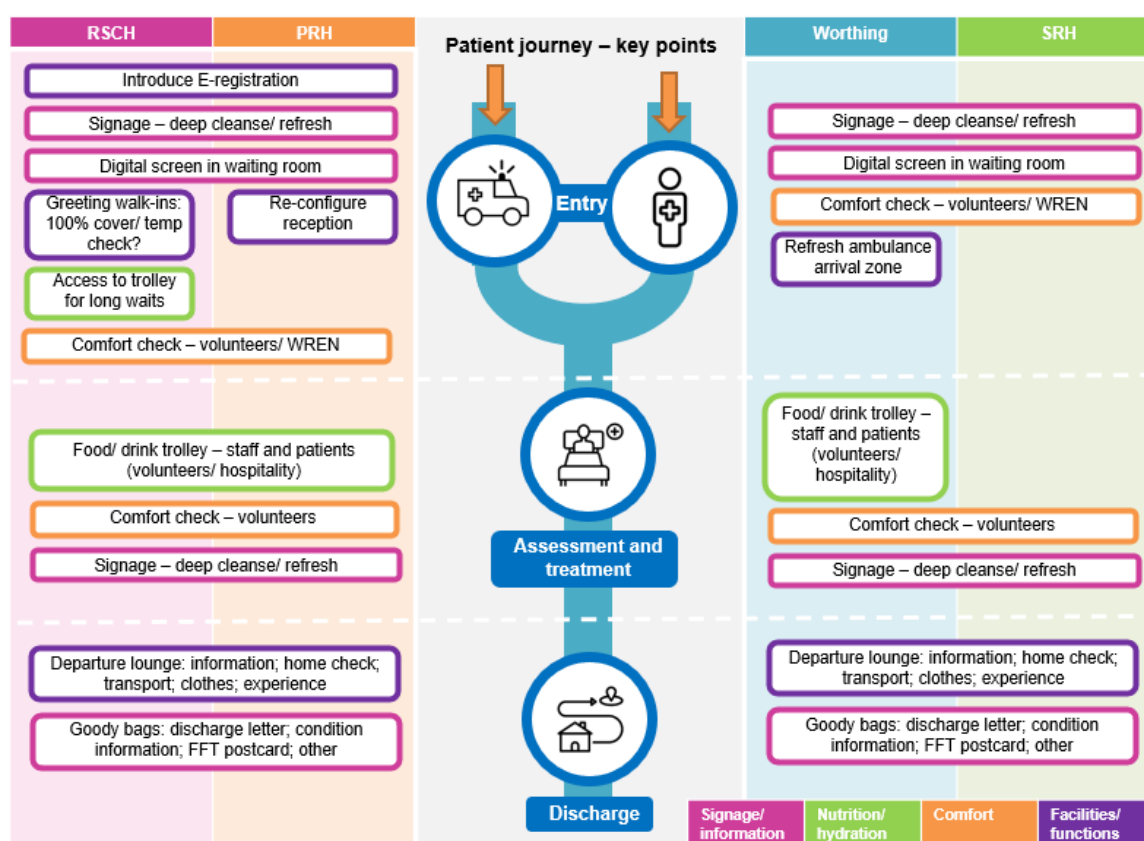
The gemba insights generated the following priorities for action on one or more sites:

- Understanding the potential benefit of using e-registration at Princess Royal and the Royal Sussex County as used currently at Worthing and St Richard's Hospitals.
- Standardising the greeting and entry protocol regarding temperature checks
- Cleansing congested posters and information that makes navigating the patient journey more complex

- Increasing messaging using digital screens

- Improving signage for way finding to reduce congestion (RSCH)

- Access to refreshments for patients in waiting area (RSCH and Worthing) and in majors (RSCH)

- Comfort checks in waiting areas

- The arrival environment for ambulance patients (Worthing)

- Reception (PRH)

- Patient information on discharge.

Some 'just do it' actions were progressed immediately, including digital screens and improved way finding signage. Others have followed the PFIS 'DMAIC' methodology (figure g).

Figure g: DMAIC model
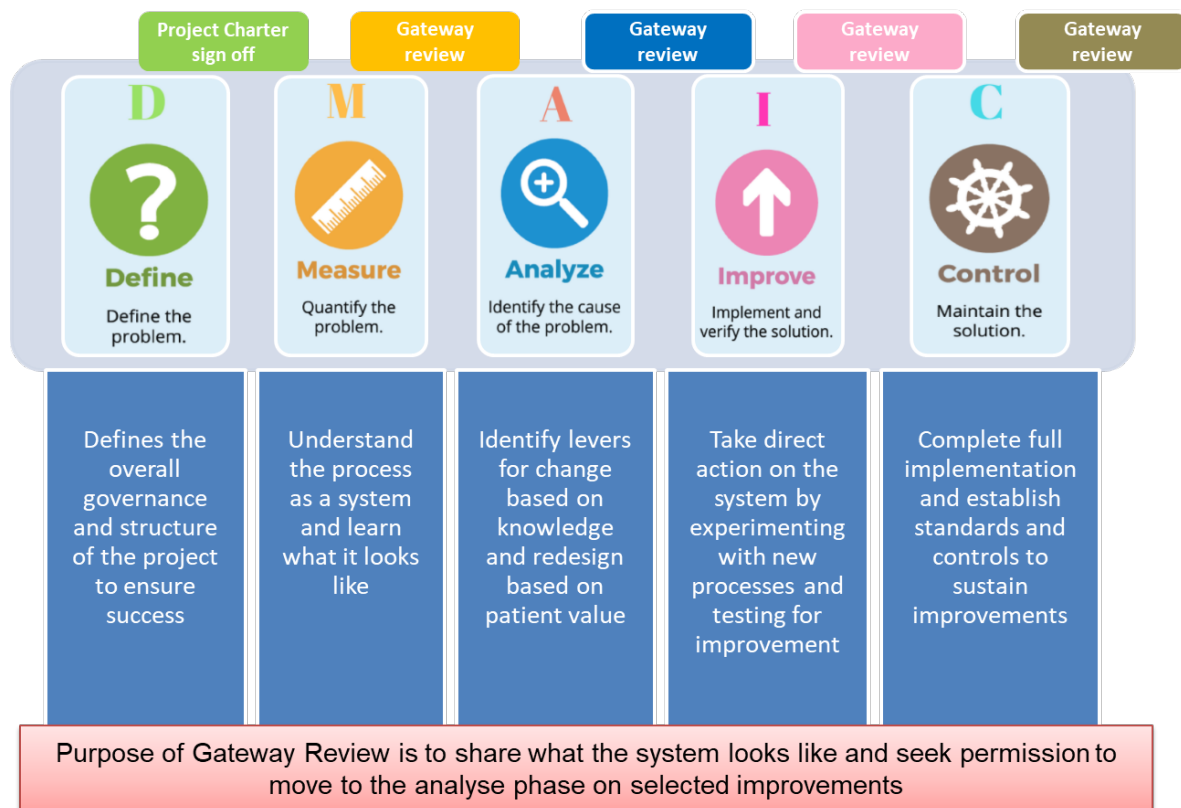
A gateway review was completed in January 2022 to progress to the analyse phase and further inform the action plan.

The breakthrough objective project made the following progress through 2021/22:

► Strengthened refreshment provision at RSCH with extended catering service hours and provision of overnight food parcels for patients out of hours

► Use of digital screens to improve information to patients

► Improved signage (see figure h)
► Planned improvements to patient arrival areas – the ambulance arrival area at Worthing and reception area at PRH to reduce queues and improve waiting experience
► Patient information leaflet improvements

Figure h: signage improvements at RSCH ED (before and after)
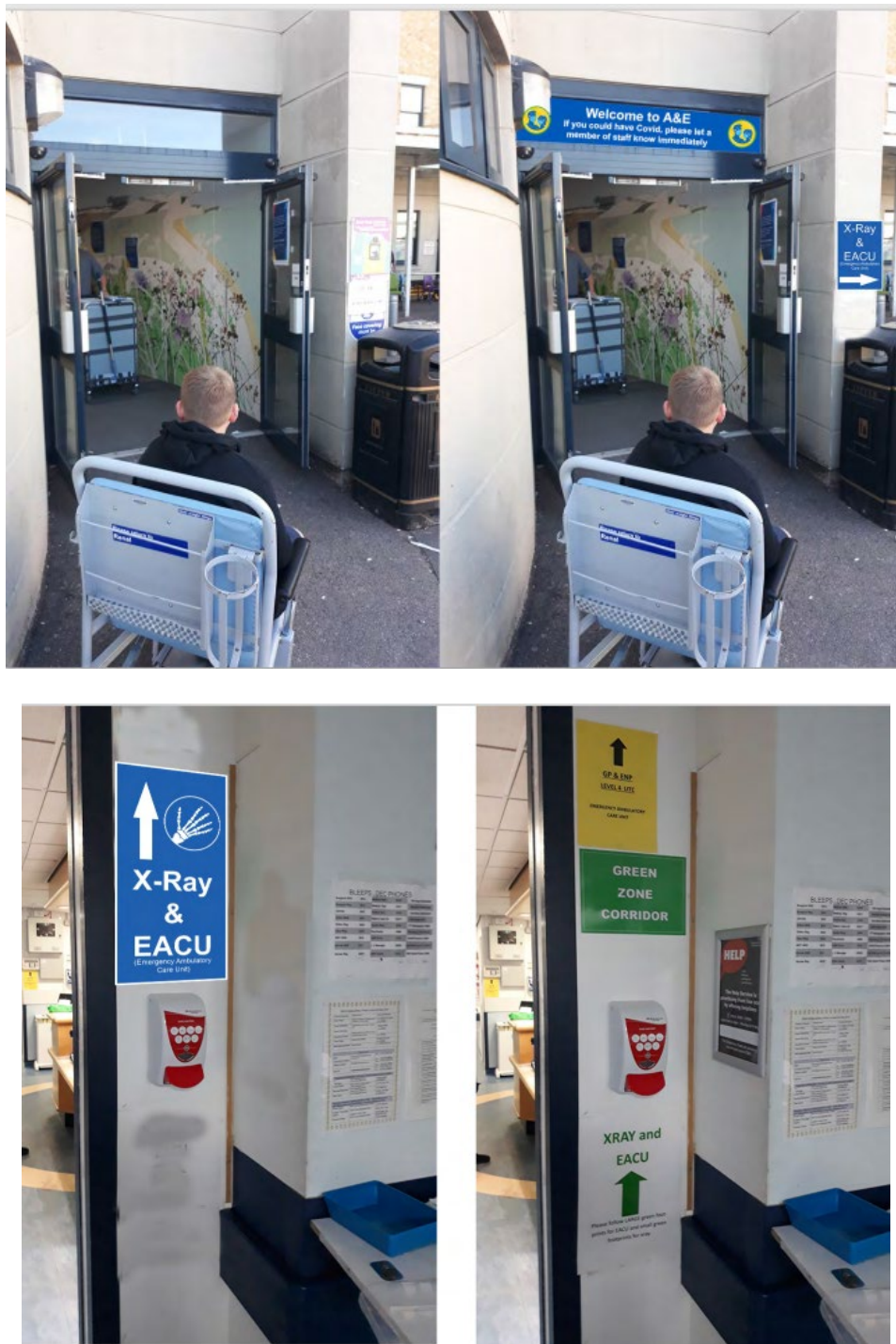
Due to the decreasing performance on 4 hour and 12 hour waits in EDs, FFT narrative data indicates that there are increasing levels of dissatisfaction due to waiting, in particular at St Richards and Worthing.

Figure i: % negative/ neutral comments citing waiting by site
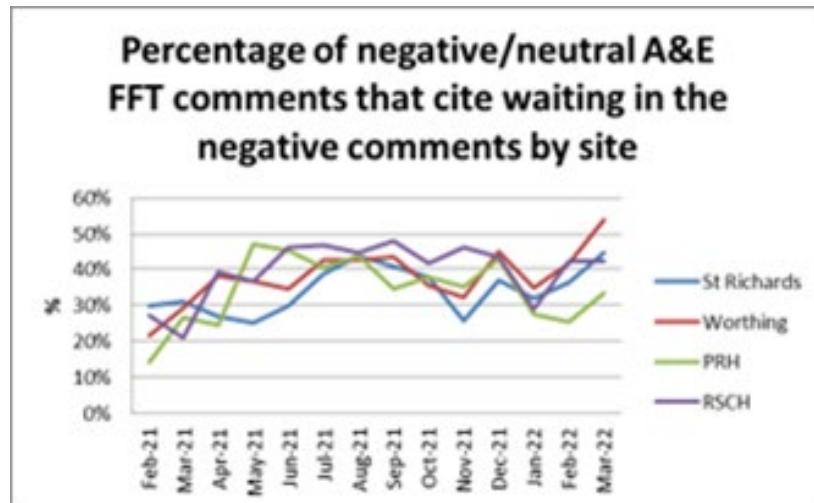
Further improvement continues into 2022/23, in line with the new patient experience strategy, including:

- ► Strengthened customer service
- ► Estates improvements
- ► Waiting time performance (4 hours and 12 hours) under the urgent and emergency care board.

4. Patient experience data – friends and family test

Friends and family test data throughout 2021/22 was affected by changes in patient use of the NHS during the pandemic, and surveys continued to be delivered by different providers for Worthing and St Richards, and RSCH and PRH. A new provider has been commissioned which will operate across all UHS sites from 2022/23. This will increase average uptake rates for FFT surveys as the methods used will incorporate more SMS and digital engagement methods which have a higher response rate than traditional paper-based approaches.

Results from the second half of 2021/22 demonstrate that satisfaction was above 90% on average across all touchpoints in all sites with the exception of ED (see Appendix A).

Figure j: Survey uptake and satisfaction for trust by touchpoints
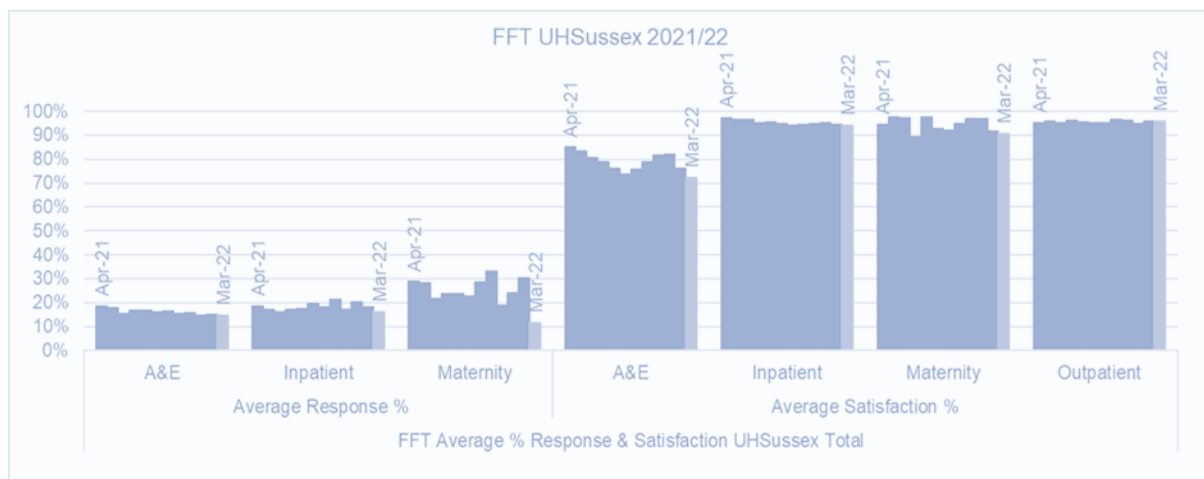
Within the inpatient survey, some wards and services achieve excellent FFT performance, with patient response levels regularly exceeding the true north ambition of 95% rating their care as good or very good, and where good take up rates for surveys are achieved. Those services are:

- ▶ **The Alex**- level 7 medical and surgical day care
- ▶ **RSCH** - level 9 haematology oncology/ kidney centre; and cardiac care unit level 6
- ▶ **PRH** – Sussex Orthopaedic Treatment Centre post anaesthesia unit.
- ▶ **SRH** – Bosham, Lavant and Selsey wards
- ▶ **Worthing** - Durrington

Increasing the uptake rate for surveys increases the validity of the data and broadens the voice of patients in shaping services at ward and specialty level. As such, increasing uptake rates working with new divisions and the new FFT provider is a priority for 2022/23 so that FFT data can shape clinically-led improvement activity.

5. Complaints and Concerns

For those wishing to make a complaint about their care, the NHS Complaints Standard was published by the Parliamentary and Health Service Ombudsman on **30th March 2021.** As well as reinforcing the NHS National Complaints Regulations, this sets out how organisations providing NHS services should approach complaint handling. The trust complies with this standard by:

- ► Welcoming complaints in a positive way
- ► Being thorough and fair
- ► Giving fair and accountable responses

An effective complaint handling system promotes a culture that is open and accountable when things do not go as they should. It creates an environment where staff feel supported and empowered to learn when things do not go as expected, rather than feeling blamed. It uses learning to improve its services and makes sure every member of staff knows their role in promoting a just and learning culture. It puts in place clear ways to demonstrate how the organisation uses learning to improve.

Our standards:

- ► Acknowledge within three working days (national standard)
- ► Provide a formal response within 25 working days in 65% or more of cases (local standard)

The number of complaints and concerns received by the trust increased throughout 2021/22, from an average of under 900 a month in quarter 1 and 2 to just under 1400 in quarter 4. And as such compliance with the local standard of 65% or more of cases provided with a formal response in 25 days was compromised.

Complaints and concerns received

In total, the trust received just under 12,000 concerns throughout 2021/22, including formal complaints and informal concerns (figure k)

Figure k: complaints and concerns received
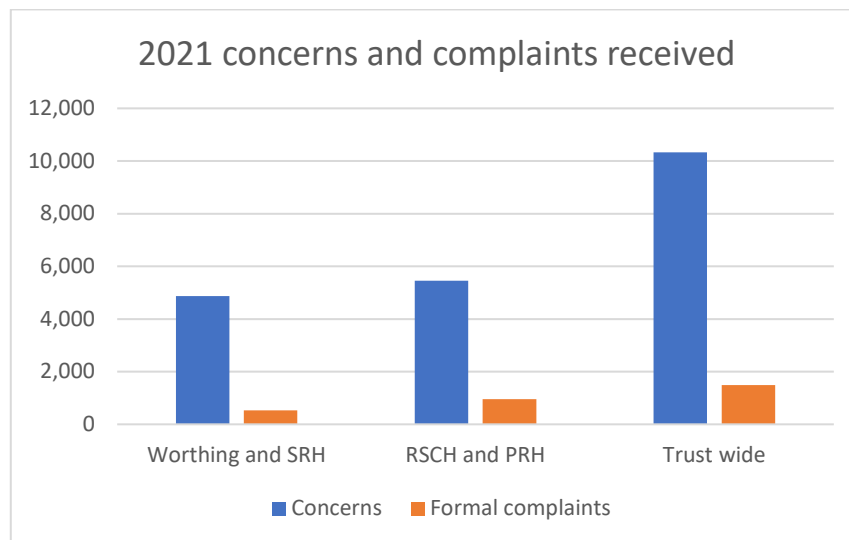
The highest number of concerns and complaints received were in medicine (Worthing and SRH) and both surgical divisions.

Figure l: Complaints and concerns received by division
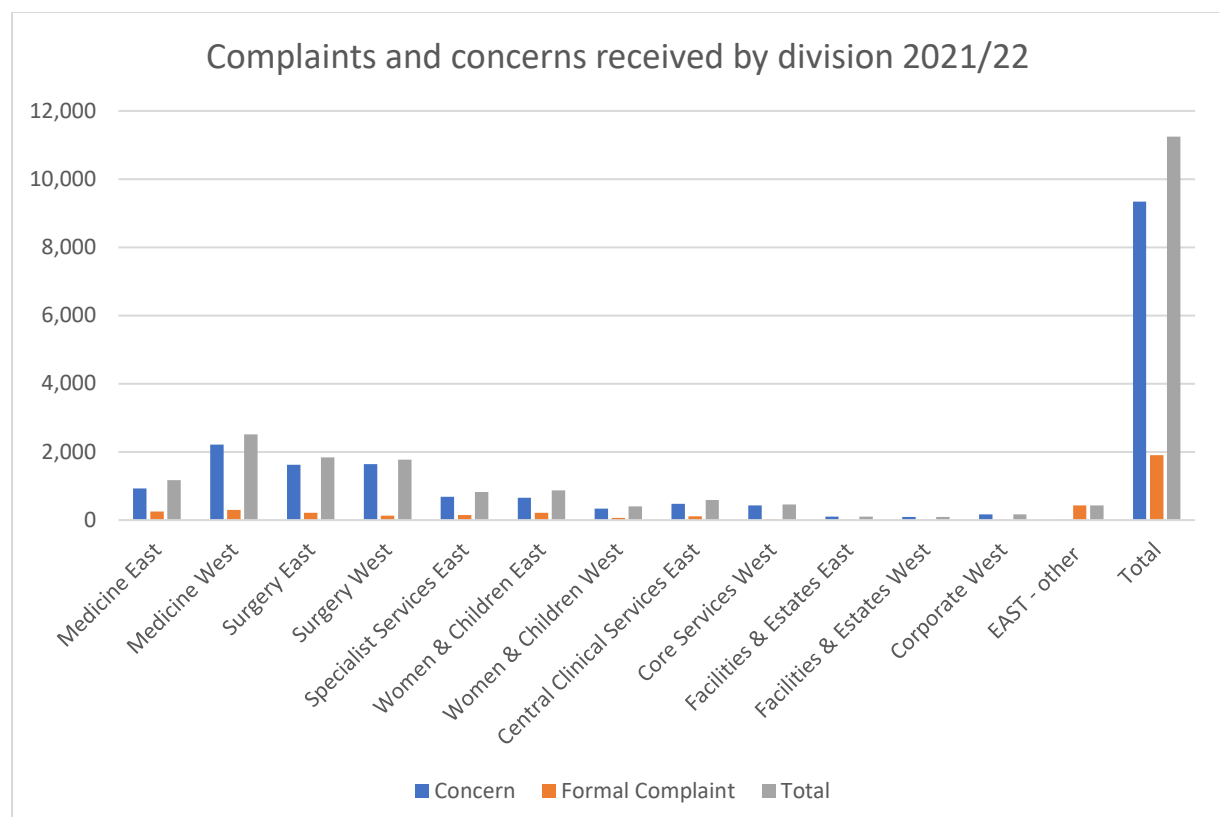
The site that received the most concerns and complaints in 2021/22 was RSCH, which is also the largest site (see Appendix A, figure ii).

When analysed by directorate/ specialty (which due to the different systems used was recorded differently in 2021/22) the most concerns were received relating to abdominal surgery (RSCH and PRH), acute floor/ED and Musculo-skeletal services (see Appendix A, figure iii and iv).

The trust has a local, aspirational target of 65% or more of complaints being resolved in 25 days or fewer. Performance against this was variable throughout the year and between divisions, with lowest % in divisions with the surgical divisions.

Figure m: % complaints resolved in 25 days

% complaints resolved in 25 days
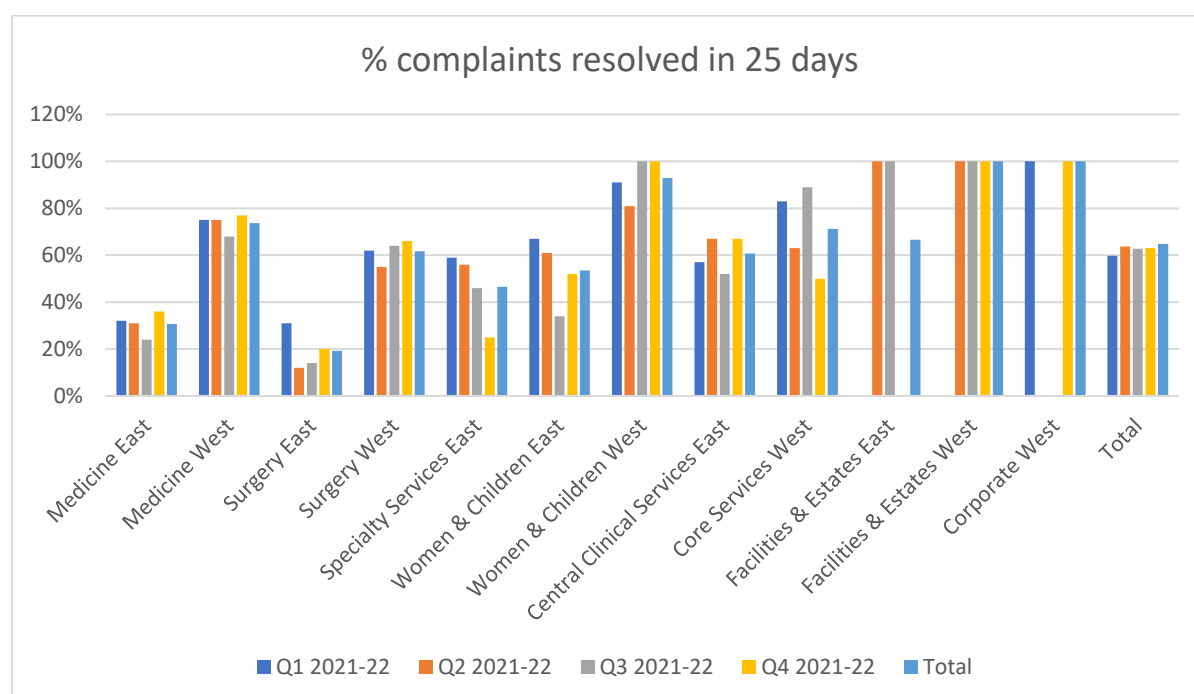
The most prevalent primary cause for formal complaints relates to clinical treatment, with staff attitudes and behaviours, communications, appointment dates and discharge also in the most prevalent themes. When concerns raised informally through PALS are analysed, the most prevalent themes are concerns about clinical treatment, dates for appointments, discharges, staff attitude and behaviour and communication.

Figure n: Most prevalent causes for complaint

Top 5 themes - PALS enquiries & Formal complaints 2021-22
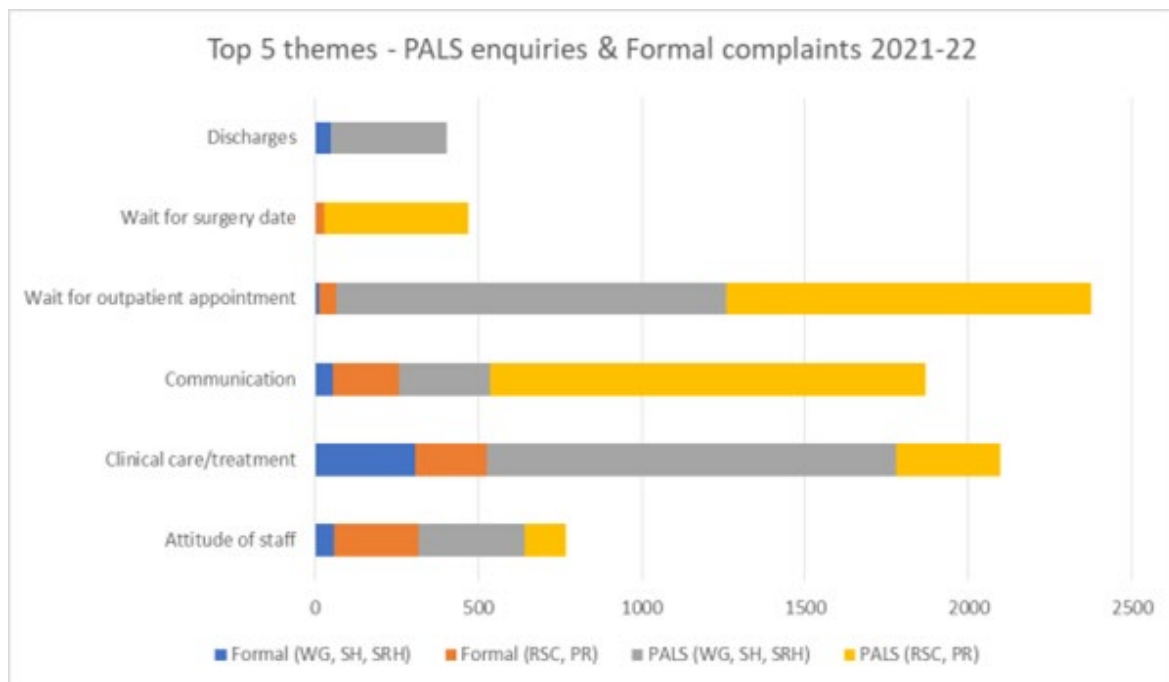
These prevalent themes are central to the patient experience strategy 2022-25.

Changes to complaints process and improvement activity

In 2021 risks relating to complaints management were identified. In October 2021 it was identified that there were a high number of outstanding and unresolved complaints at Princess Royal and the Royal Sussex County Hospitals. Since early 2020 complaints managed at these sites had been devolved into the clinical divisions, with each division having a complaints manager reporting in to a divisional quality and safety manager (DQSM). Management of the complaints investigation process rested with the divisions, with the patient safety and experience team having responsibility for leading the development of the Trust's governance framework and policy for the investigation and reporting of complaints.

An analysis took place of the circumstances and influencing factors resulting in the high open complaints numbers. The devolution of complaints management responsibility to divisions reduced the resilience of the trust's ability to respond to complaints during periods of high activity and staff absence.

There was also an increased volume of complaints in surgery, monitoring of complaints performance against targets was not undertaken routinely, and emergent risks were not escalated.

A number of actions were undertaken in response with increasing capacity for complaints coordination for the surgery division, weekly data reporting and new patient experience structures to strengthen resilience and peer support within the complaints function.

Furthermore, in 2022/23 the new Patient Experience Strategy will shape a new end to end process for responding to concerns, from receipt to triage to contact with patients and families to how concerns and complaints are managed and resolved. This will include a new process and policy supported by a cultural change and training programme with the new clinical divisions to ensure that the right response is received at the right time when patients' expectations are not met.

The actions taken during the year, reduced the total open complaints within the trust by 25% (see figure o). However case numbers remained high at the end of the year as complaints were increasing and responsiveness from clinical divisions was reduced due to operational pressures.

Figure o: complaints open cases following intervention to manage backlog in November 2021
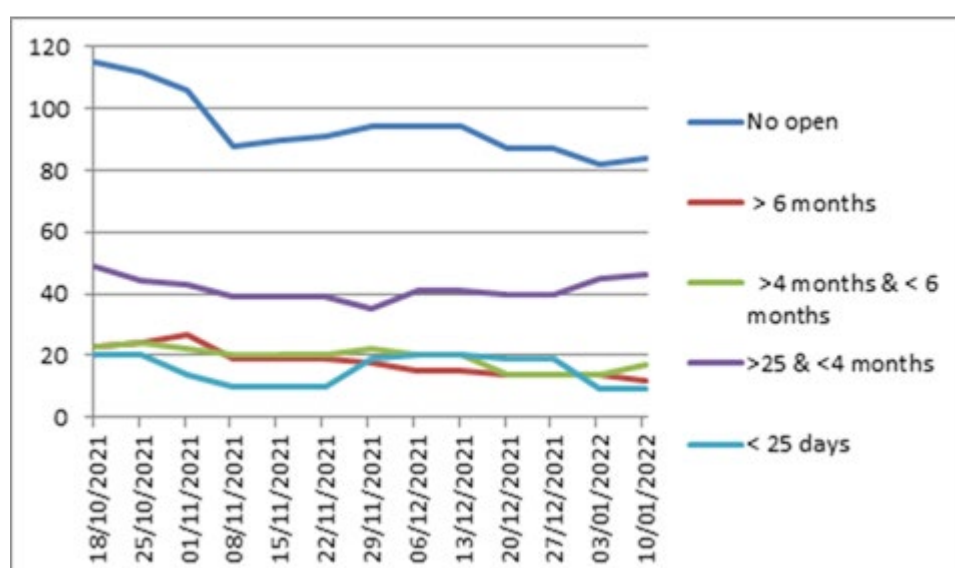
The current open cases remain higher than appropriate and manageable and the Head of Patient Experience & Engagement is now providing hands on support with individual cases

to manage levels of open cases. This will further reduce the number of long waits over coming weeks.

Maintaining manageable caseloads within the resources available is challenging as complaints are increasing and responsiveness from clinical divisions is reduced due to operational pressures. This will require ongoing monitoring and agile support from across the trust to prevent future recurrence of unmanageable backlogs and to maintain progress against the existing long waits.

Learning and action from concerns and complaints: You said, we did

Learning and improvement from concerns and complaints occurs at trust-wide, divisional and service or ward level, with the patient first improvement system (PFIS) methods supporting the voice of the customer in influencing improvement. Patient Experience stories are heard on a monthly basis at the Triangulation meeting where cross-divisional and multidisciplinary attendance ensures trust wide reflection and learning. Several examples are included in section 2 regarding in year achievements. Some further examples are included below.

Example one: Botolphs Ward

The carer of a patient contacted PALS to raise a concern about how the patient's clothes were handled. This was raised by the ward matron at the morning safety and improvement huddle using an improvement ticket. The ward introduced a new process for labelling clothes as a result.

Figure p: Matron-led improvement huddle in action on Botolphs Ward
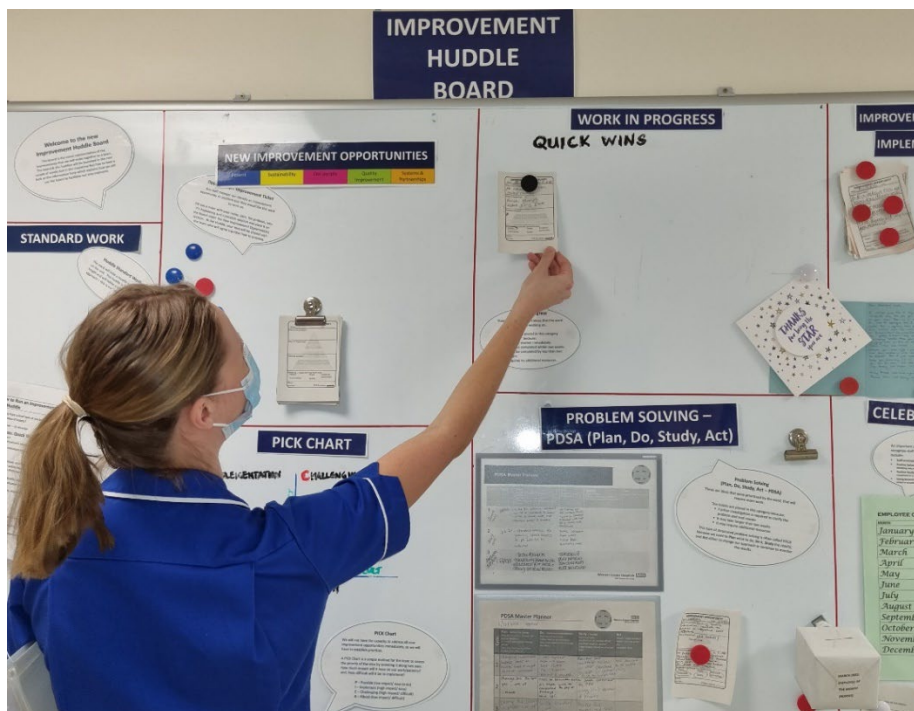
Example two: Surgery

A patient underwent a colonoscopy and despite sedation this was not effective and she experienced pain.

As a result of this complaint, a best practice guide regarding sedation and pain management was developed by the clinical team and random audits have commenced to review practice.

Example three: Emergency department at the Royal Sussex County Hospital

Friends and family test and complaints data identified that management of pain within the department was a theme in negative experiences. The divisional and departmental leaders worked together on an 'A3' and made changes, including strengthening the regularity of pain assessment in patients, as exemplified in the comfort round paperwork.

Figure q: excerpt from ED nursing comfort round paperwork

		Time	Initials	Comments
NURING DOCUMENTATION 1-2 hours in ED Time:	Observation			
	Pain score			
	Analgesia given if required			
	Is patient mobile and independent Yes / No			
	Location of property o With patient, verbal consent gained o Taken home by family/friend o Taken by police into evidence o Cashiers safe o Cut off and disposed (clothing only) Please complete property list if property remains in department.			If valuables are reported missing please complete following: Department searched Reported to Security ☐ Security reference number ☐ Comments: ☐

Example four: Cancer services

A breast cancer patient experienced distress when attending for her mammogram, biopsies and scans.   The patient was moved between procedure rooms and main reception in her clothes with wire marking in situ which left her feeling exposed and vulnerable.

In response, gowns are now provided for patients and a privacy screen was purchased. Frosted film has also been applied to the unit doors.

Equalities considerations

In a minority of concerns and complaints specific concerns were raised regarding care relating to a protected characteristic. The most prevalent was mental health followed by dementia and visual impairment.

Figure r: Concerns and complaints by characteristic
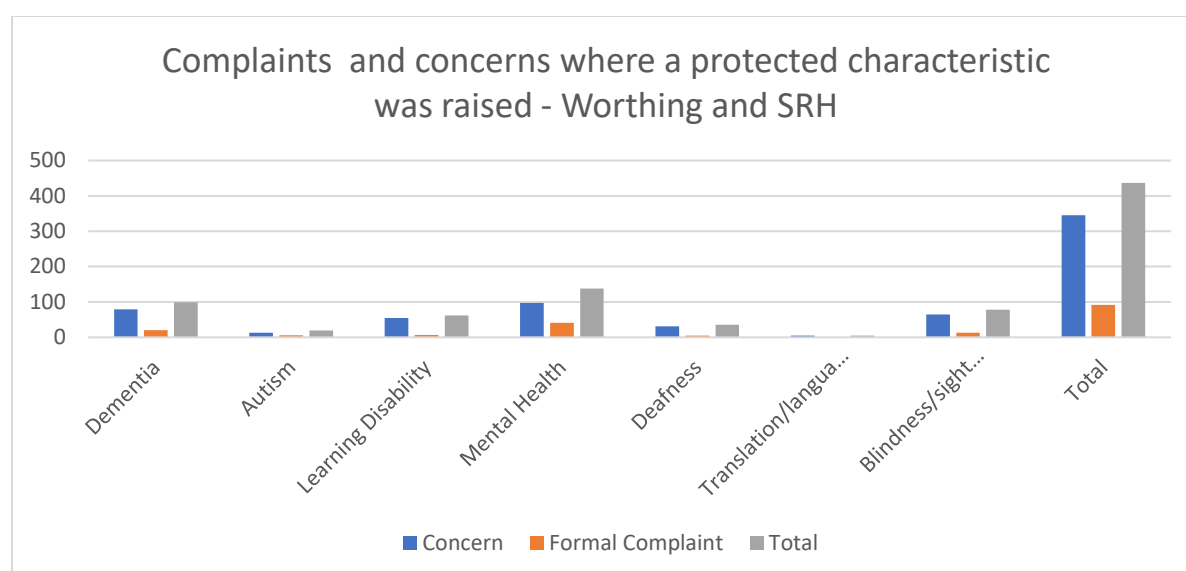
PHSO Cases

Four complaints were accepted by the PHSO for investigation in 2021/2022.

	Under investigation	Upheld	Partly upheld	Not Upheld
Medicine	1 (Worthing/ SRH)			
Surgery	2 (Worthing/ SRH)			
Specialist			1 (RSCH/ PRH)	

Of these, three remain under investigation. One complaint was partially upheld and resolved in accordance with the Ombudsman's principles of remedy.

The complainant accepted a goodwill payment of £150.00 in recognition of her distress during and after the days following her orthopaedic surgery. Evidence was also provided of the changes that we have made to ensure that staff complete the consent process in line with guidelines and that they properly document these discussions.

6. Compliments and plaudits

The trust received over 2000 plaudits in 2021/22. The number of plaudits is dependent on divisions sharing the compliments they receive for recording centrally, so this is expected to be an underestimate of the plaudits received by the trust.

The highest number of plaudits are received by the surgical divisions, followed by medicine.

Figure s: Plaudits by division

Plaudits received (average quarterly)

■ medicine ■ surgery ■ Womens and children's ■ Core/ central clinical services/ specialist ■ other
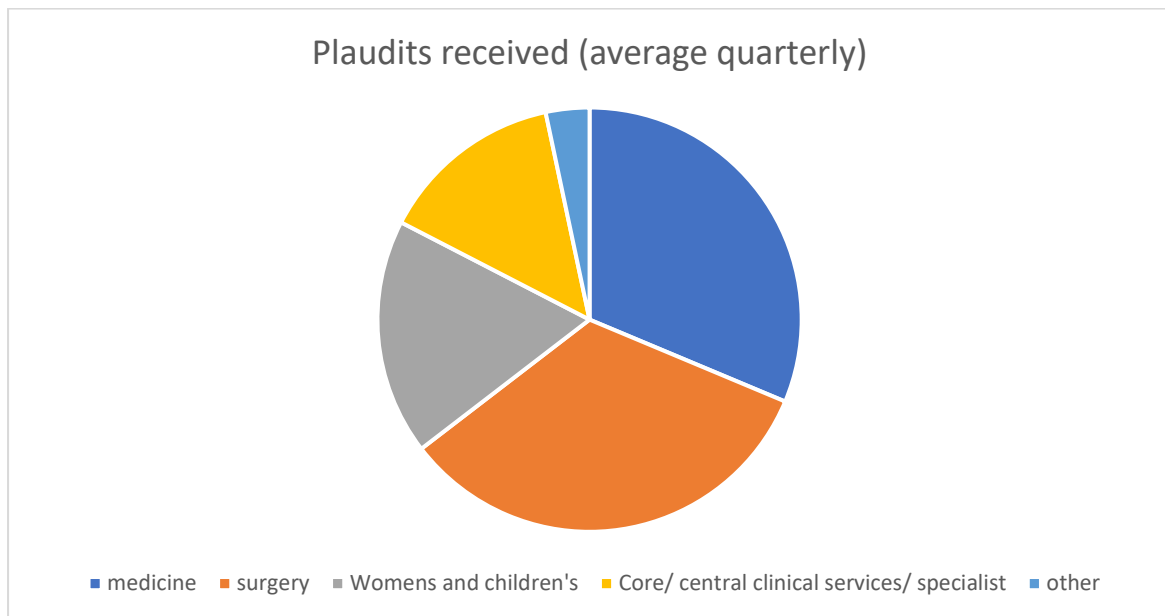
The most prevalent themes in the plaudits received are:

► Treatment by staff
► Clinical care
► Kindness
► Attention to basic needs
► Welcome and friendliness
► Environment

7. Summary and Next Steps

2021/22 was a challenging year for the trust in delivering great care every time, with the pandemic continuing through much of the year and its legacy remaining long after the most critical periods were over. In particular, the impact on elective care, demand for emergency care and the workforce have impacted on patient experience, as evidenced by the fluctuations in satisfaction in departments such as EDs and in thematic analysis of PALS contacts which demonstrate that in an unprecedented way 'waiting' dominates cases where our care has not met patient expectations.

However, there is much to celebrate with patient first continuing to support the embedding of the customer voice in improvement activity in all levels of the organisation. The ways in which patient experience is managed and responded have been strengthened within an increasingly clear and effective structure of quality governance. The patient breakthrough objective has delivered improvements in the waiting experience for patients in emergency departments, and the analysis and understanding of patient experience insights has provided valuable foundations for the patient experience strategy, coming in 2022/23. This will provide the framework for the trust's patient pillar to clearly set out expectations drawing across the key themes in patient feedback – communication, staff attitudes and behaviours, waiting and discharge – and wider strategic priorities for patient experience, as well as strengthening the link between patient experience data, learning and action.

Figure s: Thematic priorities in the patient experience strategy 2022-2025
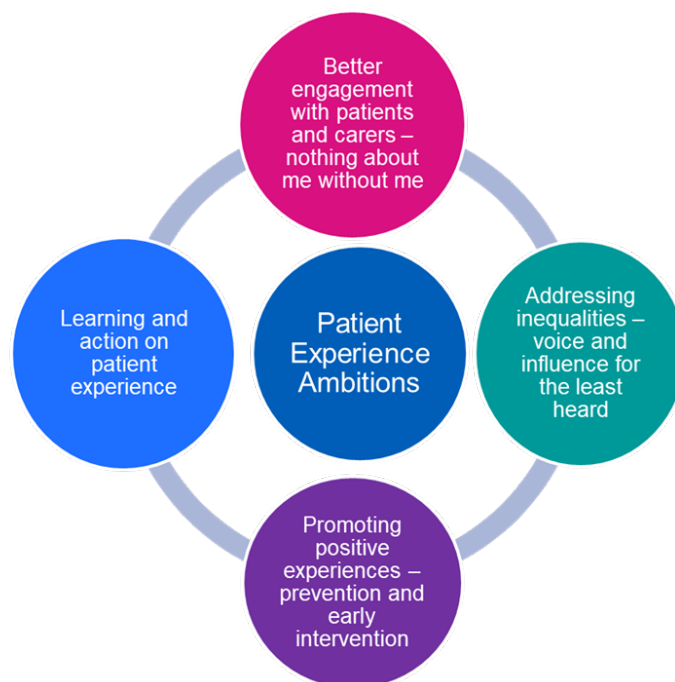
Appendix: Additional Data

Figure i: FFT satisfaction (half 2)
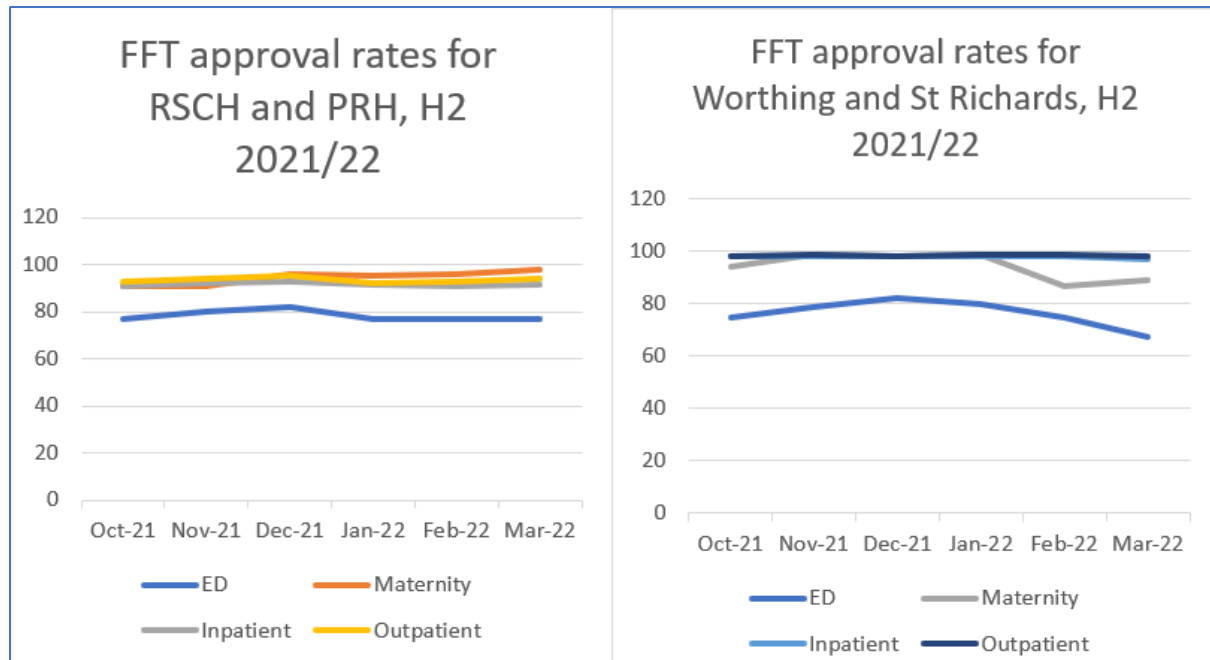
Figure ii: Concerns and complaints by site
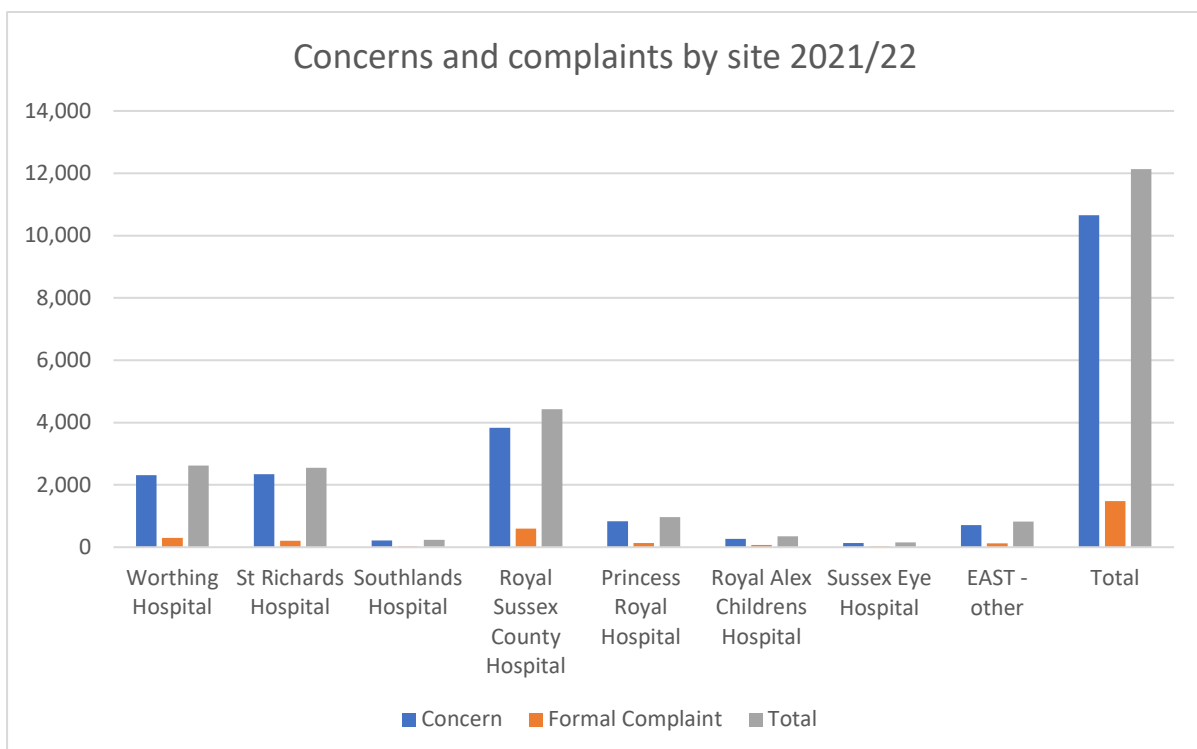
Figure iii: Concerns by directorate – RSCH and PRH

Concerns by directorate - RSCH and PRH

Legend: ■ Formal Complaint ■ Informal ■ Total*
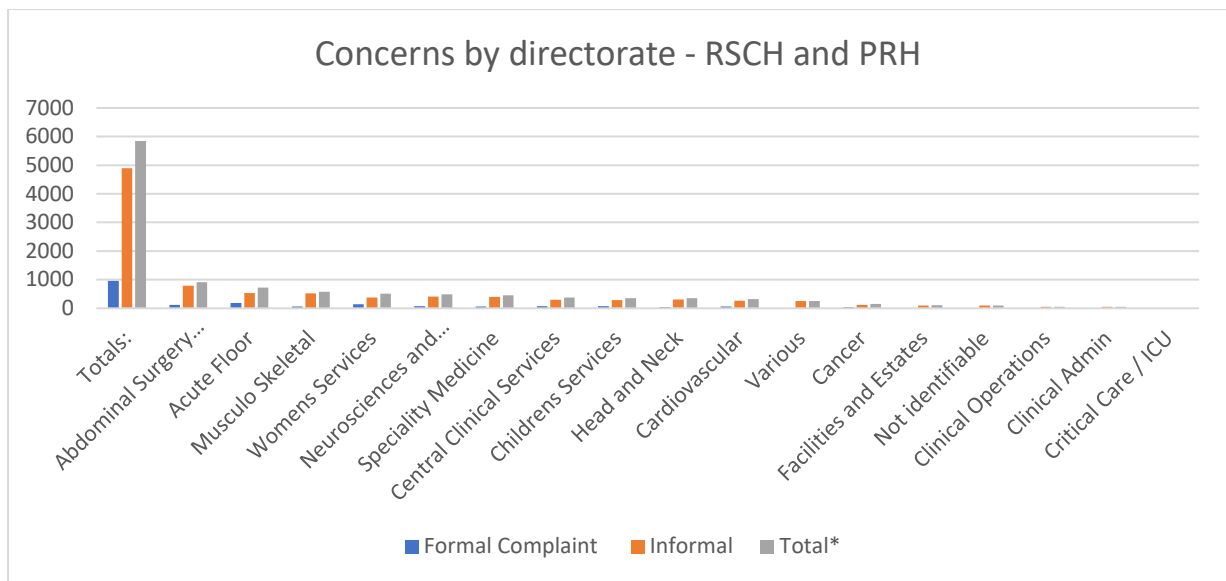
Figure iv: Concerns by specialty – Worthing and SRH

Concerns and complaints by specialty - Worthing and SRH

Legend: ■ Concern ■ Formal Complaint ■ Total

Patient Experience Strategy 2022-2025

Contents

1. Introduction

The mission of University Hospitals Sussex – what we are striving to achieve – is to provide:

'excellent care every time'

All our efforts to do this put the interests of our patients first and foremost, and are underpinned by our values which were selected by our staff, patients and public:

- Compassion

- Communication

- Teamwork

- Respect

- Professionalism

- Inclusion

At the heart of the Trust's 'Patient First' strategy is the aim for all patients to experience excellence care every time. Our patient feedback tells us that most of our patients get excellent care each time they use our services – more than 90% of patients report their care as good over very good (Friends and Family test, 2021). To improve this further our patient breakthrough objective focuses on aspects of patient experience which if improved, will make the greatest difference to the patient first ambition. This Patient Experience Strategy for 2022-2025 sets out how, using Patient First as our long-term approach to transforming hospital services for the better, positive and sustainable change in patient experience.

The strategy describes the national context for patient experience, how this aligns to the trust's ambitions and goals and how within the wider framework of quality governance a high-quality patient experience will be delivered. We describe how as an anchor institution and local partner in a multi-sector integrated care system for Sussex we can transform our engagement with local communities.

Our patients tell us that whilst most care is good there are opportunities for improvement. As such this strategy sets out how over the next three years the trust will enable:

- ► Better engagement with patients and carers – nothing about me without me
- ► Addressing inequalities – voice and influence for the least heard
- ► Promoting positive experiences – prevention and early intervention
- ► Learning and action on patient experience

These ambitions will be achieved through the following commitments for change:

Commitment 1: Nothing about me without me
Commitment 2: We will increase response rates to patient surveys
Commitment 3: We will increase engagement through visible and accessible digital methods
Commitment 4: We will improve experience of discharge – home for lunch
Commitment 5: We will embrace technology to improve patient experience
Commitment 6: We will engage differently and better with less heard groups and communities
Commitment 7: We will improve how those with barriers to services navigate places and services
Commitment 8: We will improve staff wellbeing
Commitment 9: We will implement a new approach to concerns and complaints responses, ensuring the right response at the right time
Commitment 10: We will improve the experience of 'waiting' patients
Commitment 11: We will strengthen the role of volunteers in improving patient experience
Commitment 12: We will implement patient-led customer service excellence programme
Commitment 13: We will embed learning from patient experience to shape improvement
Commitment 14: We will listen to and learn from patients on key themes
Commitment 15: We will ensure there is accountability for patient experience that is assured through good quality governance

Through delivery against these commitments over the next three years we will ensure that our patients receive excellent care, and therefore have a positive experience every time.

Dr Maggie Davies

Chief Nursing Officer,
University Hospitals Sussex

Professor Jackie Cassell

Non-executive Director and
Chair of the Patient
Committee, University
Hospitals Sussex

2. The Trust's Ambitions and Goals

2.1 The Trust Strategy – Patient First

University Hospitals Sussex (UHS) employs nearly 20,000 people across five main hospital sites (seven hospitals) in Sussex, with an operating budget of more than £1 billion and serves a population of over £1million patients, including those benefiting from tertiary and specialised services across Sussex and parts of the south east.

Patient First is University Hospitals Sussex' long-term approach to transforming hospital services for the better. It's a process of continuous improvement that is all about giving frontline staff the freedom to identify opportunities for positive, sustainable change and the skills to make it happen. It starts with the purpose, mission and values of the Trust – with the core focus on the patients, striving to achieve an excellent care every time, and underpinned by the values of compassion; communication; teamwork; respect; professionalism and inclusion.

There are five strategic themes, with which we align our work, to make sure we are focused on our True North of constantly improving standards of care:

- ▶ Sustainability
- ▶ Our people
- ▶ The patient
- ▶ Quality
- ▶ Systems and partnerships
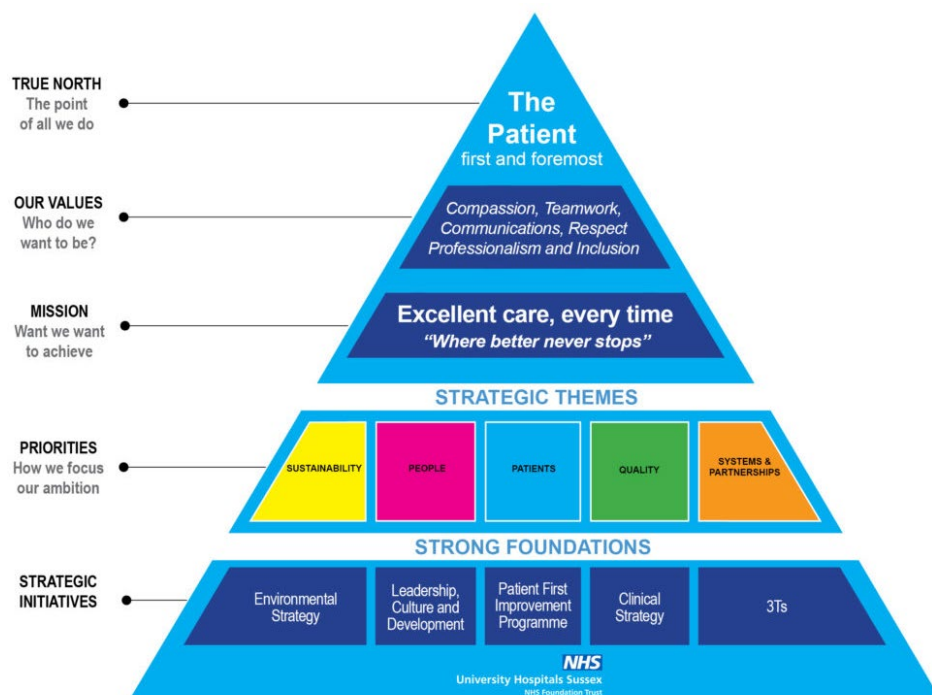
2.2 True North ambition and the patient breakthrough objective

This patient experience strategy sits at the heart of the patient first ambition, and its 'patients' strategic theme. The trust's ambition is for all patients to have a positive experience of the care they receive, with a particular goal – our true north ambition - of at least 95% of patients responding to the Friends and Family test having a good or better experience. Our breakthrough objective, described further later in this document, creates the unifying driver for the trust's improvement in patient experience by improving the quality of our services and engagement in a targeted way that will most effectively 'shift the dial' on achieving the true north ambition.

More than 90% of patients using our services would recommend them. Behind this patient satisfaction lies the work of thousands of people within scores of services that are central to securing excellent patient care. This includes those working behind the scenes – the procurement teams making sure the right equipment is in the right places at the right time; the finance teams ensuring resources are deployed to patient services; estates teams keeping the places where patients go clean and functional; human resource teams securing and supporting the workforce; administrators; booking teams; transport and many others.

This data, and insights generated from the thousands of patient feedback contacts we have each month have informed this strategy, to ensure that the patient voice provides the foundations for our improvement plans.

3. The National Context for Patient Experience

3.1 Patient Experience: the NHS Commitment

A person's experience starts from their very first contact with the health and care system, right through to their last, which may be years after their first treatment, and can include end-of-life care. The NHS Constitution established the principles and values of the NHS in England. The principles guide the NHS in everything it does and principle four states: 'The patient will be at the heart of everything the NHS does'.

The NHS has a long-standing commitment to offering high quality patient experience, as described in the NHS Patient Experience Framework and these values and commitments were re-iterated and strengthened in 2018 with the publication of the national Patient Experience Improvement Framework. This offered support to providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

Underpinning a high-quality patient experience is mature and impactful engagement and participation with patients and their representatives, as defined by the NHS 'Ladder of Engagement and Participation'.

The 'Ladder of Engagement and Participation'

There are many different ways in which people might participate in health depending upon their personal circumstances and interest. The 'Ladder of Engagement and Participation' is a widely recognised model for understanding different forms and degrees of patient and public involvement, (based on the work of Sherry Arnstein[7]). Patient and public voice activity on every step of the ladder is valuable, although participation becomes more meaningful at the top of the ladder.

Devolving	Placing decision-making in the hands of the community and individuals. For example, Personal Health Budgets or a community development approach.	Devolving
Collaborating	Working in partnership with communities and patients in each aspect of the decision, including the development of alternatives and the identification of the preferred solution.	Collaborating
Involving	Working directly with communities and patients to ensure that concerns and aspirations are consistently understood and considered. For example, partnership boards, reference groups and service users participating in policy groups.	Involving
Consulting	Obtaining community and individual feedback on analysis, alternatives and / or decisions. For example, surveys, door knocking, citizens' panels and focus groups.	Consulting
Informing	Providing communities and individuals with balanced and objective information to assist them in understanding problems, alternatives, opportunities, solutions. For example, websites, newsletters and press releases.	Informing

3.2 A new Role for Patient Experience: Anchor Institutions

More recently in the NHS Plan 2021, the role of Trusts as anchor institutions has been described, which sets out the new direction for the relationship between the NHS and the patients and communities it services through partners at different population levels – as systems, places and neighbourhoods. As an anchor institution, partner in the new Integrated Care System and as an ambitious Trust, understanding and responding to population health, public health drivers and health inequalities is critical to new ways of working for University Hospitals Sussex. We need to respond to the NHS Plan 2021, including the following priorities:

- ► The NHS will continue to contribute towards levelling-up, through its work to tackle health inequalities
- ► The NHS will better embrace technology to improve patient experience
- ► The NHS will invest in prevention to improve health outcomes'

This strategy sets out some of the ways in which UHS will deliver against these ambitions.

4. Patient Experience and Engagement in the Sussex System

The Sussex Integrated Care System (ICS) places experience and engagement at the heart of its ambitions as a system across Sussex that aims to ensure better health and care for all now and in the future. Our ambition is for every person living in Sussex to have the opportunity to access high quality and appropriate health and care services in a timely way, and be supported to achieve the best health and wellbeing outcomes possible.

The Sussex Integrated Care System (ICS) places experience and engagement at the heart of its ambitions as a system across Sussex that aims to ensure better health and care for all now and in the future. Our ambition is for every person living in Sussex to have the opportunity to access high quality and appropriate health and care services in a timely way, and be supported to achieve the best health and wellbeing outcomes possible.

Specifically, the system has the following aims:

- ► People to live for longer in good health
- ► To reduce the gap in healthy life expectancy between people living in the most and least disadvantaged communities
- ► People's experience of using services to be better
- ► People and communities to be supported to increase their resilience and develop community focussed wellbeing initiatives
- ► Staff to feel supported and work in a way that makes the most of their dedication, skills and professionalism.
- ► To make the best use of resources- staff, buildings and money- available to us.

Sussex
Health and Care Partnership

Working with people and communities strategy

2022-24

This strategy sets out the goals, principles, approaches, methods, governance and reporting structure, and immediate priorities for how we will work with people and communities as we transition into the new ways of working across the ICS, and beyond. We will work with partners across the ICS on the shared strategic approaches, driving a system shaped by insight from our people and communities, using asset-based working and removing barriers to empowerment, and working collaboratively to use insight and involvement to reduce health inequalities.

5. Enabling a High-Quality Patient Experience

Good experience of care, treatment and support is increasingly seen as an essential part of an excellent health and social care service. The NHS has coalesced around the definition of quality set out by Lord Darzi in 2008 that care provided by the NHS will be of a high quality if it is:

▶ Safe
▶ Clinically effective
▶ Delivering a high-quality patient experience.

Patient involvement is crucial to the delivery of safe, high quality and effective healthcare: at the front line, the interface between patient and clinician and at trust level. The aim of this strategy is not for patients and carers to be the passive recipients of care, but consistent with the values of Patient First to secures authentic partnership with patients – in their own care and in the processes of designing and delivering outstanding healthcare.

Quality assurance is a vital component of the trust's quality governance system. This supports a consistent approach to sharing and learning, reducing unwarranted variation, enabling interventions for improvement, ensuring visibility and accountability of actions, encouraging openness about learning and risk, and triangulating information relating to performance, patient and staff feedback and direct observation.

The Trust has made an unprecedented investment in its infrastructure to support leadership and application of quality in all aspects of the trust's delivery, across the three quality pillars of safety, effectiveness and patient experience. This includes:

- ► Creation of three new corporate director posts for each of the quality pillars
- ► Creation of integrated, trust-wide quality teams
- ► Embedded quality at all levels in the new trust clinical operating model
- ► Strengthened quality governance through a robust structure of reporting and accountability from the front-line to the trust board.

The effectiveness of this strategy in inter-related with the maturity of the trust's quality governance system, with learning from incidents, complaints, equality and inclusion insights and clinical outcomes jointly influencing and shaping improvement. Consistent with these strategic drivers and changes, and along with what our patients tell us (see section 6) this strategy sets out the following objectives, which are underpinned by the commitments set out in the following sections:

- ► Better engagement with patients and carers – nothing about me without me
- ► Addressing inequalities – voice and influence for the least heard
- ► Promoting positive experiences – prevention and early intervention
- ► Learning and action on patient experience
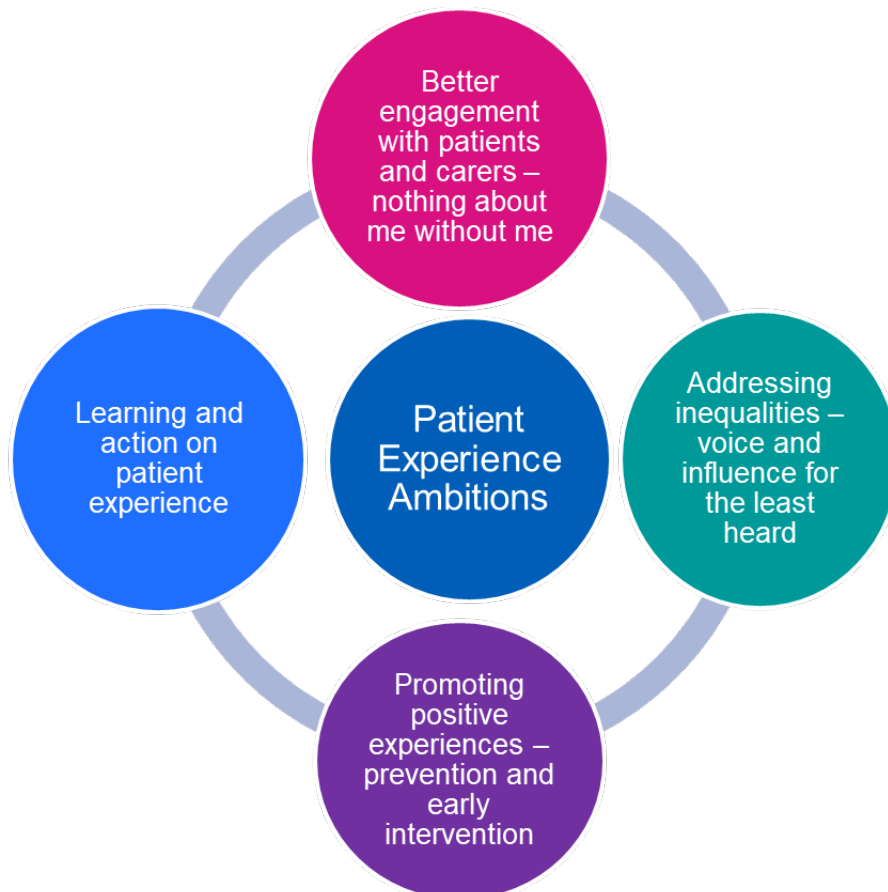
6. Patient Experience Principles

This strategy is founded on the following principles:

Data and Insight-led

The priorities set out in this strategy are underpinned by the evidence provided by our patients through their feedback and engagement with the Trust. Following the intelligence ensures that we make best use of our resources to focus our energies on the changes which can make the greatest difference to our patients and their families and carers.

Patient-centred

Our engagement with patients, citizens, families and carers will be compassionate, kind, responsive and will be appropriate to the needs of each individual.

Active listening

Our reach and engagement will be wide, and our ears will be open, minimising bias to ensure focus is on understanding what our communities are telling us, and that we respond, act and change in response to this learning.

Place-oriented

We will ensure our services respect the places and communities with which our patients identify, recognising that across a large trust, what works in one hospital may not be appropriate for the communities served by another.

Fairness and equality

The actions taken in consideration and implementation of this strategy will be underpinned by understanding of population needs, how inequalities in health and access to services can influence inequity in outcomes, and with the aim of levelling up the experience of patients across our communities.

Prevention and early intervention

By providing the right response at the right time we can support a better patient experience, act early to prevent concerns escalating and support improved health outcomes for local people

Accountability

Our progress and performance in delivering a high-quality patient experience will permeate the trust's governance and oversight to ensure an excellent experience is at the heart of everything we do.

7. What Our Patients Tell Us

7.1 How our patients share their experience

University Hospitals Sussex' patients share their voice with us thousands of times each month. This includes responding to Friends and Family Test (FFT) surveys, responding to national surveys (such as for maternity services and inpatients services), by raising concerns and complaints, through compliments, in conversations with Trust staff and through contacts with the Trust via social media.

Patient voice influences the way in the trust delivers its services in many ways:

► Use of data from patient experience as 'the customer voice' in all development work on service improvement – at scale and in each service
► Patient stories, where learning is pertinent, in particular when learning traverses experience, safety and clinical outcomes
► Through governors to ensure a link between the members of the NHS Foundation Trust, the wider community and those who run the hospital.
► Healthwatch reports and involvement
► Engagement in specific developments
► Individual influence through personal care planning between clinicians and patients

7.2 What patients tell us about their experiences

Although national public satisfaction with the NHS is reported to be at its lowest level since 1997, more than 90% of UHS patients report having a good or better experience of care. Whilst this is lower than our local ambition of at least 95% reporting an excellent experience, it is higher than the national average across all of the patient 'touch points' used in the survey, which are Accident and Emergency (A&E), maternity, inpatients and outpatients services.

Average FFT approval rates (end of 2021)
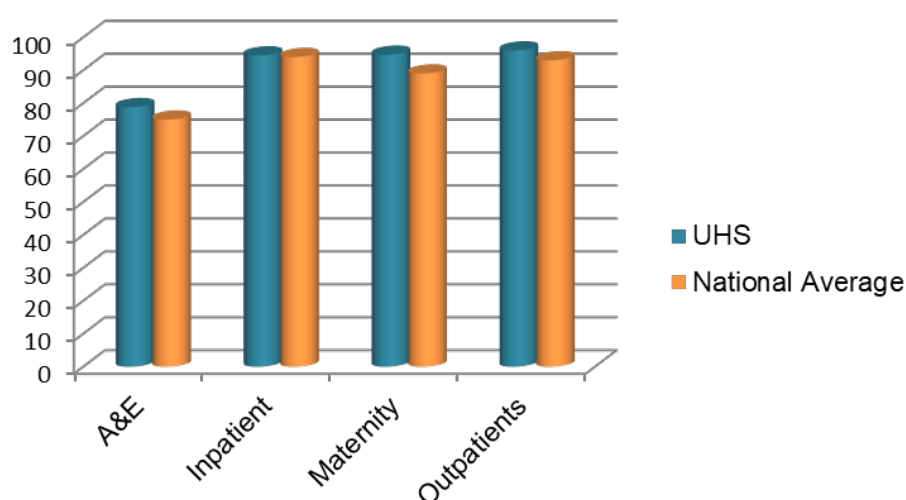
However, there is more that can be done to improve the experience of our patients. Consistently, our local FFT data tells us that patients are most concerned about waiting, communication (including about clinical treatment) and staff behaviours, whilst complaints data cites clinical treatment, dates for appointments, discharge, staff behaviour and communication as the most prevalent sources of concern. These priorities shape the ambitions described in this strategy.

Further to this, patient feedback is stratified by services, sites, wards and feedback mechanisms to provide greater detail that can shape the on-going improvement work by the Trust's services using patient first improvement methodology (see section 8.3).

Take up of surveys, in particular the FFT, is too low in some services and levels of satisfaction can vary between wards and departments – this requires improvement. There is also more that can be done to strengthen the feedback from people and groups that may be less heard or face inequalities in health. This strategy sets out how the Trust will respond to these opportunities for improvement in the following sections.

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8. Our Ambitions for Patient Experience – Measuring Success

The strategy ambitions will be achieved through the delivery of a detailed overarching action plan, identified clear milestones and lines of accountability. Overall progress on the delivery of the strategy is monitored by the Trust's Patient Experience and Engagement Group. Exceptions are reported at the Trust's Quality Governance Steering Group, with progress reports presented at all relevant Trust Group meetings (see section 11).

Whilst patient reported FFT satisfaction levels are the primary metric for the 'True North' ambition of all patients having an excellent of the care they receive, the success of the strategy will be tracked by the progress of the Trust, and its services, against a range of metrics and measures which provide a valuable proxy for improved patient experience. Stratification of this data will inform the deployment of 'breakthrough objectives' where focused work can shift the dial on key drivers of patient experience improvement.

Whilst we will not measure the number of complaints as a measure of our improvement – openness and accessible means to complain are standards of quality and provide invaluable patient feedback – we can use a range of measurables to appraise the impact of the actions described in this strategy. In some cases this will be appropriately stratified to understand the differing experiences of adult and child patients.

► **Outcome A:** Thematic analysis of patient feedback from surveys, website, social media and other sources will demonstrate improved experience. In FFT responses there will be fewer negative comments related to waiting, communication and staff behaviour. The data will demonstrate that as a proportion of overall concerns (in concerns and comments within FFT narrative responses), those relating to these key improvement areas will reduce by 25%. Within individual service areas prioritised for focused improvement work, improvement trajectories will be set.

► **Outcome B:** By 2025 the percentage of concerns citing dates for appointments and discharge will have reduced by 25%.

► **Outcome C**: By 2025, friends and family test response levels will exceed 33% for A&E, inpatient services, outpatient services and women's and children's services. The percentage of patients responding to FFTs is low across all touchpoints, meaning we lose a vast amount of information from patients accessing our services, which can help shape and transform our services. The west side of the trust response rate is significantly lower (11-19.5%) than the east (19-32%).

► **Outcome D**: By 2025 friends and family test responses will demonstrate that 95% or more of the trust's patients have a good or better experience of care, with satisfaction levels exceeding national averages. Currently (based on 2021-22 data) the Trust averages 91%, with satisfaction levels below national averages in some touch points.

► **Outcome E**: By 2025 there will be a 25% reduction in cases where concerns are escalated or re-opened. Currently there are approximately 108 cases escalated or re-opened each year (based on data from August 2021-February 2022). By 2025 we would expect no more than 81 cases to be re-opened each year.

► **Outcome F**: By 2025 the median average % of patients receiving a first formal response within 25 days will exceed 65% in all touch points.

► **Outcome G:** By 2025, the number of PFIS units selecting patient experience as a driver metric will have increased to 20% of all PFIS units from a benchmark of 432 for East and 2/5 for West.

► **Outcome H:** By 2025 the needs of potential and existing patients whose voices are currently less heard will have demonstrably led to improvements in services. This will be demonstrated by case studies.

► **Outcome I:** Number of volunteering hours will increase from March 2021 benchmark with the detailed metrics and trajectories developed in line with the development of the programme plan**.**

► **Outcome J**: Median time for discharge is before 12pm by the end of 2022

► **Outcome K:** an outcome relating to application of shared decision making will be agreed once the Trust's approach is developed as part of the delivery programme developed in response to this strategy.

► **Outcome L:** The percentage of staff recommending the trust as a place to work will increase from 2021 baseline.

► **Outcome M:** By 2025, all internally produced patient education materials will receive patient input, will be up-to-date, and will be available in print or via the Trust website (conforming with the accessible information standard). There will be greater use of video and audio materials for patient education, with captioning and British Sign Language translation where appropriate.

Delivery of the benefits will be achieved through the commitments described in the following sections.

8.1 Delivery of the benefits

	A: FFT % -ve comments re waiting, comms	B: reduction concerns: discharge/dates	C: FFT take up	D: FFT satisfaction	E: complaints re-opened	F: Complaints responses in target time	G: PFIS unit with patient driver metric	H: influence on service developments	I: Volunteers hours	J: Discharge time median <12pm	K: SDM (to be confirmed)	L: %recommending trust as a place to work	M: internal patient information up to date
Commitment 1: Nothing about me without me	▓	▓		▓									
Commitment 2: We will increase response rates to patient surveys (outcome B)			▓						▓				
Commitment 3: We will increase engagement through visible and accessible digital methods			▓					▓					
Commitment 4: Improve experience of discharge – home for lunch		▓		▓	▓					▓			
Commitment 5: We will embrace technology to improve patient experience	▓			▓									
Commitment 6: We will engage differently and better with less heard groups and communities				▓							▓		
Commitment 7: We will improve how those with barriers to services navigate places and services		▓						▓					▓
Commitment 8: We will improve staff wellbeing We will implement patient-led	▓	▓	▓	▓									
Commitment 9: We will implement a new approach to concerns and complaints responses, ensuring the right response at the right time					▓	▓							
Commitment 10: We will improve the experience of 'waiting' patients	▓			▓									
Commitment 11: We will strengthen the role of volunteers in improving patient experience		▓						▓	▓				
Commitment 12: customer service excellence programme												▓	
Commitment 13: We will embed learning from patient experience to shape improvement	▓	▓	▓	▓		▓		▓				▓	
Commitment 14: We will listen to and learn from patients on key themes	▓	▓	▓	▓									
Commitment 15: We will ensure there is accountability for patient experience that is assured through good quality governance	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓

9. Better engagement with patients – nothing about me without me

Better engagement with the patients and communities served by the Trust, at individual, service and trust-wide levels is critical to enabling services to be more responsive, better tailored and to be underpinned by stronger data intelligence to inform decision making. The following commitments set out how this will be achieved.

Commitment 1: Nothing about me without me

Personalised care represents a new relationship between people, professionals and the system. It happens when we make the most of the expertise, capacity and potential of people, families and communities. The NHS has committed to universal personalised care as 'business as usual' for 2.5 million people by 2024. Within this commitment are whole-population approaches to supporting people of all ages and their carers to manage their physical and mental health and wellbeing, build community resilience, and make informed decisions and choices when their health changes.

As a partner within the Sussex Integrated Care System, the trust will:

► Collaborate with system partners in development and implementation of a proactive and universal offer of support to people with long-term physical and mental health conditions to build knowledge, skills and confidence and to live well with their health condition, enabling supported self-management for patients
► Apply shared decision making (SDM) to ensure patients are supported to make the right decision for them through collaboration with their clinician regarding their treatment – this will support personalised care and support planning by bringing together clinician's expertise, evidence and understanding of risks and benefits with what the patient knows best – their preferences, circumstances goals and beliefs.
► Improve the quality and accessibility of health information, complying with the accessible information standard to ensure that disabled people receive information in formats that they can understand and they receive appropriate communications support to help them.
► Support implementation of personal health budgets

Commitment 2: We will increase response rates to patient surveys

Increasing response rates to surveys, in particular the FFT will enable better representation and validity of insights. The average FFT take up rates for July 2021 to January 2022 was 19%. As such, the patient experience team will:

► Procure a new, integrated survey provider for FFT

► Provide wards and departments with regular FFT data for their services, and will support clinical departments to use the patient first infrastructure, including improvement huddles and strategic development review meetings, to improve take up of surveys

► Widely promote surveys, including national surveys

Commitment 3: We will increase engagement through visible and accessible digital methods

New patient experience structures across the Trust will be made easier to access and more visible with patient liaison officers located in the places where patients are.

To facilitate more active digital engagement, including via the trust website and social media, a single 'front door' for providing feedback and raising concerns will be established with a clear and accessible 'identity' for patient engagement. Platforms for digital engagement using surveys, social media and web-based tools will be used.

Commitment 4: We will improve discharge – 'home for lunch'

Working with partners across the integrated care system and within the Trust's services the efficiency and quality of the discharge process will be improved to enable more patients who are medically ready for discharge to be safely returned to their place of residence earlier in the day. This will increase the quality of experience for patients leaving the hospital, and for those patients arriving who require an inpatient bed for their care.

Commitment 5: We will embrace technology to improve patient experience

The NHS Long Term Plan places technology at the heart of improving patient experience and sets out the need for digitally enabled care to become "mainstream" across the NHS, including:

- A flexible and digitally-experienced workforce supported by enhanced and flexible IT platforms, operating to "open standards" which facilitate joining-up of services and data.
- Fully digital personal health records which streamline the process of sharing and maintaining information between patients and their clinicians.
- Shared best-practice to reduce duplication, enable sharing of solutions between organisations, and improve inter-operability.
- Technology-enabled re-design of clinical pathways to support better patient experience and outcomes.
- Our digital strategy will support University Hospitals Sussex to play a full part in the improvement and transformation work of Sussex Health and Care Partnership ICS, and other ICSs across England.

To achieve this the Trust's new Digital Strategy is aligned to the ICS Design Framework, published in June 2021, including having a shared digital and data transformation plan connected with the broader vision for ICS development.

Patients' digital health information will be easy to access, shared appropriately across services and will support them, and their carers, to be more in control of their own health and wellbeing. Service improvement activities will be driven by robust intelligence and insight at every level from "Ward to Board". Alongside the face-to-face contacts that remain important to many people and for many conditions, people will be able to use technology to access and interact with health and care services seamlessly. We will ensure these technologies work for everyone, from the most digitally literate to the most technology averse and reflect the needs of people trying to stay healthy as well as those with complex conditions. This will include apps, electronic care records and information to inform decisions about care in line with best practice and emerging technologies.

Specifically, through implementation of the Trust's new digital strategy, patient experience will be enhanced through the following:

- **Development of the Patient Portal.** Developed with "Patients Know Best", it brings together multiple systems to enable individuals and their carers to access online their letters, appointments, tests results and virtual clinics; critically, putting patients in control of who can access their data. Linked to the NHS App, over 120,000 people are now signed up. However, this will be developed further, including with other health and care professionals, to support individuals in managing their own health and wellbeing and will provide access to locally produced patient education materials.

- **Online booking and service access**. The ability to book COVID-19 vaccinations online, and increasingly to access services such as consultations, follow-ups and prescriptions electronically, reflects an increasing expectation from a growing section of our population of services which are available round-the-clock and accessible from home.   To support this the Trust is committing to our clinical and operational processes being fully digitised by 2024, whilst manage the balance between convenience and ensuring all patients get the right care for them inclusively.

- **Recognising digital health is not for everyone**. We need to keep talking to patients in the way which is most appropriate to them and even with the support of friends, relatives and carers, digital health is not necessarily the right option for everyone. By bringing together the information the Trust holds electronically, including across different care settings and specialties, all patients will be supported to receive care that is structured around them, minimising the need for people to tell their story, multiple times, where information silos between organisations are removed, joining up patient information and data, and improving the experience and outcomes of care.

- **Data governance.** The Digital Strategy will ensure that there is appropriate governance around data being shared between University Hospitals Sussex and patients – being clear about who "owns" what so that patients can feel in control of their data, whilst adhering to the necessary data governance arrangements.

10. Addressing Inequalities – Voice and Influence for the Least Heard

Commitment 6: We will engage differently and better with less heard groups and communities

By working differently with community leaders, NHS and other public sector partners, the voluntary sectors, Healthwatches and representative groups in the 'places' covered by the Trust, the Trust will have access to new and different voices to better understand the needs of local communities, in particular those for whom inequalities in health outcomes are evident. This includes those with protected characteristics under the Equality Act (2010) – age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation - and other forms of potential disadvantage, such as socio economic status.

Such community-based collaborations and partnerships provides background knowledge and insights into the nature of the community served by the trust; enables the trust as part of the integrated care system to have a role in tackling social or economic disadvantage and the promotion of health equity; and enables the community can participate in design of new health initiatives. There is growing evidence that such engagement delivers improvements, such as more responsive services, improved outcomes, patient experience, shared decision-making and self-care.

Commitment 7: We will improve how those with barriers to services, such as physical, neurological and mental disabilities or language barriers navigate places and services

In particular within new trust developments, such as the '3Ts' building on the Royal County Sussex Hospital site, strengthened information, facilities and way finding for patients including those with barriers to access will be enabled. Tools and support, such as translation and interpretation services will be well advertised and there will be increased use of 'CardMedic'* to overcome communication barriers.
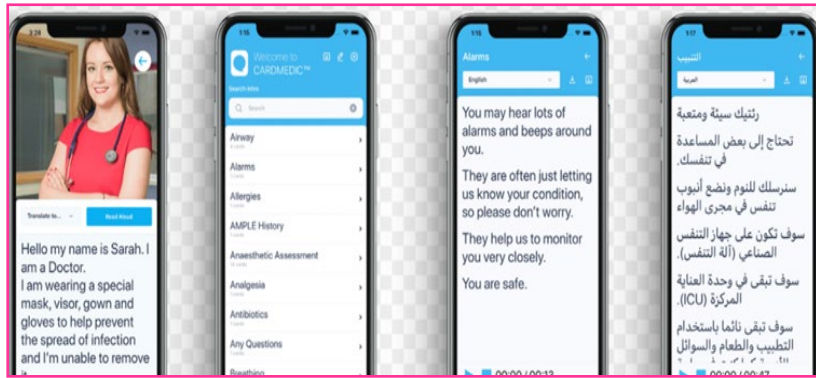
*_Card medic_ is a web-based application that can used on PCs, tablets and mobile phones to aid communication

Furthermore, the trust will use the patient first improvement system – its training, coaching, tools and methods – to apply an inclusion lens to all aspects of improvement, including the addition of a patient experience and inclusion module within training, and a focus on key inclusion priorities as divisional driver initiatives.

11. Promoting Positive Experiences - Prevention and Early Intervention

Commitment 8: We will improve staff wellbeing

Staff wellbeing impacts directly on the quality of patient care and experience. A lack of staff engagement can potentially result in a higher turnover of staff, absence, increase in incidents and reduced productivity and motivation and we know many people are mentally and physically exhausted from the demands of responding to the pandemic.

As such, the trust will prioritise taking positive action on health and wellbeing, addressing staffing issues, making wellbeing events more accessible, upskilling leaders to support colleagues with mental health and anxiety issues, increasing the visibility of leadership and develop staff communication. As a result, the trust will see an increase in staff recommending the trust as a place to work.

Commitment 9: We will implement a new approach to concerns and complaints responses, ensuring the right response at the right time

Although more than 90% of patient report a positive experience of their care with the trust, not all those using our services have a good or better experience. Currently the trust receives between 150 and 350 new concerns or complaints each week, and their negative experience can be further exacerbated when their concerns are not handled appropriately or in a timely way.

As such, the improvement programme proposes to implement a new approach to concerns and complaints responses, ensuring the right response at the right time, from initial receipt of a concern, to its review and triage, to how it is actioned and closed. As part of this, the transformational capacity will implement a programme to support the shift in practice in responding to concerns across clinical services through a training and transformation initiative. The approach and timescales for complaints responses will also be aligned across the system.

We will also seek to deploy patient liaison and support functions in the places where patients are, to provide an on-site source of information and response when patients have concerns or questions.

Commitment 10: We will improve the experience of 'waiting' patients

Patient experience data tells us that more than 90% of patients have a good or very good experience of inpatient, outpatient and maternity services. The lowest levels of satisfaction with our services as reported by FFT are with emergency departments, and when the data are stratified the most prevalent theme in negative feedback relates to waiting.

As such, the trust will prioritise reducing waiting times for elective patients and improving communication with those waiting to improve the experience of communication during the wait.

As part of increasingly personalised care (see section 8) using the 'MyPlannedCare' platform, approaches such as 'pre-hab' (pre-habilitation) in cancer pathways and by linking with system based partners and services, support will be offered for patients waiting for surgery, to improve their waiting experience and their readiness for surgery.
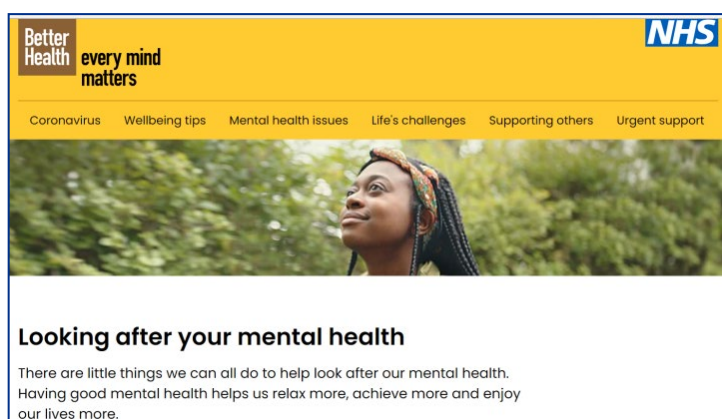
The 'My Planned Care' platform links patients waiting for surgery with sources of support for their mental, physical, social and economic wellbeing

Commitment 11: We will strengthen the role of volunteers in improving patient experience

Volunteers provide an invaluable role in delivery of a positive patient experience, including providing front line support with way-finding, improving the physical environments in our hospitals and running patient facilities such as retail venues. During the pandemic the number of active volunteers decreased substantially. To ensure that this much valued resource is most appropriately rebuilt, developed and deployed, a full review of volunteering within the Trust has been undertaken and the outcomes of this review will be implemented over the next two years. This will result in increased volunteer hours delivered in support of the Trust.

Commitment 12: We will implement patient-led customer service excellence programme

In line with the Trust's Patient First values, all contacts with our services should be compassionate, encompass practical problem solving, be flexible and offer excellent customer service.

Working with the hospitals' charities, a team of volunteer patient representatives will be recruited, in particular those who are representative of the population served by the trust and able to provide insight into the health inequalities faced by local citizens. Using the data and evidence, along with their own experience, a set of standards for customer/ patient experience will be developed, against which all elements of the trusts engagement with patients and carers can be appraised to determine whether the standard is met. Customer service standards will also be incorporated within the trusts education programmes for patient facing staff.

 The volunteers would then undertake the validation of trust services against the standards they have identified. This will be co-produced with patients and their representatives and rolled out across the trust's services following the data to inform the priority touch points.

12. Learning and action

Commitment 13: We will embed learning from patient experience to shape improvement

Using the new patient experience module on Datix, divisions will be receive feedback notifications to shape their improvement activity. Furthermore, patient experience teams working with the business intelligence unit will produce regular patient insight data packs for clinical divisions to utilise in their improvement planning, using the Patient First Improvement System methodology.

The most important insight that has informed the strategy is information received from patients, families, carers and the public over the last 12 months. Themes from all the different sources of patient feedback such as surveys, free text comments, plaudits, complaints and concerns have been reviewed and have informed this document. Due to the diversity of services in University Hospitals Sussex there are different themes that emerge from different specialties and services. Therefore, a priority for this strategy is that each clinical area will be empowered to act on this feedback, for all patients, through:

- ► Receipt of divisional quality data packs with key measures of patient experience included
- ► Improvement huddles responding live to emerging feedback from patients
- ► Development of ward and service 'A3' thinking to shape improvement plans based on patient feedback
- ► Divisional strategy development reviews
- ► Quality summits and peer reviews
- ► Taking an equality and diversity perspective on feedback and the responses to it to consider how service changes and improvements will impact on different population groups, including those with protected characteristics.

The trust will also take and implement learning from research and external good practice. This will include patient information all aspects of clinical care, including interventions to improve patient experience.

Furthermore, feedback from patients will – in line with the ambitions described in commitment 12 – form part of the process of staff management and appraisal, so that positive experiences of patients are noted and acknowledged and where changes in attitude, conduct and practice can improve patient experience through individual development this is included.

Commitment 14: We will listen to and learn from patients on key themes

Thematic patient panels and listening lunches between patients and clinicians will further facilitate deep understanding and listening to inform improvement activity, along with a 'dragons' den' style patient panel acting as gatekeepers of an innovation pot to facilitate improvements in response to patient feedback.

We will continue to embrace our constructive relationships with local Healthwatch bodies, harnessing the learning from their engagement through the patient experience and engagement group. The role of governors will continue to be critical to the governance of the trust, reflecting the needs and views of our communities and places in the trust's operations and decision making, and in holding the trust to account.

We also know that good environments matter and that every NHS patient should be cared for with compassion and dignity in a clean, safe environment. Where standards fall short, they should be able to draw it to the attention of managers and hold the service to account. PLACE assessments will provide motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced

Commitment 15: We will ensure there is accountability for patient experience that is assured through good quality governance

In line with the trust's accountability framework which will be published in 2022, this strategy sets out our commitments and ambitions over the next three years and our journey will be monitored through the Trust's governance. Peer reviews and quality summits with clinical and corporate divisions working together will inform the extent to which patient experience insights are driving improvements in care, informing strategic decisions and preventing future concerns arising, and will ensure learning is aligned with insights related to patient safety and clinical effectiveness. Key metrics will be reported monthly as part of the trust's quality scorecard, and results from patient surveys will form a core part of reporting into the trust's governing structures.

Responsibility for patient experience rests in all units of the trust's operations.

Teams	- Access FFT data, consider and respond - Receive concerns and feedback from PALS and respond through improvement and safety huddles - Ensure staff are PFIS trained and use patient experience insights in improvement activity
Services	- Access FFT data, consider and respond - Receive concerns and feedback from PALS and respond through improvement and safety huddles and A3 thinking

	• Ensure staff are PFIS trained and use patient experience insights in improvement activity • Respond in line with trust timescales when complaints are received
Divisions	• Access FFT data, consider and respond • Receive concerns and feedback from PALS and respond through improvement and safety huddles and A3 thinking • Ensure staff are PFIS trained and use patient experience insights in improvement activity • Respond in line with trust timescales when complaints are received • Ensure improvement action is taken and learning is reported through trust governance

The trust's governance structure will ensure the strategy is accountable and that patient experience is triangulated with patient safety and clinical effectiveness dimensions through the following bodies:

► Trust Board
► Patient and Quality Committees
► Quality Governance Steering Group
► Patient Experience and Engagement Group (PEEG)
► Triangulation group and the serious incident review group

PEEG, which will directly oversee the implementation of this strategy, ensures that patient experience and engagement is encompassed and embedded across the Trust. This includes delivery of the following functions:

► Collation of understanding, insight and knowledge about patient experience across the Trust's services, including performance information and best practice
► Identifying, defining and tracking progress of key improvement actions emerging from patient experience insights, triangulated with insights from patient safety and clinical effectiveness, keeping quality at the heart of the patient experience
► Ensuring that patients' voice is heard and influences impactful, positive change to service planning and delivery and Trust policies, including action to hear the voice of those at risk of health inequalities and poorer health outcomes
► Provision of assurance that there is ongoing evidence that all delivered services are patient-focused and supported by adequate and appropriate patient experience and engagement structures and processes
► Supporting the development and overseeing the implementation of the Trust's patient experience strategy.

It also receives reports and provides a role in the quality governance and assurance of key work programmes critical to the quality of the trust's core business. This strategy should be read in conjunction with the trust's accountability framework.

Agenda Item:	12	Meeting:	Board		Meeting Date:	4 August 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 has met monthly since April 2022 so this report covers three meetings in May, June and July 2022.

Meetings on 24 May, 29 June, 26 July were quorate, attended by at least two Non-Executive Directors and two executives including the Chief Medical Officer, the Chief Nurse for part of the meeting, the Chief People Officer and the Chief Governance Officer. In attendance at each meeting were the Trust's Medical Director, the Director of Patient Safety along with Director of Midwifery.

At each of the meetings in May, June and July 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, and the report from the Committee's reporting group Quality Governance Steering Group. The exception was a learning from deaths report not received in July that would be substantially updated for the September meeting. In addition, the Committee received reports on a number of areas including medicines management, clinical effectiveness (including NICE) and mental health.

The Committee also considered both the Corporate Risks with a potential quality impact and the Board Assurance Framework (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.

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Dates	Chair	Quorate	
			yes	no
Quality Committee	**24 May 2022, 29 June 2022 and 26 July 2022**	**Lucy Bloem**	✓	☐
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** considerable progress on development of the dashboard however data in some areas is incomplete and requires further work..

At each meeting the Medical Director took the Committee through the Quality scorecard narrative in respect of the dashboard segments covering the domains of mortality, clinical outcomes and effectiveness, patient safety and patient experience. Between May and July reports, there was improvement in the data flows into the quality scorecard following interruption during the Covid pandemic and gaps in data from particular Trust sites had been reduced. The Committee asked for the inclusion of discharge data within the quality scorecard following recognition of themes within incidents and clinical harms of poorer patient outcomes from protracted stays in hospital.

The Committee discussed the key elements within Patient Experience relating to complaints remaining high, predominantly due to long waits as well as the progress of the complaints team addressing their caseloads to more sustainable levels for responsiveness. The scorecard showed Patient Safety trends in incident learning as well as the Trust's performance in associated processes around incidents including the timeliness of incident investigation and adherence to duty of candour. The scorecard also reported progress around Clinical Outcome and Effectiveness with measures of compliance with NICE guidance the range of national clinical audits, local clinical audits, National Confidential Enquiries and Stroke audits (SSNAP) as well as the arrangements within the team.   The committee NOTED the Stroke National Audit Programme score was now rated C across all UHSussex and discussed the improvement plan being developed. On NICE Guidance, the data reported since May 2022 had been expanded to include compliance of all published NICE guidance. The Committee **NOTED** the impact of focused COEG meetings and action plans implemented by all divisions with support from the clinical effectiveness team, improving overall compliance.   The scorecard also listed Mortality measures while the Medical Director had also provided the Committee with detailed updates to offer the Committee clearer insight of what those measures are understood to show.

At the July Meeting, the Committee was joined by the interim Director of Business Intelligence and Performance to present the Quality Dashboard Development & Partnering Model plan. The Committee **NOTED** the gaps that had been identified and the work planned to strengthen the BI support for the scorecard to enable the automation of the manual processes that have been utilised at some sites and development of a data manual to ensure standardised data is used for the scorecard across the organisation.

Maternity
In May and June 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 had agreed that in July the formal receipt of the maternity dashboard was paused as considerable changes to the format were made in month. A verbal update from the Director of Midwifery was provided in July.

Briefings on still- births and neonatal deaths were reported to the Committee in May, June and July.

At the July meeting of the Committee, the outcome was reported of an external review into an apparent cluster of Serious Incidents at the Trust (initiated in relation to December 2021 neonatal deaths but extended to other neonatal deaths in months to March 2022). The Committee was **ASSURED** by the findings of the review that there was no Trust defect common to the deaths examined but there were however important learning themes identified.

The Committee was **ASSURED** that the Maternity Directorate continue to report neonatal deaths to the Healthcare Safety Investigation Branch (HSIB).

Work on dashboards received by the Committee had been informed by the learning from the internal audit findings received in April 2022 in respect of the Perinatal Quality Scorecard to which the Director of Business Intelligence gave an update on the BI leadership support added following the Committee's request of the Board.

Maternity Ockenden Visits

Maggie Davies outlined the Trust's engagement with the Regional Chief Midwifery team and Sussex Local Maternity and Neonatal System who have undertaken a series of site visits across each of the maternity units, as part of the scheduled and planned programme.

Maggie shared her pride and provided the excellent feedback on culture and leadership as well as areas the Trust needs to focus on. Formal feedback is awaited which will be shared with the Committee and Board later in the year.

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

Clinical Negligence Scheme For Trusts (CNST) Maternity Incentive Scheme

In June the Director of Maternity provided the Committee with an update relating to the original self-certification of the Trust's compliance with the 10 maternity safety standards which form part of the CNST maternity incentive scheme year 2. The Committee **NOTED** the review of the year 2 submitted evidence for legacy BSUH and WSHFT has been undertaken and outlined lessons learned for future approaches.

The Committee **NOTED** progress against CNST year 4 is underway for submission of evidence prior to January 2023. The Committee **NOTED** that the Trust's internal auditors, BDO, will review the process of evidence capture prior to it being presented for approval.

The Director of Maternity confirmed that there would be clear touch point dates throughout 2022 to substantiate the evidence ahead of the January submission deadline.

The Committee **NOTED** the heavy reliance on onerous paper-based audit work to substantiate compliance with one of the standards and that without the developed IT system and the scale of notes may represent a risk,

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 Annual Serious Incident Report received in May 2022. The Committee in **RECEIVING** these reports in respect of the learning being drawn from reported incidents and updates at each meeting was **ASSURED** over the Trust's continuing focus on learning through the information provided and the Trust's processes to support families through the investigation process. The Committee was **ASSURED** on the Trust's processes for ensuring learning is followed through with process redesign. Following consideration by the Committee arising from a Serious Incident investigation, the Committee **REFERRED** to the Sustainability Committee for assurance in relation to service level agreements applied for clinical service contracts.
At the meeting of the Committee in June, the Committee **NOTED** excellent work by the Director of Patient Safety and Learning that had eliminated the backlog of overdue Serious Incident investigations, ensuring the Trusts compliance with National Frameworks.

Duty of Candour
Through reports at each meeting between May and July 2022, the Committee was **ASSURED** over the Trust's compliance with the duty of candour for any patient safety incidents reported through the Trust incident reporting process.
The criteria for the duty of candour concerns those incidents where a patient has suffered at least moderate harm. Through the work on Clinical Harms Reviews, the Committee **NOTED** there may be opportunities for the Trust to apply its approach of candour more broadly and have asked this be reported back to Committee.

Reducing Harm
At meetings in May, June and July, 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. At the May meeting the Committee received a report from the Trust's Chief Pharmacist on Medicines Management. The Committee **NOTED** the update which focused on quantifying the opportunity for error, the impact of medication errors, and the best measures of medication safety. The Committee also **NOTED** information about shared risks arising from the new approach to virtual wards. The Committee were **ASSURED** of the quality of medicines administration through key performance indicator performance showing low medicine omission rates compared to peers as well as the work toward identified challenges and the actions in place to achieve the proposed improvements.

Mortality
At the May, June and July meetings of the Committee The Medical Director (Quality and Governance) took the committee through the True North on Mortality, whilst the True North metric is for crude mortality the Committee **NOTED** that the Trust also tracks both Hospitalised Standardized Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) performance 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 at some sites although the aggregated UHSussex SHMI remains within the expected range. Following the case note review of the data highlighted in my last report that suggested a coding issue as the cause for an apparent rising trend in SHMI, the Committee was ASSURED that the correct action plan is in place which includes a monthly Coding and Mortality Improvement Group, work to address the learning from deaths and an external coding Audit which will report in September.

Clinical Harm Reviews
The Committee **RECEIVED** reports 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 waiting 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.

Clinical Strategy
The Committee **NOTED** progress of the developing Clinical Strategy and received updates at the June meeting (pending the July implementation of the Trust's new clinical operating model). In June the Committee acknowledged that there was to be a review of the A3 methodology with particular focus on the Quality and Patient domains and that the findings would come back to the Committee by September 2022.

Mental Health
Following Serious Incidents reported in May, the Committee NOTED the update on work taking place with Sussex Partnership NHS Foundation Trust (SPFT). The committee received an update on the challenges facing not only the Trust but the wider system. A Summit had been held at which both Trusts recognised the current significant operational pressures in the two organisations and the increasing number of mental health patients attending the emergency departments. It was acknowledged that both Trust's work well together but that there was a requirement for training to further educate staff in mental health conditions and an understanding of how the two organisations work. The Committee looks forward to a further update once the improvement plan owned by both organisations has been endorsed.

The Committee **NOTED** UHSussex improved governance processes following the establishment of the UHSussex Mental Health Strategy and Quality Group; the Mental Health Act Group (MHA) and the Child and Young Persons Mental Health Improvement Board, which provide escalation reports to the Patient Experience and Engagement Group and subsequently the Quality Governance Steering Group (QGSG) for assurance purposes.

Resuscitation Annual Report
The Committee received a report by the Resuscitation Services Department (RSD) that outlines and describes the activities of the RSD over the period of April 2021 to March 2022, post-merger, NOTED the significant impact the Covid-19 pandemic had on the service. In particular the implications for face to face training delivery and associated STAM compliance across the Trust. This had been mitigated by a cascade approach via training of key individuals in departments. The Committee heard that the clarity of data on the Trust's recording system had been insufficient to make timely identification of the cohorts of staff due to be trained for planning purposes. The Committee **REFERRED** this matter to the People Committee.

The committee were **ASSURED** that auditing takes place to ensure that Do Not Attempt Resuscitation (DNAR) orders are respected in the event of cardiac arrests. The Committee asked for the next review to detail findings of the notes audit activity that continued to take place in order to be assured that timely opportunities are taken to introduce consideration of DNAR orders.

Infection Prevention and Control (IPC)
The Committee **RECEIVED** the quarter 4 IPC report and 2022/23 IPC Annual Report from the Director of Infection Prevention and Control at its meetings in June and July respectively. The Committee recognised that Covid-19 had remained prevalent in the Community in quarter 4 while the Trust was also informed about the extent of Monkeypox prevalence in the Sussex community and heard that locally Monkeypox and Polio cases remain under review and that treatment pathways across the Trust were well embedded.

The Committee recognised that metrics for key organisms; C.difficile, E.coli, Pseudomonas aeruginosa, Klebsiella species, MRSA and MSSA blood cultures; are all subject to specific targets, with an additional national reduction initiative to halve E.coli by 2024. The Quarter 4 updated   Trust is above trajectory in key mandatory surveillance organisms.

At the July meeting, the Committee discussed the challenge of sufficient ventilation in parts of the Trust estate and noted the implications and challenges for competing pressures for, Covid-19 IPC, environmental and financial sustainability and also staff and Patient comfort in light of recent heatwaves. The Committee noted the considerable improvement that would be introduced by the 3Ts building and noted discussions with the Director of Facilities and Estates as sustainable solutions would need to form part of planned refurbishment programme. The Committee **REFERRED** the matter of capital investment in ventilation to the Sustainability Committee.

Care Quality Commission
The Committee **RECEIVED** updates from the Chief Nurse on the responses to the re-inspection of maternity services across the Trust and surgery at RSCH as well as the new inspection of the Emergency Departments in April 2022. The updates confirmed that the Trust had responded to supplementary requests for information following the inspection and the return of factual accuracy checks to the draft report. The Committee **NOTED** the report was expected to be published by the end of July 2022.

Reporting groups
At each meeting in May, June and July the Committee **RECEIVED** an update from the Chief Medical Officer on work of the Quality Governance Steering Group (QGSG) at its preceding meetings detailed within the formal report provided to the Committee. The Chief Medical Officer confirmed that the agenda of the QGSG continued to be aligned to the work of this Committee and the key quality risks. The Committee were asked to **NOTE** that a review of divisional risks 12> had been undertaken, that there had been a material impact of the high volume of child and adolescent mental health services' (CAMHS) patients on inpatient paediatric services and an escalation of support requested and significant pressures across the divisions.   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 93 risks that have been raised that have the potential to impact on patient experience which for quarter 1 have been identified with a post-mitigation score of 12 or above. Five of these identified risks had a current risk score of 20:

- Two risks that described 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.
- A risk that management of young people requiring inpatient care for mental health problems is inadequate causing them to stay within the acute setting so increasing the potential for patient safety risk.
- 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.
- 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 BAF RISK 4.2 - the clinical harm outcomes, incident investigations and learnings, CQC and Ockenden feedback and the SSNAP rating. 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.

Actions taken by the Committee within its Terms of Reference

The Committee **AGREED** to recommend the quarter 1 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 and APPROVED the Perinatal Quality Surveillance Summaries and Dashboards

The Committee received the IPC Annual Report and **RECOMMENDED** this to the Board.

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

The discharge data is to be included within future Quality dashboards supported by the current integral programme of work being undertaken on pathway zero discharges.

Patient observation data is to be included within future Learning from Deaths updates.

Safeguarding Adults and Safeguarding Children Annual Reports 2021/22

Regular updates are to be received on how well the Trust compares with its peers in order to better support Clinical Outcomes and Effectiveness

Mental Health

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.	To Board 4 August 2022
Audit Committee – At the June meeting, the Committee sought assurance that data quality continues to feature within their Annual Audit Plan. The Audit Committee confirmed this to be the case	To Audit Committee 19 July 2022
People Committee – At the June meeting, for a review to be undertaken of the appropriate HR database to improve the accuracy of STAM data reporting on those who are out of date or have left the Trust.	To People Committee 27 July 2022
Sustainability Committee – An update on the plans for capital plans for investment in Ventilation systems	To Sustainability Committee October 2022

Director of Infection Prevention and Control
Annual Report
University Hospitals Sussex 2021-22

Director of Infection Prevention and Control Annual Report for University Hospitals Sussex

2021-22

Executive Summary:

This is the statutory Director of Infection Prevention and Control (DIPC) report for University Hospitals Sussex for 2021-22. This is the first DIPC annual report for the new trust and reflects activity over the first year since the Trusts formation from Western Sussex Hospitals and Brighton and Sussex University NHS Foundation Trusts.

Using the framework of the Health and Social Care Act, the report sets out the arrangements for infection prevention and control across the Trust, and summarises the work and projects implemented in the past year to protect patients from the risk of healthcare associated infection (HCAI). The report demonstrates that the Trust is meeting the requirements of the Health and Social Care Act (The Hygiene Code).

The report captures an extraordinary year highlighting the challenges for the whole Trust and Infection Prevention and Control Team (IPCT) during a pandemic; the scale of which the NHS has never seen before.

The IPCT and microbiologists/virologists were pivotal in every area of the hospitals guiding and advising on all aspects of infection prevention, infection management and outbreak control. This extraordinary work was recognised in the first UH Sussex 'Patient First Star Awards' where the IPCT won 'Clinical Team of the Year'.

This report will be presented to the Trust Infection Prevention Committee, followed by the Quality Committee and then to the Trust Board. It will then be published on the Trust website.

Key points to note:

The Trust is registered without conditions with the Care Quality Commission.

The Trust had an unannounced inspection in September of 2021. The newly merged organisation maintained an overall rating of Outstanding in the 2021 inspection. Issues identified regarding surgery and maternity have been largely addressed.

Overall performance in relation to UK Health Security Agency (UKHSA, formerly Public Health England) mandatory surveillance targets saw targets exceeded for *Clostridioides difficile* infection, and Meticillin resistant *Staphylococcus aureus, Escherichia coli, Pseudomonas aeruginosa* and *Klebsiella species* bacteraemia's. There are a combination of factors which contributed to this, discussed in section 5.

C.difficile, E.coli and MRSA bacteraemia are specific oversight metrics.

There were 3 attributable cases of MRSA bacteraemia. 1 was at Worthing (WGH) and 2 at Royal Sussex County Hospital (RSCH).

The Trust had 149 attributable cases of *Clostridioides difficile* infection (CDI). This was 29 over the assigned trajectory for the year.

There were 168 cases of *E,coli* bacteraemia which is 36 above trajectory.

The IPCT has played an important role in dealing with the COVID-19 pandemic which has occupied much of their time and energy.

Continued waves of new Covid infection have been challenging in terms of operational management to maintain patient flow while balancing the need for management to

prevent transmission to patients and staff. Changes to national guidance, and instructions on a stance of 'living with Covid' have meant that the Trust has relied on the commitment and expertise of the Clinical Advisory Group for decision making to ensure patient safety and operational flow is maintained.

Despite workforce challenges and pressure of the pandemic, the Infection Prevention and Control Team (IPCT) completed many of its planned audits for the year.

Audits for hand hygiene, environmental hygiene (including commodes) have demonstrated good compliance levels. The average scores for hand hygiene compliance across Royal Sussex County Hospital (RSCH) (including Royal Alexandra Childrens Hospital RACH), Sussex Eye Hospital (SHE) and Princess Royal Hospital (PRH) was 96%. The average recorded score from St Richards Hospital (SRH) and Worthing General Hospital (WGH) was 99%

Monitoring for hand hygiene is enabled on the East side using the 'Tendable' audit application. This will be rolled out across the West side of the Trust in 2022 to allow monitoring of audit compliance scores with collation and feedback of results.

The patient led assessments of the care environment (PLACE) were not undertaken this year due to the pandemic in line with other NHS trusts.

High level disinfection with a Hydrogen Peroxide Vapour (HPV) product called Bioquell continues to be used after discharge of patients with high risk organisms at SRH and WGH. It is not currently available for use at RSCH or PRH, however some UV lights are due to be purchased and Estates are investigating how HPV can be deployed across all sites.

The flu campaign was conducted alongside the booster vaccinations for COVID-19.

Approximately 47% of staff were staff vaccinated for Flu and 83% were vaccinated within the Trust for Covid.

The IPC works with the Trust antimicrobial pharmacists to reduce inappropriate antimicrobial use and thus antimicrobial resistance.

A UH Sussex Antimicrobial Stewardship Team has been established and is actively promoting best practice through participation in stewardship rounds and audit.Trust antimicrobial guidelines are being merged, with the majority going live in the UH Sussex joint MicroGuide by the end of July.

The antimicrobial pharmacy team have been an integral part of the Covid response especially in relation to vaccination role out and use of immunotherapy treatments.

Coming out of COVID-19 and with merged guidance in place, the team plans to complete a whole trust point prevalence study identify areas for improvement and highlight good practice.

Work is ongoing to develop Sussex wide standardised guidance for outpatient parental antimicrobial therapy (OPAT) and ensure improved and equitable treatment of patients across Sussex.

Introduction

This is the statutory Director of Infection Prevention and Control (DIPC) report for University Hospitals Sussex for 2021-22. This is the first DIPC annual report for the new trust and reflects activity over the first year since the Trusts formation from Western Sussex Hospitals and Brighton and Sussex University NHS Foundation Trusts. It also includes reference to planned work for 2022-23 (appendix 1).

The purpose of this report is to reassure the patients, public, staff, the Trust Board of Directors, Governors and Coastal West Sussex Clinical Commissioning Group (CCG) that the system of Health Care Associated Infection (HCAI) management meets its obligations with regard to patient safety and clinical governance.

It is also to reassure that best practice is followed as identified in the Hygiene Code and Care Quality Commission underpinning national and local guidance and provide assurance that the Trust remains compliant with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (Department of Health, 2015). A strategic framework to demonstrate compliance with the Hygiene Code can be found in appendix 2.

Using the framework of the health and social care act, the report sets out the arrangements for infection prevention and control within the Trust, and summarises the work and projects implemented in the past year to protect patients from the risk of healthcare associated infection (HCAI). The report demonstrates that the Trust is meeting the requirements of the Health and Social Care Act (The Hygiene Code).

Infection Prevention is an underpinning core part of our 'Patient First' ethos at UH Sussex. It plays a role in all of the trust strategic objectives and priorities. This report will describe how infection prevention activity across the organisation has contributed to our 'true north' objectives of safe and effective care for our patients.
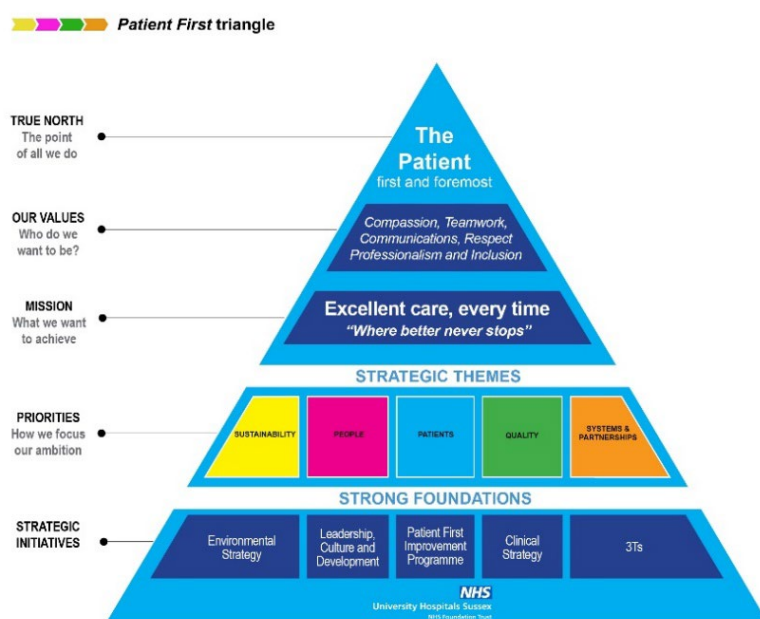
Performance against the 10 criteria detailed in the Hygiene Code

Criterion 1: Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.

1.1 The Infection Prevention and Control Team

The Chief Nurse is the Executive Director of Infection Prevention and Control (DIPC).

In October 2021 the trust appointed an Associate Director Infection Prevention and Control to manage the day to day DIPC responsibilities.

The Lead Nurse for IPC is the Deputy Director Infection Prevention and Control.

The IPCT Teams from the legacy trusts have come together to work as one UH Sussex IPC Team, collaborating on standardising policy and procedure for IPC across the organisation.

The IPC Team is due to undergo a restructure in 2022, with additional investment in staffing to ensure a robust and comprehensive, patient centred service across all sites. The agreed structure for the team is shown in the organogram (chart 1) below.
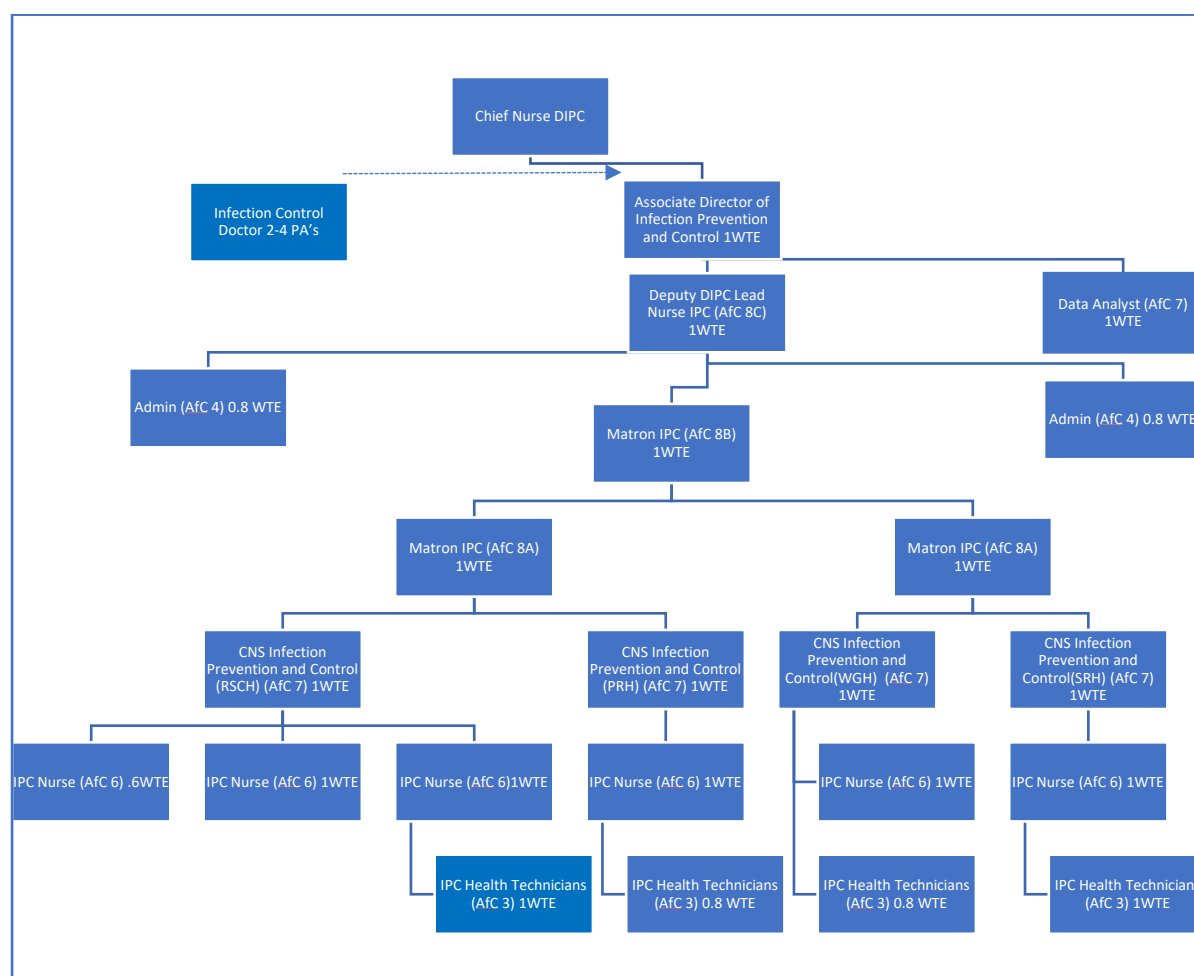
Chart 1 IPC Team structure

The team is supported by the trust Consultant Microbiologists and Virologist. There are 4 PA's for the Infection Prevention and Control Doctor (ICD). The exact arrangement will change in the coming year with a new academic IPC and Microbiology appointment.

Antimicrobial resistance is seen as one of the biggest threats to modern healthcare. The IPCT works closely with the Trusts Antimicrobial Pharmacists to strengthen the messaging around safe use of antimicrobials and avoiding antimicrobial resistance.

Recruitment and retention has been an issue for the IPCT; and the RSCH and PRH sites in particular have been under staffed mainly due to sickness and other leave. The WGH and SRHs are somewhat better resourced with a more stable team who have worked well together, both before and during the pandemic, but they still struggle to provide the proactive service needed for the trust. Overall, this may present a risk in terms of capacity to provide adequate IPC advice and support and thus the restructuring and recruitment of new staff is essential to ensure there are no gaps in assurance, that core IPC work is delivered, and mandatory targets are achieved.

The agreed new structure will enable the trust to recruit and develop practitioners at different levels, future proofing the service. Team members are supported in further training in the specialty with individual team members given time to attend relevant training and conferences to ensure they remain up to date and in turn keep mandatory training sessions for staff refreshed and current. Recruitment nationally is challenged in this field, so the 'grow our own' principle is being pursued with exciting opportunities for staff, including health care assistants.

The IPCT were delighted to be nominated in the Patient First Star Awards for 2022. The team received the 'Clinical Team of the Year' award in recognition of their work to keep staff and patients across the trust safe during the pandemic.

IPC Team at the UH Sussex Start Awards 2022

1.2 Trust Infection Prevention and Control Committee

Infection prevention and control activity in the Trust is overseen by the Trust's Infection Prevention and Control Committee (TIPC) which met quarterly.

- Chair - Chief Nurse /DIPC
- Deputy Chair – Associate DIPC
- Deputy Chair - Medical Director
- Infection Prevention & Control Doctor / Consultant Microbiologist
- Deputy DIPC
- Infection Prevention Matron(s)
- Senior Infection Prevention Nurse(s)
- Surgical Site Surveillance Lead Nurse/Matron
- Antimicrobial Pharmacist(s)
- Decontamination Lead(s)
- Heads of Nursing - Medicine
- Heads of Nursing - Surgery
- Head of Nursing - Women & Children
- Associate Director of Facilities
- Associate Director of Estates
- Health and Safety Lead(s)
- Trust Fit testing Lead
- Medical representation from each Division
- Consultant in Communicable Disease Control
- Occupational Health Manager(s)
- Clinical Commissioning Group (CCG) Infection Prevention Lead Nurse(s)
- Sussex Community Foundation Trust (SCFT) Nurse representative
- Nominated Non-Executive Director

A report is presented to the TIPC Committee summarising IPCT activity for the previous quarter.

TIPC also takes reports from a range of subgroups including Trust water safety groups(s), Ventilation Group, Trust Decontamination Committee, waste management and facilities.

The Trust Infection Prevention and Control Committee reports to the Quality Committee, which in turn reports to the Trust Board.

TIPC reports into the Patient Safety Committee quarterly and relevant data is submitted as part of the Integrated performance Review and Board Quality Scorecard.

The Trust has a monthly IPC Operational Group meeting (IPOG) chaired by the Deputy DIPC. This group includes a range of internal stakeholders and monitors progress on the IPC work plan (appendix 1). The IPOG allows operational issues to be reported, discussed, and actioned, and escalated where needed to the TIPC.

1.3 DIPC reports to the board

As an executive member of the Trust Board the DIPC reports directly to the Chief Executive.

The DIPC presents an integrated performance report including key metric data on *MRSA* bacteraemia, *Clostridioides difficile* infection, *E.coli* bacteraemia, and any issues of note at each Executive Board meeting.

The DIPC and Associate DIPC attend monthly Trust Management Board Meetings.

This DIPC annual report will be presented to the Trust Infection Prevention Committee, followed by the Quality Committee and then to the Trust Board. It will then be published on the Trust website.

A 'Board Assurance Framework' (BAF) for Covid-19 precautions, sent out by NHSE/I was completed as requested. A copy of the most recent version from Feb 2022, can be found in appendix 4.

NHSE/I are planning to introduce a 'business as usual BAF in 2022.

1.4 Healthcare-Associated Infection: Performance against Key Metrics:

Positive microbiology results for key metric infections are reported through the UKHSA Data Capture System (DCS).

MRSA, MSSA *Escherichia coli, Pseudomonas aeruginosa, Klebsiella* species bacteraemia's, and *Clostridioides difficile* infections are all captured in this mandatory surveillance.

Cases are assigned as follows:
- **Hospital onset healthcare associated (HOHA)**: cases that are detected in the hospital two or more days after admission.

- **Community onset healthcare associated (COHA)**: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.

- Community onset indeterminate association (COIA), where a patient has been discharged from hospital during the last 84 days.

- Community onset community associated (COCA).

Cases identified as HOHA and COHA are deemed attributable to the trust.

The Trust was set new trajectories for the year 2021-22. Unfortunately, the Trust had to prioritise the pandemic response and with this additional extreme pressure the trajectories were not achieved.

- The Trust had three cases of MRSA bacteraemia in 2021-22.

- The Trust had149 attributable cases of *C.difficile* against the trajectory of 120.

- There were 168 attributable *E.coli* blood stream infections against the trajectory of 132.

Further detail for these infections and how we plan to make reductions is provided below in section 5.

Organism	Annual Trajectory		Q1	Q2	Q3	Q4	YTD
CDT	120	Trajectory	30	30	30	30	120
		Actual	39	43	37	30	149
		Variance	9	13	7	0	+29
E.coli	132	Trajectory	33	33	33	33	132
		Actual	47	34	45	42	168
		Variance	14	1	12	9	+36
Klebsiella	42	Trajectory	10	11	11	10	42
		Actual	14	12	12	15	53
		Variance	4	1	1	5	+11
Pseudomonas	28	Trajectory	7	7	7	7	28
		Actual	7	11	10	9	37
		Variance	0	4	3	2	+9
MRSA	0	Actual	0	0	1	2	+3
MSSA	n/a	Actual	17	18	22	26	83

Table 1 Trust attributable mandatory surveillance data April 2021 to March 2022 as reported to the UKHSA DCS

1.5 Incidents and Datix Reports

Charts 2 and 3 below gives a summary of incidents related to infection prevention and control which were reported on the Datix system.

Health care associated Covid infection was the most common category peaking in March 22 in line with the national picture of the pandemic.
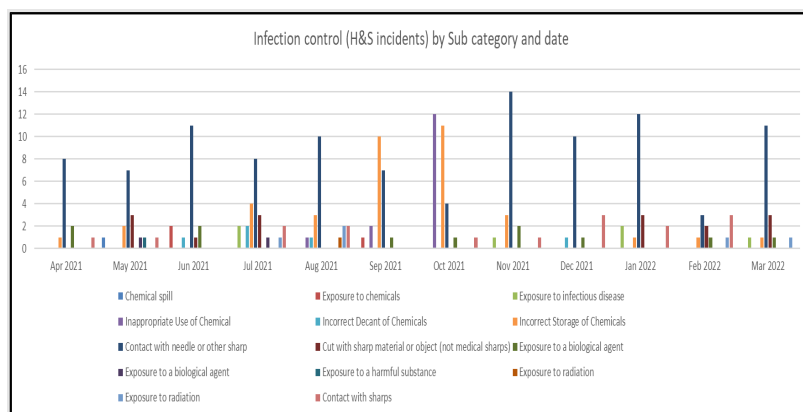
Chart 2 Datix incidents linked to IPC at PRH and RSCH
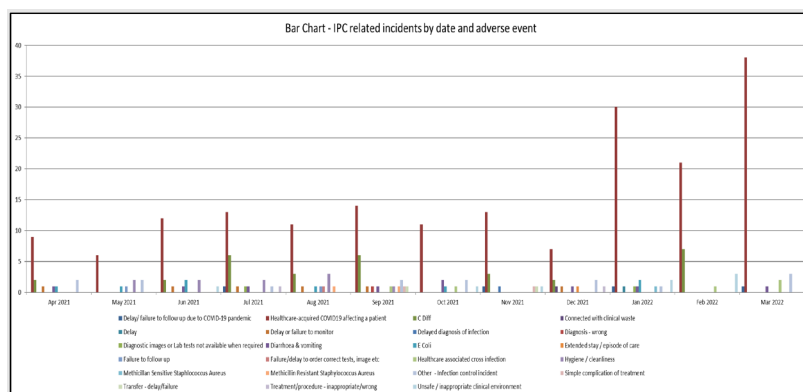
Chart 3 Datix incidents linked to IPC at SRH and WGH

1.6 Risk Assessment

The IPCT works closely with the risk management team to ensure risks are identified correctly on the Trust IPC risk registers with appropriate mitigation put in place. These risks are regularly reviewed with oversight from TIPC for any risks graded above 12.

The risk team work with the Water Safety and Ventilation Groups for water safety and ventilation risk assessments.

Specific work has been undertaken regarding Covid. These include the COVID workplace risk assessment; individual risk assessments for COVID, and 'Hierarchy of Controls' assessments of clinical areas.

Covid 'dynamic' risk assessments have been ongoing throughout the pandemic with decisions needed on many aspects including patient placement, isolation requirements and treatment options. Where needed, risk assessment for difficult or contentious decisions are taken through the Trust Clinical Advisory Group (CAG); a multi-disciplinary group of senior clinical staff who are able to review available evidence and make an appropriate decision, usually later endorsed by Gold command.

2. Criterion 2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

The IPCT work closely with the Estates and Facilities team, especially on areas such as environmental hygiene, decontamination, new builds and refurbishments, ventilation, and water safety to ensure that patients and staff have a clean and safe environment.

During the pandemic they have made a significant contribution to patient safety by contributing to the Bronze IPC meetings, adapting to the ever changing situations, and making appropriate environmental changes including creating isolation areas for red zones.

2.1 Environmental Cleanliness

The Trust manages its facilities contract 'in-house' rather than using a contractor.

Checks of clinical areas against The Hygiene Code are carried out weekly by the ward sisters with a validation check monthly by the matrons. The results are recorded on the Tendable system (previously known as 'Perfect Ward') at RSCH and PRH. They are recorded on paper at SRH and WGH, though they will move to the Tendable system in quarter 2 of 2022.

Patient Led Assessments of the Care Environment (PLACE) assessments did not occur in 2021-22 due to the ongoing pandemic response but are being refreshed for 2022-23. PLACE assessments provide a snapshot of how an organisation is performing against a range of non-clinical activities which impact on the patient's experience of care. This includes cleanliness; the condition, appearance and maintenance of healthcare premises; the extent to which the environment supports the delivery of care with privacy and dignity; the quality and availability of food and drink; and whether the facilities meet the needs of dementia sufferers. The inspections are conducted by patient assessors assisted by teams of staff.

The Facilities and Estates Division are responsible for providing a safe clean environment for patients, staff and visitors at all five trust sites.

The Housekeeping department provides a variety of cleaning methods that include both manual and automated methods of cleaning.

As part of the Trusts compliance there is the requirement to monitor and carry out Technical Audits of all areas within the hospital. These are split in to four risk categories, 1 - 4 with category 1 being very high risk areas. Table 2 below details the outcome of audits carried out in each quarter for the period April – March 2021/2. It shows that high standards were maintained throughout the year.

Quarter 1					
Risk Level	**RSCH**	**PRH**	**Worthing**	**SRH**	**South**
Very High	98.6	98.4	98.7	98.3	98.7
High	95.5	97.2	96.9	97.3	98.9
Significant	90.1	N/A	91.4	92.8	N/A
Low	N/A	N/A	95.2	N/A	N/A
Quarter 2					
Risk Level	**RSCH**	**PRH**	**Worthing**	**SRH**	**South**
Very High	98.2	98.6	98.7	98.1	98.3
High	95.8	98.8	96.8	97.5	98.8
Significant	N/A	N/A	91.4	N/A	92.8
Low	85.8	N/A	96.4	N/A	93.9
Quarter 3					
Risk Level	**RSCH**	**PRH**	**Worthing**	**SRH**	**South**

Risk Level				
Very High	98.2	98.6	98.7	98.1	98.3
High	95.8	98.8	96.8	97.5	98.8
Significant	N/A	N/A	91.4	N/A	92.8
Low	85.8	N/A	96.4	N/A	93.9
Quarter 4					
Risk Level	**RSCH**	**PRH**	**Worthing**	**SRH**	**South**
Very High	98.5	98.8	98.6	98.4	98.2
High	96.7	97.6	97.5	97.8	97.2
Significant	89.5	94.2	96.7	94	93.8
Low	91.5	N/A	93.6	N/A	N/A

Table 2 Outcome of cleaning audits.

The Estates and Facilities team use Synbiotix to record scores against the 49 key elements of the cleaning standards. New national Standards of Cleanliness are due to be rolled out in 2022 Q1.

The Synbiotix reports are spilt down in to Housekeeping, Nursing and Catering.

Daily reports are distributed to all departments detailing scores. Table 3 shows these scores with areas of failure detailed in red and rectifications at source.

Hospital	Ward	Overall	Housekeeping	Nursing	Catering	Functional Risk	Target Score	Star Ra
Outpatients Department (RSCH)	OPD (RSCH) GF	98.11%	98.13%	97.96%	N/A	FR2	95.00%	★★★
Outpatients Department (RSCH)	OPD (RSCH) L1	98.74%	98.92%	97.37%	N/A	FR2	95.00%	★★★
Millennium (A Block)	SSD Millennium	96.79%	96.66%	100.00%	N/A	FR2	95.00%	★★★
Millennium (A Block)	High Dependency Unit	98.77%	98.54%	100.00%	N/A	FR1	98.00%	★★★
Hurstwood Park Centre	OPD HPC GF	100.00%	100.00%	100.00%	N/A	FR2	95.00%	★★★
Hurstwood Park Centre	EEG	99.52%	100.00%	96.88%	N/A	FR2	95.00%	★★★
Hurstwood Park Centre	Day Surgery Unit HPC	100.00%	100.00%	100.00%	100.00%	FR2	95.00%	★★★
Hurstwood Park Centre	Diabetic Eye Screening HPC	100.00%	100.00%	100.00%	N/A	FR2	95.00%	★★★
Hurstwood Park Centre	CT Scanner HPC	99.52%	99.48%	100.00%	100.00%	FR2	95.00%	★★★
Sussex Kidney Centre	Haematology-Onc-SK-09	99.41%	99.26%	100.00%	N/A	FR1	98.00%	★★★
Tower Block (Thomas Kemp)	TMBU	96.92%	97.29%	94.87%	100.00%	FR1	98.00%	★★★
Courtyard Building	Courtyard 6	98.74%	98.56%	100.00%	95.00%	FR1	98.00%	★★★
Courtyard Building	Courtyard 7	99.11%	98.79%	100.00%	N/A	FR1	98.00%	★★★
Courtyard Building	Courtyard 8	98.78%	98.55%	99.37%	N/A	FR1	98.00%	★★★

Table 3 Synbiotix national cleaning standard scores.

The Division also carries out various Deep Cleans and Infectious Cleans within the Hospitals. Table 4 below details these showing a total of 35,703.

640	635	734	877	827	793	903	880	960	1110	864	1193	10416	WG
680	580	552	728	701	776	728	1002	921	806	907	1224	9605	SRH
687	495	601	725	700	765	741	985	834	754	829	1065	9181	RSC
528	375	457	627	606	571	684	638	800	432	687	496	6501	PRH

Table 4 Deep clean numbers

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The Division has recently gone through a restructure process that provides a robust management structure supporting the needs of the organisation.

2.2 Automated Room Disinfection

Effective room decontamination is essential to prevent cross infection of pathogenic organisms between patients. This is particularly so with *Clostridiodes difficile* spores and for control of multi-drug resistant organisms (MDRO's) including Carbapenem resistant *Enterobacteriaceae* (CRE).

Research confirms that enhanced disinfection with automated systems such as high strength of Hydrogen peroxide vapour (HPV) is very effective and enables the Trust to make effective and safe use of beds and reduce length of stay by reducing risk of infection.

There is availability of a HPV system called 'Bioquell' at SRH and WGH, however there is no provision at RSCH and PRH. Work is ongoing with estates to facilitate use of HPV at RSCH and PRH where there is identified need.

April 21	May 21	June 21	Jul 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	21/22 Total	
47	20	44	64	58	53	35	57	54	92	61	79	664	WG
36	19	36	83	72	94	82	127	98	132	113	91	983	SRH

Table 5 number of HPV disinfections 2021-22

The Estates team have planned to purchase some Ultra-Violet (UV) room disinfection lights. These are portable machines that can be used easily to give extra assurance that a room has been fully disinfected. While they are not quite as effective as the HPV (this is because HPV is a gas and can permeate everywhere, whereas UV light only travels in straight lines) this is balanced by the fact that use is much quicker and less complicated, and so can increase turnaround times and patient flow.

2.3 National Standards of Cleanliness

A large project was carried out to bench mark cleaning services across the all Trust sights following merger the scope was to pick up key elements of the existing service which included at frequencies of cleaning, methods of cleaning, productivity of cleaning, responsibilities and work force review. This ensured that the foundation was set for the introduction of the National Cleaning Standards which were launched in 2021.

The organisation has recently implemented the new National Standards of Cleaning 2021 which has replaced the older percentage score system with a Star system. Symbiotics is currently being implemented across the Trust which will deliver a standard audit tool.

2.4 Commode Audit

Cleanliness of toilets, commodes and additional toilet aids is a fundamental standard anywhere but is essential in hospitals to reduce transmission of *C.difficile*.

To ensure all commodes are consistently cleaned to an acceptable standard to render them safe for use for each patient, commodes are checked by ward staff at least 3 times per day. The IPCT aim to complete monthly commode cleaning validation audits across all sites. The IPCT plans to include shower chairs, raised toilet seats and bed pans in future audits. The results will be included within monthly IPC IPOG reports and the data outcomes facilitate learning opportunities for post infection *C.difficile* reviews.

Chart 4 Cross Trust commode cleaning compliance

2.5 Infection Prevention in the Built Environment, Estates and Capital Projects.

The IPCT continues to work with the Estates and Facilities and Capital Projects to ensure that buildings and facilities meet the appropriate standards to enable good infection prevention practices.

The key project for the Trust is the building and commissioning of the 3Ts project at RSCH. The build is nearing completion and it is expected that handover will occur in November 2022, with plans for occupation from February 2023.

The IPCT have been attending project planning meetings and have made site visits to monitor progress. They will continue to work with the Estates and Facilities team to ensure that this new and prestigious building will meet the highest standards for patient safety.

This year the IPCT has also contributed to the following projects:

- Project planning for updates to ED at SRH

- Project input for the expansion of the ED at WGH

- Patient flow input for ED at RSCH

- Project planning for the new UTC at RSCH which opened in March 2022.

- Refurbishment of the interventional radiology suite at RSCH

- Purchase and use of additional HEPA filtration units to improve air quality during the pandemic.

- Project planning for external modular buildings within SRH, WGH and RSCH.

- Project planning for capital refurbishment of Medical Day Case Unit at WGH.

- Project planning for a capital refurbishment of Laundry site at SRH.

- Refurbishment of Operating Theatres at PRH and air handling unit replacement

- RSCH Thomas Kemp Tower Fire alarm replacement

- Project planning for Lift replacements at PRH

- Project planning for new Urology Investigation Unit at PRH

- Project planning for new Audiology services in RACH

- Project planning for washer disinfector replacements in SSD

- Project planning for X-ray refurbishments at PRH

- Project planning for Cardiac catheter Lab refurbishment in RSCH

- Project planning for 3Ts link bridges to Thomas Kemp Tower

- Installation of new dental x-ray services at RSCH and PRH

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IPC Matron Martin Still visiting the 3Ts building site (with permission)

2.6 Water Hygiene Risk Management

Water hygiene has been increasingly recognised worldwide, as a significant factor in prevention of infection. Water hygiene management is essential to reduce risks from *Legionella pneumophillia, Pseudomonas aeruginosa* and other gram negative organisms. Sinks, taps and particularly drains have been implicated in outbreaks of resistant gram negative bacteria and have resulted in enhanced national guidelines.

The Water Hygiene groups have continued to meet quarterly. A new Trust wide Water Safety Committee has been established and will meet quarterly to review results of water sampling and bring together an aligned approach for water safety and management across the Trust.

The trust water safety plan has been reviewed. Routine water testing for Legionella and Pseudomonas contamination has been carried out as part of the Trust's planned preventative maintenance strategy and according to governmental advice both from Department of Health (DH), Health and Safety Executive (HSE) and Health Technical Memoranda (HTM) guidance. Water testing is carried out by different providers in each legacy trust, but work is underway, led by the chief engineer, to look at how this may be streamlined when contracts change.

The water safety groups bridge the gap between clinical infection data and water testing results. This was evidenced in January 2022 when a period of increased incidence of resistant Pseudomonas aeruginosa was detected in four patients on RSCH Level 8 Tower vascular ward. After intensive investigation typing and patient history it was determined the cases were unrelated. Pseudomonas aeruginosa was isolated from some showers in this area and remedial work was undertaken to ensure the water is being managed correctly and that faucets and shower heads are being cleaned in a manner that does not contaminate them.

The IPCT continue to monitor sink usage across the Trust. A trust wide audit is being planned through the water safety group to identify outlets that are in need of modernisation. From the audit, an appropriate replacement programme will be set up, prioritising the most important.

2.7 Decontamination

The Trust has established a Trust wide Decontamination Committee which meets quarterly to address any issues with decontamination of medical devices throughout the Trust, and to monitor the performance of the Trust's four sterile service departments (SSD's). A user group meeting will be held quarterly for each site to review local issues associated with each SSD.

The Sterile Services Departments (SSD) are all fully compliant to ISO 13485 Quality Management System; for Medical Devices.

Following Brexit the SSD departments moved away from European Medical Devices Directorate and are now compliant to UK Medical Devices Regulations 2002 and ISO 13485:2016; audited on an annual basis by a nominated notified body (on behalf of the MHRA) with a full reaccreditation audit every 3 years. This is also backed up with unannounced audits.

The Endoscope Decontamination Units (EDU) are also working within ISO 13485 and they are JAG accredited.

Audits of SSD's and EDUs are carried out on a regular basis by an external approved body on behalf of the MHRA. The SSD also had an unannounced audit by the notified body, which is a requirement to have one at some point within a 3-year period.

The SSD at RSCH is currently installing and commissioning four new Instrument washer disinfectors and the endoscope reprocessing in the RACH will be centralised to SSD in July 2022.

SRH SSD has had 1 x washer disinfector approved through the MDEMG process (on order).

2.8 Endoscopes:

The endoscopy units at all sites hold Joint Advisory Group (JAG) accreditation and ISO 13485:2016, these are carried out annually by an independent body independently from SSD.

On receipt of water test results the Trust policy for endoscopy is actioned by the Water Safety Group, this involves endoscopy decontamination team, estates team, IPC, SSD management cascading the information to the rest of the group.

An issue was identified with a faulty endoscopy brush. IPC team were contacted to advise on patient risk, and assessed this as low risk. The incident was investigated to ensure that all the correct procedures and standards were met and that the washer disinfector was working correctly to identify blockages within the endoscope channels.

The washer disinfector company was contacted to ensure the Trust had done everything to identify any problems. Following investigation, no root cause was identified. The MHRA was contacted to inform users of the cleaning brush product failure, these were removed immediately from the Trust. This incident was presented to TIPC and a Datix raised to complement the final investigation report.

3. Criterion 3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

3.1 Antimicrobial Stewardship

Resistance to antibiotics has been identified as one of the biggest challenges to modern healthcare. We rely on antimicrobials to deliver many forms of healthcare including surgery and cancer care. The 2016 report by Lord O'Neill on antimicrobial resistance puts it as the main cause of death by 2050. Stewardship is an essential component of healthcare. It includes appropriate diagnostic testing, appropriate prescribing and ensuring that where needed, antimicrobials are used according to guidelines. Effective infection prevention and control is also at the heart of stewardship in preventing the need for the antibiotic in the first place!

The trust employs 2.2 WTE pharmacists specialising in infection and antimicrobial stewardship, to oversee stewardship and guide the ward and departmental

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pharmacists in appropriate prescribing practice to reduce overall use of antimicrobials. They support our Consultant microbiologists who interpret and manage infection in patients presenting into the Trust and those who may acquire infection as a side effect of treatment. This may include cancer patients who require antibiotics to prevent their own normal flora from causing infection when they have immunosuppressant therapies, or manage the competing organisms of a patient in ITU with lots of invasive devices.

Antimicrobial Stewardship Ward rounds including an infectious disease consultant, microbiology registrar and pharmacist have started on the digestive diseases ward at RSCH. This is an area noted to have higher use of broad-spectrum antibiotics. This is in addition to the endocarditis, orthopaedic and trauma and vascular ward rounds that are already occurring. The plan is to start a further ward round on haematology/oncology to focus on appropriate antibiotic and antifungal use and stewardship in this area.

Daily combined microbiology and stewardship ward rounds with the microbiology consultant & registrar and antimicrobial pharmacist have continued throughout the year despite staffing pressures at the Worthing and St Richards sites (within both microbiology and pharmacy).

There have been some workforce challenges with provision of trained pharmacists. A business case is being prepared for further antimicrobial pharmacist support and to ensure that we have enough trained pharmacists in all clinical areas to oversee prescribing practice effectively.
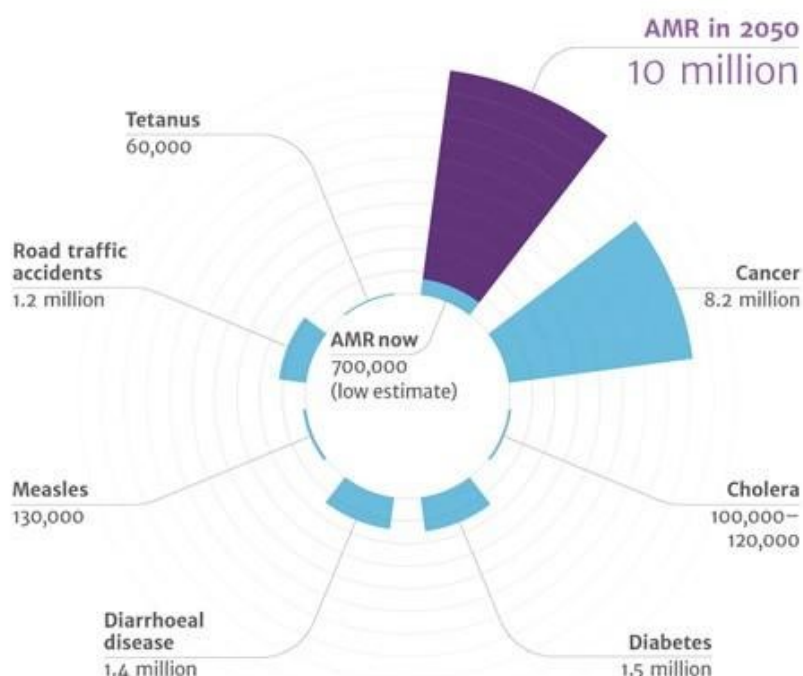
3.2 Covid response

The antimicrobial pharmacy team have been an integral part of the Covid response especially in relation to vaccination role out and use of immunotherapy treatments.

Considerable time has been spent by the antimicrobial pharmacists leading on the development of guidelines for the new treatments for COVID-19. This includes new antivirals, the new class of drugs Neutralising Monoclonal Antibodies and repurposed rheumatology drugs (IL-6 Inhibitors and JAK-2 inhibitors). They have led on implementation for the use of these drugs across secondary and primary care. They have ensured appropriate use considering the benefit and risks with these new medications.

Multiple COVID-19 guideline updates have been written in response to CAS alerts throughout 2021/22. This has now become two pathways for treatment of patients who require additional supplemental oxygen and those who do not.

The extensive input from the pharmacy team to the Covid Pandemic has impacted on the time spent on stewardship activities. There has been no additional funding for the COVID-19 work undertaken by the antimicrobial pharmacists.

3.3 Antibiotic consumption

Antibiotic consumption is reported using data from 'RxInfo'. The Trust merger has confounded the data for 2021-22 and is somewhat harder to interpret.

Standard contract target for 2021/22 was a 2% reduction in use from the 2018 baseline (DDD per 1000 admissions):

- Whole Trust 4382 DDDs per 1000 admissions – met target. The target was to use less than 4491 DDDs per 1000 admissions

The 2021/22 usage was affected by COVID-19 waves, particularly in the winter. These data do not necessarily reflect business as usual due to the pandemic and the impact this has had on acute admissions and elective work, and including time spent on antimicrobial stewardship efforts.

EUCAST recommendations to use increased dosages of antibiotics for some organisms will contribute to increased usage of some broad-spectrum agents e.g. ciprofloxacin, ceftazidime and piperacillin-tazobactam for P. aeruginosa and ceftriaxone for S. aureus. This presents an extra challenge on reducing total (and Watch and Reserve) antimicrobial usage

3.4 AWaRe (Access, Watch, Reserve) category use

The target is greater than 55% to be from the Access category. UHSussex East have not met this target historically but UHSussex West have done. This may be a reflection of the nature of services. Combined data below for 2021/22 show that we have just met the target as a joint Trust but must continue to monitor and work on improving this. Guidelines have been reviewed with this in mind but also the upcoming target of Watch and Reserve reductions for 2022/24.

2021/22 financial year by quarter	Access	Watch	Reserve
April - June 2021	55.0%	43.1%	1.9%
July – September 2021	56.0%	42.4%	1.5%
October - December 2021	57.0%	41.3%	1.7%
January - March 2022	55.2%	42.9%	1.9%

By financial year	Access	Watch	Reserve
2021/22 (UHSx)	55.8%	42.4%	1.8%
2020/21 (WSHT)	60.1%	38.5%	1.4%
2019/20 (WSHT)	62.5%	36.5%	1.0%
2020/21 (BSUH)	50.2%	46.4%	3.3%
2019/20 (BSUH)	54%	44%	2%

Table 5 AWaRe Antimicrobial consumption UH Sussex combined data for 2021/22

3.5 Carbapenem prescribing

Carbapenem prescribing was confounded by the RxInfo data merge. UKHSA fingertips website does not confirm these hugely increased carbapenem usage results so this will be investigated further by the ASG.

By financial year	DDDs per 1000 admissions
2021/22 (UHSx)	7715*
2020/21 (WSHT)	3661
2019/20 (WSHT)	3190

Table 6 Carbapenem consumption * Last 9 months of 21/22 extrapolated to 12 months (may be more accurate): 6159 DDDs per 1000 admissions.

3.6 Antimicrobial Stewardship Group

Cross-site ASG meetings have commenced from Feb 2022 and joint priorities and action plans have been agreed. Joint antimicrobial guidelines have been produced and the staff from the different hospital teams have been working together on joint guidance for the treatment of patients with COVID-19.

Coming out of COVID-19 and with merged guidance in place, the team plans to complete a whole trust point prevalence study identify areas for improvement and highlight good practice.

3.7 Guidelines

The adult antimicrobial guidance has been reviewed and merged. This was a large piece of work due to be published in July 2022. It will be hosted on the current UH Sussex MicroGuide contract.

Guidance for sepsis, pneumonia and gastrointestinal infections has been updated.

Guidance for Infection of Unknown Origin has been produced to prevent inappropriate use of broad-spectrum antibiotics in patients who are not septic.

3.8 Commissioning for Quality and Innovation (CQUIN) Targets

For 2021/22 CQUINs were suspended.

For 2022/23 we will be taking part in a community associated pneumonia CQUIN.

4. Criterion 4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion

4.1 Results

The IPC Nursing team undertake to ensure all key results are communicated both internally and to external agencies as appropriate maintaining patient confidentiality.

The IT system (ICTrack) linking to the pathology laboratory at RSCH has been noted as a risk on the Trust Risk Register. The database is beyond repair and there is a significant risk that all data will be lost. Efforts are being made to improve the situation. IPC reporting would benefit from a bespoke IPC software solution which could be used across the Trust.

4.2 Information leaflets and posters

Information leaflets are available for staff to discuss with patients and the IPCT provides further support as requested.

During the COVID pandemic, the IPCT have made significant effort to ensure that the team are visible in clinical environments providing staff with training and education and giving the support they need at this challenging time.

The IPCT have worked with the communications team to ensure effective communication of important information to staff and patients to enable safe care and compliance with guidance.

The IPCT also played an important role in the Silver level tactical command for the pandemic, giving advice and support to leaders across the organisation.

The Board Assurance Framework compiled as part of CQC requirements can be found in appendix 4. This gives further detail of actions taken to ensure compliance during the pandemic against the Hygiene Code.

4.3 Surgical Site Infection Surveillance (SSI)

4.3.1 SSI at PRH and RSCH

This service has not been as well developed as that at SRH and WGH. The collection of SSI data has sat with the IPCT rather than the relevant clinical teams, and the workload in the pandemic has precluded much activity.

The cardiac team at RSCH, are setting up a service for 2022-23 with dedicated staff and an IT platform which will support efficient data collection. It is planned to initiate something similar with elective orthopaedics which is mainly carried out at PRH.

Mandatory SSI data was collected for one quarter of 2021 at PRH. The team looked at total hip replacement. Due to the pandemic, the number of surgeries was small and no infections were found.

Plans are in place as part of the annual work programme, to meet with the team in Surgery (East) to develop a cross site strategy for SSI surveillance so that it can be undertaken in a robust manner with appropriate learning.

4.3.2 SSI at SRH and WGH

The SSI work is led by the surgical division at WGH and SRH, with dedicated nursing staff to undertake data collection.

The service reviews data from orthopaedic, breast and large bowel surgery.

Results are presented in the table below. There is not a complete picture for the year as the data always lags by at least 4 months due to the collection process.

The overall process of data collection needs a review to make it less labour intensive in terms of transcribing duplicated information from different computer systems which do not communicate with each other.

Surgery	Inpatient/ readmission rate January – March 2022	Last 4 reported periods	National Benchmark	Total January – March 2022 incl. Superficial	National Benchmark
THR SRH & Worthing	2.5% ↑ (3/121)	1.4% ↑ (8/552)	0.3%	2.5% ↑ (3/121)	0.8%
TKR	2.9% ↑ (2/69)	1.2% ↑ (4/338)	0.3%	2.9% ↑ (2/69)	1.1%
Breast SRH	1.1% ↑ (1/95)	0.6% ↓ (2/357)	0.5%	2.1% ↑ (2/95)	2.8%
Breast Worthing	3.3% ↑ (4/122)	1.4% ↑ (7/508)	0.5%	4.9% ← (6/122)	2.8%
Large Bowel SRH	1.6% ↓ (1/62)	2.8% ↓ (8/268)	8.4 %	3.2% ↓ (2/62)	10.2 %
Large Bowel Worthing	7.5% ↓ (5/67)	5.6% ↓ (16/285)	8.4 %	10.4% ↑ (7/67)	10.2 %

Table 7 SSI results SRH and WGH Jan to March 2022

Other work undertaken over the past year includes:

- A multi-disciplinary team meeting (MDT) for patients with a BMI over 35 is now established

- Protocols in place to prevent patients with oozing post-operative wounds being discharged too early.

- Review of DVT prophylaxis and oozing wounds with the Chief of Surgery.

- A wound care clinic run by the Senior SSI Nurse has been established.

- Planning in place to review the role of the ward nurses in maintaining wound care clinics.

- Development of trauma pathway for patients requiring THR to improve standardisation.

- Associate DIPC walkthrough of patient journey.

- Exploring using photographs of patients own wounds pre discharge to improve post op wound management by giving a reference point.

- Improving recording of the patient peri-operative temperatures- agreement to record temperatures 3x during procedures as hypothermia is associated with increased risk of SSI.

- Look at use of patient warming equipment including jackets.

- Review use of Tranexamic acid dose and means of administration for oozy wounds.

- Executive SSI review panel re-established.

- 'One together' workshop held with all relevant key personnel to review our current practice against standards.

- Further working group to establish a UH Sussex 'One Together' approach across the whole Trust is being set up.

- Review of targeted screening for MSSA in relevant patients.

- Decision to use side rooms on trauma wards where possible for revisions or infected arthroplasty.

5. Criterion 5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

5.1 Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia (blood stream infection)

There were 3 attributable MRSA bacteraemia's in 2021-22 shown in chart 5 below. These were all subject to clinical review. Brief findings are outlined below.

A COHA case was identified in SRH in December 2021. A collaborative post investigation review was conducted with IPC colleagues at Sussex Community Foundation Trust. Initial investigation has identified that the patient was not screened for MRSA on admission to Worthing Hospital and this learning opportunity was disseminated to the clinical teams.

Two further cases occurred in March 2022.

The first was a young person at RSCH and was related to poor documentation following insertion of a peripheral IV line. The patient developed a cellulitis associated with the cannula but was not otherwise unwell. They have since been discharged.

The second was an elderly patient at Worthing who was admitted due to fall/general decline. The patient was a known MRSA carrier with multiple co-morbidities, including end stage renal failure. The patient passed away the day after the culture was taken. A structured clinical review was completed. MRSA bacteraemia was not identified as a cause of death.
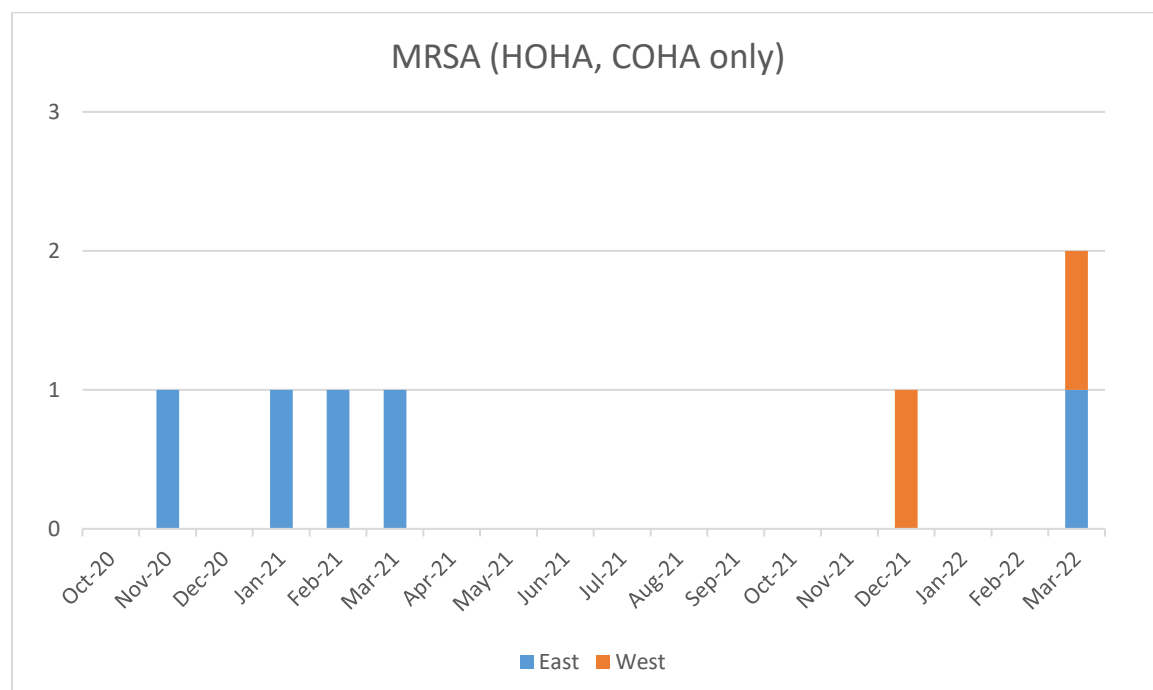
Chart 5 MRSA Bacteraemia 2021-22

5.2 Meticillin-sensitive *Staphylococcus aureus* (MSSA) Bacteraemia

MSSA (HOHA, COHA only)
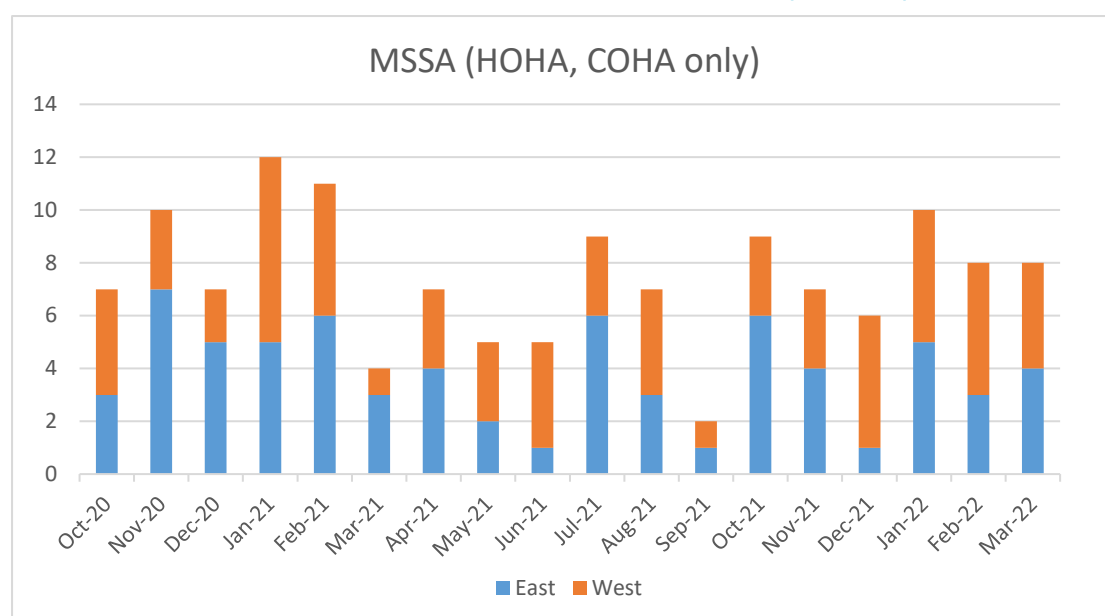
Chart 6 MSSA Bacteraemia 2021-22

MSSA, like MRSA, causes a variety of infections, of which bacteraemia is one of the most serious. However, unlike MRSA, the majority of these infections occur in the community and are unrelated to healthcare. In 2021-22 there were 186 MSSA bacteraemia's of which 83 were attributed to UH Sussex. Due to increased workload a selection of attributed MSSA bacteraemia's were reviewed and root cause analysis carried out to look for preventable causes. The cases of bacteraemia were associated with the following sources of infection: skin and soft tissue infections, biliary stents, discitis, pyelonephritis. Despite no formal target for reduction we are keen to avoid any preventable cases especially device related infection.

5.3 *Clostridioides difficile*

All stool samples found to be *C. difficile* toxin (CDT) positive must be reported as part of mandatory surveillance.

C.difficile cases identified as HOHA and COHA are deemed attributable to the trust.

The trust has a trajectory set for no more than 120 attributable cases per year. This was exceeded by 29 cases for the year (charts 7 and 8 below).

Attributed *C.difficile* cases undergo a clinical review to identify learning points. Causes for *C.difficile* transmission are varied and may include environmental contamination, antimicrobial use, chemotherapeutics, and use of hand gels as opposed to hand washing.

Some of these reviews are behind due to pandemic pressures. As the pandemic eases, the IPC team intend to catch up on any missed reviews.

A review of process and engagement with the clinical teams will be undertaken and implemented from April 2022 to ensure that we see a reduction in cases and move closer to the trajectory.

This will include a refocus on essential elements of infection control including:

- Focus on appropriate stool sampling

- Work on antimicrobial prescribing awareness

- Work on improving and standardising cleaning practice across all sites, including use of automated room disinfection as detailed in section 2.2 above.

- Improving hand hygiene auditing.
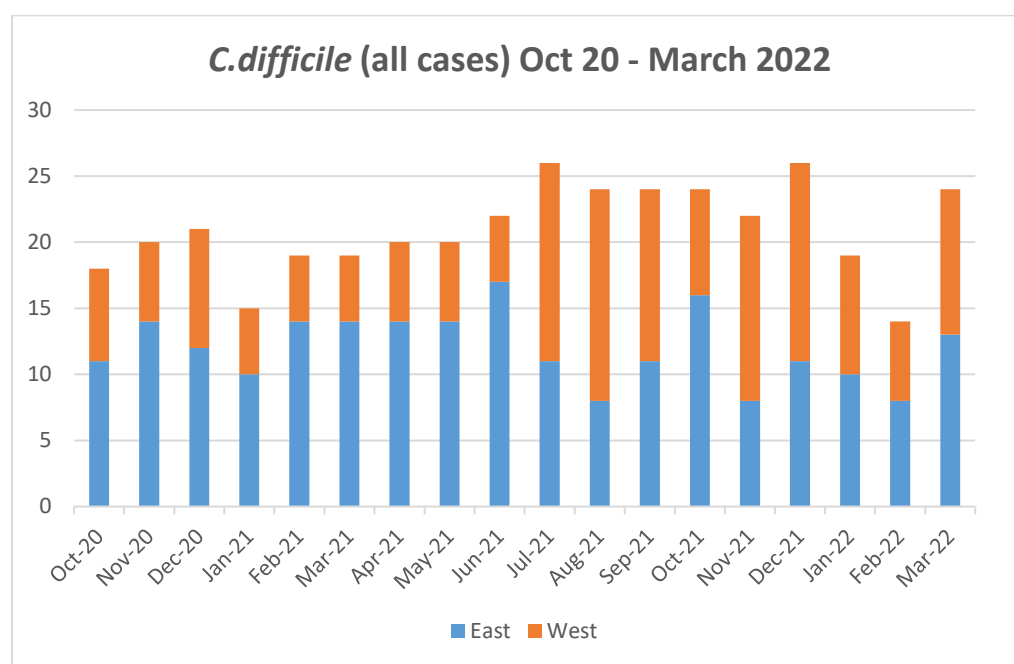
Chart 7 CDT all cases Oct 20 –Mar 22
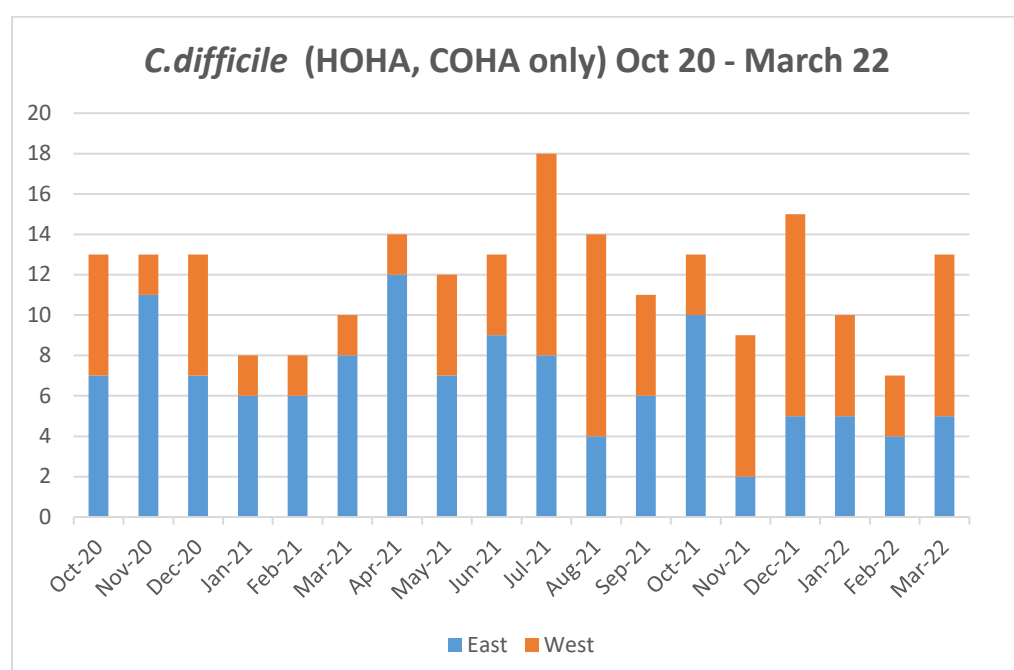
Chart 8 CDT HOHA/ COHA cases (attributable) Oct 20 –Mar 22
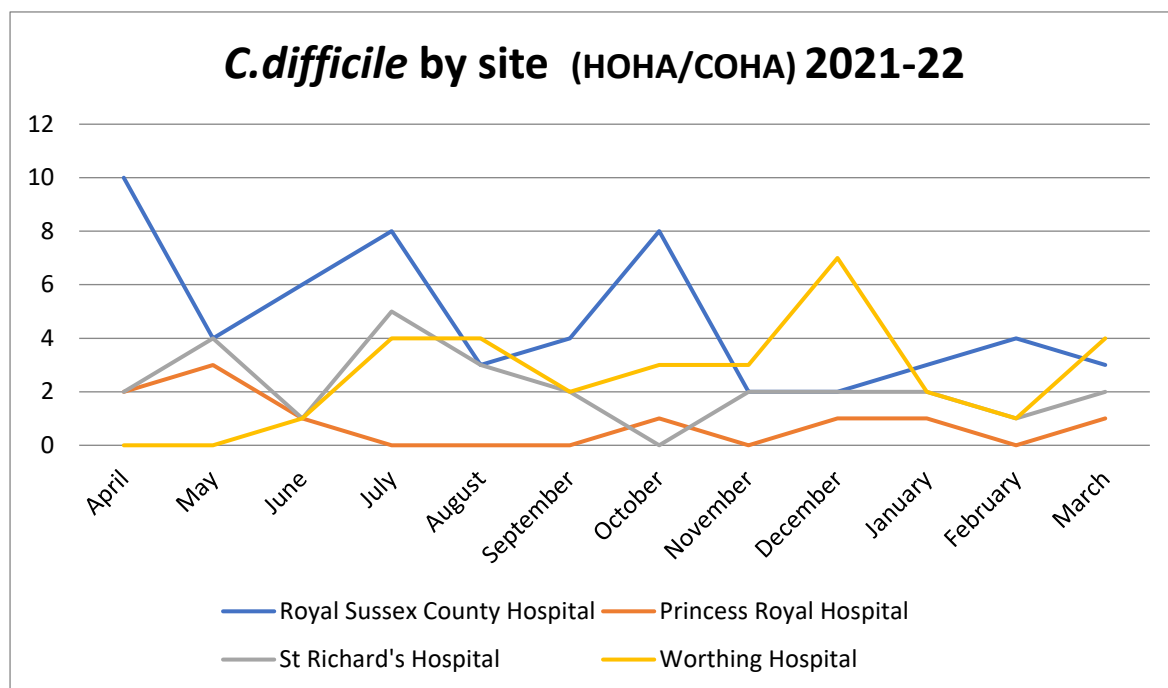
Chart 9 CDT HOHA/ COHA cases (attributable) by Trust site, April 21 –Mar 22
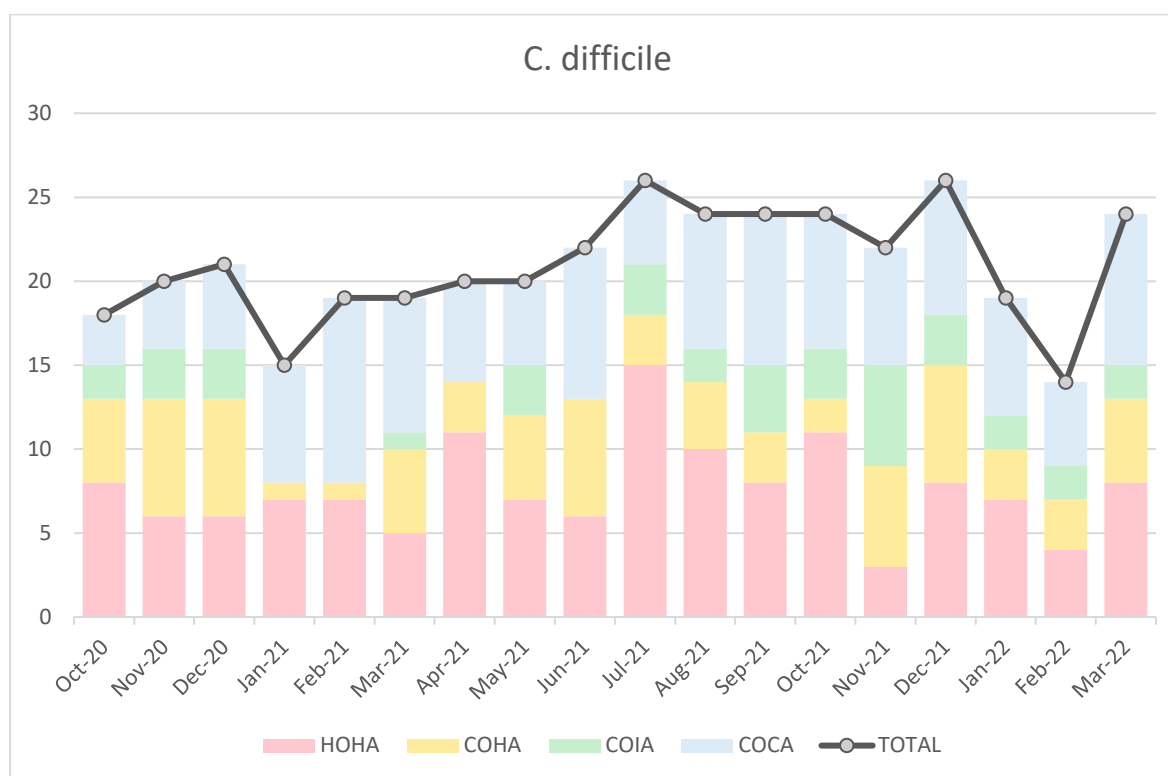
Chart 10 CDT all cases Trust wide (by attribution category) Oct 20 – March 22

5.4 *Escherichia coli* (*E.coli*) Bacteraemia

E.coli is a gram negative bacteria which is considered normal human gut flora. However, it has been increasingly implicated as a cause of blood stream infection (bacteraemia) often associated with urinary tract infection, and commonly seen in patients in the community (80% of cases occur outside of hospitals). In 2018 NHSI/E set an objective for the UK to halve healthcare associated *E.coli* bacteraemia rates by 2024.

Reporting of *E.coli* bacteraemia is mandatory through the UKHSA DCS along with *Klebsiella sp* and *Pseudomonas aeruginosa* bacteraemia.

There is an option to contribute to an enhanced data set regarding source of the infection and associated risk factors. This has not been completed due to staffing pressure during the pandemic, however it is anticipated that going forward this information will be collected and analysed to give direction to preventative activity. Main sources identified from previous clinical reviews were hepatobiliary, IV device and respiratory.

The trust reported 168 (HOHA COHA) *E.coli* bacteraemia's which is 36 over trajectory for the year.
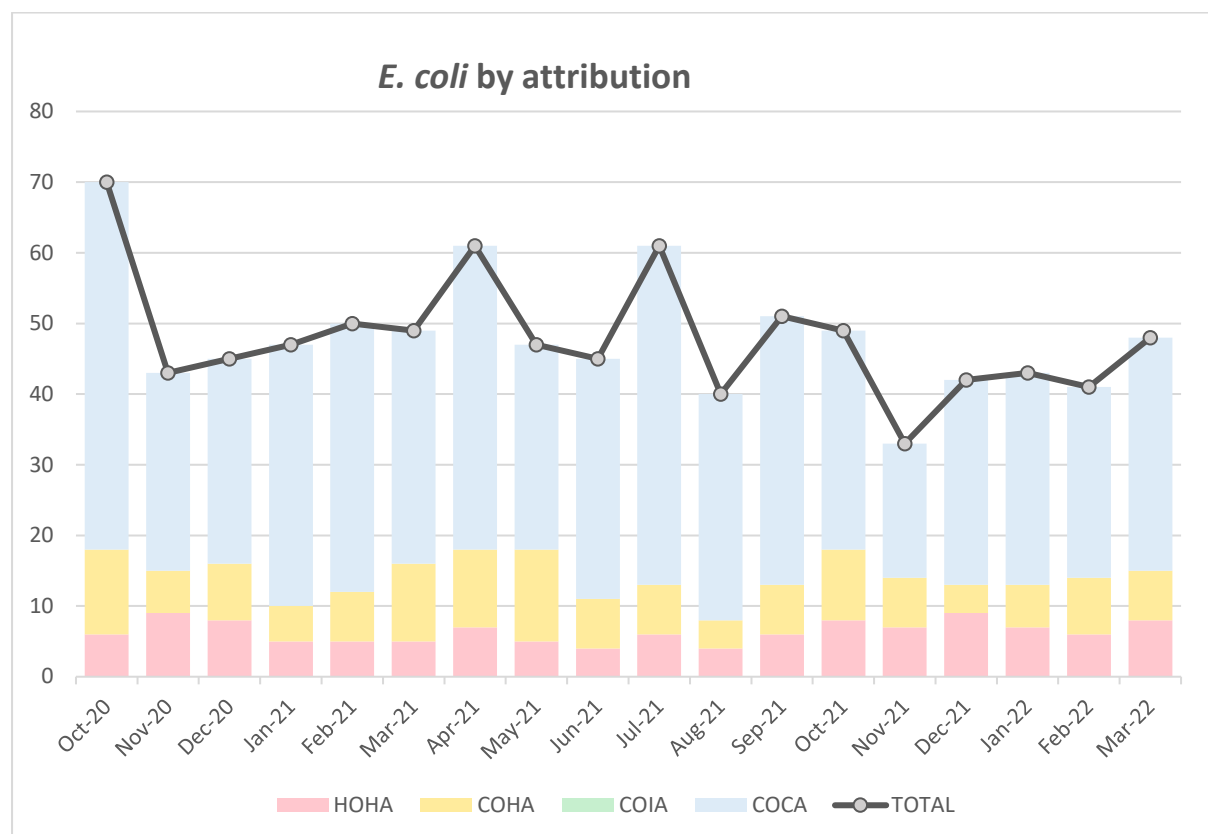
Chart 11 *E.coli* all cases Trust wide (by attribution) Oct20 –March 22

E.coli attributable by Trust site April 21 to March 22
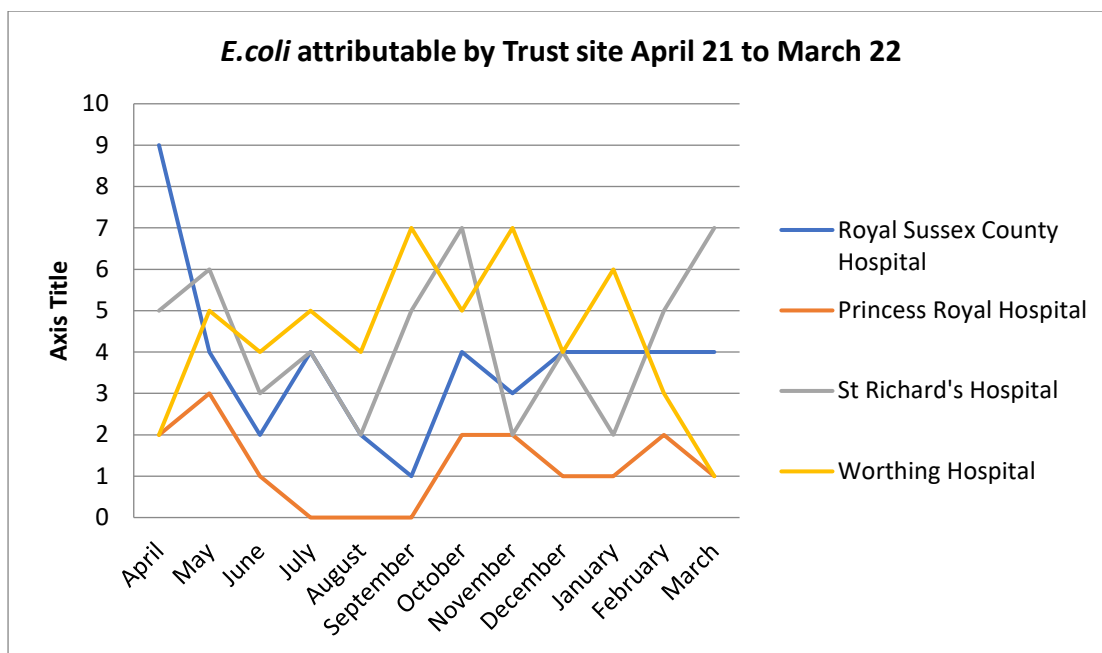
Chart 12 *E.coli* all attributable cases (by Trust site) April 21 –March 22

5.5 *Klebsiella* species and *Pseudomonas aeruginosa*

This year was the first where ambitions were set for gram negative blood stream infections caused by *Pseudomonas aeruginosa* and *Klebsiella* species. Both these organisms were above the set trajectory for the year.

Where there have been occasional isolates of *Pseudomonas*, following routine water sampling, point of use filters were put in place on the outlets as a precaution. There were no associated clinical cases. The water safety group has agreed that where there is a clinical isolate of unknown origin, we will undertake water testing of local outlets to triangulate any risk.
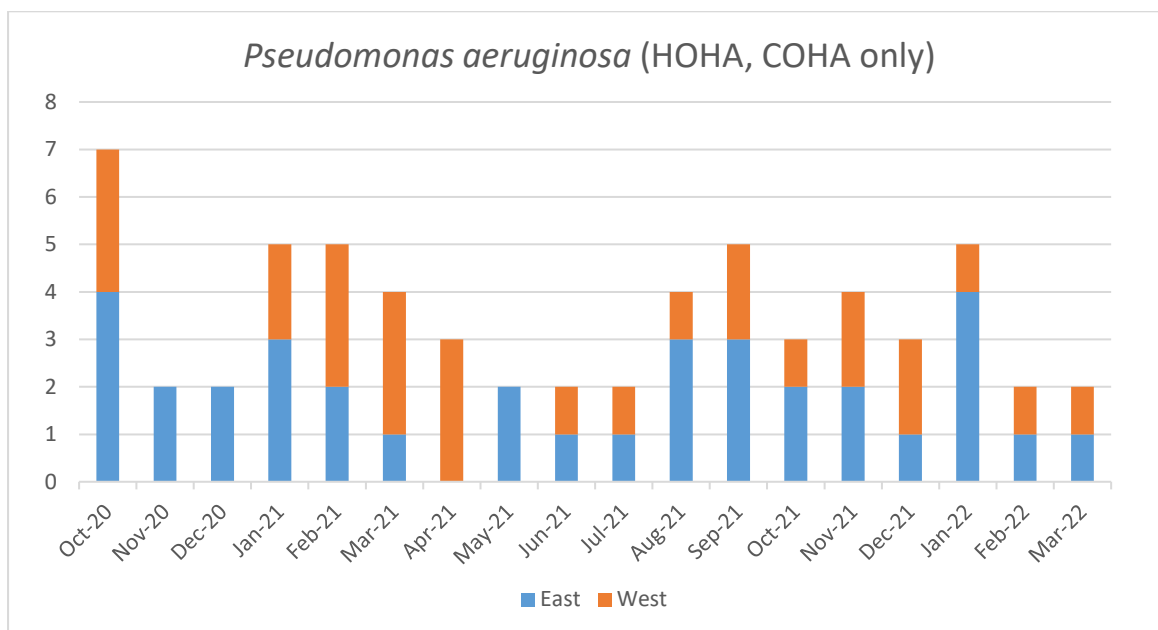
Chart 13 *Pseudomonas aeruginosa*; attributable cases Trust wide Oct20 –March 22 -all cases Trust wide (by attribution)
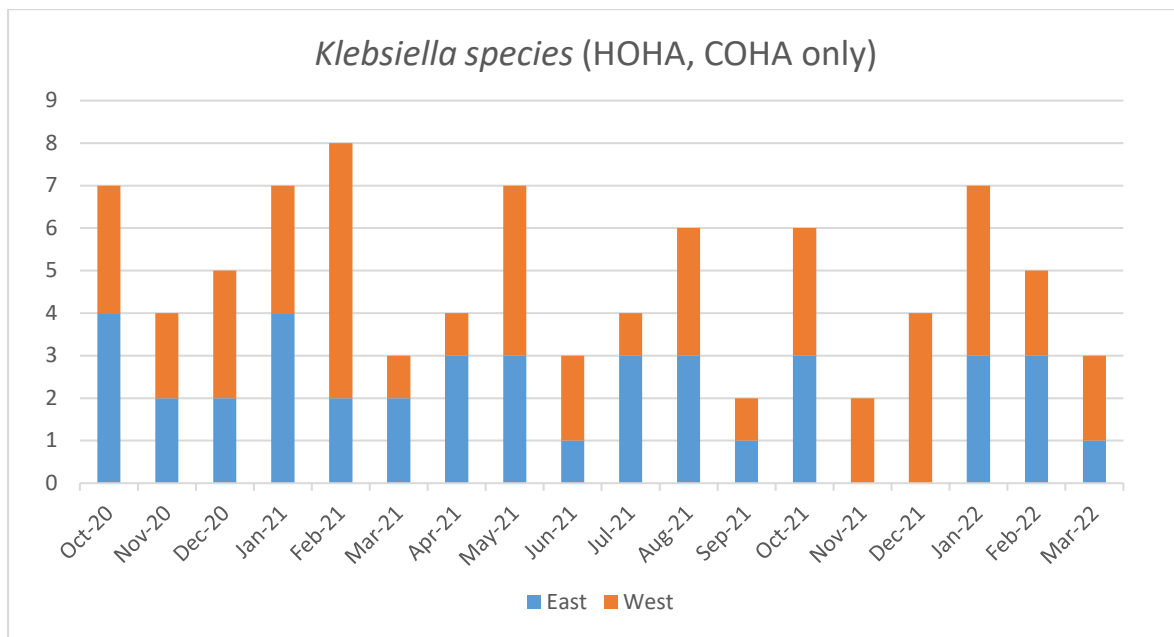
Chart 14 *Klebsiella* species; attributable cases Trust wide Oct20 –March 22

5.6 COVID-19

COVID-19 has presented the biggest health challenge across the globe in living memory. COVID-19 is the disease caused by a human coronavirus called SARS CoV2. It was named because of its similarity to the SARS virus seen in 2003, but unfortunately this virus is far more transmissible among humans and the global pandemic has resulted in 200 million cases and 4 million deaths worldwide, along with massive economic disruption and normal life curtailed for much of 2020, 2021 and 2022.

The pandemic posed a logistical challenge to keep our patients and staff safe whilst maintaining essential care for patients.

The pandemic came in ill defined 'waves. The first is generally accepted as that occurring between March and June 2020, the second October 2020 through to February 2021, the third was in summer 2021 and the 4th wave ran from December 2021 to March 2022.

The 4th wave in December 2021 was due to the Omicron variant which caused cases to soar nationally. In February and March of 2022 Omicron variant BA.2 emerged, and numbers grew further causing significant pressures across all trust sites.

Despite increasing admissions and ongoing transmission with outbreaks, Omicron was for most, though not all, a milder disease and did not result in many ITU admissions.

Significant staffing shortages were experienced, reflecting the situation in the community.

Charts 15 and 16 below show the cases for each site since 1st April 2021

There have been a total of 106 outbreaks since October 2021. Of these 48 outbreaks were in the East, of which 33 have been since January 2022; and there were 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.

Outbreak information was uploaded to the NHS Online Outbreak platform. Outbreaks were reviewed daily at a multi-disciplinary meeting including our stakeholder partners from the CCG.

Initially each outbreak had a post infection review with a multi-disciplinary team, led by the ward manager and Matron. As the number became overwhelming the process for clinical review was simplified due to the volume of cases and this was accepted by our partners at CCG and NHSI/E level.

The associate and Deputy DIPC have been active participants in the NHSE/I South East IPC Cell and the Sussex IPC Cell, working with our healthcare partners, local authority colleagues and commissioners.
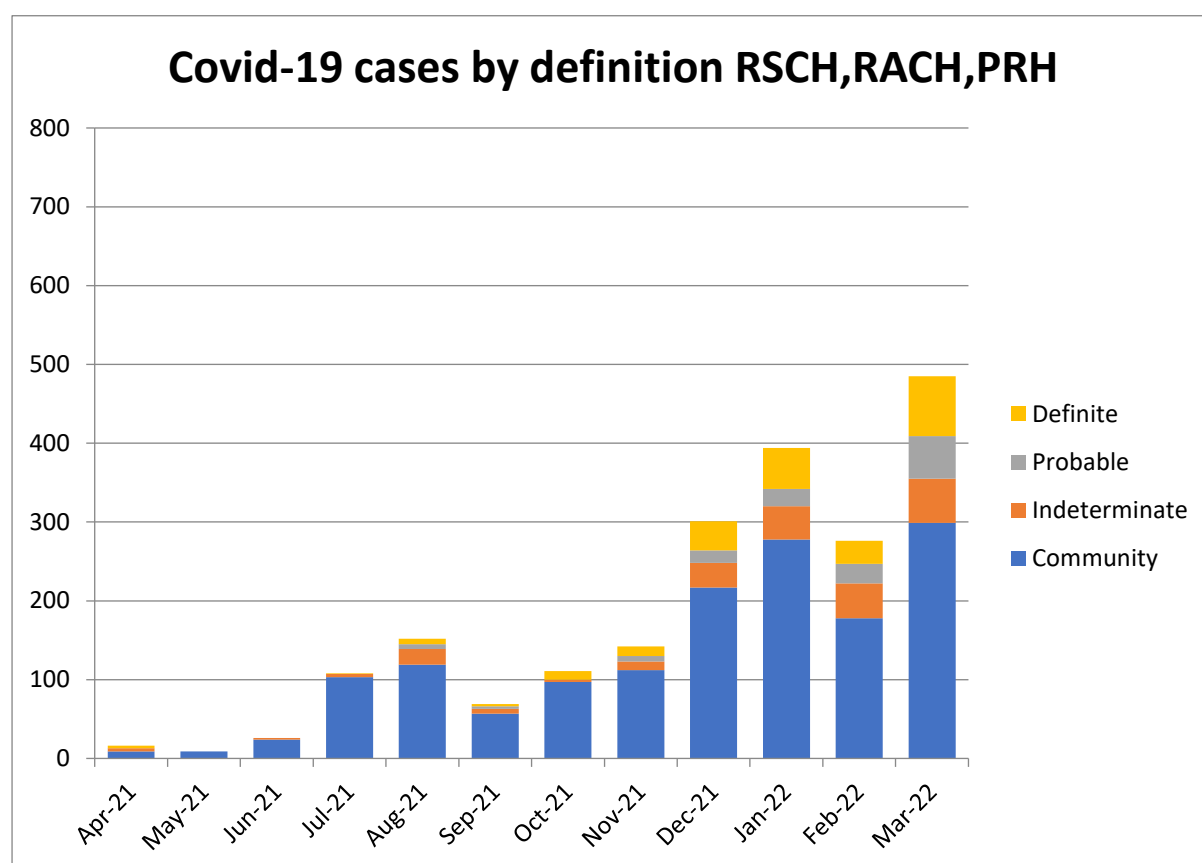
Chart 15 COVID-19 UHS East all cases (attributable= definite and probable and non attributable = Indeterminate and Community)

Covid-19 cases by definition SRH and WGH
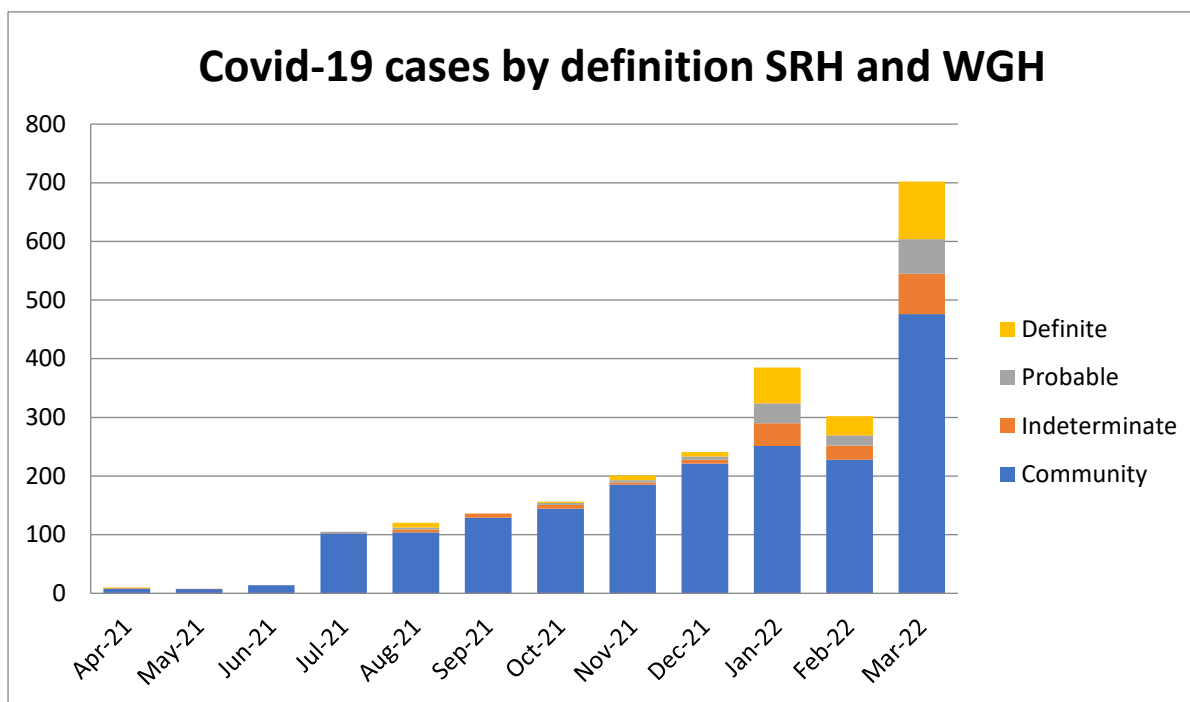
Chart 16 COVID-19 UHS West all cases (attributable= definite and probable and non attributable = Indeterminate and Community)

Key points to highlight:

Staff did not have any shortages of essential PPE, and they were supported by an enhanced Infection Prevention Team, senior nurses, managers, and the leadership team who endeavoured to ensure safe operational running of services across the Trust.

Asymptomatic screening of patients helped to ensure that infected individuals did not pose a risk to other patients or our staff, and thus allowed essential services to proceed.

The Trust set up a Bronze Command for IPC which met daily to review the clinical situation including the number of cases. This information was fed into Trust Silver meetings and hence to Gold command (Executive level). Covid Silver met 2-5 times a week during the year and included a range of staff, clinical and managerial, who coordinated the pandemic response.

The trust reviewed all guidance coming in from NHSE/I UKHSA (PHE) etc at a Clinical Advisory Group meeting (CAG). This was chaired by the Medical Directors and included a wide range of clinicians who interpreted guidance in the light of local service knowledge. Whilst the Trust acknowledged the guidance, and in particular the national ambition to start 'living beyond Covid', it was at time felt that a more cautious approach was needed in light of local prevalence and thus the Trust has continued with mitigations including patient testing and use of masks beyond that recommended. This was decided in the best interests of our patients and staff and kept under review in light of changing local prevalence.

The Trust has not carried out its own research with regard to areas such as the effectiveness of mask wearing to decrease the spread of Covid. Those looking for the science behind aspects of care such as mask wearing, have been directed to the many

resources available online or to contact NHS England and/or the UK Health Security Agency.

More than 16,00 staff (83%) of staff had their first Covid vaccination delivered by the trust. Others may have had vaccination elsewhere.

5.7 Flu

The flu campaign was conducted alongside the booster vaccinations for COVID-19.

Approximately 47% of staff were staff were vaccinated for Flu within the Trust.

There was very little Flu seen across the Trust during the winter which may in part be due to the ongoing emphasis on respiratory etiquette, social distancing and use of masks.

5.8 RSV

It had been predicted that there would be a surge in RSV during the winter of 2021-22, however this did not occur, again probably due to the ongoing pandemic precautions in place. There were no recorded outbreaks.

5.9 Carbapenamase Producing *Enterobacteriaceae* (CPE).

There is growing concern worldwide about the threat of antimicrobial resistance especially in multi-drug resistant gram negative bacteria. Some of these organisms including *Escherichia coli* and *Klebsiella pneumoniae* are showing resistance to the antibiotics of last resort the Carbapenems and even Colistin. These organisms which are usually found in the gut, are associated with a high mortality rate in vulnerable patients. They tend to be found most commonly in overseas patients from countries where these organisms are prevalent. Recognition of carriers of these highly resistant gut organisms is considered vital in limiting their spread. Robust infection prevention and control is essential for preventing spread and limiting the exposure of other patients.

During February 2021 a patient on the Royal Sussex County Hospital Intensive Care Unit (ITU) was found to have a highly resistant VIM CPE *Pseudomonas aeruginosa* in a urine specimen. The specimen was sent for typing and extensive environmental screening undertaken. Screening identified the same organism and type in a sluice hopper in the dirty utility on ITU. It is not known if the organism went from the patient to the sluice hopper, or the other way round. The literature highlights that these highly resistant organisms can colonise drains and wet areas. In fact, The Royal Sussex County Hospital has experience of the same organism on the Haematology Oncology Unit in 2010. The patient did not come to harm from the organism and IPC precautions were enforced, including weekly swabbing of the patients, replacement of the sluice hopper and specific macerator and sluice hopper cleaning. No other patients were found to have the organism and a Trust wide standard operating procedure for macerator and sluice hopper cleaning was developed.

The IPCT have worked with the clinical site teams to enable safe intra hospital transfer arrangements for patients to reduce risk of CPE transmission.

An area for development in 2022-23 is the implementation of routine screening for CPE is key areas such as the ITUs. This has been challenging due to microbiology laboratory capacity, which has been taken up with universal MRSA screening. A more targeted approach to MRSA screening in line with national guidance, will free up laboratory capacity to look for other more significant resistant organisms.

5.10 Diarrhoea and vomiting/ Norovirus

In October PRH Twineham ward bay five had two patients with vomiting. As a precaution the bay was closed to admissions and discharge to care settings whilst samples were obtained and analysed. Neither patient had Norovirus isolated and the bay was cleaned and opened.

In December PRH Hurstpierpoint was closed initially with a period of increased incidence of diarrhoea and vomiting that was confirmed to be caused by Norovirus. This resulted in ward closure until 48 hours had elapsed since the last symptom.

In December the Sussex House Nursery in Brighton was affected by a period of increased incident of diarrhoea and vomiting. Symptomatic staff and children were excluded in line with policy and guidance. No organism was identified and theorised to be viral gastroenteritis. The unit remained open throughout

In December PRH Ardingly Bay 8 experience a period of increased incidence of diarrhoea and vomiting affecting three patients. Norovirus was identified as the cause and only bay 8 needed to be closed and the rest of the ward was not affected.

No Norovirus outbreaks were reported at SRH or WGH.

It is somewhat unusual to see so little norovirus, especially in winter; but this may be a reflection of the Covid restrictions in place and represents a national picture.

6. Criterion 6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

6.1 Link Practitioners

There are some identified Link Practitioners for Infection Prevention across the Trust but this is an area for development. The link practitioners are local staff who can take a lead in embedding infection prevention into their clinical area.

This scheme has not been consistently supported and will become a priority for the team going forward with the new structure, so that we can help embed good practice across our clinical areas. We aspire to improve local understanding and interest in IPC which benefits the Trust as a whole, by setting up a series of training sessions and improving the communications through increased ward presence.

6.2 Education and Training

All clinical and non-clinical staff members are given Infection prevention training on induction. Clinical staff members (including doctors) are trained annually in Infection Prevention and Control. This has been via a video since the start of the pandemic. The IPCT training video was refreshed in autumn of 2021 in order to ensure information was current.

Infection Prevention - clinical & non clinical
% Compliance - April 2021-March 2022

Divisions at RSCH and PRH

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Infection Prevention	87	88	88	88	87	88	87	88	88	90	90	91
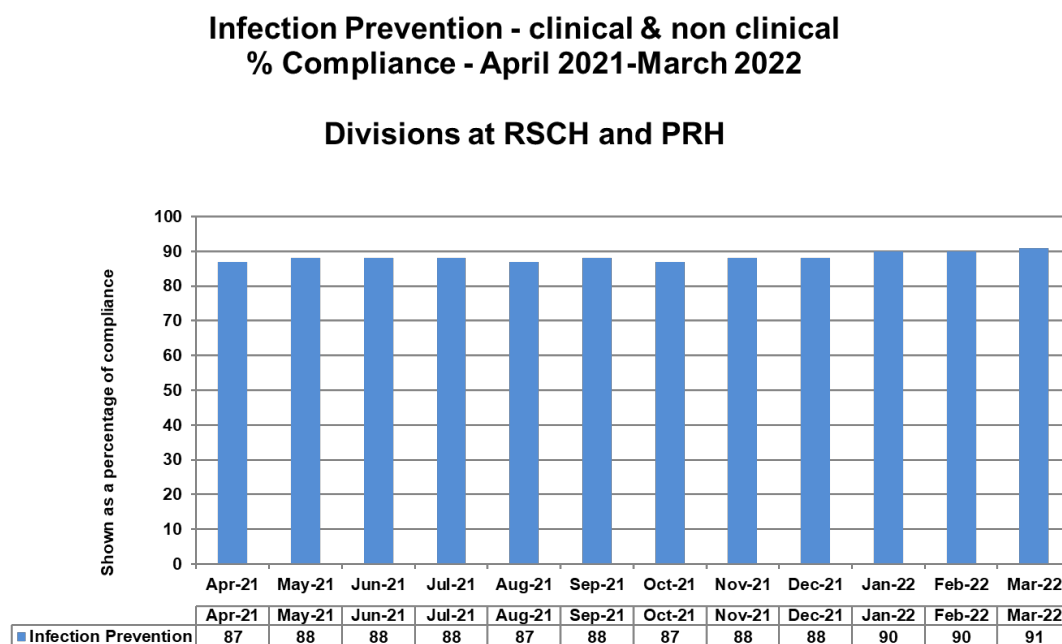
Chart 17 RSCH and PRH training compliance figures.

Infection Prevention - clinical & non clinical
% Compliance - April 2021-March 2022
Divisions in SRH & WG of UHSx

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Infection Control	81.73	82.49	81.41	77.27	77.61	74.62	73.85	75.22	75.89	76.61	77.45	79.63	82.36
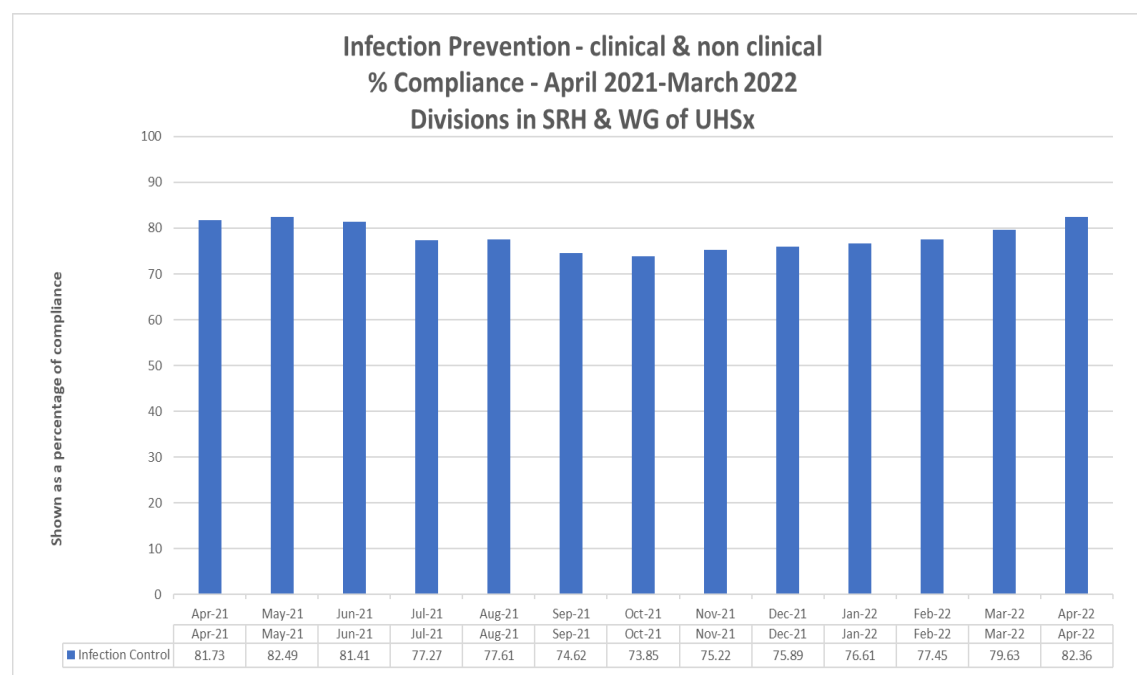
Chart 18 SRH and WGH training compliance figures.

Three members of the IPC team gave presentations at the Sussex CCG Champions Development Week, in May 2021. These included hand hygiene, CPE patient management and serious incident review.

Our Chief Nurse gave a very well received presentation at the annual IPS Conference in Liverpool about difficult decision making during the Covid pandemic.

6.3 Hand Hygiene Audit and Observational Data
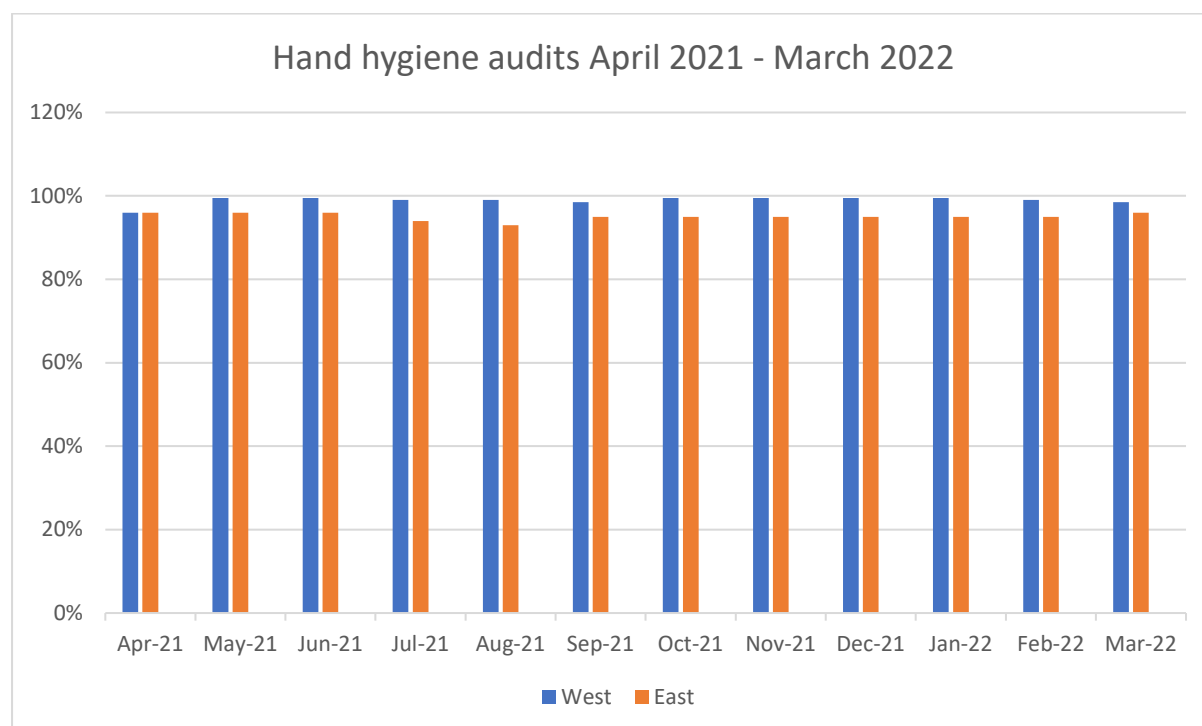
Chart 19, Hand hygiene scores UHS April 2021 – March 2022

The average score across RSCH and PRH was 96%. The average recorded score from St Richards and Worthing was 99%. These were not validated by the IPCT.

Monitoring for hand hygiene is enabled on the East side using the 'Tendable' audit application. It is intended that this is rolled out across the West side of the Trust in May 2022. This will allow monitoring of audit compliance as well as scores.

Validation audits will be undertaken in the coming year by the IPC team as part of the annual audit plan.

7. Criterion 7. Provide or secure adequate isolation facilities

7.1 Provision of Isolation Facilities

The Trust maintains a reasonable proportion of single rooms for source isolation of patients with infection. There is an infectious disease unit at RSCH which is mainly single ensuite rooms.

Appropriate signage is used throughout the Trust depending on the type of isolation required. Signage has been reviewed several times during the COVID pandemic.

Nurses and other clinical staff are regularly updated through mandatory and other training on key aspects of isolation.

Limited negative pressure source isolation facilities are available across the sites, and risk assessments determine the priority for the small number available and in use.

7.2 Ventilation

Specialist Ventilation has always been a high priority at University Hospital Sussex and the IPCT work in conjunction with the Estates Team, to ensure that systems are monitored correctly. There are frequent planned maintenance and annual external verification required for all operating theatres, sterile services department, pharmacy and endoscopy units.

Since the emergence of the Covid pandemic ventilation has been recognised as one of the most important contributing factors to ongoing transmission of infection. A key part of the national approach has been focussed on the fact that transmission is less likely outdoors and in well ventilated and uncrowded spaces, than in crowded, poorly ventilated, and indoor spaces.

The role of ventilation is recognised as an important element in the hierarchy of controls and the ventilation and the quality of air supplied to all hospital areas has come under scrutiny 'Ventilation should be integral to the COVID-19 risk mitigation strategy for all multi-occupant buildings and workplaces. This should include identification of how a space is ventilated and articulation of the strategy that is adopted to ensure the ventilation is adequate'.

University Hospital Sussex has seven main geographical sites, all built in different years with building additions and reconfigurations over many decades. It has become apparent that not all areas are compliant to the 'Health Technical Memorandum 03-01 Heating and ventilation of health sector buildings' guidance, for which most clinical

areas are required to have 6 air changes every hour. Some parts of the trust including wards at Princess Royal, Barry building at RSCH and some wards at WGH don't meet this standard. This situation will be found in many, if not most UK hospitals. The picture is further complicated by the need to put doors into bays on wards at PRH which further alters airflows as air flow is from the corridor. Rectification work to meet desired standards would require millions of pounds of capital investment and cause significant disruption through ward closures.

To mitigate and improve air quality, a limited number of 'air scrubber' machines have been purchased. These are machines with a HEPA filter which remove particles in the air, so while not supplying fresh air, they very effectively clean the air in a room and have been felt to be very beneficial in helping prevent or control Covid outbreaks.

Further evaluation and measurement of engineering ventilation systems across the Trust is required to allow full assessment and prioritisation of improvement work.

Air Scrubber in place at St Richards Hospital

8. Criterion 8. Secure adequate access to laboratory support as appropriate.

UKAS accredited microbiology services are provided on site at both RSCH and SRH.

The IPCT act upon email alerts from the microbiology lab for key organisms and conditions to ensure information is appropriately communicated.

Microbiology results are also available to IPC staff via different methodologies. On SRH and WGH sites microbiology communicate to IPC via an excel database (manual process), email or telephone call. On RSCH/PRH sites the microbiology laboratory staff communicate to IPC via a system called ICTrack.

As noted in 4.1 above, there remains an urgent need to update the IC Track IT systems used by the IPCT at RSCH and PRH as these are dependent on an old computer which is an identified cyber risk. This has been escalated and we anticipate a response soon.

9. Criterion 9. Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections

9.1 Policy provision

The IPCT has been undertaking work to merge all policies from the legacy trusts and this work is almost completed.

All policies are maintained on the Trust intranet. They are subject to three yearly review or sooner if there is change to national guidance.

Policy information including new changes is communicated to staff via mandatory training, via the senior nurse meetings and via the comms team.

A new national IPC manual is being issued from NHSE/I. This document is still in early draft and is not as complete as our own specific policies, so while this guidance document is acknowledged, we will currently maintain our own documents.

9.2 Audit Reporting

At RSCH and PRH audits have been completed using the Tendable system. This has enabled audit tools to be embedded for use at ward level by the clinical staff. At SRH and WGH this has been a manual process.

Once Tendable is available on all Trust sites the audit cycle will become electronic to ensure consistency and accuracy for feeding back to the clinical teams, monitoring actions taken and taking learning opportunities forwards.

The IPCT were able to complete about 70% of planned spot check audits of the environment, despite the pandemic pressures. Audit feedback is given directly to ward staff at the time and with a report to the ward/dept manager.

Relevant information including hand hygiene compliance is shared in the quarterly TIPC report.

Planned audits for 2023 can be found in appendix 3.

10. Criterion 10. Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

10.1 Occupational Health Service

The Occupational Health service is an in-house service for RSCH and PRH, while a contractor called 'TP Health, provide services for SRH and WGH.

OH work alongside the IPCT to ensure that any staff concerns with regard to infection are appropriately addressed so that the staff are safe and feel supported in their work. This is particularly notable with issues such as sharps injury prevention, risk assessments, hand skin integrity and vaccination for infection.

10.2 Seasonal and Pandemic Influenza Planning

The Occupational Health Department and IPCT also work closely in planning the seasonal flu prevention campaign.

10.3 Face Mask Fit Testing

A key element of protection for staff during the pandemic has been the use of face masks.

Fluid resistant surgical face masks have been in place since June 2020 for all staff in the hospitals.

For staff dealing with patients infected with Covid, it has been recommended that a filtering face piece 3 (FFP3) respirator mask is worn as this gives complete protection from viral particles in the air.

To effectively wear an FFP3 mask the user must undergo fit testing to ensure that the mask gives the correct coverage.

A programme of fit testing is in place across UH Sussex with input from an external government funded fit testing service as well as our own internal fit testing trained staff.

Despite best efforts the overall fit testing compliance remains low. In areas where staff are likely to care for Covid infected patients such as ITU, the compliance is much higher. During Q2 2022/23 all staff fit testing results will be uploaded and affiliated to the Health Rostering system. This will give line managers a transparent view on who has been fit tested within their clinical teams. This new initiative will hope to increase compliance within the clinical frontline staff.

Staff member being fit tested, using a PortaCount machine, by government funded fit tester.

11. Associate DIPC Priorities for 2022-23

The role of the Associate DIPC was created to support the executive DIPC in the day to day delivery of IPC priorities.

Whilst the IPC work plan for 2022-23 (appendix) captures planned work for the coming year, the associate DIPC has identified the following as key priorities for delivery:

- Improvement in IPC staffing levels to enable a more proactive approach to IPC across the organisation. This is being progressed through the consultation process.

- Development of an efficient SSI surveillance programme which utilises existing data and maximises the opportunity for improvement

- A reorganisation of the Clinical review process to bring down reportable infection.

- Role out of a trust wide 'mouth care matters' initiative, to improve patient comfort, dignity and reduce pneumonia infection.

- Work with sustainability team to reduce glove usage and look at how effective IPC can help deliver our trust green plan.

- Work with Estates and Facilities in the delivery of the 3Ts build, ensuring maintenance of patient and staff safety though areas such as water hygiene, ventilation and equipment.

12. Conclusion

The Trust can demonstrate compliance with requirements of the Hygiene Code across all its sites. This is further summarised in Appendix 1.

The IPCT continues to work with staff across the UH Sussex in a collaborative way to ensure Infection Prevention is fully embedded in everything we do so that our patients and staff are protected from avoidable infection.

This year has probably been the most challenging ever with the COVID pandemic continuing to disrupt services. The infection prevention and control team have put in a huge effort to provide leadership, guidance and support across the Trust in dealing with this national crisis.

The new IPC Team structure will facilitate proactive activity across the Trust, which will further improve patient safety and advance our patient first objectives.

13. References

1) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/928720/S0789_EMG_Role_of_Ventilation_in_Controlling_SARS-CoV-2_Transmission.pdf

2) https://www.gov.uk/government/publications/guidance-on-specialised-ventilation-for-healthcare-premises-parts-a-and-b

3) Jones, B. et al. (2020)'Modelling uncertainty in the relative risk of exposure to the SARS-CoV-2 virus by airborne aerosol transmission in Buildings', Preprint at Research Gate. Doi: 10.13140/RG.2.2.25874.89283

4) NHS England » (HTM 04-01) Safe water in healthcare premises HTM 04-01 Safe water in healthcare premises

5) Health Technical Memorandum 04-01: Safe water in healthcare premises. Part C: Pseudomonas aeruginosa – advice for augmented care units (england.nhs.uk) Part C: Pseudomonas aeruginosa – advice for augmented care units

IPC Work Programme on a Page 2022-23

NHS University Hospitals Sussex NHS Foundation Trust

Promoting patient and staff safety by prevention and early intervention

Principles	Our Ambitions	What do we need to do	How will we recognise success
Data and insight led Patient centred Active listening Place-oriented Fairness and equality Solution focused Prevention/early action Accountable **1. Establish full IPC workforce** **2. Reduce rates of key infections including MRSA, *CDT, E.coli* to meet national targets** **3. Ensure robust SSI process** **4. Work with Estates to improve ventilation in clinical areas** **5. Robust and complete audit programme** **6. 3Ts delivery** **7. Sustainability** **8. Role out of mouthcare matters**		1. Restructure consultation and recruitment programme 2. Strengthen arrangements for the Infection Control Doctor 3. Review the clinical review process and learning 4. Role out of a link practitioner scheme 5. Policy review 6. Hydration improvements 7. Review of stool sampling 8. Ward based education, support and learning 9. Work with surgical divisions to review process for SSI surveillance. 10. Agree resourcing to ensure work completed 11. Audit of air flows in clincal area 12. Review options for enhanced ventilation 13. Use new structure to embed a robust audit process for key metrics 14. Work with Capital projects and estates to ensure highest standards of ventilation, water safety and environmental decontamination for the new build 15. Active role in handover and commissioning 16. Participate in gloves off' work and other initiatives to improve sustainability 17. Role out trust wide engagement project to enhance patient safety, dignity and experience 18. Engage with trust leaders to identify areas for improvements 19. Establish steering group to oversee project initiation	▶ Fully Staffed and trained IPC Team including ICD support ▶ Meet national IPC Targets with improved learning from clinical review process ▶ Robust and efficient SSI Surveillance programme in place ▶ SSI results within expected range or lower ▶ Ventilation improvements help reduce infection ▶ Full audit programme completed ▶ 3Ts delivered as a safe care environment ▶ Reduction in inappropriate glove use ▶ Mouthcare Matters rolled out across Trust with MDT and cross site engagement

Appendix 2: Strategic Framework for the Prevention and Control of Infection and compliance with the Hygiene Code 2021-22

Criteria of Hygiene Code	Objectives	Assurance mechanisms	Responsible lead/s	Date to be accomplished (or monitoring method for ongoing activities)
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.	• Appropriate management and monitoring arrangements • Risk Assessments • DIPC Assurance Framework • Cleanliness program • Cleanliness infrastructure • Movement of service users • Estates maintenance programe • Staff trained in appropriate use of PPE • National guidance followed • Stand up appropriate response to COVID-19 pandemic	• The Chief nurse is Director of Infection Prevention and Control and there is a full time Associate DIPC. The lead IPC nurse is the deputy DIPC. • DIPC and IPCT report to Board and other appropriate management such as Quality Committee • The Infection Prevention and Control Annual Report is published on the Trust website. • A report is presented to the Quality Committee and the annual report is presented to the Board by the DIPC, including statistics on incidence of alert organisms including *MRSA*, *MSSA*, E.*Coli*, *Klebsiella sp*, *Pseudomonas* and CDT. • A Corporate risk register is maintained which encompasses IPC and reviewed regularly. • Clinical review is carried out on all *MRSA* and *E. coli* bacteraemia's (BSI); cases of *Clostridium difficile* infection and any outbreaks or unexplained rises in incidence of any infection. • The IPCT consists of team of specialist IPC nurses, supported by consultant microbiologists, antimicrobial pharmacists and administrative support. • The team is being restructured in 2022 with additional resource. • There is 24-hour on-call access to a Consultant Microbiologist.	Chief Nurse/DIPC IPCT Divisional Directors Trust Matrons Head of Facilities Head of Estates	Quarterly, Annual reporting and exception reporting for matters arising. Ongoing monitoring surveillance and review.

| | | • Divisional Directors ensure adequate resources are in place for IPC service provision.
• There is an overarching Trust policy in place for Infection Prevention and Control and other relevant IPC policies reviewed every 3 years.
• All staff receive sessions on infection prevention and control at induction and mandatory training.
• There is an annual IPC audit plan in place including some surgical site surveillance.
• The Associate DIPC is designated as the Trust decontamination lead.
• Estates management and maintenance procedure are in place.
• National guidance is regularly reviewed and brought to the attention of the Board as necessary.
• Silver tactical notes, agendas and daily sit-reps were maintained for the pandemic response.
• Fit-testing records are available | | |

Criteria of Hygiene Code	Objectives	Assurance mechanisms	Responsible lead/s	Date to be accomplished (

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	• Mechanisms and policies in place for the delivery of services for:
	   o Facilities management
	   o Estates management
	   o Decontamination of medical devices
	• Appropriate environmental cleaning
		• Environmental Cleaning program including rapid response.
		• Policy for cleaning and environmental decontamination (including roles, responsibilities and accountability).
		• Visible displays of cleaning schedules across all clinical departments
		• Matrons monthly audits of their areas and act on non-compliances.
		• Hand hygiene facilities are provided including alcohol hand rub at the point of care as appropriate.
			Director of Estates and Facilities
			
			Chief Engineer
			
			IPCT
			
			Matrons
				Ongoing monitoring surveillance and review.

Criteria of Hygiene Code	Objectives	Assurance mechanisms	Responsible lead/s	Date to be accomplished
	carried out as per national guidance • A full audit of water outlets is required across trust in order to RAG rate and prioritise for improvements	• IPCT input to refurbishments and capital projects to ensure safe and fit for purpose. • Response to national guidance during COVID-19 pandemic		
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	• Maintain and improve systems to manage and monitor use of antimicrobials promoting the Start Smart, then Focus principles for antimicrobial prescribing during • Use of antimicrobial prescribing App MicroGuide. • Provide adequate Microbiology laboratory support.	• Routine antimicrobial ward rounds. • Antimicrobial steering group which includes Drs from key clinical areas. • Antimicrobial policy which is audited and reported on regularly. • Antimicrobial annual report detailing improvements and successes.	Antimicrobial Pharmacist Consultant Microbiologist Laboratory Manager	Ongoing monitoring surveillance and review.
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.	• Information for service users and visitors. • Staff encouraged to be clear and transparent when describing risks of infection and where giving patient advice / instruction.	• Annual and periodic review and update of patient information and leaflets in conjunction with Comms Team, PALS and patient representatives with feedback to clinicians. • IPC mandatory training. • Visitor signage during pandemic regularly updated	IPCT Comms PALS	Ongoing monitoring and annual & periodic review as necessary.

Criteria of Hygiene Code	Objectives	Assurance mechanisms	Responsible lead/s	Date to be accomplished
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	• Restructure and strengthen the IPCT to provide effective support across UHS • Develop and train IPC nurses as necessary to attain appropriate skills and experience • Embed the culture that infection prevention is everyone's responsibility. • IPCT to notify and annotate on all new isolates in a timely manner.	• Appropriately trained infection prevention and control nurses. • All staff receive annual refresher training including awareness of IPC responsibilities. • Staff reminders and training to take appropriate samples from patients with signs of possible infection. • Microbiology laboratory communicates positive results. • IPCT communicates all results and advise on appropriate infection control precautions. • Increased training across trust, supported by information on intranet and signage to support IPC behaviours in COVID pandemic.	DIPC / ADIPC Principal Biomedical Scientists IPCT	Ongoing monitoring through: • Annual reviews & reports • Staff training records & PDR
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	• Infection Prevention in Job descriptions • Appropriate training and induction • Contractor work permits and local induction	• IPC is included in Trust induction and annual mandatory training. • Video learning available for IPC training. • The monitor records of training. • Extra IPC presence on wards to support staff during COVID pandemic – use of band 3 support workers. • Infection prevention and control responsibilities are reflected in job descriptions and reviewed at annual appraisal • Staff in departments undertakes hand hygiene and environmental audits. • Contractor training and compliance • Estates use 'permission to work' system. Contractors given IPC induction by video.	Managers Learning and Development Team IPCT Estates	Ongoing monitoring through: • Annual reviews & reports • Link worker meeting minutes • Staff training records & PDR • Contractor contracts
Criteria of Hygiene Code	Objectives	Assurance mechanisms	Responsible lead/s	Date to be accomplished
7. Provide or secure adequate isolation facilities.	• Allocate isolation facilities appropriately based on risk assessment • Review of ventilation across the Trust is required to understand	• The Trust has a reasonable number of single rooms but is sometimes unable to isolate as required. • The IPCT is consulted in respect of new builds and refurbishments. • Requirements for special ventilation are included in relevant policies.	IPCT Head of Estates	Ongoing monitoring through: • Audits • Datix

Criteria of Hygiene Code	Objectives	Assurance mechanisms	Responsible lead/s	Date to be accomplished
	where improvements can be made and plan how these can be achieved.	• Appropriate zoning and pathways is in place and regularly reviewed to reduce risk of cross infection with COVID-19		• Meeting minutes and Terms of reference
8. Secure adequate access to laboratory support as appropriate.	• Accredited microbiology labs on 3 sites • Need to establish more efficient mechanisms for obtaining results from the labs in order to ensure they are actioned in a timely and effective manner.	• Microbiology laboratory is UKAS accredited	Microbiology Consultants Principal Biomedical Scientists	Established and annual accreditation renewal.
9. Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	• Policies for infection prevention and control are being merged from legacy trusts.	All relevant policies are in place, reviewed annually and are published on the Trust intranet • Standard precautions • Aseptic technique • Outbreaks of infection, Isolation • Sharps, BBVs • Closure of wards • Decontamination of reusable medical devices • Single-use medical devices • Antimicrobial prescribing • MRSA, CDT, GRE, CROs • CJD • TB • Respiratory viruses • Diarrhoeal infection • Packing and handling of specimens • Care of deceased patients	IPCT Head of facilities Head of Estates	Published and reviewed annual & periodically as necessitated by new laws or guidance.
Criteria of Hygiene Code	Objectives	Assurance mechanisms	Responsible lead/s	Date to be accomplished
10. Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	• Occupational Health services provided by Team Prevent (WGH and SRH) and an inhouse team (RSCH and PRH)	• Occupational Health services available to all staff employed in the Trust and provide: o Pre-employment screening o Annual Flu vaccination for all staff • Some education for occupational health protection is included in IPC induction and mandatory update training • Extensive suite of SOPs and guidance to support staff during COVID-19 pandemic.	Occupational Health Teams IPCT	Established and Electronic records are maintained immunisations. Education updated annually and periodically as necessitated by new laws or guidance.

Appendix 3   Infection Prevention and Control Planned Audit Programme 2021 -22

AUDIT	INTERVAL	COMPLETED BY	RESPONSIBLE
Antimicrobial Prescribing	6 monthly	Pharmacist	Lead Antimicrobial Pharmacist
Environment	Weekly PRH/RSCH Monthly SRH/WGH	Ward Sister/Charge Nurse Ward NIC/IPC/Facilities	Ward/area
Full IPC environmental audit	Annual	IPC Team	IPC site Lead
Hand Hygiene	Weekly	Ward staff/Link practitioner	Ward Sister/Charge Nurse
Commodes	Monthly	IPC	IPC
SSI surveillance	Monthly	Ward Sister/Charge Nurse	Ward Sister/Charge Nurse
Ventilator associated pneumonia	Monthly	Ward Sister/Charge Nurse	Ward Sister/Charge Nurse
MRSA Screening	Monthly	IPC Team	IPC site Lead
Hand Hygiene	Monthly	IPC Team	IPC site Lead
Sharps	Yearly	Sharps bin provider	IPC site Lead
Decontamination-Endoscopy	Yearly	IPC Team/ Decon leads	IPC site Lead
Operating Theatre	Yearly	IPC Team	IPC site Lead

Appendix 4: Infection prevention and control board assurance framework V1.8 Presented on 24/2/22

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure that: • a respiratory season/winter plan is in place: 　○ that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services 　○ to enable appropriate segregation of cases depending on the pathogen. 　○ plan for and manage increasing case numbers where they occur. 　○ a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan. • health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone. • Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: 　○ based on the measures as prioritised in the hierarchy of controls. including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area. 　○ applied in order and include elimination; substitution, engineering, administration and PPE/RPE. 　○ communicated to staff. • safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems. • if the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been	Respiratory action card: 'non-elective respiratory admissions flowcard' is in place with a triage tool. Testing is available with Triplex (for flu, RSV and C-19), Cepheid, Samba, DnA Nudge, Menorini, Abbott I.D Now and lateral flow tests. Maintained red and green pathways. Maintained IPC Bronze and Silver meetings with appropriate multi-disciplinary participation. A Clinical Advisory Group makes recommendations to Gold. New builds planned with additional isolation facilities. Estates have undertaken preliminary assessments of ventilation to identify areas of concern. COVID secure practices remain in place as per guidance. This includes use of FRSM for all staff and visitors, with patients encouraged to wear as much possible. We continue to encourage social	Need further detail on the infrastructure of the buildings including air change rates in specific rooms. Need full engineering assessment of ventilation.	Estates team arranging detailed assessment of existing ventilation with plans for upgrades as appropriate. Mitigation in place with additional air scrubbing machines in high risk areas with suboptimal ventilation. New builds planned with additional isolation facilities.

approved through local governance procedures, for example Integrated Care Systems.	distancing and we monitor use of trust facilities.		
• risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents.	We carried out assessments of clinical areas using the hierarchy of controls.		There are weekly management briefings to staff. Staff are encouraged to open windows, spread out during breaks, avoid car sharing
• if an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered.	We carried out assessments of offices at the start of the pandemic.		
• ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services.	Staff all had risk assessments carried out for their individual risks and these have been updated as required e.g on return to the office.		
• the Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep.in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases			Staff in areas of suboptimal ventilation are encouraged to use FFP3 masks when dealing with patients who have or may have covid.
• there are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas.	Daily SitRep is seen by CEO and DIPC.		
• resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	PPE, hand hygiene and environmental audits are in place.		
• the application of IPC practices within this guidance is monitored, eg:	Online training in place and monitored.		Additional air scrubbing machines in red areas, where available
○ hand hygiene.			
○ PPE donning and doffing training.	Framework presented to the board.		
○ cleaning and decontamination.			
• the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board.	The trust has engaged Ashfield to undertake fit testing and there are 6 types of mask available. All staff undergoing testing are tested to a minimum of 2 and preferably 3 masks.	We may need to reassess office spaces with return to work	Records are maintained on IRIS or Bamboo HR Systems.
• the Trust Board has oversight of ongoing outbreaks and action plans.			
• the Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Make FFP3 masks are available to users as required.			
		Need to have rollout of a universal electronic audit system such as 'Perfect	

| | | Ward' which is currently only available at RSCH and PRH. | |
| | | Fit testing is not recorded on ESR. They need be centralised to give assurance that all relevant staff are tested. | |

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions

Systems and processes are in place to ensure that:
 	
• the Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level.
 	
• the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms
 	
• cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.
 	
• increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas.
 	
• Where patients with respiratory infections are cared for : cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance.
 	
• if an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses.
 	
• manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.
 	
• a minimum of twice daily cleaning of:
 	
    o patient isolation rooms.
 	
    o cohort areas.
 	
    o Donning & doffing areas
	This is work in progress to move to the new standard. There is a working group and the plan is to implement by April 2022.
	
	Monitoring results are presented at IPOG and TIPC.
	
	Cleaning of all isolation rooms is undertaken with Chlorclean (Chlorine 1000ppm) as per manufacturers instructions.
	
	Aim is always to clean as a minimum twice a day in high risk areas
		NSoC is not fully implemented. Functionality of rooms to be determined.
		
		May not always be possible to clean twice a
			Appropriate services in place with frequent monitoring and rectification of any issues.

o 'Frequently touched' surfaces eg, door/toilet handles, patient call bells, over bed tables and bed rails.
 	
o where there may be higher environmental contamination rates, including:
 	
  ▪ toilets/commodes particularly if patients have diarrhoea.
 	
• A terminal/deep clean of inpatient rooms is carried out:
 	
o following resolutions of symptoms and removal of precautions.
 	
o when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens);
 	
o following an AGP if room vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).
 	
• reusable non-invasive care equipment is decontaminated:
 	
o between each use.
 	
o after blood and/or body fluid contamination
 	
o at regular predefined intervals as part of an equipment cleaning protocol
 	
o before inspection, servicing, or repair equipment.
 	
• Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.
 	
• As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance.
 	
  In patient Care Health Building Note 04-01: Adult in-patient facilities.
 	
• the assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer.
 	
• a systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways
 	
• where possible air is diluted by natural ventilation by opening windows and doors where appropriate
 	
• where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group.
	Cleaning of all rooms on discharge is undertaken with Chlorclean as per manufacturers instructions.
	
	Reusable equipment cleaned as per manufacturers instruction with either Clinell universal wipe or Chlorclean.
	
	Estates have undertaken preliminary assessments of ventilation to identify areas of concern.
	
	Hierarchy of Controls assessments have been undertaken.
	
	Detailed review is planned with upgrades built into capital project bids.
	
	Windows are opened where possible.
	
	Laundry for blankets has increased
	
	Screens are put up where appropriate
		day due to staffing (pandemic)
		
		It is not always possible to open windows as elderly patients do not like the draft
			Close supervision and can pull staff in from less acute areas.
			
			Use of air scrubbers with HEPA filter to clean the air.

when considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.			

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions

Systems and process are in place to ensure that:
 	
• arrangements for antimicrobial stewardship are maintained
  • previous antimicrobial history is considered
  • the use of antimicrobials is managed and monitored:
    ○ to reduce inappropriate prescribing.
    ○ to ensure patients with infections are treated promptly with correct antibiotic.
 	
• mandatory reporting requirements are adhered to, and boards continue to maintain oversight.
 	
• risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.
	Antimicrobial pharmacists in post and regular antimicrobial stewardship meetings.
	
	AMR ward rounds (ITU and ID are daily).
	
	AMR auditing in place and reported at IPOG and TIPC
	
	Electronic prescribing rolled out.
		Staffing numbers for the AM Pharmacist need review to ensure adequate time to participate in PIR process.
		
		C.difficile numbers have gone up in 2021-22 and are under review.
			IPCT undergoing structure review to strengthen team resource and enable proactive stance including taking forward learning opportunities from PIR and other investigations.

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure that: • visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors • national guidance on visiting patients in a care setting is implemented. • restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment.	Visiting is open with limitations during times of high prevalence. Visiting has been maintained for EOI, birth partners and compassionate grounds.	none	N/A

• there is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face covering and physical distancing. • if visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM. • visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (eg, parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible. • visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment eg, carer/parent/guardian. • Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been adopted C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	We have continued to ask visitors to wear a FRSM at all times in the hospital. Information is clearly displayed and masks and alcohol gels are readily available at all entrances. Toolkit has been reviewed and used where appropriate		Toolkit presented to Nursing and Midwifery board.

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure that: • signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival. • infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred. • staff are aware of agreed template for screening questions to ask. • screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment. • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance. • triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible.	Respiratory action card: 'non-elective respiratory admissions flowcard' is in place with a triage tool. Testing is available with Triplex (for flu, RSV and C-19), Cepheid, Samba, DnA Nudge, Menorini, Abbott I.D Now and lateral flow tests. Maintained red and green pathways. Transfer letters contain all relevant information to facilitate safe transfer. Clear signage and information is displayed as	If there is patient with another respiratory virus they are cared for on the red pathway as not obvious that it is not Covid. Triplex only available at RSCH/PRH	LFT undertaken in ambulance as a local protocol. Clinical assessment and history taking. Coryzal patients placed in a side room if available, pending testing result. Testing on arrival to red area. Remove patient from red area to a green side room if Covid negative.

- there is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved. - patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated. - patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result. - patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing. - patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare eg, priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be considered. - where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes. - face masks/coverings are worn by staff and patients in all health and care facilities. - where infectious respiratory patients are cared for physical distancing remains at 2 metres distance. - patients, visitors, and staff can maintain 1 metre or greater social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, eg, to protect reception staff. - patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly. - isolation, testing and instigation of contact tracing is achieved for all patients with new-onset symptoms, until proven negative. - patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.	appropriate to discourage attendance with symptoms or direct to the correct entrance. FRS masks and alcohol gels are readily available at all entrances. Screening is undertaken at various points in the patient journey to mitigate risk to others. Surveillance screening is in place for all inpatients at day: 0,3,5, 12, and every 7 days thereafter (SRH/WGH). 0,3,5, 7, 10, 14 and every 7 days thereafter (RSCH/PRH). Contact screening is daily (RSCH/PRH) using PCR. Contact screening (SRH/WGH) is everyother day until day 7, then on day 10. Patients in a bay are encouraged to wear a FRSM as much as possible. Patients at risk of severe outcomes will be assessed for MABS. Bed spacing is being maintained as able. Patients who are positive are appropriately isolated or cohorted. A descalation protocol is in place .	Due to operational pressure we are unable to remove any beds in areas where space is limited. This is particularly noted in the Barry Building.	During quieter periods we can close some beds but at peak this is not possible. The new 3Ts phase 1 building will be due to open in April 2023.

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure that: • appropriate infection prevention education is provided for staff, patients, and visitors. • training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely. • all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it; • adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk. • gloves are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's. • the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance. • staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace • staff understand the requirements for uniform laundering where this is not provided for onsite. • all staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance. • to monitor compliance and reporting for asymptomatic staff testing • there is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals).	Online mandatory teaching and trust induction. Induction video and sign off process for contractors Donning and doffing covered in training. Fit testing is available and prioritised for key areas. PPE audits in place. PPE safety officers do rounds. SICPs and TBPs are followed. Social distancing continues to be promoted with appropriate signage. Staff are aware of Covid symptoms and are supported 'Workforce Hub' who assist with assessment of staff for return to work. Staff are encouraged to do twice weekly LFT and seek PCR if a household is positive. Rates are reviewed and discussed at Silver, CAG and at Briefings. Hospital onset definite and probable cases are reviewed. Deaths are Datix	Management of cases would be a lot easier with access to an electronic patient record where results and clinical instructions could be communicated quickly and effectively.	Currently using flow charts as reminder to undertake reviews and undertake duty of candour

• positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	and the patient has a structured Judgement Review. PIR is completed for all outbreaks and they are uploaded to NHSE electronic outbreak portal.		

7. Provide or secure adequate isolation facilities

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure: • that clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs. • separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients. • patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals. • patients are appropriately placed ie, infectious patients in isolation or cohorts. • ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements). • standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result • the principles of SICPs and TBPs continued to be applied when caring for the deceased.	Government guidance followed by offering and encouraging patients to wear a mask. Bed spacing maintained as best possible (see above section 5). Patients are isolated appropriately to reduce transmission to others. Protocols followed for elective cases, with work deferred if appropriate. Cohorting guidance in place. SIPC used at all times.	Patients frequently have to be moved due to extreme operational pressures meaning that IPC best practice may be compromised. The need to move patients has to be balanced with the need to unload ambulances at front door with often critical patients.	Decisions made with senior staff to mitigate by cohorting or isolating where possible with appropriate screening.

8. Secure adequate access to laboratory support as appropriate

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals. • patient testing for all respiratory viruses testing is undertaken promptly and in line with national guidance; • staff testing protocols are in place • there is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available. • there is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data). • screening for other potential infections takes place. • that all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission. • that those inpatients who go on to develop symptoms of respiratory infection/COVID-19 after admission are retested at the point symptoms arise. • that all emergency admissions who test negative on admission are retested for COVID-19 on day 3 of admission, and again between 5-7 days post admission. • that sites with high nosocomial rates should consider testing COVID-19 negative patients daily. • that those being discharged to a care home are tested for COVID-19, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge. • those patients being discharged to a care facility within their 14-day isolation period are discharged to a designated care setting, where they should complete their remaining isolation as per national guidance • there is an assessment of the need for a negative PCR and 3 days self-isolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of case suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance.	Continue to enjoy lab support at RSCH and St Richards. Testing is in place Video produced on how to swab on intranet. 3 HCA assist with swabbing of staff for testing.	No issues	

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				
Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure that • the application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors). • staff are supported in adhering to all IPC policies, including those for other alert organisms. • safe spaces for staff break areas/changing facilities are provided. • robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak. • all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance. • PPE stock is appropriately stored and accessible to staff who require it.	Policies, SOPs and guidance are available. Guidance is discussed and determined by a multi disciplinary Clinical Advisory Group (CAG) Staff briefings and emails to staff to share new decisions. Microguide, nursing and midwifery board and senior nurse meetings are all used to share guidance along with regular ward attendance by IPC Team. PPE stock is maintained at satisfactory levels, monitored though Silver and Gold.		

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				
Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure that: • staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy. • bank, agency, and locum staff follow the same deployment advice as permanent staff. • staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-isolate (see Staff isolation: approach following updated government guidance) • staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE.	SRH/WGH have a contracted out service. At RSCH/PRH there is an in house service with some out sourcing. Vaccination of staff commenced in December	Inconsistency of service. SRH/WGH have a contracted out service which does not deal with COVID other than as part of the risk Assessment Advisory Panel.	Workforce hub fulfil the OH responsibilities for assessment of staff for any breaches in PPE or exposure to COVID.

• a fit testing program is in place for those who may need to wear respiratory protection.
 	
• where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will:
 	
    o lead on the implementation of systems to monitor for illness and absence.
 	
    o facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce
 	
    o lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19
 	
    o encourage staff vaccine uptake.
 	
• staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance.
 	
• a risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19.
 	
    o A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups;
 	
    o that advice is available to all health and social care staff, including specific advice to those at risk from complications.
 	
    o Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff.
 	
    o A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.
 	
• vaccination and testing policies are in place as advised by occupational health/public health.
 	
• staff required to wear FFP3 reusable respirators undergo training that is compliant with HSE guidance and a record of this training is maintained and held centrally/ESR records.
 	
• staff who carry out fit test training are trained and competent to do so.
 	
• all staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used.
 	
• all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks
	2020 and approx 55% of staff have been vaccinated. Efforts are being made to promote the vaccine to those who are vaccine hesitant.
	
	PPE is available to all staff, along with other hygiene measures such as surface wipes and hand gels
	
	Risk Assessment Advisory Panels are held to review individual staff (staff, volunteers and students) concerns.
	
	Power hoods and reusable masks are available for staff that need them.
	
	Equipment library staff teach safe use of the power hoods.
	
	A daily sit rep of staff absence is produced through HR.
		At RSCH/PRH there is an in-house service but this is short staffed and the team have no electronic record system which makes the service inefficient as they rely on paper files held in one building.	

- a record of the fit test and result is given to and kept by the trainee and centrally within the organisation. - those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators and hoods. - that where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions. - members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm. - a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health. - boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board. - consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance. - health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone. - staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing. - staff who test positive have adequate information and support to aid their recovery and return to work.			

Agenda Item:	13	Meeting:	Board		Meeting Date:	4 August 2022
Report Title:		People Committee Chair report to Board				
Committee Chair:			Claire Keatinge for Patrick Boyle, Committee Non Executive Chair			
Author(s):			Claire Keatinge, 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 July 2022 and was quorate as it was attended by three Non-Executive Directors (one of whom was the Trust Chairman) as well as the Chief People Officer and Chief Executive. They were joined by the Chief Operating Officer and Chief Nurse for parts of the meeting. In attendance were the Director of Integrated Education, the Director of Workforce Planning and Deployment, Director of Midwifery, Director of Medical Education 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, a divisional presentation from Maternity; updates on health and wellbeing, leadership, culture and development, and electronic workforce deployment, workforce KPIs, an update from the Freedom to Speak up Guardian as well as a report from the Guardian of Safe Working. The Committee also received an update on the work of the Sussex Integrated Care System (ICS) People Committee as well as updates from the groups that report to the Trust People Committee across the breadth of its remit. The Committee received the annual reports for the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (DES).

The Committee also considered both the Corporate Risks with a potential people impact and the Board Assurance Framework (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 considered, with reflection on continued pressures on staff and time to fully recruit to leadership posts, and agreed the risk scores for BAF risks 3.1 to 3.4 are fairly stated for quarter 1.

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
People Committee	**27 July 2022**	**Claire Keatinge (acting for Patrick Boyle)**	✔	☐

Declarations of Interest Made
There were no declarations of interest made

Assurances received at the Committee meeting

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

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

The Chief People Officer provided an update on the analysis and actions taken in response to the 2021/22 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 reminded members that contrary to the True North the Trust is not in the upper quartile for any of the questions. The Committee considered the contributors to those responses where staff responses had identified insufficient staff numbers to do their work, time pressures and dissatisfaction with pay as the main issues attributed. The Chief People Officer updated the Committee on the work to develop both local and Trust wide improvement actions. In relation to work to address sufficient staff numbers, the Committee NOTED that those nursing bands where vacancies were most acutely felt were recruited to at a trajectory that would reach sustainable manageable levels (of 5%) within 6 months. The Committee also noted considerable numbers of overseas nurses due to start with the Trust. The Committee **NOTED** the update on areas for the improvement actions but asked for a formal report for Quarter 1 to the next Committee to detail the extent of delivery in these areas with particular emphasis on the communications that would assure staff of action taken.

The Committee **RECEIVED** an update on actions to create a culture of safety addressing 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 work against the 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 supporting the NHS People Plan. The Committee **NOTED** the developing local governance arrangements and workstreams to deliver the standard within people and quality dimensions. The Committee discussed the support required with system partners for access to centralised resources in the pursuit of sanctions against offenders.

The Committee **RECEIVED** a report introduced by the Director of Midwifery that included a summary of the factors including demographic differentials in the experienced outcomes in maternity services both locally and nationally which were understood to impact on confidence of women giving birth in Sussex as well as staff in local maternity teams. The Committee **NOTED** that previously successful Continuity of Carer arrangements had to pause pending restart once the workforce numbers recovered to a level making this safe and sustainable. The Committee **NOTED** the success and positive staff engagement with Maternity Listening events that had evolved from escalation sessions with senior individuals towards a supportive and generative network and also how these discussions connected with the improvement huddles held before each shift. The Committee **NOTED** the actions developed from the feedback structured under key themes of: recruitment, retention, education, training career pathways and career progression 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 while acknowledging that such introduction of initiatives must empower the divisions of the new clinical operating model rather than being imposed centrally.

The Committee **NOTED** the verbal update that the CQC reinspection of maternity services had fed back considerable evidence of improvement in those issues previously raised and these were expected to be described in the CQC report due to be published prior to the meeting of the August 2022 Board.

The Committee **RECEIVED** the update against Health and Wellbeing Strategy actions 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 and the findings triangulated with staff survey data. Broadly staff reported feeling more worn out and understaffed than the national average. The Committee acknowledged considerable variation between divisions and within divisions on different hospital sites. The Committee **ENDORSED** the key priorities built on foundations of health promotion and 'core offer' staff amenities through to psychological and specialist urgent referrals where targeted interventions are required for individuals and teams. These connected with the previously endorsed key principles of leadership; prevention and self care; interventions; support; and data & metrics that unpin the strategy. The Committee **NOTED** the strategy development next steps. The Committee discussed the need for the interventions to be brought into a balanced package and supporting UHSussex staff in their career journey with the Trust. The Committee asked for a detailed plan for delivery of the strategy over 3 years to be brought back to the Committee in October 2022 following engagement.

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** the integrated education oversight group report following their meeting in May 2022 that listed successes including an away day having taken place with the Nursing Preceptorship team to plan the programme for 2022/23 to support the large numbers of Overseas and Local Nurses new to the register as well as record numbers of newly registered Nurses on the Preceptorship programme in early July. The Committee **NOTED** some of the innovative approaches to growing the Trust workforce and was excited about the prospect of medical apprenticeships from September 2023. The integrated education report included details of an NMC consultation looking at the English language test and whether they should consider accepting alternative evidence of English language competence which would be significant to the Trust given the considerable recruitment of oversees nurses. The Committee also **NOTED** that the GMC National Training Survey while largely positive about teaching and supervision also provided data that correlated with other Committee discussion around staff feeling overstretched and that experience also extended to the majority of doctors working as trainers were reported to be at risk of burnout as well as trainees.

The Committee **NOTED** the actions being taken on the delivery of the integrated education board and that forum's oversight of educational risks.

The Committee **RECEIVED** the annual reports for the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (DES) that contain the data findings indicating the extent to which the Trust's workforce demographic is reflective of the population in terms of race and disability respectively. The Committee requested that the Trust Inclusion Strategy is brought back to the Committee for consideration in October 2022. There was a discussion how the data on from the Trust's recruitment system can generate data on the rates at which candidates with protected characteristics are shortlisted for interview and appointed. An apparent data anomaly around Board numbers was referred back to the executive team to check and meant that the Committee did not approve the reports and instead **REFERRED** the WRES and DES Annual reports for APPROVAL by the Board at their meeting on 4th August 2022 after the data query has been verified or corrected. The Committee **NOTED** that the data reports lack detail on the activities the Trust will be doing and these will be outlined in the Annual Equality Report.

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.

The Committee **NOTED** the report on Electronic Workforce Deployment and discussed the findings of a Medical Workforce Systems review. The report described the improving performance against the e-roster target close to the NHS England good practice measure. The report outlined local rollout of ESR Self service for access to payslips. The Committee **NOTED** some delays on e-roster rollout due to local operational pressures within the workforce team and complexity meaning there was a delay to implementing the arrangements for cohorts of staff with special pay arrangements. The Committee noted that considerable progress was required to improve e-roster uptake for medical staff and the committee discussed the connection of such initiatives to improvement work that will require measures for productivity availed by roster systems. The Committee **ENDORSED** a 4 month full diagnostic by an consultancy on the Trust's existing medical rostering systems to support an options appraisal for future consideration and **NOTED** that the governance will include a business case and a long term programme for a full e-roster system overhaul over 18 months that would require strong engagement as well as a balancing of competing priorities. The Committee noted that internal audits had indicated issues around job planning and the Committee urged consideration of a risk based approach for impactful interventions.

The Committee NOTED the Guardian of Safe Working report for quarter 4 2021/22 and was **ASSURED** that exception reports raised at Worthing Hospital (WH) and St Richards Hospital (SRH) were suitably responded to and welcomed the detail of the activity taken to enhance exception reporting including the positive impact of fines issued on the recurrence of junior doctor working time breaches and those funds generated being used to enhance medics rest facilities. The Committee **ENDORSED** the proposal that there should be no differentiation in the ability of clinical fellows to raise exception reports and for these to be responded to in a similar way. While there was a vacancy in the Guardian for Safe Working role at RSCH and PRH, Tim Taylor, Medical Director advised the committee on work to find solution while mitigating work underway ensured data on escalations for RSCH and PRH continued to be circulated. The Committee asked for a progress update on the arrangements at their October meeting.

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 **NOTED** the developing workforce scorecard that had been considered in SDR meetings since May. The Chief People Officer confirmed that potential data measures linked to the matters discussed at the meeting had been in discussion for further metrics including employer relations activity. Sickness absence was discussed and the Committee examined the extent to which changing rules around Covid-19 sick pay to mirror other types of sickness might elevate the risk of staff coming to work when unwell and/or infectious.

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

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 schematic and the support for regularising the reporting from the respective groups to this Committee. The Committee **NOTED** the Chief People Officer's assurance that the groups will continue to provide formal reports to the Committee throughout the year.

ICS Update

The Committee **RECEIVED** an update from the Chief People Officer on work being undertaken within the ICS and that the respective Chief 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 work to address violence against staff.

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 1 have been identified with a post-mitigation score of 12 or above or with an impact dimension to the risk scored at 5. These being:

- Payroll resilience (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 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

Actions taken by the Committee within its Terms of Reference
The Committee **AGREED** to recommend the quarter 4 score for BAF risks 3.1 to 3.4 to the Board.

Items to come back to Committee (Items the Committee keeping an eye on outside its routine business cycle)
Developed KPI Scorecard for October Guardian for Safe Working update addressing the gap for PRH and RSCH for October Strategy for Violence and Aggression to October Inclusion Strategy addressing WRES and DES findings

Items referred to the Board or another Committee for decision or action	
Item	**Referred to**
The Committee recommended to the Board that after careful consideration of the continued pressures facing staff that the risk scores for BAF risks 3.1 to 3.4 are fairly stated for quarter 4.	Board 4 August 2022
The Committee invites the Board to APPROVE the WRES and DES Annual Reports subject to confirmation of the board numbers	Board 4 August 2022

Workforce Race Equality Standard

Data report for 2022

Contents

1

Introduction

The NHS has a workforce of 1.4 million people, of which 20% are from a black and minority ethnic background (BME). Whilst there is a good representation of BME people in GP, hospital doctor and nursing and midwifery roles – this does not always translate to career progression and representation at more senior levels. Nor do BME colleagues enjoy the same levels of staff satisfaction or treatment in the workplace.

The NHS Workforce Race Equality Standard (WRES) was developed to help shine a light on where NHS organisations are doing well across a range of equality measures and identify areas for improvement where progress can then be tracked. It has now been collecting data on race inequality for more than five years, holding up a mirror to the NHS and revealing the disparities that exist for BME staff compared to their white colleagues. The findings of national WRES reports do not make for a comfortable read, and nor should they. The evidence from each WRES report over the years has shown that BME staff members are less well represented at senior levels, have measurably worse day to day experiences of life in NHS organisations, and have more obstacles to progressing in their careers. The persistence of outcomes like these is not something that the Trust or wider NHS should accept.

The WRES uses statistical data to demonstrate the experience and outcomes for BME staff compared to white staff through many stages of their employment journey. The standard requires NHS Trusts to develop action plans to address any areas of inequity that the data highlights.

This reporting period includes the Coronavirus Pandemic; further details can also be found in the Trust's Annual Equality Report.

The report uses the acronym BME, recognising that within this, there are numerous ethnic backgrounds and diversity included within the WRES analysis. It is not used to suggest that the identified issues affect all BME staff equally or that each group's treatment or needs are the same.

As Western Sussex Hospitals NHS Foundation Trust and Brighton and Sussex University Hospitals Trust merged on 1st April 2021, this is the first data report for the newly formed University Hospitals Sussex NHS Foundation Trust.

Background Information

The total number of staff in the Trust:

In 2022:

Total headcount: 16,658 staff

White Staff: 12,403 (74.5% of the workforce)
BME Staff: 3,595 (21.6% of the workforce)
Unknown Ethnicity: 660 (3.9% of the workforce)

Overall in 2022, 96.1% of the workforce had declared their ethnicity.

Steps taken in the last reporting period to improve the level of self-reporting by ethnicity

We collect information relating to staff ethnicity as part of the recruitment process. In addition, staff who have access to Electronic Staff Records self-service (and a range of other tools) can update that ethnicity at any time.

Planned steps during the current reporting period to improve the level of self-reporting by ethnicity?

We appreciate that the declaration within the organisation is high; however, we will continue to run programmes to increase declaration and review our information to candidates to encourage this.

What period does the organisation's workforce data refer to?

The reporting period is 1st April 2021 to 31st March 2022.

How is BME defined under the WRES?

In line with the categories taken from the 2001 Census:

The BME category includes:

- D – Mixed white and black Caribbean
- E – Mixed white and black African

- F – Mixed white and Asian
- G – Any other mixed background
- H – Asian or Asian British – Indian
- J – Asian or Asian British – Pakistani
- K – Asian or Asian British – Bangladeshi
- L – Any other Asian background
- M – Black or black British – Caribbean
- N – Black or black British – African
- P – Any other black background
- R – Chinese
- S – Any other ethnic group

The White category includes:

- A – White – British
- B – White – Irish
- C – Any other white background

The unknown category includes:

- Z – not stated
- Null (NHS Electronic Staff Records code)
- Unknown (NHS Electronic Staff Records code)

Population Demographics from the 2011 Census (Southeast England)

- 9% BME population
- 91% White population

Other factors or data which should be taken into consideration in assessing progress?

The NHS Staff Survey is now open to all Trust staff to participate. As a result, a potential sample (circa 16,000) could participate instead of a restricted sample (circa 800) in previous years.

The Trust's Annual Equality Report is also produced, and the workforce data is analysed for trends across recruitment, employee relations, training and development and demographics. The report is scrutinised and approved by the Trust's Senior Management Team, and the actions feed into the Trust's Equality Objectives.

a. **Issues of completeness of data**
   This report is based on information presented to the Trust's Board in 2021-22.

b. **Matters relating to the reliability of comparisons with previous years**
   On completing data for the WRES report, it was realised that some previous TRAC recruitment reports had been interpreted inconsistently. This inconsistency has now been rectified. In 2020 the likelihood was reported as 3.8, which should have been 1.42 for former BSUH. For former WSHFT, 1.32 was reported and should have been 1.35.

Workforce Race Equality System Indicators

The standard compares the metrics for white and BME staff (using declared status).

Indicator 1 - Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce

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

There are 20 staff that have been roles that have neither been classified clinical or non-clinical, these staff have been excluded from metric 1.

*The overall percentage in the tables is compared to the 21.6% representation of BME staff in the overall workforce. Items in bold text highlight a higher than expected representation of BME staff in that pay banding.

For Non-clinical Roles:

Pay banding	White	BAME	Unknown	Total	White %	*BAME %
Band 1	69	17	8	94	73.4%	18.1%
Band 2	1267	211	35	1513	83.7%	13.9%
Band 3	855	77	19	951	89.9%	8.1%
Band 4	680	42	12	734	92.6%	5.7%
Band 5	311	24	7	342	90.9%	7.0%

Band 6	230	15	4	249	92.4%	6.0%
Band 7	160	16	4	180	88.9%	8.9%
Band 8a	103	11	4	118	87.3%	9.3%
Band 8b	81	2	0	83	97.6%	2.4%
Band 8c	38	1	1	40	95.0%	2.5%
Band 8d	15	2	0	17	88.2%	11.8%
Band 9	16	0	1	17	94.1%	0.0%
VSM	24	2	5	31	77.4%	6.5%
Local Pay Scale	1	0	0	1	100.0%	0.0%
All Non-clinical Roles	3850	420	100	4370	88.1%	9.6%

The data highlights that in all non-clinical roles, there is a lower than an expected representation of BME staff. Representation of BME staff from bands 3-9 and VSM are particularly low..

Historical comparison from previous BSUH WRES reports
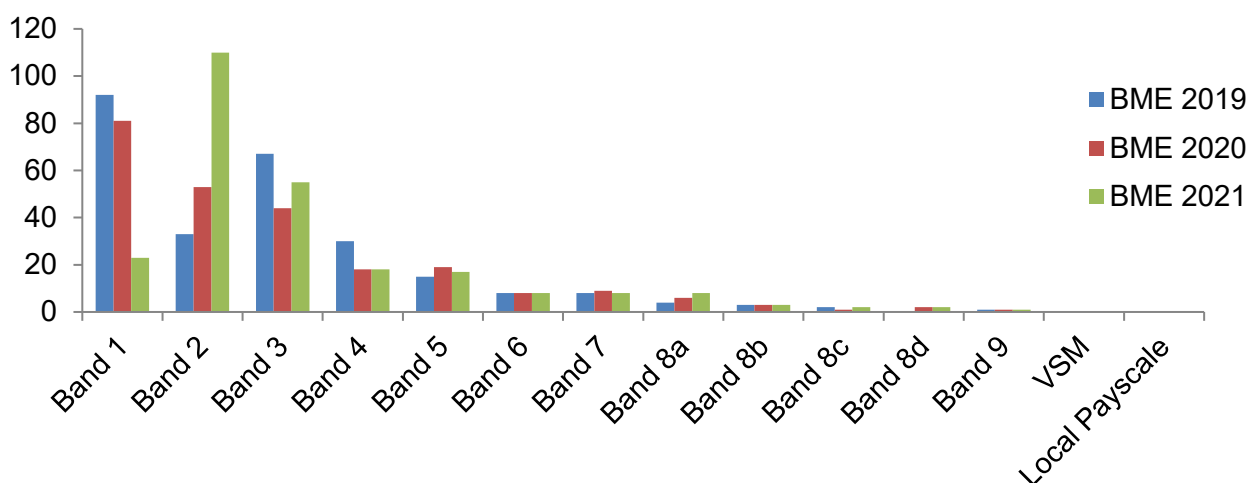
Historical comparison from previous WSHFT WRES reports
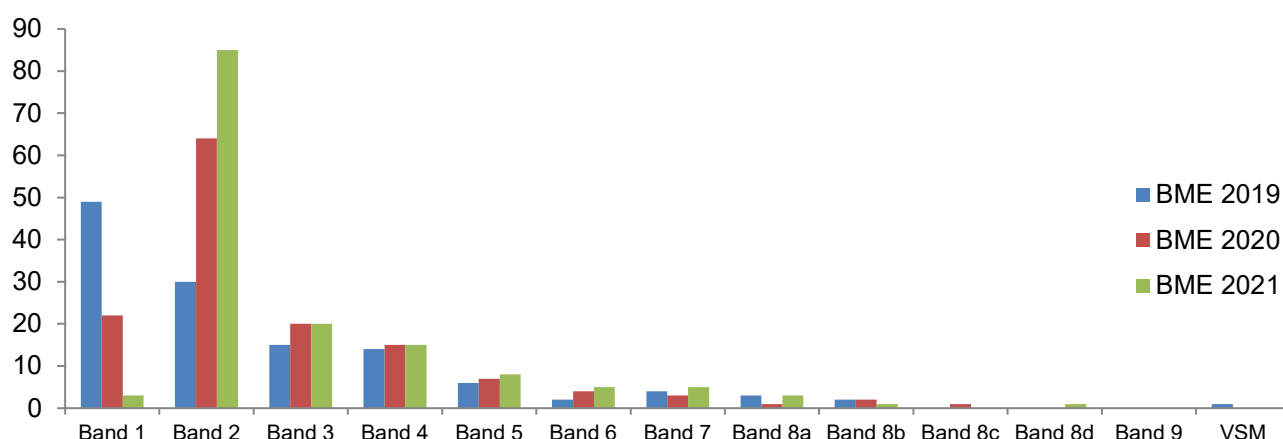
For Clinical Roles:

Pay banding	White	BME	Unknown	Total	White %	*BME %
Band 1	3	0	0	3	100.0%	0.0%
Band 2	1364	404	67	1835	74.3%	**22.0%**
Band 3	551	162	22	735	75.0%	**22.0%**
Band 4	342	101	16	459	74.5%	**22.0%**
Band 5	1419	1128	155	2702	52.5%	**41.7%**
Band 6	1864	426	75	2365	78.8%	18.0%
Band 7	1211	133	30	1374	88.1%	9.7%
Band 8a	280	44	9	333	84.1%	13.2%
Band 8b	92	5	3	100	92.0%	5.0%
Band 8c	26	0	1	27	96.3%	0.0%
Band 8d	14	0	0	14	100.0%	0.0%
Band 9	1	0	0	1	100.0%	0.0%
VSM	8	2	4	14	57.1%	14.3%
Medical: Consultants	589	242	40	871	67.6%	**27.8%**
Medical: Non-consultant career grade	104	124	14	242	43.0%	**51.2%**
Medical: Trainee	678	404	111	1193	56.8%	**33.9%**
All Clinical roles	8546	3175	547	12268	69.7%	25.9%

Historical comparison from previous WRES reports
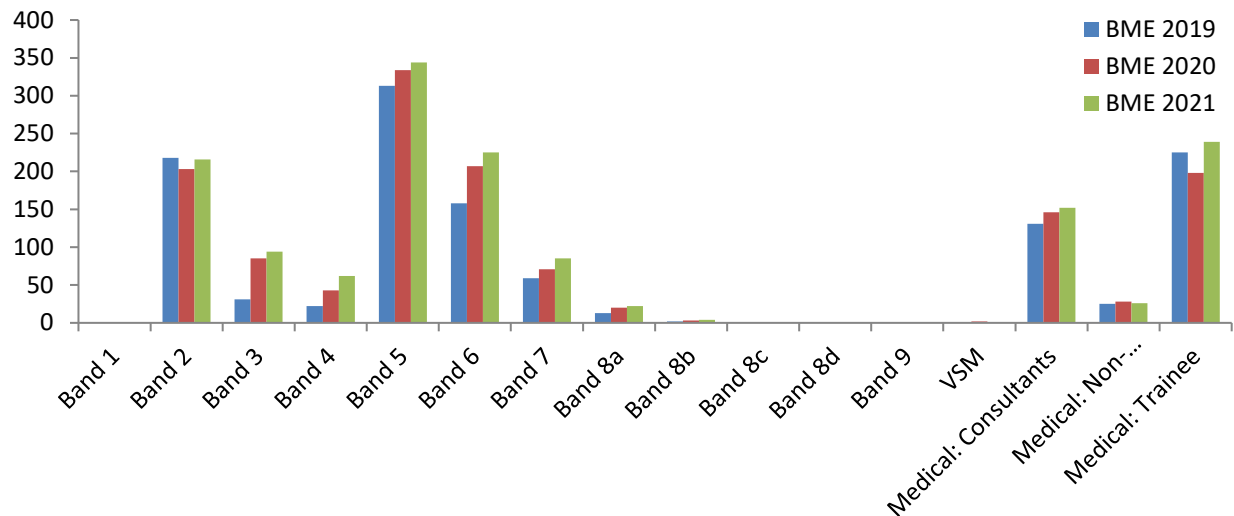
Compared to the overall workforce, there is a higher than an expected representation of BME staff in bands 2-5 and all medical grades. However, within bands 6-9 and VSM, there is a lower than an expected representation of BME staff. In band 5, medical: non-consultant carrer and trainee grades there is a much higher than expected representation of BME staff.

Historical comparison from previous WSHFT WRES reports
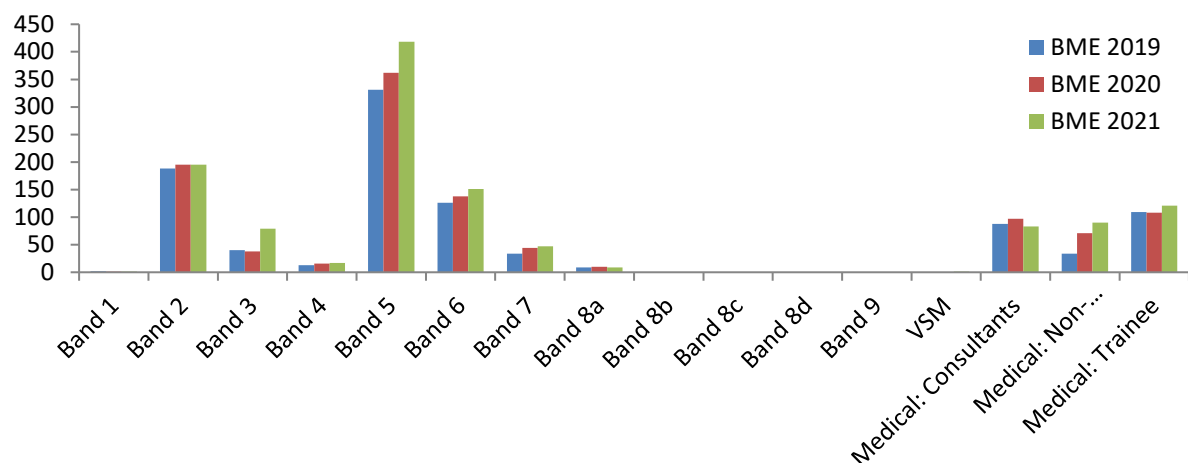
Indicator 2 - Relative likelihood of applicants being appointed from shortlisting across all posts

Applicant Ethnicity	Applicants Shortlisted	Shortlisted %	Applicants Appointed	Appointed %	Relative Likelihood of being Appointed
BME applicants	3839	27.8%	313	17.8%	**0.0815**
White applicants	8946	64.8%	1079	61.5%	**0.1206**
Not Stated / Unknown	1027	7.4%	364	20.7%	**0.3544**
Total	**13812**	**100.0%**	**1756**	**100.0%**	

To calculate the relative likelihood of white candidates being appointed from shortlisting:
1079 / 8946 = 0.1206

To calculate the relative likelihood of BME candidates being appointed from shortlisting:
313 / 3839 = 0.0815

The relative likelihood of white candidates being appointed from shortlisting compared to BME staff is 0.1206 (white candidates) / 0.0815 (BME candidates) = **1.48 times greater.**

In this instance, the data suggests white candidates are more likely than BME candidates to be appointed from shortlisting.

Historical comparison with previous BSUH WRES reports
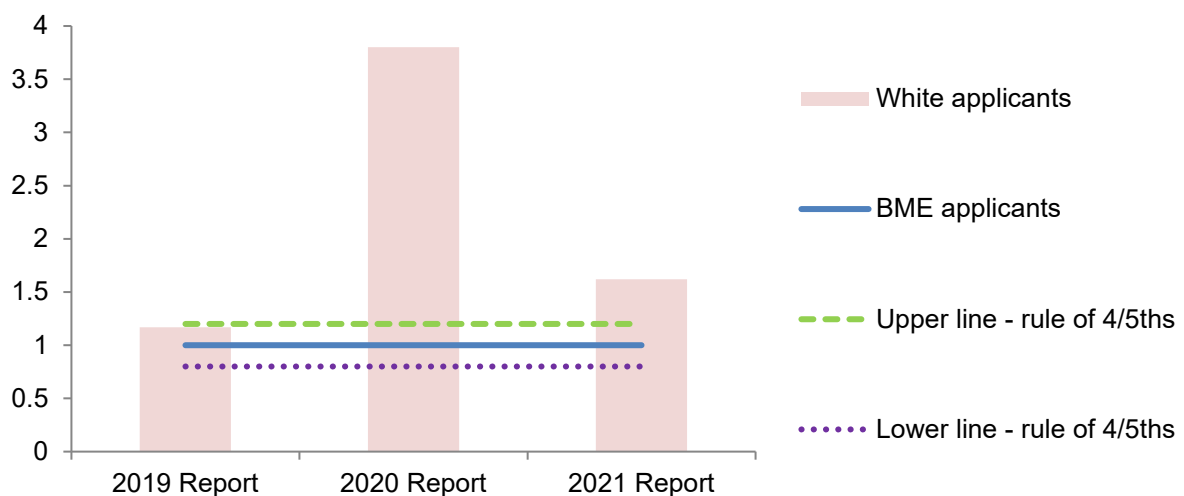
Historical comparison with previous WSHFT WRES reports
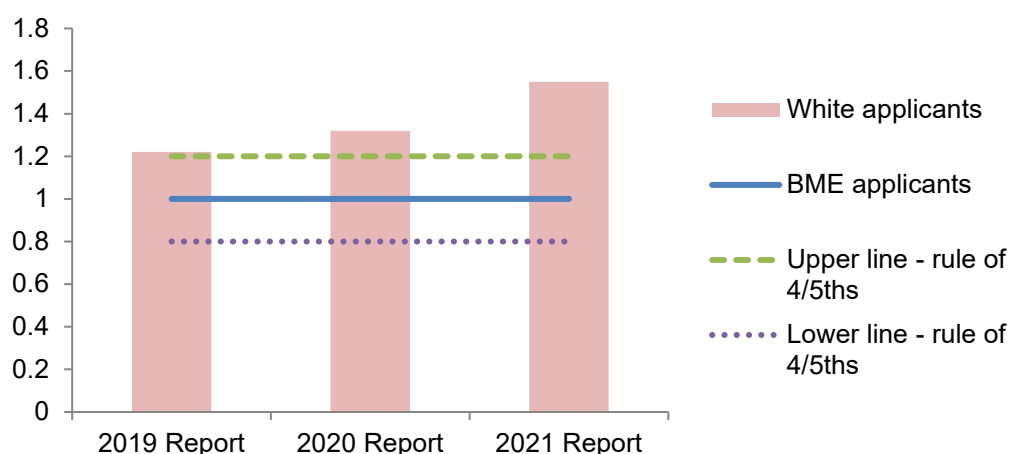
In the above charts, BME applicants have a constant measure of 1.0. So for white applicants, if their bar is below the BME line, it would suggest; that white applicants are less likely to be recruited from shortlisting than BME applicants. So naturally, if the white applicant bar is above, it indicates that they have a greater chance of being appointed.

The Trust does not share personal or equal opportunities data with managers at the shortlisting stage to help remove bias in the recruitment process.

Indicator 3 - Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

Staff Ethnicity	Number of Disciplinary Procedures	Number in Workforce	Relative Likelihood of entering procedure
White	18	12403	0.00145
BME	9	3595	0.00250
Unknown	1	660	0.0015

The likelihood of white staff entering the formal disciplinary process:
18 / 12403 = 0.00145

The likelihood of BME staff entering the formal disciplinary process:
9 / 3595 = 0.00250

The relative likelihood of BME staff entering the formal disciplinary process compared to white staff is 0.00250 (BME Staff) / 0.00145 (White Staff) = **1.725 greater.**

In this instance, the data suggest that BME staff members are more likely to enter into a formal disciplinary process than white staff.

Historical comparison with previous BSUH WRES reports
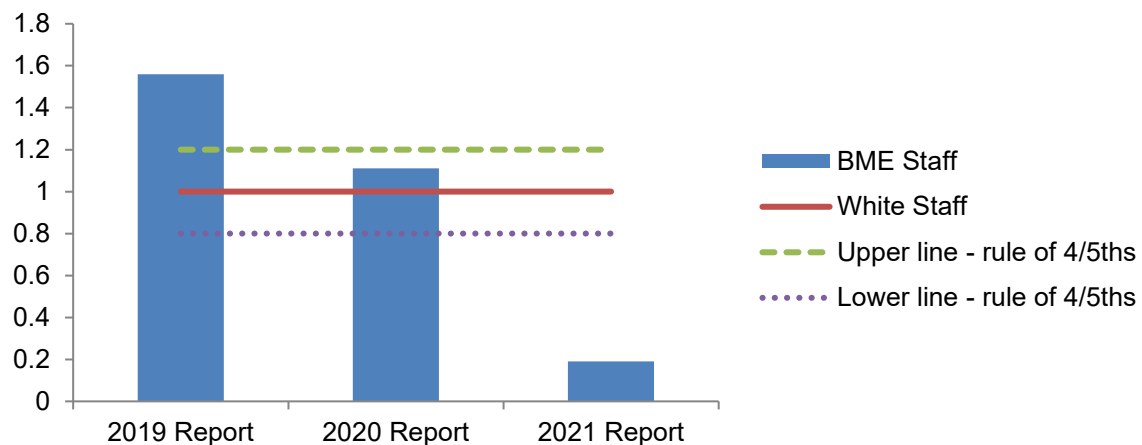
Historical comparison with previous WSHT WRES reports
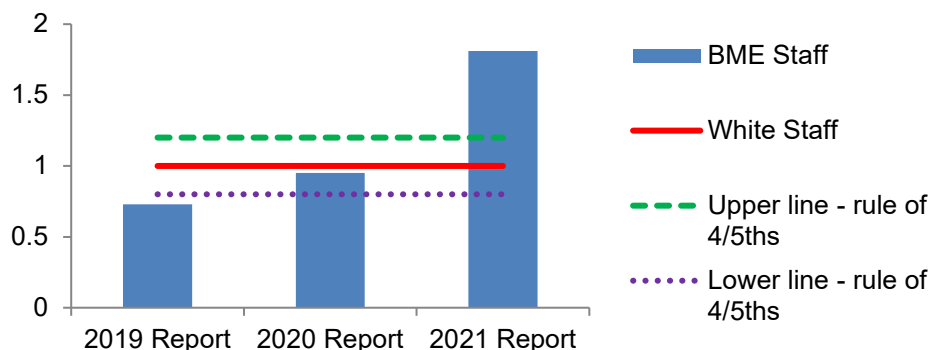
In the above chart, white staff have a constant measure of 1.0. For BME staff, if the bar is below the white staff line, it would suggest; that BME staff are less likely to enter the formal disciplinary process than white staff. Naturally, if the BME staff bar is above, it would suggest that they have a great chance of entering formal disciplinary procedures.

Indicator 4 - Relative likelihood of staff accessing non-mandatory training and CPD.

12

Staff Ethnicity	Number in workforce	No. of staff accessing non-mandatory/CPD training	Relative likelihood of accessing non-mandatory/CPD training
White	12,403	5,569	0.45
BME	3,595	1,589	0.44
Unknown	660	332	0.50
Total	16,658	7,490	

Likelihood of white staff accessing non-mandatory/CPD training:
5,569 / 12,403 = 0.45

Likelihood of BME staff accessing non-mandatory/CPD training:
1,589 / 3,595 = 0.44

Relative likelihood of white staff accessing non-mandatory/CPD training compared to BME staff: 0.45 (White Staff) / 0.44 (BME Staff) = **1.02 times.**

In this instance, the data suggests white staff are slightly more likely to access non-mandatory/CPD training than BME staff.

Historical comparison with previous BSUH WRES reports
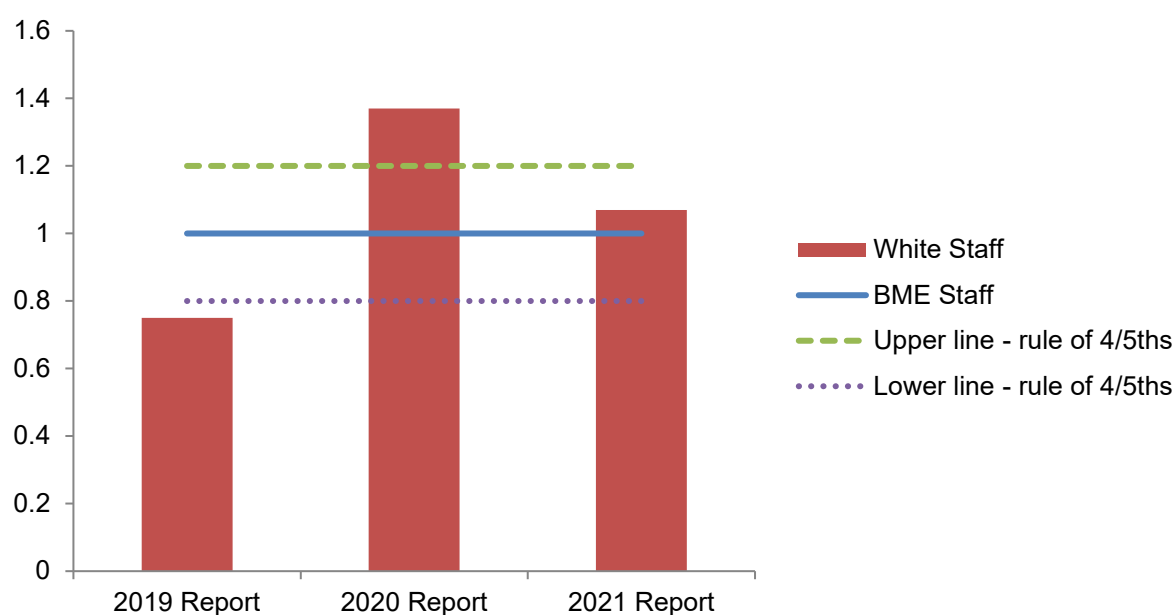
Historical comparison with previous WSHFT WRES reports
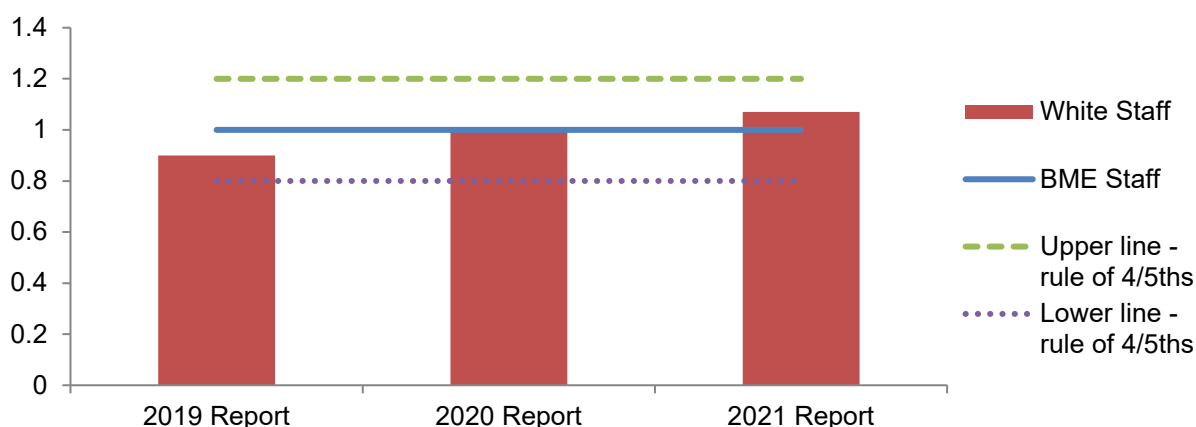
In the above chart, BME staff have a constant measure of 1.0. If the bar for white staff is below the BME line, it would suggest; that white staff are less likely to access non-mandatory/CPD than BME staff. Naturally, if the white applicant bar is above, it would indicate that they have a greater chance of accessing non-mandatory/CPD.

Indicator 5 - Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months

	Organisation	2021
White Staff	UHSussex	31.3%
	Acute Average	26.5%
Staff from all other ethnic groups combined	UHSussex	37.0%
	Acute Average	28.8%

What the data tells us:

- UHSussex BME staff are more likely to experience harassment, bullying and abuse than UHSussex white staff.
- When compared to the acute average, BME staff are more likely to experience harassment, bullying and abuse by almost 10 percentage points.
- Compared to the previous year, the acute average has risen slightly.
- Compared to legacy trust data from last year, there has been an increase of staff experiencing harassment, bullying or abuse from patients, relatives or the public for both BSUH and WSHFT.

Historical Overview Brighton and Sussex University Hospitals NHS Trust:

Staff Survey Year	BSUH BME staff	BSUH white staff	% point difference	Acute Average (BME staff)	Acute average (white staff)
2018	35.00%	30.50%	(-4.50%)	28.90%	27.00%
2019	38.10%	31.50%	(-6.60%)	29.50%	27.60%
2020	33.70%	30.70%	(-3.00%)	28.00%	25.40%

Historical Overview Western Sussex NHS Foundation Trust

Staff Survey Year	WSHFT BME staff	WSHFT white staff	% point difference	Acute Average (BME staff)	Acute average (white staff)
2018	36.1%	29.2%	(-6.9%)	28.9%	27.0%
2019	37.8%	27.6%	(-10.2%)	29.5%	27.6%
2020	33.5%	28.0%	(-5.5%)	28.0%	25.4%

Indicator 6 - Percentage of staff experiencing harassment, bullying, or abuse from staff in last 12 months

	Organisation	2021
White Staff	UHSussex	25.6%
	Acute Average	23.6%
Staff from all other ethnic groups combined	UHSussex	28.9%
	Acute Average	28.5%

What the data tells us:

- When comparing UHSussex data, BME staff are more likely to experience harassment, bullying or abuse from staff.
- Compared to the acute average, UHSussex BME staff are slightly more likely to experience harassment, bullying or abuse.
- Compared to the previous year, the acute average has decreased.
- Compared to legacy data for last year, the number of BME staff that have stated they have experience harassment, bullying or abuse has increased.

Historical Overview Brighton and Sussex University Hospitals NHS Trust:

Staff Survey Year	BSUH BME staff	BSUH white staff	% point difference	Acute Average (BME staff)	Acute average (white staff)
2018	30.40%	26.30%	(-4.10%)	28.70%	24.90%
2019	25.30%	24.70%	(-0.60%)	28.60%	24.50%
2020	26.80%	25.40%	(-1.40%)	29.10%	24.40%

Historical Overview Western Sussex NHS Foundation Trust

Staff Survey Year	WSHFT BME staff	WSHFT white staff	% point difference	Acute Average (BME staff)	Acute average (white staff)
2018	24.9%	22.9%	(-2.0%)	28.7%	24.9%
2019	24.9%	24.0%	(-0.9%)	28.6%	24.5%
2020	24.2%	24.5%	(0.3%)	29.1%	24.4%

Indicator 7 - Percentage believing that trust provides equal opportunities for career progression or promotion

	Organisation	2021
White Staff	UHSussex	55.1%
	Acute Average	58.6%
Staff from all other ethnic groups combined	UHSussex	46.2%
	Acute Average	44.6%

What the data tells us:

- Comparing UHSussex data, BME staff are less likely to believe that the trust provides equality opportunites for career progression or promotion that white staff.
- Compared to the acute average, more BME UHSussex staff believe that the trust provides equality opportunities for career progression or promotion.

- The calculation for this question has changed since previous reporting periods, it is therefore, not possible to draw a meaningful conclusion when looking back at historical data.

Historical Overview Brighton and Sussex University Hospitals NHS Trust:

Staff Survey Year	BSUH BME staff	BSUH white staff	% point difference	Acute Average (BME staff)	Acute average (white staff)
2018	72.30%	87.60%	(15.30%)	73.10%	86.80%
2019	74.10%	87.50%	(13.40%)	74.10%	87.20%
2020	71.60%	85.70%	(14.10%)	72.50%	87.70%

Historical Overiview Western Sussex NHS Foundation Trust

Staff Survey Year	WSHFT BME staff	WSHFT white staff	% point difference	Acute Average (BME staff)	Acute average (white staff)
2018	82.7%	89.8%	(7.1%)	73.1%	86.8%
2019	81.0%	88.5%	(7.5%)	74.1%	87.2%
2020	81.8%	89.3%	(7.5%)	72.5%	87.7%

Indicator 8 - In the last 12 months, have you personally experienced discrimination at work from your Manager/team leader or other colleagues?

	Organisation	2021
White Staff	UHSussex	8.1%
	Acute Average	6.7%
Staff from all other ethnic groups combined	UHSussex	15.4%
	Acute Average	17.3%

What the data tells us:

- When comparing UHSussex data, BME staff are more likely (nearly twice as much) to have experienced discrimination at work from their manager, team leader or other colleagues.
- Compared to the acute average, less UHSussex BME staff have reported that they have experienced discrimination, but more for white UHSussex staff.
- Compared to last year, the acute average has risen.
- Compared to the legacy data for last year, the number of BME staff has slightly increased by remains broadly similar.

Historical Overview Brighton and Sussex University Hospitals NHS Trust:

Staff Survey Year	BSUH BME staff	BSUH white staff	% point difference	Acute Average (BME staff)	Acute average (white staff)
2018	14.8%	6.9%	(-7.9%)	14.6%	6.3%
2019	14.2%	7.3%	(-6.9%)	14.2%	5.8%
2020	15.5%	7.1%	(-8.4%)	16.8%	6.1%

Historical Overview Western Sussex NHS Foundation Trust

Staff Survey Year	WSHFT BME staff	WSHFT white staff	% point difference	Acute Average (BME staff)	Acute average (white staff)
2018	14.3%	6.3%	(-8.0%)	14.6%	6.3%
2019	13.1%	6.3%	(-6.8%)	14.2%	5.8%
2020	15.7%	6.1%	(-9.6%)	16.8%	6.1%

Indicator 9 - compare the difference for white and BME staff: Percentage difference between:

i) The organisation's Voting membership of the Board and its overall workforce (as of 31st March 2022)

ii) The organisation's Executive membership of the Board and its overall workforce (as of 31st March 2022)

Total Board Membership

Staff Ethnicity	Number in workforce	% in workforce	Number on board	% of board	% Difference
White Staff	12,403	74.5%	21	77.8%	+3.3%
BME Staff	3,595	21.6%	3	11.1%	-10.5%
Unknown	660	3.9%	3	11.1%	+7.2%
Total	16,658	100.0%	27	100.0%	

Voting Membership

Staff Ethnicity	Number in workforce	% in workforce	Number on board	% of board	% Difference
White Staff	12,403	74.5%	8	88.9%	+14.4
BME Staff	3,595	21.6%	0	0.0%	-21.6%
Unknown	660	3.9%	1	11.1%	+7.2%
Total	16,658	100.0%	9	100.0%	

Executive Membership

Staff Ethnicity	Number in workforce	% in workforce	Number on board	% of board	% Difference
White Staff	12,403	74.5%	9	90.0%	+15.5%
BME Staff	3,595	21.6%	0	0.0%	-21.6%
Unknown	660	3.9%	1	10.0%	+6.1%
Total	16,658	100.0%	10	100.0%	

Next steps

Using the data to inform the Trusts race equality actions and inclusion strategy. The drafted version of the Equalities & Inclusion Strategy will be taken to the People Committee for the October 2022 meeting. The Trust will also continue to supplement the quantitative data will qualitative and lived experience data.

Workforce Disability Equality Standard 2022

Contents

Introduction

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

The Act goes further than just banning unfair behaviour towards workers with disabilities. It also places public sector organisations under a duty to seek opportunities to proactively address equality of opportunity and promote good relations between workers with disabilities and those without.

While there have been improvements in societal attitudes towards people with disabilities, they have not necessarily moved as quickly as the Act (and its predecessors) had intended. There are still many inequalities surrounding the employment of workers with disabilities. The employment rate of people with disabilities is 30.1%, lower than for people without. This difference is often referred to as the 'disability employment gap'. Given that 22% of working-age adults have a disability, more needs to be done to close this gap. [Briefing Paper 7540, People with Disabilities in Employment, 30th November 2018, Andrew Powell: House of Commons Library].

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

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

The Workforce Disability Equality Standard (WDES) was introduced in April 2019 by NHS England. It helps to demonstrate compliance with:

- The UK Government's pledge to increase the number of disabled people in employment – this was made in November 2017

- The NHS Constitution – relating to the rights of staff

- The 'social model of disability' - recognising that the societal barriers people with disabilities face are the disabling factor, not an individual's medical condition or impairment

- The Equality Act 2010 – specific requirements not to discriminate against workers with a disability, and to advance equality and foster good relations

- 'Nothing about us without us' - a phrase used by the disability movement to denote a central principle of inclusion: that actions and decisions that affect or are about people with disabilities should be taken with disabled people.

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

Some specific issues impact workers with disabilities and NHS organisations. These include:

- Significant under-reporting of the numbers of staff who declare themselves as having a disability, with a 16.6 percentage point difference between the Electronic Staff Record (ESR, the integrated Human Resources and Payroll system) and NHS Staff Survey declaration rates.

- Lack of representation of disabled staff at senior levels

- Disabled staff consistently report (eg. through the NHS Staff Survey):

  o Higher levels of bullying and harassment

  o Less satisfaction with appraisals and career

  o Lack of development opportunities.

The WDES programme and annual reporting enables NHS organisations to review their performance, identify issues, and look to continuously improve the position for workers with a disability – better understanding the needs of their workers with a disability, improving data (declaration rates), and improving the culture, employment and retention of all staff.

On 1st April 2021, Brighton and Sussex University Hospitals NHS Trust (BSUH) and Western Sussex Hospitals NHS Foundation Trust (WSHFT) merged to form University Hospitals Sussex NHS Foundation Trust. The data snapshot period

covers 01/04/21-31/03/22; this is the first WDES report for the newly-formed Trust. As this report is the first report for UHSussex, there is no appropriate comparative data from previous years. Data from legacy BSUH and WSHFT will be provided to enable a historic comparison where appropriate. In the 2023 WDES report, the data will have a comparative view (as previously used in the 2021 WDES reports).

Background Information

The total number of staff in the Trust:

In 2022:

Total headcount: 16,680 staff

Disabled Staff: 827 (5.0% of the workforce)
Non-disabled staff: 13,391 (80.3% of the workforce)
Unknown: 2,462 (14.8% of the workforce)

Overall in 2022, 85.3% of the workforce had declared their disability status.

Steps been taken in the last reporting period to improve the level of self-reporting by disability

We collect information relating to disability as part of the recruitment process. The Trust has also taken steps to give staff more options and opportunities to declare their equality information. This includes setting up a new online declaration form, promoting Self-Service ESR (i.e. staff are able to update their own information directly), and producing new information for staff to inform them about the process and benefits of updating their equality information.

Steps planned during the current reporting period to improve the level of self-reporting by disability

The Trust will continue to encourage all staff to share ('declare') their equality information and will promote the different methods they can use. Work is also underway with Occupational Health services to promote both support and improve declaration rates among staff who are disabled.

Reporting period for this report

1st April 2021 to 31st March 2022.

How is disability defined under the standard?

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

Population Demographics 2011 Census (Southeast England)

- 6.9% of the population indicated their day-to-day activity is limited a lot
- 8.8% of the population indicated their day-to-day activity is limited a little*

* Within this group, some (not all) people would meet the test under the Equality Act 2010 as being disabled, but it is not possible to say what proportion.

Workforce Disability Equality Metrics

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

Non-Clinical Staff:

Pay band	Disabled staff in 2022 - %	Non-disabled staff in 2022 - %	Unknown/null staff in 2022 - %	Total staff in 2022 Headcount
Cluster 1 (Bands 1 - 4)	7.5%	79.5%	13.0%	3,340
Cluster 2 (Band 5 - 7)	5.3%	82.7%	12.0%	773
Cluster 3 (Bands 8a - 8b)	7.5%	82.0%	10.5%	200
Cluster 4 (Bands 8c – 9 & VSM)	6.2%	78.8%	15.0%	113

Please note in the non-clinical group there is one person paid on a local agreement which falls outside of Agenda for Change. For the purposes of this comparison, this has been excluded from the above figures.

What the data tells us:

- Compared to the overall representation of disabled staff in the UHSussex Workforce (5.0%), there is a higher than expected representation of disabled staff in all AfC bands and VSM grades.

Clinical staff:

Pay band	Disabled staff in 2022 - %	Non-disabled staff in 2022 - %	Unknown/null staff in 2022 - %	Total staff in 2022 Headcount
Cluster 1 (Bands 1 - 4)	4.9%	80.8%	14.4%	3,025
Cluster 2 (Band 5 - 7)	4.4%	80.6%	15.0%	6,445
Cluster 3 (Bands 8a - 8b)	5.3%	80.1%	14.5%	433
Cluster 4 (Bands 8c – 9 & VSM)	4.5%	59.1%	36.4%	44
Cluster 5 (Medical and Dental staff, Consultants)	1.6%	72.4%	26.0%	869
Cluster 6 (Medical and Dental staff, Non-consultant career grade)	2.2%	66.9%	30.9%	139
Cluster 7 (Medical and Dental staff, Medical and Dental trainee grades)	3.3%	85.4%	11.3%	1,298

What the data tells us:

- Compared to the overall representation of disabled staff in the UHSussex workforce (5.0%), there is a lower than expected representation of disabled staff in most AfC bands and VSM grades.
- Furthermore, there is a disproportionately low representation of disabled staff in all medical and dental grades.
- In some AfC, VSM, Consultant and Non-consultant medical grades, there is a high number of staff where either their disability status is unknown or where staff have declined to declare.

Metric 2 - Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts.

Applicant disability status	Shortlisted applicants	Shortlisted applicants (%)	Appointed applicants	Appointed applicants (%)	Relative Likelihood of being appointed
Disabled applicants	926	6.7%	82	4.7%	0.0886
Non-disabled applicants	11,784	85.3%	1,293	73.6%	0.1097
Not Stated / Unknown	1,102	8.0%	381	21.7%	0.3457
Total	**13,812**	**100.0%**	**1,756**	**100.0%**	

The likelihood of non-disabled candidates being appointed from shortlisting:
1,293 / 11,784 = 0.1097

The likelihood of disabled candidates being appointed from shortlisting:
82 / 926 = 0.0886

The relative likelihood of non-disabled candidates being appointed from shortlisting compared to disabled candidates is 0.1097 (non-disabled candidates) / 0.0886 (disabled candidates) = **1.24 times greater.**

In this instance, the data suggests non-disabled candidates are more likely to be appointed than disabled candidates.

Historical Data from Brighton and Sussex University Hospitals NHS Trust
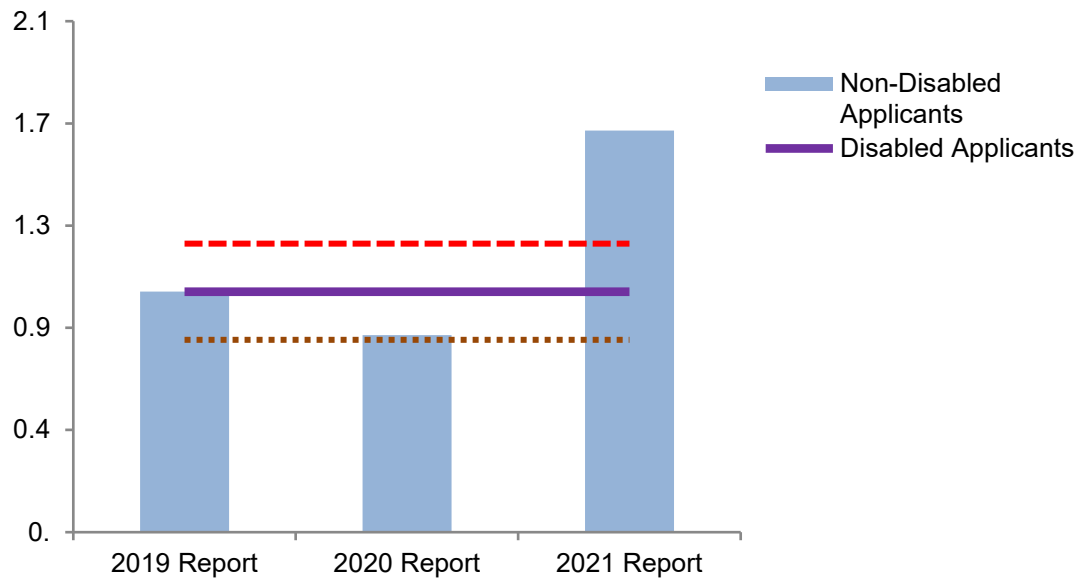
When applying the rule of 4/5ths, if the likelihood of non-disabled applicants is below 0.8 or above 1.2, it would indicate a likely statistical adverse impact.

Historical Data from Western Sussex Hospitals Foundation Trust
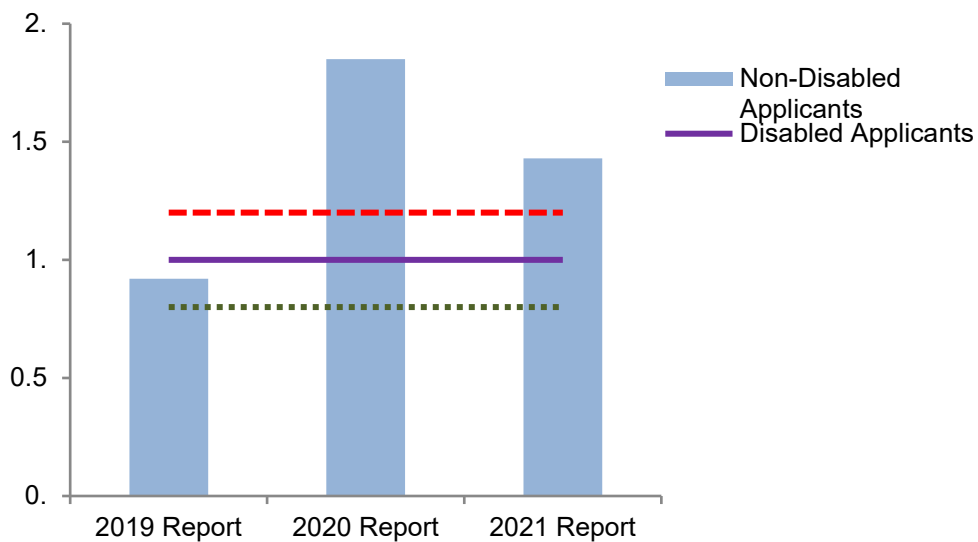
When applying the rule of 4/5ths, if the likelihood of non-disabled applicants is below 0.8 or above 1.2, it would indicate a likely statistical adverse impact.

Metric 3 - Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. (2-year rolling average)

Staff group	2-year rolling average of capability procedures	Number in Workforce	Relative Likelihood of entering procedure
Disabled staff	0	827	0
Non-disabled staff	2.5	13,391	0.000187
Not known / unspecified	5	2,462	0.002031

The likelihood of non-disabled staff entering the formal capability process:
2.5 / 13,391 = 0.000187

The likelihood of disabled staff entering the formal capability process:
0 / 827 = 0

The relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff is 0 (Disabled Staff) / 0.000187 (Non-disabled Staff) = **0.**

In this instance, the data indicates that no disabled staff members have entered the formal capability process during this reporting period.

Historical Data from Brighton and Sussex University Hospitals NHS Trust
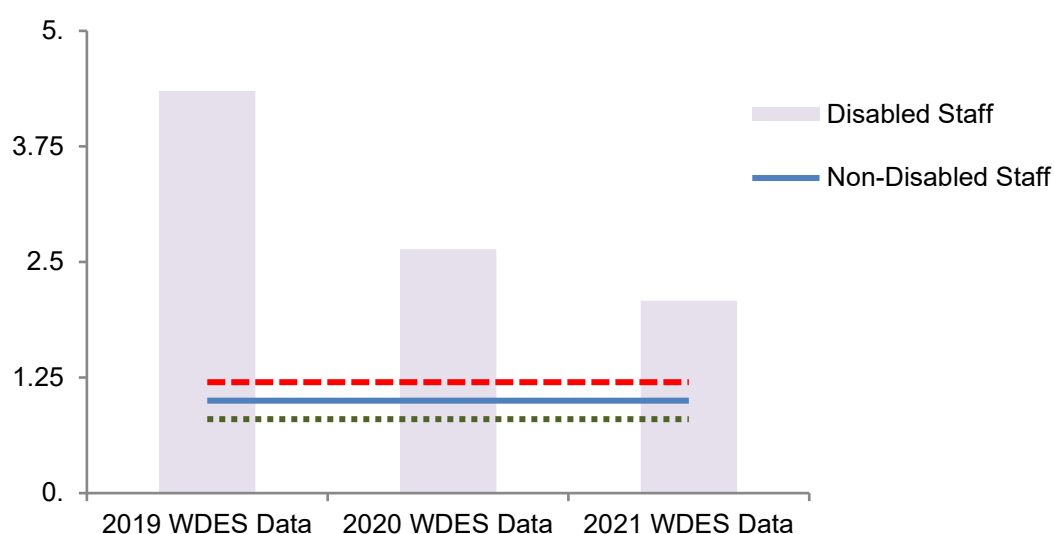
When applying the rule of 4/5ths, if the likelihood of non-disabled applicants is below 0.8 or above 1.2, it would indicate a likely statistical adverse impact.

Historical Data from Western Sussex Hospitals Foundation Trust
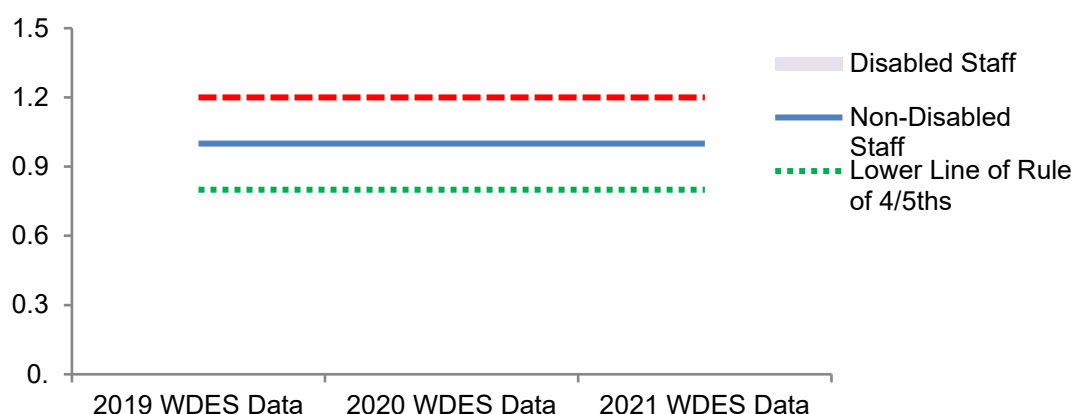
When applying the rule of 4/5ths, if the likelihood of disabled staff is below 0.8 or above 1.2, it would indicate a likely statistical adverse impact.

From 2019 to 2021, there were no recorded cases of disabled staff entering the formal capability process at Western Sussex Hospitals Foundation Trust.

Metric 4a - Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying, or abuse from: patients/service users, their relatives, or other members of the public, managers and other colleagues

Please note that the 2021 NHS Staff Survey uses the term "staff with a long lasting health condition or illness" and "staff without a long lasting health condition or illness" instead of disabled staff and non-disabled staff. Therefore, these terms will be used for Metrics 4a to 9b.

	Organisation	From Managers	From Other Colleagues	From Patients / service users, their relatives, or other members of the public
Staff with a long lasting health condition or illness	UHSussex 2021	18.0%	27.2%	35.9%
	Acute Average	18.0%	26.6%	32.4%
Staff without a long lasting health condition or illness	UHSussex 2021	10.8%	19.7%	31.3%
	Acute Average	9.8%	17.1%	25.2%

What the data tells us:

- Overall more disabled staff reported that they have experienced bullying, harassment and abuse from managers, other colleagues and patients than non-disabled staff.
- Compared to the Acute average, disabled staff at UHSussex are more likely to experience harassment, bullying or abuse from colleagues and patients, but just as likely to report harassment, bullying or abuse from their managers.
- Compared to the Acute average, non-disabled staff are more likely to experience harassment, bullying or abuse from managers, colleagues and patients.

Historical Data from Brighton and Sussex University Hospitals NHS Trust

Patients/service users, their relatives, or other members of the public

NHS Staff Survey staff group	2018	2019	2020
Disabled staff	35.0%	36.7%	34.8%
Non-disabled staff	31.0%	31.8%	30.0%
% point difference between disabled and non-disabled staff	-4.0%	-4.9%	-4.8%
Acute Average (Disabled)	33.6%	33.2%	30.9%
Acute Average (Non-Disabled)	26.5%	26.4%	24.5%

Managers

NHS Staff Survey staff group	2018	2019	2020
Disabled staff	18.2%	18.7%	17.8%
Non-disabled staff	10.7%	9.4%	10.4%
% point difference between disabled and non-disabled staff	-7.5%	-9.3%	-7.4%
Acute Average (Disabled)	19.6%	18.5%	19.3%
Acute Average (Non-Disabled)	11.7%	10.8%	10.8%

Other Colleagues

NHS Staff Survey staff group	2018	2019	2020
Disabled staff	30.1%	28.2%	29.0%
Non-disabled staff	20.5%	17.6%	17.9%
% point difference between disabled and non-disabled staff	-9.6%	-10.6%	-11.1%
Acute Average (Disabled)	27.7%	27.7%	26.9%
Acute Average (Non-Disabled)	18.0%	17.5%	17.8%

Historical Data from Western Sussex Hospitals NHS Foundation Trust

Patients/service users, their relatives, or other members of the public

NHS Staff Survey staff group	2018	2019	2020
Disabled staff	36.2%	36.7%	33.7%
Non-disabled staff	29.0%	27.6%	27.6%
% point difference between disabled and non-disabled staff	-7.2%	-9.1%	-6.1%
Acute Average (Disabled)	33.6%	33.2%	30.9%

Acute Average (Non-Disabled)	26.5%	26.4%	24.5%

Managers

NHS Staff Survey staff group	2018	2019	2020
Disabled staff	19.0%	18.3%	19.7%
Non-disabled staff	9.6%	9.8%	10.8%
% point difference between disabled and non-disabled staff	-9.4%	-8.5%	-8.9%
Acute Average (Disabled)	19.6%	18.5%	19.3%
Acute Average (Non-Disabled)	11.7%	10.8%	10.8%

Other Colleagues

NHS Staff Survey staff group	2018	2019	2020
Disabled staff	29.3%	29.5%	27.2%
Non-disabled staff	15.7%	16.5%	17.4%
% point difference between disabled and non-disabled staff	-13.6%	-13.0%	-9.8%
Acute Average (Disabled)	27.7%	27.7%	26.9%
Acute Average (Non-Disabled)	18.0%	17.5%	17.8%

What the data tells us:

- Compared to legacy data, harassment, bullying and abuse from:
    - Patients, service users, etc. has increased compared to the previous year for disabled staff. This is also true for the Acute average.
    - Managers has slightly increased for disabled staff at UHSussex compared to the previous legacy BSUH data, but has decreased in comparison to previous legacy WSHFT data.
    - Other colleagues has increased for disabled staff at UHSussex compared to legacy BSUH data, but has remained the same compared to legacy WSHFT data.

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

	Organisation	2021
Staff with a long lasting health condition or illness	UHSussex	46.2%
	Acute Average	47.0%
Staff without a long lasting health condition or illness	UHSussex	43.1%
	Acute Average	46.2%

Historical Data from Brighton and Sussex University Hospitals NHS Trust

NHS Staff Survey	2018	2019	2020
Disabled staff	48.4%	43.9%	46.0%
Non-disabled staff	44.2%	44.3%	40.0%
% point difference between disabled and non-disabled staff	-4.2%	0.4%	-6.0%
Acute Average (Disabled)	45.5%	47.0%	47.0%
Acute Average (Non-Disabled)	45.0%	46.1%	45.8%

Historical Data from Western Sussex Hospitals NHS Foundation Trust

NHS Staff Survey staff group	2018	2019	2020
Disabled staff	49.1%	43.8%	44.8%
Non-disabled staff	48.4%	44.9%	44.8%
% point difference between disabled and non-disabled staff	-0.7%	1.1%	0.0%
Acute Average (Disabled)	45.5%	47.0%	47.0%
Acute Average (Non-Disabled)	45.0%	46.1%	45.8%

What the data tells us:

- Compared to the Acute average, disabled staff at UHSussex are slightly less likely to report incidents of harassment, bullying and abuse.
- Compared to the Acute average, non-disabled staff at UHSussex are less likely to report incidents of harassment, bullying and abuse
- In 2021, Disabled staff at UHSussex are more likely to report incidents of harassment, bullying and abuse compared to the data from legacy BSUH and legacy WSHFT.

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

	Organisation	2021
Staff with a long lasting health condition or illness	UHSussex	49.6%
	Acute Average	51.4%
Staff without a long lasting health condition or illness	UHSussex	54.3%
	Acute Average	56.8%

Historical Data from Brighton and Sussex University Hospitals NHS Trust

NHS Staff Survey staff group	2018	2019	2020
Disabled staff	79.8%	77.4%	76.1%
Non-disabled staff	85.8%	86.9%	84.8%
% point difference between disabled and non-disabled staff	6.0%	9.5%	8.7%
Acute Average (Disabled)	78.4%	79.3%	79.6%
Acute Average (Non-Disabled)	85.5%	86.1%	86.3%

Historical Data from Western Sussex Hospitals NHS Foundation Trust

NHS Staff Survey staff group	2018	2019	2020
Disabled staff	83.5%	80.4%	83.3%
Non-disabled staff	89.6%	88.6%	89.1%

% point difference between disabled and non-disabled staff	6.1%	8.2%	5.8%
Acute Average (Disabled)	78.4%	79.3%	79.6%
Acute Average (Non-Disabled)	85.5%	86.1%	86.3%

What the data tells us:

- Compared to the Acute average, fewer disabled and non-disabled staff at UHSussex believe the Trust provides equal opportunities for career progression and promotion.
- There has been change in the calculation in the Staff Survey so it is not possible to draw a meaningful comparison to previous years (legacy Trust data).

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

	Organisation	2021
Staff with a long lasting health condition or illness	UHSussex	32.5%
	Acute Average	32.2%
Staff without a long lasting health condition or illness	UHSussex	23.1%
	Acute Average	23.7%

Historical Data from Brighton and Sussex University Hospitals NHS Trust

NHS Staff Survey staff group	2018	2019	2020
Disabled staff	30.1%	30.3%	28.9%
Non-disabled staff	20.6%	20.3%	20.8%
% point difference between disabled and non-disabled staff	-9.5%	-10.0%	-8.1%
Acute Average (Disabled)	33.2%	32.6%	33.0%
Acute Average (Non-Disabled)	22.8%	21.8%	23.4%

NHS Staff Survey staff group	2018	2019	2020
Disabled staff	33.3%	35.5%	34.4%
Non-disabled staff	24.1%	23.5%	24.1%
% point difference between disabled and non-disabled staff	-9.2%	-12.0%	-10.3%
Acute Average (Disabled)	33.2%	32.6%	33.0%
Acute Average (Non-Disabled)	22.8%	21.8%	23.4%

What the data tells us:

- At UHSussex, more disabled staff reported feeling pressured to attend work despite not feeling well enough to perform their duties compared to non-disabled staff.
- Compared to the Acute average, slightly more disabled staff feel pressured to attend work despite not feeling well enough to perform their duties.
- Compared to the Acute average, slightly fewer non-disabled staff feel pressured to attend work despite not feeling well enough to perform their duties.

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

	Organisation	2021
Staff with a long lasting health condition or illness	UHSussex	30.3%
	Acute Average	32.6%
Staff without a long lasting health condition or illness	UHSussex	38.4%
	Acute Average	43.3%

Historical Data from Brighton and Sussex University Hospitals NHS Trust

NHS Staff Survey staff group	2018	2019	2020

Disabled staff	37.6%	37.2%	35.5%
Non-disabled staff	45.7%	47.8%	45.1%
% point difference between disabled and non-disabled staff	+8.1%	+10.6%	-9.6%
Acute Average (Disabled)	36.8%	37.9%	37.4%
Acute Average (Non-Disabled)	47.8%	49.9%	49.3%

Historical Data from Western Sussex Hospitals NHS Foundation Trust

NHS Staff Survey staff group	2018	2019	2020
Disabled staff	37.5%	40.1%	38.1%
Non-disabled staff	52.2%	55.8%	51.4%
% point difference between disabled and non-disabled staff	14.7%	15.7%	13.3%
Acute Average (Disabled)	36.8%	37.9%	37.4%
Acute Average (Non-Disabled)	47.8%	49.9%	49.3%

What the data tells us:

- Compared to the Acute average and the legacy data from last year, fewer UHSussex staff are satisfied with the extent that the organisation values their work. This is the case for staff with and without a disability.

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

	Organisation	2021
Staff with a long lasting health condition or illness	UHSussex	71.7%
	Acute Average	70.9%

Historical Data from Brighton and Sussex University Hospitals NHS Trust

NHS Staff Survey staff group	2018	2019	2020

Disabled staff	71.8%	76.1%	75.2%
Acute Average (Disabled)	73.1%	73.4%	75.5%

Historical Data from Western Sussex Hospitals NHS Foundation Trust

NHS Staff Survey staff group	2018	2019	2020
Disabled staff	75.5%	73.8%	74.3%
Acute Average (Disabled)	73.1%	73.4%	75.5%

What the data tell us:

- Compared to the Acute average, more disabled staff at UHSussex feel that they have adequate reasonable adjustments to enable them to carry out their role.
- Nearly a third (28.3%) of disabled staff at UHSussex do not believe that the Trust has made adequate adjustments to enable them to carry out their work.
- Compared to legacy data from last year, the percentage of disabled staff at UHSussex (in 2021) who believe that the Trust has made adequate adjustments to enable them to carry out their work has decreased, as has the Acute average in 2021.

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

Please note that the NHS Staff Survey measures the overall engagement score on a scale from 0 to 10, with higher scores indicating a greater level of engagement.

	Organisation	**2021**
Staff with a long lasting health condition or illness	UHSussex	6.3
	Acute Average	6.4
Staff without a long lasting health condition or illness	UHSussex	6.7
	Acute Average	7.0

Historical Data from Brighton and Sussex University Hospitals NHS Trust

NHS Staff Survey staff group	2018	2019	2020
Disabled staff	6.6	6.6	6.6
Non-disabled staff	7.0	6.9	6.9
Acute Average (Disabled)	6.6	6.7	6.7
Acute Average (Non-disabled)	7.1	7.1	7.1

Historical Data from Western Sussex Hospitals NHS Foundation Trust

NHS Staff Survey staff group	2018	2019	2020
Disabled staff	6.9	6.9	6.9
Non-disabled staff	7.3	7.4	7.3
Acute Average (Disabled)	6.6	6.7	6.7
Acute Average (Non-disabled)	7.1	7.1	7.1

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

Yes – In February 2019, the Trust signed off a Terms of Reference for the Disability Staff Network; from that point forward, the network was formally recognised by the Trust. The network aims to provide an avenue for staff to discuss disability-related issues. In 2021, disability network from both legacy organisations merged, to ensure the representation of all UHSussex staff. The network reports to the Diversity Matters Steering Group, chaired by the Chief People Officer. The Chair of the Disability Staff Network also attends the HR Policy Group Forum, which is responsible for the development and review of non-Medical HR policies on employment issues.

UHSussex has also produced a guidance document on "How to ask the protected characteristic questions in the NHS", which was designed to help those undertaking research and evaluations to ask questions about disability in a standardised and appropriate way.

Metric 10 - The percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:

i)   By Voting membership of the Board (as of 31st March 2022).
ii) By Executive membership of the Board (as of 31st March 2022).

Total Board Membership

Staff Group	Number in workforce	% in workforce	Number on Board	% of board	% Difference
Disabled	827	5.0%	2	7.4%	+2.4%
Non-disabled	13,391	80.3%	22	81.5%	+1.2%
Not known	2,462	14.8%	3	11.1%	-3.7%
Total	16,680	100%	27	100.0%	

Voting Membership of the Board

Staff Group	Number in workforce	% in workforce	Number on Board	% of board	% Difference
Disabled	827	5.0%	0	0%	-5.0%
Non-disabled	13,391	80.3%	8	88.9%	+8.6%
Not known	2,462	14.8%	1	11.1%	-3.7%
Total	16,680	100%	9	100.0%	

Executive Membership of the Board

Staff Group	Number in workforce	% in workforce	Number on Board	% of board	% Difference
Disabled	827	5.0%	0	0%	-5.0%
Non-disabled	13,391	80.3%	9	90.0%	+9.7
Not known	2,462	14.8%	1	10.0%	-4.8%
Total	16,680	100%	10	100.0%	

In Year Actions for 2022/23:

Number	Action	Responsibility	Completion
1.	Improve the workforce declaration rates for all protected characteristics.	EDI/HR	Mar-23
2.	Write to all Executives and ask for the declaration of protected characteristic data	EDI	Aug-22
3.	Work with the Patient First team to assess the statistical significance of all the WDES Metrics	EDI/Patient First	Mar-23
4.	Review reporting processes for incidents of bullying, harassment and/or violence	EDI/HR	Mar-23
5.	Conduct a survey with the Disability Staff Network (DSN) to review staff satisfaction with Reasonable Adjustments	EDI/DSN	Mar-23
6.	Develop a Disability Leave policy	EDI/HR	Mar-23
7.	Draft the Equalities & Inclusion Strategy and take to the People Committee for the October meeting	David Grantham, CPO	Oct-22
8.	Continue to supplement the quantitative data with qualitative and lived experience data	EDI	Mar-23

Factors or data which should be taken into consideration in assessing progress?

As the reporting period of this report covers the period of the COVID-19 pandemic, many pieces of work had been on hold, delaying progression in several areas to ensure the Trust was able to meet the needs caused by the pandemic.

Any issues of completeness of data

None, although declaration of disability remains under-reported/disclosed by staff.

Any matters relating to the reliability of comparisons with previous years

On completing data for the WDES report, it was realised that some previous TRAC recruitment reports had been interepreted inconsistently. These reports provide data for Metric 2. This error has now been rectified. In 2020, the relative likelihood for Metric 2 was reported as 0.82 for BSUH and 1.85 for WSHFT, when 0.96 and 2.48 should have been reported respectively.

NHS
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Agenda Item:	14	Meeting:	Board		Meeting Date:	4 August 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 July 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, Chief Executive and the Chief Governance Officer. In attendance were the Finance Director, the Director of Capital, the Director of Estates and Facilities, the Commercial Director and the Director for Improvement and Delivery.

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 Commercial Progress, environmental sustainability, risks and the Board Assurance Framework. The Committee considered the following investment decisions: Paediatric Audiology Service Relocation, International Recruitment and a continuous positive airway pressure (CPAP) machine supplier contract award.

The Committee also received an update from the ICS Finance Leadership Group and an update on the development of the Sussex Payroll Hub

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.

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Sustainability Committee	28 July 2022	Lizzie Peers	✔	☐

Declarations of Interest Made

The Chairman, Alan McCarthy declared an indirect personal interest in a partner organisation that may join the Sussex Payroll Hub. It was noted that no decisions were due to be taken at the meeting and Aland remained in the meeting

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 at Quarter 1 and **NOTED** that the Trust was forecast to deliver its financial control total of breakeven as per the agreed plan agreed by the Board in June 2022. The Committee was **ASSURED** through their review of the Finance Report for Quarter 1 and the supporting scorecard alongside the engagement from the Trust Finance Director, on the actions undertaken toward delivery of the Trust's overall year end breakeven position, year-end cash position and the delivery of the 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 and **NOTED** that risks in relation to income and expenditure represented a more considerable challenge than in recent years and would require increased activity performance and improved delegated budget performance throughout 2022/23 for those risks to be mitigated. The Committee **NOTED** the linkage between this report and the quarter 1 Efficiency Report and the quarter 1 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 Pay Expenditure Reduction. The Committee **NOTED** the update provided by the Trust Finance Director including the analysis undertaken of the top contributors and progress against improvement actions to support the reduction in the use of agency spend including management information through the introduction of rostering. The Committee **NOTED** work to harmonise medical bank rates but acknowledged that the primary pressure of increased premium spend related to additional posts supporting the Emergency Departments and patient flow. On Nursing premium pay spend, the Committee **NOTED** progress had included a full set of proposed workforce KPIs. These metrics concern themes around: international and domestic recruitment; retention & sickness management; rota optimisation and bank & agency controls.

There was an update on the Strategic Initiative - Environmental Sustainability provided by the Director of Facilities and Estates. 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. The Committee **NOTED** continuing success to increase the numbers of green ambassadors and also the charitable funds award for x2 Clinical Fellows to support specific initiatives within the Green Plan.

The Committee discussed the governance arrangements for environment impact assessments for proposals and **NOTED** the connection between energy usage around ventilation specified by infection prevention controls as well as linked to climate adaption. Estate master planning of refurbishment schemes was **NOTED** to be the solution to address competing demands.

The Committee **NOTED** the Trust continues to champion this area as part of our engagement with the ICS. The Trust environmental team was engaged with the ICS as they introduce the Sussex Health Care Environmental Sustainability strategy.

In respect of the Corporate Project – PAS Implementation, the Committee was **ASSURED** from the feedback provided on behalf of the Director of IM&T that the project remains on track and reported high success of data migrated successfully in the most recent area of deployment and communications had been proactively initiated to ensure business continuity plan readiness ahead of switchover.   The Committee noted the PAS Board had taken an active decision not to reduce activity templates in the period of switchover in light of learning from previous deployments on other sites.
The Committee **NOTED** that the project continues to be well supported by both strong levels of clinical and operational engagement and risks and issues continued to be mitigated including bandwidth contingency for the data centre.

Use of Resources

The Committee **RECEIVED** the Q1 update against the Trust's 2022/23 capital plan and the Director of Capital informed the Committee on the Trust's capital prioritisation process. However, there remains an over programme risk. 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 update of several schemes nearing completing considerable investment across the Trusts' sites to enhance the experience of staff and driving improvements in clinical services.

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 NOTED the supply chain risks arising from current market conditions.

The Committee were **ASSURED** by the update from the Director of Capital.

The Committee **RECEIVED** the quarter 1 Efficiency Programme Report from the Director for Improvement and Delivery on the delivery of the Trust's efficiency programme for the year 2022/23 and **NOTED** the effort made by the Divisions and the Trust to secure the level of achievement during continuing operational challenges.

Through the update provided by the Director for Improvement and Delivery the Committee was **ASSURED** over the divisional engagement but NOTED more detailed articulation of plans within divisions to achieve costs reduction was required to show full matching to the scale of efficiency challenge. The Committee acknowledged the strong track record of delivering efficiencies through the arrangements described and confidence in 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 but acknowledged the strong track record of efficiency delivery. 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,

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 with continued operational pressures on the divisions but the PMO resource gap had been closed to address the previously stated risk. The Director for Improvement and Delivery advised that there would be a programme of engagement with the newly staffed clinical operating model in order to support leaders in each division to fully engage with the Trust's efficiency methodology and processes.

The Committee **RECEIVED** the quarter 1 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 quarter focusing on infrastructure and platform replacement alongside data showing the performance of the IT department itself. The Committee were advised that there had been a particular focus on overnight works and on addressing to Cyber attack risks. The IM&T team had awareness of compromised email accounts addressed those vulnerabilities when they exist and increasing staff cyber security vigilance represented a key mitigation. The Committee acknowledged the challenge that continued Clinical sponsorship of IM&T initiatives had been constrained by considerable operational pressures.

The Committee discussed the opportunities that IM&T can support within the Trust's productivity improvement including remote Radiology and noted that these were contingent on the new PAS rollout Microsoft 365 deployment had been positive.

The Commercial Director provided an update on the activities of the newly formed commercial directorate. The Committee **NOTED** Q1 activities around the payroll hub development, a retail strategy for 3Ts and supporting equipping of the new building. The Committee **NOTED** that National benchmarking had been reinitiated and the Trust had performed relatively well, reflecting that core activities had been sustained through COVID. The Commercial Director provided an update on recruitment to the Commercial team structures and **ASSURED** the Committee of prioritised work by commercial team to secure the Trust's continued supply chain. The Committee **NOTED** considerable success in the past to this but acknowledged this was a risk as activity increased. The Committee **NOTED** that work was underway to mitigate the risk of unfilled commercial unit at 3Ts and the committee acknowledged food options were an important factor in staff satisfaction and connected with feedback received.

Investment decisions

The Committee was ASSURED by the progress to recruit 300 overseas nurses supported by robust induction arrangements and pastoral support to fill vacant positions sustainably. The Committee **AGREED** TO RECOMMEND Board approval of the plan to continue recruitment.

Deep Dive Assurance / Exceptional items

The Committee **NOTED** an update in relation to the establishment of the SHCP Payroll Hub, in partnership with NHS Shared Business Services (SBS). The committee was **ASSURED** of continued engagement with payroll staff and Staffside regarding the proposals and by reports from the Commercial Director of preparatory work with SBS.

The Committee **NOTED** Sussex Health and Care organisations, including UHSussex, signed contracts with NHS Shared Business Services at the end of June 2022. The Committee **NOTED** the proactive discussions with internal audit over the arrangements. The Committee **NOTED** that the Trust executive had approved additional local funding of an assistance resource for staff having queries around pay in order to bolster timely responses in light of the particular challenges arising from the cost of living increases.

The Committee discussed and **NOTED** the digital opportunities in automation efficiency and environmental improvements with less reliance on paper that can be realised by operating at scale.

ICS

The Committee **RECEIVED** an update from the Chief Financial Officer on the work of the ICS Finance Leadership Group of the ICS in July 2022. The Committee **NOTED** the update from the Chief Finance Officer on the meeting of Sussex Health and Care CFOs at which the Q1 position of the Sussex system was discussed. The System financial position and efficiency plan position were reported including the Trust's contribution to those balances. The Committee NOTED that the Capital Programme position was in line with

plan at Q1 that was acknowledged to represent a positive opportunity as the System would seek to capital bid intentions for future years with Capital Priority decisions expected from October 2022.

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.

Risk

The Committee **REVIEWED** the quarter 1 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 19 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. This is 1 less than at Q4, with recommended closure of risks attributed to the delivery of the 2021/22 financial plan, including the capital plan but replaced by new risks attributable to 2022/23 Plan.

Five of these identified risks are identified with a current risk score of over 12, these relating to Payroll, Cyber Security and Capital Developments.
A further risk recommended for closure concerned the Trust's finance team ability to generate reports that had been resolved following Microsoft365 extended license with Power BI capability to the finance team.

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.

Actions taken by the Committee within its Terms of Reference

The Committee **AGREED** to recommend the quarter 1 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 asked that further information is brought within the reports to the Committee on productivity improvements.

The committee seeks an update on Performance Report as at October 2022.

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 4 August 2022

Agenda Item:	15	Meeting:	Board		Meeting Date:	4 August 2022
Report Title:		Systems and Partnerships Committee Chair report to Board				
Committee Chair:			Lizzie Peers, Non-Executive Director who for the July meeting was Committee Chair			
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	☐		
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 28 July 2022 and was quorate as it was attended by three Non-Executive Directors, the Trust Chair, the Chief Executive, the Chief Operating Officer, the Chief Financial Officer, and the Chief Governance Officer. In attendance was the Director of Strategy and Planning, the Managing Director for Planned Care and Cancer, the Director of Improvement and Efficiency and the Divisional Director of Operations for Cancer for the more detailed agenda item on cancer.

The Committee received its planned items including the Q1 report on the Trust's performance against the key constitutional standards, reports on the respective the Systems and Partnerships Strategic Initiative of the 3Ts development, along with updates on the Trust's work within the ICS, Systems and Partnerships key 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 outcome of the Committees review of BAF risks 5.1, 5.2 and 5.3 that the Committee's view is that these risks are fairly represented with risk 5.1 reducing to score of 12.

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Systems and Partnerships Committee	28 July 2022	Lizzie Peers acting as Committee chair for this meeting	✓	☐

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 one including the performance against the Trust's systems and partnership true norths and breakthrough objectives for emergency and planned care for the same quarter

The Committee **NOTED** the Trust has continued to focus on reducing the patients waiting the longest, those over 104 weeks for elective RTT treatment and that for this co-hort of patients the Trust delivered its plans and saw no patients wating over 104 weeks by June 2022 unless the patient had elected to wait or those that fall within specific complexity categories. The Committee was **ASSURED** by the Chief Operating Officer's update and that of the Managing Director for Planned Care and Cancer that the Trust has a robust plan to achieve the 96 week wait target by the end of quarter 2 and the 78 week wait trajectory by the end of the year.

The Committee **RECEIVED** an update on the Trust's performance within urgent and emergency care NOTING the improvements in a number of metrics including the Time to triage and the Ambulance hand-over times. The Committee **NOTED** the linkage of these improvements with the detailed action plan it received at its last meeting from the Director for the urgent care recovery programme.

The Committee **NOTED** the Trust's cancer performance and the information given by the Chief Operating Officer that the Service had developed plans to address this performance deterioration (see the next section within this update covering the receipt of the cancer services detailed report to Committee).

The Committee also **NOTED** the reported performance against the diagnostic standard improved marginally in June is now tracking albeit marginally, better that the national performance average.

The Committee **NOTED** the interlinkage between the activity reports received at this Committee the reports at the People Committee on workforce pressures and the reports at the Sustainability Committee in respect of productivity challenges.

Cancer Performance focused update (deep dive)

Both the Chief of Services and Divisional Director of Operations for the Cancer Service provided a focused update on the developed Trust Cancer Division. The Committee **NOTED** the divisions ambition for enhancing the services link to research and innovation. The Committee **RECEIVED** an update on the Cancer Delivery Targets, the Trust's current performance against these and the actions being taken the those under development to improve the Trust's performance. The Committee **NOTED** the service

challenges linked to referral growth, workforce resourcing challenges along with access to timely diagnostics and the opportunities being pursued to address these. The Committee through the report and information provided by the Chief of Services and Divisional Director of Operations supported by the Chief Operating Officer was **ASSURED** of the Service's focus on performance improvement.

3Ts Strategic Initiative

The Committee **RECEIVED** updates on the Trust 3Ts hospital development Strategic Initiative from the Director of Improvement and Efficiency. 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 **NOTED** that an emerging issue as the work on the deployment into 3Ts is progressing through the development of detailed occupation plans which is likely to see a new risk on workforce capacity being added.

The Committee **RECEIVED** an update on the work of the 3Ts readiness steering group which is overseeing the move. These plans see the preoccupation phase deliver through to January 2023 ensuring there are robust, benchmarked and quality assurance plans for non-clinical and clinical team moves.

The Committee discussed the utilisation of the building and the benefits this will bring to our patients across Sussex and to the working conditions for our staff.

ICS and Systems Collaborations

The Committee **NOTED** that the Sussex Acute Collaborative Network (SACN) has met since the Committee's last meeting. The role and operation of the SACN is under review given the launch of the ICB to ensure there is no duplication with the ICB assurance processes allowing the Collaborative to link to the PLACE based partnerships key deliverables. The Committee **NOTED** from the update by the Chief Executive that collaborative projects continue to be pursued for the benefit for the patients in Sussex

The Committee **RECEIVED** an update on the Trust's work with Queen Victoria Hospital NHS Foundation Trust and **NOTED** the establishment of 8 workstreams, each with an Executive Lead and Senior Responsible Officer. Each workstream is working to support the development of the Full Business Case.

Risk and BAF

The Committee **RECEIVED** and discussed the quarter 1 System and Partnership Risk Paper on the programme risks which may impact the delivery of the Systems and Partnership True Norths along with the overarching risks from the respective Strategic Initiative and Corporate Project. The Committee **NOTED** that a number of the risks included are due to be reviewed as the outcomes of the Strategic Filter concludes in the forthcoming months.

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

The Committee **AGREED** the risk paper summary correlated with the discussions had on the prior papers

The report identified 1 risk with a current score of 12 or above and a further risk with an impact of 5 but scoring below 12 covering the areas of Restoration and Recovery Corporate Project and the 3Ts Strategic Initiative

along with the operational workforce and capacity risks within the divisions impacting on an increase in elective waiting times across a wide range of services.

The Committee **REVIEWED** the BAF risks it has oversight for, and **AGREED**, having regard to both the BAF summary and the Committee's consideration of the reports and the more detailed risk paper during the meeting, that the quarter two score for risks 5.1, 5.2 and 5.3 were fairly stated, confirming the reduction of risk 5.1 was consistent with updates to the Committee or direct to Board.

Actions taken by the Committee within its Terms of Reference
The Committee **AGREED** to recommend the quarter 2 scores 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 noted that within the performance report national and south east comparison data and the quartile position of the Trust will be added from the next quarter.

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 4 August 2022

Agenda Item:	16	Meeting:	Board		Meeting Date:	4 August 2022
Report Title:		Audit Committee Chair report to Board				
Committee Chair:			David Curley, Non-Executive Director and Committee Chair			
Author(s):			David Curley, Non-Executive Director and Committee Chair			
Report previously considered by and date:						

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

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

Implications for Trust Strategic Themes and any link to BAF risks		
Patient	✓	The work of Internal Audit and Counter Fraud provided assurance in respect of various elements of the Trusts' the systems of internal control relied upon in managing a number of BAF risks. The Internal Audit plan is aligned to the BAF, therefore their assurance is linked to the strategic risks facing the Trust.
Sustainability	✓	
People	✓	
Quality	✓	
Systems and Partnerships	✓	

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

Communication and Consultation:

Executive Summary:

The Audit Committee met on the 19 July 2022 and was quorate as it was attended by four Non-Executive Directors. In attendance was the Chief Financial Officer, the Chief Governance Officer, the Trust's Deputy Director of Finance, the Trust's Commercial Director, and the Company Secretary along with the Trust's Internal and External Auditors and Local Counter Fraud team members. The Trust's Medical Director attended to provide an update on the consultant job planning internal audit report and presented the Trust's Information Governance and Caldicott Guardian report.

The Committee received its planned items with the focus being on receiving the reports in relation to work undertaken by Internal Audit and Counter Fraud during Quarter 1 of 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 received the Trust BAF and a report on the process enhancements to the reporting of compliance against the Trust's risk management policy.

The Committee reviewed the Annual Report in respect of the work of the Audit Committee over 2021/22 from the Chair of the Committee during that period and the Committee reviewed its Terms of Reference and agreed these remain appropriate but requested that these are subject to annual confirmation.

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 sought greater executive support to ensure agreed management actions resulting from internal audit reviews were provided and that actions were taken within the timescales agreed.

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.

NOTE the Audit Committee's Annual Report covering the Committee's activity relating to 2021/22. (Appendix 1)

NOTE that the Audit Committee has referred the oversight of the delivery of the management actions in respect of the Internal Audit report into consultant job planning processes to the People Committee.

NOTE that the Audit Committee sought greater executive support to ensure agreed management actions resulting from internal audit reviews were provided and that the agreed management actions were taken within the timescales agreed.

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Audit Committee	19 July 2022	David Curley	✔	☐

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 against the 2022/23 internal audit plan. The Committee **NOTED** the plan had been developed to continue to use the Internal Audit resources to assist the Trust to make improvements. The original plan contained a degree of flexible resource to deal with changing or emerging matters.

The Head of Internal Audit informed the Committee that nationally NHS Internal Auditor had been mandated by NHS England to undertake a review of certain elements of NHS Trust's Internal Financial Control frameworks. This review was a condition placed on all NHS providers where additional funding to support excess inflation had been accepted. The Chief Financial Officer remined the Committee that this condition was accepted by the Board when the approved the revised plan for submission to the ICS. The Committee **AGREED** this change to the plan.

The Head of Internal Audit also informed the Committee that a request had been made for Internal Audit to review the Trust's processes supporting their CNST submission this year. The Committee **AGREED** this change to the plan.

The Committee reflected on the request made by the Quality Committee to utilise some of the unallocated Internal Audit resource to review data quality. The Head of Internal Audit confirmed that within the plan there was allocated resources to review elements of the Trust's data quality processes and in 2022/23 this would focus on unscheduled care data reporting. The Head of Internal Audit suggested that as the Trust develops its data quality framework and processes this year that a review of these overall framework would be useful to be undertaken in early 2023/24. The Committee supported by the Chief Governance Officer **ENDORSED** that approach and use of Internal Audit resources for 2023/24.

The Committee discussed the timing of the planed EDI audit and **AGREED** that this review should be retained within the 2022/23 Internal Audit activity plan.

The Committee considered the Internal Audit report in respect of the Consultant Job Planning. The Committee was reminded this was an area where the Trust sought an independent review of the Trust's current processes for job planning to enable it to take any learning into its planned revised harmonised UHSussex wide processes. The Committee noted that some of the job planning processes had been impacted by nationally recommended changes to Trust processes in recognition of resources being diverted from planned activity to deal with Covid demands. The Deputy Chief Medical Officer provided a detailed update on the actions being taken in respect of the audit findings and confirmed that the findings were useful as the Trust's develops its revised harmonised processes. The Committee agreed that this area fell within the remit of the People Committee and that through the reporting to that Committee on this area then the People Committee would have initial oversight of the delivery of the agreed actions to the timescales agreed. The Committee agreed that these reports should also be shared with Internal Audit to allow the routine Internal Audit report on progress against all agreed actions to capture this progress to support the oversight role the Audit Committee has for internal control improvements. The Audit Committee, therefore, **AGREED** to refer the oversight of these actions initially to the People Committee.

The Committee **RECEIVED** the Internal Audit follow up review which provided information in respect of actions completed. This gave **ASSURANCE** over the delivery of agreed actions and in respect of those not yet completed that the revised timescales were reasonable. The Audit Committee noted however that there had been an increase in the number of agreed actions without any update as to their progress. The Audit Committee **ENDORSED** the action recommended by the Executives to have the named executive lead for that area where recommendations had been made to allow the relevant Executive to be able to support in securing responses.

Local Counter Fraud

The Committee **RECEIVED** the Local Counter Fraud progress report for Quarter 1, 2022/22. This report provided information in respect of their proactive work undertaken, fraud awareness raising work with our staff and the work in response to any reported concerns. The update from the Trust LCFS also included benchmarking information of referral patterns across the sector and case studies offering opportunities to learn from wider sector. The Committee **AGREED** that for future benchmarking reports it would be beneficial to have this information for context in respect of the size of the Trust. and number of employees as having a high reporting culture is a positive cultural indicator.

Through the update from the Local Counter Fraud Specialists the Committee received **ASSURANCE** that training is provided across all key areas of the Trust including, finance, procurement, contracting etc and for anyone who becomes a requisitioner / budget holder then the person must undertake fraud and anti-bribery training and pass a dedicated test on this area to secure their system access.

The Committee received **ASSURANCE** from the update provided by the Local Counter Fraud Specialists on their work during the quarter that there were no significant fraud risks which Trust needed to be actioned urgently within the Trust.

External Audit

The Committee **RECEIVED** a verbal update on the work of the external auditors post the submission of their 2021/22 unqualified opinion and their annual report for 2021/22. The Committee **NOTED** that the work in relations to 2021/22 had been successfully delivered and are attending the Trust's Annual Members Meeting on the 27 July to provide the Governors and the Public with their annual report.

The Committee **RECEIVED** a report from the Chief Financial Officer in respect of the performance of the External Auditors in respect of their 2021/22 work. The Committee discussed the way the Finance Team and the Auditors worked during their first year of their Audit Contract. The Committee **NOTED** that this report is to be presented to the Council of Governors in August give the appointment of the external auditors is made by the Council supported by the Trust's Audit Committee.

Losses and Special Payment Report and Tender Waiver Report

The Committee **RECEIVED** the Trust's Losses and Special Payments registers. The Trust's Deputy Director of Finance provided information on those cases in Quarter 1 alongside the overall position for the preceding year, noting that the levels of these cases in quarter 1 were lower than those for that period last year. The Committee discussed the processes for learning from these instances whilst not large in number each offer an opportunity to learn. The Commercial Director updated the Committee on the work that has been undertaken with the procurement teams and the divisions which supports the continued reduction in the number of waivers required, noting for Quarter 1 the numbers were within the trajectory for a reduction to be achieved for the year 2022/23. The Committee, through these reports, was **ASSURED** over the underlying processes applied to manage Trust resources.

Audit Committee Reporting Group – Health and Safety

The Committee received **ASSURANCE** from the Health and Safety Committee Chair's report from its meeting in May 2022. The Committee noted that work continues to schedule the Health and Safety Committee meetings to have the full quarters data available to the Committee and thus enhance the assurance this report provides to the Audit Committee. The report from the Committee Chair confirmed the Trust has effective oversight of the Trust's H&S key risks and requirements, especially the Trust's compliance with those in relation to RIDDOR. The report also provided the Committee on the active management of the Health and Safety risk assessments as 20% of the risks has activity moved in line with the reports presented to the Committee with the vast majority of these reducing based on the delivery of the planned mitigations. For the two risks where the score had increased the Committee Chair's report provided information on the reasons for the change, the endorsement of these by the Committee as supporting the change in risk score and their linkage to the Trust's wider risk management process for the tracking of improvement.

Information Governance and Caldicott Guardian Report

The Committee **RECEIVED** the Annual report in respect of Information Governance and Caldicott Guardian activity across 2021/22. The Committee **NOTED** the breadth of activity undertaken over the year including the outcomes of management audits showing a high level of compliance with the Trust's processes. The Committee **NOTED** the relatively low level of IG incidents during 2021/22 and that whilst there had been one case where the Trust had referred a matter to the Information Commissioners Office (ICO), the Committee noted that the ICO were satisfied by the actions taken by the Trust and informed the Trust that no further action was needed. Through the presentation of this report and the further information provided in respect of questions asked by the Caldicott Guardian, the Deputy Chief Medical Officer, the Committee was **ASSURED** over the underlying processes for information governance.

Risk Register and BAF reports

The Committee **RECEIVED** the latest risk report providing information on the Trust risks scoring over 15, and of these the Committee noted that there were six risks scoring 20. The report showed the mapping of these risks to the relevant patient first domains and thus which Committee would provide the oversight of these risks and their actions. The Committee **RECEIVED** information on the progress with the Trust risk register alignment programme and **NOTED** this project would provide enhanced reporting over the Corporate and Operational compliance with the Trust Risk Management Policy. The Committee **RECEIVED** the Quarter 2 BAF, noting that this information is to be subject to review by each of the Board Committee's in their meetings next week. The Committee after considering the BAF did not refer any specific risks for a more detailed review by any of the other Board Committees. The Committee **AGREED** that in future meetings these items would be taken earlier in the agenda to allow these to frame discussions in respect of the receipt of the various forms of management assurance.

Audit Committee Annual Report for 2021/22

The Committee **RECEIVED** the Annual Audit Committee Report for the period 2021/22 drafted by the previous Audit Committee Chair. The Committee **AGREED** this correctly reflected the activity of the Committee but asked the initial appendix reflect the work undertaken by internal audit rather than their initial plan. The Committee **AGREED** that this report be presented to the Trust Board for noting as the report provides the Board with an understanding of the Committee's work over the last year.

Terms of Reference

The Committee **RECEIVED** a report from the Company Secretary on the review of the Committee's Terms of Reference. 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 also **AGREED** that the supporting Committee cycle of business adequately supports the basis for the agenda planning for the meetings across 2022/23. The Committee debated the inter linkage with the work of the Sustainability Committee in respect of the oversight of the benefits realisation from significant investments

and agreed that this was adequately reflected in the Terms of Reference without curtailing the work of the Sustainability Committee.

Actions taken by the Committee within its Terms of Reference

The Committee **RECEIVED** the Annual Audit Committee Report for the period 2021/22 and **RECOMMENDED** this be presented to the Trust Board for **NOTING** as the report provides the Board with an understanding of the Committee's work over the last year.

The Committee **APPROVED** the minor revisions to the Audit Committee Terms of Reference and **AGREED** that a fuller formal review would take place in three years that annually the Terms of Reference will be subject to Committee endorsement that no change was needed.

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

The Committee asked that in respect of Fraud Awareness Training that within future reports further information is provided over the effectiveness of the training and the coverage of that training over a 12 to 24 month period.

The Committee asked that more detailed information is provided on this learning from the losses be provided to the Committee members within the next meeting. noting that for any significant event then an after action review is undertaken which will provide information on the learning taken to prevent a reoccurrence.

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

Item	Referred to
The Committee recommended to the Board for their information the Committee's annual report of their activity during 2021/22 as agreed by the previous Audit Committee Chair. The Committee also recommend to the Board that they note the review of the Committees terms of reference and that they remain appropriate.	The Board
The Committee referred the oversight of the delivery of the management actions in respect of the Internal Audit report into consultant job planning processes to the People Committee.	People Committee

To: Audit Committee   Date: July 2022

From: Chair of the Audit Committee   Agenda Item: 16.1

FOR ENDORSEMENT

ANNUAL REPORT FROM THE AUDIT COMMITTEE TO THE BOARD 2021-22

1.0 INTRODUCTION

1.01   The purpose of this report is to formally report to the Board on the work of the Audit Committee during the period 1 April 2021 to 31 March 2022 and to set out how the Committee has met its terms of reference and key priorities.

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

2.00   EXECUTIVE SUMMARY

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

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

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

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

2.05   The Committee was pleased to see the use of the Trust's Board Assurance Framework within each Board Committee meeting shaping their assurance reporting to the Board.

2.06   The Audit Committee was pleased to see the introduction of a new quarterly risk review of the risks pertinent to each individual Board sub-Committee, during the quarter 4 Committee meetings.

2.07   The Audit Committee was presented with a clear Internal Audit plan that was aligned to the Trust's Board Assurance Framework.

2.08   The 01 April 2021 saw the formation of the new University Hospitals Sussex NHS Foundation (UHSussex) Trust and the transition from two legacy Trusts to one new larger Trust. Having worked increasingly closer together to respond to the global Covid-19 pandemic since 2020, the transition from Brighton and Sussex University Hospitals NHS Trust and Western Sussex Hospitals NHS Foundation Trust to the new UHSussex Trust has been aided by the bonds and working relationships forged over the previous two years.

3.00   COMMITTEE MEMBERSHIP AND MEETINGS

3.01   The Audit Committee comprises solely of independent Non-Executive Directors in line with the Code of Governance for Foundation Trusts. There are five Non-Executive Directors who are allocated to the Committee although all Non-Executive Directors, except for the Chair, can attend the meeting.

3.02   The Audit Committee, who play a pivotal role in providing assurance over the risk management processes of the Trust, has a membership of only Non-Executive Directors. Through the Non-Executive Chairs and the Audit Committee membership all have a responsibility to challenge robustly the effective management of risk and to seek reasonable assurance of adequate control. This Non-Executive Director Committee chair membership of the Audit Committee has increased from three to five following the merger of the former legacy Trusts, Brighton and Sussex University Hospitals (BSUH) and Western Sussex Hospitals NHS Foundation Trust (WSHFT).

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

3.04   The table below details the membership and attendance of Committee members in respect of the period 1 April 2021 to 31 March 2022.

Name	Apr	Jun**	Jul	Oct	Jan	Total
Jon Furmston (Non-Executive Director and Committee Chair)	✓	✓	✓	✓	✓	5 of 5
Lizzie Peers (Non-Executive Director)	✓	✓	✗	✓	✓	4 of 5
Joanna Crane (Non-Executive Director)	✓	✗	✓	✓	✓	4 of 5
Patrick Boyle (Non-Executive Director)	✓	✓	✓	✓	✓	5 of 5
Jackie Cassell* (Non-Executive Director)	✗	✗	✗	✗	✗	0 of 5

*Jackie was unable to reset her diary to attend the meetings in 2021/22 but other NEDs from the Patient Committee were able to input into the Audit Committee meetings.
**Annual Accounts Audit Meeting in Common with BSUH

3.05   In order to share learning and to ensure linkages are made across Trust Committees the membership of the Audit Committee includes the Chair of the Quality Committee (Joanna Crane), the Chair of the People Committee (Patrick Boyle), the Chair of the Patient Committee (Jackie Cassell), the Chair of the Sustainability Committee (Lizzie Peers) and the Chair of the Systems & Partnerships Committee (Patrick Boyle).

4.00   CYCLE OF BUSINESS

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

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

4.03   In order to maintain independent channels of communication, the members of the Audit Committee hold a private meeting collectively with External Audit, Internal Audit and Counter Fraud ahead of

each Audit Committee. This provides all parties the opportunity to raise any issues without the presence of management.

4.04   The Committee followed its agreed annual work plan throughout the year and received a series of executive presentations around internal audit, external audit and Local Counter Fraud Services including a Committee effectiveness review following the change of Committee structure that was aligned to the Trust's True North Strategic themes.

4.05   The Board recognised the continued challenges facing the Trust as it managed the Covid-19 pandemic and maintained its proactive adaptation of its Board and Committee Governance processes which had commenced at the end of 2019/20 for both former legacy Trusts BSUH and WSHFT. These changes have seen the continued provision of regular updates on Covid-19 at Trust Board and Committee meetings, which have been held virtually with the continued use of technology. During the third wave of the pandemic these were enhanced with regular Gold Command briefings to the Board, led by the Chief Executive complemented by the wider Executive team.

5.00   INTERNAL AUDIT

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

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

5.03   The Internal Audit plan for 2021/22 was approved by the Audit Committee in April 2021 as part of the wider three-year Strategic Audit Plan for 2021-2024. Performance against the approved plan is attached as Appendix A. The plan was based upon discussions held with management and the Audit Committee and was constructed in such a way as to gain a level of assurance on the main financial and management systems reviewed. In October 2021 a revised plan for the remainder of the year was present to the Committee, due to the ongoing impact of the pandemic it was proposed that five of the original internal audits would be deferred into 2022/2023, the Committee approved this revision in accordance with its Terms of Reference.

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

5.05   During the year the Audit Committee received 9 finalised Internal Audit reports, with those in draft and in progress being carried forward to 2022/23. Internal Audit Reports receive two Assurance ratings; one relates to the Design of the system being reviewed whilst the other relates to the Effectiveness of the system being reviewed. Internal Audit can provide Assurance Levels of: 'substantial', 'moderate', 'limited' or 'no' assurance. Of the audits relevant to this period five received an assurance level of either substantial or moderate, whilst four received an assurance level of limited. However, the Head of Internal Audit reflected in his opinion that UHSussex is, "proactive in directing internal audit to the areas in which risks are known, this reflects both the appetite to address areas of control weakness and the risk management processes in place to ensure these areas are identified". In addition, it was noted that in a number of cases limited opinions related to processes delayed by the merger with mitigating actions in place.

5.06   Based on work undertaken during the period of this report the Head of Internal Audit has stated in his Head of Internal Audit Opinion that "Overall, we are able to provide moderate assurance that there is a sound system of internal control, designed to meet the Trust's objectives and that controls are being applied consistently".

5.07   In forming their opinion Internal Audit took into account that, the Trust had delivered its control total, that the majority of audits provided moderate assurance including the key audits of Key Financial Systems & Budgetary Control, Freedom of Information and Data Security & Protection Toolkit. In

respect of all recommendations made, the Head of Internal Audit noted that "the has been some slippage in implementation dates experienced during the year, primarily due to the operational impact of Covid", but was assured but the Audit Committees close monitoring of these noting that discussions were underway to further improve the process moving into 2022/2023.

6.00   LOCAL COUNTER FRAUD SERVICE (LCFS)

6.01   The Counter Fraud service is a hybrid provision combining the resources of the Trust's respective Counter Fraud Services prior to merger, thus being an internal provision and an external provider RSM, who work closely together and report quarterly to the Committee. Collectively the team is responsible for day to day awareness and activities. The reports describe proactive work to prevent or deter fraud and also set out the results of reactive work undertaken in response to referrals about suspected fraud.

6.02   A work plan for 2021/22 was agreed with the Finance Director and approved at the Audit Committee in April 2021. The work plan outlined the core Local Counter Fraud Specialist (LCFS) activities to be undertaken during the financial year within the agreed resources. Key activities undertaken include areas of strategic governance, inform and involve, prevent and deter and hold to account.

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

6.04   The Local Counter Fraud Specialist reports annually on behalf of the Trust to the Counter Fraud Authority in relation to compliance against the Standard for Providers. The Standards for Providers against which the Trust reports has changed to the Government Functional Standards. The Trust was rated as green for the last Self Review Tool which was fully compliant with the Standards and demonstrating the impact of work undertaken. The annual submission against the new requirements will be presented to the Audit Committee in due course.

7.00   BOARD ASSURANCE FRAMEWORK

7.01   The Committee was pleased to see the use of the Trust's Board Assurance Framework within each Board Committee meeting shaping their assurance reporting to the Board.

8.00   YEAR END REPORTING

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

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

8.03   The Committee received a report on the Trust's processes for registering declarations of interest, the receipt of gifts, hospitality and sponsorship along with the compliance with the fit and proper persons' regime. The Committee was informed of the high return rate across the Trust with 1029 of 1044 consultants making a declaration, of those consultants that did not provide a return none had any budgetary responsibilities.

8.04   The submission of the 2021/22 Accounts and Annual Report took place on the 21 June 2022. This was in line with the national timetable.

9.00 EXTERNAL AUDIT

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

9.02 The Trust's external auditors are Grant Thornton and were newly appointed following a tender process in early 2021.

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

Area of Work	Conclusion
Opinion on the Trust's:	
Financial statements	Unqualified opinion – Grant Thornton completed their audit of the financial statements and issued an unqualified audit opinion on 21 June 2022, following the Audit Committee meeting on 15 June 2022.
Parts of the remuneration and staff report to be audited	Grant Thornton identified some minor amendments to the draft report, these were actioned. There were no further matters to report.
Consistency of the annual report and other information published with the financial statements	Grant Thornton had nothing to report in this regard.
Reports by exception:	
Value for money arrangements	Grant Thornton are satisfied that the Trust has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources.
Consistency of Annual Governance Statement	Grant Thornton had nothing to report in this regard.
Referrals to the NHS Regulator	Grant Thornton have not referred any issues to the NHS Regulator for UHSussex.
Public interest report and other auditor's powers	Grant Thornton have not issued a Public Interest Report
Reporting to the Trust on their consolidation schedules	Grant Thornton concluded that the Trust's consolidation schedules agreed to the Trust's audited financial statements.
Reporting to the National Audit Office (NAO) in line with group instructions	Grant Thornton had nothing to report in this regard.

9.04 It is normal practice for there to be a full debrief to the Audit Committee following the submission of the year-end accounts. The Audit Committee noted that this had been the first year with Grant Thornton as the Trusts External Auditors and noted the positive transition and the pragmatic approach to completing the audit.

10.00   Reporting to the Trust Board

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

11.00   Engagement with the Council of Governors

11.01   The Chair of the Audit Committee continued to ensure the Governors were kept informed of the work of the Committee and how the Committee discharged its responsibilities.

12.00   Conclusion

12.01   The Audit Committee of University Hospitals Sussex NHS Foundation Trust is of the view that it has taken appropriate steps to perform its duties as delegated by the Board and it has no cause to raise any issues of significant concern with the Board arising from its work during 2021/22.

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

12.03   The Audit Committee supported the work undertaken by the Board as it recognised the challenges facing the Trust in continuing to manage the ongoing pandemic and the decision of the Board to proactively adjust its Board and Committee Governance processes to ensure they were appropriately focused. The Audit Committee, like the Board and other Committees embraced the use of technology to enable it to function effectively and continue to meet and deliver against its terms of reference.

12.04   During 2022/23, the Committee will keep under review its working arrangements and ensure it continues to develop its own practice to improve its own effectiveness.

13.00   Recommendation

13.01   The Committee is asked to:
▪   **Endorse** that this Annual Report be provided to the Board

Jon Furmston
Chair of the Audit Committee
July 2022

APPENDIX A: INTERNAL AUDIT OPERATIONAL PLAN 2021/22

Audit	Exec Lead	Start Date
Mental Health Act Administration	Chief Nurse	July-21
Key Financial Systems	Chief Financial Officer	Nov-21
Disability confident	Chief People Officer	Nov-21
Freedom of Information	Chief Financial Officer	Nov-21
End to End Recruitment	Chief People Officer	Nov-21
Data quality	Chief Delivery and Strategy Officer	Nov-21
Facilities and Estates	Chief Medical Officer	Nov-21
IT post-merger implementation	Chief Medical Officer	Nov-21
DSP Toolkit	Chief Medical Officer	Mar-22

Agenda Item:	17	Meeting:	Trust Board in Public		Meeting Date:	August 2022
Report Title:		Charitable Funds Committee Chair report				
Committee Chair:		Lizzie Peers, Non-Executive Director				
Author(s):		Lizzie Peers, Non-Executive Director				
Report previously considered by and date:						

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

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

Implications for Trust Strategic Themes and any link to BAF risks			
Patient	✓	The Charities' activities underpin the Trust's strategic themes.	
Sustainability	✓		
People	✓		
Quality	✓		
Systems and Partnerships	✓		

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 July 2022 and was quorate as it was attended by three Non-Executive Directors, the Trust Chair, the Chief Financial Officer and Chief Governance Officer. In attendance was the Interim Charity Director for both BSUH and Love Your Hospital (LYH) Charities and other members of the Trust's finance and Charity's teams.

The Committee received the 2022/23 Operating Plan and budget and agreed that this provided clear information on fundraising expectations and a clear investment proposal that addressed comments on the previous draft. The Operating Plan and Budget were agreed to be recommended to the Board.

The Committee received, considered and approved a series of funding requests supporting enhanced patient experience and mental and physical wellbeing through accelerated investment in additional equipment and facilities.

Key Recommendation(s):

The Board is asked to **NOTE** the activity of the Committee and the assurances received over the stewardship of the funds.

The Board is also asked to **NOTE** the decisions taken by the Committee within its delegated authority that included support for a funding proposal that exceeded the Committee's delegated authority.

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
Charitable Funds Committee	**12 July 2022**	**Lizzie Peers**	**yes**	**no**
			✓	☐
Declarations of Interest Made				
There were no declarations of interest made.				
Assurances received at the Committee meeting				

BSUH and LYN Charities Operations - Quarter 1

The Committee was **ASSURED** there had been no identified regulatory or compliance issues with the operation of both Charities.

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

The Committee was **ASSURED** that both Charities were operating within their respective objectives through the receipt of Q1 performance reports from the Charity Director for both Charities. The operations update included the performance scorecard that provided a progress update for both BSUH and LYH Charities along with a review of the Charities risk register and mitigations.

The funding bid log was submitted from the BSUH Charity for review and was reviewed and the Committee **NOTED** the level of support the donations will make to the Trust's patients through the approval of the bids to use donated funds.

Investment Fund Manager Update

The Committee **NOTED** the stewardship of funds through a report from the investment fund managers for the investments of both BSUH and LYH Charities and that these investments were in line with the Trustee's appetite for ethical investment of the Charities' funds.

Charity Annual Reports and Accounts 2021/22

The Committee **RECEIVED** and reviewed the draft Charity Annual Reports and Accounts 2021 for both BSUH Charity and Love Your Hospital. The Committee endorsed the draft reports to be presented to the Charities External Auditors for audit.

Actions taken by the Committee within its Terms of Reference

The Committee **AGREED** that the 2022/23 operational budgets for both LYH and BSUH Charities be presented to a Board meeting.

The Committee **APPROVED** the following funding bids
- GE Air MAC ECG machines at Worthing Hospital
- 'RITA' app based therapies pilot to enhance rehabilitation in the Critical Care units at RSCH and PRH (subject to agreement from the July 2022 Capital Investment Group).
- DS100 monitors to enhance the monitoring of stroke patients at Lavant Ward, St. Richards Hospital.
- Extensions to the pastoral support for staff across all sites by extending the current provision post a prior pilot

- The provision of money management advice support for staff.

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

The accelerated development of spending plans to come to the October 2022 meeting

The outcome of the External Audit of the Charities Annual Reports and Accounts.

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; - the assurances received in respect of the stewardship of the donated funds; and - the Committee endorsed the submission of the draft annual report and accounts for both the BSUH and Love Your Hospital Charities to the Charities auditors.	Board

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	18	Meeting:	Public Board	Meeting Date:	August 2022

Report Title:	2022/23 Quarter 2 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 July.

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 has continued with the 13 strategic risks identified in 2021/22. These risks will be reassessed during the planed review of the Trust's True Norths and associated Breakthrough Objectives, Corporate Projects and Strategic Initiatives which is planned to take place during Quarter 2.

Each risk has been assessed against the Trust's risk appetite when setting their target score, and each segment of the BAF continues to have a lead executive and lead oversight committee.

For each segment of the BAF the respective lead executive has considered their risks along with the supporting highly scored and corporate risks when determining the quarter 2 score.

The quarter 2 BAF elements were considered by the respective Board Committees in July 2022.

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 Q2 and Q1, Q1 and Q4 from the prior year. (⟷ No change, ↑ an increase in risk and ↓ a decrease in risk)

BAF: Strategic Objectives and Strategic Risks (Key: I = Impact L = Likelihood T = Total)	Risk Scores														
	2021/22 Q4			2022/23 Q1			2022/23 Q2			Q3			Target		
	I	L	T	I	L	T	I	L	T	I	L	T	I	L	T
1. Patient *(Oversight provided by the Patient Committee)*															
1.1 We are unable to deliver or demonstrate a continuous and sustained improvement in patient experience resulting in adverse reputational impact and poor patient outcomes	4	4	16 ↔	4	4	16 ↔	4	4	16 ↔				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	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	2	8
2.3 We are unable to meet high standards of financial stewardship meaning we cannot sustain compliance with our statutory financial duties	4	3	12 ↔	4	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	4	16 ↑	4	4	16 ↔	4	4	16 ↔				4	2	8

Risk														
3.2 We are unable to effect cultural change and involve and engage staff in a way that leads to continuous improvements in patient experience, patient outcomes, and staff morale and wellbeing	4	4	16 ↑	4	4	16 ↔	4	4	16 ↔				4	2	8
3.3 We are unable to meet our workforce requirements through the effective recruitment, development, training and retention of *sufficient* staff adversely impacting on patient experience and the safety, quality and sustainability of our services	4	5	20 ↔	4	5	20 ↔	4	5	20 ↔				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	2	8

4. Quality   *(Oversight provided by the Quality Committee)*

Risk														
4.1 We are unable to deliver safe and harm free care to reduce non-covid mortality.	4	4	16 ↔	4	4	16 ↔	4	4	16 ↔				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.	4	4	16 ↔	4	4	16 ↔	4	4	16 ↔				3	2	6

5. Systems and Partnerships   *(Oversight provided by the Systems and Partnerships Committee)*

Risk														
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	4	4	16 ↔	4	4	16 ↔	4	3	12 ↓				4	2	8

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.	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	2	8

Quarter 2 summary

Following review at the end of quarter 2 the Executives this have agreed that the all risks exceed their target score and that for 11 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 a continuing high number of risks scoring 16.

Risk 5.1 has reduced to 12 given that progress is being made in respect to partnership working and the wider system structures have now been established. There remains work to be undertaken to ensure there are full and consistent benefits realised for our patients though this system and partnership working which when delivered will reduce this risk to its target score.

Supporting Key Risks

Each Committee at their meetings in July 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 overleaf 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 (scoring 20 or above)
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	Operational pressures including recovery from the Covid-19 pandemic, acute system pressures, escalation wards and staffing, referral to treatment delay and workforce constraints are all impacting on the experience of our patients. 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 all impacting on the experience of our patients. Risk to staff and patients by violent and aggressive patients.	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 Increase in demand for emergency care treatment. A&E Cohort Areas 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. There is an increased level of risk for cybersecurity. This is an on-	Capital Developments Cyber Security

	going and known risk requiring continuous oversight.	
People		
3.1 We are unable to develop and sustain the leadership and organisational capability and capacity to lead on-going performance improvement and build a high performing organisation 3.2 We are unable to effect cultural change and involve and engage staff in a way that leads to continuous improvements in patient experience, patient outcomes, and staff morale and wellbeing 3.3 We are unable to meet our workforce requirements through the effective recruitment, development, training and retention of *sufficient* staff adversely impacting on patient experience and the safety, quality and sustainability of our services 3.4 We are unable to consistently meet the health, safety and wellbeing needs of our staff as we recover and restore services in line with CV-19 restrictions	The stretch on staffing and their morale and wellbeing. These pressures are not unique to UHSussex but nevertheless pose a significant risk to delivery. Operational pressures including Covid-19 pandemic and workforce constraints are impacting on people, patient safety and trust operational costs and productivity. The general pressure on staffing of being able to sustain the levels of workforce needed, particularly at times of stretch (escalation beds, extra RTT activity etc)	Risk of insufficient medical staff Insufficient numbers of registered nurses and health care nurses Covid absence 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	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. Patient profile, frailty, mental health, delays to specialist	Levels nursing cover due to high levels of nursing and consultant 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

requirements or clinical standards	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.	Increase in RTT waiting times
Systems and Partnerships		
5.1 We are unable to develop and maintain collaborative relationships with partner organisations based on shared aims, objectives, and timescales leading to an adverse impact on our ability to operate efficiently and effectively within our health economy 5.2 We are unable to define and deliver the strategic intentions, plans and optimal configuration that will enable our services to be sustainable, leading to an adverse impact on their future viability. 5.3 We are unable to deliver and demonstrate consistent compliance with operational and NHS constitutional standards resulting in an adverse impact on patient care and financial penalties and the Trust's reputation.	Operational pressures including Covid-19 pandemic, increased system demand and delays, and workforce constraints are impacting on all operational capacity and workstreams including delivery of constitutional targets, and indirectly potential risks to the objectives of 3Ts, and 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 plan to have no patient waiting more than 78 weeks for treatment	Delivery of the Recovery and Restoration programme. Capacity constraints leading to Increase in elective waiting times Service Demands

Committee Review

Each of the Board Committees reviewed their assigned BAF risks at their meetings in July. This review alongside the reports they received including the overview of risks with the potential to impact on the relevant patient first domain each Committee agreed that the scores determined by the Executive were fairly stated.

Conclusion

All the Committees during their review of the risk information presented along with the reports they received directly at their meetings in July confirmed the BAF risks were for quarter 2 reasonably scored and should be recommended to the Board for approval.

The Executive led Strategic Filter which considers the Trust's Breakthrough Objectives, Corporate Projects and Strategic Initiatives aligned to the Trust's True Norths is continuing and its outcome will be used to reflect and adjust where relevant the Trust's strategic (BAF) risks.

Key Recommendation(s):

The Board is asked to consider and approve the Q2 risk scores recognising that these scores have been reviewed by the respective oversight committees and their recommendations to the Board that the scores are fairly represented.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	20	Meeting:	Trust Board	Meeting Date:	04 August 2022
Report Title:		UHSFT 2021-22 Medical Appraisal and Revalidation Board Report			
Sponsoring Executive Director:		Charlotte Hopkins, Interim Chief Medical Officer			
Author(s):		Dr Rob Haigh, Medical Director and Responsible Officer Neil Cripps, Lead for Appraisal and Revalidation Dr Rachael James, Deputy Medical (Standards)/Lead for Appraisal and Revalidation Caroline Wiggs, Medical Appraisal and Revalidation Manager			
Report previously considered by and date:		Quality Committee, 26 July 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	☐

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 report has been prepared by the Medical Appraisal and Revalidation (MAAR) Team in conjunction with Leads for Medical Appraisal and Revalidation and the Medical Director.

Executive Summary:

The purpose of this report is to provide assurance to the Board that the statutory functions of the Responsible Officer are being undertaken in accordance with the requirements of the Framework of Quality Assurance for Responsible Officers and Revalidation (2014.)

The report updates the Board on the 2021-22 end of year position with regard to medical appraisal and revalidation and seeks Board sign off of the NHS England statement of compliance.

Key Recommendation(s):

The Board is asked to **APPROVE** the Board Report inclusive of NHS England Statement of Compliance.

UHSFT 2021-22 Annual Medical Appraisal and Revalidation Board Report

Section 1 - General:

As at 31 March 2022, there were **1365** doctors with a prescribed connection to **University Hospitals Sussex NHS Foundation Trust.**

Of **1365** doctors, 1170 medical appraisal meetings have taken place. There were **195** 'approved missed' appraisals, with 46 doctors unable to be allocated a trained appraiser, due to an insufficient number of appraisers. Other reasons for 'approved missed' appraisals included maternity leave, prolonged (approved) leave and sickness absence during the due appraisal window.

393 revalidation recommendations to the General Medical Council were scheduled in 2021-22 and all were carried out in a timely manner.

The requirement to submit a 2021-22 Annual Organisational Audit (AOA) to NHS England was cancelled and is not therefore included within this report.

University Hospitals Sussex NHS Foundation Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

   > The current Responsible Officer and Medical Director is Dr Rob Haigh. The appointment was made in line with statutory requirements, with appropriate training given.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

   > The Responsible Officer is supported in their role by Dr Rachael James and Mr Neil Cripps, Leads for Medical Appraisal and Revalidation and the Medical Appraisal and Revalidation (MAAR) Team.
   >
   > A budget for the management and administration of Medical Appraisal and Revalidation is agreed with Finance at the beginning of the financial year.
   >
   > Action: To merge legacy BSUH and WSHT cost centres to create single, centralised budget.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

> The web-based GMC Connect list of prescribed connections to the Trust is continuously updated by the MAAR Team, with new starters and leavers. All policies which support medical revalidation are actively monitored and regularly reviewed.
>
> There is a policy review cycle in place for those policies that support medical appraisal and revalidation.

4. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

> Legacy BSUH and WSHT appraisal and revalidation processes have been satisfactorily reviewed by the NHS England (South) Higher Responsible Officer Team within the last 5 years.
>
> Action: A further peer review will need to be undertaken within the next 1 year, however, this is subject to NHS England's cycle of reviews which have been delayed due to the COVID-19 pandemic.

5. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

> All fixed term (locum) doctors are supported in their continuing professional development and governance. Fixed term doctors with a prescribed connection to the Trust are allocated an appraiser and supported with their revalidation. Staff bank and agency doctors are supported according to their relationship with the Trust.

Section 2a - Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore

choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

> Appraisals for doctors with a prescribed connection to the Trust are completed on the Trust's web-based appraisal system, which meets the GMC and NHS England requirements for appraisal. L2P (Licence to Practice) is the legacy BSUH system and Allocate the legacy WSHT system.
>
> Doctors are responsible for ensuring that sufficient supporting information, covering their whole scope of work, is uploaded to facilitate an effective appraisal discussion and doctors sign a declaration within the system to that effect.
>
> Significant events and information held on DATIX and through the complaints team are shared with the doctor prior to the appraisal.
>
> The organisation supports doctors to collect the required supporting information.
>
> Action: To undergo competitive tender for single web-based appraisal system Trust wide.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

> N/A - see above.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

> An in-date medical appraisal policy is in place and is aligned with national policy (legacy WSHT policy.) The policy will be reviewed within the next 1 year.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

> The Trust had **162** trained appraisers during 2021-22.
>
> Unfortunately, a number of appraisers have stepped down from the role and UHSx currently has insufficient numbers of appraisers to carry out annual medical appraisals for all doctors with a prescribed connection to the Trust.
>
> Going forwards, a review of appraiser remuneration, (including harmonisation between the legacy organisations), recruitment and retention strategies will be implemented to increase capacity.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Appraisers are supported in their role in the following ways:
- Development and calibration workshops.   - There is open access appraisal and revalidation advice and discussion opportunities as they arise with the Responsible Officer, Leads for Medical Appraisal and Revalidation and/or Medical Appraisal and Revalidation Manager.   - Monthly email bulletins are sent to all doctors with a prescribed connection, detailing local, regional and national medical appraisal developments.   - In order to support their development, appraisers receive an annual report based on 360° feedback from doctors appraised.   - Senior Appraisers and/or the Medical Appraisal and Revalidation Team review the appraisal summaries of new appraisers and provide individual feedback to support development.   - The Responsible Officer, Leads for Medical Appraisal and Revalidation and Medical Appraisal and Revalidation Manager are members of the South East RO network, with events held remotely during the 2021-22 appraisal year.

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[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

6.   The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

> Within the last 5 years an independent verification of the Trust's legacy BSUH and WSHT processes has been undertaken by NHS England (South) Higher Responsible Officer Team. A number of areas of good practice were identified. A further peer review will be undertaken within the next 1 year, subject to NHS England's review cycle.
>
> Following appraisal, doctors are asked to complete an anonymised appraisal feedback form. Collated responses are shared with appraisers and any particular issues or themes are discussed and taken forward with appraisers and Leads for Medical Appraisal and Revalidation.
>
> An annual audit of appraisal summaries is undertaken by a Senior Appraiser and/or the Medical Appraisal and Revalidation Team using an NHS England audit tool. General themes and areas for development are taken forward with appraisers and Leads for Medical Appraisal and Revalidation.
>
> A Medical Appraisal and Revalidation Report is submitted to the Quality Committee and Board annually.

Impact of COVID-19 pandemic

From 01 October 2020, the GMC and their partner organisations confirmed a rebalanced approach to appraisals using 'the Appraisal 2020 model'. Using this model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings - the model focuses on the doctor's professional development and wellbeing, and simplifies expectations around supporting information and pre-appraisal paperwork. The change of focus was reflected in the Trust's appraisal system.

The new appraisal model was welcomed by doctors as less time consuming and laborious and with more time at the appraisal meeting to reflect on their practice. The new approach continued into the 2021-22 appraisal year. The GMC and their partner organisations are reviewing the approach with a view to further simplification for the 2022-23 appraisal year.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation: University Hospitals Sussex NHS Foundation Trust	
Total number of doctors with a prescribed connection as at 31 March 2021	1365
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	1170
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	195
Total number of agreed exceptions	195

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

> Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol:

- There were **393** GMC recommendations due during the 2021-22 year.
- **86** deferral recommendations were submitted. Of these, **82** were due to insufficient supporting information and **4** because the doctor was subject to an ongoing process.
- There were no missed or late Responsible Officer recommendations to the GMC.
- There was **1** non-engagement recommendation.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

> All revalidation recommendations made to the GMC during 2021-22 were confirmed to the doctors in a timely manner by the Leads for Medical Appraisal and Revalidation and/or Medical Appraisal and Revalidation Manager, on behalf of the Responsible Officer.
>
> The reasons for recommending a deferral or non-engagement are always discussed with doctors before the recommendation is submitted.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

   > The Trust fosters a continuous improvement culture with well embedded and effective governance arrangements in place. There are clear systems in place for reporting and reviewing incidents and complaints. Openness and reporting is encouraged.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

   > BSUH (HR049 Policy Implementing Maintaining High Professional Standards) and WSHT (Implementing MHPS) legacy policies are based on the national Maintaining High Professional Standards in the Modern NHS (MHPS) framework setting out the variety of ways that concerns can come to light and the actions to take when a concern arises. The Trust is currently in the process of drafting and agreeing a new MHPS policy for UHSx.
   >
   > The Trust's Medical Appraisal and Revalidation Policy sets out the process for managing appraisals for a doctor under investigation or subject to a disciplinary process or GMC fitness to practice proceeding.
   >
   > Doctors with a prescribed connection to UHSx are provided with an annual DATIX report and/or Annual Medical Appraisal Return (AMAR) for their appraisal.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

> BSUH and WSHT legacy policies, based on MHPS, set out the established processes to follow when responding to concerns about doctors.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[2]

> In line with MHPS, a Non-Executive Trust board member is allocated to each case to provide assurance and oversight. The Trust's NHS Resolution Adviser is always approached to provide expert, independent advice, support and critique on handling complex concerns.
>
> The Responsible Officer and Leads for Medical Appraisal and Revalidation meet quarterly with the GMC Employment Liaison Adviser.
>
> Formal performance management processes have been Equality Impact Assessed to minimise potential for bias and disadvantage.
>
> As part of the Race Equality Standard, the Trust analyses the number of BAME staff going through disciplinary processes to assess whether there is a negative impact.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[3]

> Regular and ad-hoc transfers of information requests both to and from the organisation are responded to promptly and in line with national requirements.
>
> For Trust doctors on the GP Performers List, the Responsible Officer meets twice yearly with the NHS England (south) Responsible Officer's office and part of the purpose of that meeting is to share any information of note and to ensure a consistent approach to concerns involving GPs.

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[2] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

For those doctors with a prescribed connection to another organisation, a year-end audit of appraisals is undertaken. The purpose of the audit is to provide assurance that doctors are engaging in appraisal with their Designated Body.

Doctors working for the Trust under a Service Level Agreement are managed through those arrangements.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

See above.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Permanent, fixed term and bank appointments are subject to the full NHS Pre-Employment Check Standards.

Agency guidelines are in place which includes a medical agency worker pre-engagement checklist for Staff Direct and the authorising managers' use.

Section 6 - Summary of comments, and overall conclusion

The 2020-21 medical appraisal completion rate was impacted by COVID-19.

The 2021-22 end of year medical appraisal completion date for doctors with a prescribed connection for revalidation was **86%**. (Of the **1365** doctors with a prescribed connection to the Trust as of 31 March 2022**, 1170** medical appraisal meetings took place.) There were **195** 'approved missed' appraisals agreed.

The Board is asked to review the content of this report, noting that it will then be shared with the Tier 2 Responsible Officer at NHS England. The Board is asked to

note the Statement of Compliance which confirms the Trust as a Designated Body is in compliance with the regulations.

Section 7 – Statement of Compliance:

The Board / executive management team of **University Hospitals Sussex NHS Foundation Trust** has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Official name of designated body: **University Hospitals Sussex NHS Foundation Trust**

Name: Dr George Findlay   Signed: _ _ _ _ _ _ _ _ _ _

Role: Chief Executive

Date: _ _ _ _ _ _ _ _ _ _

Agenda Item:	21	Meeting:	Public Board		Meeting Date:	04 August 2022
Report Title:		System Oversight Framework				
Sponsoring Executive Director:			Darren Grayson, Chief Governance Officer			
Author(s):			Darren Grayson, Chief Governance Officer			
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:

This presentation is being shared with the Board to provide an explanation of the role of System Oversight Framework and its impact on the Trust.

The Trust intends to integrate the System Oversight Framework into the Integrated Performance Report presented to the Board from its next Public meeting in November.

Key Recommendation(s):

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

NHS Accountability and Regulatory Regimes

Board Workshop

07/07/2022

Introduction

► Health and Care act 2022 – statutory footing of ICSs

► 1st July 2022 ICBs came into being

  ► Statutory function of arranging health services for population

  ► Responsible for performance and oversight within the ICS

  ► 2022/23 transition year. NHSE consult on long term model of oversight of effective system care

► Oversight framework 2022/23 build on 2021/22 but takes account of:

  ► Statutory role of ICBs

  ► NHSE duty to undertake annual performance assessment of ICBs

  ► Learning from implementation of SOF during 2021/22

  ► Revised NHS priorities set out in 2022/23 planning documentation

Purpose and Principles

► Ensure alignment of priorities across NHS and with system partners

► Identify where ICBs or Providers may benefit from, or require, support

► Provide an objective basis for decisions about when and how NHSE will intervene

► Working with and through ICBs (wherever possible)

► Greater emphasis on system performance and quality of care outemes

► Matching accountability for results with improvement support

► Autonomy for ICBs and providers as default position

► Compassionate leadership behaviours

Approach to Oversight

▶ Focused on delivery of priorities from NHS planning guidance, LTP, People plan and local priorities

▶ NHS Oversight Framework built around 5 themes

    ▶ Quality of care, access and outcomes; preventing ill-health and reducing health inequalities; people; finance and use of resources; leadership and capability

    ▶ A set of high level metrics aligned to these themes

▶ A 6th theme – local strategic priorities recognises:

    ▶ Systems have unique challenges

    ▶ Each ICP will set out an integrated care strategy & ICB must have due regard in planning and allocating NHS resources

▶ A three-step oversight cycle that frames how NHSE teams and ICBs will work together to identify and deploy the right delivery support and intervention to drive improvement and address the most complex and challenging problems, respectively

Scope of NHS Oversight Framework 2022/23
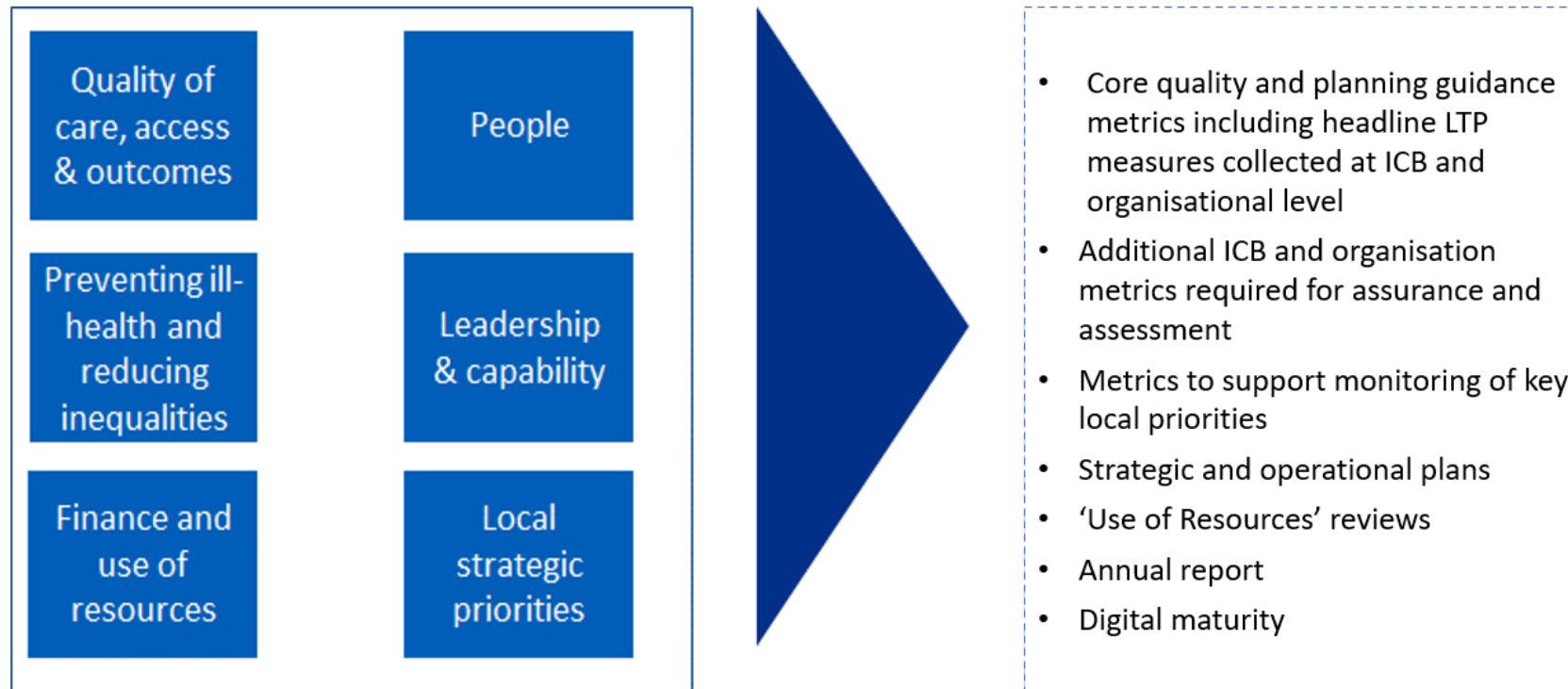
Approach to Oversight

► The oversight process follows an ongoing cycle of:

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

Oversight Cycle
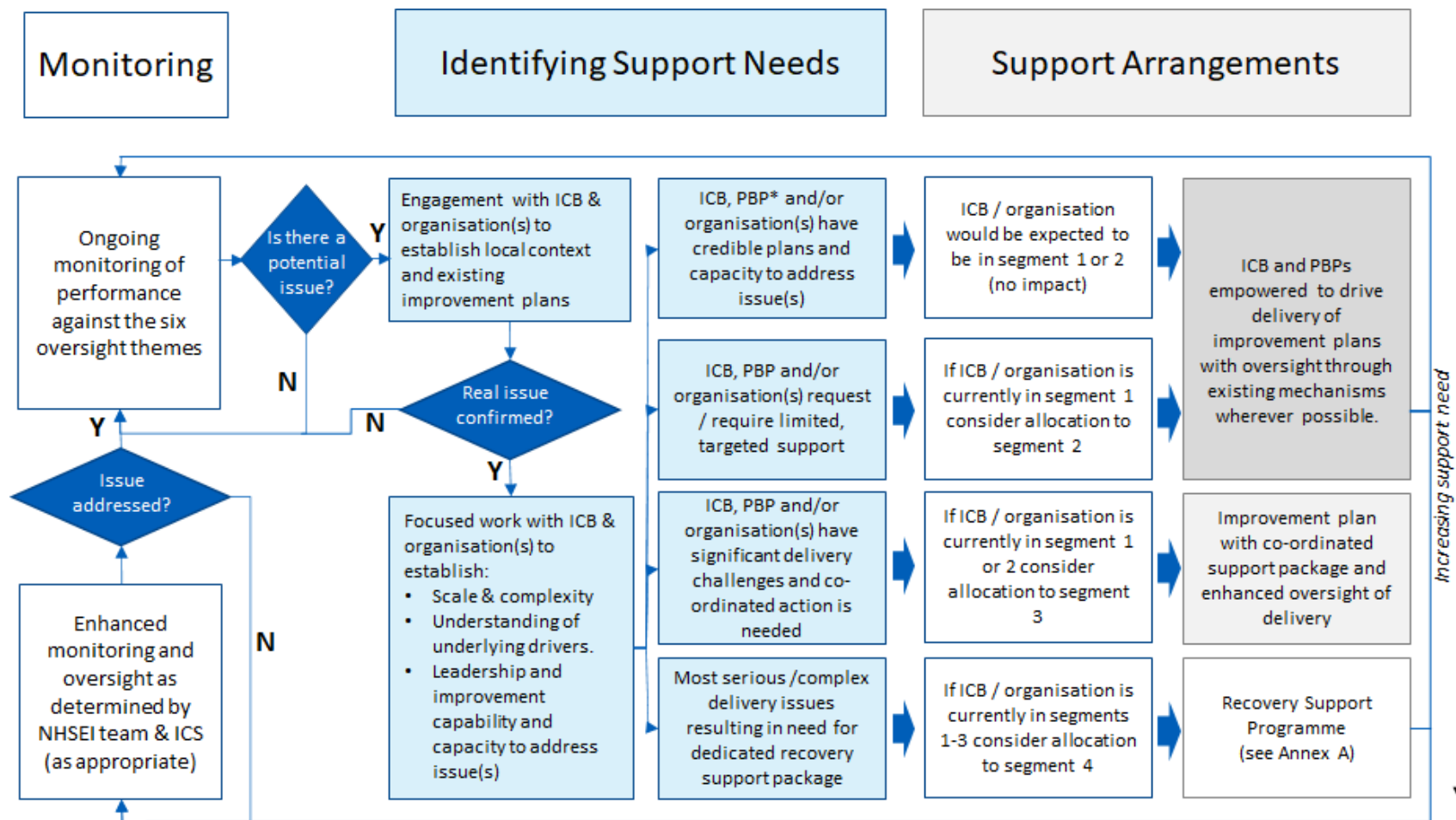
Monitoring Process – Review Meetings

- ► Roles and participation
  - ► Led by ICB with:
    - ► senior leaders from relevant providers/collaboratives
    - ► NHS England, where appropriate and by mutual agreement
- ► Frequency of review meetings
  - ► The default arrangements should be agreed between the ICB and partner organisation, and set out within the MoU
    - ► Currently bi-monthly for UHSussex
      - ► Weekly UEC and planned care meetings

Segmentation

- ► Segments 1-4

- ► To allow overview of level and nature of support required, inform oversight arrangements, target support as effectively as possible

- ► Segmentation decisions determined by assessing level of support required based on a combination of objective criteria

- ► For us, NHSE and ICB will discuss segmentation and support required

- ► Segmentation indicates scale and nature of support needs
  - ► Segment 1 – no specific needs
  - ► Segment 4 – mandated intensive support

Segmentation

► The principles and approach to oversight will apply across all segments. These criteria have two components

- ► objective, measurable eligibility criteria based on performance against the six oversight themes using appropriate oversight metrics
- ► additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

► Where the objective, measurable eligibility criteria are met this will trigger consideration of the additional factors that will determine the overall segmentation decision

► Autonomy will be the default position with the expectation that ICBs and trusts will be allocated to segment 2 unless specific mandated support is required

Segments

Segment description		Scale and nature of support needs
ICB	**Trust**	
1 Consistently high performing across the six oversight themes Capability and capacity required to deliver on the statutory and wider responsibilities of an ICB are well developed	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place based and overall ICB priorities	No specific support needs identified. Trusts encouraged to offer peer support Systems are empowered to direct improvement resources to support places and organisations, or invited to partner in the co-design of support packages for more challenged organisations
2 On a development journey, but demonstrate many of the characteristics of an effective ICB Plans that have the support of system partners are in place to address areas of challenge	Plans that have the support of system partners in place to address areas of challenge Targeted support may be required to address specific identified issues	Flexible support delivered through peer support, clinical networks, the NHS England universal support offer (e.g. GIRFT, Right Care, pathway redesign, NHS Retention Programme) or a bespoke support package via one of the regional improvement hubs
3 Significant support needs against one or more of the six oversight themes Significant gaps in the capability and capacity required to deliver on the statutory and wider responsibilities of an ICB	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts)	Bespoke mandated support, potentially through a regional improvement hub, drawing on system and national expertise as required (see Annex A)
4 Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	In actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Mandated intensive support delivered through the Recovery Support Programme (see Annex A)

Segments and Support

	Eligibility criteria	Additional considerations
1	• Performance against the oversight themes typically in the top quartile nationally based on the relevant oversight metrics and • Balanced plan, actual/forecast breakeven or better and • CQC 'Good' or 'Outstanding' overall and for well-led (trusts)	**For ICBs:** • Success in tackling variation across the system and reducing health inequalities • Whether the ICB consistently demonstrates that it has built the capability and capacity required to deliver on its statutory and wider responsibilities **For trusts:** • Evidence of established improvement capability and capacity • The degree to which the trust plays a strong, active leadership role in supporting and driving place-based priorities, provider collaboration and overall ICB priorities
2	This is the default segment that all ICBs and trusts will be allocated to unless the criteria for moving into another segment are met	
3	• Performance against multiple oversight themes in the bottom quartile nationally based on the relevant oversight metrics or • A dramatic drop in performance, or sustained very poor (bottom decile) performance against one or more areas or • Plan not balanced and/or a material actual/forecast deficit or • A CQC rating of 'Requires Improvement' overall and for well-led (trusts)	**For all:** • Existence of other material concerns about a system's and/or organisation's governance, leadership, performance and improvement capability arising from intelligence gathered by or provided to NHS England (e.g. delivery against the national and local transformation agenda) • A material concern with regard to the quality or safety of services being provided or a failure to escalate such risks • Evidence of capability and capacity to address the issues without additional support, e.g. where there is clarity on key issues with

Segments and Support

Eligibility criteria	Additional considerations
	an existing improvement plan and a recent track record of delivery against plan and/or of agreed recovery actions • There are other exceptional mitigating circumstances **For ICBs:** • Evidence of collaborative and inclusive system leadership across the ICB, e.g. where the system is not in financial balance, whether it has been able to collectively agree credible plans for meeting the system envelope • Clarity and coherence of system ways of working and governance arrangements **For trusts:** • Whether the trust is working effectively with system partners to address the problems

4   In addition to the segment 3 criteria:
 	
• Longstanding and/or complex issues that are preventing agreed levels of improvement for ICBs or trusts
   or
• A catastrophic safety failure
   or
• A catastrophic failure in leadership or governance that risks damaging the reputation of the NHS
   or
• A significant underlying deficit and/or significant actual or forecast gap to the financial plan
   or
• CQC recommendation (trust)	

Intervention and mandated support

► Trusts will be placed in segment 3 or 4 if support required

  ► Subject to enhanced oversight by NHSE (in partnership with ICB)

  ► May be subject to additional reporting requirements or financial controls

► 2 levels of support

  ► Mandated support that is led and co-ordinated by NHS England regional teams with input from the national intensive support team where requested. This level of support means automatic entry to segment 3

  ► Mandated intensive support that is agreed with NHS England regional teams and delivered through the nationally co-ordinated Recovery Support Programme. This level of support means automatic entry to segment 4.

► For ICBs and trusts in segments 1 and 2, overall support needs will be formally reviewed on a quarterly basis in partnership with the ICB. Where ongoing monitoring suggests that the support needs may have changed, this will trigger a review of the segment allocation

Oversight Metrics

Oversight Theme	NHS Long Term Plan / People Plan Area	Measure Name (Metric)	ICB level metric	Trust level metric
Quality of care, access and outcomes	Elective care	Total patients waiting more than 52, 78 and 104 weeks to start consultant-led treatment	✓	✓
	Elective care	Total elective activity undertaken compared with 2019/20 baseline	✓	✓
	Elective care	Total diagnostic activity undertaken compared with 2019/20 baseline	✓	✓
	Cancer	Total patients waiting over 62 days to begin cancer treatment compared with baseline	✓	✓
	Cancer	Proportion of patients meeting the faster cancer diagnosis standard	✓	✓
	Cancer	Total patients treated for cancer compared with the same point in 2019/20	✓	✓
	Outpatient transformation	Outpatient follow-up activity levels compared with 2019/20 baseline	✓	✓
	Urgent and emergency care	Proportion of ambulance arrivals delayed over 30 minutes	✓	✓
	Urgent and emergency care	Ambulance average response times by category		✓
	Urgent and emergency care	Proportion of patients spending more than 12 hours in an emergency department	✓	✓
	Maternity and children's health	Neonatal deaths per 1,000 total live births	✓	
	Maternity and children's health	Stillbirths per 1,000 total births	✓	
	Primary care and community services	Proportion of Urgent Community Response referrals reached within two hours	✓	
	Primary care and community services	Proportion of patients discharged from hospital to their usual place of residence	✓	✓

Oversight Metrics

Oversight Theme	NHS Long Term Plan / People Plan Area	Measure Name (Metric)	ICB level metric	Trust level metric
	Primary care and community services	Available virtual ward capacity per 100k head of population	✓	✓
	Primary care and community services	Number of general practice appointments per 10,000 weighted patients	✓	
	Primary care and community services	Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from a. general practice and b. NHS111 per 100,000 population	✓	
	Primary care and community services	Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	✓	
	Mental health services	Number of children and young people accessing mental health services as a % of population	✓	
	Mental health services	Proportion of people with severe mental illness receiving a full annual physical health check and follow-up interventions	✓	
	Mental health services	Access rate for IAPT services	✓	
	Mental health services	Access rates to community mental health services for adult and older adults with severe mental illness	✓	
	Mental health services	Inappropriate adult acute mental health placement out-of-area placement bed days		✓
	Learning disabilities and autism	Proportion of people aged 14 and over with a learning disability on the GP register receiving an annual health check	✓	
	Learning disabilities and autism	Inpatients with a learning disability and/or autism per million head of population	✓	
	Personalised care	Rate of personalised care interventions	✓	
	Safe, high quality care	Summary Hospital-level Mortality Indicator		✓
	Safe, high quality care	National Patient Safety Alerts not completed by deadline		✓

Oversight Metrics

Oversight Theme	NHS Long Term Plan / People Plan Area	Measure Name (Metric)	ICB level metric	Trust level metric
	Primary care and community services	Available virtual ward capacity per 100k head of population	✓	✓
	Primary care and community services	Number of general practice appointments per 10,000 weighted patients	✓	
	Primary care and community services	Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from a. general practice and b. NHS111 per 100,000 population	✓	
	Primary care and community services	Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	✓	
	Mental health services	Number of children and young people accessing mental health services as a % of population	✓	
	Mental health services	Proportion of people with severe mental illness receiving a full annual physical health check and follow-up interventions	✓	
	Mental health services	Access rate for IAPT services	✓	
	Mental health services	Access rates to community mental health services for adult and older adults with severe mental illness	✓	
	Mental health services	Inappropriate adult acute mental health placement out-of-area placement bed days		✓
	Learning disabilities and autism	Proportion of people aged 14 and over with a learning disability on the GP register receiving an annual health check	✓	
	Learning disabilities and autism	Inpatients with a learning disability and/or autism per million head of population	✓	
	Personalised care	Rate of personalised care interventions	✓	
	Safe, high quality care	Summary Hospital-level Mortality Indicator		✓
	Safe, high quality care	National Patient Safety Alerts not completed by deadline		✓

Oversight Metrics

Oversight Theme	NHS Long Term Plan / People Plan Area	Measure Name (Metric)	ICB level metric	Trust level metric
	Safe, high quality care	Potential under-reporting of patient safety incidents		✓
	Safe, high quality care	Overall CQC rating		✓
	Safe, high quality care	Percentage of patients describing their overall experience of making a GP appointment as good	✓	
	Safe, high quality care	Acting to improve safety - safety culture theme in the NHS staff survey		✓
	Safe, high quality care	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate		✓
	Safe, high quality care	Clostridium difficile infection rate		✓
	Safe, high quality care	E. coli bloodstream infection rate	✓	✓
	Safe, high quality care	Antimicrobial resistance: appropriate prescribing of antibiotics and broad-spectrum antibiotics in primary care	✓	
Preventing ill health and reducing inequalities	Reducing inequalities	Performance against relevant metrics for the target population cohort and five key clinical areas of health inequalities[1]	✓	✓
	Prevention and long term conditions	Number of people receiving mechanical thrombectomy as a % of all stoke patients	✓	
	Prevention and long term conditions	Proportion of people with CVD treated for cardiac high-risk conditions	✓	
	Prevention and long term conditions	Proportion of diabetes patients that have received all eight diabetes care processes	✓	
	Prevention and long term conditions	Number of people supported through the NHS diabetes prevention programme as a proportion of patients profiled	✓	

Oversight Metrics

Oversight Theme	NHS Long Term Plan / People Plan Area	Measure Name (Metric)	ICB level metric	Trust level metric
	Prevention and long term conditions	Number of referrals to NHS digital weight management services per 100k head of population	✓	
	Prevention and long term conditions	Proportion of acute or maternity inpatient settings offering smoking cessation services	✓	✓
	Prevention and long term conditions	Proportion of patients who have a first consultation in a post-covid service within six weeks of referral	✓	✓
	Screening, vaccination and immunisation	Bowel screening coverage - % patients aged 60 - 74 screened in the last 30 months	✓	
	Screening, vaccination and immunisation	Breast screening coverage - % females aged 53 - 70 screened in the last 36 months	✓	
	Screening, vaccination and immunisation	Cervical screening coverage - % females aged 25 - 64 attending screening within the target period	✓	
	Screening, vaccination and immunisation	Proportion of people over 65 receiving a seasonal flu vaccination	✓	✓
	Screening, vaccination and immunisation	Population vaccination coverage – MMR for two doses (5 year olds)	✓	
Leadership and capability	Leadership	Aggregate score for NHS staff survey questions that measure perception of leadership culture	✓	✓
	Leadership	CQC well-led rating		✓
Finance and Use of Resources	Finance	Financial efficiency - variance from efficiency plan	✓	✓
	Finance	Financial stability - variance from break-even	✓	✓
	Finance	Achievement of Mental Health Investment Standard	✓	
	Finance	Agency spending		✓
People	Looking after our people	Staff survey engagement theme score	✓	✓
	Looking after our people	Staff survey bullying and harassment score	✓	✓
	Looking after our people	Leaver rate	✓	✓

Oversight Metrics

Oversight Theme	NHS Long Term Plan / People Plan Area	Measure Name (Metric)	ICB level metric	Trust level metric
	Looking after our people	Sickness absence rate	✓	✓
	Belonging in the NHS	Proportion of staff in senior leadership roles who are from a) a BME background or b) are women	✓	✓
	Belonging in the NHS	Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	✓	✓
	Growing for the future	FTE doctors in General Practice per 10,000 weighted patients	✓	
	Growing for the future	Direct patient care staff in GP practices and PCNs per 10,000 weighted patients	✓	

Agenda Item:	22	Meeting:	Public Board		Meeting Date:	4 August 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	☐	
Systems and Partnerships	☐	

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

Communication and Consultation:

Executive Summary:

This report provides the Board with an update, including matters for which the Trust has complied with NHS I or other regulatory requirements. This report does not seek to duplicate matters that are subject to separate agenda items at today's meeting.

Annual General Meeting

The Annual General Meeting took place on the 27 July and below for information is the link to where the slides used in the meeting can be found can be found on the Trust's website. The event was videoed, and this will be loaded to the same web page in due course. The annual report, including the Trust's financial statements and the Trust's quality account for the Trust can also be found using the same link. https://www.uhsussex.nhs.uk/about/trust-board/

Governor Elections

Our elections concluded in June 2022 and these returned the following members as Governors, Maria Rees for Arun, John Todd for Adur and Pauline Constable for Worthing (noting that John and Pauline were Governors previously thus making this there second terms).

Lead Governor

Following the retirement of Lyn Camps as Governor for Arun the Governors undertook a selection process for a new Lead Governor. The outcome of this process has seen Frank Simms, public governor for Brighton and Hove, appointed as Lead Governor.

Non-Executive Director Appointments

Following the successful round of interviews, the Council of Governors Nomination and Remuneration Committee approved the appointment of, David Curley, Bindesh Shah and Paul Layzell as Non-Executive Directors and Sadie Mason as an Associate Non-Executive Director.

Key Recommendation(s):

The Board is recommended to

NOTE the outcome of the recent Governor elections that saw Maria Rees elected for Arun, John Todd elected for Adur and Pauline Constable elected for Worthing (noting that John and Pauline were Governors previously thus making this there second terms).

NOTE that Frank Simms has been appointed as Lead Governor

NOTE that the appointments approved by the Council of Governors Nomination and Remuneration Committee of, David Curley, Bindesh Shah and Paul Layzell as Non-Executive Directors and Sadie Mason as an Associate Non-Executive Director.