University Hospitals Sussex
NHS Foundation Trust

Meeting of the Board of Directors

10.00 to 13:30 on Thursday 05 August 2021

Virtual MS Teams

AGENDA – MEETING IN PUBLIC

1.	10.00	**Welcome and Apologies for Absence** To note	Verbal	Alan McCarthy
		Confirmation of Quoracy To note *A meeting of the Board shall be quorate and shall not commence until it is quorate. Quoracy is defined as meaning that at least half of the Board must be present, including two Non-executive Directors and two 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 06 May 2021** 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 **INTEGRATED PERFORMANCE REPORT including REFRESH, RESTORE, RECOVERY UPDATE**	Presentation	Dame Marianne Griffiths
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	Carolyn Morrice
7.	10.45	**Quality** **Including an update on Patient Safety Specialists** 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	Enclosure	David Grantham

		At this point the Chair of the People Committee will be invited to provide their report included at item 13 To receive assurance from Committee and recommendations from the Committee		
9.	11.20	**Sustainability** To receive and agree any necessary actions *After this section the Chair of the Sustainability Committee will be invited to provide their report included at item 14* To receive assurance from Committee and recommendations from the Committee	Enclosure	Karen Geoghegan
10.	11.40	**Systems and Partnerships** To receive and agree any necessary actions *After this section the Chair of the Systems and Partnerships Committee will be invited to provide their report included at item 15* To receive assurance from Committee and recommendations from the Committee	Enclosure	Pete Landstrom
		ASSURANCE REPORTS FROM COMMITTEES		
11.	12.00	**Report from Patient Committee** - **from the meeting held on the 29 June 2021** To receive assurance from Committee and recommendations from the Committee	Enclosure	Jackie Cassell
12.	12.00	**Report from Quality Committee** - **from the meeting held on the 29 June 2021 including** - ***Annual Patient Experience Report 2020/21*** Former BSUH and WSHFT To receive assurance from Committee and recommendations from the Committee	Enclosure Enclosure	Joanna Crane
13.	12.05	**Report from People Committee** - **from the meeting held on the 30 June 2021 including:** - ***Annual Workforce Race Equality Survey*** Former BSUH and WSHFT - ***Annual Disability Equality Survey*** Former BSUH and WSHFT To receive assurance from Committee and recommendations from the Committee	Enclosure Enclosure Enclosure	Patrick Boyle
14.	12.20	**Report from Sustainability Committee** - **from the meeting held on the 01 July 2021** To receive assurance from Committee and recommendations from the Committee	Enclosure	Lizzie Peers

15.	12.20	**Report from Systems and Partnerships Committee** - **from the meeting held on the 01 July 2021 including** To receive assurance from Committee and recommendations from the Committee	Enclosure	Patrick Boyle
16.	12.25	**Report from Audit Committee** - **from the meeting held on the 20 July 2021 including** - ***Annual Audit Committee Reports*** Former BSUH and WSHFT - ***NHSI Self-Certification Declarations*** Former BSUH and WSHFT To receive assurance from Committee and recommendations from the Committee	Enclosure Enclosure Enclosure	Jon Furmston
17.	12.40	**Report from Charitable Funds Committee** - **from the meeting held on the 13 July 2021** To receive assurance from Committee and recommendations from the Committee	Enclosure	Kirstin Baker
18.	12.50	**Board Assurance Framework** To approve	Enclosure	Glen Palethorpe
		WELL LED & COMPLIANCE		
19.	13.00	**Company Secretary Report** To note	Enclosure	Glen Palethorpe
		OTHER		
21.	13.05	**Any Other Business** To receive and action	Verbal	Alan McCarthy
22.	13.10	**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
23.	13.30	**Date and time of next meeting:** The next meeting in public of the Board of Directors is scheduled to take place at 10.00 on Thursday 04 November 2021. **To resolve to move to into private session** *The Board now needs to move to a private session due to the confidential nature of the business to be transacted*	Verbal	Alan McCarthy

Minutes

University Hospitals Sussex
NHS Foundation Trust

Minutes of the Board of Directors meeting held in Public at 10.00am on Thursday 06 May 2021, held virtually via Microsoft Teams Live Broadcast.

Present:

Alan McCarthy MBE DL	Chair
Dame Marianne Griffiths	Chief Executive
Joanna Crane	Non-Executive Director
Jon Furmston	Non-Executive Director
Kirstin Baker	Non-Executive Director
Lizzie Peers	Non-Executive Director
Patrick Boyle	Non-Executive Director
Jackie Cassell	Non-Executive Director
Karen Geoghegan	Chief Financial Officer
Pete Landstrom	Chief Delivery and Strategy Officer
Maggie Davies	Chief Nurse
Carolyn Morrice	Chief Nurse
Denise Farmer*	Chief Organisational Development Officer

*Non-voting member of the Board

In Attendance:

Rob Haigh	Medical Director
Gethin Hughes	Interim Chief Operating Officer – West
Ben Stevens	Interim Chief Operating Officer – East
Amanda Clifton	Head of Maternity Royal Sussex County and Princess Royal Hospitals
Gail Addison	Head of Maternity St Richard's and Worthing Hospitals
Glen Palethorpe	Company Secretary
Tanya Humphrys	Board and Committee Administrator

TB/05/21/1 WELCOME AND APOLOGIES FOR ABSENCE **ACTION**

1.1 The Chairman welcomed all those present to the meeting.

1.2 There were apologies of absence were received from Mike Rymer and Lillian Philip.

1.3 Alan McCarthy informed the Board that George Findlay had left the Trust to become the CEO of Medway NHS Foundation Trust. Alan took the opportunity to thank George for all he has done for the Trust and to wish him all the best for the future.

1.4 Alan also highlighted that it was the last Board meeting for Non-Executive Director Mike Rymer, Alan thanked Mike for his many years of service to the Trust, firstly as a consultant, then a Staff Governor and laterally as a NED. On behalf of the Board Alan wished Mike all the very best for the future.

TB/05/21/2 DECLARATIONS OF INTERESTS

2.1 There were no interests declared.

TB/05/21/3 MINUTES OF THE MEETING HELD ON 01 APRIL 2021

3.1 The Board received the minutes of the meeting held on 01 April 2021.

3.2 Joanna Crane commented that the majority of the content of the first University Hospitals Sussex NHS Foundation Trust Board meeting was pertaining to WSHFT therefore this should be explicitly stated within the minutes.

3.3 Subject to the amendment above it was agreed that the minutes of the meeting held on 01 April 2021 would be **APPROVED** as a correct record of the meeting.

TB/05/21/3.1 MINUTES FROM THE BSUH PUBLIC BOARD MEETING HELD ON 30 MARCH 2021

3.1.1 The minutes of the meeting held on 30 March 2021 were **APPROVED** as a correct record.

TB/05/21/4 MATTERS ARISING FROM THE MINUTES OF THE PREVIOUS MEETING

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

TB/05/21/5 Chief Executive Report

5.1 Dame Marianne Griffiths introducted the Chief Executive's report.

5.2 Marianne began by thanking the staff of both legacy Trusts, BSUH and WSHFT, commenting that they had been nothing short of incredible over the past 12 months and that the merger had been a very binding process thanking everyone involved and explaining that it was a really exciting time for the whole of the organisation.

5.3 The Board was advised that to celebrate the new UHSussex Trust on 01 April the Executive Team had visited staff across the Trust in wards and departments delivering cake, Marianne added that after a difficult year it was a fabulous opportunity to meet face to face with so many colleagues. The Board was advised that the Trust would continue celebrating and planned plant some commemorative trees to symbolise growth and the new organisation.

5.4 Marianne highlighted that the Trust was continuing to seek new members for the new Trust, having already recruited over a 1000 new members in addition the Trust is looking to elect new Public and Staff governors the Board was advised that all nominations had now been submitted and voting would begin later in the month with results declared 15 June 2021.

5.5 Marianne highlighted the new UHSussex media channels welcoming the Board and members of the Public to follow the Trust on Twitter, Facebook and Instagram.

5.6 Marianne took the opportunity to thank Dr George Findlay following his departure from the Trust to become CEO at Medway, noting that the Board recognised the recruitment process for a new Chief Medical Officer is required. Marianne explained that Professor William Roche would be joining the Trust to provide interim cover 2- 3 days a week with the support of the Medical Directors Dr Tim Taylor and Dr Rob Haigh. The Board was advised that UHSussex had also appointed the first of two Managing Directors, Kate Slemeck, from the Royal Free group in London would be joining UHSussex on 01 September 2021.

5.7 In other news the Board was advised that Covid numbers remain low with the Trust caring for 4 patients with Covid [at the time of the meeting], Community transmission remains low which Marianne highlighted was particularly positive as the Country has seen some non-essential retail open up.

5.8 Congratulations to the Trust vaccination hubs, which have administered more than 100,000 doses of the Covid vaccines with over 95% of staff vaccinated the Board was advised that the second dose programme was almost complete. The Trust focus now moves to restoration of services with UHSussex having an ambitious but achievable target to restore services to pre-Covid levels.

5.9 Finally, Marianne drew the Board's attention to a number of diary highlights and noted that the next steps for the Trust in relation to the Corporate Clinical Operating model for the Trust and the five new strategic initiatives including our environmental strategy as the Trust work towards Care Without Carbon to become a net zero carbon emitter.

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

TB/05/21/6 Integrated Performance Report

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

6.2 Alan McCarthy explained that the Trust had aligned its governance to the patient first domains and through the revision of its Committee structure had completely aligned the UHSussex Board Committee structure to the True North Strategic Themes. Alan explained that the Integrated Performance Report now mirrors this new structure with reporting aligned to the new Committees and the Committee Chairs would be invited to provide their Chairs report after each section of the IPR.

6.3 Finally, Alan explained that the much of the data within this performance report was based on Month 12 for both legacy Trusts, BSUH and WSHFT.

TB/05/21/7 Patient

7.1 Carolyn Morrice 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 UHSussex continued to have the target of 95% recommend rate from patients and despite FFT being put on hold during the pandemic the legacy Trusts had continued to collect data.

7.3 Carolyn explained that both legacy organisations had experience increased pressure across all A&E departments which had impacted slightly on the recommend rate in those areas. It was noted that going forward all figures would be looked at in detail by the Patient Committee, Carolyn explained that patient experience leaders across the organisation had already been working closely together to ensure aligned reporting.

7.4 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.

7.5 Jackie commented that it had been a fantastic first meeting after a period of working out what the new Committee might look like and added that it was really heartening to hear really positive stories from both former Trusts and how patients' stories have been used.

7.6 The Board was advised that there would be a real focus on health equality and equality more generally. Jackie explained that there were many inequalities for patients in relation to after hospital care and the Committee would be taking a closer look at ways to improve those experiences for patients.

7.7 Jackie noted that it was a real opportunity to ensure the Trust is providing the very best experience for our patients and to continue to improve on what is already in place, noting that as the Committee becomes more embedded there would be greater feedback to share with the Board.

7.8 Alan McCarthy thanked Carolyn and Jackie for their updates. Alan took the opportunity to clarify that the Committee was the forum to bring the patient voice into the Board Committee structure but that it was a Committee consisting of Executives and Non-Executives, no patients would be in attendance.

TB/05/21/8 Quality

8.1 Rob Haigh updated the Board on the key messages from the Quality section of the report with a particular focus on mortality,

8.2 The Board was reminded HSMR is measured in two ways and that the data being presented was the data available up to January 2021 for legacy Trusts BSUH and WSHFT:

- HSMR in BSUH for the previous 12 months was 95.1, with 1034 observed deaths against an expected 1087 deaths.
- HSMR in WSHFT for the previous 12 months was 91.7, with 1526 observed deaths against an expected 1663 deaths.
- Combining BSUH and WSHFT mortality data would result in a HSMR of 93.1.

8.3 Rob explained that BSUH was currently ranked 31st out of 131 Trusts nationally and WSHFT was ranked 25th nationally. It was noted that using this data the Trust has calculated that this would place UHSussex in the top 20% nationally for HSMR.

8.4 It was noted that between March 2020 and March 2021 BSUH recorded 458 deaths for patients who had tested positive for Covid-19. In WSHFT the number of deaths was 465. Rob explained that during the first wave deaths peaked in April with 73 deaths in BSUH and 71 in WSHFT. In the second wave January 2021 saw the highest number of deaths 148 in BSUH and 216 in WSHFT

8.5 Maggie Davies continued the Covid theme by advising the Board that during March UHSussex saw a significant decrease in the reported number of positive Covid cases. At WSHFT there were 55 new cases confirmed in March 2021 of these 9 were hospital acquired, there was one outbreak in March on Ford ward. At BSUH there were 52 new cases confirmed in March 2021 of these 17 were hospital acquired, there were 2 outbreaks in March at Princess Royal Hospital both on Twineham ward the Board was advised that a full root cause analysis was underway.

8.6 Maggie drew the Board's attention to the Avoidable Harm metrics for both legacy Trusts highlighting that the positive work had continued in this area with no grade 3 pressure injuries reported in month and some fantastic collaboration already underway.

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

8.8 Joanna explained that the Committee had felt a little in two halves with the focus of the first half looking forward with the project charters for the new Trust and the second half of the Committee focussed on closing out the history of WSHFT and BSUH. Joanna noted that the critical objective for the Committee was the Trust safe and were risks being managed.

8.9 The Board was advised that the Trust was very well set up for the new organisation and the reports received were very assuring, including data in relation to Serious Incidents, maternity dashboards and Ockenden.

8.10 Lizzie Peers commented that there was a high number of patients presenting with Pressure Ulcers obtained within the community and asked if this was impacting on length of stay and if there was any heightened infection risk. Maggie explained that at WSHFT there had been a lot of work with community providers, it was noted that WSHFT had found that around 70% of patients weren't known in the Community or primary care. Maggie added that there had been an increased number as an unintended consequence of Covid with patients not wanting to visit hospital.

TB/05/21/9 People

9.1 Denise Farmer presented the People section of the Integrated Performance Report and explained to Board that previously the areas covered by this Committee had fed into other Committees however the new structure allowed for People to have its own Committee.

9.2 The Board was advised that the key areas of focus for the Committee were:
- True North - Performance against Staff Engagement Target
- Breakthrough Objective – Becoming the best place to work
- People Strategic Initiative – Leadership, Culture, Development

9.3 In relation to staff engagement Denise explained that there had been a number of opportunities for staff to provide feedback both prior to the merger, leading up to the merger itself with One Trust Workshops and then immediately after the merger with One Trust Survey's. It was noted that the key themes that came out of these engagement events were:
- Staff Health and Wellbeing
- Working Together; and
- Career Development.

9.4 Denise summarised for the Board some of the feedback under the key themes. These included flexible working opportunities, mental wellbeing and resilience, collaborative working and shared best practice, career progression, management and leadership development and many more detailed within the presentation.

9.5 The Board was provided with a People Strategy progress update. It was noted that the Trust was in the process of recruiting new Non-Executive Directors, that the internal recruitment for the Corporate Directors was largely completed and the new Chief People Officer had been appointed.

9.6 Denise drew the Board's attention to the key performance indicators for both legacy Trusts and explained that there would be work ongoing with the

Committee to ensure that the most appropriate targets are reported against for UHSussex.

9.7 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.

9.8 Patrick advised the Board that the Committee had an excellent first meeting and had discussed the really extensive plans outlined by Denise that are already in place to achieve the True North and Breakthrough objectives. Patrick highlighted that as the new merged Trust UHSussex now has around 20k staff making it a very substantial organisation and a substantial employer.

9.9 The Board was advised that the Committee had received report on the Staff Survey with a focus on the analysis of the results and their link to the Trust's people Breakthrough Objective.

9.10 Patrick explained that the Committee had received reports in relation to the revised national contract for speciality doctors and a report for process around employee relations, along with a good discussion regarding possible areas for deep dives.

9.11 Alan McCarthy commented that with the NHSE operational plan having an emphasis on supporting staff the timing is right for the introduction of the new People Committee as our staff are our most important asset.

TB/05/21/10 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 legacy Trusts BSUH and WSHFT have operated within the interim financial framework for Q3 & Q4 2020/21, in which each Integrated Care System (ICS) was provided with a fixed funding allocation; including resources to meet the additional costs of Covid-19 response and recovery. The collective intent was for individual organisations within the Sussex ICS to deliver a breakeven position. Both legacy Trusts delivered financial year end positions which met the target of breakeven.

10.3 Karen explained that at the end of March 2021 the BSUH Trust delivered a cumulative surplus of £4k against a planned deficit of (£5.64m), resulting in a favourable variance of £9.64m. The WSHFT delivered a cumulative surplus of £5k against a planned deficit of (£2.98m), resulting in a favourable variance of £7.98m.

10.4 In relation to legacy Trust BSUH the Board was advised that the Trust had been able to secure just over £26m of additional funding to cover costs of the Trusts Covid response, cash was significantly above plan, however, it was noted this is a timing issue in relation to the receipt of block payments for lost non-recurrent income. The delivery of the capital programme had been very positive with the Trust having spent just under £28m having had secured additional national funds to support the Trust's Emergency Departments.

10.5 In relation to legacy Trust WSHFT the Board was advised that the Trust had been able to secure just over £21m to cover costs of the Covid response including specific items for the vaccination hubs, as with legacy Trust BUSH, WHSFT cash was significantly above plan due to a timing issue in relation to

the block payments received for lost non-recurrent income. WSHFT also had a really successful year in terms of the delivery of its capital programme.

10.6 The Board was updated in relation to the Financial Framework H1 2021/2022. Karen explained that the NHS Operational Planning Guidance had been received and advises that Integrated Care Systems (ICSs) and their constituent organisations should develop and agree operational plans to summarise how, as systems, the priorities set out for the 2021/22 year will be delivered, with a focus on the six months to the end of September 2021. The guidance confirms that income allocations for Q1 & Q2 (H1), have been based on Q3 2020/21 actual expenditure, including allocations for marginal Covid expenditure, growth, CNST, junior doctor pay agreement and some provision for inflation. It was noted that the overall financial settlement does provide additional funding of £1.5bn which has been allocated for elective recovery which can be earnt when delivering activity above pre-Covid activity levels.

10.7 Karen explained that the Trust Financial Plan fully triangulated with system plans that match Trust activity, workforce and affordability. It was noted that all financial plans within the system were being based on a breakeven plan and the Sussex system have been working together to deliver a balanced plan and that every organisation within the ICS will deliver a break even position.

10.8 The Chairman 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.

10.9 Lizzie advised the Board that it had been a really positive first Sustainability meeting with a great deal of excitement in relation to the breadth and scope of the agenda. It was noted that it had been a mix of Month 12 data and new objectives. Lizzie highlighted that it was absolutely phenomenal the both legacy Trusts had achieved breakeven given the challenging year.

10.10 The Committee reflected on the Capital programme and how the Trusts had managed to spend and to mitigate the risks of not achieving it. the Committee received the Capital Plan for 2021/2022.

10.11 An update on the Efficiency Programme for both Legacy Trusts was received highlighting that both Trusts had achieved their target and maintained a focus despite not being required to with continued high levels of engagement from staff.

TB/05/21/11 Systems & Partnerships

11.1 Pete Landstrom explained that one of the day one deliverable requirements of the merger was that the Trust was required to report as one organisation from midnight on 01 April 2021, so the Trust is already recording data as one Trust. Pete provided the Board with a summary of the Trust's operational performance for March 2021 and drew out the following salient points.

11.2 **A&E**
Overall the combined Trust treated 87.8% of patients within 4 hours of attending A&E departments. WSHFT achieved 92.0% and BSUH achieved 84.9%. It was noted that there have been continued increases in the numbers of patients attending A&Es with both ambulance and self-attending patient numbers back to pre-pandemic levels.

11.3 **RTT**
Overall the combined Trust has 56.9% of patients waiting longer than the target 18 weeks at the end of March. WSHFT achieved 56.6% and BSUH achieved

57.2%. Overall the total number of patients waiting for elective treatment are 92,590 with elective activity levels increasing in both Trusts as the pandemic numbers reduce.

11.4 **Cancer**
Overall 58.1% of patients who commenced cancer treatment were treated within 62 days as a combined Trust. WSHFT achieved 58.3% and BSUH achieved 57.7%. Both Trusts have seen continued reductions in the overall numbers of patients waiting longer than 62 and 104 days for treatment, and have recovery plans implemented to ensure a return to compliance with the standards as part of the restoration of services.

11.5 **Diagnostics**
Overall the combined Trust had 33.4% of patients waiting more than 6 weeks for a diagnostic against a 1% target. WSHFT achieved 39.8% and BSUH achieved 26.4%. This is an improvement in both Trusts compared to previous months and in part reflects the commencement of restoration plans, particularly in Endoscopy.

11.6 Pete advised the Board that the Trust had received national planning guidance on 23 March 2021 which requires Trusts to plan to deliver a minimum level of activity for the first 6 months of 2021/22. It was noted that both WSHFT and BSUH have developed and mobilised plans that significantly exceed that National expectation, which is essential given the size and backlogs of patients waiting for elective treatment. These plans include increases in core capacity, through productivity measures and restoration of pre-Covid services, combined with additional insourcing and outsourcing capacity. Pete explained that the Trusts are also coordinating the flow of patients to Independent Sector providers, to maximise capacity for the longest waiters, and working with other Trusts to coordinate care where appropriate.

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 establishment of the new S&P Committee was welcomed and is very timely as the Trust handles the impact of the pandemic in a situation where the NHS is changing. It was noted that the Committee received a good presentation on the role and responsibility of the Committee and oversight on the 3 key areas, True North and Constitutional targets, the way in which the agendas will be constructed and the work plan that will provide the Committee with assurances going forward, alongside engagement within the ICS.

11.9 It was noted that the Committee had been assured through the attendance of members from other Board Committees to support the governance flow.

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

TB/05/21/12 Report from Patient Committee Chair from the meeting on 27 April 2021

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

TB/05/21/13 Report from Quality Committee Chair from the meeting on 27 April 2021

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/05/21/14 Report from People Committee Chair from the meeting on 28 April 2021

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

TB/05/21/15 Report from Sustainability Committee Chair from the meeting on 29 April 2021

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/05/21/16 Report from Systems & Partnerships Committee Chair from the meeting on 29 April 2021

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

TB/05/21/17 Report from Audit Committee Chair from the meeting on 23 April 2021

17.1 Jon Furmston, Chair of the Audit Committee, presented the report from the last Audit Committee meeting drawing out the key points and commenting that it had been the first Audit Committee following the merger of BSUH and WSHFT which had two key reflections. The first being that the former Trust's had a good degree of synergy already in place allowing there to be one Internal Audit Plan and a collaborative Counter Fraud Plan drawing on the best of the Trust's in-house local counter fraud specialist and the contracted agent RSM.

17.2 The other reflection highlighted by Jon was that the membership of the Committee continued to include the NED chairs from the Board Committees that now sees there being five members of the Audit Committee. Having the developed the thematic Committees having these all as members of the Committee is really positive and will provide the structures and foundations to ensure really strong assurance feeds through all aspect of the new Board Committee structure, which in turn would assure the Board.

17.3 It was noted that the Committee had received a number of internal audit reports all of which provided positive assurance with the exception of one element in the area of IT relating to the former BSUH, however the Committee had been assured that there were mitigations in place and had itself received a report on this element. A referral was made to the Quality Committee following the Adult Safeguarding audit for BSUH which would be followed up and actioned.

17.4 Jon highlighted that the Committee had received the Heads of Internal Audit Opinion which had both provided positive assurance. It was noted that the update from the External Auditors had highlighted the areas of learning from last year with remote stock takes already completed. A very positive return of Annual Declarations of Interest for both Trusts were also noted in addition to an update on the Payroll Project Plan.

17.5 The Board **NOTED** the Report from the Audit Committee Chair.

TB/05/21/18 Report from Charitable Funds Committee Chair from the meeting on 20 April 2021

18.1 Kirstin Baker, Chair of the Charitable Funds Committee, presented the report from the Charitable Funds Committee and drew out the following key points.

18.2 The Board was advised that it was the first combined meeting overseeing the business of both legacy Trust charities, BSUH Charity and Love Your Hospital (LYH) for WSHFT, Kirstin explained that the Charities would continue to be run separately however there was plenty of shared learning.

18.3 Kirstin advised the Board that the Committee had heard about all the operational work of both Charities over the last quarter and all the incredible Community support throughout the pandemic in addition to the receipt of central funding following a national campaign.

18.4 The Board was advised that the Committee ratified the approval of a number of bids that had been approved virtually and received the operational plans for both BSUH Charity and LYH for the coming year.

18.5 The Board **NOTED** the Report from the Charitable Funds Committee.

TB/05/21/19 Board Assurance Framework

19.1 Glen Palethorpe drew the Board's attention to the summary of the key strategic risks within the Board Assurance Framework (BAF) and noted that the information received through the integrated performance report and assurance reports from Committee Chair's link to the details in the BAF.

19.2 The Board was advised that the BAF covered the 13 key risks facing the organisation with each risk having Committee oversight from the appropriate Patient First Committee. Glen highlighted that the scores being presented had been endorsed by the Committees.

19.3 The Board **APPROVED** the Board Assurance Framework recognising that the Committee had recommended the risk scores as being a fair reflection of the risks facing the Trust.

TB/05/21/20 CNST Submission UHSFT (BSUH & WSHFT)

20.1 Carolyn Morrice presented the CNST Maternity Incentive Scheme submission for UHSussex comprising of the evidence collated by legacy Trusts BSUH and WSHFT.

20.2 The Board was advised that for the third year, NHS Resolution was running the Maternity Incentive Scheme. Carolyn explained that Trusts that can demonstrate they have achieved all ten maternity safety actions will recover an element of their contribution to the Clinical Negligence Scheme for Trusts (CNST) and will receive a share of any additional unallocated funds. The legacy BSUH contribution for 2020/21 is £858,411, for legacy WSHFT it is £752,957.

20.3 It was noted that UHSussex was compliant against all 10 actions and had met the 10 safety actions required to be eligible for the unallocated funds that the Trust would hope to recover. Carolyn highlighted that prior to presenting the action plan to the Board it had been through a number of iterations and governance processes to ensure compliance.

20.4 Maggie Davies paid tribute to the heads of midwifery for both legacy Trusts for their hard work and dedication in collating the information for submission. Maggie asked the Board to note that there are two additional areas, actions 4 and 8, of compliance for legacy Trust WSHFT where the Trust is required to agree compliance and that there is an action plan in place, Maggie explained that BSUH does not require an action plan.

20.5 The Board **APPROVED** the CNST Submission for both the legacy Trusts of BSUH and WSHFT.

TB/05/21/21 Maternity Update including Ockenden

21.1 Maggie Davies introduced the Maternity update including Ockenden Assurance and explained that the presentation would provide a high level overview of how maternity services are developing for the new merged Trust. Maggie welcomed Amanda Clifton to talk through the presentation.

21.2 Amanda explained to the Board that the presentation highlighted the collaborative working that was already underway for UHSussex maternity services and the legacy services running through 2020/2021 for both BSUH and WSHFT.

21.3 The Board was advised that it was business as usual for maternity services throughout the pandemic and that the teams were incredibly proud of the infographics being presented to the Board which highlighted the following:

- Total babies born – BSUH: 4819, WHSFT: 4470
- Sets of twins – BSUH: 61, WSHFT: 46 and
- two sets of triplets at BSUH.

21.4 Amanda explained that both legacy Trusts had ceased home births during the height of the pandemic however for the short period of time that home births continued BSUH had 264.

21.5 The Committee's attention was drawn to slide 6 of the presentation which highlighted the demographic of the differing populations within the UHSussex footprint and examples of the collaborative working between the legacy Trusts prior to the merger.

21.6 Amanda highlighted images from the 2020 International Day of the midwife at both Trusts and explained that the previous day [05 May] had been the 2021 International Day of the Midwife which had been celebrated socially distanced with cake and was an opportunity to say thank you not only to UHSussex midwives but every profession providing support to patients.

21.7 Maggie explained to the Board that there have been a significant amount of national maternity documents and requirements to support the continued development of maternity services to support patients. It was noted that the Board had already received an update in relation to the Trust CNST submission.

21.8 In relation to Better Births guidance both legacy Trusts and UHSussex going forward have made good progress around the key objectives and meets the current compliance of 35% for merged continuity of care, in relation to personalised care plans all women have access to a digital version of their care plan with some hand held copies also available.

21.9 Maggie explained that a second version of guidance in relation to Saving Babies lives had been introduced of which there are 5 elements, the Board was advised that UHSussex meets the benchmark for growth restriction guidance it was noted that there was County wide action underway for Smoking Cessation.

21.10 Maggie drew the Boards attention to slide 17 of the presentation which highlighted the seven immediate actions required following the publication of the Ockenden Report in December 2020, it was noted that following the

2019/2020 national independent review of maternity services all NHS Trusts are required to complete a comprehensive piece of work tracking each Trust's performance. For our Trust the detail in the report presented provides the snapshot of combined performance across RSCH, PRH, St Richards and Worthing.

21.11 Finally, Maggie highlighted the opportunities for the future for UHSussex maternity services some of which included, investment for workforce and MDT training, review of specialist roles, improved service for people living on the boundaries of the UHSussex area along with a number of other actions.

21.12 Joanna Crane took the opportunity to applaud all the work that has gone into it the Ockenden submission and explained that the Quality Committee had received significant assurance regarding the Trusts compliance.

21.13 Alan McCarthy thanked Amanda and Maggie for the presentation commenting that it was an excellent showcase of maternity services at both legacy Trusts.

21.14 The Board **NOTED** the Maternity Services presentation and the legacy BSUH and WSHFT compliance against the Ockenden Report actions.

TB/05/21/22 Clinical Strategy

22.1 Dame Marianne Griffiths introduced the UHSussex Clinical Strategy Phase 1 and explained that the presentation provided a reflection of where the Trust had got to with planning and now the progression of those Plans and invited Rob Haigh to present the update to the Board.

22.2 Rob explained that a Clinical Strategy was being developed for the new Trust. The strategy would be central to the achievement of the True North objectives by ensuring the organisation developed and improved its services in a way that satisfied the requirements of all the True North domains and enabled the Trust to deliver the benefits of merger.

22.3 Rob advised that the development and delivery of the Clinical Strategy was one of the strategic initiatives and, as such, was part of the overall strategic deployment approach the Trust was taking to achieve True North. It would contribute to and be enabled by the other strategic initiatives, corporate projects and breakthrough objectives. The wellbeing of staff, clinical leadership and the systems and processes that support the delivery of safe and high quality services were integral to enabling the success of the strategy.

22.4 The strategy was being developed in phases with the paper setting out the outcome of phase 1 which provided a framework for the strategy and the initial priorities. The systematic approach harnessed data, staff and patient input to inform decisions so that informed choices were made about the priorities for improving clinical services.

22.5 All the clinical specialities would use the Patient First continuous improvement methodology to make improvements, some have the opportunity to take additional actions through other aspects of the Trusts strategic deployment such as corporate projects and strategic initiatives or through delivering specialty strategies developed across the Sussex system, and a smaller number would benefit from a more transformative approach either within the Trust or at a system level.

22.6 Taking account of the Trust's transformation capacity, four specialties had been prioritised for year one development. These included Ophthalmology, Trauma

and Orthopaedics, Care of the Elderly / DOME and Digestive Diseases/Gastroenterology.

22.7 Rob went on to advise that the paper also set out the approach to the further phases of development for the Clinical Strategy which were inclusive of all specialties. In phases 2 and 3, the options for delivering further improvements and transformation of the clinical services would be developed and assessed. These would be based on really listening to the voice of patients, working with people and partners, reviewing best practice and assessing opportunities to innovate and improve the way resources were used. Initial recommendations would start to be implemented as part of phase 4.

22.8 Marianne thanked Rob for the presentation and commented that the Executive Team was completely aligned to the areas of greatest challenge and explained that each speciality needed mission statements and a clear vision about the destination of any service transformation which would encourage clinical engagement and ownership from the outset of the process.

22.9 Joanna Crane concurred with Marianne's comments adding that such an approach would make service transformation far more manageable.

22.10 The Board **APPROVED** the approach to the development of the Clinical Strategy and the Phase 1 priorities highlighted in the presentation.

TB/05/21/23 OTHER BUSINESS

23.1 There was no other business to discuss.

TB/05/21/24 Questions from Members of the Public

24.1 In response to a question from a member of the Public in relation to whether it was the Trust's intention to have a two-linac satellite radiotherapy unit at St Richard's Hospital, Chichester, as planned by both predecessor Trusts some years ago, Dame Marianne Griffiths advised that currently the Trust couldn't provide that assurance. Marianne went on to explain that having just described the Trust plans as part of the proposed Clinical Strategy, if UHSussex took the decision that it would like to be the primary provider of cancer services across Sussex there would need to be a process of testing that decision, including the requisite consultation in relation to what that would mean for radiotherapy and oncology services currently outside the scope of UHSussex. Marianne added that assurance could be taken from the updates during the Board meeting in relation to the Trust's commitment to cancer services at the Trust.

TB/05/21/25 Resolution into Board Committee

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

TB/05/21/26 The Chair formally closed the meeting

TB/05/21/27 DATE OF NEXT MEETING

27.1 It was noted that the next Board Meeting would take place at 10.00 on Thursday 05 August 2021 via Microsoft Teams Broadcast.

Tanya Humphrys
Board & Committee Administrator
06 May 2021

Signed as a correct record of the meeting

…….. Chair

..…… Date

NHS
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NHS Foundation Trust

CEO Board Report

Marianne Griffiths

August 2021

Contents

University Hospitals Sussex NHS Foundation Trust

- News
- Diary Highlights
- Looking Ahead

News

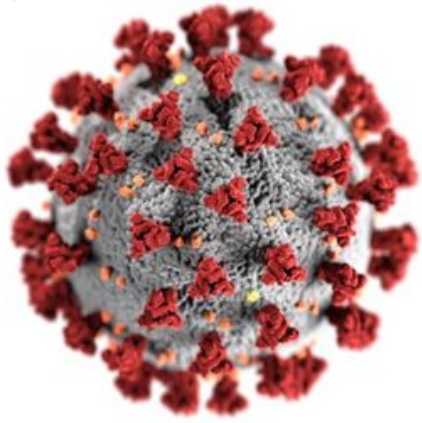
University Hospitals Sussex
NHS Foundation Trust

Covid-19 cases have risen ten-fold since May

We are currently caring for 43 patients* with Covid-19 in our hospitals, with 11 critical care

- Royal Sussex County Hospital: **20** (including 3 in ITU)
- Princess Royal Hospital: **2** (including 1 in ITU)
- Worthing Hospital: **10** (including 5 in ITU)
- St Richard's Hospital: **11** (including 2 in ITU)

Covid-related staff absences peaked at more than 400 in July

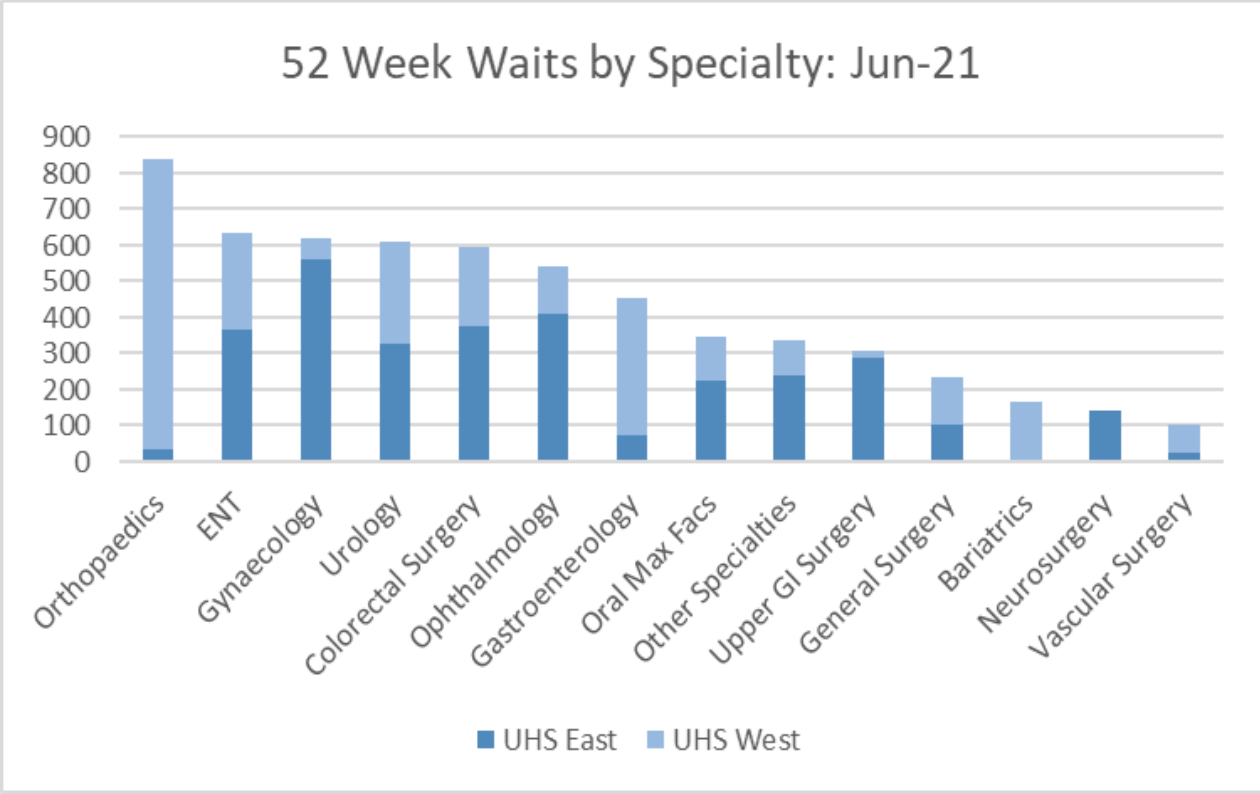


*correct as of 28 July 2021

News

University Hospitals Sussex
NHS Foundation Trust

Restoration and recovery of services on track



OP FIRST	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Target	70%	75%	80%	95%	95%	95%
Plan	88%	85%	97%	93%	96%	97%
Actual	98%	107%	112%			

OP FUP	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Target	70%	75%	80%	95%	95%	95%
Plan	78%	82%	93%	93%	95%	97%
Actual	114%	109%	113%			

EL DC	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Target	70%	75%	80%	95%	95%	95%
Plan	85%	106%	117%	108%	110%	106%
Actual	103%	116%	116%			

EL IP	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Target	70%	75%	80%	95%	95%	95%
Plan	85%	106%	117%	103%	120%	110%
Actual	96%	104%	108%			

News

University Hospitals Sussex
NHS Foundation Trust

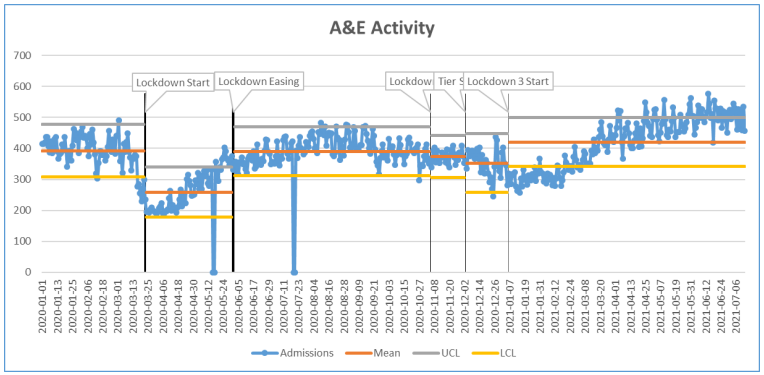
But demand remains very high for emergency care

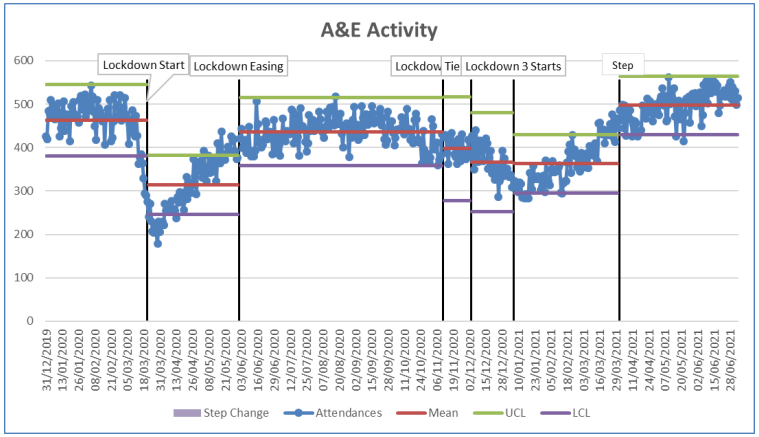
Worthing & Chichester A&Es

+16.5% increase in A&E attendances in June compared to 2019/20 (above pre-pandemic level)

Brighton & Haywards Heath A&Es

+7.8% increase in A&E attendances in June compared to 2019/20 (above pre-pandemic level)





News

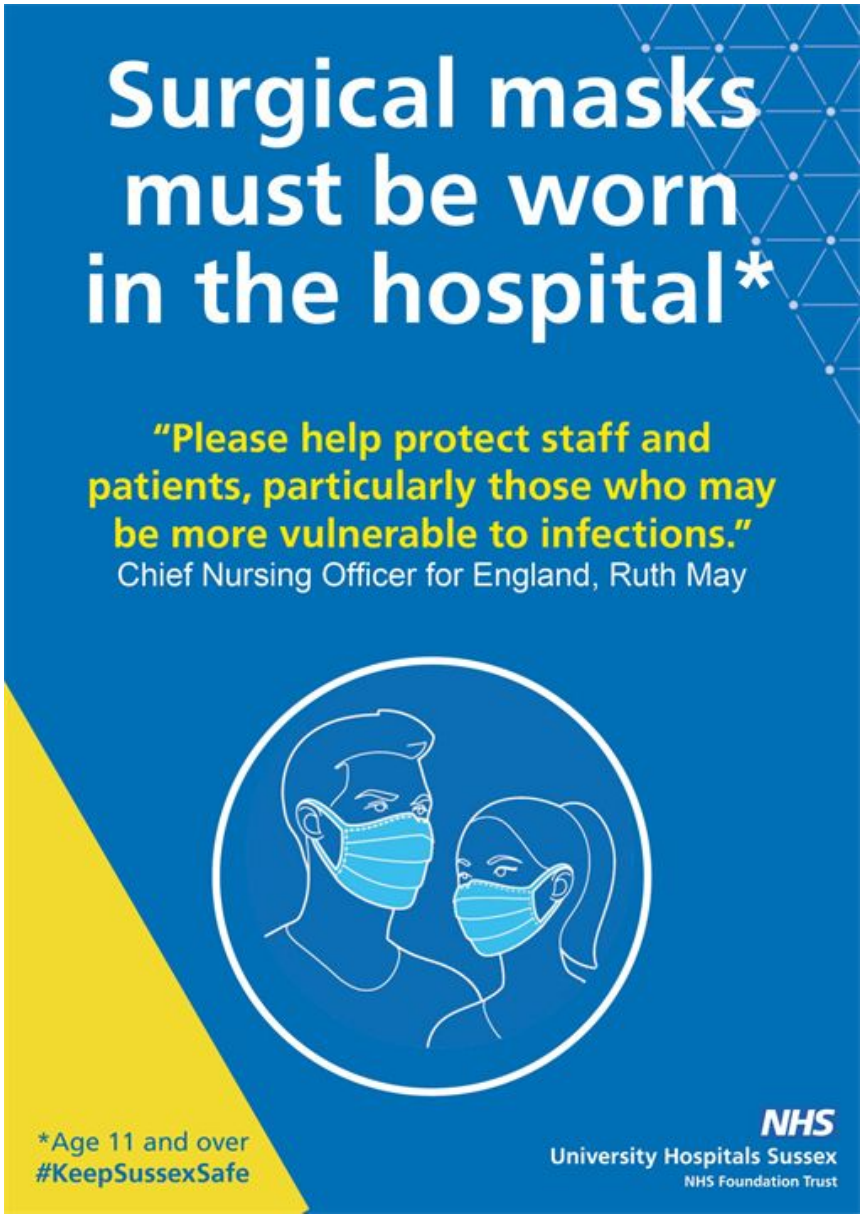
End of lockdown restrictions on 19 July

To protect vulnerable patients and staff, surgical masks continue to be worn in hospital

Our compassionate visitor guidance allowing one visitor at a time also remains in place

Sadly, we experienced an increase in non-compliance and even abuse from the public

We cannot tolerate this behaviour and are doing all we can to support our people at work



News

University Hospitals Sussex
NHS Foundation Trust

Impact on staff health and wellbeing is significant

- 18 months of pandemic with no let up
- High demand for services remains a constant
- Staff are tired with uncertainty continuing
- We must continue to protect our most valuable resource
- All our health and wellbeing services for staff have been collated on accessible new web pages at www.uhsussex@nhs.net

News

We are expanding our staff health and wellbeing activities

Wellbeing Workshops

- The Princess Royal hosted our first creative wellbeing workshops for staff on 22 and 23 July
- The workshops offer a chance for colleagues to reflect on Covid-19, reset and relax
- Organised by our Health and Wellbeing team in partnership with local arts charity ONCA Trust and Onward Arts

Wellbeing Webinars

- A new series of wellbeing webinars have started and will run through until December.
- Designed in response to staff feedback, the content covers topics from positivity to stress.

News

University Hospitals Sussex
NHS Foundation Trust

UHSussex Environment Week (12-16 July)

- Our first ever UHSussex Environment Week took place in July
- Environmental Sustainability is a key strategic initiative for UHSussex
- We are developing a Green Plan to reduce our environmental impact
- Each day, during Environment Week, a different theme was explored
- More than 100 staff suggestions for improvement received
- Scores of new UHSussex Green Ambassadors recruited

News

University Hospitals Sussex
NHS Foundation Trust

UHSussex wins prestigious place in national Green Surgery Challenge

- A green surgery team have won a prestigious place in the first ever national Green Surgery Challenge
- The team at Princess Royal and Royal Sussex County Hospital have been awarded one of only six places in the competition, organised by the Royal College for Surgeons and Centre for Sustainable Healthcare.
- Led by F2 doctor Alyss Robinson, the project aims to safely reduce the number of blood tests a patient needs before an operation
- Estimated saving of 2.5 tonnes CO_2 and equivalent gases

News

New non-executive directors (NED) appointed

Dame Denise Holt - chair of the University of Sussex Council | former British Ambassador

Lucy Bloem - NHS NED | partner at Deloitte's Consulting | international oil industry executive

Claire Keatinge – Northern Ireland Prison Service NED | consumer and older person's advocate

News

Dame Julie Walters officially opened new Urology department on 21 July

- The £2.1 million Urology Investigation Unit (UIU) in Worthing brings together a multidisciplinary team of doctors and specialist nurses in a purpose-built facility
- UIUs are recommended by the national GIRFT (Getting it right first time) programme
- The outpatients' is used to investigate, diagnose and treat urology patients, to improve patient experience, quality and safety

News

Our staff get a boost with new clinical trial

- Research teams recruit 148 participants to world-leading COV-Boost clinical study
- The trial is looking at effectiveness of seven different Covid vaccines used as booster jabs
- Resuscitation Services lead Alan Street (right) was the first volunteer locally to participate
- Our research teams have recruited more than 5,000 participants to Covid trials

News

New Serenity Garden opens in Worthing

- A new memorial garden has opened at Worthing Hospital for patients, visitors and staff
- The Serenity Garden, located by the Penguin Foyer in the hospital, has been completely transformed into a tranquil space which was previously inaccessible to the public
- The hospital's chaplain, Reverend David Hill and his wife Sandra, commissioned the new garden in loving memory of their sons, Jason and Stuart, who lost their lives in a helicopter accident in 2018

Diary Highlights

University Hospitals Sussex NHS Foundation Trust

- Sussex Health & Care Partnership Executive Meeting
- Presented at Management & Leadership in Ophthalmology
- Royal Free and St George's Patient First visit
- Presented at Bristol Trust Board Meeting
- Presented at the Next Generation of Nurses
- Presented at West Sussex Safeguarding Adults Conference Day
- Presented at Trainee Excellence Awards

Looking Ahead

Development of new Clinical Operating Model

- Our new Clinical Operating Model will become the “spine” of UHSussex
- We had excellent engagement with clinical leaders and managers at workshops in June
- New preferred model now under review
- Formal consultation taking place in due course
- New corporate operating model will support

Looking Ahead

University Hospitals Sussex
NHS Foundation Trust

Continued focus on:

- Protecting staff health and wellbeing
- Restoration and recovery of services
- Meeting increasing demand for urgent care
- Patient First strategic improvement priorities
- Planning for winter 2021/22 underway
- Working with Sussex Heath and Care Partnership colleagues
- Change at the top as Amanda Pritchard appointed NHSE/I CEO

Any questions?

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University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	6-10	**Meeting:**	Trust Board	**Meeting Date:**	5 August 2021
Report Title:	**Integrated Performance Report – Quarter 1 2021/22**				
Sponsoring Executive Directors:	Marianne Griffiths, William Roche, Maggie Davies, Carolyn Morrice Pete Landstrom, Karen Geoghegan and David Grantham				
Author(s):	Marianne Griffiths, Rob Haigh, Maggie Davies, Carolyn Morrice Pete Landstrom, 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 2021/22.

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

Key Recommendation(s):

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

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Integrated Performance Report

August 2021

Contents

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Structure of the report

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

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

Patient First Strategy Deployment Framework

University Hospitals Sussex
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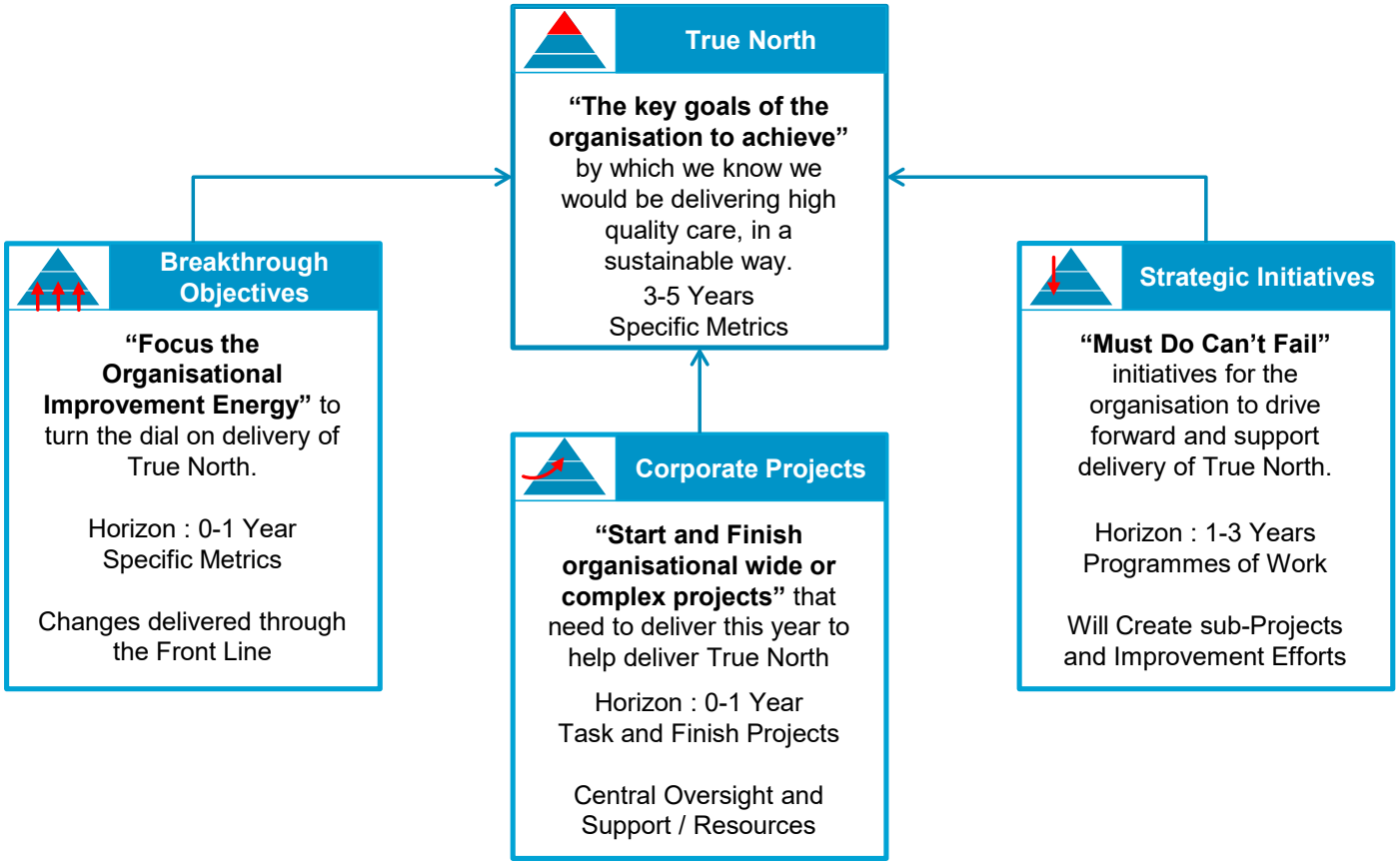

Patient First True North

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NHS Foundation Trust

Patient

Patient Experience:

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

Sustainability	People	Quality	Systems & Partnerships
Financial Sustainability: To deliver the Trust's financial plan	**Staff Engagement:** To be within the top quartile of acute Trusts for the National staff engagement score	**Mortality:** To achieve a 10% reduction in the crude mortality rate **Harm:** To achieve a 5% reduction in the levels of DATIX reported harm to patients	**Planned Care:** To have no patients waiting in excess of 40 weeks on an RTT pathway to be seen and treated **Emergency Care:** To achieve 95% of patients are treated within 4 hours in Emergency Care services

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

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Patient

Integrated Performance Report Section

PATIENT

University Hospitals Sussex NHS Foundation Trust

True North Metric: 95% of patients rating FFT surveys as Very Good or Good.

Family & Friends Test Current Position

Overall patient experience summarised below is based on the Trust recommend rate from April – June 2021, and national average by FFT touchpoint:

Table 1: FFT recommend rates April – June 2021:

	UHS MAT	Nat Mat	UHS IP	Nat IP	UHS OP	Nat OP	UHS ED	Nat ED	UHS Overall
Apr-21	**95.4%**	96%	**97.3%**	95%	**96.6%**	93%	**84.6%**	84%	**93.5%**
May-21	**97.9%**	95%	**96.5%**	95%	**97.2%**	93%	**83.4%**	82%	**93.7%**
Jun-21	**98.7%**	tbc	**96.5%**	tbc	**96.1%**	tbc	**80.8%**	tbc	**93.0%**

Analysis of feedback received for ED's to establish contributors to significant decrease (initial findings relate to increased attendances and delays)

An FFT refresh is planned in Q2 2021 to reinvigorate staff engagement. This will include staff training on data analysis and targeted summary reports to divisional and ward level.

FFT feedback continues to be triangulated with complaints. PALS and plaudit data is utilized to inform continuous service improvement.

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Quality

Integrated Performance Report Section

Focus of this section

University Hospitals Sussex NHS Foundation Trust

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

2) Breakthrough Objective – Harm-free care (5% reduction in harm for low/moderate harm)

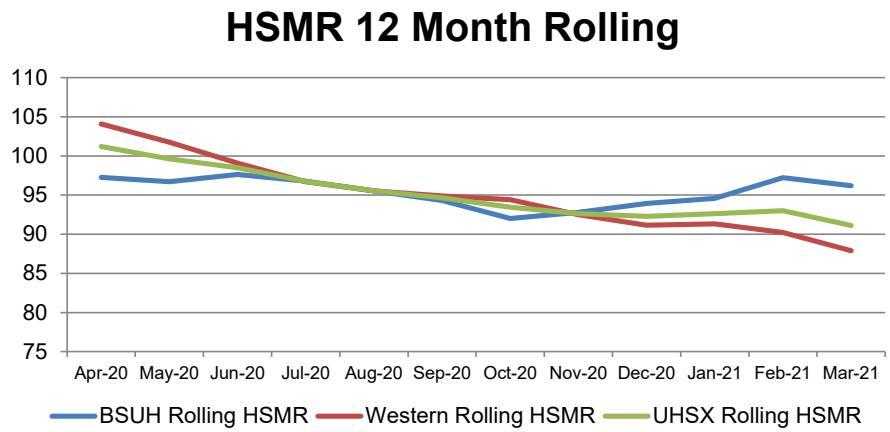
- Falls
- Pressure damage

The stratification on low & moderate harms has been completed and shared with the PFIS teams and divisions.
Venous thromboembolism (VTE) has been selected as the third theme from the category of 'recognition and escalation of clinical deterioration' and work is underway to review the data collection and the data actual for this harm. Currently, 2019/20 data shows continued improvement from previous breakthrough. Continued vigilance required with R&R.

3) National Patient Safety Specialist role

HSMR

University Hospitals Sussex
NHS Foundation Trust



Note: Standardised Mortality Ratios for UHS will in future be reported by HEDs (which formally provided SMR data to legacy BSUH)

HSMR data is available until March 2021.

HSMR in 'BSUH' for the 12 months to March 2021 was 96.2 (1028 observed deaths against 1087 expected deaths).

HSMR in 'WSHFT' for the 12 months to March 201 was 87.9 (1466 observed deaths against 1668 expected deaths).

Combining BSUH and WSHFT mortality data would result in a HSMR of 91.3.

Dividing the number of observed deaths by the number of expected deaths for both legacy Trusts enables us to calculate an HSMR of 91.3 for UHS; placing the new organisation in the top 20% for HSMR

SHMI

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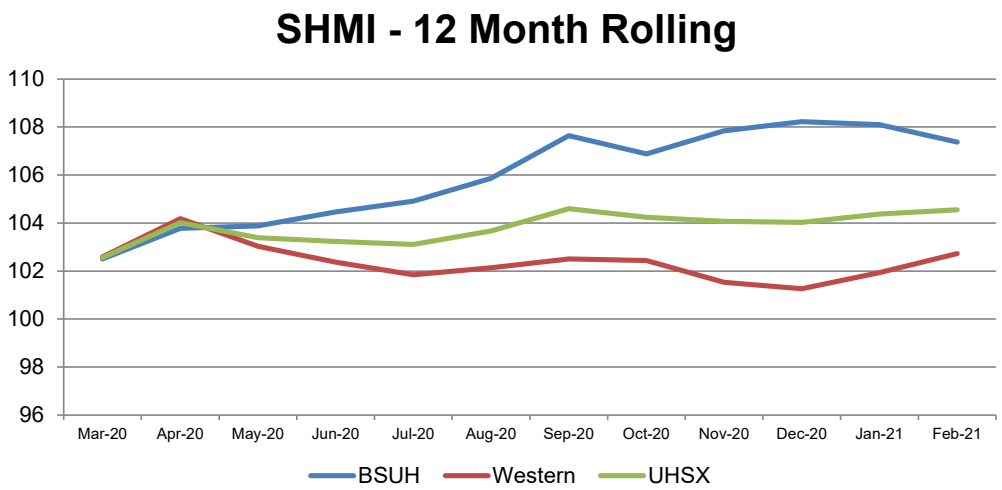


SHMI is available until February 2021.

SHMI in BSUH for the 12 months to February 2021 was 107.4,(1750 observed against 1630 expected deaths).

SHMI in WSHFT THE 12 MONTHS TO February 2021 was 102.7, (2578 observed against 2509 expected deaths).

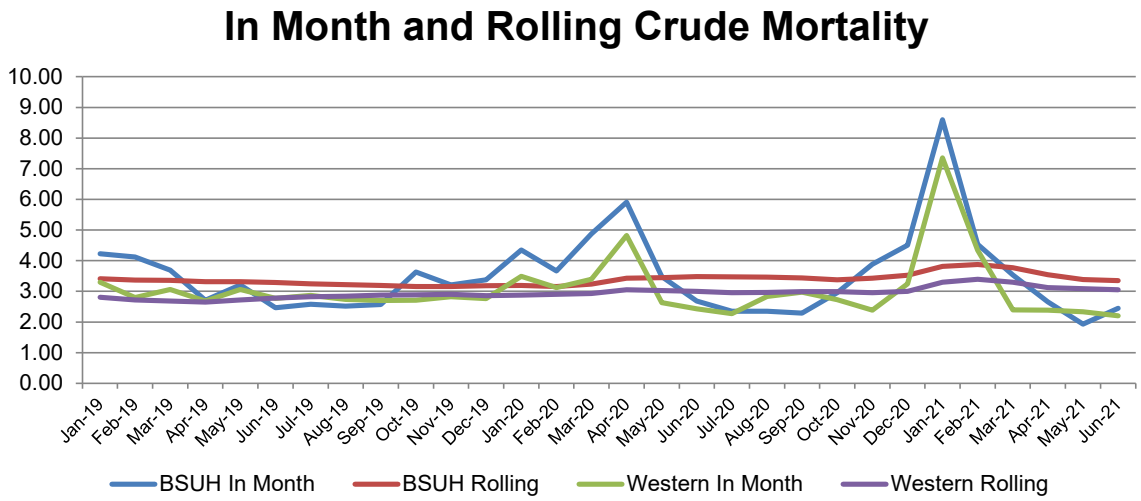
Combining legacy BSUH and WSHFT mortality data results in a SHMI of 104.37.

Further examining legacy data reveals that **in** hospital deaths account for 64% of the total number of deaths at BSUH and 62% at WSHFT.

For both legacy Trusts the out of hospital SHMI was higher than the in-hospital SHMI (110.9 at BSUH and 109.5 at WSHFT.)

Crude Mortality

University Hospitals Sussex NHS Foundation Trust



The in month Crude Mortality exceeded the Upper Control Limit in both Trusts in April 20 and January 21.

In BSUH the crude mortality in January 2021 rate was 8.6% against a seasonally predicated rate of 5.7%.

In WHSFT the crude mortality rate was 7.35% against a seasonally predicated rate of 4.7%.

The higher than expected crude mortality rates in January 2021 are due to the large number of inpatient deaths (262 BSUH and 377 WSHFT).

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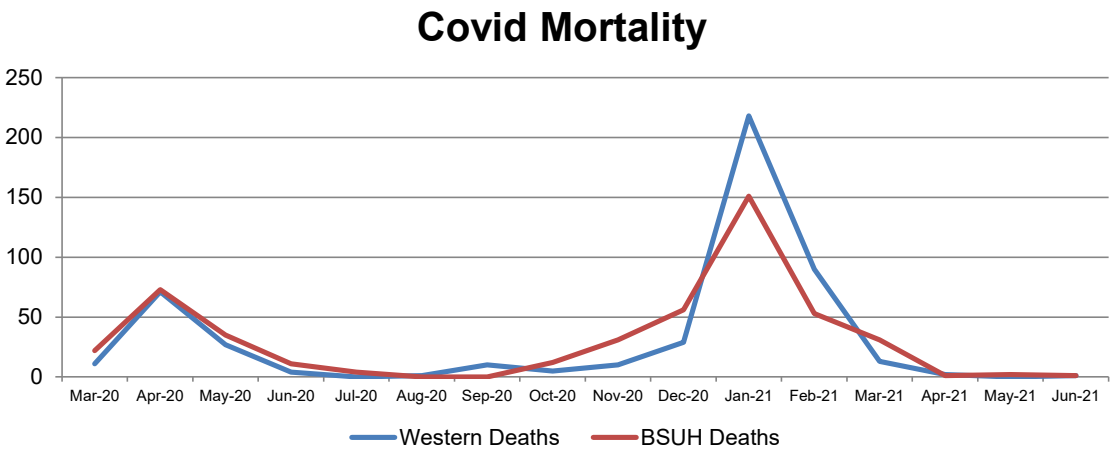
NHS Foundation Trust

Covid Mortality



Between March 2020 and June 2021 BSUH recorded 483 deaths for patient who had tested positive for covid-19.

In WSHFT the number of deaths was 492.

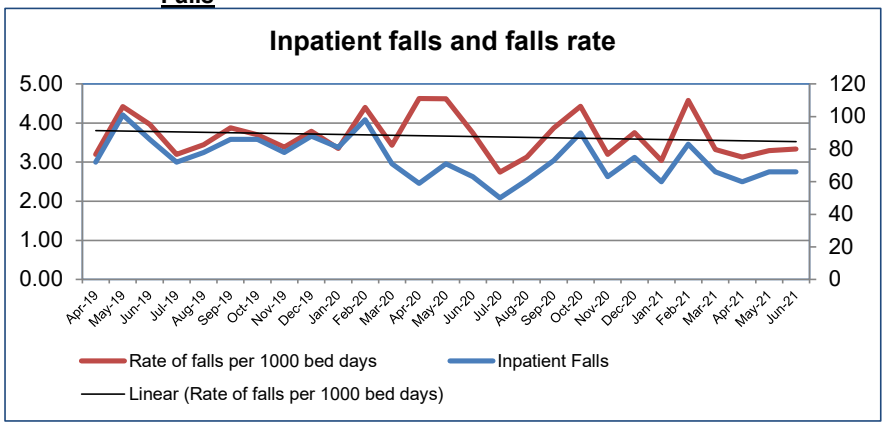
During the first wave deaths peaked in April with 73 deaths in BSUH and 71 in WSHFT.

In the second wave January 2021 saw the highest number of deaths 151 in BSUH and 218 in WSHFT

Avoidable Harm– Key Metrics: East

University Hospitals Sussex NHS Foundation Trust

Falls



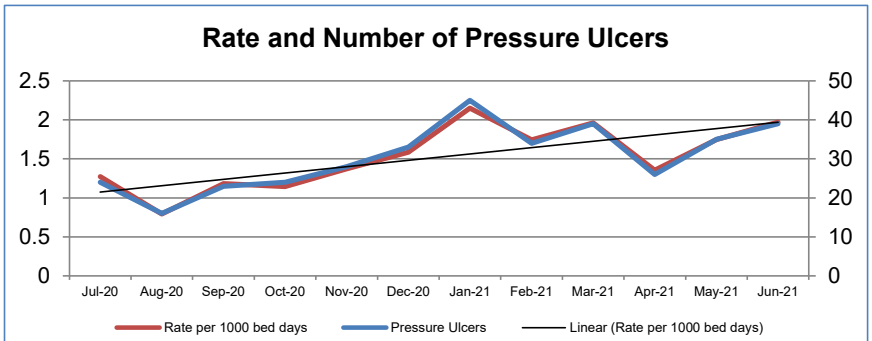
There were 66 inpatient falls reported in June 2021 at a rate of 3.34 falls per 1000 bed stay days, 2 falls met the threshold of moderate harm.

Falls Assessment data continues to be collected via the Perfect ward audit tool. This is reported, together with serious incident and moderate harm investigations, on a monthly basis to the Harm Free Care Group to ensure learning regarding identified risk areas and improvement opportunities.

The UHSussex falls policy is currently being reviewed to include the use of post falls immediate review.

Falls relating to the use of toilet and commode placement remain an issue as does the measurement of lying and standing BPs which is due to be flagged on Patientrack e-observation next month.

Pressure Ulcers



There were 39 incidents of hospital acquired pressure ulcers in June 2021 with a rate of 1.98 per 1000 bed stay days.

Over the past 12 months there have been 366 acquired pressure ulcers at a rate of 1.52.

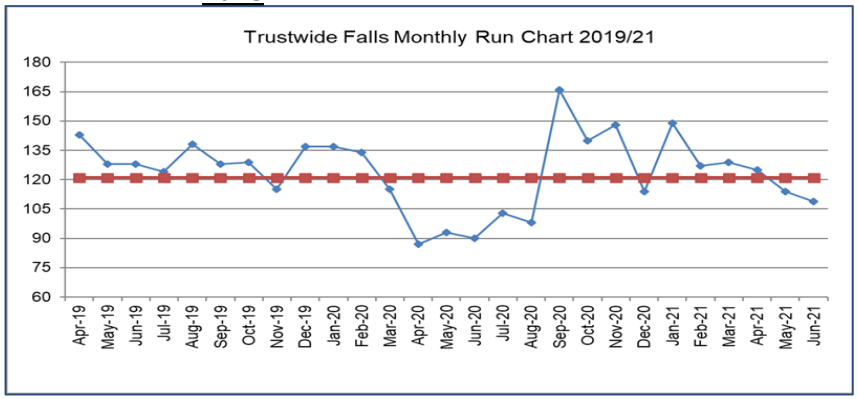
In an average month the Trust's Wound Care Team review 186 reports. The trend over the past 12 months has been for the number of pressure ulcer reports to decrease. In the 12 months to June 21 a total of 2235 pressure ulcer incidents were submitted via the Datix Incident reporting system, these reports involved 1923 admissions or presentation to the ED. 1294 of these admissions involved a patient who presented with a pressure ulcer.

The team are liaising with the practice development team to reintroduce PD prevention into mandatory training and relaunching the Wound Care link nurses to further improve education

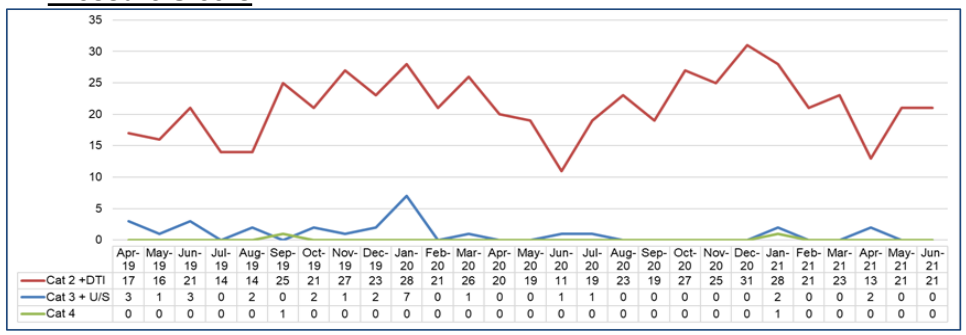
Avoidable Harm– Key Metrics: West

University Hospitals Sussex NHS Foundation Trust

Falls



Pressure Ulcers



Trust goal: 30% reduction i.e. no more than 2 patients develop category 3 and above ulcer in hospital

Current Performance and Actions (June 2021 data):

- June falls maintained within target range, continuing the improving trend of the previous 5 months.
- Due to the patient age demographic and comorbidities, deconditioning and delirium continue as dominant risks.
- Falls related to continence needs is significant, requiring improvement.
- Notable reduction in falls on Emergency Floor Worthing for past 2 months.
- Introduction of “Call don’t fall” reminder prompt cards distributed to wards.
- Beacon, Birdham, EF SRH & Lavant are areas of focus and improvement work underway.
- Trial of red walking frames for confused patients on EF Worthing continues. For expansion to other areas.

Current Performance and Actions (June 2021 data):

- There were 0 patients with Cat 3 or above reported ulcers, which has reached the target for this month.
- There was an 80 percent reduction in the past year in Cat 3 hospital pressure ulcers, well done everybody!
- Sacrum damage and Moisture Associated Skin Dermatitis is a theme this month.
- TV team continue to trial iPad photography of pressure ulcers and/or wounds and uploading directly into patient evolve notes.
- TV team continue to socially distanced face-to-face training provide close support to wards experiencing particular challenges with pressure ulcer prevention activities, including preceptorship and frailty modules.
- The tissue viability conference in November has been arranged, which will focus on pressure ulcer prevention.
- TV team to focus teaching on identifying patients at risk of moisture related skin breakdown and implementing appropriate care.

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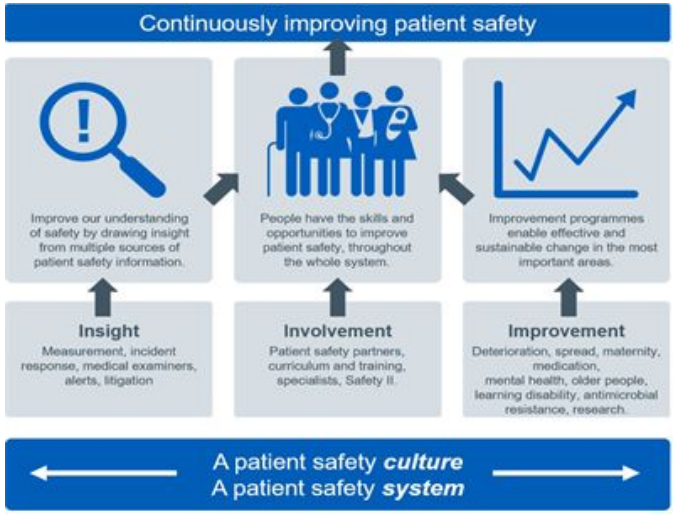
Patient Safety Specialists (PSS)

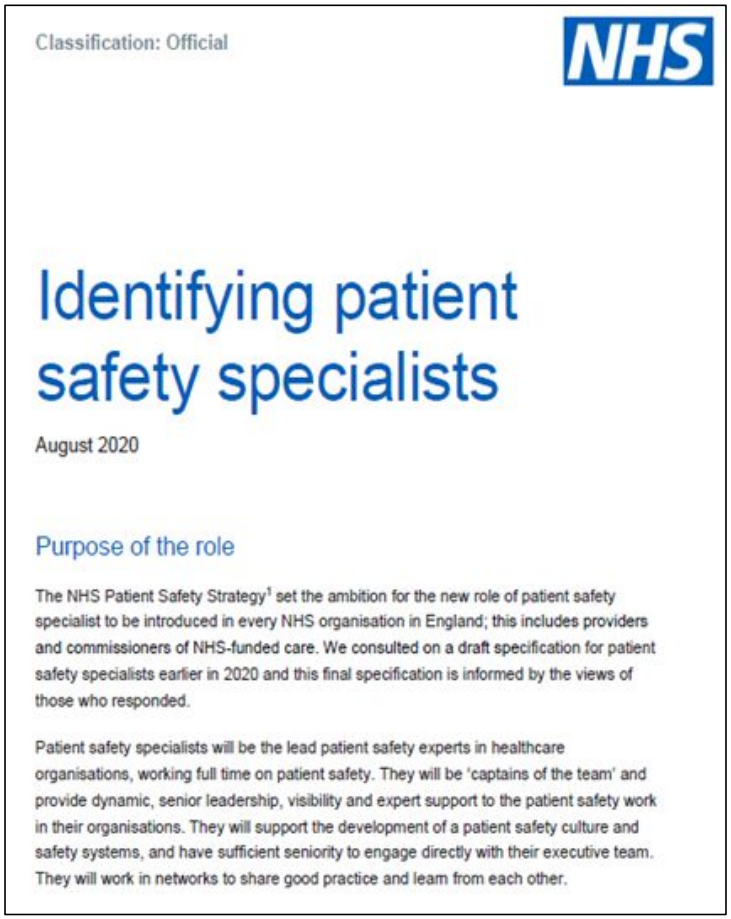
Executive briefing document

2021

Patient Safety Specialists



Formally creating this role provides status and the expectation that having a patient safety specialist(s) who is fully trained in the national patient safety syllabus is standard across the NHS



Classification: Official

Identifying patient safety specialists

August 2020

Purpose of the role

The NHS Patient Safety Strategy[1] set the ambition for the new role of patient safety specialist to be introduced in every NHS organisation in England; this includes providers and commissioners of NHS-funded care. We consulted on a draft specification for patient safety specialists earlier in 2020 and this final specification is informed by the views of those who responded.

Patient safety specialists will be the lead patient safety experts in healthcare organisations, working full time on patient safety. They will be 'captains of the team' and provide dynamic, senior leadership, visibility and expert support to the patient safety work in their organisations. They will support the development of a patient safety culture and safety systems, and have sufficient seniority to engage directly with their executive team. They will work in networks to share good practice and learn from each other.

Patient safety specialist role

- Lead patient safety experts in their organisation, working full time on patient safety
- Able to escalate immediate risks or issues to Exec team
- ‘Captains of the team’, provide dynamic senior leadership, visibility and expert support
- Work with others including: Medication safety officer (MSO), Medical device safety officer (MDSO), Maternity safety champions
- Lead /support the local implementation of the NHS patient safety strategy: insight, involvement and improvement
- Support the development of a patient safety culture and safety systems
- Work in networks to share and learn
- Lead, and may directly support, patient safety improvement activity
- Ensure that systems thinking, and just culture principles are embedded
- Support patient safety partners (Framework for involving patients in patient safety)
- Learn and develop, complete the Patient safety syllabus

Key deliverables

- 2019 - Role identified as part of the NHS patient safety strategy
- 2020 Mar - Patient safety specialists made a contractual requirement within the NHS Standard Contract 2021/22 section 33.7
- 2020 Aug/Nov - Identifying Patient Safety Specialists and providing nominations to NHSEI from every NHS organisation by 3011/20
- 2020 Nov – National webinars provided to support patient safety specialist training
- 2021 Apr – patient safety specialists to be full time in post
- 2021 Apr – patient safety specialist priorities document provided
- 2021 Jun - Patient safety syllabus available for patient safety specialists and training for the Board

Early milestones

- Over 700 Patient Safety Specialists representing 96% coverage of relevant organisations
- We have held 16 national meetings – topics including:
  - National patient safety improvement programmes
  - Views on patient safety culture
  - PSIRF progress update
- Involvement in two national safety issues:
  - Beckton Dickinson infusion devices
  - Phillips device recall
- Involvement in national working groups including:
  - National Patient Safety Syllabus
  - Development of NHSX digital strategy
- Development of FutureNHS Collaboration platform (access via patientsafetyspecialists.info@nhs.net)
- Patient safety priorities document provided
- Starting to create region and ICS patient safety specialist networks

PSS priorities (Apr-21)

- Just culture support and advice
- National Patient Safety Alerts advice
- Improving quality of incident recording
- Support transition from NRLS and StEIS to the new Learn from patient safety events (LFPSE) service
- Preparation for implementing the new Patient Safety Incident Response Framework (PSIRF) when it is launched in 2022
- Implementation of the Framework for involving patients in patient safety (published in June 2021)
- Patient safety education and training including the first two levels of the Patient safety syllabus launched in summer 2021
- Supporting involvement in the National Patient Safety Improvement Programmes, working with local AHSNs and Patient Safety Collaboratives
- COVID-19 recovery support – more information will be provided shortly

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Short – medium term priorities for Patient Safety Specialists

April 2021

This paper describes how Patient Safety Specialists (PSSs) can support implementation of the NHS Patient Safety Strategy and operational recovery during 2021/22.

We have identified nine key work programmes, with associated actions and timescales where appropriate:

1. Just culture
2. National Patient Safety Alerts
3. Improving quality of incident reporting
4. Support transition from NRLS and StEIS to PSIMS
5. Involvement in implementing the new Patient Safety Incident Response Framework (PSIRF)
6. Implementation of the Framework for Involving Patients in Patient Safety
7. Patient safety education and training
8. National patient safety improvement programmes
9. COVID-19 recovery planning

We appreciate due to current workloads it may not be possible for PSSs to immediately be actively involved in all these work programmes. You should review the programmes identified in this paper with your executive team and agree a phased approach to implementation. For some programmes there may be opportunity to ensure that others in your organisation are already aware and involved and that minimal support from you is needed. There are programmes where, although there are associated timescales, a flexible approach can be taken. For example, it may not be possible to go live with the new patient safety incident management system (PSIMS) immediately if your local risk management system (LRMS) vendor hasn't undertaken the necessary local modifications.

Executive PSS support requirements

1. The Patient Safety Specialist was required to be identified by Apr-21. The expectation is 1FTE at band 8 range, but this may be a shared role, or more than 1FTE across large organisations. ✓
2. The PSS's name(s) has been provided to NHSEI by executive lead for patient safety. ✓
3. An executive lead for patient safety should be identified as the direct contact point for the PSS. The PSS should also link with the NED who leads on patient safety. ✓
4. All Board members should be aware of and support the PSS's role and discuss as a board agenda item. ✓
5. The PSS priorities document (circulated Apr-21) should be reviewed and a PSS work plan agreed with the patient safety executive lead. ✓
6. The PSS should be provided with sufficient time and resources to undertake their role, network and complete the patient safety training requirements (to level 5 of the Patient safety syllabus once available). ✓
7. There should be sufficient support/ coaching / mentoring in place for the PSS to progress their personal and leadership development. ✓

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People

Integrated Performance Report Section

Focus of this section

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- 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 True North

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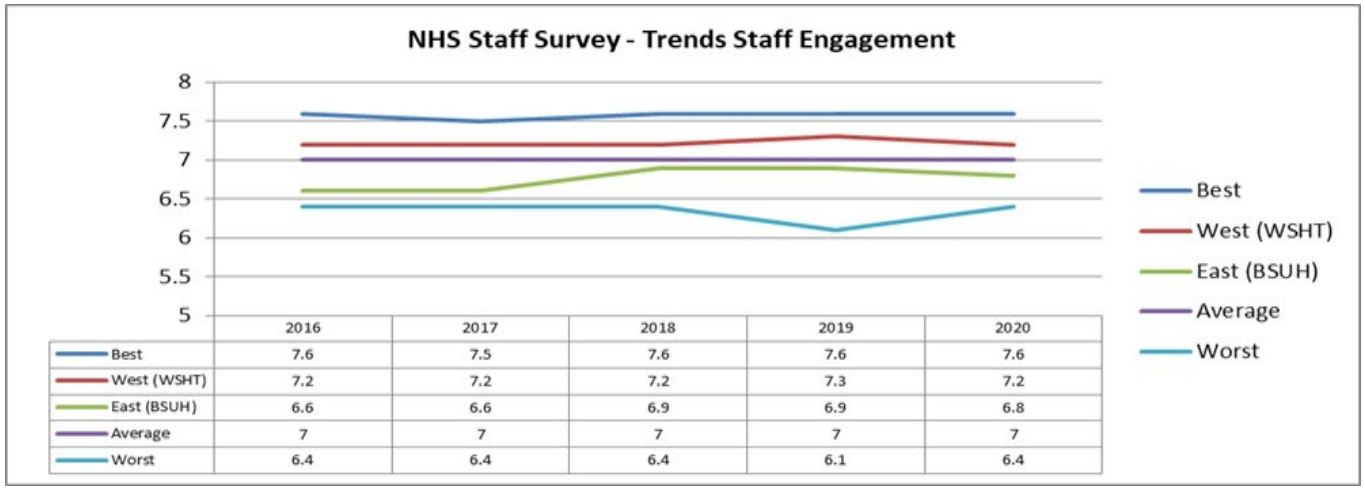
The agreed True North Goal for Our People is to be the Top Acute Trust for Staff Engagement. Our Target is to be within the top quartile of acute Trusts for the National staff engagement score.



	2016	2017	2018	2019	2020
Best	7.6	7.5	7.6	7.6	7.6
West (WSHT)	7.2	7.2	7.2	7.3	7.2
East (BSUH)	6.6	6.6	6.9	6.9	6.8
Average	7	7	7	7	7
Worst	6.4	6.4	6.4	6.1	6.4

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

Breakthrough Objective Progress Update

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Our Aim – To increase number of staff who would recommend the organisation as a place to work

Corporate Key Actions:

Health and Wellbeing:

- Countermeasure summary completed which is aligned to the overall strategy.
- Further analysis being undertaken for rostering and staffing capacity themes to understand drivers and the correlation to Breakthrough Objective.

Teamworking:

- Analysis of Team Working staff survey questions ('My Team has shared objectives' and 'My Team meets to discuss effectiveness') is being finalised to understand the driver of the significant decrease for this Theme and the correlation to the Breakthrough Objective.

Career Development:

- Completed a review of the approach to restoring appraisal & performance development which includes annual objective setting and wellbeing. Outline proposal approved and detailed plan now in development with intention to launch in October 2021.

Divisional Key Actions:

- Work on-going with Divisions to identify specific priorities which will support achievement of the Breakthrough Objective.

Other:

- Local Pulse Survey developed and launched Trust wide on 1 July to measure and monitor staff engagement on a monthly basis, to allow us to understand the organisation on a more frequent basis.
- The national quarterly staff survey has launched in July closing on 2 August which will provide further data on staff engagement.

People Strategic Initiate Progress Update

University Hospitals Sussex NHS Foundation Trust

The Leadership, Culture and Development Strategic Initiative drives the Trust's response to the NHS People Plan and People Promise whilst also ensuring it is fully aligned to support Patient First. The early focus of improvement and delivery will enable completion of Post Transaction Integration Plan (PTIP) so that merger benefits are realised, and will ensure a continued focus on staff well-being.

Theme	Progress
Board Development	Tender process now commenced and plan to complete by August.
Leader skills	PFIP for leaders continues to be delivered Leadership skills content and approach under review
Branding	Phase 3 plans under development
Health and Wellbeing	Detailed action plan under development for Violence and Aggression for review and agreement in August Approach to appropriate and sustainable support services being undertaken.
Equality, Diversity and Inclusion	Review of current position to ensure it is aligned to priorities and able to support the new people structures
Integrated Education (IE)	Interim Director of Integrated Education appointed – who will lead on IE strategy development and implementation. Additional Learning Technologist resource to be provided to west of UHSussex Ongoing review and refresh of standards and delivery of statutory & mandatory training and Learning Management systems.

Corporate Project:
Electronic Workforce Deployment (EWD)

Modernisation of job planning and rostering in our Trust is key to delivering our ambition to have the most highly engaged workforce within the NHS. EWD will also deliver more effective workforce planning and deployment.

UHSussex has partially implemented electronic workforce systems using a number of different platforms, parts of our workforce are reliant on non-automated processes with no standardised method to ensure effective deployment of the substantive and bank workforce, nor is there adequate operational workforce reporting.

NHSE/I Levels of Attainment Target	90%+ in-scope staff have an eJob Plan	Baseline	90%+ staff are on a eRoster	Baseline
EWD SDR	% Doctors job plans active	EAST: 55% WEST: 55% **TRUST: 55%**	% Nursing , AHP & other Clinical on an eRoster	EAST: 30% WEST: 95% **TRUST: 62%**
	% doctors with an active eJobPlan	EAST: 0% WEST: 54% **TRUST: 18%**	% Non-clinical staff on an eRoster	EAST: 21% WEST: 90% **TRUST: 49%**
	% doctors on an eRoster	EAST: 22% WEST: 73% **TRUST: 40%**	% eRosters issued 6 weeks in advance	EAST: 21% WEST: 35% **TRUST: 26%**

Baseline KPI have been set which support NHSE/I targets.

Key EWD Workstreams are:

- Non-Medical Rostering
- Medical Rostering & Central Rota Management
- Job Planning
- Bank Implementation
- ESR & Other Systems
- Benefits Realisation
- Finance & Business Cases

Workforce KPIs

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People Committee Scorecard - UHSx

June 2021

	Key Performance Indicator	Target	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Trend
	True North - Engagement		7.2	7.3	7.1	7.0	7.1	7.0	7.1	7.3	7.3	7.3	7.1	7.4	7.2	
	Breakthrough - Place to work (included in some of the surveys)		80.54%	84.55%	82.44%	76.88%	80.44%	78.79%	76.47%	85.71%	84.81%	83.41%	84.02%	79.72%	77.5%	
Workforce Capacity	FTE - Budgeted		15,514.78	15,522.29	15,520.28	15,549.67	15,578.42	15,627.42	15,620.91	15,700.40	15,703.12	15,684.49	15,916.00	15,915.64	15,880.63	
	FTE - Substantive contracted		14,225.33	14,266.94	14,685.35	14,239.06	14,209.12	14,188.77	14,224.28	14,292.17	14,383.60	14,387.58	14,468.75	14,420.36	14,406.04	
	FTE - Substantive contracted variance from Budget		1,289.45	1,255.35	834.93	1,310.61	1,369.30	1,438.65	1,396.63	1,408.23	1,319.52	1,296.91	1,447.25	1,495.28	1,474.59	
	Vacancy Factor (Substantive contracted FTE)		8.31%	8.09%	5.38%	8.43%	8.79%	9.21%	8.94%	8.97%	8.40%	8.27%	9.09%	9.40%	9.29%	
	Spend - Bank as a % of total staffing		7.29%	6.44%	6.69%	6.51%	6.57%	7.11%	6.86%	7.74%	8.13%	6.08%	7.39%	10.51%	6.81%	
	Spend - Agency as a % of total staffing		2.36%	3.61%	3.43%	3.92%	3.98%	3.67%	3.99%	3.54%	3.44%	1.98%	3.43%	3.05%	2.85%	
	Substantive Headcount		16,243	16,303	16,147	16,105	16,140	16,198	16,203	16,316	16,350	16,379	16,419	16,435	16,452	
Workforce Efficiency	Absence - Sickness (12 month)		-	-	-	-	-	-	-	-	-	4.04%	3.87%	3.81%		
	Absence - Sickness in month		3.99%	3.88%	3.59%	3.91%	4.00%	4.15%	4.08%	4.45%	4.00%	3.40%	2.87%	3.48%		
	Absence - Maternity in month		2.15%	2.15%	2.11%	2.21%	2.11%	2.17%	2.24%	2.28%	2.30%	2.16%	2.01%	2.14%		
	Absence - Special, Study & Other Leave in month		-	-	-	-	-	-	-	-	-	8.23%	7.20%	7.28%		
	Absence - Total in month		-	-	-	-	-	-	-	-	-	13.79%	12.08%	12.90%		
	Sickness - Short Term (< 28 days)		1.48%	1.53%	1.41%	1.73%	1.74%	1.77%	1.64%	2.06%	1.53%	1.56%	1.40%	1.73%		
	Sickness - Long Term (>= 28 days)		2.51%	2.34%	2.18%	2.18%	2.26%	2.38%	2.44%	2.39%	2.47%	1.84%	1.47%	1.74%		
	Sickness - Stress in month		1.26%	1.23%	1.08%	1.07%	1.06%	1.02%	1.03%	0.98%	1.03%	0.84%	0.65%	0.85%		
	Sickness - Gastro Intestinal in month		0.27%	0.29%	0.29%	0.33%	0.29%	0.30%	0.30%	0.28%	0.29%	0.19%	0.21%	0.31%		
	Sickness - Other Musculoskeletal in month		0.32%	0.33%	0.31%	0.38%	0.37%	0.43%	0.38%	0.36%	0.31%	0.32%	0.34%	0.46%		
	Sickness - Cough, Cold & Flu in month		0.12%	0.11%	0.10%	0.25%	0.30%	0.26%	0.20%	0.28%	0.20%	0.18%	0.16%	0.16%		
	Sickness - Back in month		0.27%	0.26%	0.24%	0.21%	0.24%	0.28%	0.24%	0.20%	0.22%	0.20%	0.19%	0.22%		
	Episodes - New sickness episodes in month		-	-	-	-	-	-	-	-	-	2,103	1,889	2,077		
	Episodes - On-going sickness episodes in month		-	-	-	-	-	-	-	-	-	506	506	536		
	Episodes - Total sickness episodes in month		-	-	-	-	-	-	-	-	-	2,609	2,395	2,613		
	Maternity - Number of staff on maternity leave		-	-	-	-	-	-	-	-	-	430	399	430		
	Turnover - Trust (12 month)		-	-	-	-	-	-	-	-	-	9.97%	9.84%	9.81%	9.80%	
	Turnover - Medical & Dental (12 month)		-	-	-	-	-	-	-	-	-	16.09%	17.44%	17.56%	15.65%	
	Turnover - Nursing & Midwifery (12 month)		-	-	-	-	-	-	-	-	-	9.05%	8.93%	8.89%	8.92%	
	Turnover - Scientific, Therapeutic & Technical (12 Month)		-	-	-	-	-	-	-	-	-	10.19%	9.64%	9.31%	9.31%	
	Turnover - Admin, Clerical & Estates (12 months)		-	-	-	-	-	-	-	-	-	8.84%	8.69%	8.73%	9.05%	
	Turnover - Support Staffing (12 months)		-	-	-	-	-	-	-	-	-	11.00%	10.68%	10.70%	10.73%	
	Stability %		-	-	-	-	-	-	-	-	-	-	89.16%	89.07%	88.79%	
Training and Development	% of appraisals up to date (excl Medical staff)	90%	73.83%	73.27%	73.18%	75.09%	75.44%	76.15%	77.58%	73.90%	72.98%	75.72%	81.74%	82.84%	81.70%	
	STAM Weighted Average	90%	85.46%	84.94%	85.04%	85.24%	83.77%	84.69%	84.96%	84.28%	82.38%	84.90%	82.81%	83.34%	84.24%	
	% In Date - Fire	90%	83.78%	83.45%	83.19%	83.69%	82.99%	84.20%	84.58%	84.02%	82.32%	85.20%	83.46%	85.10%	84.27%	
	% In Date - Infection Control (Role Specific)	90%	83.58%	83.35%	83.19%	83.02%	82.23%	83.13%	83.40%	83.14%	81.12%	84.13%	82.48%	84.38%	83.73%	
	% In Date - Back Training (Role Specific)	90%	87.85%	87.91%	88.49%	88.93%	87.64%	88.23%	87.80%	85.77%	83.65%	85.12%	80.53%	69.06%	71.12%	
	% In Date - Child Protection (Role Specific)	90%	89.63%	89.19%	89.76%	90.22%	88.95%	89.99%	89.93%	89.99%	88.98%	90.20%	87.62%	88.60%	87.92%	
	% In Date - Information Governance	90%	82.85%	82.14%	81.97%	82.25%	81.59%	82.77%	83.14%	82.43%	79.15%	82.21%	80.61%	82.68%	82.08%	
	% In Date - Adult Protection	90%	88.46%	87.83%	88.16%	88.28%	79.78%	79.77%	81.70%	84.83%	84.54%	85.11%	84.90%	86.93%	87.64%	
	% in Date - Equality & Diversity	90%	92.99%	92.28%	92.49%	92.96%	92.35%	93.10%	92.92%	92.45%	91.06%	92.00%	89.54%	90.98%	90.83%	
	% in Date - Health & Safety	90%	87.98%	87.51%	87.63%	88.30%	87.38%	89.20%	89.28%	88.66%	87.20%	89.70%	87.20%	89.35%	94.74%	
	% in Date - Resus	90%	65.85%	64.22%	63.71%	62.17%	63.03%	63.57%	63.95%	57.83%	53.31%	62.56%	62.12%	67.53%	71.37%	
Capacity	Starters	-	141	155	470	219	213	168	143	210	182	182	185	130	151	
	Leavers	-	113	189	535	245	172	124	124	118	153	152	122	95	105	
COVID	Absence		701	648	52	87	180	319	267	695	501	491	169	59	89	
	Vaccination % First Dose		-	-	-	-	-	-	-	81.3%	86.0%	88.8%	89.5%	89.6%	89.6%	
	Vaccination % Second Dose		-	-	-	-	-	-	-	-	-	65.4%	84.1%	86.2%	86.2%	
	Clinically Extremely Vulnerable		537	534	17	8	3	92	20	320	336	403	115	10	11	

Workforce KPIs - Commentary

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Current Performance	Response / Actions Planned
Turnover • June UHSussex Turnover Rate (external leavers) rate stood at 9.8%, which is a small reduction from 9.84% in April 21. • UHSussex East Turnover (external leavers) rate stood at 11.52% having decreased from 11.93% in March 21. • UHSussex West Turnover (external leavers) stood at 7.79% which has seen an increase from 7.68% in March 21	Work being undertaken on a new leavers survey to better capture reasons. Divisional plans developed for local action to support retention.
Sickness Absence • In May the UHSussex one month Sickness Absence rate was 3.48% and the 12 month rate 3.81%. • The UHSussex East one month Sickness Absence rate was 4.05% in May, down from a rate of 4.66% seen in May 20. The 12 month Sickness Absence rate is now 4.6% down from 4.88% in Mar 21. The current in month absence split is 1.89% Short Term and 2.16% Long Term (28 days or more). • Over the same time frame, the UHSussex West in month rate for May (2.78%) saw a decrease from 3.58% in May 20. The 12 month Sickness Absence rate is 2.84% which is a reduction from 2.99% in March 21. The current in month absence split is 1.54% Short Term and 1.24% Long Term (28 days or more).	Sickness absence has significantly reduced across the organisation compared to the same time last year. However, this has been impacted by the recording of covid related absence separately to sickness absence. Isolation absence has significantly increased in July and the Trust is implementing the new PHE guidance on isolation to mitigate absences in key areas. A review is underway on the management of long covid absence. ER teams continue to support managers to manage sickness absence. New Health and Wellbeing at work policy has been drafted. Ongoing provision of health and wellbeing initiatives such as mental health first aid training, wellbeing webinars, wellbeing workshops.

Workforce KPIs - Commentary

University Hospitals Sussex
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Current Performance	Response / Actions planned
Appraisal • The June UHSussex (non medical) Appraisal rate stood at 81.7%. • The UHSussex East (non medical) Appraisal rate for June stood at 77.35%, down from a rate of 79.4% in May, but up on the June 20 rate of 71.26%. • In comparison the UHSussex West (non medical) rate increased to 86.66% over a 12 month period having stood at 75.68% in June 20.	Divisions are completing their A3s on increasing appraisal rates and identifying any additional support required. 3 Divisions are above 90%, 7 are between 80 and 90% and the remaining are below 80% Refreshed appraisal process is being developed with supporting training and guidance for managers. This will include wellbeing appraisal.
STAM • The UHSussex STAM compliance rate stood at 84.24% for June. • The UHSussex East Trust STAM compliance rate stood at 83.13%. • The UHSussex West Trust STAM compliance rate stood at 85.5%.	Completed STAM deep dive analysis across East and West UHSussex with specific corrective actions identified as follows: Increased frequency of compliance reporting, sourcing additional trainer capacity, sourcing additional training space capacity, bespoke reporting for Medical and Dental workforce. Continued deep dive analysis to support departments reporting lower compliance rates.
Vacancy • The June UHSussex overall Vacancy Rate stood at 9.29% • In June the UHSussex East overall Vacancy Rate stood at 8.65%, a slight increase from 8.47% seen in June 20. There are currently 747 FTE of vacancies across East. • The June the UHSussex West Vacancy Rate figure stood at 10.04% which has seen an increase from 8.11% in June 20. There are currently 727.5 FTE vacancies across West.	Recruitment and retention initiatives are focusing on our nursing workforce. Engagement and insight activities are in place to better understand how UHSussex can be a more attractive employer. New recruitment campaigns are being arranged aimed at attracting applicants from a wider demographic. One-stop recruitment assessment days are being introduced. Our induction and on-boarding arrangements are being updated to become be more timely and also more comprehensive.

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Sustainability

Integrated Performance Report Section

Sustainability Summary

University Hospitals Sussex NHS Foundation Trust

- The Trust is operating under an interim financial framework for April – Sept (H1), in which each Integrated Care System (ICS) has been provided with a fixed funding envelope; including resources to meet the additional costs of COVID-19.

- During 2020/21, COVID-19 significantly disrupted NHS elective services leading to long waits for patients who had been referred before the pandemic. To support activity recovery, the Department of Health created a £1bn non-recurrent fund to be used to support delivery of additional activity, the Elective Recovery Fund (ERF).

- Systems are expected to report a balanced position at the end of H1 and the agreement reached by the Accountable Finance Officers in the Sussex ICS is that the system would collectively and individually deliver breakeven positions in 2021/22

Sustainability
True North

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- The Trust True North domain 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 has 4 components:
  - I&E Performance: achieving the agreed I&E plan;
  - Cash: maintaining sufficient cash balances;
  - Capital: achieving the agreed capital plan; and
  - Efficiency: achieving the agreed efficiency programme.

- The overarching Financial Plan has been set in accordance with the H1 Financial Framework guidance in addition to local priorities. The target of the Financial Plan is to deliver breakeven whilst restoring elective services and supporting COVID recovery.

- The Q1 performance has delivered the breakeven Financial Plan.

Sustainability Key Metrics

University Hospitals Sussex NHS Foundation Trust

			G
I&E £k	**YTD Plan**	**YTD Actual**	**Variance**
Income	(324,298)	(321,151)	(3,147)
Operating Costs	318,898	315,689	3,209
Finance Costs	5,245	5,272	(27)
Performance Adjustments	155	190	(35)
Overall performance	0	0	0

In line with the financial framework guidance issued by NHSE/I, the Trust is reporting a break-even position at the end of Quarter 1.

			G
Cash £k	**YTD Plan**	**YTD Actual**	**Variance**
	92,415	94,701	2,286

The variance to plan reflects the under spend on the internally funded capital programme.

Following on from last year, the Trust's cash position remains strong and is expected to reduce as longer term commitments are realised.

			A
Capital £k	**YTD Plan**	**YTD Actual**	**Variance**
3T's Scheme	20,788	20,846	58
Operational Schemes:			
Internally Funded	7,414	4,491	(2,923)
Externally Funded	2,100	0	(2,100)
Overall performance	30,302	25,337	(4,965)

The externally funded operational schemes are £2.1m behind plan, pending NHSEI approval to access the funding. The internally funded operational schemes are £2.9m behind plan with business cases and orders now being progressed.

			G
Efficiency £k	**YTD Plan**	**YTD Actual**	**Variance**
	2,024	1,950	(74)

The year-to-date efficiency scheme is in line with the plan.

The full year efficiency plan is £24.4m and £24.9m of efficiencies have been identified. This will be delivered through a combination of productivity improvements, procurement opportunities and reducing premium spend.

Sustainability
Forward look to Q2 and beyond

University Hospitals Sussex
NHS Foundation Trust

- All NHS providers and systems have submitted their plans for elective recovery and ERF income in line with expectations. The thresholds for accessing ERF income have recently increased from 85% to 95% for July to September and the Trust is assessing the impact of this change.

- H2 2021/22 financial settlements are expected to be confirmed in Sept 2021, alongside issuing of guidance for the period to the end of March 2022. Planning templates are due to be submitted in November 2021.

- H1 system funding envelopes will be the starting point for H2 funding arrangements, albeit with a greater efficiency ask than H1, and block payment arrangements will continue.

- It is expected that COVID-19 and elective recover funding allocations will continue, coupled with an increased efficiency requirement.

Sustainability - Actions & Recommendations

University Hospitals Sussex NHS Foundation Trust

There are no actions required of the Board.

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

- The Quarter 1 performance has delivered the financial plan for I&E Performance, cash management and efficiency delivery.
- The year-to-date capital expenditure is £4.96m behind plan, due to delays on operational capital schemes.
- The key risks to financial performance, particularly the lack of guidance regarding the new financial framework arrangements for H2.
- Detailed financial performance information has been shared with Sustainability Committee; who continue to provide oversight on behalf of the Board.

NHS
University Hospitals Sussex
NHS Foundation Trust

Systems & Partnerships

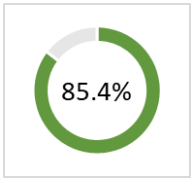
Integrated Performance Report Section

Performance Summary Q1

University Hospitals Sussex
NHS Foundation Trust

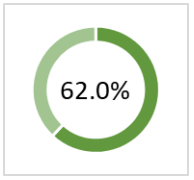
True North and Constitutional Standards

A&E



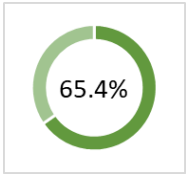
- Overall the Trust treated 85.4% of patients within 4 hours of attending A&E departments in Quarter 1 which was better than the National performance of 83.4%. There was considerable variation across the different units with the Princess Royal, Royal Alex Children's, and Sussex Eye Hospitals all achieving over 90%.
- There have been continued increases in the numbers of patients attending A&Es with both ambulance and self attending patient numbers at all departments which are well above pre-pandemic levels.

RTT



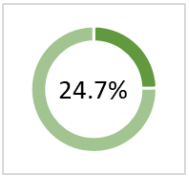
- The Trust has 62% of patients waiting less than the target 18 weeks at the end of June 2021, which is an improvement of +5.1% compared to the start of Quarter 1. Similarly the number of patients waiting over 52 weeks for treatment has reduced significantly from 10,030 at the start of April to 5,969 at the end of June.
- Overall the total number of patients waiting for elective treatment has increased slightly to 95,831 as a result of increasing elective demand but with activity levels increasing in both Trusts.

CANCER



- Overall 65.4% of patients who commenced cancer treatment were treated within 62 days. UHSussex West services achieved 60.2% and UHS East services achieved 71.8%.
- There has been an increase in over 62 day prospective waits in June, although the Trust has continued to reduce patients potentially waiting over 104 days for treatment. Both direct and tertiary cancer referrals to the Trust are now back to and above pre-pandemic levels. The Trust has plans in place to ensure a return to compliance by the second half of the year.

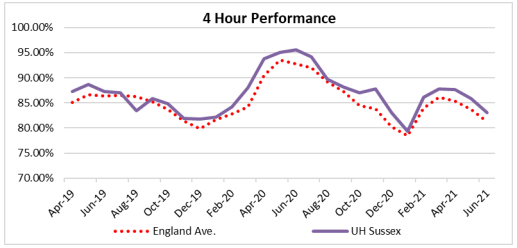
DIAGNOSTICS

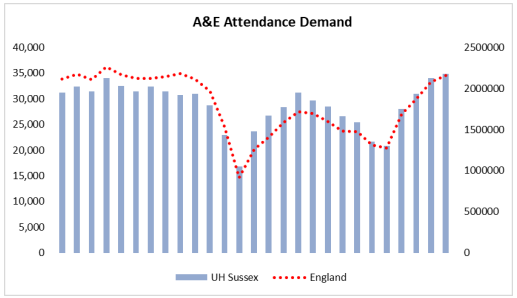


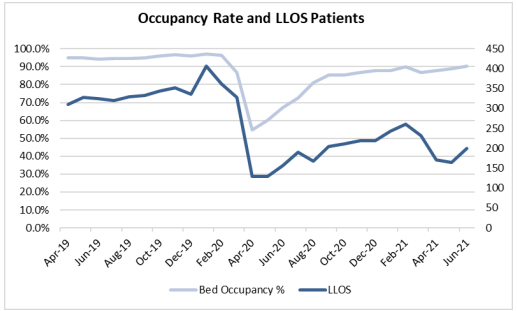
- Overall the Trust had 24.7% of patients waiting more than 6 weeks for a diagnostic test at the end of June which is an improvement of +11.3% compared to the beginning of April. UHSussex West services achieved 28.7% and UHS East services achieved 19.9%.

A&E UHSussex

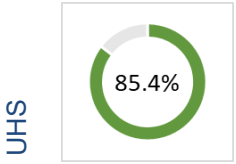
University Hospitals Sussex
NHS Foundation Trust

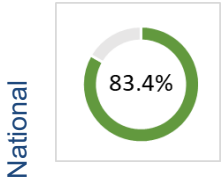






- A&E 4hr performance was 85.4% in Quarter 1, which was a deterioration of -2.4% compared to the same period in 2019/20.
- There was an overall increase of +5% in A&E attendances in comparison to 2019/20, above pre pandemic levels. However overall emergency admissions were -4.1% below 19/20.
- Performance was +2% above the National 4hr performance of 83.4% in Q1 2021/22.
- Bed occupancy was 89.0% on average, compared to 94.7% Q1 2019/20 and on average there were 178 patients in hospital for more than +21 days compared to 245 Q4 2019/20, and 321 Q1 2019/20.
- Whilst the above metrics describe quarterly performance, there has been material variation by site, by day, and by month in terms of increasing volumes and resulting pressures throughout the last 3 months at all of the A&E units.
- As the numbers of COVID patients reduced the hospitals de-escalated COVID capacity/configuration.
- The focus in Q1 was to maintain high levels of flow and the hospitals as general activity increases, but maintaining flexibility as covid wave 3 commenced July-21.

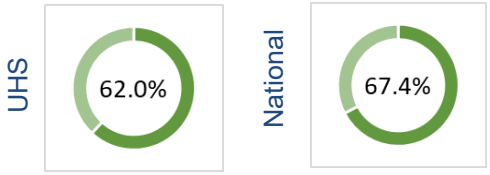


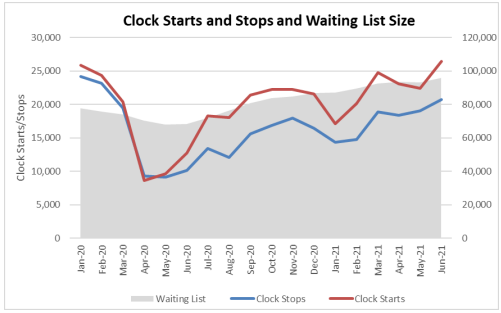


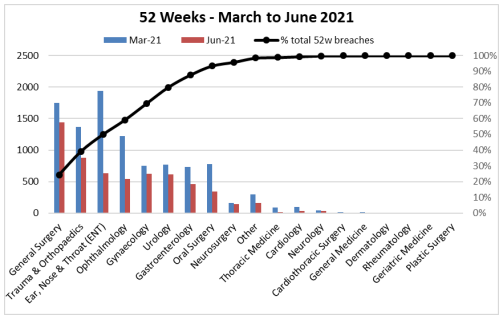
	2019/20				2021/22				
Site	Apr-19	May-19	Jun-19	Q1	Apr-21	May-21	Jun-21	Q1	*Target*
Time to Triage	19.0	17.5	19.0	18.5	15.8	17.7	18.8	17.4	15
Time to Treatment	86.1	83.9	88.0	86.0	83.6	91.4	99.8	91.6	60
Mean Wait Time	208.5	205.8	209.5	207.9	199.3	203.9	210.3	204.5	

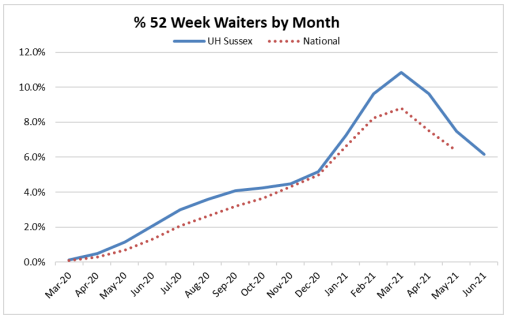
Elective Treatment (RTT) UHSussex

University Hospitals Sussex
NHS Foundation Trust





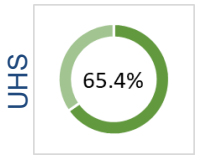


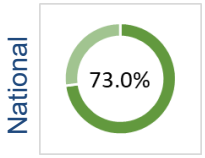


- RTT 18 weeks performance was 62.0% against the 18 week target at the end of June 2021, a +5.1% improvement since the beginning of April.
- There were 5,916 patients waiting over 52 Weeks end the quarter, compared to 10,030 at the start of March 2021, an reduction of 4,114 patients (-41%). The Trust is one of the fastest recovering Trusts in the country in terms of both restoring activity levels and reductions in the number of long waiting patients.
- There has been an increasing number of elective referrals (clock starts) throughout the quarter, with levels 94% restored compared to Quarter 1 2019/20, but with an overall increasing trajectory.
- As a result overall referrals into the Trust were +11% higher in June-21 compared to June-19 which resulted in the growth in the overall numbers of patients waiting.
- The numbers of patients starting definitive treatment was 92% restored in Q1 relative to 2019/20, with June restoration of 101% compared to June-19.
- As a result of the gap in demand (clock starts) to demand (clock stops), the total RTT Incomplete waiting list was 95,831, an increase of 3,240 since March-21
- Most challenged specialties with largest numbers of 52 week waits are General Surgery (which includes colorectal surgery/endoscopy), and Orthopaedics although all specialties have significantly improved their long waiting position.

Cancer Treatment UHSussex Total

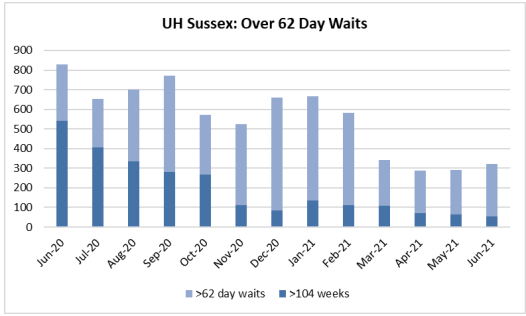
University Hospitals Sussex
NHS Foundation Trust

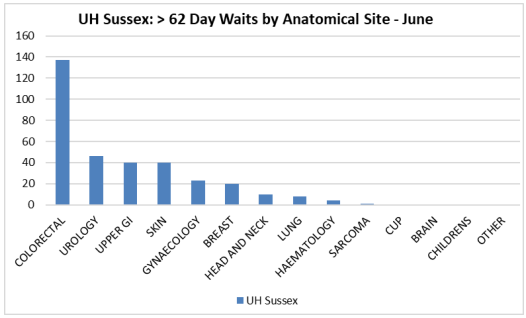


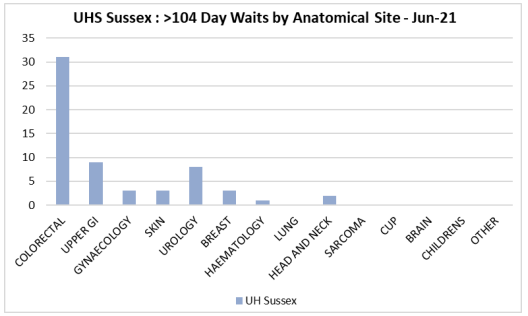


	Apr-21	May-21	Jun-21	Target
62 Day - GP Refs	68.09%	65.35%		85%
28 Day FDS	71.2%	74.5%	74.1%	75%
> 62 Day Prospective Waits	267	301	323	207
> 104 Day Waits	71	66	55	53

- 62 day referral to treatment targets were not met in May-21 with 65.4% of patients starting treatment in under 62 days against the 85% National target. National performance was 73.0%.
- The Trust has achieved significant improvement against the new 28 Day Faster Diagnosis Standard in Quarter 1, with performance of just above 74% against the 75% target since May-21.
- Cancer referrals have increased significantly, and were above +9% above June-19 levels, with most of this growth within the colorectal/lower GI and skin tumour sites.
- At the end of June 2021 UHSussex had 323 patients waiting > 62 days for cancer treatment. There were 55 104 day patients waiting end June-21
- As a result of both the increased new demand, the high levels of patients waiting for diagnosis, endoscopy and treatment post pandemic, the largest number of patients waiting longer than both 62 days and 104 days are in colorectal services.
- The Trust has plans in place for all Cancer services, and in Endoscopy both the West and East services of the Trust have increased activity to well above 100% of pre-covid levels through comprehensive plans including new pathways, insourcing, and extra-capacity.

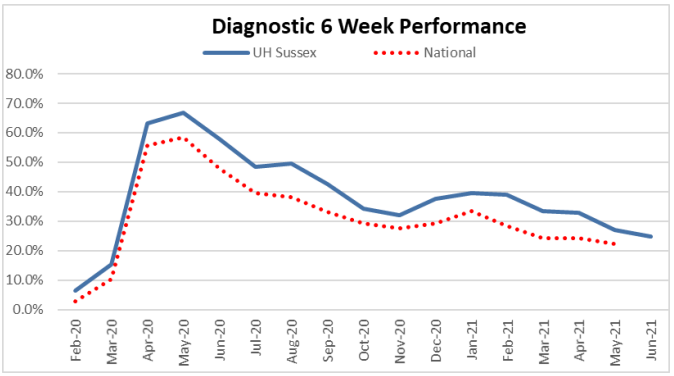


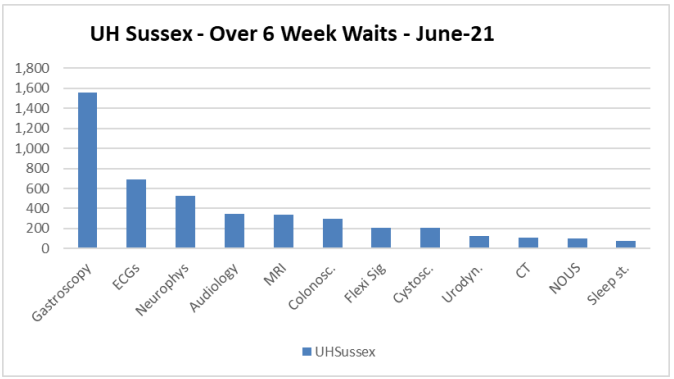




Diagnostics UHSussex

University Hospitals Sussex
NHS Foundation Trust





- UHS performance was 24.7% of patients waiting longer than 6 weeks for a diagnostic at the end June, a +8.6% improvement from the beginning of April.
- National performance was 22.3% (May-21).
- The most impacted area of diagnostics in both Trusts as a result of the COVID pandemic was Endoscopy where activity was largely focused on emergency activity only
- Endoscopy staff were also redeployed through the first and second waves to the emergency departments and critical care to support the increases in capacity to treat COVID patients at those peaks.
- As staff have now largely returned to their core services both Trust have developed and implemented significant recovery plans for Endoscopy, which also include those patients waiting for a planned follow up Endoscopy that were delayed during the pandemic.

Activity Recovery Progress

University Hospitals Sussex NHS Foundation Trust

OP FIRST	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Target	70%	75%	80%	95%	95%	95%
Plan	88%	85%	97%	93%	96%	97%
Actual	98%	107%	112%			

OP FUP	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Target	70%	75%	80%	95%	95%	95%
Plan	78%	82%	93%	93%	95%	97%
Actual	114%	109%	113%			

EL DC	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Target	70%	75%	80%	95%	95%	95%
Plan	85%	106%	117%	108%	110%	106%
Actual	103%	116%	116%			

EL IP	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Target	70%	75%	80%	95%	95%	95%
Plan	85%	106%	117%	103%	120%	110%
Actual	96%	104%	108%			

- In terms of current performance, the Trust met and exceeded target recovery activity levels in April, May and June
- The ICS in Sussex is the second highest nationally in terms of overall recovery of activity, and UHSussex one of the highest Trusts nationally, including the ‘accelerator’ Trusts who received additional funding.
- Nationally all organisations have been issued with a revised activity target (backdated to start of July’21) of 95%. This is a +10% increase on previous target of 85%.
- The Trust’s performance over the first 3 months of 2021/22 gives confidence that this target is achievable if current performance is maintained and based on the existing plans, however there are key risks to maintaining activity at this level.
- The most notable risks are the continued impact and stretch on the Trust’s workforce given the pandemic and increased emergency and elective activity.
- Similarly the Trust has seen some increase in patients admitted with COVID over the last month, and the impact on non-elective and elective demand increases.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	11	**Meeting:**	Board	**Meeting Date:**	5 August 2021
Report Title:	Patient Committee Chair report to Board				
Committee Chair:		Jackie Cassell, Committee Non Executive Chair			
Author(s):		Jackie Cassell, Committee Non Executive Chair			
Report previously considered by and date:					

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

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

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

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

Communication and Consultation:

Executive Summary:

The Patient Committee met on the 27 July and was quorate as it was attended by four Non-Executive Directors, the Trust Chair, the Chief Nurses and Chief Executive. In attendance was Director of Improvement and Delivery along with members of the patient experience and quality teams. The Committee also heard directly from a patient on their experiences of the Trust and wider NHS services and the work the Trust is undertaking as a result of this feedback.

The Committee received its planned items including the reports on the respective Patient First Trust North, Breakthrough and Strategic Initiatives, patient experience reports, an update on the work being undertaken in respect heath inequalities and the BAF.

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 the BAF risk 1.1, for which it has oversight, that for the start of quarter 2 this is fairly represented.

University Hospitals Sussex
NHS Foundation Trust

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
Patient Committee	**27 July 2021**	**Jackie Cassell**	yes	no
			✓	☐

Declarations of Interest Made

There were no declarations of interest made

Assurances received at the Committee meeting

Patient Stories

The Committee **RECEIVED** information on two patient stories. One of these was from the patient themselves who provided both an insight into their experiences, and of other patients with disabilities on a group she has established, both within the Trust and the wider NHS and also offered some practical ways improvements could be made. The Committee **NOTED** the work the Trust intends to do to secure improvements resulting from this feedback. The second story was taken as background to a patient who is due to attend the Committee in October 2021 to give their observations directly to the Committee with the Trust feedback on the improvement work undertaken.

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 Committee **NOTED** the work being undertaken in respect of the True North and Breakthrough Objective and recognised that for both of these there is a need to progress from the analysis phase to the delivery phase with a clear set of improvement actions with clear timeframes and prioritisation. The Committee requested that outcomes are measured against the progress from the current patient feedback levels to those expected so that these projects clearly show the Committee the value to the patient as judged by the patients themselves, drawing on insights from highly scoring areas The Committee was **ASSURED** over the work undertaken within the strategic initiative and corporate projects and the planned actions.

Committee Activity

The Committee **RECEIVED** reports on the patient experience feedback and the actions taken as a result, for quarter 1 of 2021/22. The Committee **NOTED** the feedback provided through the various mechanisms where we capture patient comments and feedback. The Committee was **ASSURED** that the Trust is driving forward on the explicit improvements made as a result of patient feedback.

The Committee **NOTED** the update from the Chief Nurse on the Quality Governance Steering Group and the Patient Experience Engagement Group (PEEG). The Committee **NOTED** there were no matters which either Groups were seeking Committee support or action. The Committee **NOTED** that PEEG received the Brighton and Hove Healthwatch report which was included within the meeting papers. The Committee **NOTED** that report.

The Committee **RECEIVED** an update on work the Trust is undertaking in collaboration with the ICS in relation to health inequalities and that this work is starting with elective patients with learning disabilities. The Committee **NOTED** this was at an early stage and asked for a further update to come to the next meeting.

ICS Update

The Committee **NOTED** there was nothing further to update the Committee outside the information already provided in respect of health inequalities and the work the Trust is engaging with within the area of experiences for patients with learning disabilities.

RISK

The Committee had a detailed discussion on the BAF risk 1.1 and the level of assurances flowing to the Committee and recognised that whilst earlier discussions had been in respect of the Committees' expectation for greater clarity on actions to secure higher levels of patient experience in the key areas underpinning the Trust's True North and Breakthrough Objective. Following the discussion, the Committee **AGREED** the quarter one score for risk 1.1 was fairly stated in the BAF.

Actions taken by the Committee within its Terms of Reference

There were no specific actions taken within the Committee other than the recommendation of the BAF risk 1.1 current quarter 2 score to the Board.

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

The Committee asked that a further update be provided on the Trust's work with the ICS to address health inequalities is brought back to the next meeting ahead of a more detailed report within the last quarter of the year.

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

Item	Date
The Committee following a detailed discussion felt it could recommend to the Board that the risk within the BAF for which it has oversight is fairly represented.	To Board 5 August 2021

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	12	**Meeting:**	Board	**Meeting Date:**	5 August 2021
Report Title:	Quality Committee Chair report to Board				
Committee Chair:	Joanna Crane, Committee Non Executive Chair				
Author(s):	Joanna Crane, Committee Non Executive Chair				
Report previously considered by and date:					
Purpose of the report:					
Information	☐		Assurance	✓	
Review and Discussion	☐		Approval / Agreement	☐	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	☐		Staff confidentiality	☐	
Patient confidentiality	☐		Other exceptional circumstances	☐	
Implications for Trust Strategic Themes and any link to BAF risks					
Patient	✓				
Sustainability	☐				
People	☐				
Quality	✓	Assurances in relation to risk 4.1 and 4.2			
Systems and Partnerships	☐				
Link to CQC Domains:					
Safe	✓		Effective	✓	
Caring	✓		Responsive	✓	
Well-led	✓		Use of Resources	☐	
Communication and Consultation:					

Executive Summary:

The Quality Committee met on the 27 July 2021 and was quorate as it was attended by four Non-Executive Directors, the Chair, the Chief Nurse and the Chief Executive. In attendance were the Trust's Medical Directors, Chief Operating Officer for RSCH and PRH along with senior members of the Trust's patient and quality teams along with senior staff from the maternity service.

The Committee received its planned items including the reports on the respective Patient First Trust Norths, Breakthrough Objectives, Strategic Initiatives and Corporate Projects, quality performance reports, the national Ockenden report metrics, reports covering SIs and the respective learning, duty of candour audit outcomes, learning from deaths reports, reports on patient experience, reports from the Committees respective reporting groups and the Board Assurance Framework.

Key Recommendation(s):

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

The Board is asked to **NOTE** the Committee recommendation in respect of the BAF risk 1.1, for which it has oversight, that for the start of quarter 2 this is fairly represented.

University Hospitals Sussex
NHS Foundation Trust

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
Quality Committee	**27 July 2021**	**Joanna Crane**	yes	no
			✓	☐

Declarations of Interest Made

There were no declarations of interest made

Assurances received at the Committee meeting

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

The Committee **RECEIVED** updates on the delivery of the respective True Norths, Breakthrough Objective, Strategic Initiative and Corporate Project. The Committee **NOTED** the significant level of work being undertaken in respect of the Trust strategy deployment. The Committee asked that within future updates that the respective focus of the True North on harm reduction and the Breakthrough Objective are as delineated as possible. The Committee was **ASSURED** over the work undertaken and the planned actions.

Committee Activity

The Committee **RECEIVED** an update on the work being undertaken to further develop the Trust's Quality Governance Framework which ensures that the best of the former frameworks within BSUH and WSHFT is retained whist ensuring the framework delivers against the UHSussex merger ambitions to make these processes as efficient as is possible. The Committee also recognised how this work links to the Patient Corporate Project.

The Committee **RECEIVED** reports in respect of the learning being drawn from reported incidents and was **ASSURED** over the actions being taken to improve processes. This included learning from the first waves of Covid and how those lessons had brought about changes when dealing with the current wave.

The Committee **RECEIVED** reports on the Trust's quality performance metrics and the work that is planned to better align these dashboards to the propose of this Committee and allow a separate dashboard to be developed for the Patient Committee focused more on patient experience outcomes.

The Committee **RECEIVED** the Trust's learning from deaths reports for quarter 1 of 2021/22 nothing that these remained spilt across the hospital sites of St Richards, Worthing and Southlands and Royal Sussex County and Princess Royal. The Committee was **ASSURED** over the progress made with undertaking structured judgement reviews where medical examiner investigation recommended the process be applied to seek out learning and **NOTED** the whilst there were low levels of poor care identified where shortcomings were noted robust actions and feedback loops had been established to promote learning.

The Committee was **ASSURED** over the Trust's continued levels of compliance with the duty of candour and the rigours auditing processes applied to provide this assurance.

The Committee **RECEIVED** reports on patient experience, which included the annual reports for the former Trusts of BSUH and WSHFT and the 2021/22quarter 1 reports for UHSussex. The Committee **AGREED** the annual reports would be recommended to the Board for publication, which are attached at appendix 1 and 2 to this report. The Committee **NOTED** the feedback provided through the various mechanisms and the

actions as result and the Committee was **ASSURED** that the Trust is driving forward on the explicit improvements made as a result of patient feedback.

The Committee **RECEIVED** an update from the Chief Nurse and Medical Directors on work of the Quality Governance Steering Group and former Quality Board. The Committee **NOTED** there were no matters which either Groups were seeking Committee support or action on but **NOTED** that their work supported many of the workstreams providing reports to the Committee, including, end of life care which is supporting the Trust learning from deaths and work on ventilation supporting the learning from covid wave 2.

ICS Update

The Committee **RECEIVED** an update on work within the ICS on Child and Adolescent Menth Health provision and the focus given by the system on the learning from never events and serious incidents.

RISK

The Committee **RECEIVED** an update on process of oversight through the respective divisions and the Quality Governance Steering Group of all highly scored quality risks and **NOTED** that the work on the datix project will see more efficient reporting of risks to each Committee supporting their review of the BAF.

The Committee reviewed the BAF risks it has oversight for, and **AGREED** that that risk 4.2 was correctly increased reflecting the workforce pressures and that risk 4.1 should remain unchanged.

Actions taken by the Committee within its Terms of Reference

The Committee **AGREED** to review its Terms of Reference now it has undertaken a cycle of SDR meetings and the more formal quarterly meeting.

Items to come back to Committee (Items the Committee is seeking to keep an eye on)

There were no specific matters over those planned within its cycle of business that it asked to return to the Committee.

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

Item	Date
The Committee recommended to the Board the publication of the 2020/21 Annual Patient Experience Reports for BSUH and WSHFT.	To Board 5 August 2021
The Committee recommended to the Board that the risk within the BAF for which it has oversight is fairly represented.	To Board 5 August 2021
The Committee referred to the People Committee a legacy action in respect of safeguarding training performance and the need to understand if the reduction in reported performance was due to an change in the frequency required for this training, This referral was made as the People Committee receive the reports on mandatory training compliance.	To the People Committee 28 July 2021

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Agenda Item:	12	**Meeting:**	Trust Board	**Meeting Date:**	July 2021
Report Title:	BSUH Legacy Patient Experience Annual Report 2020-2021				
Sponsoring Executive Director:	Carolyn Morrice, Chief Nurse				
Author(s):	Anne Middleton, Associate Director for Quality Jane Carmody, Head of Patient Safety, Experience, and Engagement Hannah Pacifico, Patient Experience and Engagement Manager				
Report previously considered by and date:					

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

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

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

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

Communication and Consultation:

This report has been prepared by the Patient Experience team. It links to the Patient True North objective.

Executive Summary:

The purpose of this report is to bring to the attention of the Board qualitative and quantitative patient experience data collected from patient and public engagement, the Friends and Family Test (FFT), local and national patient surveys (NPS) and informal and formal concerns received by Brighton and Sussex University Hospitals NHS Trust (BSUH) in 2020/21.

Key Recommendation(s):

The Board is asked to note this report for information and assurance.

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Patient Experience, PALS and Complaints Annual Report 2020/21

BSUH legacy report Royal Sussex County, Princess Royal, Sussex Eye and Royal Alexandra Children's Hospitals

1. Introduction

The purpose of this report is to bring to the attention of the Board qualitative and quantitative patient experience data collected from patient and public engagement, the Friends and Family Test (FFT), local and national patient surveys (NPS) and informal and formal concerns received by Brighton and Sussex University Hospitals NHS Trust (BSUH) in 2020/21.

1.1. The Patient First improvement methodology continues to underpin our True North of keeping 'The patient first and foremost' in everything we do.

1.2. The Patient Experience, Patient Advice and Liaison (PALS) and divisional complaint managers work closely with the Divisional Quality and Safety Managers (DQSM) to ensure triangulation of quality and safety events and embed learning across all specialties. This enables Trust-wide triangulation of issues, clear accountability and greater visibility of patient experience from ward to Board.

2. Patient Experience during COVID-19 pandemic

2.1. The COVID-19 pandemic necessitated a shift in emphasis from responding to patient feedback received, to proactively creating positive experiences.

2.2. The Patient Experience team quickly responded to the emerging pandemic and introduced a number of initiatives to enable patients to maintain contact with their loved ones. Plans are in place for these to continue post COVID:

- **Bringing families together** - mobile telephones were provided for patients without access to a mobile device, enabling them to facetime/skype their family and friends.

- **Hearts for the dying and the bereaved** - together with community volunteers and the critical care and palliative care teams we provided matching pairs of handmade hearts to be shared between dying patients and their loved ones.

- **Letters to loved ones** - Relatives and friends unable to visit our hospitals are able to write to their loved ones via bsuh.letterstolovedones@nhs.net or call the PALS team who will print or transcribe the message and ensure that it is quickly and safely delivered.

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2.3. The NHS Complaints process was suspended in April 2020 due to the COVID-19 pandemic. Both the PALS and Complaints teams were redeployed to a variety of roles, using their specific skills and knowledge to support communication with patients, their relatives and representatives, during this fast changing and difficult time.

3. Learning from feedback

3.1. Patient feedback identified a number of learning opportunities across the organisation.

3.2. Examples of **'You said - We did'** in 2020/21

- 'Hello my name is' badges provided for all non-clinical staff working in the Emergency Departments
- The introduction of whiteboard magnets to alert staff to those patients requiring assistance at meal and snack times due to hearing or sight impairment
- Detailed patient diaries, provided by the occupational and physiotherapy teams, to ensure a though and all-encompassing evaluation, avoiding the risk of failed discharges due to inadequate ward assessment
- The introduction of a Medical Examiner Officer role to liaise with bereaved families

4. Plaudits

4.1. Many patients, their families and visitors to the Trust take the time to give thanks for the care they, or their loved one, has received. These are received directly by staff teams or via the Trust website and NHS Choices. It is just as important for our staff to know when they have done things well and there is valuable learning from the positive feedback received.

4.2. All plaudits are recorded and shared with senior nursing and clinical teams and with the individual staff and teams involved. All letters of thanks and commendation are responded to in writing by the patient experience team or by the Chief Executive or her deputy.

4.3. Leaders of our clinical services use the feedback to shape quality improvement activities at ward level and to measure improvements to patient experience over time.

4.4. 1,210 plaudits were received for our services in 2020/21.

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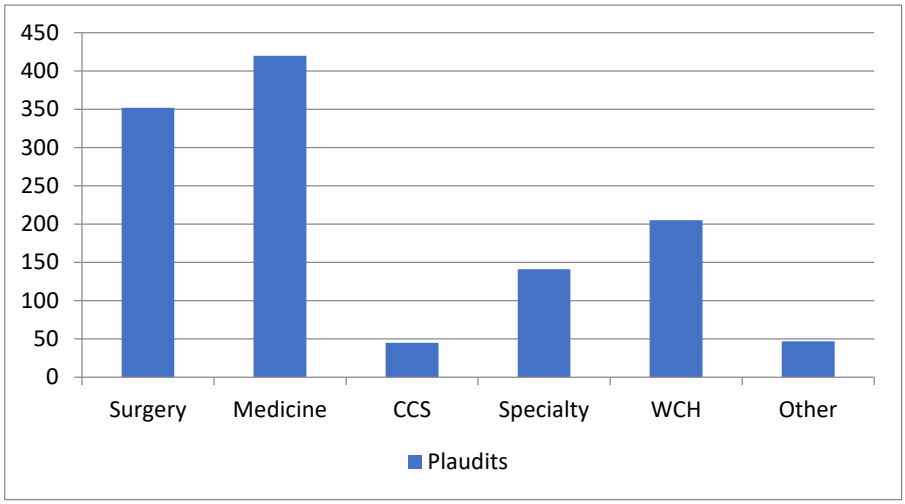
4.5. Chart 1: Plaudits received by Division



4.6. Table 1: Plaudits received by Division and Quarter 2020/21

	Q1	Q2	Q3	Q4	Total
Surgery	90	61	80	121	352
Medicine	118	65	46	191	420
CCS	4	10	9	22	45
Specialty	27	22	19	73	141
WCH	73	21	54	57	205
Other	19	6	12	10	47

4.7. Examples of plaudits received in 2020/21

- *My thank you to you, is that the Princess Royal and its staff is an amazing place; my daughter and son were both born there, we've had a few minor knocks and illnesses since and the service you always give is first rate*

- *I just wanted you and your staff to know that I was extremely impressed with the efficiency and speed that my appointment was handled. The contact from the hospital to make the appointment was so quick - a great relief to me. Even though the appointment on the day was delayed I was kept fully informed of the delay - which did not cause me any problems. The Registrar and the Nurse were extremely polite, professional and helpful. I could not have expected better treatment from them*

- *I would just like to say a huge thank you to staff and volunteers at Sussex House. I had my jab yesterday. The whole process was made very easy and was extremely well organised from beginning to end*

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- *Just wanted to say a huge thank you to all staff and volunteers for the fantastic work you do… and the complete love and dedication of the staff at the Trevor Mann Unit*

- *I would just like to convey my sincere gratitude and thanks for the service I received, from the ambulance personnel up to the consultant and the tea lady - everybody was most kind and courteous, and waiting time was minimal, thank you all - three cheers to the NHS!*

5. How we Share and Act on Feedback

5.1. Patient feedback (including PALS, complaints, Friends and Family Test and local and national patient surveys) is reported and discussed at the monthly divisional governance meetings. The divisional report (produced by the Divisional Quality and Safety Manager - DQSM) is also a standing item on the monthly Patient Experience and Engagement quality management group (PEEG) agenda. The divisions also present a deep dive into their patient experience and engagement data, and the quality improvements actions they have taken in response to the feedback received, on a rotational basis.

5.2. Patient stories arising from feedback are routinely shared with the teams involved and via PEEG (Appendix 1).

5.3. Issues are escalated from PEEG to the Quality Assurance Committee (QAC). This meeting, together with the Patient Experience Engagement Committee (PEEC), facilitates Non-Executive Director review of patient experience feedback and the associated quality improvement activities.

5.4. The Chief Nurse is the Executive Lead for patient experience and provides regular reports to the Trust Board, providing an oversight. Quarterly reports are shared at public Trust Board meetings.

6. Friends and Family Test (FFT)

6.1. The Trust aims to give every patient the opportunity to respond to the FFT question 'Overall how was your experience' within 48 hours of discharge.

6.2. Trust goal: to achieve a greater than 22% response rate with a satisfaction score of more than 95%.

6.3. From 1 April 2018 an external company has been contracted to collect FFT data electronically, using text (SMS) and interactive voice messaging (IVM) across all areas of the Trust. Since this time the number of inpatients (including children's services) responding to the FFT has increased from an average of 11% to 25%.

6.4. Despite FFT data collection being suspended on 1 April 2020 (in response to the COVID-19 pandemic) 50,471 patients responded to the FFT question in 2020/21.

6.5. In 2020/21 the average inpatient recommend rate was 93.1%.

6.6. Whilst this is below the target of 95% it is important to note that, due to the method of electronic collection, the average rate is commonly lower than other methods of collection i.e. paper surveys.

6.7. The national Inpatient FFT average response rate for February 2021 (latest available data) was 23.7%. In the same period, BSUH had an average response rate of 25.1%.

6.8. Table 2: FFT recommend rates 2018 – March 2021

Patient Touchpoint	2018/19	April 2019 - February 2020	December 2020 - March 2021
Trust wide	93.60%	92.91%	92.00%
A&E	89.40%	88.10%	88.20%
Maternity/Birth	97.80%	95.70%	94.60%
Inpatient & Day Case	93.30%	93.83%	93.10%
Outpatient	93.90%	94.00%	93.60%

6.9. The Patient Experience team engaged with the FFT Development Project in 2018/19, which included the trial of the new FFT question. Following this, NHS England implemented revised guidance on 1 March 2020 including the use of a new FFT mandatory question and six new response options:

6.10. Table 3: FFT questions:

A&E	Thinking about your recent visit to A&E, overall how was your experience of our service?
Inpatients	Thinking about your stay in hospital, overall how was your experience of our service?
Outpatients	Thinking about your recent appointment, overall how was your experience of our service?
Maternity (antenatal)	Thinking about our antenatal service, overall how was your experience of our service?
Maternity (birth)	Thinking about our maternity service, overall how was your experience of our service?
Maternity (postnatal community)	Thinking about our postnatal community service, overall how was your experience of our service?

6.11. The six new response options are:
- Very good
- Good
- Neither good nor poor
- Poor
- Very poor
- Don't know

6.12. There is also opportunity for free text feedback in response to the question "Please tell us why you gave that response."

6.13. FFT feedback is reported on a monthly basis to the Heads of Nursing and included in the quality scorecard provided to the Trust Board. All ward staff and department managers are provided with training and access to the live FFT feedback system (envoy) which allows then to access their data in real time.

6.14. Table 4: FFT Feedback: Top words and themes 2020/21

Top 10 Words (Positive)	Top 10 Words (Negative)	Top 10 Themes (Positive)	Top 10 Themes (Negative)
Staff (13851)	Staff (840)	Staff Attitude (24768)	Staff Attitude (2052)
Good (5927)	Time (828)	Implementation of Care (13627)	Environment (1726)
Attitude (4281)	Waiting (812)	Environment (9890)	Waiting Time (1491)
Excellent (3794)	Hours (766)	Patient Mood / Feeling (7973)	Communication (1427)
Time (3773)	Doctor (596)	Communication (7213)	Implementation of Care (1352)
Service (3772)	Pain (587)	Waiting Time (7213)	Clinical Treatment (1188)
Thank (3730)	Nurse (521)	Clinical Treatment (5999)	Patient Mood / Feeling (1134)
Friendly (3669)	Wait (521)	Admission (4670)	Admission (938)
Care (3432)	Seen (423)	Staffing Levels (2007)	Staffing Levels (416)
Helpful (3106)	Left (398)	Catering (634)	Catering (174)

7. National Patient Surveys 2020/21

7.1. National patient surveys and the action plans arising from them are presented to, and monitored via, the Patient Experience and Engagement Group.

7.2. There were no National Patient Surveys published during 2020/21.

7.3. Table 5: Surveys undertaken in 2020/21 due to be published in 2021/22

	Patients receiving care	Sampling	Fieldwork period

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The Urgent and Emergency Care Survey	September 2020	October 2020	Oct 20 – March 21
The Adult Inpatient Survey	November 2020	December 2020	Jan 21 – May 2021
The Children and Young People's Patient Experience Survey	Nov/Dec 2020	January 2021	Feb 21 – June 2021
National Cancer Patient Experience Survey	April 2020 – June 2020	March 2021	April 21 – July 2021
National Maternity Services Survey	February 2021	May 2021	June 2021 - TBC

8. Patient Experience and Engagement activity

8.1. Community engagement continued throughout 2020/21 despite the COVID-19 pandemic. Initiatives included 3Ts way finding focus groups and an engagement event - attended by over 50 members of the public, Healthwatch, Clinical Commissioning Groups (CCG) and Possabilty People – to raise awareness of the Patient Knows Best service and provide an opportunity for comment on the system before its launch.

8.2. In 2020/21 BSUH strengthened it partnerships with commissioners, other NHS providers, local authorities and Voluntary and Community Sector organisations to plan and provide coordinated care and communication across the Sussex Integrated Care System.

9. NHS Choices

9.1. Patients have the opportunity to provide feedback on our services via public forums such as NHS Choices and Patient Opinion. The Patient Experience team responds to all such posts and shares the feedback received with the appropriate teams. Our NHS choices site covers 12 pages: a BSUH specific page and separate pages for our hospitals and satellite units.

9.2. Examples of NHS Choices comments received in 2020/21

- *Having broken my ankle in three places I was referred to the fracture clinic in Brighton. From the outset the communication and treatment was first class, despite the pressure of the ongoing pandemic. The appointments I was asked to make were met with curious staff and prompt (I don't mind waiting if necessary but didn't have to) x rays, then consultation. The care I have received is a testament to our NHS staff and how we are all looked after*

- *Our daughter attended for a minor surgical procedure. At first we went to the wrong building. The receptionist there couldn't have been more helpful in pointing us in the right direction. Additionally, a nurse phoned through to the correct ward and told staff there we were on our way. A member of the cleaning*

staff was also helpful in telling us where we needed to go once in the main hospital building. Subsequently, while waiting for our daughter to have her operation (admittedly, a few hours, but not unexpected), a nurse asked us if we wanted a drink and gave us some biscuits. Small gestures, perhaps, but ones that were very much appreciated. The procedure was a success and our daughter felt she'd had received a great service

- *My teen has Aspergers and recently needed surgery for an injury, which was very stressful, as they don't cope well with anything unexpected or new. What made it better is that the staff listened to us and worked in partnership to make the op go as smoothly as possible. Our surgeon, anesthetist and nurse were all absolutely brilliant - having them onside and being so understanding of my child's needs made a huge difference to the experience so thank you to all on Ward 7, you are a fabulous team!*

- *I had wonderful treatment from very caring and compassionate Doctors and Nurses. It was so well managed in these difficult circumstances. First class treatment and care. Thank you all*

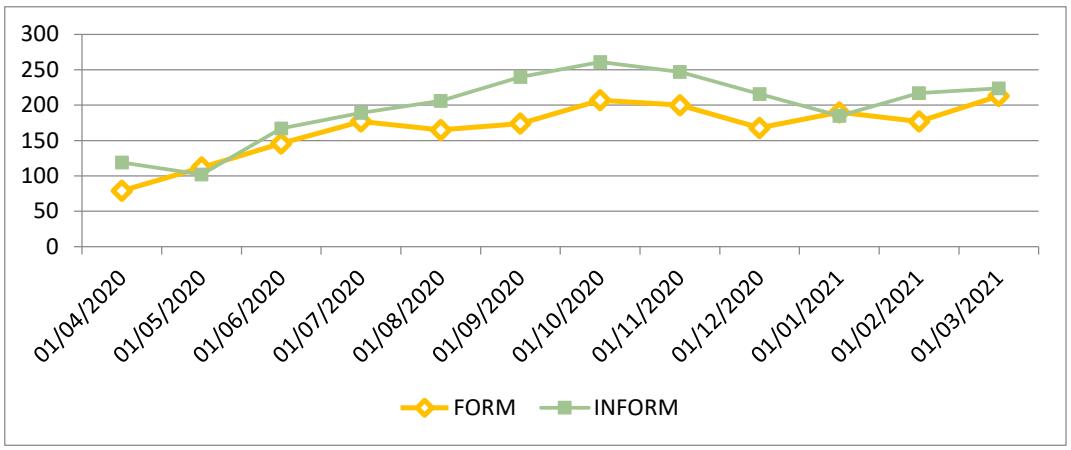
10. Complaints and PALS

10.1. Since April 2018 all concerns received by the Trust are categorised and managed as either an informal or formal concern. All concerns raised about the Trust are triaged by the PALS team and, wherever possible, quickly resolved without the need for a formal written response from the Medical Director or Chief Nurse.

10.2. The complaints monthly scorecard is accessible to all divisions and directorates via a shared drive. This allows all specialties easy access to their complaints data, including a specific report highlighting concerns about staff attitude.

10.3. In 2020/21 the Trust received 2371 informal and 2004 formal concerns.

10.4. Chart 2: Informal and formal concerns received April 2020 - March 2021



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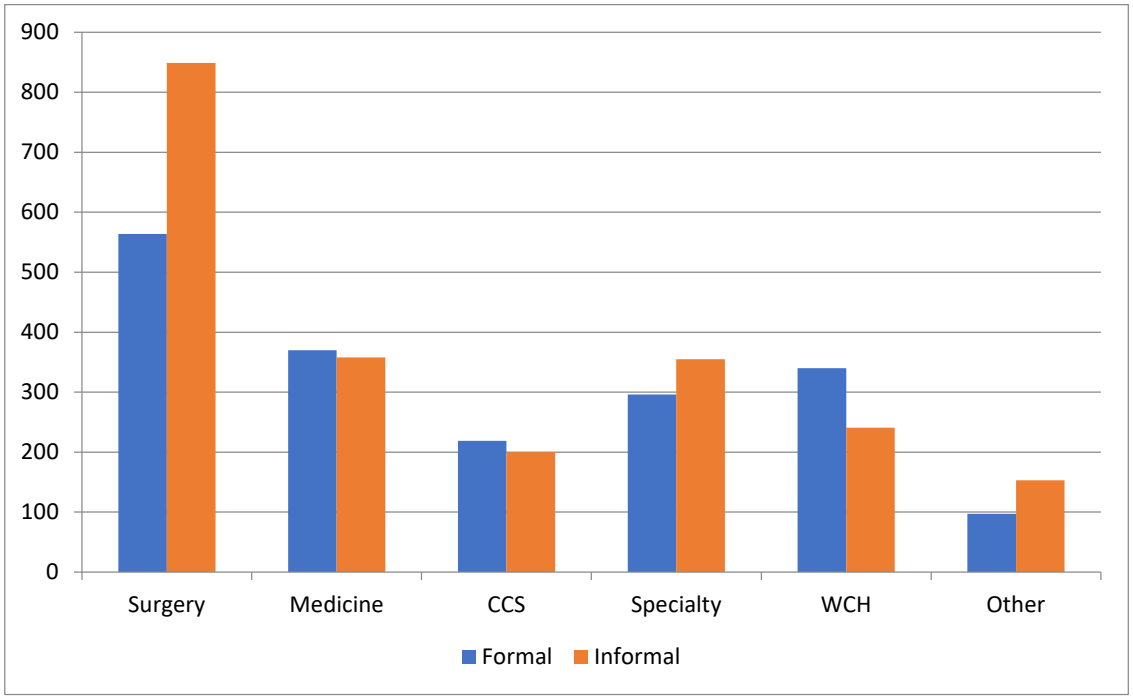
10.5. Chart 3: 2020/21 Informal and formal concerns received by Division



10.6. Table 6: Complaints by patient activity 2020/21

Type	Total Attendances	Formal Rate per 100	Informal Rate per 100
Inpatients and Day cases	129,006	1.5	1.8
Emergency Department	153,725	1.3	1.5
Outpatients	511,912	0.4	0.5

10.7. Chart 4: Cases received by type and financial year

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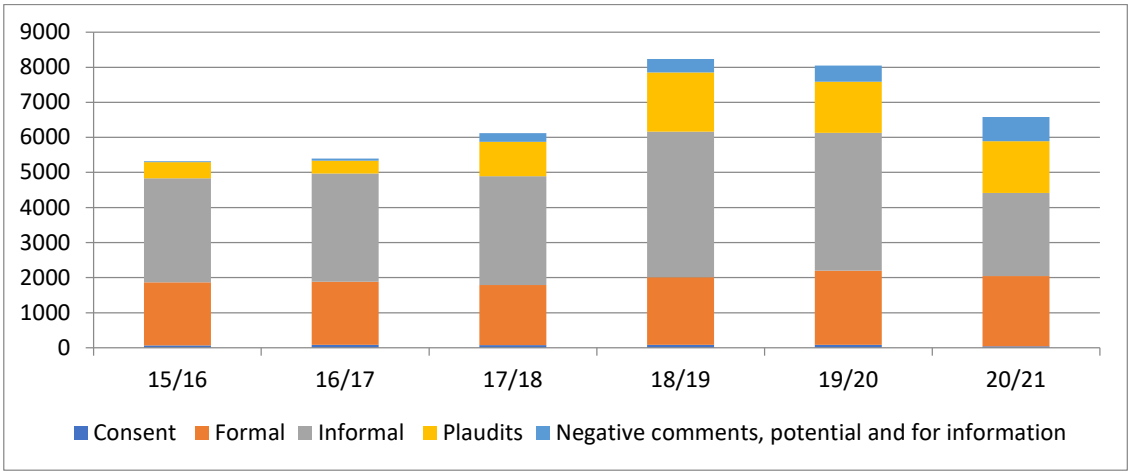


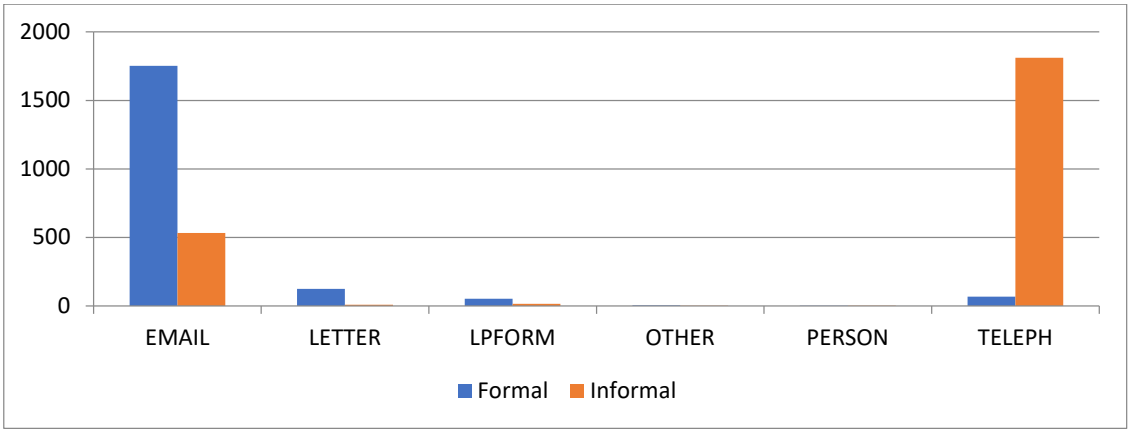
10.8. Table 7: Cases received by type and financial year (excluding plaudits)

	15/16	16/17	17/18	18/19	19/20	20/21	Total
Consent	64	88	74	80	88	44	438
Formal concerns	1805	1792	1719	1929	2114	2004	11363
Informal concerns	2968	3089	3096	4153	3930	2371	19607
Information requests	20	60	242	377	459	524	1682
Totals:	4857	5029	5131	6539	6591	4943	33090

10.9. Table 8: Concerns received by site

	Other	Hurstwood Park	PRH	RACH	RSCH	SEH	SOTC	Total
Formal	113	15	187	136	1471	54	16	1992
Informal	128	111	570	94	1267	98	86	2354
Totals:	241	126	757	230	2738	152	102	4346

10.10. Chart 5: Method of contact 2020/21



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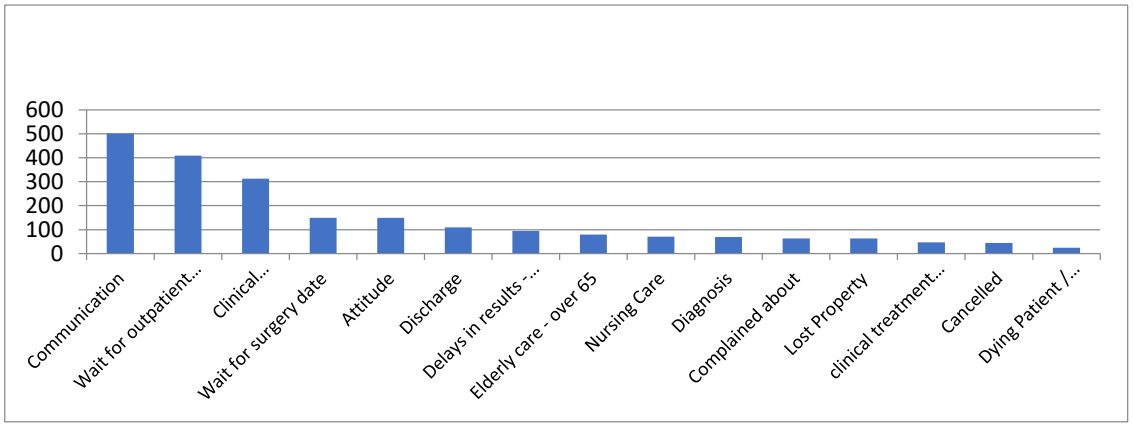
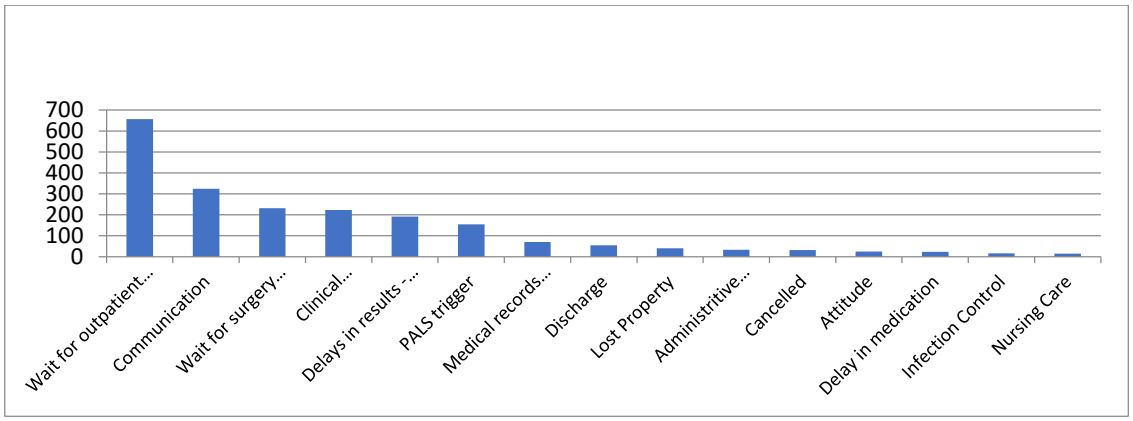
10.11. Chart 6: Top 15 themes cited in formal concerns

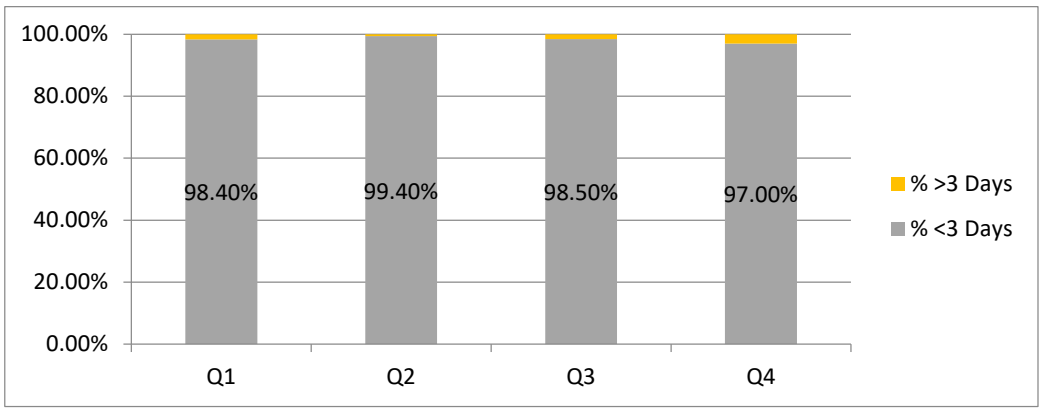


10.12. Chart 7: Top 15 themes cited in informal concerns



10.13. The Trust has an internal target to respond to formal complaints within three working days.

10.14. Chart 8: Formal Concern Acknowledged within three working days



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10.15. BSUH aims to respond to 95% of informal concerns and 80% of formal concerns within 25 working days. In 2020/21 the Trust responded to 98.1% of informal concerns and 78.6% of formal concerns within this timeframe.

10.16. Table 9: Formal concerns performance

2020/21	Q1	Q2	Q3	Q4	Total
Opened	336	516	575	577	2004
Closed	324	452	580	552	1908
Reopened	31(0.9%)	56(1.1%)	58(1.0%)	41(0.7%)	186(0.9%)
Closed within 25 WD	84.3%	76.5%	80.9%	76.5%	78.6%

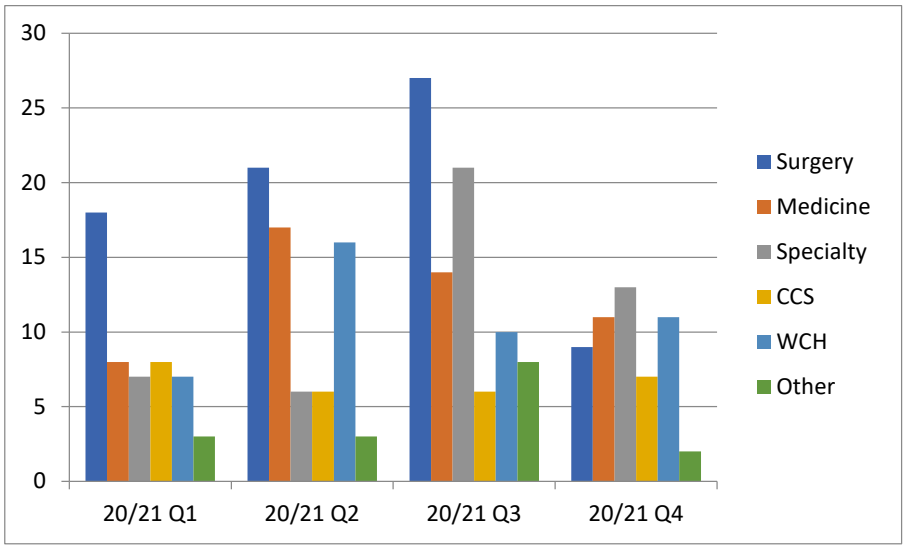
10.17. Table 10: Informal concerns performance

2020/21	Q1	Q2	Q3	Q4	Total
Opened	388	635	723	625	2371
Closed	379	621	733	619	2352
Reopened	20(0.5%)	13(0.2%)	33(0.5%)	14(0.2%)	80(0.3%)
Closed in 25 WD	99.1%	97.9%	97.9%	98.0%	98.1%

10.18. Table 11: 25 WD response rate% by Division

	Surgery	Medicine	CCS	Specialty	WCH	Other
Formal	80.6%	58.0%	91.0%	83.4%	77.6%	94.7%
Informal	98.3%	95.4%	100.0%	98.9%	97.1%	100.0%

10.19. Chart 9: Reopened Concerns by quarter



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10.20. Table 11: Reopened concerns by quarter

Reopened	20/21 Q1	20/21 Q2	20/21 Q3	20/21 Q4	Total
Surgery	18	21	27	9	75
Medicine	8	17	14	11	50
Specialty	7	6	21	13	47
CCS	8	6	6	7	27
WCH	7	16	10	11	44
Other	3	3	8	2	16

11. Second stage review of the NHS Complaints Process – the Parliamentary and Health Service Ombudsman

11.1. The Parliamentary and Health Service Ombudsman (PHSO) represents the second and final stage of the NHS complaints process. The Trust continues to work directly with PHSO to resolve complaints.

11.2. The PHSO's Principles for Remedy are central to the Trust's management of complaints. We always try to speak directly with anyone who is unhappy with the care either they or their family members have received and hope to agree with them how best to resolve their concerns. Once the issues of the complaint have been thoroughly investigated patients and/or their representatives will receive a verbal or written response from the CEO or, if they prefer, will be invited to meet with senior medical and nursing staff to discuss their experiences in person. If, despite all our efforts, complainants remain unhappy with our response to their concerns they can request an independent review of their complaint by the Ombudsman.

11.3. In 2020/21 three complaints were accepted for second stage review by the PHSO. This represents 01.5% of all formal concerns received by the Trust in year. Of these, no complaints were fully upheld or partially upheld, with one remaining open from the previous year.

11.4. Table 12: PHSO cases closed in 2020/21

ID	PHSO opened	PHSO Closed	Findings and learning	Progress
44881	21/07/2020	01/03/2021	No failings in the actions of the Trust	NOT UPHELD
43296	07/07/2020	01/01/2021	No failings in the actions of the Trust	NOT UPHELD

11.5. Table 13: PHSO cases 2015 – March 2021

	2016/17	2017/18	2018/19	2019/20	2020/21
Total number of formal concerns	1792	1719	1929	2114	2004
Number of formal concerns accepted by the Ombudsman	19	9	12	5	3
***Number of these formal concerns upheld by the Ombudsman**	2	0	1	0	0
***Number of these formal concerns partly upheld by the Ombudsman**	4	2	1	1	0

12. Patient First True North Breakthrough Objective 2021/22 – Patient Discharge

12.1. We want all our patients to have a safe and positive experience of being discharged from our hospitals; we know this issue has a substantial impact on our patient experience of care and it is therefore one of the key pillars of our Patient Experience Strategy. It is also now a Trust Breakthrough Objective to support its True North Goals in 2021/22.

12.2. The Patient True North is for all patients to have a positive experience of the care they receive, with a target of 95% of patients rating FFT surveys as 'Very Good 'or 'Good'.

12.3. The Chief Nurse is the executive lead for the Breakthrough Objective and holds weekly huddles with support from the Kaizen team to monitor progress of the improvement work that remains ongoing.

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Appendix 1

Example Patient Story

PATIENT STORY

Patient Experience Team

BRIGHTON & SUSSEX UNIVERSITY HOSPITALS NHS TRUST

For the attention of ward staff

The Trust's Patient Experience, PALS and Complaints Team received concerns from the family of a patient who was recovering on one of our wards following surgery.

The family of the patient, who has since sadly passed away, would like to share her anonymised story with you.

Mary was 76 years old and recovering on a surgical ward from a spinal operation. Unfortunately, due to emergency trauma patients being admitted, Mary had to be woken in the middle of the night and temporarily transferred to a different ward.

This was, understandably, very distressing to both Mary, and to her family, who were not informed that she had been moved to another ward.

As well as this, Mary's family explain that she was not someone to make a fuss and would not have wanted to be a bother to staff.

They believe that this resulted in delays in her being given pain relief on both wards as she would not always ask for assistance and, at times, had called her family in tears, as she had been waiting for so long.

When Mary did use her call-bell it was not always responded to as quickly as it could have been, causing her further upset when her family say she was experiencing unbearable pain.

What can we learn?

Mary's family believe that her quiet and unimposing nature, together with her wish not to be a burden to staff, meant that the nursing team did not always realise how much pain she was experiencing and how quickly she needed attention.

Mary's family hope her story will help staff to recognise other patients, like her, who may not seem in need of help or attention, but very much are.

What can we do?

- Highlight to the person in charge of the ward if a requested transfer of a patient seems inappropriate
- Always inform families if a patient does have to be moved to a different ward. Mary's family say if they had been contacted they would have had the opportunity to insist she was not moved after such a major operation, and a more appropriate patient to transfer could have been identified
- Provide timely pain relief as per the World Health Organisation (WHO) analgesic ladder and ensure patients understand how their pain scores effect the analgesia they receive
- Respond to call bells as quickly as possible and reassure patients you will tend to them as soon as you can
- Be aware of those patients who may be keeping their pain to themselves,
- Open lines of communication - a quiet patient may not be a settled patient. Regularly check that they are comfortable and not in need of assistance

THANK YOU FOR READING

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	12.2	**Meeting:**	Trust Board	**Meeting Date:**	July 2021
Report Title:	WSHFT Patient Experience Annual Report 2020/2021				
Sponsoring Executive Director:	Maggie Davies Joint Chief Nurse				
Author(s):	Ashlee Metcalfe head of Patient Experience Tracey Nevell patient Experience Team Lead Janet Campbell Patient Experience & Insight Officer – Patient Experience Team				
Report previously considered by and date:					

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

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

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

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

Communication and Consultation:

The purpose of this report is to provide a review of the Patient Experience data collected through the Friends and Family Test (FFT), the real time survey system, National surveys as well as themes from PALS enquiries and formal complaints received during 2020/2021.

Executive Summary:

- FFT data collected shows an overall performance of 93% patients rated their experience as very good or good.
- During 2020/21 an overall response rate of 64% was achieved, marginally missing the 65% goal.
- The top two themes during 2020/21 for formal complaints were attributed to clinical treatment and oral communication.
- During 2020/21 the top two themes in PALS were date for appointment and clinical treatment.

Key Recommendation(s):

The Board are asked to note the content of this report.

University Hospitals Sussex
NHS Foundation Trust

Patient Experience Annual Report

2020 – 2021

Worthing, St. Richard's & Southlands Hospitals

Presented by:
Ashlee Metcalfe – Head of Patient Experience
Tracey Nevell - Patient Experience Team Lead
Janet Campbell – Patient Experience & Insight Officer

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Introduction

Patient experience matters. Patient experience is a fundamental consideration when reviewing the safe effective delivery of care. The Trust's vision is that all patients will feel safe, comfortable and listened to whilst in our care. Overall, excellent patient experience is indicative of excellent patient care.

The Trust's strategy and Patient First Programme is the commitment where patients are at the heart of everything we do and that a patient centred way of working is embedded across the Trust. Improving patient experience is our long term approach to transforming our services for the better, by giving staff the skills to deliver continuous improvement and to put our patients first.

During 2020/21 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 complaints[1].

The purpose of this report is to provide a review of the feedback data collected through these methods during the fiscal year 2020/21.

Patient Experience During the National Covid-19 Pandemic

The impact of the Coronavirus (COVID-19) has been, and continues to be, profound. The virus has had a huge impact on the delivery of NHS care, with staff having to adapt services under huge pressure, while ensuring our hospitals remain a safe environment for patients and staff. The following schemes were introduced during the Pandemic to enable patients to maintain contact with their families and friends while visiting was suspended or restricted;

- **Messages for Loved Ones**
  A dedicated email address was set up to enable patients' families and friends to send a personal message in confidence. Alternatively, loved ones could call the PALS team to leave a message. These personal messages were then printed and laminated and delivered to inpatients.

- **"Thinking of You" Messages**
  A number of local schools and parish groups have written in to support and lift the spirits of our more isolated patients by sending in messages or drawings, to let them know they are being thought of.

- **Keeping in Touch**
  Every inpatient ward has received an iPad to enable staff to offer help to patients who have relatives that are able to and would like to facetime each other during the visiting restrictions. Mobile telephones have also been made available across the wards for patients who do not have mobile technology to be able to telephone their relatives.

- **Handmade "Thinking of You" Heart**
  Handmade hearts were provided in pairs, one for the patient and the second for their loved one, for those receiving palliative care and patients in our ITU areas. The Chaplaincy team offered support to these patients and their families and the ward teams proactively made daily contact with a nominated relative to update them on the care and comfort of patients receiving end of life care.

Due to Covid-19 priorities, NHS England (NHSE) suspended the collection and reporting of FFT data, however the implementation of the new FFT format was completed in the Trust during the months of July and August, across all patient touchpoints. This was scheduled as part of the restoration to business as usual, and automated reports to divisions have recommenced. FFT data submission to NHSE is due to start with December 2020 data being submitted in January 2021.

The Patient Experience team saw a reduction in PALS and complaints during the height of the pandemic as a result of reduced activity and visiting. This allowed the team to work with the clinical staff to facilitate responses on behalf of the divisions whilst they were clinically operational.

[1] Friends and Family Test is a national survey used to measure patient experience

Learning from Feedback

As a result of PALS and complaints received, there were many opportunities identified for learning across the organisation. The complaints team developed an improvement tracker that is shared with the divisions to capture and monitor actions taken as a result of feedback. Examples of these initiatives were as follows:

- Video conferencing was updated allowing scan reporting to be e-mailed directly to the requesting physician.
- An alert was added to the electronic prescribing system alerting staff to “must give” medications.
- Communication sheets are now in place to improve dialogue between staff and next of kin on the wards.
- The introduction of a Medical Examiner Officer role to liaise with bereaved families.

Compliments

Plaudits and shared experiences help our service learn from the positive feedback received across the organisation from patients and relatives to the Chief Executive’s office and from wards/departments. There were 839 compliments captured during the year, summarised by division below:

Division	Q1	Q2	Q3	Q4	**Total**
Medicine	43	90	51	76	**260**
Core Services	64	59	53	54	**230**
Women & Child Health	57	73	25	30	**185**
Surgery	6	31	44	36	**117**
Corporate	21	4	4	3	**32**
Facilities & Estates	0	1	1	6	**8**
Unknown	0	0	0	7	**7**
Total	**191**	**258**	**178**	**212**	**839**

How we Share and Act on Feedback

The Chief Nurse is the Executive Lead for patient experience and provides regular reports to the Trust Board, providing an oversight. Quarterly reports are shared at public Trust Board meetings.

Non-Executive Directors’ review the patient experience feedback and associated quality improvement activities at the Quality Assurance Committee (QAC). Further reviews occur on a quarterly basis at the Patient Experience Engagement Committee (PEEC). Membership of PEEC includes representation from: Director of Estates and Facilities, Director of Research, Innovation and Clinical Effectiveness, Head of Nursing for Outpatients and Access, Trust Company Secretary, Coastal West Sussex Clinical Commissioning Group, Trust Governors, and Healthwatch. Their role is to review the programme and be assured that action on improving and responding to patient experience concerns are addressed.

Patient experience monthly reports are provided to operational teams and patient comments are automatically shared with our staff. Leaders of our clinical services use the feedback we receive from patients to shape quality improvement activities at ward level and see whether the improvements we are making improve patient experience over time.

Local Improvements Implemented during 2020/21, improving Patient Experience

True North Breakthrough Objective - Noise at Night

Sleep is important for healing; sleep deprivation is recognised as a major concern for patients in hospital and has been shown to lead to induced stress, increased pain sensitivity, high blood pressure and poor mental health. The two most recent National Inpatient Surveys carried out in 2017 and 2018 (published in 2018 and 2019 respectively) confirmed that noise at night, particularly from other patients, was a major area requiring improvement. National trends are similar, with the CQC reporting around 40% of patients are affected by noise from other patients at night time, a figure which has been static for some time.

For 2019/20 we set ourselves a goal to improve noise at night satisfaction from 54% to 65% as measured by our inpatient real time patient experience surveys. We narrowly missed this target and therefore continued this programme of work in 2020/21, building on our positive successes and aiming to embed approaches put in place as business as usual.

We aimed to deliver and maintain patient satisfaction scores at 65% through 2020/21 however the volume of data was very limited due to the Covid-19 impact on patient experience volunteers not being able to conduct the surveys with patients and they were paused for most of the year. For those surveys carried out, satisfaction in 2020/21 was 57%.

True North Breakthrough Objective – Patient Discharge

We want all our patients to have a safe and positive experience of being discharged from our hospitals; we know this issue has a substantial impact on our patient experience of care and it is therefore one of the key pillars of our Patient Experience Strategy. It is also now a Trust Breakthrough Objective to support its True North Goals in 2021/22. Up until now, we have only asked inpatients about their discharge experience and they have rates their satisfaction of discharge planning on average at 53%.

The Trust has been working hard over the past year to support patients to spend the shortest possible time in hospital; through our 'discharge before midday' work stream we have worked to ensure a smooth and timely process for our patients on their day of discharge during the Covid-19 Pandemic.

During 2020/21 we aimed to improve the discharge experience for all patients by improving the discharge process and timeliness of discharge activities. To support this, the Kaizen team produced an A3 plan to focus on improvement which is in the first phase. A number of actions were taken:

- Data was gathered and triangulated from PALS, complaints and surveys.
- A Discharge Quality Board was set up to review progress of this objective with multidisciplinary input.
- Virtual discharge surveys were commenced by a group of volunteers to gather information about patients' experience of their discharge.

Other Forms of Feedback – Healthwatch Reports

590 People's Stories of Leaving Hospital during Covid-19

The purpose of the report is to bring to the attention of the Committee the findings of a recent Healthwatch report centered on the experience of almost 600 patients, carers and staff about their hospital discharge during the coronavirus pandemic. The final report was published on the Healthwatch website in October 2020.

Following on from last year's feedback to Healthwatch through comments in response to their national 'Because We All Care' campaign, a closer look at people's experiences of leaving hospital during the coronavirus pandemic (COVID-19) was undertaken. Previous reports 'Healthwatch England's 'Safely Home' and the British Red Cross report 'Home to the Unknown' and 'In and out of hospital' found that when the hospital discharge process is not followed properly, people can feel lonely and uncertain about next steps.

Due to the pandemic, the NHS needed to urgently free up capacity in hospitals and to support this a new hospital discharge process was introduced nationally in March 2020. People leaving hospital who may need out-of-hospital support to recover would now have their ongoing support needs assessed after they were discharged, rather than in hospital.

The findings of these surveys highlighted that;

- 82% of patients did not receive a follow up visit or assessment from a health and care professional, with nearly 1 in 5 (18%) of those who did not receive a visit, reporting unmet needs after leaving hospital.
- 45% of patients with a disability and 20% with a long term condition shared that they had support needs that were not being met following their discharge.
- Patients with outstanding needs reported that they were unsure of
  - How to manage their condition following discharge

  - How to administer medication
  - Who to contact for further advice and support
  - Issues relating to provision of mobility aids and other equipment in the home
  - A lack of consideration of peoples' home situation e.g. Living at home or mobility constraints
- 64% of people discharged at night were not asked if they needed transport support. The main barrier to this was lack of communication. The impact of this was exacerbated at night.
- Patient transport featured highly in feedback. Waiting times and availability was impacted by the need to clean vehicles and poor co-ordination of transport arrangements varied from region to region. This is an issue that Healthwatch has previously raised prior to the pandemic.
- 61% of patients did not receive information about the new discharge process during their hospital stay. Owing to restrictions on hospital visits, there was also an ongoing need for families to have clear lines of communication with hospital staff and patients. However, family members and carers encountered difficulty with this in relation to updates, outcome of COVID testing and 47% did not feel involved in their loved one's discharge.
- 30% of patients tested for COVID did not receive their test results before they left hospital. Not receiving test results before discharge into the community was raised as a barrier to ensuring patients were able to manage their care safely after discharge and avoid putting family and carers at risk. This was particularly problematic for care homes which resulted in infection control issues.
- 19% of patients did not feel ready to leave hospital, felt rushed and unprepared. Paid carers reported problems that led to delays and readmission.

A number of recommendations have been made by Healthwatch in response to these findings, in the immediate, short and medium term as follows:

Immediate
- Providing a follow up contact for all patients being discharged.
- Improved COVID testing conducted on admission to all patients on discharge, ensuring that every patient discharged to a care home is tested.
- Routine offer of transport.
- Improved information about administration of medication and management of this to patients and carers.

Short term
- Increased follow up visits and assessment of ongoing healthcare needs.
- Review and clarification of discharge pathways to ensure all front line staff are confident in this in particular in preparation for winter.
- Roll out post discharge check-ins over the telephone or in person. A well-being check should be carried out to include holistic needs and other support services as appropriate.
- Improved access to equipment to support recovery.
- Involve carers and family despite visitation restrictions by improving special arrangements, support and providing a single point of contact.
- Continued improvement in technology.
- Improved policies and multidisciplinary involvement.

Long term
- Resource and commissioning to be acted upon to ensure beneficial and sustainable change is made for patients.

In summary, leaving hospital during the pandemic has been a very different experience to pre lockdown as a result of the transition causing additional stress for patients and their carers. NHS and care staff have had to deal with the pressures of implementing new systems at speed, and frequently changing guidance, while navigating additional burdens in their work all on top of the challenges of managing their own health.

Friends and Family Test

The Friends and Family Test (FFT) is a national survey designed to give patients a quick way to express their satisfaction with the care and service they have received. Initially, FFT results help raise any issues patients may have with any of our services, highlighting issues which are not raised through the formal

complaints process. Negative feedback is swiftly analysed and provides us with an initial step for improvement.

How Do We Monitor It?

The new national FFT question was implemented in July 2020 and can be asked at any time during a person's care and treatment. The question is phrased dependent on the 4 main FFT patient touchpoints, as below:

A&E	Thinking about your recent visit to A&E, overall how was your experience of our service?
Inpatients (including day case)	Thinking about your stay in hospital, overall how was your experience of our service?
Outpatients	Thinking about your recent appointment, overall how was your experience of our service?
Maternity (antenatal)	Thinking about our antenatal service, overall how was your experience of our service?
Maternity (birth)	Thinking about our maternity service, overall how was your experience of our service?
Maternity (postnatal community)	Thinking about our postnatal community service, overall how was your experience of our service?

The six new response options are:

- Very good
- Good
- Neither good nor poor
- Poor
- Very poor
- Don't know

There is also opportunity for free text feedback in response to the question "Please tell us why you gave that response, including what we could have done better to improve the experience for patients and their families/carers."

How Do We Report It?

Patient feedback, both from FFT comments and recommendation rates together with Real Time Patient Experience (RTPE) surveys are routinely provided directly to ward and department managers on a monthly basis. Key metrics are included in the Quality Scorecard provided to the Trust Board.

FFT - Specific Goals for 2020/21

Our True North goal is to increase FFT scores to a level that places us in the top 20% of NHS Trusts in the country for recommendation rates.

A&E:

- Our internal Trust target is to achieve a recommendation rate (of equal or greater than) 93% and a response rate of (equal or greater than) 20%. Achieving these internal targets would place the Trust in the top 20% NHS Trusts for FFT response and the top 30% position for recommendation rates.

Maternity:

- To improve our current very positive position aiming for a top 30% ranking for both FFT response rates and recommendation rates on both sites. It should be noted that the national FFT results for maternity only allow for comparison of the question asked at delivery. The Trust has set Maternity's response target at 40% and the recommendation target at 97%.

Inpatient:

- To achieve 40% FFT response rate for inpatients, 97% recommendation rate, and not to exceed 0.7% not recommend rate.

Outpatient:

- To improve FFT response rates and achieve recommendation rates in line with other touchpoints, of 97%.

FFT Performance 2020/21

Data presented by patient touchpoint is inclusive from December 2020 to March 2021, due to the suspension of reporting during the Covid-19 pandemic.

Patient Touchpoint	2020/2021 Data December 2020 to March 2021	2019/20	2018/19	2017/18	2016/17	2015/16
Overall Trustwide	93%	95.77%	96.65%	95.06%	94.20%	93.03%
A&E	90%	93.2%	95.2%	85.8%	89.01%	91.39%
Maternity/Birth	96%	97.9%	97.3%	97.8%	97.64%	96.20%
Inpatient & Day Case	97%	97.2%	97.3%	96.8%	96.06%	95.20%
Outpatient	98%	97.3%	96.8%	97.0%	95.43%	92.40%

National Patient Surveys

During 2020/21 we have participated in or received results for five key national surveys conducted on behalf of the Care Quality Commission (CQC):

- National Inpatient Survey 2019.
- National Maternity Care Pathway Survey 2019.

Summaries of our performance are listed in the sections below.

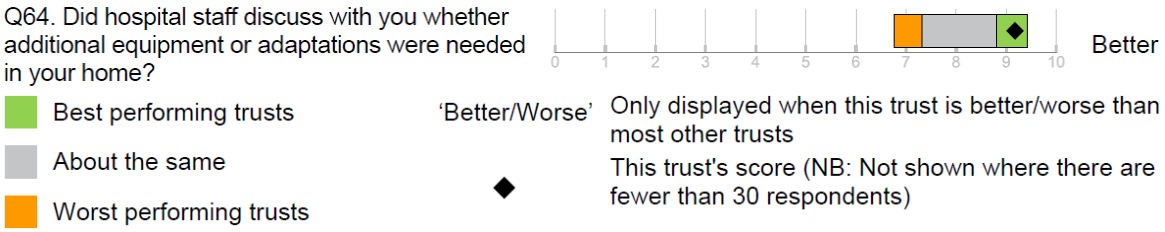
National Inpatient Survey 2019

To improve the quality of services that the NHS delivers, it is important to understand what people think about their care and treatment. One way of doing this is to ask people who have recently used health services to tell us about their experiences. The survey of adult inpatients involved 143 acute and specialist NHS Trusts in England with 76,915 (45%) of people responding.

Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital and were not admitted to maternity or psychiatric units. Patients were sampled from July 2019, with the sample size being a minimum of 1,250 patients.

Overall, 615 patients completed the questionnaire, (a response rate of 52%) compared with a national response rate of 45%.

The Trust's results were banded as 'about the same' as most trusts for 73 questions and better than most Trusts for 1 question:



There were no questions where the Trust was banded as worse than most Trusts.

Our top scoring questions scoring 9.0 or above (out of a possible score of 10) are as follows:

- Q4, Were you given enough privacy when being examined or treated in the A&E Department? (9.1);

- Q11, Did you ever share a sleeping are with patients of the opposite sex? (9.0);
- Q16, In your opinion, how clean was the hospital room or ward that you were in? (9.1);
- Q22, During your time in hospital, did you get enough to drink? (9.4);
- Q72, Did you feel well looked after by the non-clinical staff (9.3);
- Q27, Did you have confidence and trust in the nurses treating you? (9.1);
- Q28, Did nurses talk in front of you as it you weren't there? (9.2);
- Q36, How much information about your condition or treatment was given to you? (9.0);
- Q40, Were you given enough privacy when being examined or treated? (9.6);
- Q45, Did a member of staff answer your questions about the operation or procedure in a way you could understand? (9.0);
- Q64, Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home? (9.2);
- Q67, Overall did you feel you were treated with respect and dignity while you were in hospital? (9.2);

Our questions scoring 5.0 or below (out of a possible 10), are shown below:

- Q58, Did a member of staff tell you about medication side effects to watch for when you went home? (4.1);
- Q60, Did a member of staff tell you about any danger signals you should watch for after you went home? (4.9);
- Q70, During your hospital stay, were you ever asked to give your views on the quality of your care? (1.8);
- Q71, Did you see or were given any information explaining how to complain to the hospital about the care you received? (1.6);

Questions scoring lower than 2018, are identified below:

- Q16, In your opinion, how clean was the hospital room or ward that you were in? (moving from 9.3 to 9.1);
- Q19, How would you rate the hospital food? (moving from 6.0 to 5.3);
- Q23, When you had important questions to ask a doctor, did you get answers that you could understand? (moving from 8.5 to 8.1);
- Q29, In your opinion, were there enough nurses on duty to care for you in hospital? (moving from 7.9 to 7.4);
- Q43, If you needed attention, were you able to get a member of staff to help you within a reasonable time? (moving from 8.2 to 7.5);
- Q 48, Did you feed you were involved in decisions about your discharge from hospital? (moving from 7.3 to 6.5);
- Q49, Were you given enough notice about when you were going to be discharged? (moving from 7.6 to 6.7);
- Q53, How long was the delay (your discharge)? (moving from 7.9 to 7.3);
- Q57, Did a member of staff explain the purpose of the medicines you were to take home in a way you could understand? (moving from 8.4 to 7.9);
- Q59, Were you given clear written or printed instructions about your medicines (at discharge)? (moving from 7.8 to 7.1);
- Q60, Did a member of staff tell you about any danger signals you should watch for after you went home? (moving from 5.6 to 4.9);
- Q69, Your overall experience? (moving from 8.4 to 8.1);

Demographic Information relating to the respondents has been provided as shown below:

Data	WSHT	All Trusts
Number of Respondents	614	76,915
Response Rate	52%	45%
Demographic	WSHT %	All Trusts %
Male	48	48
Female	52	52

Aged 16-35	4	5
Aged 36-50	7	8
Demographic	WSHT %	All Trusts %
Aged 50-65	18	22
Aged 66 and older	72	65
White	96	92
Multiple ethnic group	0	1
Asian or Asian British	0	2
Black or Black British	0	1
Arab or other ethnic group	0	0
Not known	3	3
No religion	19	18
Buddhist	0	0
Christian	76	74
Hindu	0	1
Jewish	0	0
Muslim	0	2
Sikh	0	0
Other religion	1	1
Prefer not to say	3	3
Heterosexual/straight	95	93
Gay/lesbian	1	1
Bisexual	0	1
Other	0	1
Prefer not to say	4	4

Patient Experience Surveys (RTPE)

The Trust supplements the information received from the Friends and Family Test with more detailed inpatient surveys carried out by patients on hand-held tablets. Overall from April 2020 to March 2021, 1,258 surveys have been completed by patients in many different areas including inpatient wards, outpatients, paediatrics and a number of specialist services.

The data below references satisfaction by the use of the FFT question, for all surveys carried out:

Name of Survey	Satisfaction	Number of Surveys completed
Adult Inpatient	88%	198
Antenatal	80%	5
Birth & Post Natal	80%	10
Breast Screening Client (Mobile Units)	100%	17
Bronchoscopy	100%	13
Children's Inpatient	100%	28
Endoscopy Units	100%	2
Gynaecology Outpatients Clinics	99%	150
Neonatal Units	98%	132
PHIN (Private Patients)	94%	36
Physiotherapy Outpatients	94%	70
Postnatal Community	95%	42
Therapies Outpatient	96%	26
Virtual Discharge *	93%	489
Virtual Fracture Clinic	75%	40

** Question used "did you agree you were well enough to be discharged from hospital."*

In addition, there were 198 responses to the adult inpatient Real Time Patient Experience (RTPE) survey during this period, a reduction on the previous year following the suspension of RTPE surveys in March 2020, due to the Covid-19 Pandemic.

An overview is shown below, which identifies a trend of discharge planning, food and noise at night as the areas of most concern for patients:

Questions	2020									2021			Benchmark
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
FFT Recommend/Satisfaction	100	90	89	100	91	95	100	88	75	100	100	100	75
Welcome & Kindness	98	98	89	95	97	94	92	98	100	97	100	100	75
Cleanliness	88	91	87	98	93	89	88	93	100	94	96	100	75
Food	68	70	60	64	73	74	68	78	75	89	75	94	75
Assistance with Meals	100	91	92	95	100	100	98	97	100	100	100	100	75
Noise at Night	92	61	56	64	37	61	45	53	50	56	83	67	65
Call Button Response	95	88	77	94	90	100	93	98	100	100	75	83	75
Medication Explanation	92	94	87	95	95	100	94	97	100	100	100	100	75
Pain Control	92	98	78	100	93	100	96	100	100	100	100	100	75
Care Decisions	85	80	67	100	95	88	86	88	50	100	100	100	75
Discharge Planning	83	66	84	83	94	74	60	85	25	88	100	88	75
Communication	100	91	80	90	100	95	77	100	100	100	100	100	75
Privacy	89	88	91	83	82	82	89	88	83	86	83	81	75
Safe & Confident	100	100	88	95	95	100	96	100	100	100	100	100	75
Respect & Dignity	100	98	88	100	100	100	96	100	100	100	100	100	75
Trust Score	90	85	80	90	87	88	82	90	84	93	94	92	75
Number Of Responses	14	33	16	11	23	21	24	33	4	9	6	4	198

This data is broken down further by question and division overleaf:

		Cleanliness												Food												Assistance with Meals											
Division	Number of Responses	Apr - 20	May - 20	Jun - 20	Jul - 20	Aug - 20	Sept - 20	Oct - 20	Nov - 20	Dec - 20	Jan - 21	Feb - 21	Mar - 21	Apr - 20	May - 20	Jun - 20	Jul - 20	Aug - 20	Sept - 20	Oct - 20	Nov - 20	Dec - 20	Jan - 21	Feb - 21	Mar - 21	Apr - 20	May - 20	Jun - 20	Jul - 20	Aug - 20	Sept - 20	Oct - 20	Nov - 20	Dec - 20	Jan - 21	Feb - 21	Mar - 21
Medicine	45	100	-	-	-	90	88	84	97	-	94	-	100	75	-	-	-	65	73	70	81	-	81	-	100	100	-	-	-	100	100	96	100	-	100	-	100
Surgery	151	88	91	87	98	94	91	94	92	100	95	96	100	67	70	60	64	75	75	64	76	75	95	75	92	100	91	92	95	100	100	100	96	100	100	100	100
	Overall	88	91	87	98	93	89	88	93	100	94	96	100	68	70	60	64	73	74	68	78	75	89	75	94	100	91	92	95	100	100	98	97	100	100	100	100
	Total	13	33	15	10	22	21	24	32	3	9	6	4	13	32	15	11	22	21	23	32	3	9	6	4	13	32	16	11	22	21	24	32	3	8	6	3
		Call Button Response												Medication Explanation												Pain Control											
Division	Number of Responses	Apr - 20	May - 20	Jun - 20	Jul - 20	Aug - 20	Sept - 20	Oct - 20	Nov - 20	Dec - 20	Jan - 21	Feb - 21	Mar - 21	Apr - 20	May - 20	Jun - 20	Jul - 20	Aug - 20	Sept - 20	Oct - 20	Nov - 20	Dec - 20	Jan - 21	Feb - 21	Mar - 21	Apr - 20	May - 20	Jun - 20	Jul - 20	Aug - 20	Sept - 20	Oct - 20	Nov - 20	Dec - 20	Jan - 21	Feb - 21	Mar - 21
Medicine	45	100	-	-	-	100	100	90	93	-	100	-	50	100	-	-	-	100	100	97	100	-	100	-	-	-	-	-	-	88	100	93	100	-	100	-	100
Surgery	151	94	88	77	94	88	100	100	100	100	100	75	100	91	94	87	95	94	100	88	96	100	100	100	100	92	98	78	100	94	100	100	100	100	100	100	100
	Overall	95	88	77	94	90	100	93	98	100	100	75	83	92	94	87	95	95	100	94	97	100	100	100	100	92	98	78	100	93	100	96	100	100	100	100	100
	Total	13	32	15	11	23	21	23	30	3	8	6	3	12	33	16	10	22	21	24	32	3	8	6	3	13	33	16	11	23	21	24	32	3	9	6	3
		Care Decisions												Discharge Planning												Communication											
Division	Number of Responses	Apr - 20	May - 20	Jun - 20	Jul - 20	Aug - 20	Sept - 20	Oct - 20	Nov - 20	Dec - 20	Jan - 21	Feb - 21	Mar - 21	Apr - 20	May - 20	Jun - 20	Jul - 20	Aug - 20	Sept - 20	Oct - 20	Nov - 20	Dec - 20	Jan - 21	Feb - 21	Mar - 21	Apr - 20	May - 20	Jun - 20	Jul - 20	Aug - 20	Sept - 20	Oct - 20	Nov - 20	Dec - 20	Jan - 21	Feb - 21	Mar - 21
Medicine	45	100	-	-	-	80	85	80	81	-	100	-	-	100	-	-	-	67	70	54	69	-	75	-	50	100	-	-	-	100	94	77	100	-	100	-	100
Surgery	151	83	80	67	100	100	91	100	91	50	100	100	100	82	66	84	83	100	78	71	92	25	100	100	100	100	91	80	90	100	100	-	100	100	100	-	-
	Overall	85	80	67	100	95	88	86	88	50	100	100	100	83	66	84	83	94	74	60	85	25	88	100	88	100	91	80	90	100	95	77	100	100	100	-	100
	Total	13	33	15	10	22	21	24	32	3	8	6	3	12	30	16	10	21	20	23	28	2	8	6	4	14	32	15	5	6	11	15	5	1	3	0	1
		Privacy												Safe & Confident												Respect & Dignity											
Division	Number of Responses	Apr - 20	May - 20	Jun - 20	Jul - 20	Aug - 20	Sept - 20	Oct - 20	Nov - 20	Dec - 20	Jan - 21	Feb - 21	Mar - 21	Apr - 20	May - 20	Jun - 20	Jul - 20	Aug - 20	Sept - 20	Oct - 20	Nov - 20	Dec - 20	Jan - 21	Feb - 21	Mar - 21	Apr - 20	May - 20	Jun - 20	Jul - 20	Aug - 20	Sept - 20	Oct - 20	Nov - 20	Dec - 20	Jan - 21	Feb - 21	Mar - 21
Medicine	45	75	-	-	-	90	90	89	93	-	75	-	75	100	-	-	-	100	100	94	100	-	100	-	100	100	-	-	-	100	100	94	100	-	100	-	100
Surgery	151	90	88	91	83	79	75	88	86	83	95	83	83	100	100	88	95	94	100	100	100	100	100	100	100	100	98	88	100	100	100	100	100	100	100	100	100
	Overall	89	88	91	83	82	82	89	88	83	86	83	81	100	100	88	95	95	100	96	100	100	100	100	100	100	98	88	100	100	100	96	100	100	100	100	100
	Total	14	30	14	10	23	21	24	31	3	9	6	4	13	32	13	11	22	20	23	30	2	9	6	4	13	32	16	10	22	20	23	30	2	9	6	4
		Welcome & Kindness												Noise at Night																							
Division	Number of Responses	Apr - 20	May - 20	Jun - 20	Jul - 20	Aug - 20	Sept - 20	Oct - 20	Nov - 20	Dec - 20	Jan - 21	Feb - 21	Mar - 21	Apr - 20	May - 20	Jun - 20	Jul - 20	Aug - 20	Sept - 20	Oct - 20	Nov - 20	Dec - 20	Jan - 21	Feb - 21	Mar - 21												
Medicine	45	100	-	-	-	95	93	88	100	-	100	-	100	100	-	-	-	25	89	40	50	-	50	-	0												
Surgery	151	98	98	89	95	97	95	100	98	100	95	100	100	92	61	56	64	40	33	57	55	50	60	83	100												
	Overall	98	98	89	95	97	94	92	98	100	97	100	100	92	61	56	64	37	61	45	53	50	56	83	67												
	Total	13	33	16	11	23	20	24	32	3	9	6	4	13	31	16	11	20	20	23	30	2	9	6	3												

Other Forms of Feedback – NHS Choices

Patients have the opportunity to provide feedback through public forums such as NHS Choices and Patient Opinion, the communications team respond to most of this feedback. Our NHS choices cover 4 pages: a WSHT specific page, and separate pages for Southlands, St Richard's, and Worthing hospitals. Our current scores are overall 5 stars. Patient comments throughout the year include:

- "I was very impressed with my first visit to A&E. From reception to the porters, doctors, x-ray staff and back again everyone was so polite, friendly, helpful and professional at every point of my visit. With all the pressure your staff are under during this crisis, I can only congratulate them all on their professionalism and dedication to their work. Thank you so very much."
- "Emergency admission with sepsis. Doctors and nurses straight onto the problem and saved my life. Thank you hardly seems enough."
- "I am 78 years old and spent my first ever hospital stay in Worthing Hospital. I was amazed at the professionalism and cheerfulness that I experienced every day. To see just how busy all levels of staff were and how they went about such taxing work has left me with the very best impression of the NHS."
- "All the way through from arrival at St. Richard's A&E to being admitted, my care was outstanding. Doctors, nurses, HCA's and catering staff were all obviously working at full capacity and above, but they were all amazing. Every person I encountered was totally professional and incredibly kind. I feel very fortunate to have this great hospital so close to me and can't praise the staff highly enough."
- "I have visited both Southlands and Worthing hospitals on a number of occasions, recently as an outpatient in different departments. On each occasion I have been very pleased with the service I have received. All the staff were friendly, efficient and professional. The standard of care I found to be excellent."
- "My mother sadly passed away on the Emergency Floor at Worthing hospital. We were allowed to sit with her in a private room in those last precious moments. Mum and our family were treated with compassion and the utmost respect and I wanted to thank the doctors, nurses and palliative care teams who made a very distressing time as comfortable and comforting as possible. Thank you all from the bottom of my heart."
- "As a disabled person my many experiences in hospitals have been traumatic, as many medical people do not treat me as a human being. I had to have a cataract operation at St. Richard's and was terrified. I need not have worried as all the staff were absolutely amazing. They treated me as a human being and were so kind, understanding, caring and truly wonderful. I cannot thank them enough for all they did for me. Well done to all the most wonderful staff at the eye surgery clinic."
- "Sadly I had to attend A&E due to an extreme reaction and unable to obtain a GP appointment, nor could pharmacist make a diagnosis. Felt so guilty attending and applying pressure, but what brilliant staff. Reassuring, kind and treated with courtesy, respect and kindness – cups of tea and biscuits offered throughout my stay there. I can't name the nurse in CDU last night, but she was lovely, straight talking, to the point but kind. She went of a break when I was discharged – huge thanks to her. The doctor that looked no older than my grandson was brilliant and kept coming back till he left for home at around 1 am. No doubt liked by staff as much, and I am sure he will go a long way in his career. Grateful thanks for all you did, particularly as you picking up the strain of so many other services."

PALS and Complaints Service

The Patient Experience Team gather and analyse patient feedback and provide advice on how and where to complain, investigate matters of concern and help facilitate a resolution when things have gone wrong. The Patient Advice and Liaison Service (PALS) carry out signposting, provide information, advice or reassurance and manage issues that can be resolved quickly, assisting patients/relatives who need time to discuss concerns and operate a triage service for telephone and face to face enquiries. The complaints team investigate more complex and serious concerns that require a formal investigation about past events.

Complaints & Patient Activity

The tables below show both inpatient and outpatient complaints as compared to patient activity, by site:

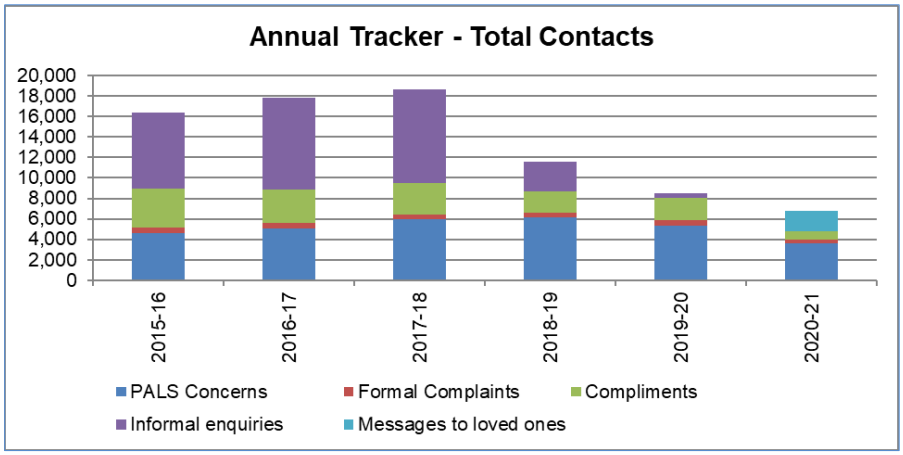
Inpatients & Day Case	Complaints	Total Inpatients & Day Cases	Rate per 1,000
Worthing & Southlands	125	56,782	2.2
St. Richard's	119	39,010	3.1
Total	**244**	**95,792**	**2.5**

Outpatients	Complaints	Total Attendances	Rate per 10,000
Worthing & Southlands	84	282,364	3.0
St. Richard's	45	201,076	2.2
Total	**129**	**483,440**	**2.7**

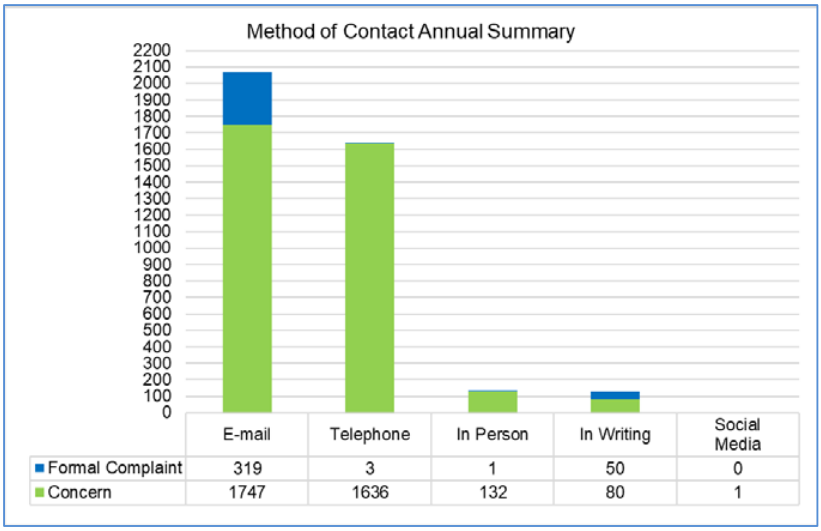
Type of Cases

	2015/16	2016/ 17	2017/ 18	2018/ 19	2019/ 20	2020/ 21
PALS cases	4,582	5,061	5,990	6,152	5,368	3,596
Informal enquiries	7,426	8,914	9,106	2,897	463*	0
Formal complaints	587	576	431	416	535	373
Compliments	3,823	3,246	3,084	2,123	2,149	839
Messages to loved ones	-	-	-	-	-	1,976**
Total	**16,418**	**17,797**	**18,611**	**11,588**	**8,515**	**6,784**

** Informal enquiries are no longer recorded to focus effort on the themes emerging from concerns.*
*** Messages to loved ones were implemented during Covid-19 pandemic.*



Methods of contact for concerns and formal cases are summarised below:



Formal Complaints Performance

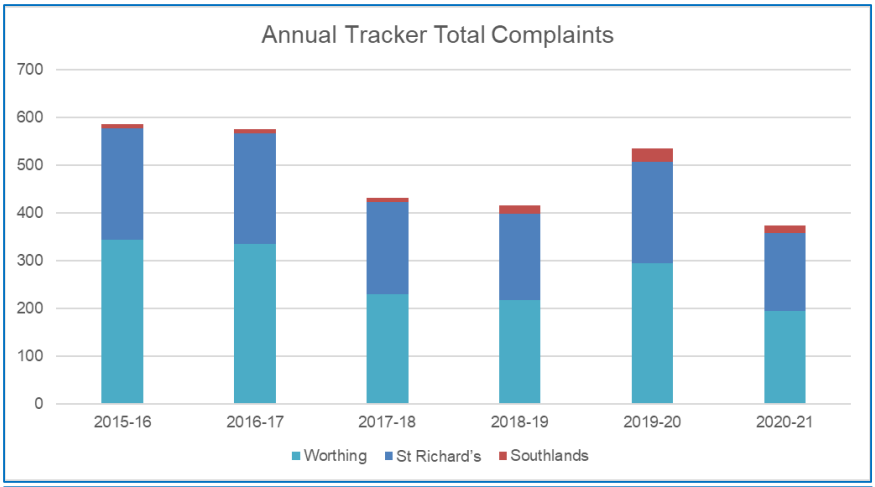
Performance Metrics	Q1	Q2	Q3	Q4	Total
Number of new complaints:	55	118	99	101	373
Number of closed cases:	112	92	140	88	432
Number closed in 25 days (%)	39%	66%	75%	76%	64%
Re-opened cases	5	14	18	10	47

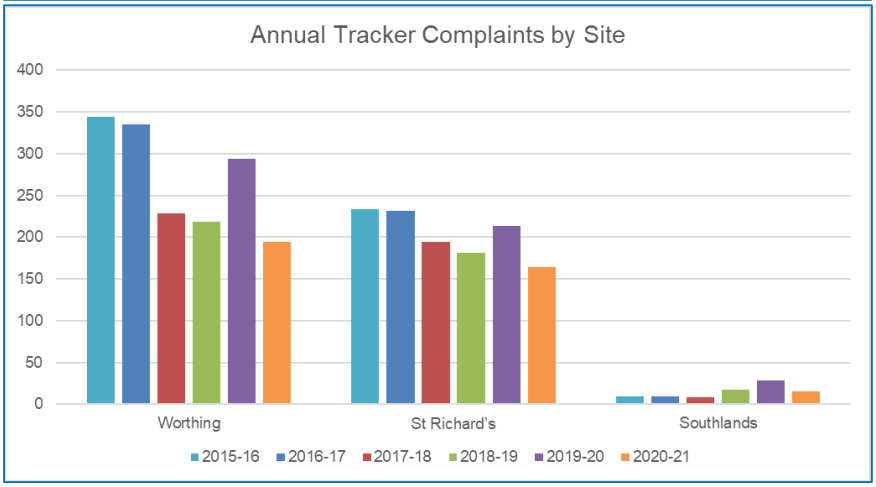
The number of closed cases exceeded the number received due to the Covid-19 Pandemic. This enabled the Trust to respond to a number of existing cases. The Trust goal was to respond to 65% of its formal complaints consistently.

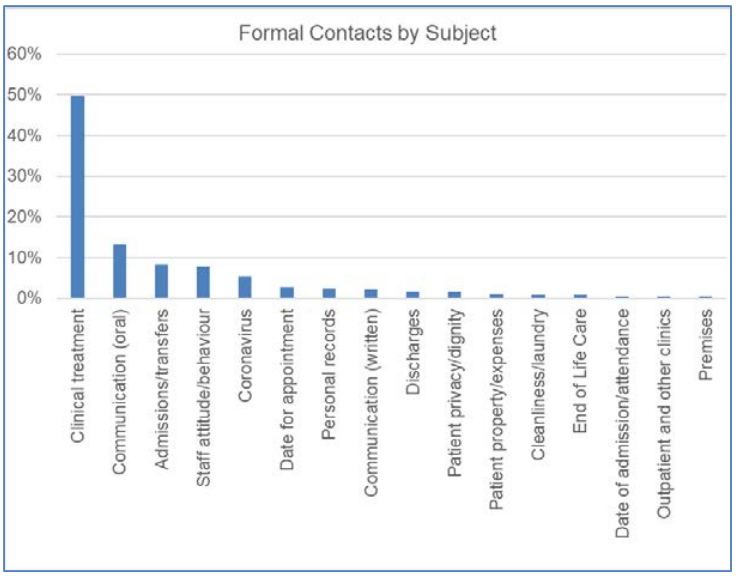
During 2020/21 an overall response rate of 64% was achieved, marginally missing the 65% goal. During Q1 the number of complaints resolved in 25 working days overall fell to 39%. The team's efforts during the system wide pause of the NHS Complaints process during this quarter allowed them to resolve as many overdue responses as possible, whilst not distracting clinical staff. This change in focus meant that we were able to reduce the number of open formal complaints from 131 to 69 at this time.

Formal Complaints Received by Site

	2015/ 16	2016/ 17	2017/ 18	2018/ 19	2019/ 20	2020/ 21
Worthing	344	335	229	218	294	194
St Richard's	234	232	194	181	213	164
Southlands	9	9	8	17	28	15
Total	**587**	**576**	**431**	**416**	**535**	**373**



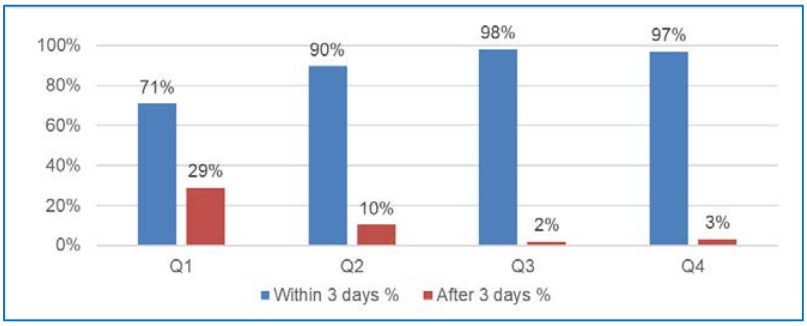




The top two themes during 2020/21 for formal complaints were attributed to clinical treatment and oral communication. There was also an increase in the number of complaints about staff attitude. These trends can be attributed to the immense pressure staff were under during the pandemic and the organisation has implemented a wide range of measures to support staff well-being to help address this.

Formal Complaint Acknowledgement Times

The Trust has an internal target to respond to formal complaints within 3 working days, a summary of compliance by quarter is shown below:



The Trust has a system in place that requires the division responsible for the complaint to call each complainant within 48 hours of receipt of their concerns. This practice helps patients and their families feel listened to and enables dialogue to be started promptly to ensure effective investigation. This is in addition to the corporate response necessary to log each complaint. In Q1 & 2 the team were relying on confirmation from the divisions that they had made contact with the complainant before a corporate response was sent but this delayed the processing of the complaint when the division was unable to respond quickly. The Patient Experience Team now automatically sends a corporate acknowledgement letter to all new complaints upon receipt.

Formal Complaint Response Times

The Trust has an internal target to respond to formal complaints within 25 working days at least 65% of the time. The breakdown of response rates during 2020/21, both Trustwide and across all divisions is shown below:

	% in 25 days			
	Q1	Q2	Q3	Q4
Trust wide	**39%**	**66%**	**75%**	**76%**
Women & Child Health	47%	89 %	87 %	100 %
Core Services	83 %	0 %	68 %	100 %
Corporate	100 %	-	-	100 %
Facilities & Estates	0 %	50 %	100 %	100 %
Medicine	38 %	68 %	70 %	79 %
Surgery	30 %	60 %	77 %	56 %

The Divisional scorecards capture this performance and the Executive Team review this with each division at regular strategic (SDR) meetings throughout the financial year.

Formal Complaints Re-opened

Overall 47 formal complaints have re-opened, as summarised by quarter below:

	Number Re-opened
Q1	5
Q2	14
Q3	18
Q4	10
Total	**47**

The Trust re-open rate in 2020/21 was 13% compared with 8% in 2019/20. Whilst this percentage in 2020/21 was in part due to a much reduced number of new cases, the Patient Experience Team is now recording the reasons for a case re-opening so that the divisions can understand more fully why and look to try and prevent this in future cases.

Parliamentary Health Service Ombudsman (PHSO)

There are currently 9 PHSO cases open, 4 being new referrals in 2020/21. The table below shows the activity:

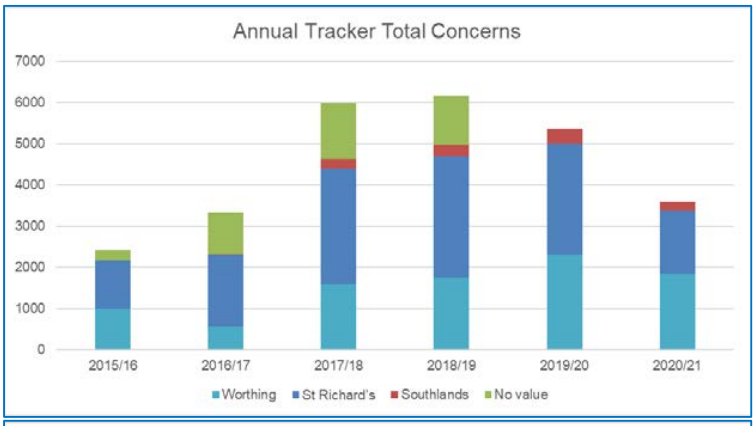
Number of Cases	Q1	Q2	Q3	Q4	**Totals**
New Referrals	1	2	1	0	**4**
Closed	1	2	1	1	**5**
Closed Case Outcomes	Q1	Q2	Q3	Q4	**Totals**
Upheld	1	0	0	0	**1**
Partly Upheld	0	2	1	0	**3**
Not Upheld	0	0	0	1	**1**

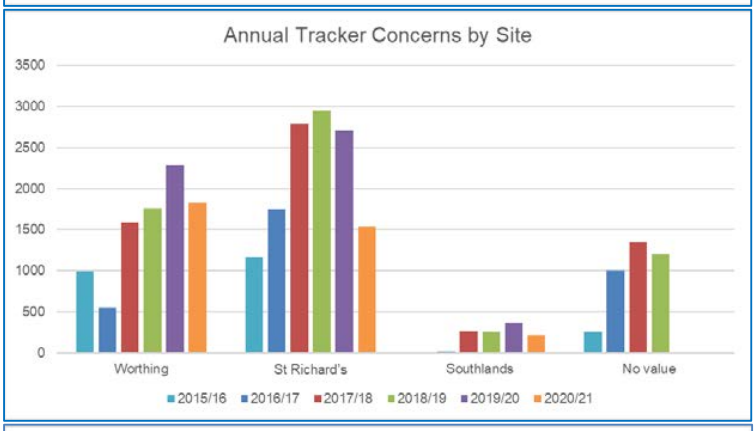
Details of cases closed are highlighted below:

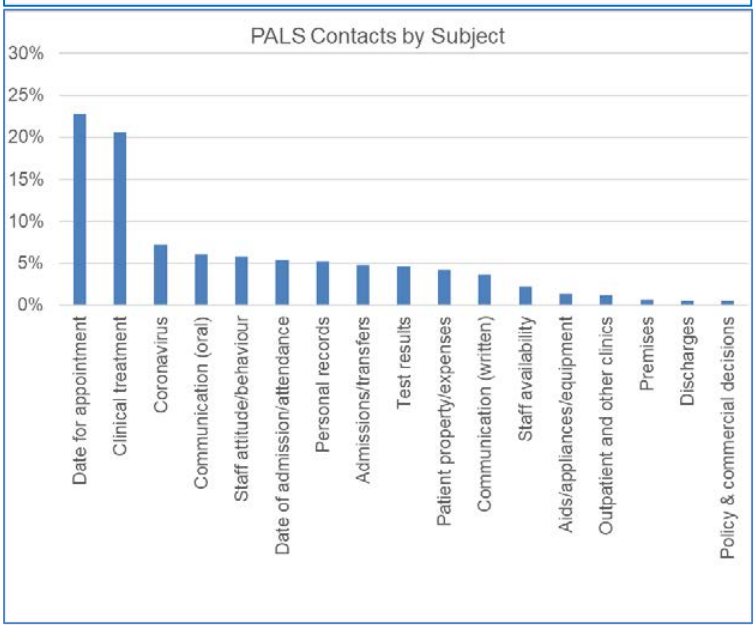
ID	PHSO Opened	PHSO Closed	Outcome	Findings & Learning
64086	2020	2021	Not upheld	No failings in the actions of the Trust.
55781	2019	2020	Not upheld	Apology for the impact of not making mental health referral nor raising safeguarding issue; Action plan for patient pathway, education/awareness and referral processes implemented.
43992	2020	2020	Partly upheld	Medical records updated with statement that patient did not agree with the content.
57327	2018	2020	Not upheld	Assessment completed – no further investigation.
27114	2019	2020	Upheld	Action plan for severe sepsis pathway, education/training, EPMA and antibiotic prescribing monitoring implemented.

PALS Concerns Received by Site

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Worthing	994	552	1,592	1,755	2,290	1,832
St Richard's	1,174	1,750	2,785	2,943	2,712	1,542
Southlands	2	15	261	258	366	222
Location not recorded	252	1,006	1,350	1,204	0	0
Total	**2,422**	**3,323**	**5,988**	**6,160**	**5,368**	**3,596**



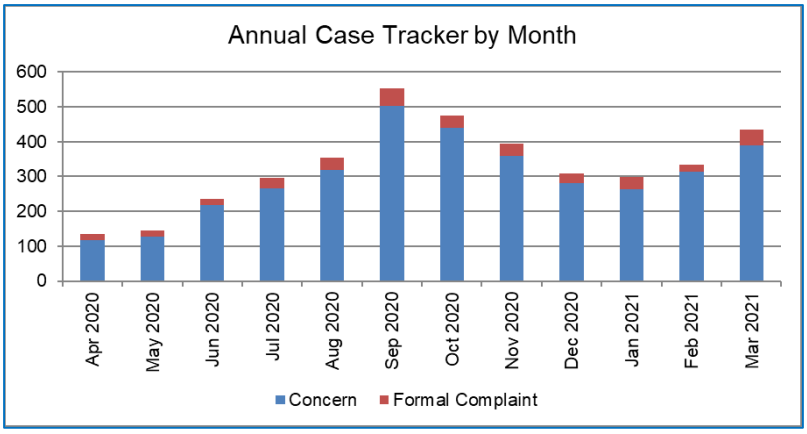




During 2020/21 the top two themes in PALS were date for appointment and clinical treatment. Again staff attitude and COVID related concerns were themes. The Access team are working closely with the Patient Experience team to ensure that the restore and recovery programme in outpatients includes a clear communication process to help manage patient expectations and reduce anxiety for those who have had their appointments delayed during the pandemic.

Complaints and PALS Improvement

There is an increasing focus on listening to, acting upon and learning from feedback from service users because of the importance placed on our values of prioritising the patient voice. This includes ensuring that feedback from the Friends and Family Test, from audits and surveys, and from complaints feeds into learning and quality assurance and improvement processes.



PALS Activity During Covid-19 Pandemic – Messages to Loved Ones

The number of messages reduced as suspended visiting was lifted. Positive feedback was regularly provided to the PALS team from families about the value of this service and it will therefore continue.

Month	Worthing	St.Richard's	**Totals**
Apr-20	0	0	**0**
May-20	342	144	**486**
Jun-20	249	124	**373**
Jul-20	67	18	**85**
Aug-20	4	6	**10**
Sep-20	0	0	**0**
Oct-20	0	0	**0**
Nov-20	0	0	**0**
Dec-20	65	99	**164**
Jan-21	276	181	**457**
Feb-21	102	144	**246**
Mar-21	52	103	**155**
Total	**1,157**	**819**	**1,976**

Conclusion

A rich source of qualitative and quantitative data has been provided to enable the organisation to celebrate the positive experience of patients in the majority of areas and also to support actions for improvement.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	13	**Meeting:**	Board	**Meeting Date:**	5 August 2021
Report Title:	People Committee Chair report to Board				
Committee Chair:		Patrick Boyle, Committee Non Executive Chair			
Author(s):		Patrick Boyle, Committee Non Executive Chair			
Report previously considered by and date:					
Purpose of the report:					
Information		☐	Assurance	✓	
Review and Discussion		☐	Approval / Agreement	☐	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		☐	Staff confidentiality	☐	
Patient confidentiality		☐	Other exceptional circumstances	☐	
Implications for Trust Strategic Themes and any link to BAF risks					
Patient	☐				
Sustainability	☐				
People	✓	Assurances in relation to risks 3.1 – 3.4			
Quality	☐				
Systems and Partnerships	☐				
Link to CQC Domains:					
Safe		✓	Effective	✓	
Caring		✓	Responsive	✓	
Well-led		✓	Use of Resources	☐	
Communication and Consultation:					

Executive Summary:

The People Committee met on the 28 July 2021 and was quorate as it was attended by four Non-Executive Directors, the Trust Chair, the Chief People Officer, the Chief Culture and Organisational Development Officer and the Chief Executive. In attendance were members of the HR and Wellbeing teams.

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 analysis, health and wellbeing strategy update, workforce performance reports, the former Trusts' Workforce Race Equality Scheme (WRES) and Workforce Disability Equality Scheme (WDES) annual reports for 2020/21 and an update on the work of the ICS people committee.

Key Recommendation(s):

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

The Board is asked to **NOTE** the Committee's review and approval for publication the BSUH and WSHFT 2020/21 WRES and WDES annual reports.

The Board is asked to **NOTE** that the Committee after careful consideration of new pressures facing staff in respect of verbal abuse that risk 3.4 should remain at its quarter one score and with that adjustment the Committee agreed the BAF risks 3.1, 3.2, 3.3 and 3.4, for which it has oversight, are fairly represented.

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COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
People Committee	**28 July 2021**	**Patrick Boyle**	yes	no
			✓	☐

Declarations of Interest Made

There were no declarations of interest made

Assurances received at the Committee meeting

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

The Committee **RECEIVED** updates on the delivery of the respective True North, Breakthrough Objective, Strategic Initiative and Corporate Project. The Committee **NOTED** the significant level of work being undertaken in respect of the Trust people strategy deployment. The Committee **NOTED** the linkage with the committee activity reports and the strategy deployment, which provided further **ASSURANCE** over the work undertaken and the Trust's planned actions

Committee Activity

The Committee **RECEIVED** an update on the Trust's health and wellbeing strategy showing its linkage to the People Breakthrough Objective and Strategic Initiative. The Committee was **ASSURED** over the work being undertaken within the areas of support for staff, leadership and communication alongside the programmes supported by the NHS Charities together funding grant to the Trust.

The Committee **RECEIVED** an update on Staff Survey with a focus on the analysis of the results and their link to the Trust's people breakthrough objective. The Committee was **ASSURED** over the work undertaken to move to the national quarterly staff (pulse) survey and that the Trust has established plans to analyse and use this data to target areas for improvements in conjunction with the service areas of the Trust.

The Committee **RECEIVED** the workforce KPIs for quarter 1 of 2021/22. The Committee **NOTED** the work being undertaken in respect of both recruitment and retention including the use of the welfare appraisal processes.

The Committee **RECEIVED** an update from the Chief People Officer that there were no matters that needed escalation from the Committee's reporting groups.

The Committee **RECEIVED** former Trusts' Workforce Race Equality Scheme (WRES) and Workforce Disability Equality Scheme (WDES) annual reports for 2020/21. Whilst the Committee recognised the limitations of this being a national process and its being reliant on self-assessments the Committee **APPROVED** the reports for publication and reporting to Board. The Committee noted that the Trust has been recognised for its work in the areas of inclusion and that it needed to develop a mechanism to complement the national WRES and WDES reporting to capture and promote these activities and actions across the Trust

ICS Update

The Committee **RECEIVED** an update on work of the ICS people committee and their areas of focus which had been on violence and aggression, workforce planning, occupational health and wellbeing aswell as

additional roles development within primary care. The Committee recognised that the breadth of the bodies on the Committee and the desire to have a diverse agenda that the Trust will need to complement the ICS with its own drive for delivery on its key items of talent management especially for minority staff and actions on combatting violence and aggression directed at our staff. RISK The Committee **NOTED** the wider people risks, the actions being taken to address these and the context these provide to the BAF people risks. The Committee reviewed the BAF risks it has oversight for, and **AGREED** the quarter one score for risks 3.1 to 3.4 as stated in the BAF. The Committee agreed that for the other risks, 3.1, 3.2 and 3.3 were fairly stated and agreeing that risk 3.3 was correctly increased to reflect the pressures on the Trust's workforce.
Actions taken by the Committee within its Terms of Reference
The Committee **APPROVED** the publication of the BUSH and WSHFT 2020/21 WRES and WDES annual reports.
Items to come back to Committee (Items the Committee is seeking to keep an eye on)
There were no specific matters over those planned within its cycle of business that it asked to return to the Committee.
Items referred to the Board or another Committee for decision or action

Item	Date
The recommended to the Board that it notes the Committee's approval for publication the BSUH and WSHFT 2020/21 WRES and WDES annual reports.	To Board 5 August 2021
The Committee recommended to the Board that the risks within the BAF for which it has oversight following the adjustment to risk 3.4 for which it has oversight, are fairly represented.	To Board 5 August 2021

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NHS Foundation Trust

University Hospitals Sussex NHS Foundation Trust

(Brighton and Sussex University Hospitals NHS Trust and Western Sussex NHS Foundation Trust)

Workforce Race Equality Standard 2021

Introduction

"*It can't be right that ten years after the launch of the NHS race-equality plan, while 41% of NHS staff in London are from Black and ethnic minority backgrounds, similar in proportion to the Londoners they serve, only 8% of trust board directors are, with two-fifths of London trust boards having no BME directors at all.*

Similar patterns apply elsewhere, and have actually been going backwards".

Simon Stevens, Chief Executive – NHS England, May 2014

The NHS has a workforce of 1.4 million people, of which 20% are from a Black or Minority Ethnic (BME) background. 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. Of BME staff in senior management roles in the NHS in England, there are:

- 8 BME CEOs (236 Trusts) as of March 2019
- 9 BME Chairs as of March 2018
- 11 BME Executive Directors of Nursing as of March 2019
- 37 BME Medical Directors as of March 2018
- Less than 6% of very senior managers are from BME backgrounds

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 measures of equality, and identify areas for improvement where progress can then be tracked. 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.

The WRES is an annual process and helps NHS organisation demonstrate that they are making progress year on year by improving working conditions for BME staff in the NHS.

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 issues identified affect all BME staff equally or that each groups' 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 report contains data for both Trusts. However, the data snapshot period falls outside of the merger. It provides an

overview of the closing position of each of the previous Trusts and therefore will be the baseline from which future progress is measured for the new combined Trust, University Hospitals Sussex, as we pursue equality and inclusion for all staff.

Background Information

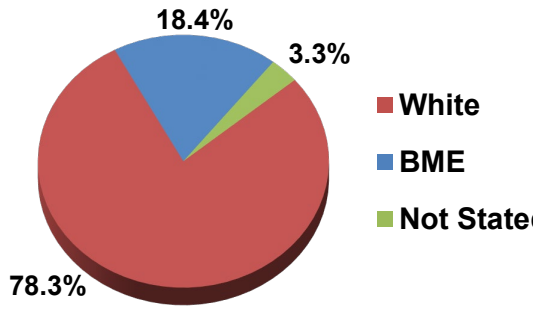
1) The total number of staff:

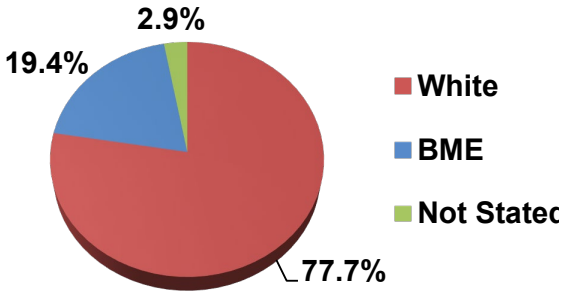
Brighton and Sussex University Hospitals NHS Trust:

2020	2021
8598 headcount	8873 headcount

The proportion of BME staff employed within this organisation at the date of this report:

	2020		2021	
	Headcount	% of Staff	Headcount	% of Staff
White	6731	78.3%	6890	77.7%
BME	1585	18.4%	1725	19.4%
Not Stated	282	3.3%	258	2.9%
Total	8598	100.0%	8873	100.0%





2020 2021

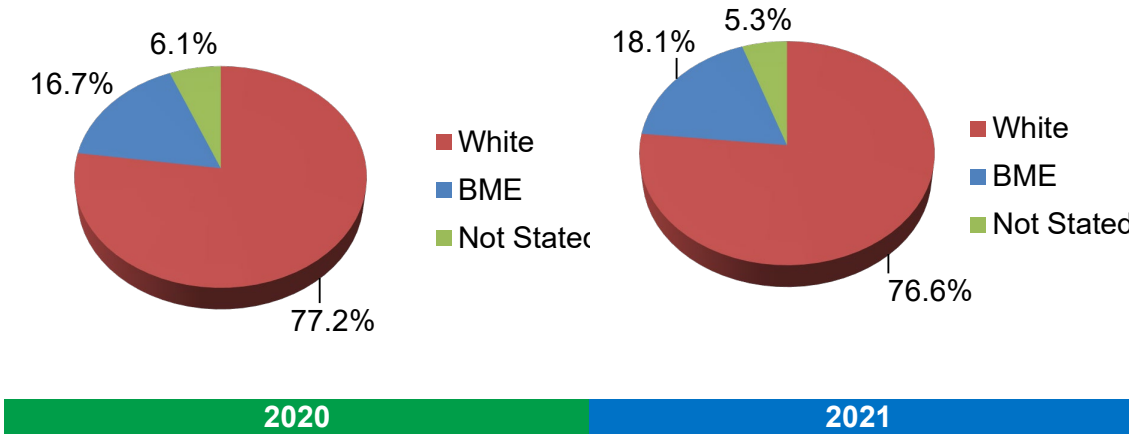
Western Sussex Hospitals Foundation NHS Trust:

2020	2021
7317 headcount	7519 headcount

The proportion of BME staff employed within this organisation at the date of this report:

	2020		2021	
	Headcount	% of Staff	Headcount	% of Staff

White	5650	77.2%	5763	76.6%
BME	1219	16.7%	1359	18.1%
Not Stated	448	6.1%	397	5.3%
Total	7317	100.0%	7519	100.0%



2) Self-reporting

a) The proportion of total staff who have self-reported their ethnicity:

Brighton and Sussex University Hospitals NHS Trust:

	2020		2021	
	Headcount	% of Staff	Headcount	% of Staff
Ethnicity Declared	8316	96.7%	8615	97.1%
Ethnicity Not Declared	282	3.3%	258	2.9%
Total	8598	100.0%	8873	100.0%

Western Sussex Hospitals NHS Foundation Trust:

	2020		2021	
	Headcount	% of Staff	Headcount	% of Staff
Ethnicity Declared	6869	93.9%	7122	94.7%
Ethnicity Not Declared	448	6.1%	397	5.3%
Total	7317	100.0%	7519	100.0%

b) Have any steps been 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 that have access to Electronic Staff Records self-service (and a range of other tools) enabling them to update that ethnicity at any time.

c) **Are any steps planned 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.

3) Workforce Data

a) **What period does the organisation's workforce data refer to?**
1st April 2020 to 31st March 2021.

4) How is BME defined under the WRES?

In line with the categories taken from the 2001 Census:

BME Categories	Unknown	White Categories
D – Mixed white and black Caribbean	Z – not stated	A – White – British
E – Mixed white and black African	NULL	B – White – Irish
F – Mixed white and Asian	Unknown	C – Any other white background
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		

5) Population Demographics 2011 Census (Southeast England)

	Census 2011
BME	9%
White	91%
Unknown	0%

Workforce Race Equality Indicators

For each of the indicators, the standard compares the metrics for white and BME staff (using declared status).

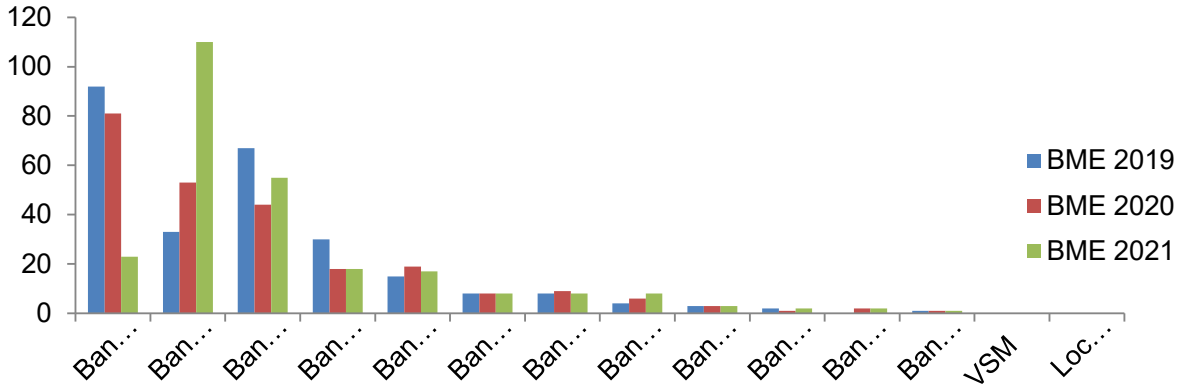
Indicator 1 - Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce
Note: Organisations should undertake this calculation separately for non-clinical and for clinical staff.

Brighton and Sussex University Hospitals NHS Trust:

*Compared to the declared representation of BME staff in the overall workforce: 19.4%

	Non-Clinical Roles					
	White	BME	Unknown	Total	White %	*BME %
Band 1	59	23	7	89	66.3%	25.8%
Band 2	639	110	19	768	83.2%	14.3%
Band 3	512	55	8	575	89.0%	9.6%
Band 4	391	18	10	419	93.3%	4.3%
Band 5	182	17	3	202	90.1%	8.4%
Band 6	121	8	3	132	91.7%	6.1%
Band 7	95	8	3	106	89.6%	7.5%
Band 8a	61	8	2	71	85.9%	11.3%
Band 8b	50	3	0	53	94.3%	5.7%
Band 8c	18	2	1	21	85.7%	9.5%
Band 8d	9	2	0	11	81.8%	18.2%
Band 9	12	1	1	14	85.7%	7.1%
VSM	5	0	3	8	62.5%	0.0%
Local Pay Scale	1	0	0	1	100.0%	0.0%
Total	**2155**	**255**	**60**	**2470**	**87.2%**	**10.3%**

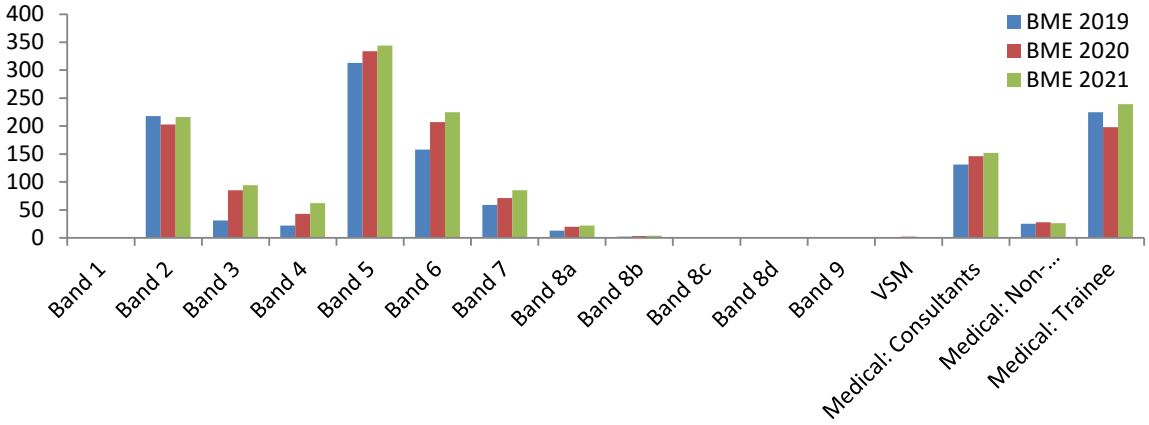
Historical comparison from previous WRES reports



The data highlights that in most non-clinical roles, the is a lower than an expected representation of BME staff. Band 1 has a higher than an expected representation of BME staff, and band 8d is slightly under compared to the overall representation of BME staff in the workforce. Compared to the previous year, there has been an increase of BME staff in bands 8a and 8c. Over the last few years, there has been a programme for migrating staff where appropriate from band 1 to band 2.

	Clinical Roles					
	White	BME	Unknown	Total	White %	*BME %
Band 1	-	-	-	-	-	-
Band 2	618	216	10	844	73.2%	25.6%
Band 3	280	94	4	378	74.1%	24.9%
Band 4	182	62	5	249	73.1%	24.9%
Band 5	862	344	27	1233	69.9%	27.9%
Band 6	1110	225	31	1366	81.3%	16.5%
Band 7	654	85	7	746	87.7%	11.4%
Band 8a	164	22	1	187	87.7%	11.8%
Band 8b	53	4	2	59	89.8%	6.8%
Band 8c	19	0	0	19	100.0%	0.0%
Band 8d	10	0	0	10	100.0%	0.0%
Band 9	1	0	1	2	50.0%	0.0%
VSM	1	1	1	3	33.3%	33.3%
Medical: Consultants	322	152	15	489	65.8%	31.1%
Medical: Non-consultant career grade	27	26	2	55	49.1%	47.3%
Medical: Trainee	432	239	92	763	56.6%	31.3%
Total	**4735**	**1470**	**198**	**6403**	**73.9%**	**23.0%**

Historical Comparison from previous WRES reports



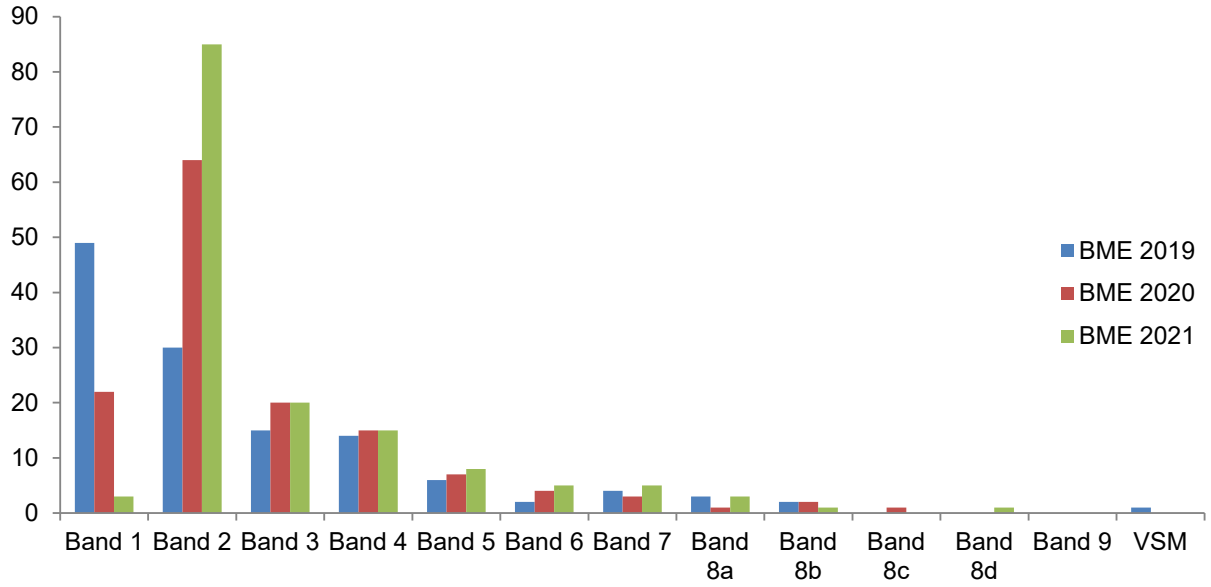
Compared to the overall workforce, there is a higher than an expected representation of BME staff in band 1-5 and medical grades. However, within bands 6-9, there is a lower than an expected representation of BME staff. Compared to recent years that has been a year-on-year increase in the representation of BME staff in bands 6-8a.

Western Sussex Hospitals NHS Foundation Trust:

***Compared to the declared representation of BME staff in the overall workforce: 18.1%*

	Non-Clinical Roles					
	White	**BME**	**Unknown**	**Total**	**White %**	****BME %**
Band 1	28	3		31	90.3%	9.7%
Band 2	685	85	24	794	86.3%	10.7%
Band 3	363	20	10	393	92.4%	5.1%
Band 4	286	15	4	305	93.8%	4.9%
Band 5	122	8	5	135	90.4%	5.9%
Band 6	95	5	3	103	92.2%	4.9%
Band 7	73	5	1	79	92.4%	6.3%
Band 8a	48	3	2	53	90.6%	5.7%
Band 8b	36	1		37	97.3%	2.7%
Band 8c	18			18	100.0%	0.0%
Band 8d	4	1		5	80.0%	20.0%
Band 9	5			5	100.0%	0.0%
VSM	11		2	13	84.6%	0.0%
Total	**1774**	**146**	**51**	**1971**	**90.0%**	**7.4%**

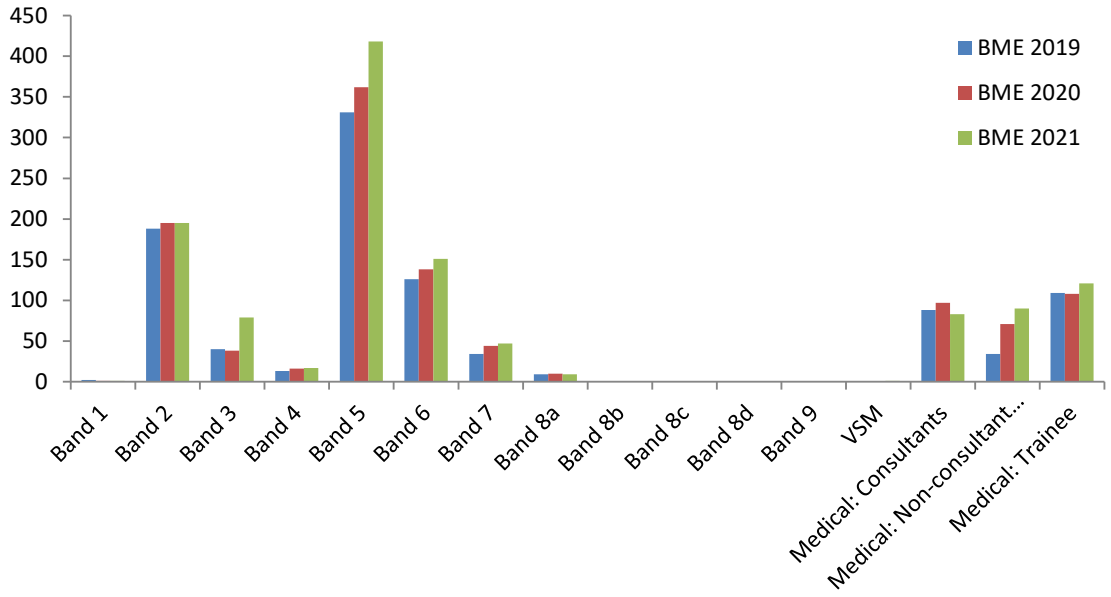
Historical comparison from previous WRES reports



The data highlights that in most non-clinical roles, there is a lower than an expected representation of BME staff. Band 8d has a higher than an expected representation of BME staff. Compared to the previous year, there has been an increase of BME staff in bands 5-8a and 8d.

	Clinical Roles					
	White	BME	Unknown	Total	White %	**BME %
Band 1	7	1	2	10	70.0%	10.0%
Band 2	851	195	74	1120	76.0%	17.4%
Band 3	231	79	12	322	71.7%	24.5%
Band 4	163	17	6	186	87.6%	9.1%
Band 5	674	418	109	1201	56.1%	34.8%
Band 6	843	151	48	1042	80.9%	14.5%
Band 7	515	47	29	591	87.1%	8.0%
Band 8a	101	9	5	115	87.8%	7.8%
Band 8b	33		1	34	97.1%	0.0%
Band 8c	11		1	12	91.7%	0.0%
Band 8d	3			3	100.0%	0.0%
Band 9	2			2	100.0%	0.0%
VSM	5	1	2	8	62.5%	12.5%
Medical: Consultants	246	83	18	347	70.9%	23.9%
Medical: Non-consultant career grade	63	90	14	167	37.7%	53.9%
Medical: Trainee	240	121	26	387	62.0%	31.3%
Total	**3988**	**1212**	**347**	**5547**	**71.9%**	**21.8%**

Historical Comparison from previous WRES reports



The data highlights a lower than expected representation of BME staff in the majority of clinical roles. However, this excludes bands 3 and 5 and medical roles where there is a higher than expected representation compared to the overall workforce BME representation; band 2 is slightly under. From the previous year, there has been an increase of BME staff in bands 6 and 7.

Indicator 2 - Relative likelihood of staff being appointed from shortlisting across all posts

Brighton and Sussex University Hospitals NHS Trust:

	Shortlisted		Appointed		Relative Likelihood of being appointed
	Number	%	Number	%	
BME applicants	2239	25.2%	232	14.6%	**0.1036**
White applicants	5854	66.0%	981	61.9%	**0.1676**
Not Stated / Unknown	776	8.7%	371	23.4%	**0.4781**
Total	8869	100.0%	1584	100.0%	

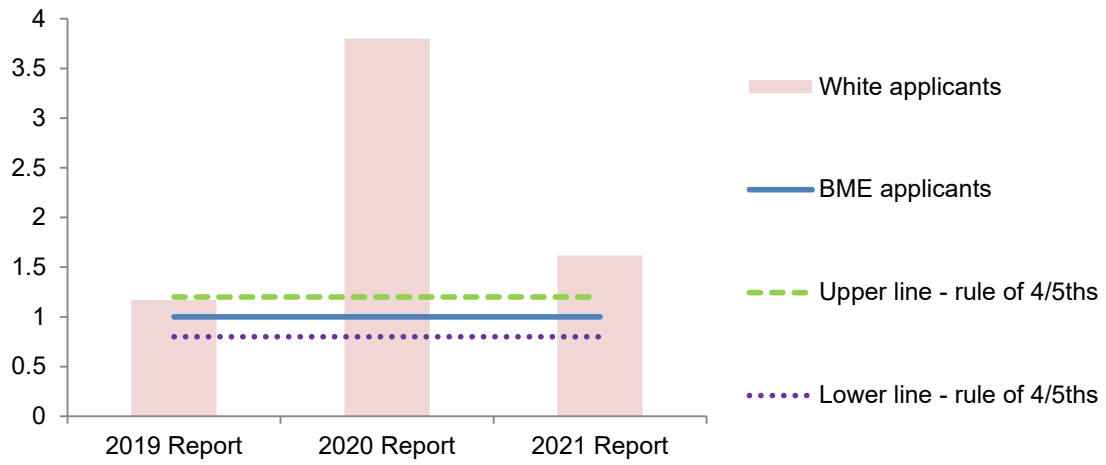
The relative likelihood of white candidates being appointed from shortlisting:
981 / 5854 = 0.1676

The likelihood of BME candidates being appointed from shortlisting:
232 / 2239 = 0.1036

The relative likelihood of white candidates being appointed from shortlisting compared to BME staff is: 0.1676 (white candidates) / 0.1036 (BME candidates) = **1.62 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 WRES reports



In the above chart, 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.

Using the rule of four-fifths, if the likelihood of white applicants is below 0.8 or above 1.2, it would suggest there is an adverse statistical impact.

Western Sussex Hospitals NHS Foundation Trust:

	Shortlisted		Appointed		Relative Likelihood of being appointed
	Number	%	Number	%	
BME applicants	1132	20.0%	76	13.6%	**0.0671**
White applicants	4372	77.2%	456	81.6%	**0.1043**
Not Stated / Unknown	161	2.8%	27	4.8%	**0.1677**
Total	5665	100.0%	559	100.0%	

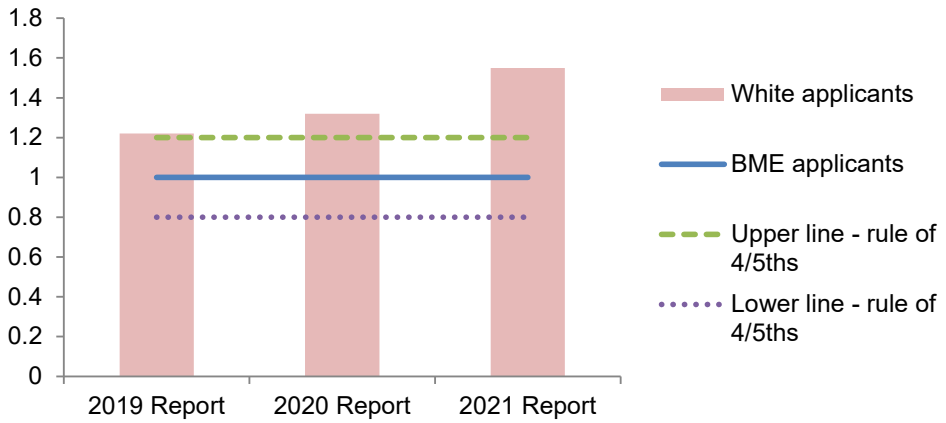
The relative likelihood of white candidates being appointed from shortlisting:
456 / 4372 = 0.1043

The likelihood of BME candidates being appointed from shortlisting:
76 / 1132 = 0.0671

The relative likelihood of white candidates being appointed from shortlisting compared to BME staff is: 0.1043 (white candidates) / 0.0671 (BME candidates) = **1.55 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 WRES reports



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The Trust does not share personal or equal opportunities data with managers at the shortlisting stage to help remove bias in the recruitment process.

Using the rule of four-fifths, if the likelihood of white applicants is below 0.8 or above 1.2, it would suggest there is an adverse statistical impact.

Indicator 3 - Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

Brighton and Sussex University Hospitals NHS Trust:

	Number of Disciplinary Procedures	Number in Workforce	Relative Likelihood of entering procedure
White	22	6890	0.0032
BME	1	1725	0.0006
Unknown	0	258	0.0000

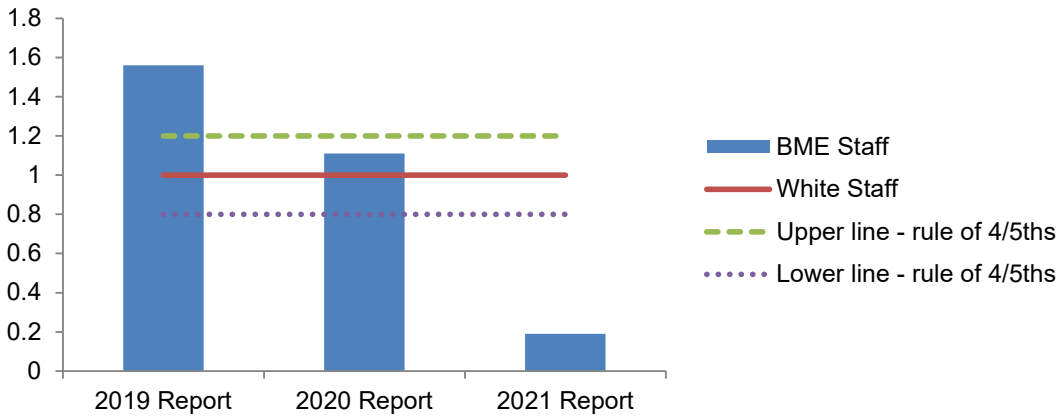
The likelihood of white staff entering the formal disciplinary process:
22 / 6890 = 0.0032

The likelihood of BME staff entering the formal disciplinary process:
1 / 1725 = 0.0006

The relative likelihood of BME staff entering the formal disciplinary process compared to white staff is: 0.0006 (BME Staff) / 0.0032 (White Staff) = **0.19 times.**

In this instance, the data suggest that BME staff members are less likely than white staff to enter into a formal disciplinary process.

Historical comparison with previous 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.

Using the rule of four-fifths, if the likelihood of BME staff is below 0.8 or above 1.2, it would suggest there is an adverse statistical impact.

Western Sussex Hospitals NHS Foundation Trust:

	Number of Disciplinary Procedures	Number in Workforce	Relative Likelihood of entering procedure
White	9	5763	0.0016
BME	4	1359	0.0029
Unknown	4	397	0.0101

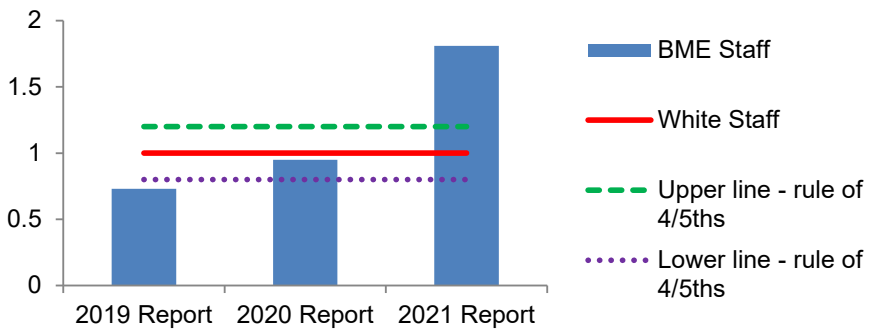
The likelihood of white staff entering the formal disciplinary process:
9 / 5763 = 0.0016

The likelihood of BME staff entering the formal disciplinary process:
4 / 1359 = 0.0029

The relative likelihood of BME staff entering the formal disciplinary process compared to white staff is: 0.0029 (BME Staff) / 0.0016 (White Staff) = **1.81 times greater.**

In this instance, the data suggests BME staff are more likely to enter a formal disciplinary process than white staff.

Historical comparison with previous WRES reports



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above, it would suggest that they have a great chance of entering formal disciplinary procedures.

Using the rule of four-fifths, if the likelihood of BME staff is below 0.8 or above 1.2, it would suggest there is an adverse statistical impact.

There was an error in the calculation in the 2019 report. The report incorrectly stated the likelihood is 0.07; this should be 0.73 as highlighted in the chart above.

Indicator 4 - Relative likelihood of staff accessing non-mandatory training and CPD.

Brighton and Sussex University Hospitals NHS Trust:

	Number in workforce	No. of staff accessing non-mandatory/CPD training	Relative likelihood of accessing non-mandatory/CPD training
White	6890	261	0.038
BME	1725	70	0.041
Unknown	258	3	0.012
Total	8873	334	

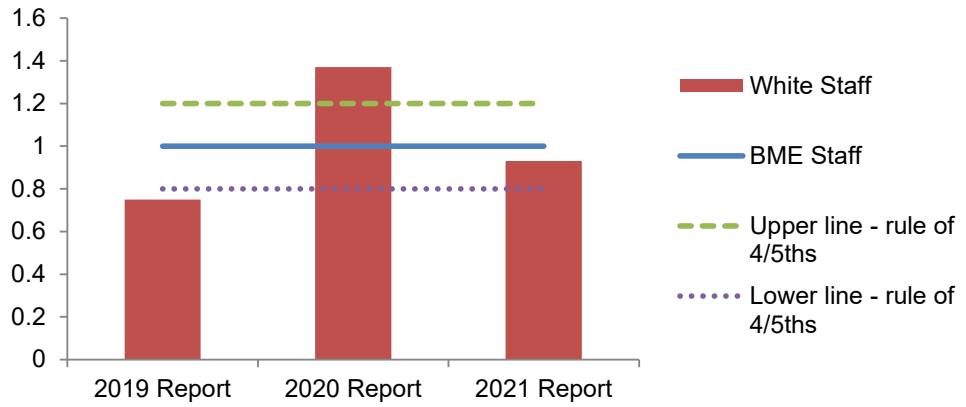
Likelihood of white staff accessing non-mandatory/CPD training:
261 / 6890 = 0.038

Likelihood of BME staff accessing non-mandatory/CPD training:
70 / 1725 = 0.041

Relative likelihood of white staff accessing non-mandatory/CPD training compared to BME staff: 0.038 (White Staff) / 0.041 (BME Staff) = **0.93 times.**

In this instance, the data suggests white staff are less likely to access non-mandatory/CPD training than BME staff.

Historical comparison with previous 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.

Using the rule of four-fifths, if the likelihood of white staff is below 0.8 or above 1.2, it would suggest there is an adverse statistical impact.

This analysis is limited by the numbers of staff declaring ethnicity and whether all training oppolrtuniies have been captured.

BSUH Data including Apprenticeships:

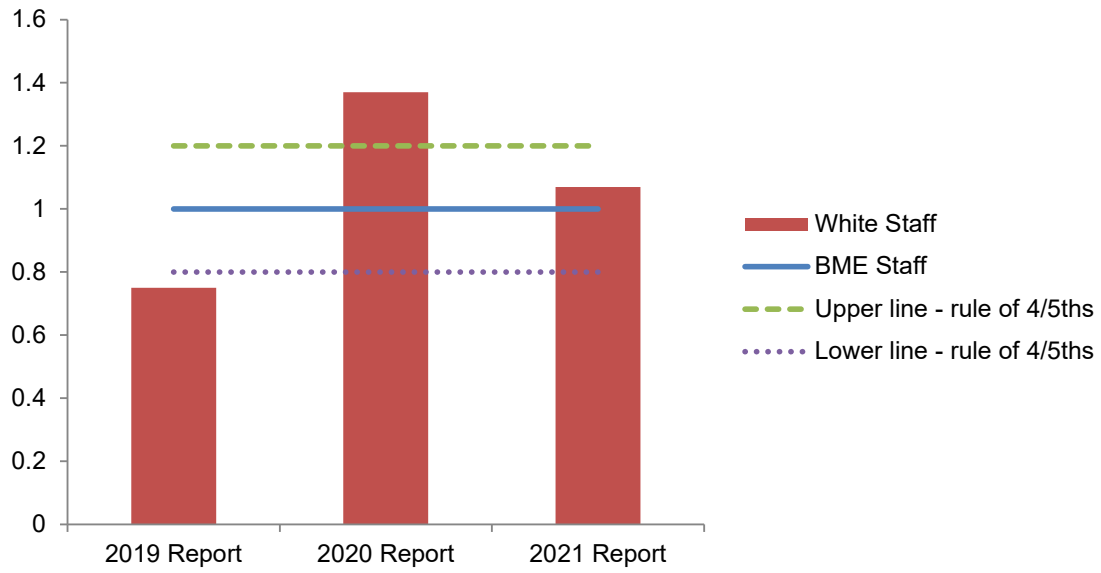
	Number in workforce	No. of staff accessing non-mandatory/CPD training	Relative likelihood of accessing non-mandatory/CPD training
White	6890	401	0.058
BME	1725	94	0.054
Unknown	258	3	0.012
Total	8873	498	

Likelihood of white staff accessing non-mandatory/CPD training:
401 / 6890 = 0.058

Likelihood of BME staff accessing non-mandatory/CPD training:
94 / 1725 = 0.054

Relative likelihood of white staff accessing non-mandatory/CPD training compared to BME staff: 0.058 (White Staff) / 0.054 (BME Staff) = **1.07 times.**

In this instance, the data suggests white staff are slightly more likely to access non-mandatory/CPD training than BME staff.



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.

Using the rule of four-fifths, if the likelihood of white staff is below 0.8 or above 1.2, it would suggest there is an adverse statistical impact.

The 2021 data includes information about the staff that entered into apprenticeships, which the previous years do not consider.

This analysis is limited by the numbers of staff declaring ethnicity and whether all training oppolrtuniies have been captured.

Western Sussex Hospitals NHS Foundation Trust:

	Number in workforce	No. of staff accessing non-mandatory/CPD training	Relative likelihood of accessing non-mandatory/CPD training
White	5763	468	0.081
BME	1359	103	0.076
Unknown	397	24	0.060
Total	7519	595	

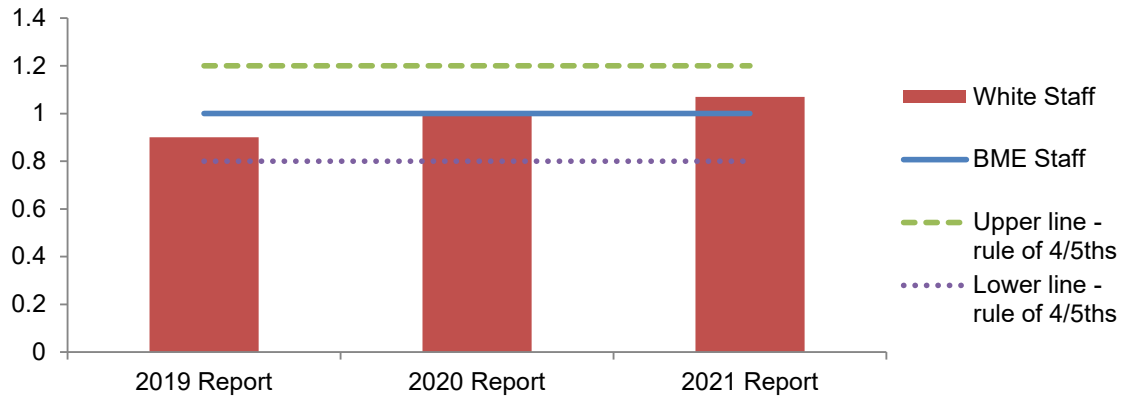
Likelihood of white staff accessing non-mandatory/CPD training:
468 / 5763 = 0.081

Likelihood of BME staff accessing non-mandatory/CPD training:
103 / 1359 = 0.076

Relative likelihood of white staff accessing non-mandatory/CPD training compared to BME staff: 0.081 (White Staff) / 0.076 (BME Staff) = **1.07 times.**

In this instance, the data suggests white staff are slightly more likely to access non-mandatory training than BME staff.

Historical comparison with previous WRES reports



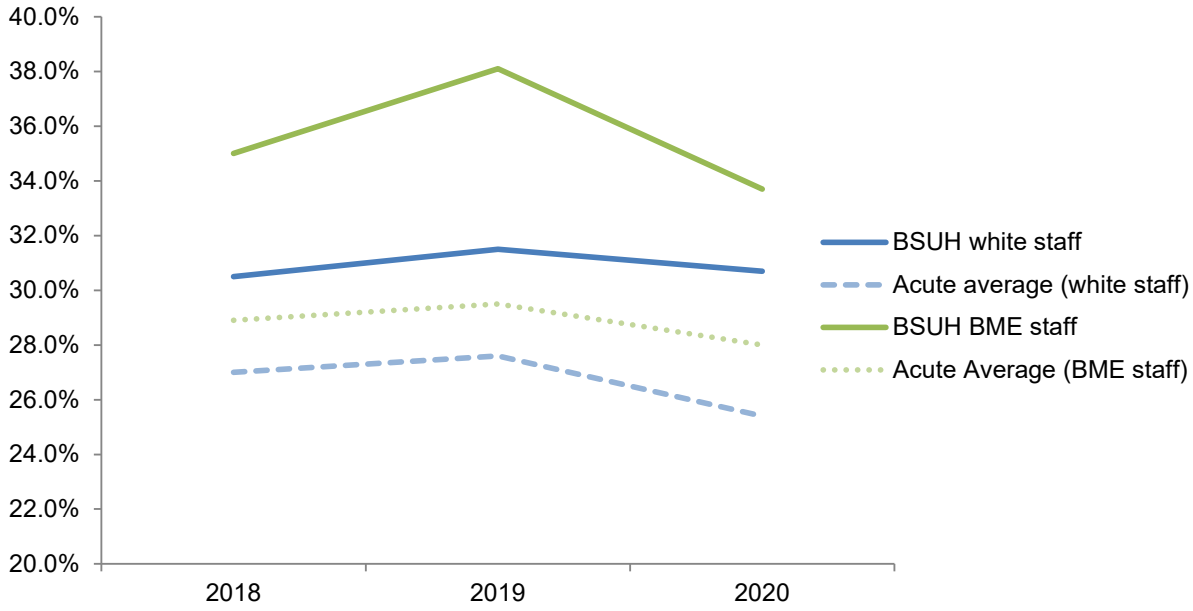
In the above chart, BME staff have a constant measure of 1.0. If the bar for white staff is below the BME line, it would suggest; that white staff are less likely to access non-mandatory/CPD than BME staff. Naturally, if the white applicant bar is above, it would indicate that they have a greater chance of accessing non-mandatory/CPD.

Using the rule of four-fifths, if the likelihood of white staff is below 0.8 or above 1.2, it would suggest there is an adverse statistical impact.

Indicator 5 - Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months – KF25 from NHS Staff Survey

Brighton and Sussex University Hospitals NHS Trust:

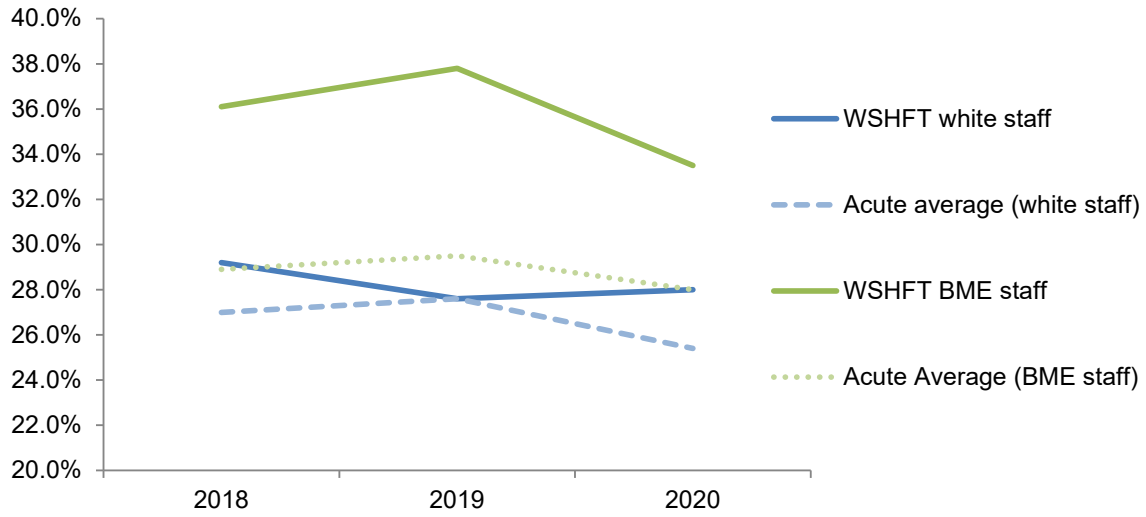
	BSUH BME staff	BSUH white staff	% point difference	Acute Average (BME staff)	Acute average (white staff)
2018	35.00%	30.50%	(-4.50%)	28.90%	27.00%
2019	38.10%	31.50%	(-6.60%)	29.50%	27.60%
2020	33.70%	30.70%	(-3.00%)	28.00%	25.40%



Compared to the previous year, there has been a decrease in the number of Trust BME and white staff, highlighting in the staff survey that they have experienced harassment, bullying or abuse from patients, relatives, etc. This has led to the percentage point difference between the two groups getting smaller. However, the overall Trust data for staff experiencing bullying and harassment from patients is worse than the NHS acute trust average.

Western Sussex NHS Foundation Trust

	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%

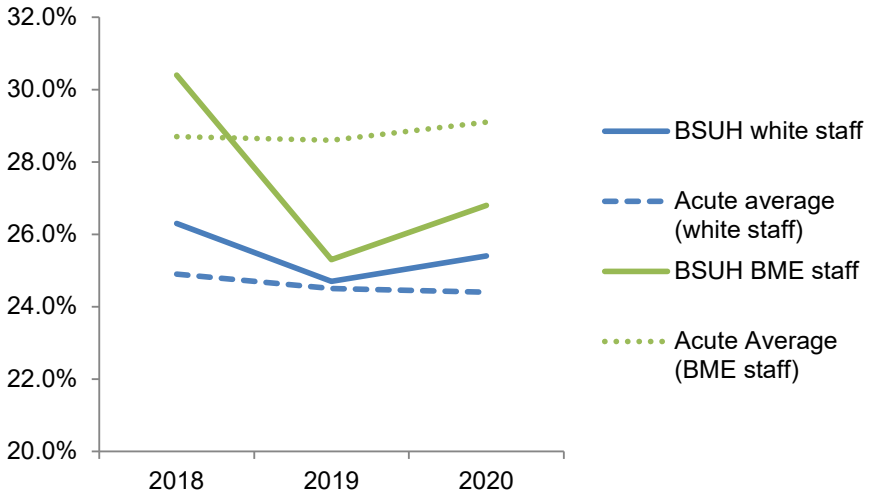


Compared to the previous year, there has been a decrease in the number of Trust BME staff (and a small increase for white staff), highlighting they have experienced harassment, bullying or abuse from patients, relatives, etc. This has led to the percentage point difference between the two groups getting smaller. However, the overall Trust data for staff experiencing bullying and harassment from patients is worse than the NHS acute trust average, particularly for BME staff.

Indicator 6 - Percentage of staff experiencing harassment, bullying, or abuse from staff in last 12 months – KF26 from NHS Staff Survey

Brighton and Sussex University Hospitals NHS Trust:

	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%

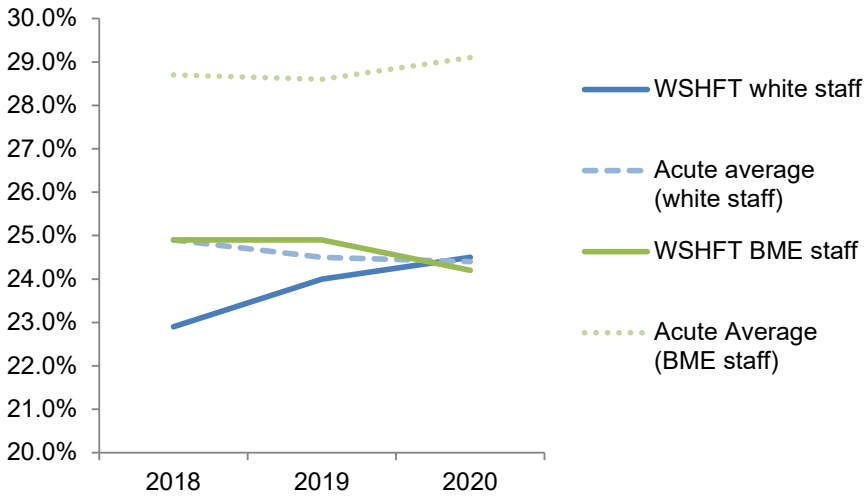


Compared to the previous year, there has been an increase in the number of Trust BME staff, highlighting in the staff survey they have experienced harassment, bullying or abuse from staff. There is also been an increase for white staff but at a lower level. This has led to the percentage point difference between the two groups increasing.

The data does not give an indication of the nature of the bullying or harassment that staff have reported experiencing.

Western Sussex NHS Foundation Trust

	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%



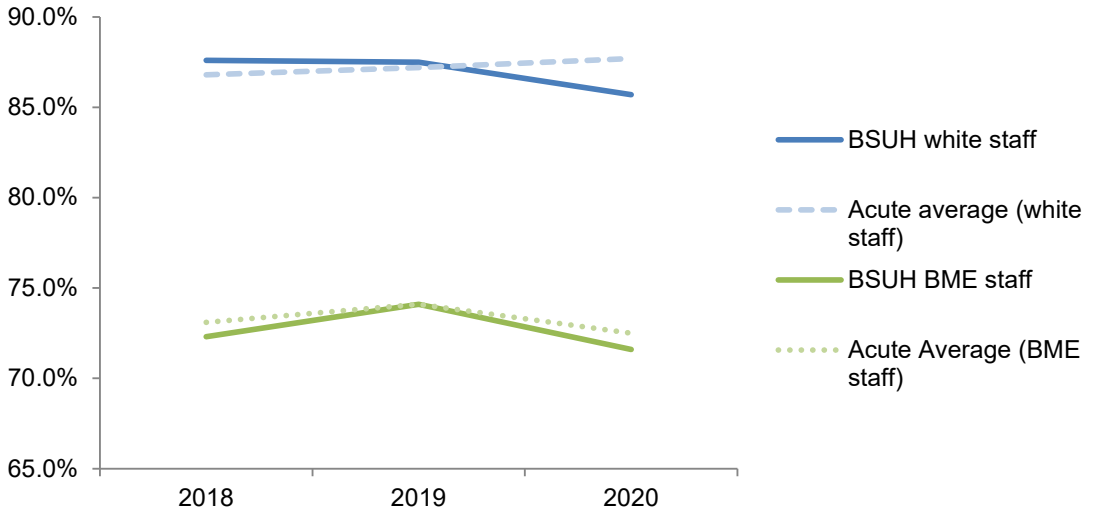
Compared to the previous year, there has been a decrease in the number of Trust BME staff (but an increase for white staff), highlighting they have experienced harassment, bullying or abuse from staff. This has led to the percentage point difference between the two groups closing. The reported experience of both groups of staff appears close to the typical Trust average.

The data does not give an indication of the nature of the bullying or harassment that staff have reported experiencing.

Indicator 7 - Percentage believing that trust provides equal opportunities for career progression or promotion – KF21 from NHS Staff Survey

Brighton and Sussex University Hospitals NHS Trust:

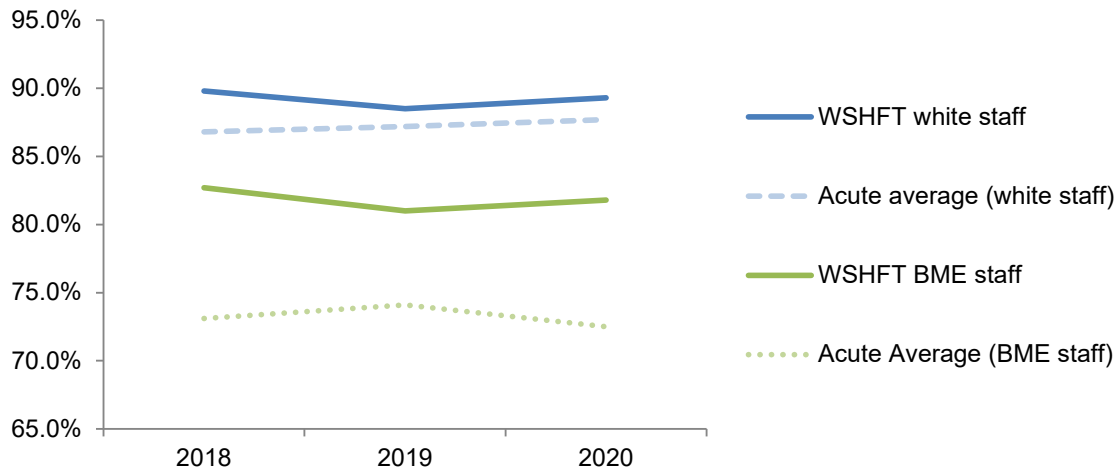
	BSUH BME staff	BSUH white staff	% point difference	Acute Average (BME staff)	Acute average (white staff)
2018	72.30%	87.60%	(15.30%)	73.10%	86.80%
2019	74.10%	87.50%	(13.40%)	74.10%	87.20%
2020	71.60%	85.70%	(14.10%)	72.50%	87.70%



Compared to the previous year, there has been a decrease for both BME and white Trust staff, believing that the Trust offers equal opportunities for carer progression or promotion. This has led to the overall experience widening between the two groups. When comparing to the acute average, both Trust BME and white staff score worse.

Western Sussex NHS Foundation Trust

	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%

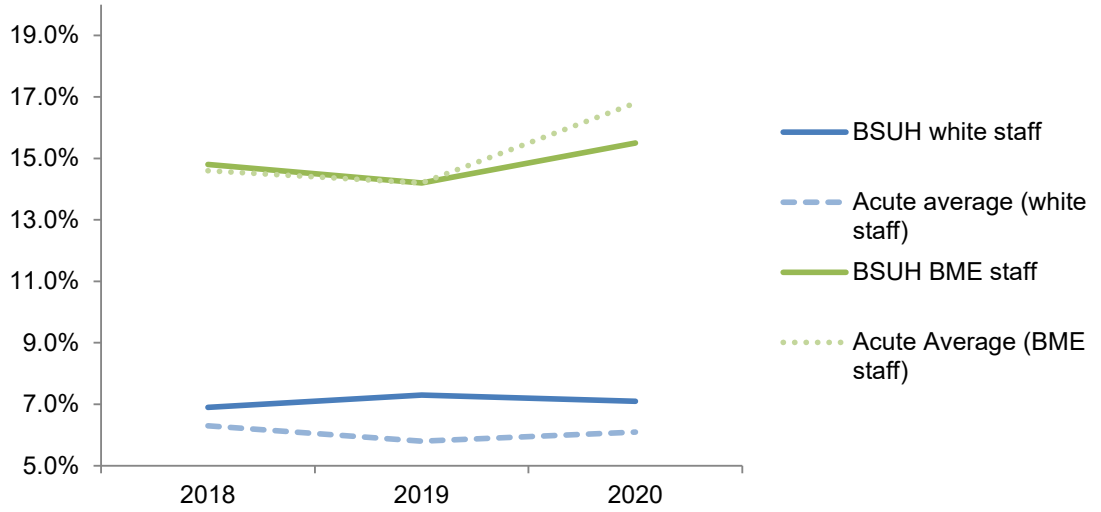


Compared to the previous year, there has been an increase in both Trust BME and white staff stating that they feel that the Trust offers equal opportunities for carer progression and promotion. The difference in experience between the two groups remains the same as the previous year. Comparing to the acute average, both Trust BME and white staff score better.

Indicator 8 - In the last 12 months, have you personally experienced discrimination at work from your Manager/team leader or other colleagues? Q15(b) from the Staff Survey

Brighton and Sussex University Hospitals NHS Trust:

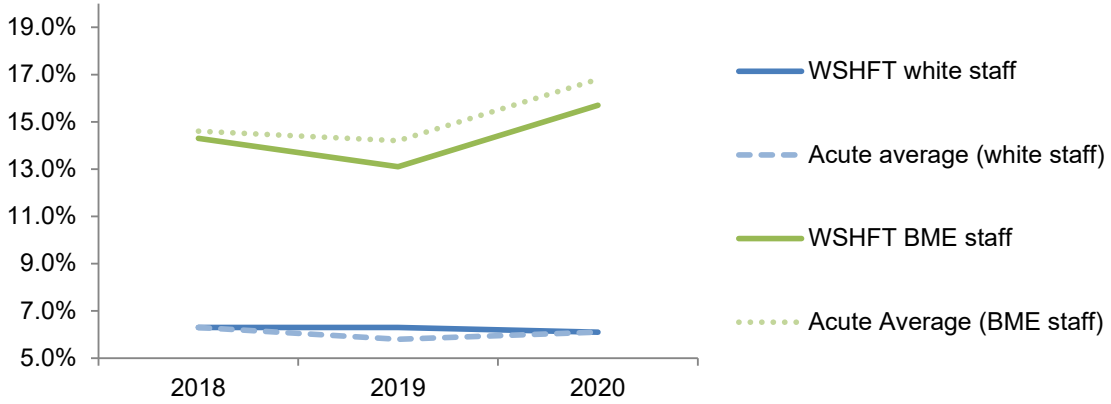
	BSUH BME staff	BSUH white staff	% point difference	Acute Average (BME staff)	Acute average (white staff)
2018	14.8%	6.9%	(-7.9%)	14.6%	6.3%
2019	14.2%	7.3%	(-6.9%)	14.2%	5.8%
2020	15.5%	7.1%	(-8.4%)	16.8%	6.1%



Compared to the previous year, Trust BME staff saw an increase (and white staff a slight decrease) in stating they have experienced discrimination from their manager/team leader or other colleagues. This has led the experience between the two groups to widen.

Western Sussex NHS Foundation Trust

	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%



Compared to the previous year, Trust BME staff saw an increase (and white staff a slight decrease) in stating they have experienced discrimination from their manager/team leader or other colleagues. This has led the experience between the

two groups to widen. The reporting is broadly comparable to the the acute trust average.

Indicator 9 - compare the difference for white and BME staff: Percentage difference between:

(i) The organisation's Board executive membership and its overall workforce

Brighton and Sussex University Hospitals NHS Trust:

	Overall Workforce		Executive Board Membership		
	Number in workforce	% in workforce	Number on board	% of board	% Difference
White Staff	6890	77.7%	11	78.6%	**+0.9%**
BME Staff	1725	19.4%	1	7.1%	**-12.3%**
Unknown	258	2.9%	2	14.3%	**+11.4%**
Total	8873	100.0%	14	100.0%	

Western Sussex NHS Foundation Trust:

	Overall Workforce		Executive Board Membership		
	Number in workforce	% in workforce	Number on board	% of board	% Difference
White Staff	5763	76.6%	11	78.6%	**-2.0%**
BME Staff	1359	18.1%	1	7.1%	**-11.0%**
Unknown	397	5.3%	2	14.3%	**+9.0%**
Total	7519	100.0	14	100.0%	

6) Are there any other factors or data which should be taken into consideration in assessing progress?

In 2016 the NHS Staff Survey was open to all BSUH Trust staff to participate. As a result, a potential sample of circa 8,000 was permitted to participate instead of a restricted sample of circa 800 as 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. Any issues of completeness of data

This report is based on information presented to the Trust's Board in 2021.

b. Any matters relating to the reliability of comparisons with previous years

On completing data for the WRES report, it was realised that there had been an

inconsistency in interpreting TRAC recruitment reports. This has now been rectified. In 2020 the likelihood was reported as 3.8, which should have been 1.42 for BSUH. For WSHFT, 1.32 was reported and should have been 1.35.

The requirements for indicator three has changed for the 2020/21 reporting period. Instead of a 2-year rolling average, this is now based on year-end.

University Hospitals Sussex
NHS Foundation Trust

University Hospitals Sussex NHS Foundation Trust

(Brighton and Sussex University Hospitals NHS Trust and Western Sussex NHS Foundation Trust)

Workforce Disability Equality Standard 2021

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. This being the case, 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 which 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 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 it is the societal barriers that people with disabilities face which is 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, advancing equality and fostering 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 15% difference between Electronic Staff Records (ESR) and Staff Survey declaration rates. ESR is the integrated human resources and payroll system for the NHS.
- Lack of representation of disabled staff at senior levels
- Disabled staff consistently report:
    - higher levels of bullying and harassment
    - less satisfaction with appraisals and career
    - lack of development opportunities.

Through the WDES programme and annual reporting, NHS organisations can review their performance, identify issues and look to continuously improve the position for workers with a disability, better understanding of the needs of their workers with a

disability, improving data (declaration rates), and improvements to the culture, employment and retention of all staff.

On 1st April 2021, Brighton and Sussex University Hospitals NHS Trust (BSUH) and Western Sussex Foundation NHS Trust merged to form University Hospitals Sussex NHS Trust. The data snapshot period covers 01/04/20-31/03/21; the report looks at each section of the Workforce Disability Equality Standard metrics for the two separate predecessor organisations.

It provides an overview of the closing position of each of the previous Trusts and therefore will be the baseline from which future progress is measured for the new combined Trust, University Hospitals Sussex, as we pursue equality and inclusion for all staff, including those with disability.

Background Information

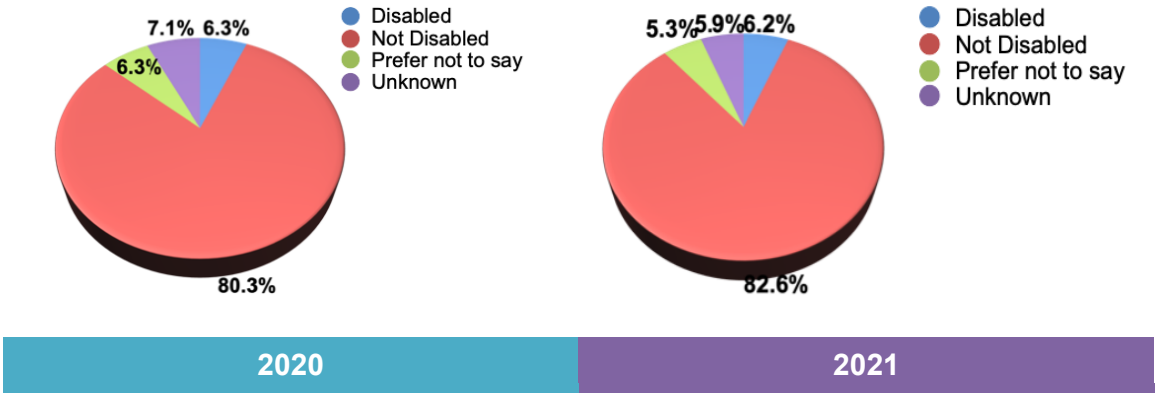
1) **The total number of staff:**

Brighton & Sussex University Hospitals NHS Trust

2020	2021
8598	8873

The proportion of staff with a disability declared who are employed within this organisation at the date of this report:

	2020		2021	
	Headcount	% of Staff	Headcount	% of Staff
Disabled	541	6.3%	547	6.2%
Not Disabled	6902	80.3%	7331	82.6%
Prefer not to say	543	6.3%	473	5.3%
Unknown	612	7.1%	522	5.9%
Total	8598	100.0%	8873	100%

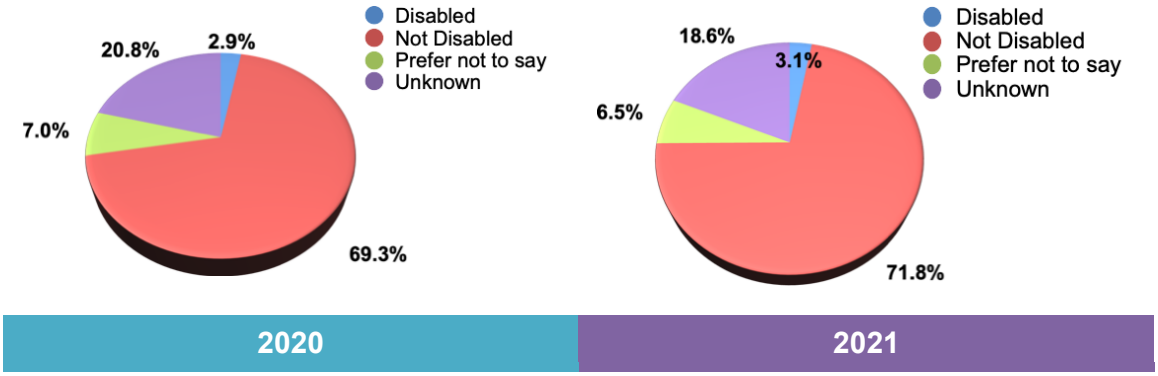


Western Sussex NHS Foundation Trust

2020	2021
7317	7519

The proportion of staff with a disability declared who are employed within this organisation at the date of this report:

	2020		2021	
	Headcount	% of Staff	Headcount	% of Staff
Disabled	212	2.9%	230	3.1%
Not Disabled	5068	69.3%	5401	71.8%
Prefer not to say	514	7.0%	487	6.5%
Unknown	1523	20.8%	1401	18.6%
Total	7317	100.0%	7519	100.0%



2) Self-reporting

a) The proportion of total staff who have self-reported their disability status:

Brighton and Sussex University Hospitals NHS Trust

	2020		2021	
	Headcount	% of Staff	Headcount	% of Staff
Disability Status Declared	7443	86.6%	7878	88.8%
Disability Status Not Declared	1155	13.4%	995	11.2%
Total	8598	100.0%	8873	100.0%

Western Sussex NHS Foundation Trust

	2020		2021	
	Headcount	% of Staff	Headcount	% of Staff
Disability Status Declared	5280	72.2%	5631	74.9%
Disability Status Not Declared	2037	27.8%	1888	25.1%
Total	7317	100.0%	7519	100.0%

b) Have any 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. Including setting up a new online declaration form, promoting Self-Service ESR, and producing new information for staff to inform them about updating their equality information.

c) Are any 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 declare their equality information and promote the different methods they can use. Work is also underway that Occupational Health services can promote both support and improving declaration of staff that are disabled.

3) Workforce Data

a) What period does the organisation's workforce data refer to?
1st April 2020 to 31st March 2021.

4) How is disability defined under the standard?

The standard uses the definition of disability that can be 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.

5) Population Demographics 2011 Census (Southeast England)

	Census 2011
Activity limited a lot	6.9%
Activity limited a little*	8.8%

* Within this section, some (not all) people would meet the test under the Equality Act 2010 as being disabled, but it is impossible 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

Metric 2 - Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.

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

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
- Other colleagues

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

Metric 5 - Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion

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

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

Metric 8 - Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work

Metric 9a - The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation

Metric 9b - Has your trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?

Metric 10 - The percentage difference between the organisation's board voting membership and its organisation's overall workforce

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

Brighton and Sussex University Hospitals NHS Trust

Non-Clinical Staff:

Compared to the overall representation of disabled staff in the BSUH workforce: 6.2%

	Disabled staff in 2020 - %	Disabled staff in 2021 - %	Disabled staff in 2020/2021 % point difference (+/-)	Non-disabled staff in 2020 - %	Non-disabled staff in 2021 - %	Non-disabled staff in 2020/2021 % point difference (+/-)	Unknown/null staff in 2020 - %	Unknown/null staff in 2021 - %	Unknown/null staff in 2020/2021 % point difference (+/-)	Total staff in 2020 Headcount	Total staff in 2021 Headcount
Cluster 1 (Bands 1 - 4)	10.6	10.1	(-0.5)	81.5	83.1	(+1.6)	7.9	6.8	(-1.1)	1829	1851
Cluster 2 (Band 5 - 7)	7.5	6.6	(-0.9)	82.9	85.9	(+3.0)	9.6	7.5	(-2.1)	426	440
Cluster 3 (Bands 8a - 8b)	8.3	8.9	(+0.6)	85.0	85.5	(+0.5)	6.7	5.6	(-1.1)	120	124
Cluster 4 (Bands 8c – 9 & VSM)	5.7	7.4	(+1.7)	81.1	77.8	(-3.3)	13.2	14.8	(+1.6)	53	54

What the data tells us:

- There is a better representation of disabled staff in non-clinical roles
- All clusters have a higher than expected level of representation of disabled staff (compared to the overall number of disabled staff in the workforce)
- There has been a decrease of disabled staff in clusters 1 and 2 compared to the previous year, both in percentage point difference and actual headcount
- There has been an increase of disabled staff in clusters 3 and 4 compared to the previous year, both in percentage point difference and actual headcount.

Clinical staff:

	Disabled staff in 2020 - %	Disabled staff in 2021 - %	Disabled staff in 2020/2021 % point difference (+/-)	Non-disabled staff in 2020 - %	Non-disabled staff in 2021 - %	Non-disabled staff in 2020/2021 % point difference (+/-)	Unknown/null staff in 2020 - %	Unknown/null staff in 2021 - %	Unknown/null staff in 2020/2021 % point difference (+/-)	Total staff in 2020 Headcount	Total staff in 2021 Headcount
Cluster 1 (Bands 1 - 4)	5.8	5.5	(-0.3)	82.4	85.4	(+3.0)	11.8	9.1	(-2.7)	1346	1,471
Cluster 2 (Band 5 - 7)	5.1	5.4	(-0.3)	80.9	82.8	(+1.9)	14.0	11.8	(-2.2)	3287	3,345
Cluster 3 (Bands 8a - 8b)	7.3	6.9	(-0.4)	81.3	81.7	(+0.4)	11.4	11.4	(0.0)	246	246
Cluster 4 (Bands 8c – 9 & VSM)	0.0	2.9	(+2.9)	64.5	70.6	(+6.1)	35.5	26.5	(-9.0)	31	34
Cluster 5 (Medical and Dental staff, Consultants)	1.3	1.0	(-0.3)	72.1	73.8	(+1.7)	26.6	25.2	(-1.4)	476	489
Cluster 6 (Medical and Dental staff, Non-consultant career grade)	1.8	1.8	(0.0)	59.6	58.2	(-1.4)	38.6	40.0	(+1.4)	57	55
Cluster 7 (Medical and Dental staff, Medical and Dental trainee grades)	4.7	4.2	(-0.5)	74.9	81.5	(+6.6)	20.4	14.3	(-6.1)	726	763

What the data tells us:

- Most Clinical roles (except cluster 3) have a lower than expected representation of disabled staff compared to the overall workforce representation (based on declared rates).
- There is a higher than expected representation of disabled staff in cluster 3 compared to the overall disabled workforce representation.
- In all other non-medical roles, there is a lower than expected representation of disabled staff when compared to the overall workforce.
- A high proportion of medical staff has not declared their disability status
- Compared to the previous year, several clinical clusters (except 4 and 6) have seen a slight decrease in the representation of disabled staff.
- There has been an overall reduction in the number of clinical staff whose disability status is unknown or null.
- Relating to headcount, compared to the previous year – there's been an increase in disabled staff in clusters 1, 2 and 4. All other clusters have seen a slight decrease, except six, which remained the same.

Western Sussex Hospitals NHS Foundation Trust

Compared to the overall representation of disabled staff in the WSHFT workforce: 3.1%

Non-Clinical Staff:

	Disabled staff in 2020 - %	Disabled staff in 2021 - %	Disabled staff in 2020/2021 % point difference (+/-)	Non-disabled staff in 2020 - %	Non-disabled staff in 2021 - %	Non-disabled staff in 2020/2021 % point difference (+/-)	Unknown/null staff in 2020 - %	Unknown/null staff in 2021 - %	Unknown/null staff in 2020/2021 % point difference (+/-)	Total staff in 2020 Headcount	Total staff in 2021 Headcount
Cluster 1 (Bands 1 - 4)	3.8	3.9	(+0.1)	70.1	72.4	(+2.3)	26.1	23.7	(-2.4)	1524	1523
Cluster 2 (Band 5 - 7)	1.7	2.8	(+1.1)	73.6	75.1	(+1.5)	24.8	22.1	(-2.7)	303	317
Cluster 3 (Bands 8a - 8b)	2.2	2.2	(0.0)	82.2	85.6	(+3.4)	13.3	12.2	(-1.1)	90	90
Cluster 4 (Bands 8c – 9 & VSM)	0.0	0.0	(0.0)	80.5	80.5	(0.0)	19.5	19.5	(0.0)	41	41

What the data tells us:

- There is a higher than expected representation (compared to overall representation) of declared disabled staff in cluster one. There was an increase from the previous year (percentage difference from the previous year and headcount).
- Clusters 2-4 have a lower than expected (compared to overall representation) of disabled staff.
- There has been no year-on-year increase of disabled staff in clusters 3 and 4 of representation compared to the previous year.
- Cluster 3 saw an increase in representation of disabled staff from the previous year in terms of headcount.
- In clusters 1-3, there has been a decrease in staff where their disability status is unknown. In cluster 4, this remained static.

Clinical staff:

	Disabled staff in 2020 - %	Disabled staff in 2021 - %	Disabled staff in 2020/2021 % point difference (+/-)	Non-disabled staff in 2020 - %	Non-disabled staff in 2021 - %	Non-disabled staff in 2020/2021 % point difference (+/-)	Unknown/null staff in 2020 - %	Unknown/null staff in 2021 - %	Unknown/null staff in 2020/2021 % point difference (+/-)	Total staff in 2020 Headcount	Total staff in 2021 Headcount
Cluster 1 (Bands 1 - 4)	3.2	3.2	(0.0)	71.8	73.8	(+2.0)	25.0	23.0	(-2.0)	1552	1638
Cluster 2 (Band 5 - 7)	2.4	2.8	(+0.4)	69.1	71.5	(+2.4)	28.5	25.7	(-2.8)	2784	2834
Cluster 3 (Bands 8a - 8b)	3.5	4.0	(+0.5)	71.8	72.5	(+0.7)	24.6	23.5	(-1.1)	142	149
Cluster 4 (Bands 8c – 9 & VSM)	0.0	0.0	(0.0)	53.8	48.0	(-5.8)	46.2	52.0	(+5.8)	13	25
Cluster 5 (Medical and Dental staff, Consultants)	1.8	1.4	(-0.4)	66.3	66.9	(+0.6)	31.9	31.7	(-0.2)	383	347
Cluster 6 (Medical and Dental staff, Non-consultant career grade)	2.2	1.2	(-1.0)	56.5	56.9	(+0.4)	41.3	41.9	(+0.6)	138	167
Cluster 7 (Medical and Dental staff, Medical and Dental trainee grades)	4.1	3.4	(-0.7)	55.9	69.0	(+13.1)	40.0	27.6	(-12.4)	340	387

What the data tells us:

- Clusters 1, 3 and 7 have a higher than expected representation of disabled staff compared to the representation in the overall workforce; cluster 2 is slightly under.
- Clusters 4-6 have a lower than expected representation of disabled staff compared to the representation in the overall workforce.
- In terms of percentage point difference from the previous year, clusters 2 and 3 saw an increase. However, clusters 1 and 4 remained the same and clusters 5-7 saw a decrease.
- In terms of headcount, clusters 1-3 saw an increase of disabled staff, whilst 4-7 either saw a slight decrease or remained the same.
- Most clusters (except 4 and 6) saw a decrease in staff members where their disability status was not known.

Metric 2 - Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.

Brighton and Sussex University Hospitals NHS Trust

	Shortlisted		Appointed		Relative Likelihood of being appointed
	Number	%	Number	%	
Disabled applicants	544	6.1%	47	3.0%	**0.09**
Non-disabled applicants	7532	84.9%	1160	73.2%	**0.15**
Not Stated / Unknown	793	8.9%	377	23.8%	**0.48**
Total	**8869**	**100.0%**	**1584**	**100.0%**	

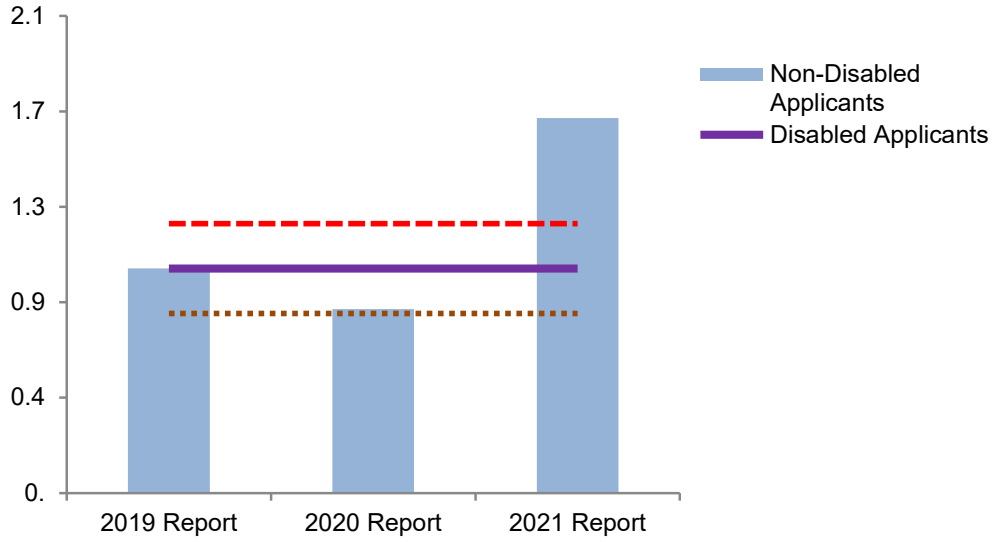
The likelihood of non-disabled candidates being appointed from shortlisting:
1160 / 7532 = 0.15

The likelihood of disabled candidates being appointed from shortlisting:
47 / 544 = 0.09

The relative likelihood of non-disabled candidates being appointed from shortlisting compared to disabled candidates is 0.15 (non-disabled candidates) / 0.09 (disabled candidates) = **1.67 times greater.**

In this instance, the data suggests non-disabled candidates are more likely to be appointed than disabled candidates.

Historical comparison



The above chart shows data from 2019, 2020 and 2021 reports. The disabled applicants (purple line) are at a constant of 1.00. In the 2019 report, the relative likelihood for non-disabled applicants was 1.00, which means an equal chance of being appointed compared to disabled applicants. In 2020 the likelihood was 0.82, demonstrating that disabled applicants are more likely to be appointed than non-disabled applicants. In 2021 the relatively likelihood is 1.67, which means non-disabled applicants are more likely to be appointed from shortlisting than disabled applicants.

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.

Western Sussex Hospitals NHS Foundation Trust

	Shortlisted		Appointed		Relative Likelihood of being appointed
	Number	%	Number	%	
Disabled applicants	315	5.6%	22	3.9%	0.07
Non-disabled applicants	5152	90.9%	501	89.6%	0.10
Not Stated / Unknown	198	3.5%	36	6.4%	0.18
Total	**5665**	**100.0%**	**559**	**100.0%**	

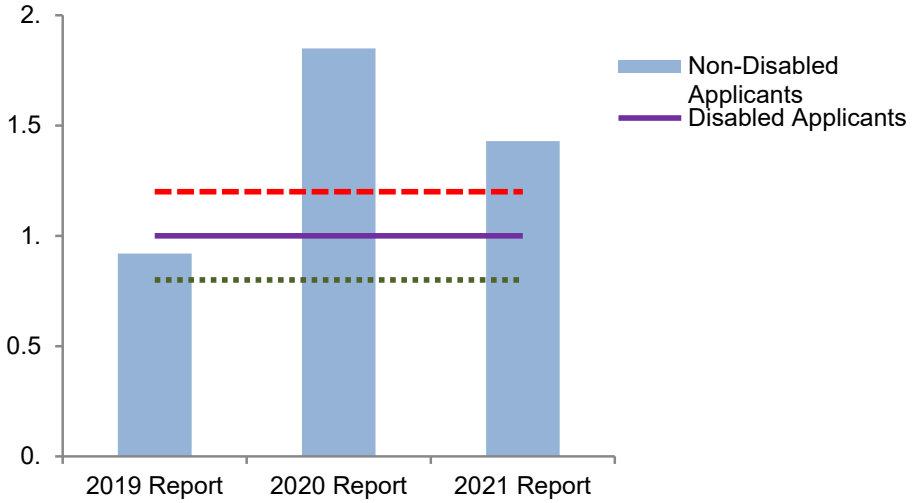
The likelihood of non-disabled candidates being appointed from shortlisting:
501 / 5152 = 0.10

The likelihood of disabled candidates being appointed from shortlisting:
22 / 315 = 0.07

The relative likelihood of non-disabled candidates being appointed from shortlisting compared to disabled candidates is 0.10 (non-disabled candidates) / 0.07 (disabled candidates) = **1.43**

In this instance, the data suggest that non-disabled candidates are more likely to be appointed from shortlisting than disabled candidates.

Historical comparison



The above chart shows data from 2019, 2020 and 2021 reports. The disabled applicants (purple line) are at a constant of 1.00. In the 2019 report, the relative likelihood for non-disabled applicants was 0.92, which means disabled applicants are slightly more likely to be appointed than non-disabled applicants. In 2020 the likelihood was 1.85, demonstrating that non-disabled applicants are more likely to be appointed than non-disabled applicants. In 2021 the relatively likelihood is 1.43, which means non-disabled applicants are more likely to be appointed from shortlisting than disabled applicants.

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)

Brighton and Sussex University Hospitals NHS Trust

	2-year rolling average of capability procedures	Number in Workforce	Relative Likelihood of entering procedure
Disabled staff	1.5	547	0.0027
Non-disabled staff	9.5	7331	0.0013
Not known / unspecified	4.5	995	0.0045

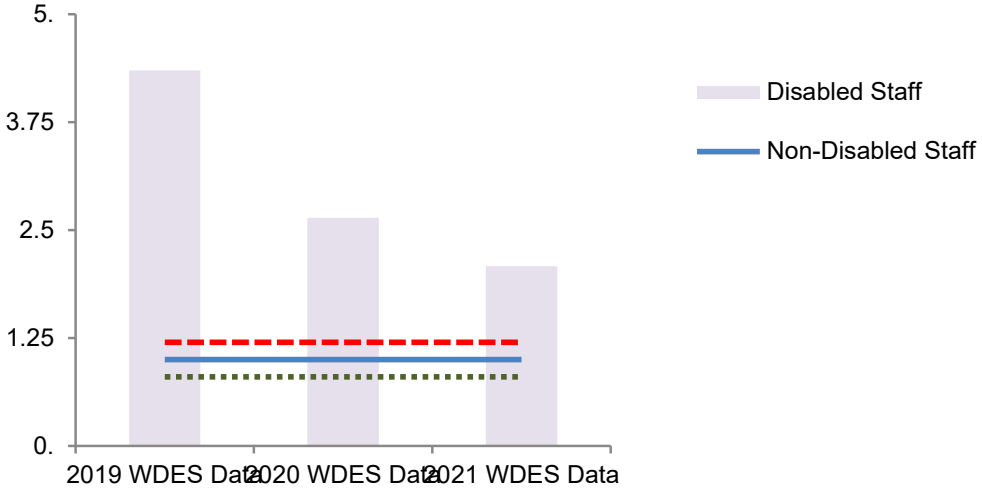
The likelihood of non-disabled staff entering the formal capability process:
9.5 / 7331 = 0.0013

The likelihood of disabled staff entering the formal capability process:
1.5 / 547 = 0.0027

The relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff is 0.0027 (Disabled Staff) / 0.0013 (non-disabled Staff) = **2.08 times greater.**

In this instance, the data suggests that disabled staff members are more likely than non-disabled staff to enter into a formal capability process.

Historical Comparison



The above chart demonstrates data from the 2019 and 2020 reports. The non-disabled staff (blue line) are at a constant of 1.00. In 2019 the relatively likelihood was 4.35. This means that disabled staff are more likely to enter into a formal capability process than non-disabled; this dropped to 2.64 in 2020 and further in 2021 2.01 in 2021.

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.

Western Sussex Hospitals NHS Foundation Trust

	2-year rolling average of capability procedures	Number in Workforce	Relative Likelihood of entering procedure
Disabled staff	0	230	0.0000
Non-disabled staff	2.5	5401	0.0005
Not known / unspecified	0	1888	0.0000

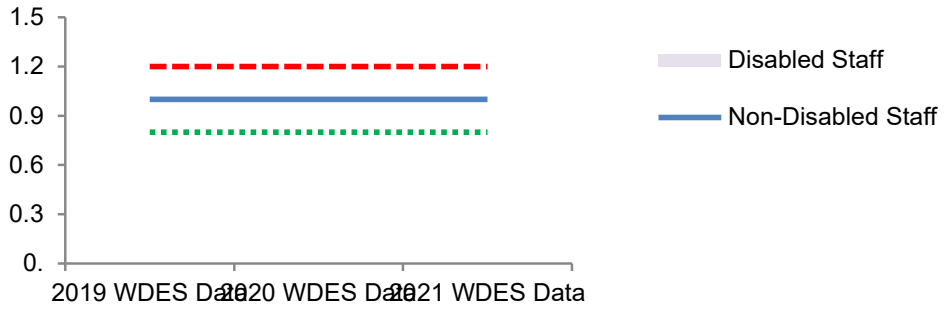
The likelihood of non-disabled staff entering the formal capability process:
2.5 / 5401 = 0.0005

The likelihood of disabled staff entering the formal capability process:
0 / 230 = 0.0000

The relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff is 0.0000 (Disabled Staff) / 0.0005 (non-disabled Staff) = **0.00**

In this instance, the data suggests that disabled staff members have not entered the disciplinary process.

Historical Comparison



The above chart illustrates, throughout the last 3 reporting periods, there have been no disabled staff entering the formal capability process.

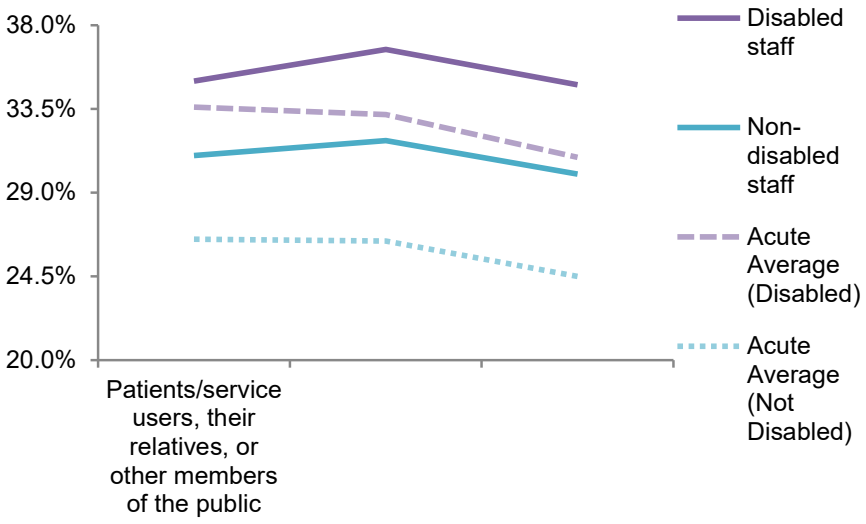
When applying the rule of 4/5ths, if the likelihood of disabled staff is below 0.8 or above 1.2, it would indicate a likely statistical adverse impact.

Metric 4a - Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying, or abuse from:

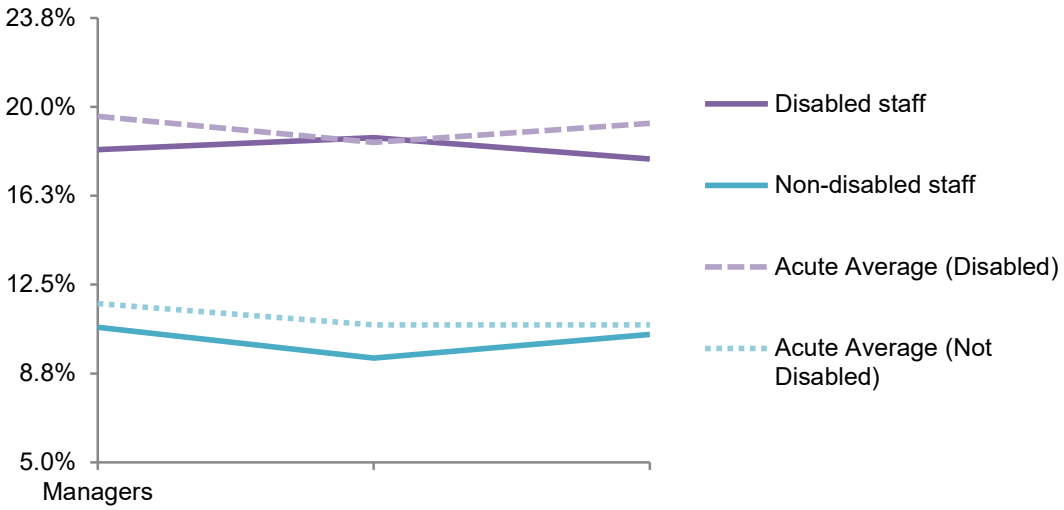
- **Patients/service users, their relatives, or other members of the public**
- **Managers**
- **Other colleagues**

Brighton and Sussex University Hospitals NHS Trust

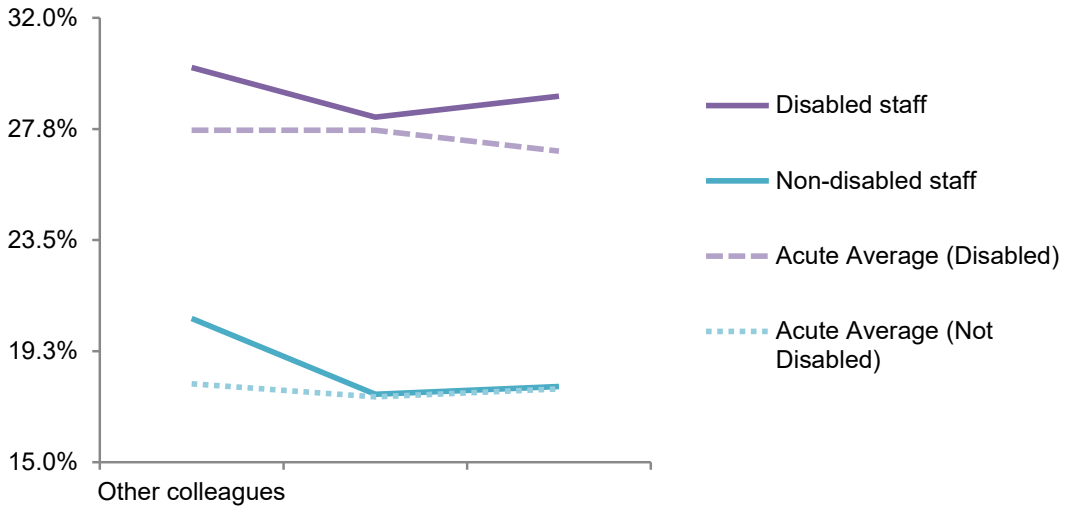
	Patients/service users, their relatives, or other members of the public		
	2018	2019	2020
Disabled staff	35.0%	36.7%	34.8%
Non-disabled staff	31.0%	31.8%	30.0%
% point difference between disabled and non-disabled staff	(-4.0%)	(-4.9%)	(-4.8%)
Acute Average (Disabled)	33.6%	33.2%	30.9%
Acute Average (Non-Disabled)	26.5%	26.4%	24.5%



	Managers		
	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		
	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%

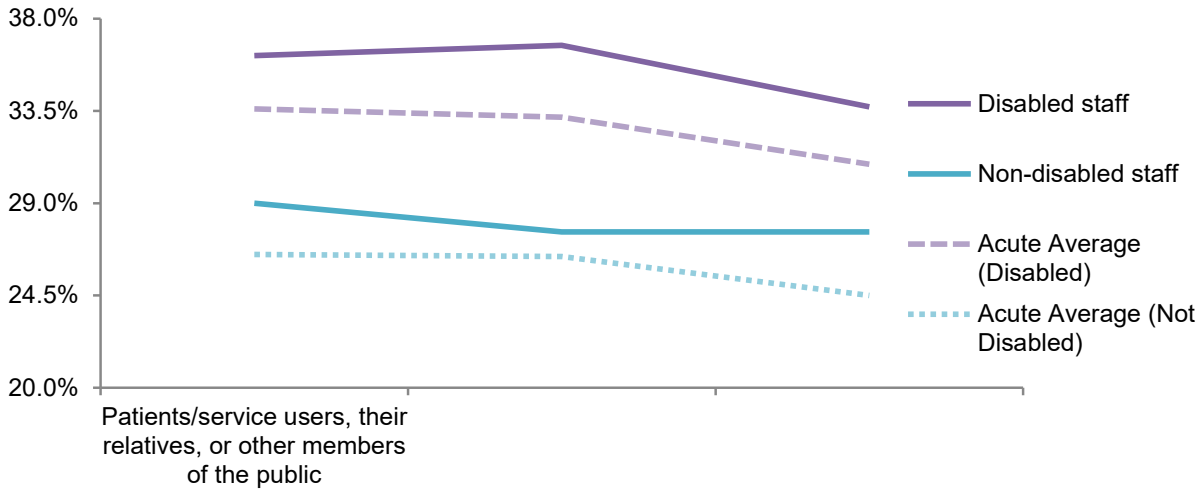


What the data tells us:

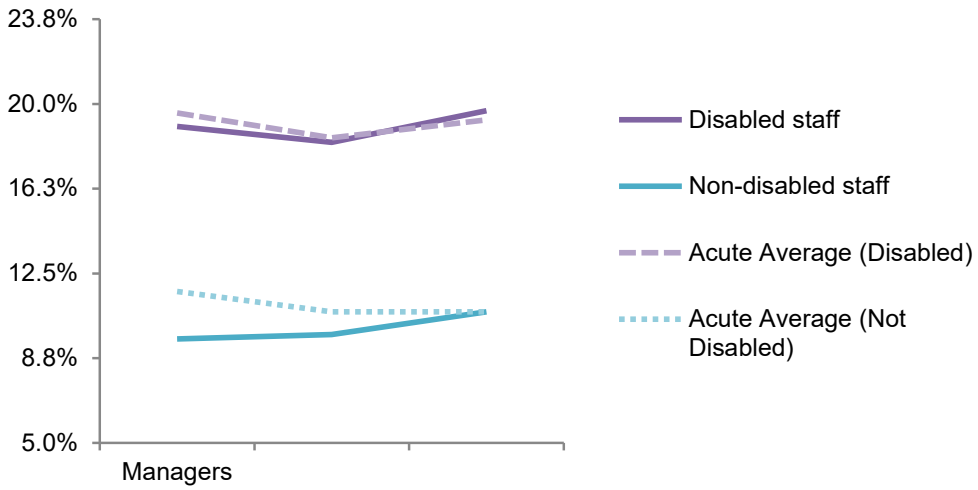
- Overall disabled staff report that they have experienced bullying, harassment and abuse than non-disabled staff.
- There has been an improvement in the reported experience by disabled staff of bullying, harassment and abuse from patients, services users, etc. and managers. The difference in reported experiences between disabled and non-disabled staff got (compared to the previous year)
- The reported experience of bullying, harassment and abuse from other colleagues was worse in the 2020 staff survey compared to the previous year. This also meant the difference in experience between disabled and non-disabled staff widened.
- Compared to the acute average, in the 2020 staff survey, the Trust's reported rate of bullying, harassment and abuse from patients, service users, etc. and other colleagues was worse for disabled staff.
- Compared to the acute average, in the 2020 staff survey, the Trust's reported rate of bullying, harassment and abuse from managers was better for disabled staff.

Western Sussex Hospitals NHS Foundation Trust

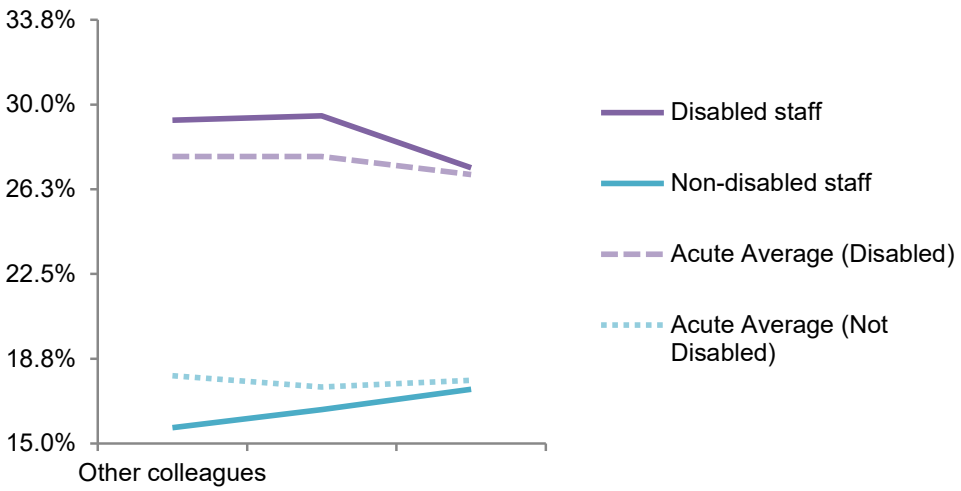
	Patients/service users, their relatives, or other members of the public		
	2018	2019	2020
Disabled staff	36.2%	36.7%	33.7%
Non-disabled staff	29.0%	27.6%	27.6%
% point difference between disabled and non-disabled staff	(-7.2%)	(-9.1%)	(-6.1%)
Acute Average (Disabled)	33.6%	33.2%	30.9%
Acute Average (Non-Disabled)	26.5%	26.4%	24.5%



	Managers		
	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		
	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:

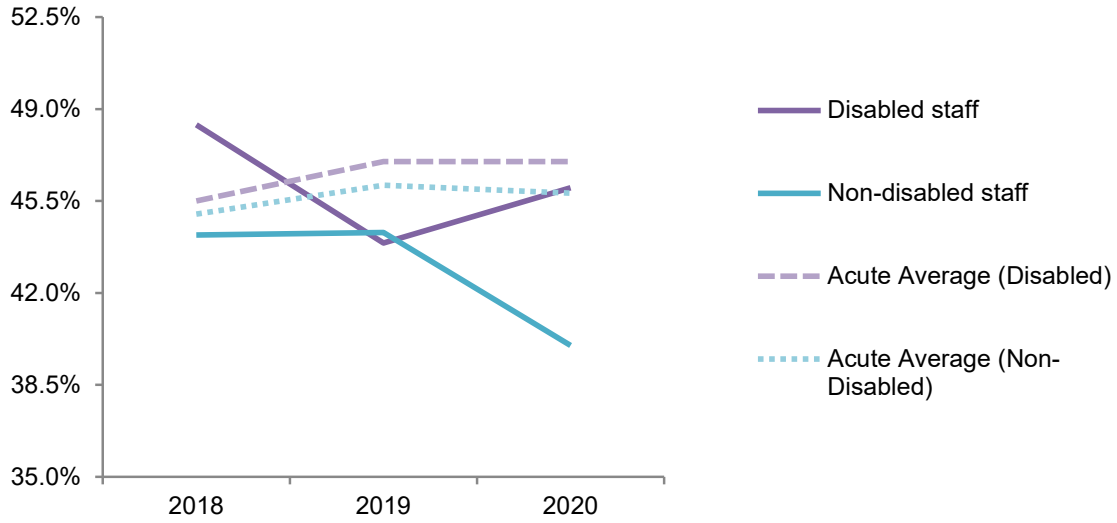
- Overall disabled staff report that they have experienced bullying, harassment and abuse than non-disabled staff.
- There has been an improvement in the reported experience by disabled staff of bullying, harassment and abuse from patients, services users, etc. and other colleagues. The difference in reported experiences between disabled and non-disabled staff got smaller (compared to the previous year)
- The reported experience of bullying, harassment and abuse from managers was worse in the 2020 staff survey compared to the previous year. This also meant the difference in experience between disabled and non-disabled staff widened.

- Compared to the acute average, in the 2020 staff survey, the Trust's reported rate of bullying, harassment and abuse from patients, service users, etc., was worse for disabled staff.
- Compared to the acute average, in the 2020 staff survey, the Trust's reported rate of bullying, harassment and abuse from managers and other colleagues was broadly in line.

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.

Brighton and Sussex University Hospitals NHS Trust

	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%

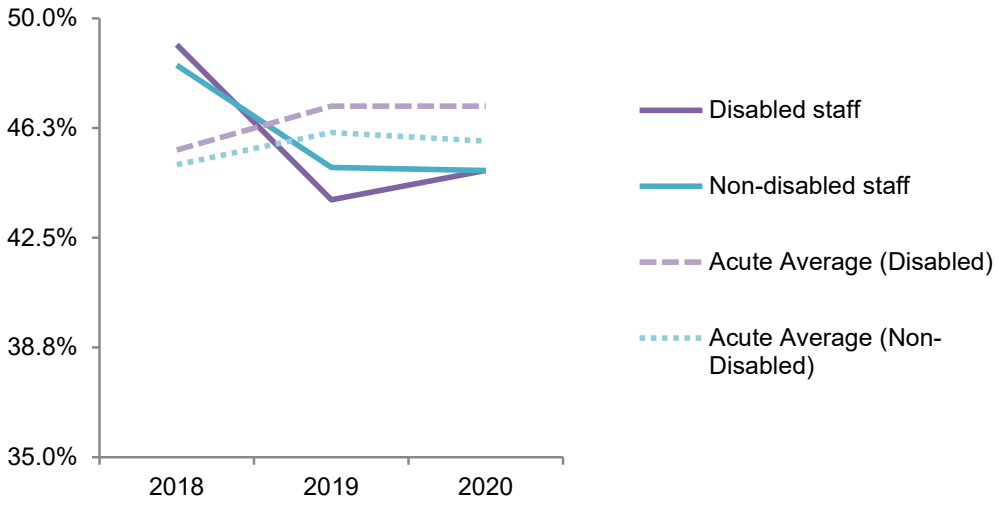


What the data tells us:

- Compared to the previous year, disabled staff are more likely to report incidents of bullying, harassment and abuse
- Compared to the previous year, there has been a decrease in the number of non-disabled staff reporting bullying, harassment, and abuse, leading to the difference between Trust staff between the two groups widening.
- Compared to the acute average, both disabled and non-disabled staff at the Trust report incidents of bullying, harassment and abuse less.

Western Sussex Hospitals NHS Foundation Trust

	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:

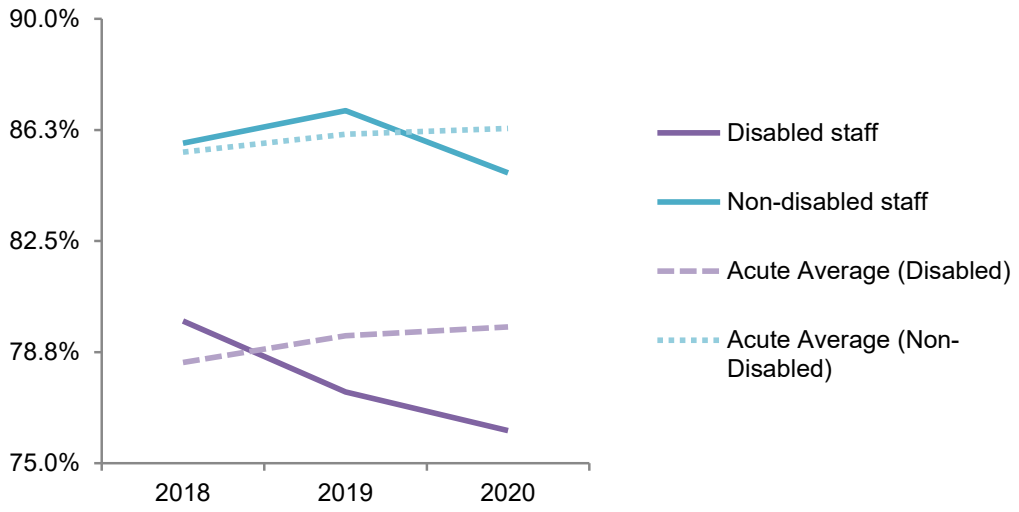
- Compared to the previous year, disabled staff are more likely to report bullying, harassment, and abuse incidents, which has led to the difference between Trust staff between the two groups being equal.

- Compared to the previous year, there has been a decrease in the number of non-disabled staff reporting bullying, harassment and abuse
- Compared to the acute average, both disabled and non-disabled staff at the Trust are reporting incidents of bullying, harassment and abuse less

Metric 5 - Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.

Brighton and Sussex University Hospitals NHS Trust

	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%



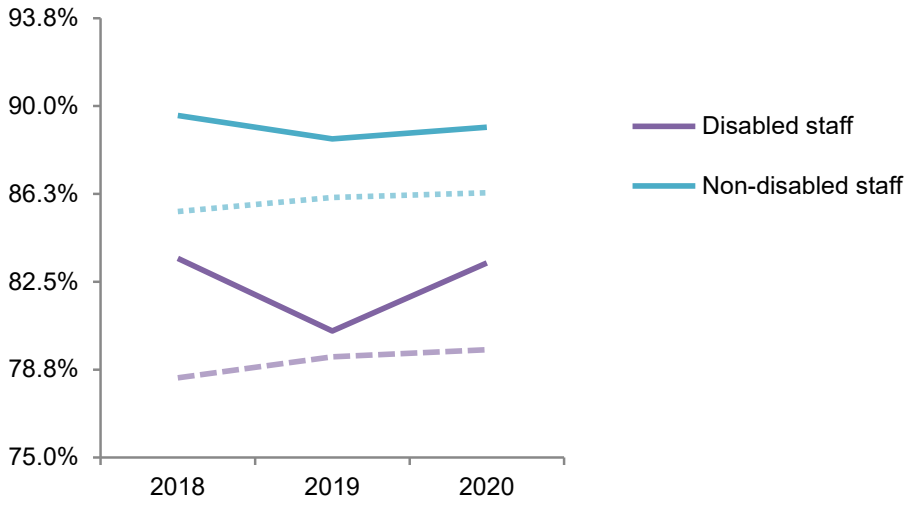
What the data tells us:

- Compared to the previous year, both disabled and non-disabled staff feel that the Trust provides equal opportunities for career progression or promotion has decreased

- Compared to the previous year, the experience difference between the two groups has got smaller
- Both disabled and non-disabled staff score lower than the acute average.

Western Sussex Hospitals NHS Foundation Trust

	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%



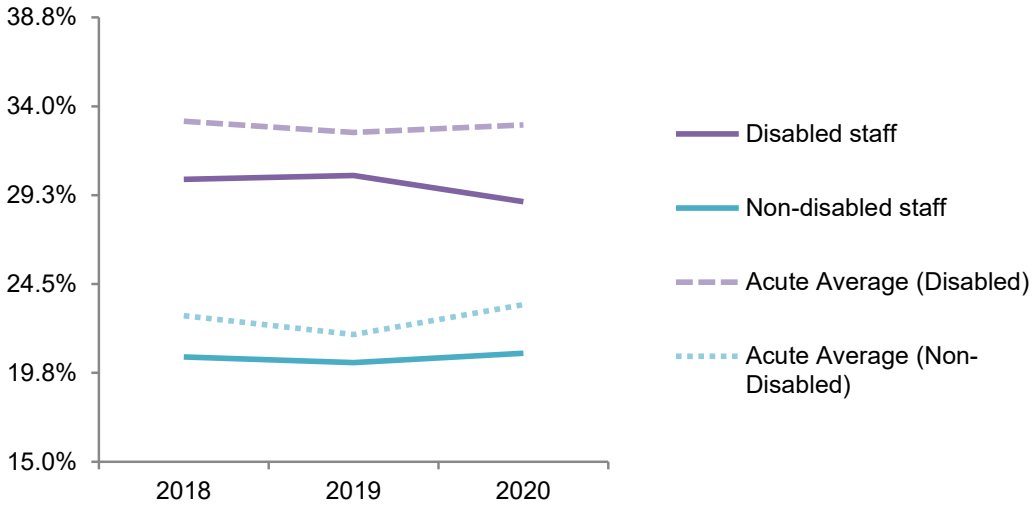
What the data tells us:

- Compared to the previous year, both disabled and non-disabled staff feel that the Trust provides equal opportunities for career progression or promotion has increased
- Compared to the previous year, the experience difference between the two groups has got smaller
- Both disabled and non-disabled staff score better than the acute average.

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.

Brighton and Sussex University Hospitals NHS Trust

	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%

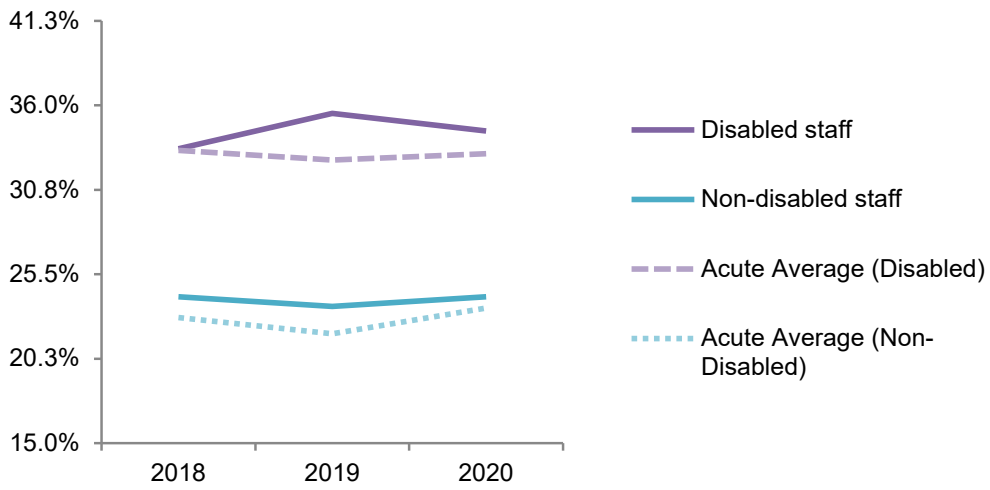


What the data tells us:

- Compared to the previous year, fewer disabled staff feel pressured by their manager to attend work despite not feeling well enough.
- Compared to the previous year, the gap between the difference between disabled and non-disabled staff's experience got smaller
- Compared to the acute average, the Trust relating to both disabled and non-disabled staff is better.

Western Sussex Hospitals NHS Foundation Trust

	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%



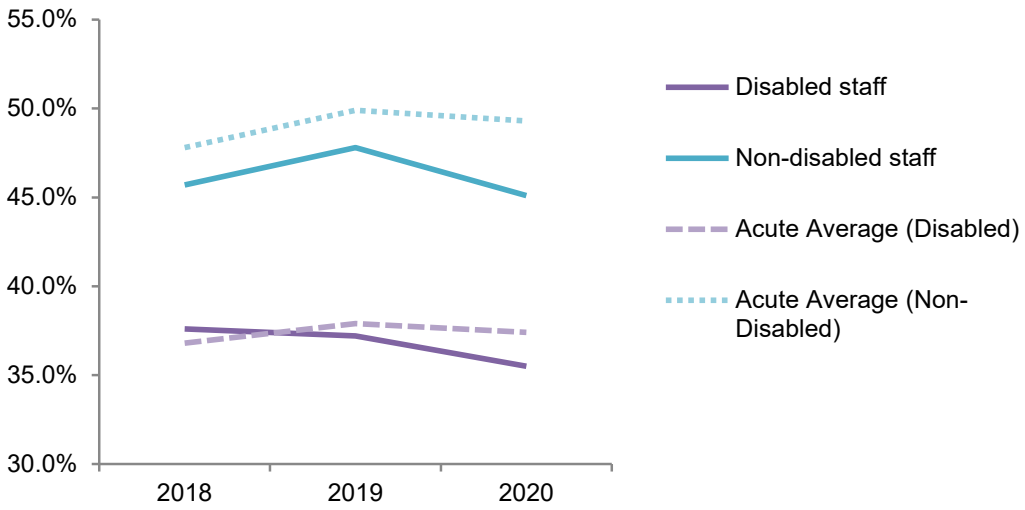
What the data tells us:

- Compared to the previous year, fewer disabled staff feel pressured by their manager to attend work despite not feeling well enough.
- Compared to the previous year, the gap between the difference between disabled and non-disabled staff's experience got smaller
- Compared to the acute average, the Trust relating to both disabled and non-disabled staff is slightly worse.

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.

Brighton and Sussex University Hospitals NHS Trust

	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%

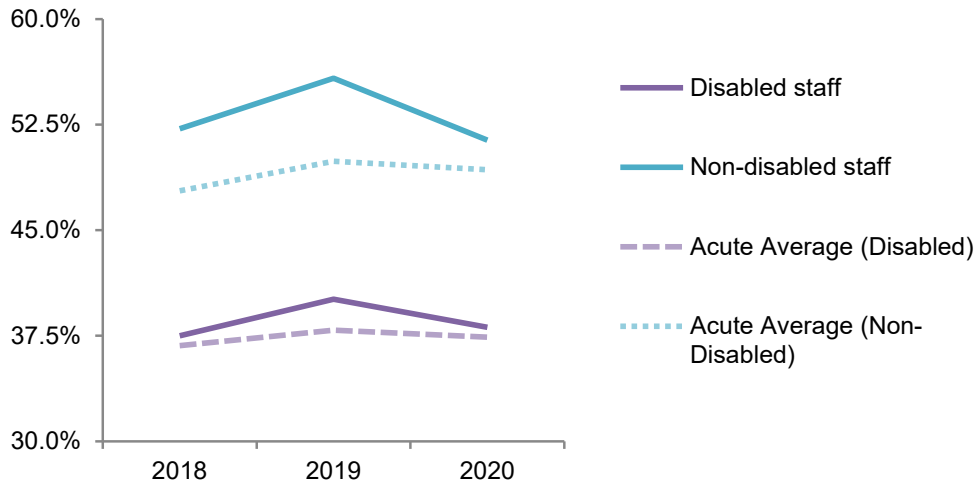


What the data tells us:

- Compared to the previous year, fewer disabled and non-disabled staff felt satisfied that the Trust values their work.
- Compared to the previous year, the gap between the difference between disabled and non-disabled staff's experience got smaller
- Compared to the acute average, the Trust relating to both disabled and non-disabled staff is worse.

Western Sussex Hospitals NHS Foundation Trust

	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%



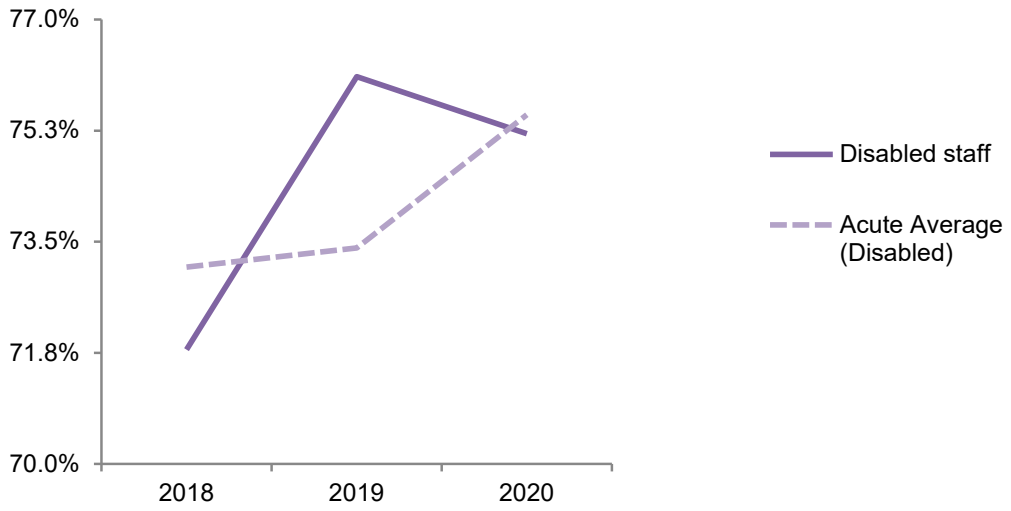
What the data tells us:

- Compared to the previous year, fewer disabled and non-disabled staff felt satisfied that the Trust values their work.
- Compared to the previous year, the gap between the difference between disabled and non-disabled staff's experience got smaller
- Compared to the acute average, the Trust relating to both disabled and non-disabled staff is better.

Metric 8 - Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.

Brighton and Sussex University Hospitals NHS Trust

	2018	2019	2020
Disabled staff	71.8%	76.1%	75.2%
Acute Average (Disabled)	73.1%	73.4%	75.5%

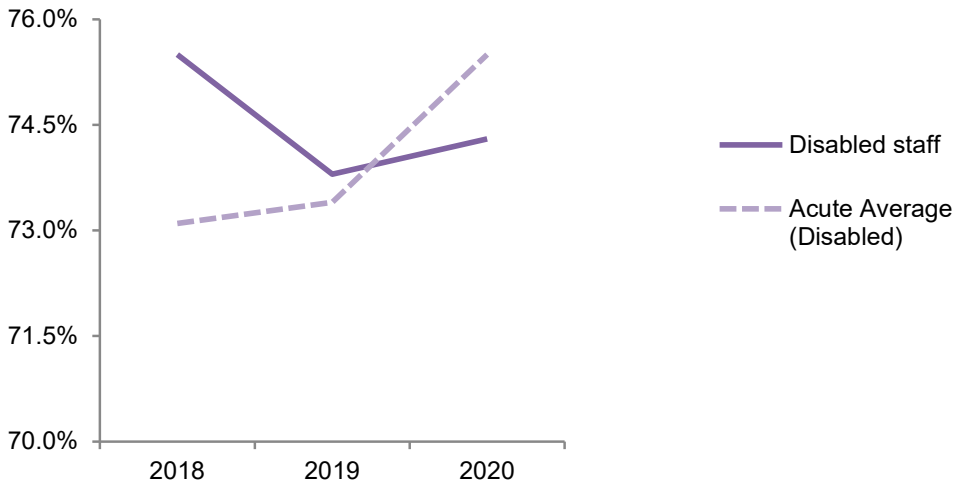


What does the data tell us:

- Compared to the previous year, fewer disabled staff felt that they have adequate, reasonable adjustments
- Compared to the acute average, the Trust scores slightly less.

Western Sussex Hospitals NHS Foundation Trust

	2018	2019	2020
Disabled staff	75.5%	73.8%	74.3%
Acute Average (Disabled)	73.1%	73.4%	75.5%



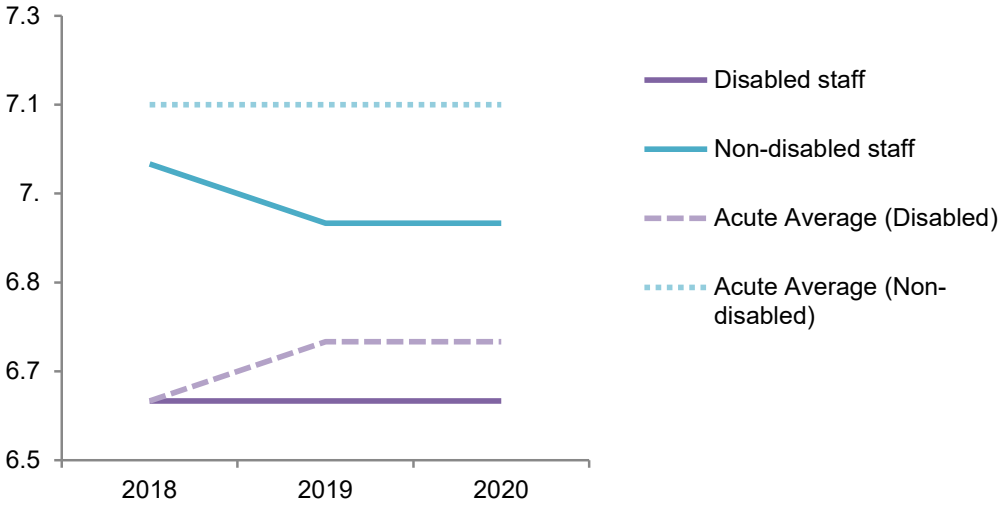
What does the data tell us:

- Compared to the previous year, more disabled staff felt that they have adequate, reasonable adjustments
- Compared to the acute average, the Trust scores less.

Metric 9a - The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.

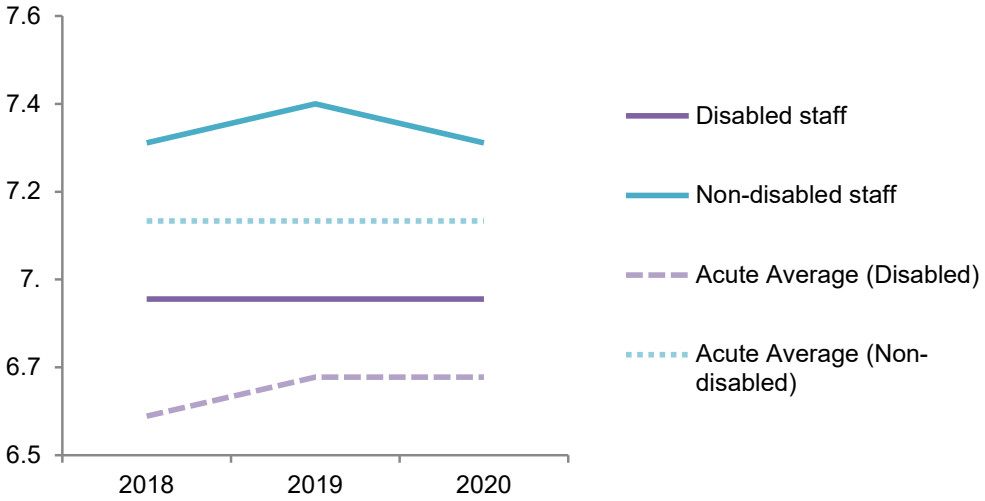
Brighton and Sussex University Hospitals NHS Trust

	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



Western Sussex Hospitals NHS Foundation Trust

	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?

Brighton and Sussex University NHS Trust

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. The network reports to the Diversity Matters Steering Group, chaired by the Chief Executive and the Chief Workforce and Organisational Development Officer.

Western Sussex Hospitals NHS Foundation Trust

Yes - The Trust has a disability staff network. The network aims to provide an avenue for staff to discuss disability-related issues, the WDES outcomes and action plan are discussed with the network. The network reports to the Diversity Matters Steering Group, which the Chief Executive and HR Director chair.

Metric 10 - The percentage difference between the organisation's board voting membership and its organisation's overall workforce, disaggregated:

(i) The organisation's Board executive membership and its overall workforce

Brighton and Sussex University Hospitals NHS Trust

	Overall Workforce		Executive Board Membership		
	Number in workforce	**% in workforce**	**Number on board**	**% of board**	**% Difference**
Disabled	547	6.2%	0	0.0%	**-6.2%**
Non-disabled	7331	82.6%	5	35.7%	**46.9%**
Not known	995	11.2%	9	64.3%	**-53.10%**
Total	8873	100.0%	14	100.0%	

Western Sussex Hospitals NHS Foundation Trust

	Overall Workforce		Executive Board Membership		
	Number in workforce	**% in workforce**	**Number on board**	**% of board**	**% Difference**
Disabled	230	3.1%	0	0.0%	**-3.1%**
Non-disabled	5402	71.8%	5	35.7%	**36.1%**
Not known	1888	25.1%	9	64.3%	**-39.2%**
Total	7519	100.0%	14	100.0%	

In Year Actions for 2021/22:

	Action	Responsibility	Completion
1.	Executive Director sponsor for Disability Staff Network	EDI	Feb-22
2.	Improve on declaration rates of the workforce	EDI/HR	Mar-22
3.	Review disparity in Recruitment data	HR Employment Services	Mar-22

6) Are there any other 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.

a. **Any matters relating to the reliability of comparisons with previous years**
   On completing data for the WDES report, it was realised that there had been an inconsistency in interpreting TRAC recruitment reports. This has now been rectified. In 2020 the likelihood was reported as 0.82, which should have been 0.96 for BSUH. For WSHFT, 1.85 was reported and should have been 2.48.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	14	**Meeting:**	Board	**Meeting Date:**	5 August 2021
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 29 July 2021 and was quorate as it was attended by four Non-Executive Directors, the Chair, the Chief Financial Officer, the Chief Delivery and Strategy Officer, the Chief People Officer and the Chief Executive. In attendance were the Commercial Director, the Director of Efficiency and Delivery and the Director of IM&T.

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, an IM&T update, an ICS finance update and the Board Assurance Framework.

Key Recommendation(s):

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

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

University Hospitals Sussex
NHS Foundation Trust

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Sustainability Committee	**29 July 2021**	**Lizzie Peers**	✓	☐

Declarations of Interest Made

There were no declarations of interest made

Assurances received at the Committee meeting

Patient First Trust North, Breakthrough Objective and Strategic Initiative

The Committee **RECEIVED** an update on financial performance of the Trust and **NOTED** that the Trust was achieving its financial control total of breakeven for quarter 1 providing ASSURANCE on the delivery of the Trust True North.

The Committee **RECEIVED** updates on the delivery of the Sustainability Breakthrough Objective, Strategic Initiative and Corporate Project. The Committee **NOTED** the significant level of work being undertaken in respect of their delivery. The Committee **NOTED** the positive work done to support a reduction in the use of Nurse Agency and the increased use of the Trust's bank arrangements,. It also noted the strong clinical engagement in the development of the Trust's sustainability initiatives and the development of the Trust's green plan which will detail the Trust ambition in this area and allow delivery to be tracked. In respect of the corporate project the Committee was ASSURED that the lessons learnt from the BSUH PAS implementation have been incorporated into this project. The Committee also **NOTED** the high level of clinical engagement with this project and the enthusiasm from the staff to realise the identified benefits.

Use of Resources

The Committee **RECEIVED** a report on the Trust's efficiency programme and **NOTED** its successful delivery against the quarter 1 plan. The Committee was updated on the work undertaken to assure the delivery of the schemes within the programme. The Committee **NOTED** the continued good level of engagement in the development of schemes and the plans alignment to the restoration programme.

The Committee **RECEIVED** a report on the wide-ranging Trust's IM&T programme of work. The Committee was **ASSURED** over the work being done to integrate systems where appropriate and the work underway to develop the UHSussex clinically led IT Strategy.

A number of business developments were presented to the Committee who **APPROVED** their progression recognising the patent benefits each would bring.

ICS

The Committee **RECEIVED** an update on work the Trust is undertaking within the ICS and **NOTED** the role the Trust is playing through the ICS Finance Leadership Group.

RISK The Committee reviewed the BAF risks it has oversight for, and **AGREED,** the quarter two score for risks 2.1, 2.2 and 2.3 were fairly stated.
Actions taken by the Committee within its Terms of Reference
Items to come back to Committee (Items the Committee is seeking to keep an eye on)
The Committee agreed to have receive a deep dive on the operation of the Elective Recovery Fund.
Items referred to the Board or another Committee for decision or action

Item	**Date**
The Committee recommended to the Board that the risks within the BAF for which it has oversight are fairly represented.	To Board 5 August 2021

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	15	**Meeting:**	Board	**Meeting Date:**	5 August 2021
Report Title:	Systems and Partnerships Committee Chair report to Board				
Committee Chair:		Patrick Boyle, Committee Non Executive Chair			
Author(s):		Patrick Boyle, Committee Non Executive Chair			
Report previously considered by and date:					
Purpose of the report:					
Information		☐	Assurance	✓	
Review and Discussion		☐	Approval / Agreement	☐	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		☐	Staff confidentiality	☐	
Patient confidentiality		☐	Other exceptional circumstances	☐	
Implications for Trust Strategic Themes and any link to BAF risks					
Patient	☐				
Sustainability	☐				
People	☐				
Quality	☐				
Systems and Partnerships	✓	Assurances in relation to risks 5.1, 5.2 and 5.3			
Link to CQC Domains:					
Safe		✓	Effective	✓	
Caring		✓	Responsive	✓	
Well-led		✓	Use of Resources	✓	
Communication and Consultation:					

Executive Summary:

The Systems and Partnerships Committee met on the 29 July 2021 and was quorate as it was attended by four Non-Executive Directors, the Trust Chair, the Chief Delivery and Strategy Officer, the Chief Financial Officer, the Chief People Officer, the Chief Culture and Organisational Development Officer and the Chief Executive. In attendance were, the Commercial Director, the Director of Efficiency and Delivery and the Director of Strategy and Planning.

The Committee received its planned items including the reports on the respective the Systems and Partnerships Trust North, Breakthrough Objectives, Strategic Initiatives and Corporate Projects, along with updates on the Trust's work within the ICS, the development of a Strategic Case for the potential future relationship with QVH and the Board Assurance Framework.

Key Recommendation(s):

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

The Board is asked to **NOTE** the Committee recommendation that the BAF risks 5.1, 5.2 and 5.3, for which it has oversight, are fairly represented.

University Hospitals Sussex
NHS Foundation Trust

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Systems and Partnerships Committee	**29 July 2021**	**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 and Strategic Initiative

The Committee **RECEIVED** an update on constitutional performance for quarter one including the performance against the Trust's systems and partnership true norths for emergency and planned care. The Committee **NOTED** the Trust's performance against the national A&E, RTT, Cancer and Diagnostic targets and was **ASSURED** over the work being undertaken by the Trust, and its work with the ICS to address the challenges with the current increases in emergency demand, and delivering the Trust restoration plans.

The Committee **NOTED** the positive performance of the Trust in respect of the Cancer 28 day faster diagnosis target and that some service areas of the Trust have already achieved the October target. The committee also noted the reductions in 104 day cancer patient numbers.

The Committee **RECEIVED** updates on the delivery of the respective Breakthrough Objectives, Strategic Initiative and Corporate Projects. The Committee **NOTED** the significant level of work being undertaken in respect of their delivery especially the continued positive work in respect of the UHSussex merger and integration post-transaction programme. The Committee also **NOTED** the significant work delivered this quarter that sees the Trust ahead of its restoration and recovery corporate project delivery plan.

ICS and Systems Collaborations

The Committee **RECEIVED** an update on work the Trust is undertaking within the Sussex Acute Collaborative Network across all of the workstreams within the collaborative and was **ASSURED** that the Trust was playing an active role in the development and delivery of actions to enhance acute collaboration for the benefit of the patients of Sussex.

The Committee **RECEIVED** an update on the work undertaken over the last quarter to develop a Strategic Outline Case jointly with Queen Victoria Hospital Trust in respect of potential options for collaboration with QVH. The Committee reviewed the process through which the Trusts had developed the options and Strategic Case, and that they met the requirements of the National guidance. The Committee **NOTED** the potential service and sustainability drivers for the proposals, the benefits to QVH, UHSussex and wider System of the strengthening these arrangements, and that the QVH Board would also be considering the case at its Board this month for decision.

The Committee were **ASSURED** that the case had been developed appropriately and met the required process requirements, and recommended that it be taken to the Board for review and decision.

RISK

The Committee reviewed the BAF risks it has oversight for, and **AGREED,** the quarter one score for risks 5.1, 5.2 and 5.3 were fairly stated and were **ASSURED** by the actions and controls in place.

Actions taken by the Committee within its Terms of Reference

There were no specific approvals taken by the Committee at this meeting.

Items to come back to Committee (Items the Committee is seeking to keep an eye on)

The Committee did not identify any specific matters over its planned business that needed to come to the next meeting.

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

Item	Date
The Committee recommended to the Board that the risks within the BAF for which it has oversight are fairly represented. The Committee recommended that the QVH Strategic Outline Case be taken to the Board for review and decision.	To Board 5 August 2021 To the private Board given the commercially confidential matters within the case

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	16	**Meeting:**	Board	**Meeting Date:**	5 August 2021
Report Title:	Audit Committee Chair report to Board				
Committee Chair:		Jon Furmston, Non-Executive Director and Committee Chair			
Author(s):		Jon Furmston, Non-Executive Director and Committee Chair			
Report previously considered by and date:					

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

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

Implications for Trust Strategic Themes and any link to BAF risks		
Patient	✓	The work of Internal Audit and Counter Fraud provided assurance in respect of various elements of the Trusts' the systems of internal control relied upon in managing a number of BAF risks. The 2021/22 Internal Audit plan was aligned to the BAF and the strategic risks facing the Trust. Also the draft AGS for both BSUH and WSHFT referenced the respective significant BAF risks.
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 20 July 2021 and was quorate as it was attended by five Non-Executive Directors. In attendance were the Chief Financial Officer, the Trust Finance Director, Deputy Director of Finance, the Company Secretary along with the Trust's Internal and External Auditors and Local Counter Fraud team members.

The Committee received its planned items with the focus being on receiving the reports in relation to work undertaken by Internal Audit, Counter Fraud and External Audit across UHSussex during Quarter 1 2021/22. The Committee also received the University Hospitals Sussex Counter Fraud Strategy for 2021–2024.

Key Recommendation(s):

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

The Board is also asked to **NOTE** the Annual Reports from the former BSUH and WSHFT Audit Committees at Appendix 1 and 2.

The Board is asked to **APPROVE** the Annual Licence Declarations for the former BSUH and WSHFT Trust for submission to NHSI at Appendix 3 and 4.

University Hospitals Sussex
NHS Foundation Trust

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
Audit Committee	**20 July 2021**	**Jon Furmston**	yes	no
			✓	☐

Declarations of Interest Made

There were no declarations of interest made

Assurances received at the Committee meeting

The Committee **RECEIVED** the Internal Audit progress report incorporating the management action plans for the work undertaken since the last meeting for UHSussex. Internal Audit provided the final report for legacy Trust BSUH in relation to Rostering the Committee was **ASSURED** by the management actions in place to progress implementation of E-Rostering. The Committee **RECEIVED** a presentation from Internal Audit regarding the approach to follow-up actions from legacy Trusts BSUH and WSHFT.

The Committee received **ASSURANCE** from the Local Counter Fraud Specialists that there were no significant fraud risks, for UHSussex that needed to be actioned urgently within the Trust. The Committee **RECEIVED** the 2021-2024 Counter Fraud Strategy which was aligned to the mandated areas of counter fraud activity.

The Committee welcomed Grant Thornton as the Trusts External Auditors who provided the Committee with an outline of the work they planned to start and advised that they would be providing the Committee with a proposed timeline for the coming year to within the next quarter.

The Committee **RECEIVED** the newly combined Losses and Special payments registers and Tender Waiver Reports for UHSussex for quarter one of 2021/22. The Committee through these reports was **ASSURED** over the underlying processes applied to manage Trust resources.

The Committee **RECEIVED** the quarter one Information Governance and Caldicott Guardian update and was **ASSURED** by the low level of IG incidents reported and that there had been no referrals to the Information Commissioners Office. It was **NOTED** that the DPS Toolkit had been submitted for both former BSUH and WSHFT ahead of the deadline with strong compliance across all areas.

The Committee received **ASSURANCE** from the Health and Safety Committee Report from both former BSUH and WSHFT Trusts in respect of the Trust compliance with the Trust's H&S requirements, especially those in relation to RIDDOR.

Actions taken by the Committee within its Terms of Reference

The Committee **RECEIVED** the Annual Audit Committee Reports for both BSUH and WSHFT legacy Trusts and **RECOMMENDED** them to Trust Board for noting as they provide the Board with an understanding of the Committee's work over the last year.

The Committee **RECEIVED** the Annual Licence Declarations for both former BSUH and former WSHFT and **RECOMMENDED** them to the Board for approval and submission to NHSI.

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

There were no specific items requested to come back to the Committee over and above the routine reporting on action tracking and progress. The Committee did ask that the format of the reporting provided by Internal Audit, Counter Fraud and Management allows the Committee to understand if the matter relates to the whole Trust or specific sites.	
Items referred to the Board or another Committee for decision or action	
Item	**Date**
There were no matters referred to another Committee of the Board. The Board was asked to **APPROVE** the Annual Licence declarations for both former BSUH former WSHFT for submission to NHSI.	

University Hospitals Sussex
NHS Foundation Trust

To: Trust Board

Date: August 2021

From: Chair of the Audit Committee

Agenda Item: 16.1

FOR ENDORSEMENT

ANNUAL REPORT FROM THE BSUH AUDIT COMMITTEE TO THE BOARD 2020/2021

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 2020 to 31 March 2021 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 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 presented with a clear Internal Audit plan that was aligned to the Trust's Board Assurance Framework.

2.07 The management contract with Western Sussex Hospitals NHS Foundation Trust was due to expire on the 31 March 2021, and having worked increasingly closely together to respond to

the global Covid-19 pandemic, the Trust board explored options for an ongoing relationship, which resulted in a formal merger, to become University Hospitals Sussex NHS Foundation Trust, on the 1 April 2021.

3.00 COMMITTEE MEMBERSHIP AND MEETINGS

3.01 The Committee comprises solely of independent Non-Executive Directors in line with the Code of Governance for NHS Trusts. There are three Non-Executive Directors who are allocated to the Committee although all Non-Executive Directors, except 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 continues into the enlarged Trust.

3.03 The Chief Financial Officer, Finance Director, Company Secretary, Local Counter Fraud Specialist, Internal and External Auditors are regular attendees at meetings of the Committee. Trust Executives and 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 2020 to 31 March 2021.

Name	Apr	June *	Jul	Oct	Jan	Total
Kirstin Baker (Non-Executive Director and Committee Chair)	✓	✓	✓	✓	✓	5/5
Lizzie Peers (Non-Executive Director)	✓	✓	✓	✓	✓	5/5
Patrick Boyle (Non-Executive Director)	✓	✓	✓	✓	✓	5/5
Mike Rymer (Non-Executive Director)	✓	×	✓	×	✓	3/5

*Annual Accounts Audit Meeting in Common with WSHFT

3.05 In order to share learning and to ensure linkages are made across Trust Committees the membership of the Audit Committee includes both the Chair of the Quality Assurance Committee (Mike Rymer) and the Chair of the Finance and Performance 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 post project reviews and executive presentations around internal audit, external audit and Local Counter Fraud Services.

4.05 The Board recognised the continued challenges facing the Trust as it manages 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. These changes have seen the continued provision of updates on Covid-19 at each Board & Committee meetings, which have been undertaken via the continued use of technology. Within the second wave of the pandemic these were enhanced with regular Board Non-Executive Director briefings from the Chief Executive complemented by wider Executive updates from the Executive Gold meetings.

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 2020/21 was approved by the Audit Committee in April 2020. Progress 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 and those of perceived risk.

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 2021/22. Internal Audit Reports receive two Assurance ratings; one relates to the Design of the system being reviewed while 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 all received assurance levels of either moderate or limited and action plans are in place, and monitored, to ensure recommendations are addressed.

5.06 The Head of Internal Audit stated in his Head of Internal Audit Opinion that Overall, stated 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 There have been three different financial frameworks during 2020/21 each one requiring the Trusts' to amend their financial plans, their contracting approach and refine how Covid-19 costs are recorded. On 17th March 2020, Sir Simon Stevens and Amanda Pritchard announced a series of actions that the NHS would take to respond to Covid-19 and the funding regime for the period April 2020 to July 2020 including block contract payments and Covid-19 funding.

5.08 The majority of core audits provided moderate or substantial assurance in the design of controls, including key audits such as key financial systems and data security and protection toolkit. Three audit areas (Cyber Security, Contract management and Rostering) were given part limited assurance for the design of the controls and actions to address the findings are underway. For Cyber security in particular, our high risk finding related to management accepted risk owing to the Covid-19 pandemic. With regards to both Contract management and Rostering, we note plans are in place post-merger with Western Sussex NHS Hospitals Trust to address the identified control gaps in place.

5.09 The areas where limited assurance was awarded were primarily specified by the Trust for inclusion in the audit programme as known areas of concern.

5.10 The Trust has had some challenges in closing off key recommendations raised during the 2018/19 and 2019/20 internal audit plans. Internal Audit recognised that both the Covid-19 pandemic and the merger have impacted the Trust's capacity to implement a number of these key recommendations. Discussions to improve this process moving into 2021/22 are ongoing with key Trust leads at the new organisation (University Hospitals Sussex NHS Foundation Trust).

6.00 LOCAL COUNTER FRAUD SERVICE (LCFS)

6.01 The Counter Fraud service is provided by a directly employed Counter Fraud Specialist and reports quarterly to the Committee. 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 2020/21 was agreed with the Finance Director and approved at the Audit Committee in February 2020. 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 during the financial year include areas of strategic governance, inform and involve, prevent and deter and hold to account.

6.03 In addition the update report from LCFS included an organisational risk profile, updated each meeting, which helps to provide a 'tracker' of where the Trust sits in relation to key fraud risks.

6.04 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.

6.05 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 Trust has again achieved an overall status of GREEN for the year 2020/21 as shown below:

Area of Activity	SRT Rating
Strategic governance	Green
Inform and involve	Green
Prevent and deter	Green
Hold to account	Green
Overall rating	Green

6.06 During the year the Audit Committee asked that the Specialist work closely with the appointed Counter Fraud provider RSM at Western Sussex Hospitals NHS Foundation Trust.

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 pleased to see the level of compliance move from 90.4% to 99.8%.

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 retained Ernst and Young LLP (EY) as its external auditors to April 2021.

9.03 EY 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:	
Financial statements	Unqualified - the financial statements of BSUHT give a true and fair view of the financial position of each trust as at 31 March 2021 and of its expenditure and income for the year then ended. We issued our auditor's report on 18 June 2021 and it included a paragraph to emphasise to the reader the disclosures made about the merger and resultant transfer of services to UHSussex.
Parts of the remuneration report and staff report subject to audit	We identified the need for BSUHT to revise its draft disclosures. We had no other matters to report.
Consistency of the annual report and other information published with the financial statements	Financial information in the annual report and published with the financial statements was consistent with the audited accounts.
Reports by exception:	
Value for money (VFM) arrangements	We had no matters to report by exception on BSUHT's VFM arrangements.
Consistency of the annual governance statement	We were satisfied that the annual governance statement was consistent with our understanding of BSUHT.
Referrals to the Secretary of State	We made a referral in respect of BSUHT's cumulative deficit position and failure to break even over a 3 year period.
Public interest report and other auditor powers	We had no reason to use our auditor powers.
Reporting to the Trust on their consolidation schedules	We concluded that the Trust's consolidation schedule agreed, within a £300,000 tolerance, to the audited financial statements.
Reporting to the National Audit Office (NAO) in line with group instructions	We had no matters to report to the NAO.
Issued a report to those charged with governance of the Trust communicating significant findings resulting from our audit.	We issued an Audit Results Report dated 8 June 2021 to the 10 June 2021 UH Sussex Audit Committee. We issued the final Audit Results Report on 18 June 2021.
Issued a certificate that we have completed the audit in accordance with the requirements of the Local Audit and Accountability Act 2014 and the National Audit Office's 2020 Code of Audit Practice.	Certificate issued on 18 June 2021.

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 the conclusion of the year-end process saw the end of Ernst & Young's contract with the Trust and the introduction of Grant Thornton as the Trusts new External Auditor for the audit year 2021/22

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 CONCLUSION

11.01 The Audit Committee of Brighton & Sussex University Hospitals NHS 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 2020/21.

11.02 In making this statement, the Committee members acknowledge the support given to it by management, in particular the Chief Financial Officer, the Trust Finance Director and the Company Secretary, and by the internal and external auditors along with the local counter fraud specialist.

11.03 The Audit Committee supported the work undertaken by the Board as it recognised the challenges facing the Trust in managing the Covid-19 issues and the decision of the Board to proactively adjust its Board and Committee Governance processes to ensure there were appropriately focused. This was supported by an increased frequency of Quality Assurance Committee meetings to maintain a focus on quality in line with the Board's risk appetite. 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.

11.04 During 2021/22, the Committee will keep under review its working arrangements and ensure it continues to develop its own practice to improve its own effectiveness.

12.00 RECOMMENDATION

12.01 The Board is asked to:

- **Note** this Annual Report

Jon Furmston
Chair of the Audit Committee
August 2021

APPENDIX A: INTERNAL AUDIT OPERATIONAL PLAN 2020/21

- **The review of the Operational Plan 20/21 was completed and an appropriate action plan was taken and approved at Audit Committee.**

INTERNAL AUDIT OPERATIONAL PLAN 2020/21

Area	Days	Timing	Description of the Review	Reason for Inclusion
Corporate Objective 1: Patient Care				
Rostering / Safe Staffing (joint audit with WSHT)	20	Q3	This review will look at the Trust's rostering system and assess whether all functionality is being used to maximum benefit. Additionally it will provide assurance over the Trust's arrangements for safer staffing.	Key area of risk per BAF
CQC Preparation	15	Q3	The time can be used to review Provider Information returns (PIRs) for consistency or to review discrete outcomes areas / Key Lines of Enquiry (KLOE) areas in advance of inspection for compliance,	BDO led based on risks seen elsewhere within our client base.
Total	35			

Area	Days	Timing	Description of the Review	Reason for Inclusion
Corporate Objective 2: Sustainability				
Key Financial Systems	15	Q3	Cyclical review of key systems and controls to provide assurance on the core financial controls in place.	This is a core component required to deliver the Head of Internal Audit opinion and provides a core foundation for the Annual Governance Statement. In 2020/21 we will review the adequacy of agency invoice checking and authorisation processes.
Budgetary Control	15	Q2	Using an innovative approach we will conduct interviews with operational management to understand their knowledge and understanding of key budgetary management principles. We will risk assess key budget areas and target our sample accordingly.	Key area of risk per BAF

Cyber Security (joint audit with WSHT)	15	Q4	This review will verify whether adequate procedures are in place to classify/secure the Trust's data security assets. It will also review whether threats to the Trust are adequately identified and procedures are in place to prevent vulnerabilities being exploited.	Despite having previously audited in 2019/20 this area continues to see significant evolution in the domain of cyber security risks. As such it is important to continue to evaluate the effectiveness of the Trust's IT controls including patch management, incident management and social engineering.
Total	**45**			

Area	Days	Timing	Description of the Review	Reason for Inclusion
Corporate Objective 3: People				
Consultant Job Planning (joint audit with WSHT)	20	Q4	To review the job planning processes in place for consultants, to confirm they have been appropriately compiled, recorded and approved, that NHS clinical work is completed and paid in line with the plans and that there is consistency in approach in line with the 2017 NHSI Consultant Job Planning Best Practice Guidance.	Key area of risk per BAF
Sickness Management	20	Q2	The purpose of the audit is to provide assurance over the Trusts Health and Wellbeing Policy ensuring it is fit-for-purpose as well as assessing the adequacy of oversight and reporting of data available.	Key area of risk per BAF
Total	**40**			

Area	Days	Timing	Description of the Review	Reason for Inclusion
Corporate Objective 4: Quality				
Contracts Management	20	Q2	Due to the significant number of contracts in place across the Trust, the review would determine how effectively they are being managed. We will assess whether the Trust paying for goods/services not received, or receiving goods / services that aren't required yet being paid for.	BDO led based on risks seen elsewhere within our client base / area raised by management.
Total	**20**			

Area	Days	Timing	Description of the Review	Reason for Inclusion
Corporate Objective 5: Systems and Partnerships				
Discharge Planning (joint audit with WSHT)	15	Q4	This audit will focus on the discharge process, including internal arrangements for planning discharge and the approach to planned versus actual length of stay, including links with partners in the community health and social care system.	Key area of risk per BAF
3Ts	20	Q3	To review the adequacy of governance, risk management and reporting arrangements of the 3T Programme Board.	Area raised by management

Data Security & Protection Toolkit (joint audit with WSHT)	15	Q3	The purpose of this audit is to provide an independent high level review of the assertions and evidence items in the DSP Toolkit self-assessment and to identify how compliance could be improved for the year-end returns.	Given the importance of protecting patient data which has been heightened following the introduction of the GDPR, there is a greater level of public awareness of key principles of information governance.
Learning from Winter Planning (joint audit with WSHT)	15	Q4	This review will analyse how the Trust have taken the learning from Winter planning and ensured robust actions are taken for future years.	BDO led based on risks seen elsewhere within our client base.
Group Governance (joint audit with WSHT)	10	Q3	Advisory time has also been set aside in this and Western Sussex Hospitals NHS Foundation Trust plan to review the adequacy of the group governance arrangements now that the joint management arrangement has been extended.	Area raised by management.
Total	**75**			

Area	Days	Timing	Description of the Review	Reason for Inclusion
Corporate Objective 6: All				
Covid Governance (joint audit with WSHT)	15	Q1	The purpose of the audit is to provide assurance over the adequacy of governance arrangements implemented in response to Covid-19.	Key area of risk per BAF
Total	**15**			

Area	Days	Timing	Description of the Review	Reason for Inclusion
Planning, Reporting, and Follow-up				
Planning/ liaison/ management	10	Q1 - Q4	Creation of audit plan, meeting with each Trust Director	N/A
Recommendation follow up	10	Q1 - Q4	Assessment and reporting of recommendations raised	N/A
Audit Committee	10	Q1 - Q4	Attendance at all Audit Committee meetings	N/A
Total	**30**			

Grand Total	**260**			

University Hospitals Sussex
NHS Foundation Trust

To: Board

Date: August 2021

From: Chair of the Audit Committee

Agenda Item: 16.2

FOR ENDORSEMENT

ANNUAL REPORT FROM THE WSHFT AUDIT COMMITTEE TO THE BOARD 2020-21

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 2020 to 31 March 2021 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 presented with a clear Internal Audit plan that was aligned to the Trust's Board Assurance Framework.

2.07 The management contract with Brighton and Sussex University Hospitals NHS Trust was due to come to an end on the 31 March 2021. Having worked increasingly closely together to respond to the global Covid-19 pandemic, the Trust Board explored options for an ongoing relationship, which resulted in a formal merger via acquisition, to become University Hospitals Sussex NHS Foundation Trust, on the 1 April 2021.

3.00 COMMITTEE MEMBERSHIP AND MEETINGS

3.01 The Committee comprises solely of independent Non-Executive Directors in line with the Code of Governance for Foundation Trusts. There are three Non-Executive Directors who are allocated to the Committee although all Non-Executive Directors, except 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 continues into the enlarged Trust.

3.03 The Chief Financial Officer, Finance Director, 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 2020 to 31 March 2021.

Name	Apr	Jun**	Jul	Oct	Jan	Total
Jon Furmston (Non-Executive Director and Committee Chair)	✓	✓	✓	✓	✓	5 of 5
Lizzie Peers (Non-Executive Director)	✓	✓	✓	✓	✓	5 of 5
Joanna Crane (Non-Executive Director)	✓	✓	✓	✓	✓	5 of 5
Patrick Boyle * (Non-Executive Director)					✓	1 of 1

*Patrick is not a regular member but as all NEDs are invited to be members he attended this meeting to ensure quoracy was remained as two NEDs had other commitments during the meeting with NHSE/I

**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 Assurance Committee (Joanna Crane) and the Chair of the Finance and Performance Committee (Lizzie Peers).

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 post project reviews and executive presentations around internal audit, external audit and Local Counter Fraud Services.

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. These changes have seen the continued provision of updates on Covid-19 at each Board and Committee meeting, which have been held virtually with the continued use of technology. Within the second 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 2020/21 was approved by the Audit Committee in April 2020. 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.

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 2020/21. Internal Audit Reports receive two Assurance ratings; one relates to the Design of the system being reviewed while 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 all received assurance levels of either substantial or moderate, throughout all audit work completed Internal Audit only raised one high priority finding. This was a managed risk owing largely to the Covid-19 pandemic.

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". This level of opinion is the same as provided for the previous year, 2019/20.

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, Covid Governance and Data Security & Protection Toolkit. In respect of all recommendations made, the Head of Internal Audit noted that "the Trust has had some challenges in closing off key recommendations raised during 2018/19 and 2019/20, it is noted that both the Covid-19 pandemic and merger had impacted on the Trust's capacity to implement a number of these", but was assured by discussions underway to improve the process moving into 2021/2022.

6.00 LOCAL COUNTER FRAUD SERVICE (LCFS)

6.01 The Counter Fraud service is provided by RSM and reports quarterly to the Committee. There is a dedicated team 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 2020/21 was agreed with the Finance Director and approved at the Audit Committee in April 2020. 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 In addition the update report from LCFS included an organisational risk profile, updated each meeting, which helps to provide a 'tracker' of where the Trust sits in relation to key fraud risks.

6.04 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.

6.05 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 and only one consultant who did not submit a return although required to do so.

8.04 The submission of the 2020/21 Accounts and Annual Report took place on the 15 June 2021. 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 Ernst and Young.

9.03 Ernst Young 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 – the financial statements give a true and fair view of the state Trust's affairs as at 31 March 2021 and of its income and expenditure for the year then ended. We issued our auditor's report on 15 June 2021 and it included a paragraph to emphasise to the reader the disclosures made about the merger and resultant transfer of services to UHSussex.

Area of Work	Conclusion
Parts of the remuneration and staff report to be audited	We identified the need for the Western to revise its draft disclosures. We had no other matters to report.
Consistency of the annual report and other information published with the financial statements	Financial information in the Annual report and published with the financial statements was consistent with the audited accounts.
Reports by exception:	
Value for money arrangements	We had no matters to report by exception on Western's VFM arrangements.
Consistency of Annual Governance Statement	We were satisfied that the annual governance statement was consistent with our understanding of Western.
Referrals to the Secretary of State	We made no referrals for Western
Public interest report and other auditor's powers	We had no reason to use our auditor powers.
Reporting to the Trust on their consolidation schedules	We concluded that the Trust's consolidation schedule agreed, within a £300,000 tolerance, to the audited financial statements.
Reporting to the National Audit Office (NAO) in line with group instructions	The NAO included Western in its sample of Department of Health component bodies and we completed the additional procedures required on 15 June. We reported the unadjusted audit differences to the NAO.

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 the conclusion of the year-end process saw the end of Ernst & Young's contract with the Trust and the introduction of Grant Thornton as the Trusts new External Auditor for the audit year 2021/22.

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.

11.02 On 16 October 2020, the Chair reported to the Council of Governors on the work of the Audit Committee. The update also provided the Council of Governors with a report on the performance of the External Auditor, Ernst & Young across the year 2019/20.

12.00 Conclusion

12.01 The Audit Committee of Western Sussex Hospitals 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 2020/21.

12.02 In making this statement, the Committee members acknowledge the support given to it by management, in particular the Chief Financial Officer, Trust 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 managing the Covid-19 issues and the decision of the Board to proactively adjust its Board and Committee Governance processes to ensure they were appropriately focused. This was supported by an increased frequency of Quality Assurance Committee meetings to maintain a focus on quality in line with the Board's risk appetite. 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 2021/22, 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 Board is asked to:

- **Note** this Annual Report

Jon Furmston
Chair of the Audit Committee
August 2021

APPENDIX A: INTERNAL AUDIT OPERATIONAL PLAN 2020/21

Area	Days	Timing	Description of the Review	Reason for Inclusion
Corporate Objective 1: Patient Care				
Rostering / Safe Staffing (Joint audit with BSUH)	20	Q3	This review will look at the Trust's rostering system and assess whether all functionality is being used to maximum benefit. Additionally it will provide assurance over the Trust's arrangements for safer staffing.	Key area of risk per BAF
Total	**20**			
Area	**Days**	**Timing**	**Description of the Review**	**Reason for Inclusion**
Corporate Objective 2: Sustainability				
Key Financial Systems	15	Q3	Cyclical review of key systems and controls to provide assurance on the core financial controls in place.	This is a core component required to deliver the Head of Internal Audit opinion and provides a core foundation for the Annual Governance Statement pertaining to the functionality of the Trust's internal controls
Cyber Security (joint audit with BSUH)	15	Q4	This review will verify whether adequate procedures are in place to classify/secure the Trust's data security assets. It will also review whether threats to the Trust are adequately identified and procedures are in place to prevent vulnerabilities being exploited	Despite having previously audited in 2019/20 this area continues to see significant evolution in the domain of cyber security risks. As such it is important to continue to evaluate the effectiveness of the Trust's IT controls including patch management, incident management and social engineering.
Budgetary Control	15	Q2	Using an innovative approach we will conduct interviews with operational management to understand their knowledge and understanding of key	Key area of risk per BAF

			budgetary management principles. We will risk assess key budget areas and target our sample accordingly.	
Total	45			

Area	Days	Timing	Description of the Review	Reason for Inclusion
Corporate Objective 3: People				
Cultural Maturity	20	Q3	Using BDO's innovative cultural maturity toolkit, we will assess five key domains and score the Trust from 'unestablished' to embedded. Including tone from the top, perception, oversight, compliance and employment life cycle.	A unique cultural assessment tool, offered as part of our internal audit contract, that seeks to identify any cultural blind spots – and provide a roadmap to an effective and embedded cultural ethos.
Violence & Aggression	20	Q2	This review will analyse the preventative measures put in place by the Trust and also determine if all violent incidents are being accurately recorded. Additionally, we would analyse the support mechanisms in place in the event of a violent or aggressive incident.	Key area of risk per BAF
Consultant Job Planning (joint audit with BSUH)	20	Q4	The purpose of this audit is to review the job plans in place for consultants, including ensuring the right balance of clinical work to development and private practice. Monitoring of clinical productivity will also be reviewed.	Key area of risk per BAF
Total	**60**			

Area	Days	Timing	Description of the Review	Reason for Inclusion

Corporate Objective 4: Quality				
Mortality Governance	20	Q3	The purpose of this review is to assess the effectiveness of the governance processes in place across the Trust to investigate deaths, adopt learning and when to scrutinise practices based upon key performance metrics.	BDO led based on risks seen elsewhere within our client base.
Covid Restoration / Recovery	20	Q3	To support the restoration / recovery process, we will review specific aspects of the key workstreams (such as Outpatients, Diagnostics) to help understand the benefits as well as the implications in changes in pathways/practice instigated during Covid.	Key area of risk per BAF. BDO led based on risks seen elsewhere within our client base.
Total	**40**			

Area	Days	Timing	Description of the Review	Reason for Inclusion
Corporate Objective 5: Systems and Partnerships				
Discharge Planning (Joint audit with BSUH)	20	Q4	This audit will focus on the discharge process, including internal arrangements for planning discharge and the approach to planned versus actual length of stay, including links with partners in the community health and social care system	Key area of risk per BAF
Data Security & Protection Toolkit (joint audit with	15	Q3	The purpose of this audit is to provide an independent high level review of the assertions and evidence items in the DSP Toolkit self-assessment return and to identify how compliance	Given the importance of protecting patient data which has been heightened following the introduction of the GDPR, there is a greater

BSUH)			could be improved for the 2020/21 year-end return.	level of public awareness of key principles of information governance.
Learning from Winter Planning (joint audit with BSUH)	15	Q4	This review will analyse how the Trust have taken the learning from Winter planning and ensured robust actions are taken for future years.	BDO led based on risks seen elsewhere within our client base.
Group Governance (joint audit with BSUH)	10	Q3	Advisory time has also been set aside in this and Brighton & Sussex University Hospitals NHS Trust plan to review the adequacy of the group governance arrangements now that the joint management arrangement has been extended	Area of concern raised by management
Total	**60**			

Area	Days	Timing	Description of the Review	Reason for Inclusion
Corporate Objective 6: All				
Covid Governance (joint audit with BSUH)	20	Q1	The purpose of the audit is to provide assurance over the adequacy of governance arrangements implemented in response to Covid-19.	Key area of risk per BAF
Total	**20**			
Planning, Reporting, and Follow-up				

Planning/ liaison/ management	10	Q1 – Q4	Creation of audit plan, meeting with each Executive Director	
Recommendation follow up	5	Q1 – Q4	Assessment and reporting of recommendations raised	
Audit Committee	10	Q1 – Q4	Attendance at all Audit Committee	
Total	**25**			

Grand Total	**270**			

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	16.3	**Meeting:**	Trust Board	**Meeting Date:**	August 2021
Report Title:	NHS Improvement Provider Licence self-certifications for 2020/21 (for former WSHFT and BSUH)				
Sponsoring Director:	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	✓	The provider licence covers all aspects of the Trust's delivery. A compliant assessment provides baseline information for UHSussex.
Sustainability	✓	
People	✓	
Quality	✓	
Systems and Partnerships	✓	

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

Communication and Consultation:

Executive Summary:

As part of each Trust's provider licence, the Trust is required to make an annual self-declaration against a number of the licence specific conditions and published these on their web site.

NHS improvement provide a template for these declarations where explanations are required if the Trust cannot provide a compliant declaration. Only for condition FT4 does the template allow for a rationale to be included for the Trust's ability to signify compliance to be included, therefore as well as the required template a short explanatory paper has been prepared to allow the Committee (and then the Board) to understand the supporting rationale for the compliant declarations being recommended to the Committee to recommend to the Board to make on behalf of WSHFT and BSUH for 2020/21.

It should be noted that the Boards of both BSUH and WSHFT had to make similar compliant declarations as part of the merger, these were made in March and agreed through the granting of merger application to be correct.

Key Recommendation(s):

The Board is asked to agree that the certifications are a correct view and that they can be signed and published as evidence of the Trust's compliance.

University Hospitals Sussex
NHS Foundation Trust

Provider Licence – Self Certifications for 2020/21 for BSUH

Introduction

Each Board is required to make a number of declarations at the year-end in respect of their compliance with their provider licence and Trusts should publish their declaration on their web site.

University Hospitals Sussex NHS FT was operated during 2020/21 as Brighton & Sussex University Hospitals NHS Trust and thus these declarations refer to that Trust.

Certifications

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

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

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

Trust Position

Declaration 1 (appendix 1)

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

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

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

It is recommended the Board a positive "confirmed" declaration is made.
Whilst the Trust was initially identified at being at risk of being non-compliant with its licence by NHSI they received positively the letter of undertakings and for 2020/21 the Trust delivered a breakeven position. As part of the merger all Trust undertakings fell away.

University Hospitals Sussex
NHS Foundation Trust

Continuity of Service condition 7 – Availability of Resources

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

Declaration 2 (appendix 2)

Condition FT4 - Corporate Governance Statement

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

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

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

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

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

Also during the period where the Trust was operating within the Covid-19 national pandemic then the Trust's Board Governance arrangements were adapted to have a focus on quality and safety risks with extra Quality Assurance Committee meetings within the first quarter of 2020/21. As the County moved through the second national lockdown then the Board received regular monthly Gold briefings and updates from the Chief Executive ensuring the Board was aware of any emerging risks and their mitigations

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

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

Board governance arrangements put in place as the Trust was dealing with the national pandemic and the processes established to manage the Covid-19 challenges facing the NHS and the Trust. This saw the continuance of an established bronze, silver and gold command structure complemented by regular Gold briefings to the Board and updates from the Chief Executive to the Non Executives.

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

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

It is recommended the Board signify its compliance as the Board both directly and through its Committee structure has been assured that the Trust's designed systems of internal control have been operating effectively and as intended over the year. Where issues have arisen during the year, for example in respect of operational performance, timely actions have been implement to improve these areas.

The Trust has delivered, with tolerable allowances, a breakeven position along with the delivery of its efficiency programme and the Audit Committee has recommended based on the information it has received that the Trust can prepare its financial statements on a going concern basis.

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

Key risks and associated assurances have been reported to the Audit Committee and Board during the year through receipt and review of the Trust's Board Assurance Framework.

University Hospitals Sussex
NHS Foundation Trust

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

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

It is recommended the Board signify its compliance as there is clear leadership and accountability for the delivery of high quality and safe services within the Trust. These are detailed with the Trust's Annual Report and the statements contained therein. The Board both directly and through its Committee structures ensures that a focus is maintained on the delivery of quality services. Reporting of the delivery against the Trust's stated quality priorities is provided to the Board and as part of the merger process to the Council of Governors though an information session and our Commissioners. The effectiveness of these processes was again considered by the Accounting Officer in drafting the Annual Governance Statement which in turn was subject to consideration by the Audit Committee prior to its submission to the Auditors and inclusion within the Annual Report.

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

It is recommended the Board signify its compliance as the Trust has established a process that ensures that all Board Members are "fit and proper" persons. This process has been applied to Board appointments made in the year. An annual review of all Board Members continuation as fit and proper persons has been undertaken and reported to the Audit Committee at the end of the year. The Board and its Committees through its receipt of Workforce reports has been assured over the actions being taken to mitigate the workforce risks in relation to recruitment and retention complimented and the Board's review of workforce BAF risks. Regular reporting is also provided to the Board on the Trust's compliance with the nursing safer staffing levels and the revalidation of its nursing and medical workforce. All transformation schemes are subject to a detailed quality impact assessment and this

rigor includes those schemes which include any workforce reduction and through this process the Board is assured that the Trust retains an appropriately qualified workforce to deliver its services. The Trust has developed a number of established Executive and Senior Management development programmes and these activities are designed to support and strengthen the personnel on the Board, those reporting to the Board and those within the rest of the Trust.

Declaration 3 (appendix 2)

Training of Governors

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

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

Self-Certification Template - Conditions G6 and CoS7

Brighton and Sussex University Hospitals NHS Trust *Insert name of organisation*

NHS Improvement

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

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

These self-certifications are set out in this template.

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

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates **2020/2021** Please complete the explanatory information in cell E36

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

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

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

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

Confirmed — OK

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

EITHER:

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

Please Respond

OR

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

Please Respond

OR

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

Please Respond

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

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

[e.g. key risks to delivery of CRS, assets or subcontractors required to deliver CRS, etc.]

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

Signature		**Signature**	
Name	Alan McCarthy	**Name**	Marainne Griffiths
Capacity	Trust Chair	**Capacity**	Chief Executive
Date	05 August 2021	**Date**	5 Augist 2021

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

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

Self-Certification Template - Condition FT4

Brighton and Sussex University Hospitals NHS Trust

Insert name of organisation

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

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

These self-certifications are set out in this template.

How to use this template

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

Worksheet "FT4 declaration" | **Financial Year to which self-certification relates** | **2020/2021** | Please Respond

Corporate Governance Statement (FTs and NHS trusts)

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

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Board is assured from the work of the Audit Committee, its Internal and External Auditors and their opinions received during the year. The Board's view as to its governance processes is reflected within the Trust's Annual Governance Statement.	#REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Chief Financial Officer and Trust Board Secretary has made the Board, Audit Committee and Executives aware of monitor guidance and any impact / improvements to be made within Trust systems as a result. Also during the period where the Trust is delivering the Covid-19 challenges then the established Gold structure ensures the NEDs are updated on any governance guidance, this corroborated the changes the Trust enacted to focus the Board and Committees during this period.	#REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	These processes were referred to and their effectiveness was considered by the Accountable Officer when drafting the Trust's Annual Governance Statement with this description then considered by the Audit Committee as it endorsed the AGS for submission to the Auditors. Respective Committee reporting to the Board is operating effectively as evidenced by the regular reports to the Board from each Committee Chair.	#REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	The Board both directly and through its Committee structure has been assured that the Trust's designed systems of internal control have been operating effectively and as intended over the year. Where issues have arisen during the year, for example in respect of operational performance, timely actions have been implemented to improve these areas, albeit the Trust has recognised and reported that it has not met the constitutional targets. The Trust has delivered its control total and has delivered its efficiency programme and the Audit Committee has recommended based on the information it has received that the Trust can prepare its financial statements on a going concern basis. Assurance is obtained as to the quality of the data supporting the Trust's performance reporting through the annual internal audit work programme. The Board has received regular assurance over the delivery of the Trust's control total and efficiency plan. Key risks and associated assurance have been reported to the Audit Committee and Board during the year through receipt and review of the Trust's Board Assurance Framework. Whilst the Trust gave undertakings to NHS I when it was within segment 3 of NHS I's Single Oversight Framework, NHS I witjhin these recognsied that "The Trust has taken effective action to address its previous governance failures since the issue of the former undertakings in March 2017". These undertaking all fell away with the merger, further indictaing that NHS I are satified with the Trust.	#REF!

5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	There is clear leadership and accountability for the delivery of high quality and safe services within the Trust. This is detailed with the Trust's Annual Report and the statements contained therein. The Board both directly and through its Committee structures ensures that a focus is maintained on the delivery of quality services. There is regular reporting to the Board and our Commissioners of the delivery against the Trust's established quality priorities. These priorities are set in conjunction with the Trust's clinical strategy and annual plan. The effectiveness of these processes was again considered by the Accountable Officer in drafting the Annual Governance Statement which in turn was subject to consideration by the Audit Committee prior to its submission to the Auditors and inclusion within the Annual Report. The CQC has rated the Trust as "good" overall and "outstanding" for caring providing further evidence to the Board on the quality of the Trust's services and the CQC has provided positive feedback from their regular engagement visits.	#REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Trust has established a process that ensures that all Board Members are "fit and proper" persons. This process has been applied to Board appointments made in the year. An annual review of all Board Members continuation as fit and proper persons has been undertaken and reported to the Audit Committee at the end of the year. The Board through its receipt of Workforce, Leadership and Organisational Development reports has been assured over the actions being taken to mitigate the workforce risks in relation to recruitment and retention complimented by the review undertaken by the Audit Committee in respect of workface BAF risks. Regular reporting is provided to the Board on the Trust's compliance with the nursing safer staffing levels and the revalidation of its nursing and medical workforce. All transformation schemes are subject to a detailed quality impact assessment and this rigor includes those schemes which include any workforce reduction and through this process the Board is assured that the Trust retains an appropriately qualified workforce to deliver its services. The Trust has a number of established Executive and Senior Management development programmes these activities are designed to support and strengthen the personnel on the Board, those reporting to the Board and those within the rest of the Trust.	#REF!

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

Signature	**Signature**
Name Alan McCarthy	**Name** Marianne Griffiths

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

A

Please Respond

Worksheet "Training of governors"

Financial Year to which self-certification relates **2020/2021** Please Respond

Certification on training of governors (FTs only)

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

Training of Governors

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

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

Signature		**Signature**	
Name	Alan McCarthy	**Name**	Marianne Griffiths
Capacity	Trust Chair	**Capacity**	Chief Executive
Date	06 May 2021	**Date**	06 May 2021

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

A	This is not applicable as BSUH is not a Foundation Trust

University Hospitals Sussex
NHS Foundation Trust

Provider Licence – Self Certifications for 2020/21 for WSHFT

Introduction

Each Board is required to make a number of declarations at the year-end in respect of their compliance with their provider licence and Trusts should publish their declaration on their web site.

University Hospitals Sussex NHS FT was operated during 2020/21 as Western Sussex Hospitals NHS FT and thus these declarations refer to that Trust.

Certifications

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

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

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

Trust Position

Declaration 1 (appendix 1)

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

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

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

It is recommended to the Board a positive "confirmed" declaration is made. WSHFT did not have any conditions placed on its Licence and had not entered into any formal undertakings with NHS Improvement. The Trust was judged to be in segment 1 for finance and use of resources where only segments 3 & 4 indicate a risk or actual breech of the Licence.

University Hospitals Sussex
NHS Foundation Trust

Continuity of Service condition 7 – Availability of Resources

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

Declaration 2 (appendix 2)

Condition FT4 - Corporate Governance Statement

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

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

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

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

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

Also during the period where the Trust was operating within the Covid-19 national pandemic then the Trust's Board Governance arrangements were adapted to have a focus on quality and safety risks with extra Quality Assurance Committee meetings within the first quarter of 2020/21. As the County moved through the second national lockdown the Board received regular monthly Gold briefings and updates from the Chief Executive ensuring the Board was aware of any emerging risks and their mitigations

3) The Board is satisfied that the Trust implements:

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

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

the Trust's Annual Governance Statement details of the revised Committee and Board governance arrangements put in place as the Trust was dealing with the national pandemic and the processes established to manage the Covid-19 challenges facing the NHS and the Trust. This saw the continuance of an established bronze, silver and gold command structure complemented by regular Gold briefings to the Board and updates from the Chief Executive to the Non Executives.

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

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

It is recommended the Board signify its compliance as the Board both directly and through its Committee structure has been assured that the Trust's designed systems of internal control have been operating effectively and as intended over the year. Where issues have arisen during the year, for example in respect of operational performance, timely actions have been implement to improve these areas.

The Trust has delivered, with tolerable allowances, a breakeven position along with the delivery of its efficiency programme and the Audit Committee has recommended based on the information it has received that the Trust can prepare its financial statements on a going concern basis.

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

Key risks and associated assurances have been reported to the Audit Committee and Board during the year through receipt and review of the Trust's Board Assurance Framework.

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

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

It is recommended the Board signify its compliance as there is clear leadership and accountability for the delivery of high quality and safe services within the Trust. These are detailed with the Trust's Annual Report and the statements contained therein. The Board both directly and through its Committee structures ensures that a focus is maintained on the delivery of quality services. Reporting of the delivery against the Trust's stated quality priorities is provided to the Board and the Council of Governors and our Commissioners. The effectiveness of these processes was again considered by the Accountable Officer in drafting the Annual Governance Statement which in turn was subject to consideration by the Audit Committee prior to its submission to the Auditors and inclusion within the Annual Report.

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

It is recommended the Board signify its compliance as the Trust has established a process that ensures that all Board Members are "fit and proper" persons. This process has been applied to Board appointments made in the year. An annual review of all Board Members continuation as fit and proper persons has been undertaken and reported to the Audit Committee at the end of the year. The Board and its Committees through its receipt of Workforce reports has been assured over the actions being taken to mitigate the workforce risks in relation to recruitment and retention complimented and the Board's review of workforce BAF risks. Regular reporting is also provided to the Board on the Trust's compliance with the nursing safer staffing levels and the revalidation of its nursing and medical workforce. All

transformation schemes are subject to a detailed quality impact assessment and this rigor includes those schemes which include any workforce reduction and through this process the Board is assured that the Trust retains an appropriately qualified workforce to deliver its services. The Trust has developed a number of established Executive and Senior Management development programmes and these activities are designed to support and strengthen the personnel on the Board, those reporting to the Board and those within the rest of the Trust.

Declaration 3 (appendix 2)

Training of Governors

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

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

It is recommended the Board signify its compliance as the Trust has established a programme of training for the Governors, which includes new governors taking part in the Trust's induction programme, complemented by tailored governor induction training supplemented by information workshops where information on Trust and NHS developments are discussed. Also at the Council of Governors meetings a presentation is made by a Non-Executive Director on their role and work of their Committee thus allowing Governors knowledge over the governance of the Trust to be enhanced.

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

The Trust is working with the Governors on updating and refining its induction and training programme in order to support the revised Council of Governors in place for University Hospitals Sussex NHS FT.

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

Self-Certification Template - Conditions G6 and CoS7

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

NHS Improvement

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

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

These self-certifications are set out in this template.

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

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates **2020/2021** Please complete the explanatory information in cell E36

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

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

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

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

Confirmed OK

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

EITHER:

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

OR

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

OR

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

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

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

[e.g. key risks to delivery of CRS, assets or subcontractors required to deliver CRS, etc.]

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

Signature		**Signature**	
Name	Alan McCarthy	**Name**	Marainne Griffiths
Capacity	Trust Chair	**Capacity**	Chief Executive
Date	05 August 2021	**Date**	05 August 2021

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

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

Self-Certification Template - Condition FT4

Western Sussex Hospitals NHS Foundation Trust

Insert name of organisation

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

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

These self-certifications are set out in this template.

How to use this template

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

Worksheet "FT4 declaration" | **Financial Year to which self-certification relates** | **2020/2021** | Please Respond

Corporate Governance Statement (FTs and NHS trusts)

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

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

6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Trust has established a process that ensures that all Board Members are "fit and proper" persons. This process has been applied to Board appointments made in the year. An annual review of all Board Members continuation as fit and proper persons has been undertaken and reported to the Audit Committee at the end of the year. The Board and its Committees through its receipt of Workforce reports has been assured over the actions being taken to mitigate the workforce risks in relation to recruitment and retention complimented and the Board's review of workforce BAF risks. Regular reporting is also provided to the Board on the Trust's compliance with the nursing safer staffing levels and the revalidation of its nursing and medical workforce. All transformation schemes are subject to a detailed quality impact assessment and this rigor includes those schemes which include any workforce reduction and through this process the Board is assured that the Trust retains an appropriately qualified workforce to deliver its services. The Trust has developed a number of established Executive and Senior Management development programmes and these activities are designed to support and strengthen the personnel on the Board, those reporting to the Board and those within the rest of the Trust.	#REF!

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

Signature	**Signature**
Name Alan McCarthy	**Name** Marianne Griffiths

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

A

Please Respond

Worksheet "Training of governors"

Financial Year to which self-certification relates **2020/2021** Please Respond

Certification on training of governors (FTs only)

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

Training of Governors

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

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

Signature		**Signature**	
Name	Alan McCarthy	**Name**	Marianne Griffiths
Capacity	Trust Chair	**Capacity**	Chief Executive
Date	06 May 2021	**Date**	06 May 2021

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

A

NHS
University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	17	**Meeting:**	Trust Board in Public	**Meeting Date:**	August 2021
Report Title:	Charitable Funds Committee Chair report to Board				
Committee Chair:	Kirstin Baker, Non-Executive Director				
Author(s):	Kirstin Baker, 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	☐				
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 15 July 2021 and was quorate as it was attended by three Non-Executive Directors, the Chief Nurse and the Chief People Officer. In attendance were the Charity Director for BSUH Charity and Head of Charities for LYH Charity and the Trust Finance Director and other members of the Trust's finance team.

The Committee received its planned items in respect of the two Charities, BSUH and LYH.

Key Recommendation(s):

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

The Board is also asked to **NOTE** that there were no matters referred to either the Board at this meeting in public or another Committee for action.

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COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Charitable Funds Committee	**15 July 2021**	**Kirstin Baker**	✓	☐

Declarations of Interest Made

There were no declarations of interest made

Assurances received at the Committee meeting

The Committee received updates on the activity of the BSUH Charity and LYH Charity for the Q1 period and was **ASSURED** that both charities were focused on activities that supported both patient benefits and staff wellbeing. The Committee recognised the support of our communities in making donations to both Charities or to the central NHS Charities together which has enabled such remarkable schemes to be delivered across the Trust's hospitals.

The Committee was **ASSURED** that both Charities were operating within their respective objectives through the receipt of Q1 performance reports from both Charities.

The Committee was **ASSURED** over the oversight of the funds and work being undertaken to secure their spending but recognised that the current work needed to continue to streamline processes which would bring benefits to the efficiency with which funds can be spent.

Actions taken by the Committee within its Terms of Reference

The Committee ratified the approval given by the Committee members in between the last meeting in respect of four BSUH Charity bids, these were in respect of:

- Electronic Discharge Planner
- Ultrasound for haematology
- Urology service
- The funding application made to the national charities together for staff health and wellbeing matters

The Committee approved one LYH Charity bid:

- The purchase of three span barrel timber canopies to be part of the St Richard's Staff garden refurbishment project.

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

There was nothing outside the Committee's routine business to come back to the next meeting.

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

Item	Date
There were no matters referred to either the Board or another Committee	

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	18	**Meeting:**	Board	**Meeting Date:**	5 August 2021
Report Title:	2021/22 Quarter 2 BAF				
Sponsoring Executive Director:	Chief Executive				
Author(s):	Company Secretary				
Report previously considered by and date:	Respective elements of the BAF considered by each Board Committee in July 2021				
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:					

Executive Summary:

Introduction

The Trust has identified 13 strategic risks which have been assessed against the Trust's risk appetite when setting their target score. The Board in April confirmed these risks and that their opening quarter 1 scores were reasonably stated.

Each segment of the BAF continues to have a lead executive and oversight committee. There also remains the process whereby one Committee, can refer matters to another Committee, if they believe they have received information that may impact on a risk for which they are not the principle oversight committee.

BAF Summary

The table overleaf shows by risk, their current score and their target risk score along with the movement in risk score between quarter 1 and quarter 2.

There has been an increase to two BAF risks, risk 3.3 increases to 15 and risk 4.2 increases to 12. There has also been a decrease in one of the BAF risks, this being risk 2.3 which is reduced to 12.

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BAF: Strategic Objectives and Strategic Risks (Key: I = Impact L = Likelihood T = Total)	Risk Scores														
	Q1			Q2			Q3			Q4			Target		
	I	L	T	I	L	T	I	L	T	I	L	T	I	L	T
1. Patient *(oversight provided by 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 loss of market share.	3	4	**12**	3	4	**12** ↔							3	2	**6**
2. Sustainability *(oversight provided by 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	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	2	**8**
2.3 We are unable to meet high standards of financial stewardship meaning we cannot sustain compliance with our statutory financial duties	4	4	**16**	4	3	**12** ↓									**8**
3. People *(oversight provided by People Committee)*															
3.1 We are unable to develop and sustain the leadership and organisational capability and capacity to lead on-going performance improvement and build a high performing organisation	4	3	**12**	4	3	**12** ↔							4	2	**8**
3.2 We are unable to effect cultural change and involve and engage staff in a way that leads to continuous	4	3	**12**	4	3	**12** ↔							4	2	**8**

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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 staff adversely impacting on patient experience and the safety, quality and sustainability of our services	3	4	**12**	3	5	**15** ↑							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	2	**8**
4. Quality *(oversight provided by Quality Committee)*															
4.1 We are unable to deliver and demonstrate compliance with regulatory requirements or clinical standards adversely impacting on patient safety and our registration and accreditation by regulatory and supervisory bodies	3	4	**12**	3	4	**12** ↔							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	3	3	**9**	3	4	**12** ↑							3	2	**6**
5. Systems and Partnerships *(oversight provided by Systems and Partnership Committee)*															
5.1 We are unable to develop and maintain collaborative relationships with partner organisations based on shared aims, objectives, and timescales leading to an adverse impact on our ability to operate efficiently and effectively within our health economy	4	3	**12**	4	3	**12** ↔							4	2	**8**
5.2 We are unable to define and deliver the strategic intentions, plans and optimal configuration that will enable	4	4	**16**	4	4	**16** ↔							4	2	**8**

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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.	4	5	**20**	4	5	**20** ⟷							4	2	**8**

Quarter 1 summary of highest scored risks

The highest current risk score remains as risk 5.3 which is in relation to the Trust's consistent delivery of the NHS Constitutional targets.

Risks 2.1 and 2.2 remain scored at 16 with oversight provided by the Sustainability Committee and risk 5.2 also remains scored at 16 with oversight provided by the Systems and Partnership Committee. Risk 3.4 remains at 16 with oversight provided by the People Committee.

Risk 3.3 has increased in Q2 to score 15, linked to the impact on our staff of the current demand pressures on the Trust oversight is provided by the People Committee.

Respective Committee review of risks

Each of the five Board Committees with oversight for specific BAF risks met in July and their respective reviews over their allocated risks confirmed that they considered the current scores for each are fairly represented. Within the discussion at the People Committee risk 3.4 was agreed not to be reduced although lots of work has been undertaken to support staff with their wellbeing so the Committee asked that the risk remain at 16.

Key Recommendation(s):

The Board is asked to consider the current risk scores in light of the assurances provided by the respective oversight committees and the assurances received directly at the Board and agree the current scores are fairly represented.

NHS
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NHS Foundation Trust

Agenda Item:	19	**Meeting:**	Trust Board in Public	**Meeting Date:**	August 2021
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	✓	The AGM reflected on the experiences and feedback provided by our patients (risk 1.1)			
Sustainability	✓	The AGM reflected on the Trust's systems of internal control and the delivery of the Trust's financial plan (risk 2.1 to 2.3)			
People	✓	The AGM recognised the valuable contribution made of our staff and the support being provided for their wellbeing (risks 3.1 to 3.4)			
Quality	✓	The learning from Deaths Reporting provides assurance over the Trust processes over utilising the learning for continued improvement (risk 4.1)			
Systems and Partnerships	☐				
Link to CQC Domains:					
Safe		✓	Effective	✓	
Caring		✓	Responsive	✓	
Well-led		✓	Use of Resources	✓	
Communication and Consultation:					
Executive Summary:					

This report provides the Board with an update, including matters for which the Trust has complied with a NHS I or other regularly requirements. This report does not seek to duplicate matters that are subject to separate agenda items at today's board meeting.

Learning from Deaths reports 2021/22 quarter 1 – Appendix 1 and 2

The Trust is required to receive reports on learning from deaths. The Board is reminded that the detail of these reports is scrutinised by the Quality Governance Steering Group / Quality Board who report to 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 these reports at its meeting on the 27 July. Appendix 1 relates to reviews covering Royal Sussex County and Princess Royal Hospitals. Appendix 2 relates to reviews covering St Richards and Worthing Hospitals.

Annual General Meeting

The Annual General Meeting took place on the 29 July and below for information is the link to where the slides including the embedded video extracts used in the meeting can be found.

https://www.uhsussex.nhs.uk/about/trust-board/ - University Hospital Sussex NHS FT

The annual reports for both Trusts have been placed on both the former Trust Board pages and on the page for University Hospital Sussex (within the same link where the AGM slides are placed)

Links to each former Trust's specific website are

https://www.westernsussexhospitals.nhs.uk/your-trust/about/annual-report/ - Western Sussex Hospitals NHS FT

https://www.bsuh.nhs.uk/wp-content/uploads/sites/5/2016/09/Combined-BSUH-AR-Quality-Report-Website-Version.pdf - Brighton and Sussex University Hospitals NHS Trust

Governor Elections

We have commenced our governor elections for those positions were the governor's term of office comes to an end in September / October 2021.

This sees us seeking nominations from our membership for 2 positions in Chichester, 1 for Out of Area and East Sussex. At the same time, we are seeking nominations for our staff governor positions for St Richards and Worthing and Southlands staff constituencies.

The nominations close on the 16 August where for contested positions elections will then be undertaken.

Key Recommendation(s):

The Board is recommended to

NOTE the Trust's learning from deaths report and note the learning identified from the structured judgement review process, recognising the detail of this work is subject to scrutiny and oversight at the Quality Assurance Committee.

NOTE the publication of the AGM recording and associated slides to allow those who were not able to attend the watch the meeting to understand what was presented.

NOTE that the governor election process has commenced for five positons where the terms of office end in September / October 2021.

Appendix 1

Agenda Item:	19.1	**Meeting:**	UHSussex Trust Board	**Meeting Date:**	5 August 2021
Report Title:	Brighton and Princess Royal Hospitals Learning from Deaths Report Q4 2020/21 (January, February, March) and Q1 (April, May, June) 2021/2022				
Sponsoring Executive Director:			Rob Haigh - Medical Director (East)		
Author(s):			Anne Middleton, Mark Renshaw, Jane Carmody,		
Report previously considered by and date:					
Purpose of the report:					
Information		✓	Assurance		✓
Review and Discussion		✓	Approval / Agreement		☐
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		☐	Staff confidentiality		☐
Patient confidentiality		☐	Other exceptional circumstances		☐
Link to Trust Strategic Themes:					
Patient Care		✓	Sustainability		☐
Our People		☐	Quality		✓
Systems and Partnerships		☐			
Any implications for:					
Quality	The Trust's True North Objective is for a reduction in crude mortality rates for the top five contributors to mortality				
Financial					
Workforce	Human Resource Implications: Training and protected time requirements for clinical staff undertaking SJRs.				
Link to CQC Domains:					
Safe			Effective		✓
Caring		✓	Responsive		✓
Well-led		✓	Use of Resources		✓
Communication and Consultation:					
This report has been completed by the corporate quality team					
Executive Summary:					
This report is produced in line with National Guidance on Learning from Deaths, and provides the Trust Board with information relating to local implementation of the guidance; recent Structured Judgment Review activity; and the themes and learning that are emerging from this work.					
Key Recommendation(s):					
The Board is asked to NOTE the report.					

Appendix 1

1. Purpose

1.1 Approximately 1600 deaths occur at UHSFT East – (former BSUH) every year. For many people, death under NHS care is an inevitable outcome and there is no indicator of suboptimal care. However, some patients experience poor care resulting from a variety of factors. The purpose of a structured judgement review (SJR) is to identify and learn from any issues of concern that may have contributed to the death to prevent recurrence.

1.2 This paper updates the board on the implementation of the Learning from Deaths Policy at UHSFT (East). Data is included on rates of SJR, the outcomes of SJR's.and mortality statistics.

2. Background

2.1 The 2016 CQC report 'Learning, Candour and Accountability' outlines the importance of mortality review as a source of learning and improvement. In March 2017, the National Quality Board published guidance for Trusts on mortality review processes and Learning from Deaths.

2.2 UHSFT (East) Learning from Deaths Policy was implemented in 2017 and quarterly data has been collected since, using the National Learning from Deaths Dashboard.

3. Governance

3.1. The CMO is the responsible executive for Learning from Deaths.

3.2. The Medical Director (East) chaired the former BSUH Trust Mortality Review Group and is accountable for the implementation of the Learning from Deaths Policy.

3.3. In the future governance structure, with TMRG will report to the Clinical Outcomes and Effectiveness Group (COEG) and by exception to the Quality Governance Steering Group (QGSG).

4. Process

4.1. Deaths requiring review are triangulated via the Serious Incident Review Group (SIRG), Complaints, Medical Examiners (ME), Medico-legal Department, Learning Disabilities Team, or in response to risk adjusted mortality statistics.

4.2. Structured Judgement Review (SJR) methodology uses a structured case note review format, ensuring that all relevant aspects of care are included.

4.3. SJRs are completed on an electronic form within PANDA (the Trust's electronic patient information system). PANDA is also used to alert the Divisional Quality and Safety Managers (DQSM) to those cases requiring an SJR. The DQSM allocates each case to a trained reviewer (multidisciplinary) to complete an SJR and share any findings for learning. All consultants can submit and review SJRs on PANDA.

4.4. The 'assessment of problems in healthcare' section of the SJR records quantitative data on the nature of the problem type and whether this resulted in harm to the patient. The attached SJR scorecard shows the number of SJRs in the last four quarters where a problem in care was identified as causing or probably causing harm.

4.5. Any deaths identified as potentially resulting from failures in care are recorded on the DATIX incident reporting system and considered by SIRG for Serious Incident (SI) investigation.

4.6. Deaths in patients with Learning Disabilities (LD) are referred to the Learning Disabilities Mortality Review (LeDeR) Programme for independent care pathway review but also undergo local SJR, to ensure timely scrutiny and learning.

4.7. The LeDeR programme commenced in 2015 to support the review of deaths of people with learning difficulties and take forward the lessons learned in the reviews in order to make improvements to service provision. The LeDeR programme collates and shares anonymised information about the deaths of people with learning disabilities so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements.

5. SJR Training

5.1. The Palliative Care Team has produced an SJR training video and bespoke training for staff teams is currently being explored.

6. Involving Families / Carers

6.1. All deaths at the Royal Sussex County Hospital (RSCH) are reviewed by an ME who speaks with the family/carers of the deceased to ascertain any concerns regarding care. If concerns are raised either by the family or following ME review, the ME automatically refers the case for an SJR.

6.2. Two Medical Examiner Officers (MEO) have been appointed, start date August 2021. This will enable all hospital deaths to be scrutinised both at RSCH and PRH.

7. Mortality Review Outcomes

7.1. The objective of the review method is to look for strengths and weaknesses in the care given, to provide information about what can be learnt about the hospital systems where care goes well, and to identify any issues in care.

7.2. To the end in the 12 months to June 2021 47 non-CovidSJRs were carried out.

7.3. In addition, 60 mortality reviews have been undertaken for patients who died in hospital with nosocomial Covid-19 infection and whose death certificates identified Covid-19 as a cause or contributory factor in their death. The mortality reviews used a modified SJR framework approach and with a focus on whether the care provided gave the best chance of recovery and whether overall holistic care needs were met.

7.4. In total 7.5% of the deaths occurring in BSUH during the past four quarters have been subject to an SJR or Covid mortality review.

Table 1: SJR's, investigation reviews and mortality reviews undertaken in BSUH during the last 4 quarters

	Q2 20/21	Q3 20/21	Q4 20/21	Q1 21/22	Total
Total Inpatient Deaths	288	415	566	207	1476

Appendix 1

Total number of SJRs undertaken for adult inpatient deaths in Quarter	5	8	9	25	47
Following investigation adult inpatient deaths found to be more likely than not a result of problems in care	2	1	1	5	9
Review of nosocomial Covid-19 deaths	7	2	31	26	60
Known Learning Disabilities Deaths	0	1	2	1	4
Total known Learning Disabilities deaths in quarter reviewed using SJR	0	1	1	1	3
LD deaths more likely than not a result of problems in care	0	1	0	0	1
Total % of all deaths in Quarter having a SJR or other mortality review	**4.2%**	**2.7%**	**7.2%**	**25.1%**	**7.5%**

7.5. All adult deaths recorded as 'more likely than not a result of problems in care' have been fully investigated in line with Trust Serious Incident policy. There were 9 serious incidents investigations following adult patient death ongoing in Q4 2020/21 and Q1 2021/22. An additional two serious incident investigations were declared following the identification of wave 1 and 2 of nosocomial Covid-19 deaths.

7.6. **Table 2**: Serious Incident investigations following adult patient death commenced in Q4 2020/21 and Q1 2021/22

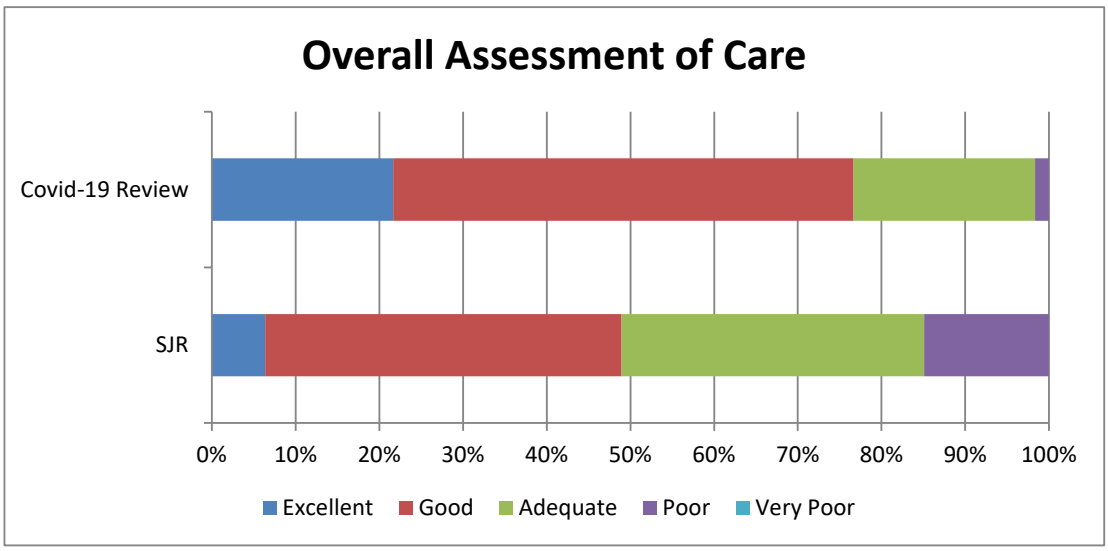
Datix no	Date reported & STEIS No	Description	Division	Target completion date
214587	11/03/2021 2021/5462	Missed opportunity to diagnose and treat lung cancer earlier	CCS	Submitted & Closed
215822	22/04/2021 2021/8607	Delayed diagnosis and treatment of a case of necrotising fasciitis	Medicine	15/07/2021
218923	26/04/2021 2021/8867	Lost to follow up leading to delay in diagnosing metastatic brain cancer	CCS	19/07/2021
215560	12/05/2021 2021/10048	Delayed reporting of a diagnosis of metastatic lung cancer	CCS	22/07/2021
219726	12/05/2021 2021/9960	Missed opportunity to diagnose and treat TC cancer	CCS	22/07/2021
220953	25/05/2021 2021/10999	Delayed diagnosis and treatment for epilepsy	Specialist	18/07/2021

7.7. **Table 3** and **Figure 1** display the overall assessment of the level of care made by both the SJR programme and the Covid-19 mortality review.

Overall Assessment of Care	Non-Covid SJR	Covid-19 Review
Excellent	3	13
Good	20	33
Adequate	17	13
Poor	7	1
Very Poor	0	0
Total	47	60

**Unrecorded in*

Appendix 1



7.8 Themes emerging from the 7 SJR's assessed as overall poor care were: lack of recognition that the patient was dying (n=2); delay commencing the end of life care plan (n=2); lack of clarity resulting in inappropriate EOLC planning and prescribing in the last few hours of life (n=1); delayed EOLC due to consideration of differential diagnosis (n=1); and the failure of prior outpatient follow-up possibly contributing to the patients poor health.

7.9 In the Covid-19 review one case was assessed as poor because of the lack of clear documentation and the absence of a patient centred approach to managing the patients comfort in the final stage of life.

7.10 Trust Mortality Review Group

The TMRG is Chaired by the Medical Director and attended by the divisional Chiefs of Service, DQSMs, the central Quality and Safety team, Medico-legal Services, Medical Examiners, Learning Disability Nurse Specialist, Palliative care, End of Life Care and RTT Performance teams. Clinical and nursing job planning is also being undertaken to ensure a multidisciplinary SJR programme and attendance at TMRG.

7.11 Serious Incident Review Group (SIRG)

SIRG East is currently held twice weekly, but within the new Quality Governance Framework there will be unified weekly UHSussex SIRG with amalgamated terms of reference to include mortality, complaints, medico legal and True North harm updates.

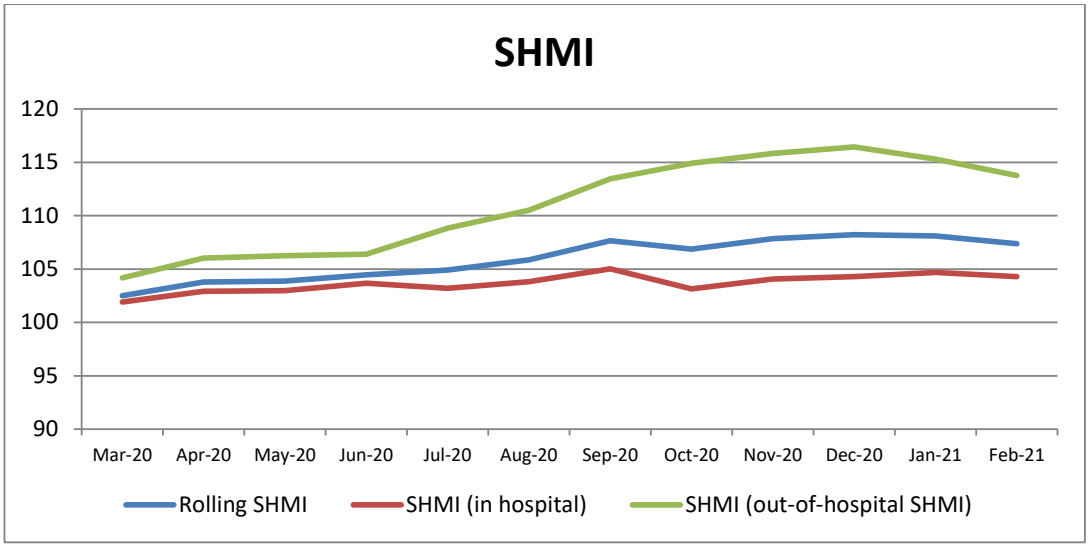
8 Summary Hospital-Level Mortality Indicator (SHMI)

8.1. The SHMI is the ratio between the actual number of patients who die following hospitalisation at a Trust and the number that would be expected to die. Unlike HSMR, the SHMI includes all deaths regardless of diagnosis – with the exception of CoVid. It also includes patients who die in the community but had an admission to the Trust within the previous 30 days.

Appendix 1

8.2. To the end of February 2020, the 12 month rolling SHMI was 107.37 (in-hospital SHMI 104.29 and out of hospital SHMI 113.77). Over the past year the trend has been upwards for the 12 month rolling SHMI.

8.3. **Figure 2**: highlights that over the past 12 months the SHMI has been increasing with out of hospital deaths being 14% higher than expected, whilst in-hospital deaths are 4% above the expected level. The SHMI for this period is 107.4.



8.4. **Table 3**: displays the in-month SHMI, expected and observed deaths for the period March 2020 to February 2021 this analysis excludes all Covid-19 patients[1]. During the past 12 months 1750 patients have either died in hospital or within 30 days of discharge, this is against an expected number of 1630.

Discharge Month	SHMI	Expected number of deaths	No. of patients who died in hospital or within 30 days
Mar-20	121.56	187.56	228
Apr-20	103.02	102.89	106
May-20	97.20	122.42	119
Jun-20	102.24	127.16	130
Jul-20	100.85	146.75	148
Aug-20	109.36	151.79	166
Sep-20	114.48	141.51	162
Oct-20	107.50	150.69	162
Nov-20	108.15	139.62	151
Dec-20	109.77	133.92	147
Jan-21	118.38	105.60	125
Feb-21	88.31	120.04	106

[1] All SHMI datasets have COVID-19 activity removed from them by detecting the ICD10 codes of U07.1 or U07.2 in any of the Diagnosis 1-20 fields.

Appendix 1

9 HSMR

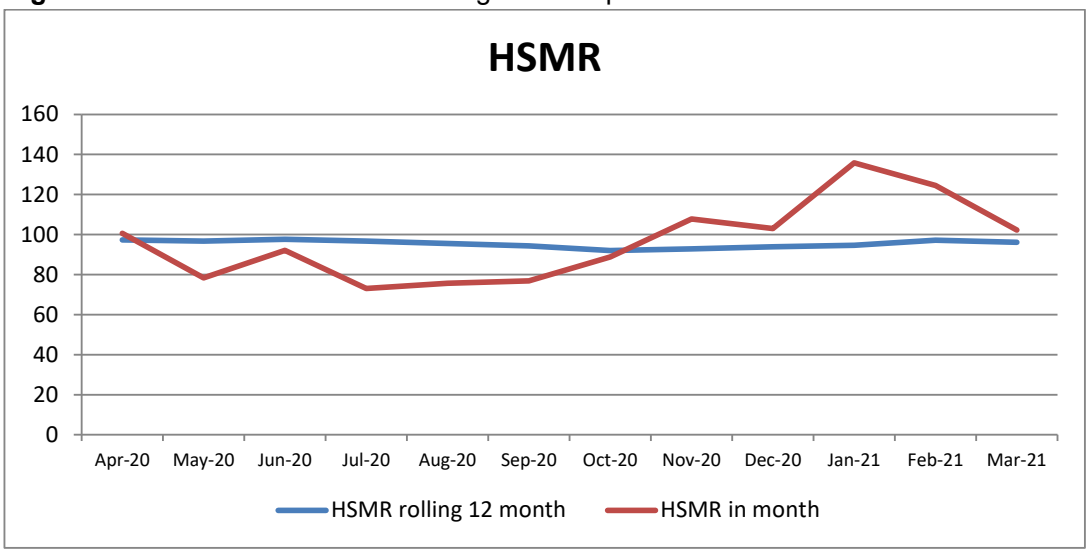
9.1. HSMR is based on the 56 diagnosis groups which contribute to 80% of in-hospital deaths in England. COVID-19 is also excluded from HSMR analysis. The volume and case-mix of non-COVID patients admitted to hospital will also impact on the Trust's HSMR. Table 4 shows that the current in-month trend for the Trust's HSMR is upwards, whilst the rolling 12-month trend is downwards. This is accounted for by the lower HSMR recorded between April 2020 and March 2021. The most recent HSMR data is from March 2021 when the 12 month rolling HSMR was 96.19 (1028 observed deaths against an expected number of 1069).

9.2. **Table 4**: In-Month and 12 month rolling HSMR

Month of discharge	HSMR rolling 12 month	HSMR in month
April-20	97.26	100.65
May-20	96.70	78.37
June-20	97.64	92.06
July-20	96.80	73.06
August-20	95.54	75.63
September-20	94.33	76.84
October-20	92.01	88.75
November-20	92.79	107.75
December-20	93.94	102.96
January-21	94.58	135.83
February-21	97.22	124.56
March-21	96.19	102.22

Appendix 1

9.3. **Figure 3**: In-month and 12 month rolling HSMR April 2020 – March 2021



9.4. Combining the number of observed and expected deaths from each legacy organisation produces an HSMR of 91.1 (2494 observed deaths VS.2737 expected) placing UHS in the top quartile ranked as the 28th lowest HSMR.

10 Crude Trust Mortality – Non-Elective

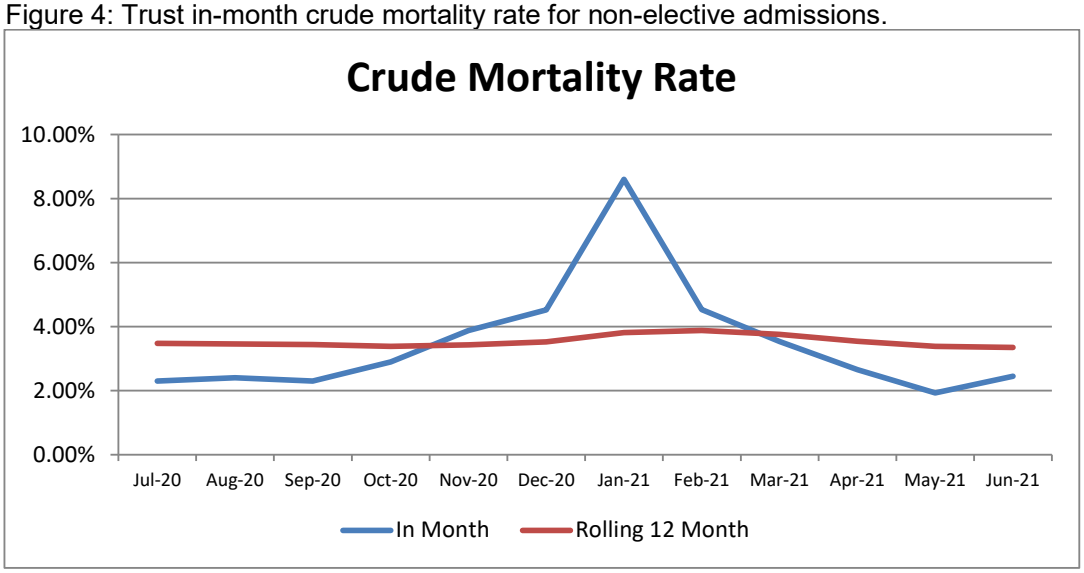
10.1. The crude mortality rate looks at the number of deaths of non-elective patients that occur in hospital in any given month or year as a ratio of the number of patients discharged.

10.2. Table 5: Crude mortality data Q2, 3 and 4 20/21 and Q1 21/22

Month	Number of Deaths	Number of Discharges	Mortality Rate (In Month)	Mortality Rate (Rolling 12)
Jul-20	87	3705	2.3%	3.48%
Aug-20	93	3950	2.4%	3.46%
Sep-20	90	3929	2.3%	3.44%
Oct-20	116	3754	2.9%	3.38%
Nov-20	139	3579	3.88%	3.43%
Dec-20	151	3339	4.52%	3.52%
Jan-21	262	2785	8.60%	3.81%
Feb-21	140	2950	4.53%	3.88%
Mar-21	135	3687	3.53%	3.76%
Apr-21	106	3881	2.66%	3.54%
May-21	84	4273	1.93%	3.38%
Jun-21	109	4335	2.45%	3.35%

Appendix 1

10.3. Figure 4: Trust in-month crude mortality rate for non-elective admissions.



10.4. The in-month Crude Mortality rate exceeded the Upper Control Limit in January 21 with a rate of 8.6% against a seasonally predicated rate of 5.7%.The higher than expected rate in January 2021 was due to the large number of inpatient deaths with 262 with a low number of discharges.

10.5. In accordance with the requirements of National Guidance on Learning from Deaths, BSUH have published the specified data on deaths.

11. Recommendation

The Board is asked to note the report.

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Appendix 2

Agenda Item:	19.2	**Meeting:**	Board	**Meeting Date:**	5 August 2021
Report Title:	Learning from Deaths Q1 21/22 University Hospitals Sussex NHS Foundation Trust (West)				
Sponsoring Executive Director:	Professor William Roach - Chief Medical Officer				
Author(s):	Tim Taylor - Medical Director, Alison Young - Head of Quality Improvement, Mary Evans - Learning from Deaths Manager				
Report previously considered by and date:					
Purpose of the report:					
Information	☐		Assurance	✓	
Review and Discussion	✓		Approval / Agreement	☐	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	☐		Staff confidentiality	☐	
Patient confidentiality	☐		Other exceptional circumstances	☐	
Link to Trust Strategic Themes:					
Patient Care	✓		Sustainability	☐	
Our People	☐		Quality	✓	
Systems and Partnerships	☐				
Any implications for:					
Quality	Learning and quality improvement from the review of deaths				
Financial	Nil				
Workforce	Training requirements and time for individuals to undertake and respond to learning				
Link to CQC Domains:					
Safe	✓		Effective	✓	
Caring	✓		Responsive	✓	
Well-led	☐		Use of Resources	☐	
Communication and Consultation:					
A plan for communication is being developed					
Executive Summary:					
The purpose of the briefing is to update the Board of progress in the implementation of the structured approach for reviewing the deaths of patients to provide assurance on care and identify areas where it could have been improved.					
Key Recommendation(s):					
The Board is asked to: Receive and discuss the progress toward implementation of the 'Learning from Deaths' policy and the learning identified from structured mortality reviews.					

University Hospitals Sussex NHS Foundation Trust

Learning from Deaths Mortality Report Quarter 1 2021/22 as at 09/07/2021 for University Hospitals Sussex NHS Foundation Trust (UHS) - West

1. Background:

1.1 The mortality process for the UHS (West) reverted back to the electronic consultant level screening system at the beginning of June 2020. This was in line with the expected process and previous outcome reports to the Divisions, with exception of the report submitted July 2020. That report covered mid quarter four 2019/20 to the end of quarter one 2020/21 reporting period following Corona virus (Covid-19) business continuity screening, of all trust adult deaths in April and May 2020.

1.2 The Department of Health and Social Care remains committed to making the medical examiner system statutory. It is anticipated the non-statutory system will continue throughout the financial year 2021/22. Phased Medical Examiner (ME) activity across UHS (West) commenced quarter 2 2020/21.

2. Electronic Screening quarter one 2021/22 reporting period:

2.1 Electronic consultant screening has continued to operate until the Medical Examiner Office has been fully implemented across the west end. The provisional date to turn off consultant screening was January 2021. However due to corona virus (wave 2) business continuity during quarter 4 2021, this was postponed and will be happening imminently. The consultant will continue to receive an email informing them of the death of a patient under their care and there will be a link to enable them to refer directly for Structured Judgement Review (SJR) if there are any areas of concern.

3. Activity and outcomes from consultant screening during quarter one 2021/22:

Table 1: Details the total number of adult deaths during quarter 1 2021/22 against the number screened electronically, per hospital site.

Table 1: Total Deaths	**St Richards**			**Worthing**		
	Number	**Screened**	**% Screened**	**Number**	**Screened**	**% Screened**
April	71	44	62↑	75	37	49↑
May	69	38	55↑	79	25	32↓
June	59	33	56~	71	24	34↓
Total	**199**	**115**	**58↑**	**225**	**86**	**38↓**

A total of 201(47 %↓) out of the 424 quarter 1 2021/22 inpatient adult deaths have been electronically screened at the time of writing this report. This percentage and total number is less than the 368 (50%) of the 737 deaths that were electronically screened for quarter 4 2020/21.

Table 2: Details the total number of adult deaths during quarter 1 2021/22 against the number of deaths scrutinised by the Medical Examiner Office, according to site.

Table 2:	St Richards			Worthing		
	Number	Scrutinised	% Scrutinised	Number	Scrutinised	% Scrutinised
April	71	75*	100↑	75	79*	100↑
May	69	74*	100↑	79	81*	100↑
June	59	65*	100↑	71	75*	100↑
Total	**199**	**214***	**100↑**	**225**	**235***	**100↑**

N.B. Until such a date that the electronic screening is switched off, there will be some deaths that will have been electronically screened as well as being scrutinised by the ME.

Of the 424 adult deaths all 424 (100 %↑) have been scrutinised to date. This percentage of deaths scrutinised is an increase from the 99% of deaths that were scrutinised by the Medical Examiner Office for quarter 4 2020/21.

* The number of deaths scrutinised by the Medical Examiner Office exceeds the number of documented inpatient deaths, as the Medical Examiner Office also scrutinises the deaths that occur in the accident and emergency departments. These deaths are not classified as inpatient deaths and thus do not fall within the mortality review process.

4. Structured Judgement Reviews (SJR) during quarter 1 2021/22

Table 3: Details the number of deaths for quarter 1 2021/22, escalated to SJR.

Table 3	St Richards		Worthing	
	Referrals from Electronic Screening	Referrals from MEs	Referrals from Electronic Screening	Referrals from MEs
April	7	11	9	6
May	8	10	7	10
June	10	11	2	9
TOTAL	**25↓**	**32↓**	**18↓**	**25↑**

N.B. A percentage of deaths escalated to SJR may have been referred via multiple sources e.g. electronic screening, ME's, patient safety team.

4.1 A total of 98 (23% ↑) of the total adult inpatient deaths (424) for quarter 1 2021/22, were escalated for SJR.

At the time of writing this report, a total of 15 (15%) of cases for quarter 1 2021/22 deaths, where SJR's were requested *(n=98),* have completed the mortality review process.

Table 4: Details the final overall outcome scores of SJRs that have been completed for quarter 1 deaths *(n= 15)* at the time of writing this report*:*

Table 4

Overall outcome score	St Richards (*n=8**)	Worthing (*n=7**)
1 – Very poor	0	0
2 – Poor	1	3
3 – Satisfactory	3	1
4 – Good	4	3
5 – Very good	0	0

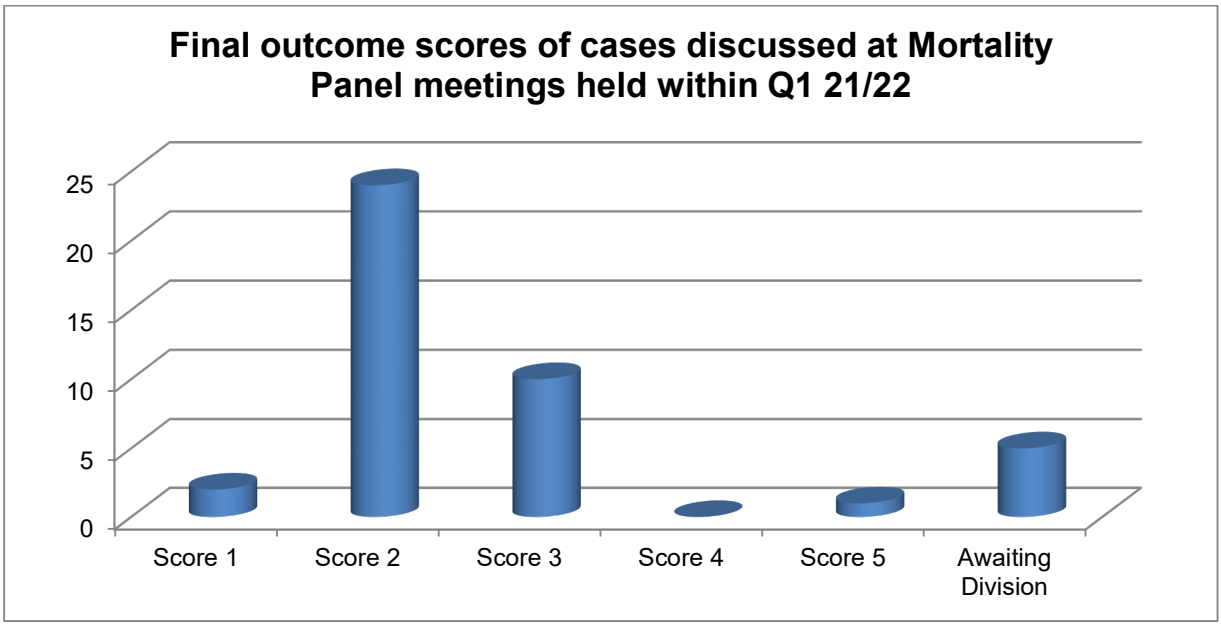
*None of these deaths were deemed more likely than not due to problems in care.

N.B. A total of 83 cases have not been included in this report, as at the time of writing the report, the learning from deaths review process was incomplete. Of these 83 cases, 9 x 1st SJR's are with reviewers, 3 cases are awaiting a second review and 3 cases are awaiting a mortality panel discussion, leaving 68 cases to be allocated to reviewers.

4.2 During quarter 1 2021/22 a total of 42 cases were discussed at the weekly mortality panel meetings. These involved 11 cases from quarter 3 2020/21, 29 cases from quarter 4 2020/21 and 2 cases from quarter 1 2021/22.

Graph 1: Details final outcome scores for all cases discussed at mortality panel meetings that took place within quarter 1 2021/22.

Graph 1



N.B. None of the cases that were discussed at the mortality panel meetings in quarter 1 2021/22, where a final outcome score was determined were identified as the deaths being more likely than not due to problems in care *(n=37).* Five cases are awaiting further information and/or investigation form the Divisions. This information will then be fed back to the mortality panel meeting and a final outcome score will be given.

University Hospitals Sussex NHS Foundation Trust

5. Mortality reviews for people with a Learning Disability (LD) quarter 1 2021/22

Table 5: Details the different stages of the mortality reviews and the number completed at each stage, for patients with a learning disability that died during Q1 2021/22.

Table 5:

	St Richards			Worthing		
	Screened	SJR completed	Mortality Review Process % Completed	Screened	SJR completed	Mortality Review Process % completed
April	0	0	0	1	1	100%
May	1	1	100%	0	0	0
June	1	1	100%	0	0	0
Total	**2**	**2**		**1**	**1**	

5.1 In total for quarter 1 2021/22, 3 patients with a LD were identified as having died, and had their care scrutinised by the ME and were referred on for SJR, as per policy. The Learning Disabilities Mortality Review (LeDeR) programme was notified for all three cases, within the agreed timeframe. All three cases have completed the mortality review process at UHS (West), having had SJR's completed and the reviews uploaded to either the LeDeR record and /or sent to the Sussex LeDeR programme lead. None of these deaths have been identified as being more likely than not due to problems in care.

Table 6: Details the final overall outcome scores of SJRs that were completed from quarter 1 2021/22 deaths for LD patients *(n=3):*

Table 6

Overall outcome score	St Richards (*n=2*)	Worthing (*n=1*)
1 – Very poor	0	0
2 – Poor	0	1
3 – Satisfactory	1	0
4 – Good	1	0
5 – Very good	0	0

5.1 Rapid reviews for patients with a LD were reintroduced on 06/12/2020 in light of the escalating numbers of people with Covid-19. Completion of these was to help identify any learning or practise that would improve: local support, escalate concerns or prevent further deaths in patients with a LD. These reviews are not part of the NHS England/Improvement LeDeR programme and a full review for each case is also required. Information from UHS (West) was submitted via the Sussex LeDeR programme lead, to aid the rapid reviews as required. The SJR's for these cases were expedited through the learning from deaths process at UHS (West), to assist with these rapid reviews.

5.2 The backlog of LeDeR reviews have now been completed by The North of England Commissioning Support (NECS) on behalf of local clinical commissioning groups and NHS England supported by UHS (West) by sharing SJR's and mortality panel discussions, from which feedback and identified learning is then received. In the last quarter, no LeDeR external reviews were received via the Sussex LeDeR programme lead. Once the reviews have been received, the feedback is shared at the Learning Disabilities Strategy Group. The identified learning and recommendations from these reviews is then scrutinised at the LeDeR Action Review Group who initiate and facilitate the required quality improvement work streams.

6 Covid-19 mortality reviews quarter 1 2021/22

6.1 The number of patients who died in quarter 1 2021/22 who's leading cause of death was Covid-19 diminished hugely to just 1 case. This case underwent ME scrutiny and has been escalated to SJR.

6.2 On 19/05/2020 NHSE (National Health Service England) and NHS Improvement published identified categories re interim data collection to assist with monitoring of in-hospital transmission. The three categories were identified as:

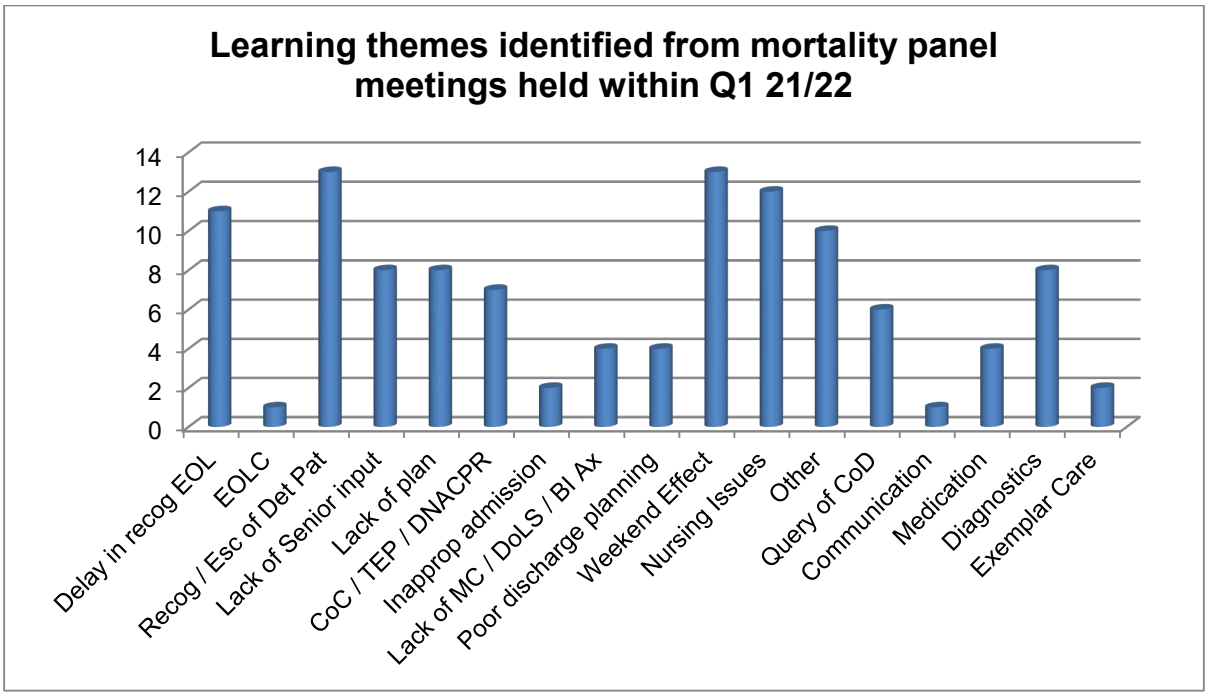
- Category 1 = Hospital onset indeterminate healthcare-associated – first positive specimen date 3-7 days after admission to Trust.
- Category 2 = Hospital onset probable healthcare-associated – first positive specimen date 8-14 days after admission to Trust.
- Category 3 = Hospital onset definite healthcare-associated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

There were no cases of a Hospital Onset Healthcare Associated (HOHA) Covid-19 during quarter 1 2020/21.

7 Learning from deaths themes quarter 1 2021/22

Graph 2: Details learning themes identified from mortality panel meetings that took place within quarter 1 2021/22.

Graph 2:



Glossary of terms:
Delay in recog EoL - Delay in recognising patient was approaching End of Life
EOLC – Issues with the End of Life Care the patient received
Recog/Esc of Det pat – Lack of recognition or escalation of the deteriorating patient

Lack of senior input – Lack of input from senior doctors
Lack of plan – Lack of treatment plan for the patient
CoC / TEP / DNACPR – Ceilings of Care and/or Treatment Escalation Plan were not discussed or completed and/or lack of Do Not Attempt Cardio-Pulmonary Resuscitation documentation or discussion
Inapprop admission – Inappropriate admission to hospital
Lack of MC / DoLS / BI Ax – Lack of documentation regarding Mental Capacity / Deprivation of Liberties / Best Interests discussions/assessments
Poor discharge planning – Poor discharge planning
Weekend Effect – Patient care may have been compromised due insufficient clinical review at the weekend or over a Bank Holiday
Nursing Issues – Issues with nursing care identified
Query of CoD – There is a query over the accuracy of the Cause of Death as stated on the Medical Certificate of Cause of Death.
Communication – Where poor communication between staff, teams or with the family has been identified
Medication – Where there were delays or errors in prescribing/administering drugs; drug errors or omissions
Diagnostics – Where there were delays or errors in completing/reporting/actioning diagnostic tests.
Other – Refers to any other learning identified that does not fit into the above categories
N.B. 'Other' includes a variety of issues including for this quarter – Medical Consultant input in a surgical patient case delayed, Covid-19 swabbing & protocol not followed, delayed referral, poor documentation, no safety net on discharge and management of complex nutritional & pain relief needs

The main recurring themes identified at mortality panel meetings throughout quarter 1 2021 are;

7.1 Late recognition and escalation of a deteriorating patient.

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

- Management and monitoring of fluid balance
- Delayed recognition and treatment of Acute kidney Injury (AKI)
- Medical oversight of surgical patients
- Management of hyper/hypo glycaemia
- Weekend effect

7.2 Delayed recognition in end of life

Issues identified in contributing to a delay in recognising the patient is approaching the end of their life included;

- Inappropriate medical interventions
- The patient not dying in their preferred environment
- Symptoms not being managed appropriately potentially causing distress to the patient and/or their loved ones

7.3 Weekend Effect

Patient care may have been compromised due insufficient clinical review at the weekend or over a Bank Holiday. There was either a lack of medical review or the review was undertaken by an inappropriately junior member of the medical team, which has then contributed to poor care

8 Current capacity and future sustainability of robust mortality review processes

8.1 The activity of the mortality reviewers undertaking SJRs can be constrained by their clinical commitments. Following a step down from business continuity as a result of both waves of the Corona virus pandemic, SJR activity has slowly increased during quarter 1 2021/22. A recovery plan remains ongoing to assist in managing the SJR backlog.

8.2 As per SJR reviewers, business continuity impacted ME availability during Q4 2020/21. However quarter 1 2021/22 has seen the Medical Examiner Office scrutinise every adult inpatient death. A third Medical Examiner Officer (MEO) was recruited (April 2021) in advance of the community roll out, and has recently commenced post.

9 Recommendations

The Board is asked to NOTE

- All mortality screening to be undertaken by the Medical Examiner Office in place of the existing electronic screening process from end of quarter 2 2021/22.
- Ongoing recruitment of both ME and MEO will be required for roll out of ME service fully to include all community deaths.
- Joint working between ME office, Learning from Deaths Manager and Bereavement team to develop the DatixCloud IQ® Mortality Module.

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Table 8: Details ongoing actions and planned actions in response to learning themes from mortality panel meeting outcomes

Colour	Status
	Due
	Open
	Open on track
	Closed/complete

QUARTER	THEME	ACTION	LEAD	UPDATE	RAG rating
Q2 20/21	Missed/ delayed diagnosis of chest pains	Communicate with the Medical Division (urgent care) and Thrombosis Committee – pathways require updating	TT	Ongoing	
Q2, 3 & 4 20/21	Raised standardised mortality ratio for #NOF at Worthing with increased numbers of deaths for this patient group and elements of poor care identified at mortality review panel	Orthogeriatric Steering Group re-established to review #NOF pathway and outcomes chaired by the Medical Director. Time to theatre for #NOF patients incorporated into surgery SDR	TT	Closed - SMR for #NOF is now reducing and better than expected on both sites.	
All	Varied response from divisions with regards learning from mortality panel feedback/actions	Internal audit	TT/ME	Completed	
		Update Learning from Deaths Policy – to include divisional/speciality M&M leads roles and responsibilities	AY	Completed	
		Scope divisional/speciality mortality leads & M & M meetings	ME	Ongoing	
		Design DatixCloud IQ® mortality module	ME	Ongoing	
		Use of DatixRL® incident module (interim solution)	ME	Ongoing	
All	Recognition and escalation of deteriorating patients	Merged deteriorating patient group for UHS (commenced May 2021)	AY	Ongoing	
		Launch of Orthopaedic Improvement Board	TT	Ongoing	

		Task and finish group established to establish out of hours resilience & implement findings of ECIST visit (Spring 2020).	TT/BH	Ongoing	
		Implementation of blood gas results incorporation into main results systems & use of ↑lactate as marker for deteriorating patient on Patientrack	TT/LH	Ongoing	
All	Issues around Ceilings of Care / Treatment Escalation Plans / DNACPR	Targeted educational sessions with Capsticks on DNACPR and mental capacity complete.	TT	Completed	
		Across UHS task and finish group underway for implementation of TEP and RESPECT tool.	TT	Ongoing	
Q3 & Q4 20/21	Recurrent themes from LeDeR reviews; MCA, BI, communication and lack information being available in easy read format	LeDeR Action Review Group	ME	Ongoing	
Q3 & Q4 20/21	Threshold for elderly patients with head injuries having CT scans being undertaken upon presentation is varied. Additional requirements for those >65 yrs with cognitive impairment who fall from standing height with regards to missed neck #.	Communicate with Medical Division (urgent care) - pathways require updating	TT	Ongoing	
All	Delay in recognising EoLC	Successful palliative care business case to extend service - consultant appointed at Worthing and recruitment underway at SRH. Nursing cover 7 days across site	TT	Ongoing	
		Merged UHS End of Life and Mortality Board (commenced June '21)	TT	Ongoing	

Mary Evans – Learning from Deaths Manager UHS (West)

Western Sussex Hospitals NHS Foundation Trust

Meeting of the Board of Directors

10:00 – 13:30
Thursday 05 August 2021

Item 22 - QUESTIONS FROM THE PUBLIC

From	Question	
John Gooderham	Will the Board consider holding a ballot of members on the merger with Queen Victoria Hospitals NHS Foundation Trust at some stage in the process? ***Response will be provided by Pete Landstrom.***	