Meeting of the Board of Directors

10.00 to 14.00 on Thursday 3 February 2022

Virtual MS Teams

AGENDA – MEETING IN PUBLIC

1.	10.00	**Welcome and Apologies for Absence** To note	Verbal	Alan McCarthy
		Confirmation of Quoracy To note *A meeting of the Board shall be quorate and shall not commence until it is quorate. Quoracy is defined as meaning that at least half of the Board must be present this being nine Board members.*	Verbal	Alan McCarthy
2.	10.00	**Declarations of Interests** To note	Verbal	All
3.	10.00	**Minutes of UHSussex Board Meeting held on 04 November 2021** To approve	Enclosure	Alan McCarthy
4.	10.05	**Matters Arising from the Minutes of 04 November 2021** To note	Enclosure	Alan McCarthy
5.	10.05	**Report from Chief Executive** To receive and note overview of the Trust's activities	Presentation	Dame Marianne Griffiths
		INTEGRATED PERFORMANCE REPORT		
6.	10.30	**Patient** To receive and agree any necessary actions *After this section the Chair of the Patient Committee will be invited to provide their report included at item 11* To receive assurance from Committee and recommendations from the Committee	Enclosure	Maggie Davies
7.	10.45	**Quality** To receive and agree any necessary actions *After this section the Chair of the Quality Committee will be invited to provide their reports included at item 12* To receive assurance from Committee and recommendations from the Committee	Enclosure	Maggie Davies Charlotte Hopkins
8.	11.00	**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.	11.15	**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.	11.30	**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.	11.45	**Report from Patient Committee from the meeting held on the 25 January 2022** To receive assurance from Committee and recommendations from the Committee	Enclosure	Jackie Cassell
12.	11.50	**Report from Quality Committee from the meeting held on the 25 January 2022 and 22 December 2021**	Enclosure	Joanna Crane

		- *Infection Prevention & Control Annual Report 2020/2021*
		  - *Former BSUH*
		  - *Former WSHFT*
			Presentation	Pat Cattini

		- *Annual Adults Safeguarding Report 2020/2021*
		  - *Former BSUH*
		  - *Former WSHFT*
			Presentation	Maggie Davies

		- *Annual Children's Safeguarding Report 2020/2021*
		  - *Former BSUH*
		  - *Former WSHFT*		

		To receive assurance from Committee and recommendations from the Committee		
13.	12.05	**Report from People Committee from the meeting held on the 26 January 2022**	Enclosure	Patrick Boyle

		- *UHSussex Annual Gender Pay Gap Report 2021*
		  - *Former BSUH*
		  - *Former WSHFT*
			Enclosure	

		- *UHSussex Annual Equality Report 2021*	Enclosure	
		To receive assurance from Committee and recommendations from the Committee		
14.	12.20	**Report from Sustainability Committee from the meeting held on the 27 January 2022** To receive assurance from Committee and recommendations from the Committee	Enclosure	Lizzie Peers
15.	12.25	**Report from Systems and Partnerships Committee from the meeting held on the 27 January 2022 including:**	Enclosure	Patrick Boyle
		- *Emergency Planning, Preparedness and Response Annual Report 2021/2022*	Enclosure	
		To receive assurance from Committee and recommendations from the Committee		
16.	12.35	**Report from Audit Committee from the meeting held on the 13 January 2022** To receive assurance from Committee and recommendations from the Committee	Enclosure	Jon Furmston
17.	12.45	**UHSussex Green Plan** To note	Presentation	Karen Geoghegan David McLaughlin Mahmood Bhutta
18.	13.05	**Board Assurance Framework** To approve	Enclosure	Glen Palethorpe
		WELL LED & COMPLIANCE		
19.	13.10	**CQC Action Plan** To note	Enclosure	Maggie Davies
20.	13.35	**Company Secretary Report** To note	Enclosure	Glen Palethorpe
		OTHER		
21.	13.45	**Any Other Business** To receive and action	Verbal	Alan McCarthy
22.	13.50	**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.	14.00	**Date and time of next meeting:** The next meeting in public of the Board of Directors will be a short Board meeting at **13:30** on **Thursday 31 March 2022** with the next full Board meeting scheduled to take place at **10.00** on **Thursday 05 May 2022**.	Verbal	Alan McCarthy

To resolve to move to into private session

The Board now needs to move to a private session due to the confidential nature of the business to be transacted

Minutes of the Board of Directors meeting held in Public at 10.00am on Thursday 04 November 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
Dame Denise Holt	Non-Executive Director
Claire Keatinge	Non-Executive Director
Lucy Bloem	Non-Executive Director
Lillian Philip*	Associate Non-Executive Director
Karen Geoghegan	Chief Financial Officer
Pete Landstrom	Chief Delivery and Strategy Officer
Maggie Davies	Chief Nurse
David Grantham	Chief People Officer
Professor William Roche	Chief Medical Officer
Denise Farmer *	Chief Workforce and Organisational Development Director
Andy Heeps	Managing Director – West
Kate Slemeck	Managing Director – East

*Non-voting member of the Board

In Attendance:

Rob Haigh	Medical Director
Gethin Hughes	Interim Chief Operating Officer
Glen Palethorpe	Company Secretary
Tanya Humphrys	Board and Committee Administrator

TB/10/21/1 WELCOME AND APOLOGIES FOR ABSENCE **ACTION**

1.1 The Chairman welcomed all those present to the meeting and began by welcoming the new governors joining us in the public gallery and thanked those governors that have left the Trust.

1.2 Alan went on to acknowledge that Dame Marianne Griffiths had announced her retirement, Alan thanked Marianne for her innovation and dedication to the Trust over the last decade adding that she would be very difficult to replace and there would be many opportunities for colleagues to thank Marianne and say goodbye in person before she leaves in June 2022. Alan also acknowledged that Chief Delivery and Strategy Officer Pete Landstrom would also be leaving the Trust in the early part of the new year to join the Royal Free in London, Alan thanked Pete for his dedication and support provided to the Trust adding that he would also be very difficult to replace but wished him well in his new role.

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

TB/11/21/2 DECLARATIONS OF INTERESTS

2.1 There were no other interests declared.

TB/11/21/3 MINUTES OF THE MEETING HELD ON 05 AUGUST 2021

3.1 The Board received the minutes of the meeting held on 05 August 2021.

3.2 The minutes of the meeting held on 05 August 2021 were **APPROVED** as a correct record.

TB/11/21/4 MATTERS ARISING FROM THE MINUTES OF THE PREVIOUS MEETING

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

TB/11/21/5 Chief Executive Report

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

5.2 Marianne began by updating the Board in relation to current Covid numbers explaining that over the last month the Trust was beginning to see the number of positive cases rise again as was also the case in the Community. It was noted that the Trust was currently caring for 60 patients across all four hospitals with Covid, with 12 in Critical Care.

5.3 The Board was advised that maintaining staff safety was paramount and the Trust was continuing to support the vaccine roll out of both Covid booster jabs and flu jabs, both of which have been going well, Marianne advised that the Trust was trying to get achieve over 90% of vaccinated staff.

5.4 Marianne explained to the Board that the Trust was continuing to experience very high demand on its services with an increase of 9.5% activity across the Emergency Departments. Marianne went on to explain that this was having a significant impact across the whole of the Trust and that a system wide approach was being taken to ensure that patients are signposted to the most appropriate healthcare provider. In addition to the increase in activity in A&E the Trust was continuing with its restoration and recovery elective pathways and was working hard to reduce the waiting list.

5.5 It was noted that winter planning was underway at a system level of which UHSussex is a key element of. Marianne noted that the Sussex winter plan had been commended by NHSEI for its demand and capacity modelling and robust assurance processes.

5.6 Marianne took the opportunity to reiterate a big thank you to staff who continue to work under unprecedented pressure noting that it has been inspirational some of the lengths some staff will go through to keep patients safe. It was noted that although the Trust has more staff than ever before given the demands on the Trust work is ongoing to recruit to vacancies across the Trust. The Health and Wellbeing activities implemented to support staff during the pandemic continues as the Trust strives to continue to protect our staff as they are our most valuable asset.

5.7 In the news section of the update Marianne drew out the following highlights:

- The Trust launched Star of the Month, with more than 100 nominations in month 1. The winner was Healthcare Assistant Bronwyn Powell, following a public nomination.

- Congratulations to David Grantham who won 'Director of the Year 2021' at the HPMA People Awards for his 'outstanding' work at his former organisation.
- Meghann Creffield won the 'Outstanding Contribution by an Apprentice to an Employer' prize at the Brighton and Hove Apprenticeships Awards.
- Congratulations to Company Secretary Glen Palethorpe who has been shortlisted for Company Secretary of the year with the Chartered Governance Institute.
- The Trust approved a new £5.6 million Urology Investigation Unit at Princess Royal, which will provide a one-stop clinic for patients.

5.8 Lizzie Peers commented on the phenomenal contributions made by Marianne during her time at the Trust and that she would be greatly missed by everyone. Lizzie asked if there was a shared view of risk amongst ICS providers supporting the winter plan. Marianne explained that the biggest contributor was the high number of medically ready for discharge (MRD) patients which was having a significant impact on flow within the organisation due to the domiciliary care market having been so deeply affected by the pandemic, Marianne assured the Board that this had been escalated to the Council.

5.9 Andy Heeps advised the Board that conversations were taking place at least once a day with system partners and that the winter plan does allow for a certain number of MRD patients, in addition the Trust has invited our regulators to a quality and risk summit to further explore how the Trust responds to pressures currently being experienced.

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

TB/11/21/6 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, it was noted that the Integrated Performance Report is aligned to the Trust Committees and that the Committee Chairs would be invited to provide their Chairs report after each section of the IPR.

TB/11/21/7 Patient

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

7.2 The Board was advised that there was some variation in the data and it was important to reflect that inpatient satisfaction remains high with aggregated figures of 98% in the West and 91% in the East, Maggie explained that the figures link to what the Trust is seeing across our A&E departments primarily the amount of time patients are waiting to be seen. Maggie added that it is important that the way the Trust communicates regarding waiting times to patients to support reducing anxiety in relation to long waits.

7.3 Maggie explained that despite the huge pressure staff are currently under, patients who report their positive experiences of care do so around a number of dominant themes:

- Treatment by staff, characterised by kindness, dedication, efficiency

- Clarity of explanation and involvement, including of waits and in decision making
- Attention to basic needs such as refreshments and supplies

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 explained to the Board that the update from Maggie provides an insight to the detailed level of understanding the Trust has for patient experience and what the key contributors are to patient experience. It was noted that the Committee agreed a new breakthrough objective in relation to dealing with aspects of waiting and how this will seek to reduce the number of negative experiences citing waiting as factor for patient dissatisfaction.

7.6 Jackie highlighted the reinvigoration of the Patient First System was positive and the continued embedding of that philosophy, the Committee considered the implication of planning for the Trusts recent unannounced CQC visit and the ability to continuously improve patient experience. Finally, Jackie advised that the Committee had been joined by the new Director of Patient Experience and Engagement who was keen to continue the good work to improve patient experience at UHSussex.

7.7 Lizzie Peers asked what the Trust was doing to capture patient experience feedback within outpatients, Lizzie also commented that the plaudits received by patients and families should be celebrated widely and often.

7.8 Maggie commented that as part of the reinvigorated Patient First programme improvement huddles have been reinstated on all wards and there is a specific section related to celebrations and the Executive team are supporting huddles.

7.9 Dame Marianne Griffiths added that one of the things the Trust did when it had its announced inspection previously was a 'book of good' which was a really positive way to share plaudits and celebrations.

7.10 Pete Landstrom explained that the Trust receives a substantial number of response rates in terms of FFT for outpatients however they do vary significantly but assured the Board, as with the other services, there is a proportion that reflected positively on their experience. Pete added that the sheer volume of responses within this area is what is making collating the data challenging to then include in a meaningful way within the snapshot data.

7.11 Alan McCarthy thanked Maggie and Jackie for their updates and reiterated that the Patient Committee was one of the new Committees with real aspirations in relation to the positive impact that the Trust will have on our patients.

TB/11/21/8 Quality

8.1 Professor William Roche 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 against an expected number of deaths and that the data being presented was the data available up to June 2021 for UHSussex broken down into UHSussex East and UHSussex West:

- HSMR in UHSussex East for the 12 months to June 2021 was 96.0, with 1045 observed deaths against an expected 1088 deaths.
- HSMR in UHSussex West for the 12 months to June 2021 was 87.4, with 1510 observed deaths against an expected 1728 deaths.

- The combined HSMR for East and West is 90.7 with 2555 observed deaths against an expected 2816 deaths.

8.3 A HSMR of 90.7 would rank the Trust 33rd out of 125 Trusts, i.e. just outside the top quartile.

8.4 The Board was advised that the higher than expected crude mortality rates in January 2021 were due to the large number of inpatient deaths which reflected the ongoing Covid-19 pandemic.

8.5 Maggie Davies reminded the Board that the Quality True North for the Trust was zero harm occurring to patients in our care, it was noted that there were a number of improvement actions in place to support harm reduction at the Trust:

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

8.6 The Board was advised that the stratification of data with the respective legacy organisations was ongoing with some interesting variation work in relation to falls, the Trust continues with 'Bay Watch' on wards and regular checking of postural blood pressures.

8.7 Maggie explained that the Trust was seeing a lot of patients admitted with community acquired pressure damage, Maggie went on to further explain that it was to be expected that with the reduced availability of domiciliary care, a greater number of patients are likely to present with a degree of self-neglect when unable to get the required support at home.

8.8 The Board was advised that the CQC undertook an unannounced inspection at the Royal Sussex County Hospital, Princess Royal Hospital, Worthing Hospital and St Richard's Hospital on the 28 September 2021 and 4 October 2021.

8.9 Maggie explained that these inspections focused on Maternity at all four sites, as well as Surgical Services at the Royal Sussex County Hospital. The outcome of these inspections, whilst identifying a number of areas of good practice and care, did also identify a number of areas of concern. It was noted that the CQC has subsequently provided the Trust with a warning notice, which identifies specific areas for required improvement.

8.10 Maggie explained that the Trust has commenced improvements. It was noted that the Trust expected to receive the final inspection report in the coming weeks, its findings and other supporting information would be shared with the Board.

8.11 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.

8.12 Joanna advised the Board that had received an update on the delivery of the respective True Norths, Breakthrough Objective, Strategic Initiative and Corporate Project and was assured by the progress to date.

8.13 It was noted that the Committee had spent some time scrutinising how the Committee receives its assurance and how it can be certain it is receiving the right level of assurance, Joanna explained that the Committee had received a plethora of reports all of which provided the Committee with assurance. Joanna highlighted that the Committee had received reports from maternity including the mandatory Ockenden data sets which had provided assurance in respect of the outcomes.

8.14 Joanna explained that the Committee had a long debate in respect of the Board Assurance Framework and patients waiting to be seen in A&E, it was noted that the Committee had received an update from Dr Rob Haigh from the Quality Governance Steering Group which provided the Committee with assurance that patients waiting to be seen in A&E are monitored and triaged according to the severity of their need.

TB/11/21/9 People

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

9.2 The Board was advised that the level of staff engagement, not unexpectedly, has reduced. David explained that getting enough feedback from staff is challenging currently as the national staff survey is underway therefore creating multiple forums for staff to provide the same information, with the Trust currently showing a 37% response rate for the national survey which is positively higher than the current national average for Acute and Community Trusts.

9.3 In respect of the Breakthrough Objective, increasing the number of staff who would recommend the organisation as a place to work, David explained that the Trust had been engaging with divisional teams in relation to how we support staff and listening to staff. A number of good presentations have been received by the Patient First steering group for staff and the way we work to support them.

9.4 David explained that in respect of Electronic Workforce Deployment (EWD) the Trust was trying to harmonise the systems for the deployment of staff, moving everyone onto the same platform and how the Trust utilises those systems to provide the greatest benefit.

9.5 Finally, the Board's attention was drawn to the workforce KPIs David explained that the Trust continues to successfully recruit and positively despite the pressure staff are currently under vacancies at the Trust are slowly declining.

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

9.7 Patrick explained that the Committee had spent time looking at leadership culture and a whole range of KPIs noting that it was important to acknowledge that it was still a very challenging time and although improving, staffing continues to be challenging and the redeployment of staff to other areas to ensure patients remain safe continues and has been executed excellently.

9.8 The Committee received a tremendous presentation from the Surgery division providing assurance on their application of the Patient First tools in surgery

explaining what a positive and effective tool it was for engaging with staff and championing improvement.

9.9 Patrick took the opportunity to acknowledge the Trust's chaplaincy service and the support they have provided during the pandemic. It was noted that the new leadership development programme was being rolled out across the whole of the Trust and the Committee received an update in relation to the Corporate structure which has a really good mix of new directors joining the Trust together with existing staff being appointed.

9.10 Lizzie Peers commented that as the Chair of the Sustainability Committee she echoed the importance of e-rostering and allowing staff to have a good work life balance with early sight of their rosters.

TB/11/21/10 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 the Trust has continued to operate under the interim financial framework set for the period April 2021 to September 2021 (H1), in which each Integrated Care System (ICS) was provided with a fixed funding envelope; including resources to meet the additional costs of COVID-19. The intent of the framework was for individual organisations within the Sussex ICS to deliver a breakeven position. It was noted that at the end of quarter two, the Trust financial performance met the target of breakeven. In H1 the Department of Health created a £1bn non-recurrent fund to be used to support delivery of additional activity, the Elective Recovery Fund (ERF). The Trust had expenditure commitments of £23m in relation to the delivery of additional activity and earned income of £22m from the ERF. Karen explained that the H2 Financial Framework guidance has recently been issued and is applicable from the 1st October 2021 and was the fifth financial framework the Trust has operated under in 18 months.

10.3 Karen advised the Board that the True North for Sustainability had 4 key metrics; income & expenditure, cash, capital and efficiency, it was noted that the financial performance at the end of H1 reflected that two areas, Capital and Efficiency were not quite on plan, however full recovery was expected in the second half of the year. Karen highlighted that although the Trust had delivered a breakeven position it had not earned as much ERF as expected due to the high level of non-elective activity.

10.4 The Board was advised that the Trust had recently received formal planning guidance for H2 income allocations, it was noted that in terms of construct the guidance was broadly the same however, there was an increased efficiency requirement and a reduction in some income flows with a significant change in income recovery for elective activity. Additional funding allocations are being made available to the System via a new construct of the £1bn Elective Recovery Fund (ERF) and a new Targeted Investment Fund (TIF). The continuation of an ERF, albeit significantly different in complexity, construct and application, is intended to support additional elective recovery as in H1 but with a focus on reducing waiting lists.

10.5 Karen drew the Boards attention to the H2 Financial Risks in particular the impact of operational pressures on Trust capacity to deliver the efficiency programme and the ability to protect elective capacity and increase the Trusts restore and recover activities.

10.6 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.

10.7 Lizzie advised the Board that the Committee had noted the level of risk with the new H2 guidance and the increasing range of financial pressures. The Committee had acknowledged that it was positive the Trust had achieved break-even despite significant pressure, Lizzie assured the Board that reporting to the Committee was very transparent and the key areas for concern were discussed in detail.

10.8 In relation to the Capital programme although slightly behind plan the Committee had discussed the areas where spending could increase ahead of year-end and a number of projects in the pipeline that are anticipated to support Capital spending to get back on track. Lizzie highlighted that the Committee had discussed at length the Trust Efficiency programme and the need to embed productivity improvements. The Committee also received updates on the Environmental Sustainability Strategic Initiative and the Patient Administration System Corporate Project.

10.9 Dame Marianne Griffiths commented that the risk appetite of the Board was that patient safety would always take priority over finance but recognised that the Trust will continue to govern the use of its funds appropriately but patient safety is paramount and the Board will always do what is best for our patients. Marianne added that the Trust had increased bank rates and that she had no doubt there would need to be further expenditure as ensuring we maintains patient safety and support our patient centred culture are the overriding factors for focus as we enter winter.

TB/11/21/11 Systems & Partnerships

11.1 Pete Landstrom presented the Systems and Partnerships (S&P) section of the Integrated Performance Report drew out the following key points and noted that as had been the theme throughout the Board meeting the Trust had been operationally extremely busy over the last quarter with both emergency demand and its restoration and recovery plan.

11.2 **A&E**
Overall the combined Trust treated 71.2% of patients within 4 hours of attending A&E departments. UHSussex West achieved 71.35% and UHSussex East achieved 71.0% compared to National performance of 75.19%. It was noted that there was continued pressure on the Trust emergency departments with both ambulance and self-attending patient numbers above pre-pandemic levels.

11.3 **RTT**
It was noted that the combined Trust had 59.9% of patients waiting longer than the target 18 weeks at the end of September. UHSussex West achieved 60.2% and UHSussex East achieved 59.2%. Overall the total number of patients waiting for elective treatment is 102,178 with elective demand increasing across the whole of the Trust.

11.4 **Cancer**
Pete explained that overall 63.4% of patients who commenced cancer treatment were treated within 62 days as a combined Trust. UHSussex West achieved 60.6% and UHSussex East achieved 67.6%. It was noted that there had been an increase in over 62 day prospective waits in September, Pete advised the Board that recovery plans had been developed to ensure a return to compliance by March 2022.

11.5 **Diagnostics**
Overall the combined Trust had 27.9% of patients waiting more than 6 weeks for a diagnostic test against a 1% target. UHSussex West achieved 31.7% and UHSussex East achieved 22.5%. This is an improvement of 1.7% since August 2021. It was noted that the most impacted area of diagnostics as a result of the pandemic was Endoscopy, as staff have now largely returned to their core services the Trust has developed and implemented significant recovery plans for Endoscopy, which will also address those patients waiting for a planned follow up Endoscopy that were delayed in the pandemic.

11.6 Pete advised the Board that in respect of activity recovery progress the most notable risks are the continued impact and stretch on the Trust's workforce given the pandemic with an increase in patients admitted with Covid and the continued increase in emergency activity. In addition, the H2 Framework focuses on pathway 'clock-stop' volumes rather than total activity with changes in thresholds. It was noted that the Trust has developed a plan, inclusive of insourcing and outsourcing to increase and protect elective activity over the winter and deliver the National requirement of holding the numbers of waiting list and 52 week waiting patients, and eliminating patients waiting longer than 104 weeks.

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 had discussed the drivers of the current performance challenges especially within Urgent and Emergency care and noted the multi-dimensional aspects to these challenges. It was noted that the Committee had been reminded that despite the challenges across all emergency departments 7 out of 10 patients are seen within the 4-hour target. The Committee also discussed the Trust's focus on the Cancer 28-day faster diagnosis target and the positive impact this has on the patients.

11.9 Patrick noted that the Committee had received an update on the 3Ts Hospital Development project advising that it was continuing to progress and the Trust had now taken ownership of the helideck which was hugely positive, the Committee also spent time discussing the Restoration and Recovery corporate project and the impact of the new H2 guidance. Patrick noted that the Committee had discussed the BAF and agreed that due to the increased demand being experienced by the Trust that it would be prudent to increase risk 5.1 for which the Committee has oversight.

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

TB/11/21/12 Report from Patient Committee Chair from the meeting on 26 October 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/11/21/13 Report from Quality Committee Chair from the meeting on 26 October 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/11/21/14 Report from People Committee Chair from the meeting on 27 October 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/11/21/15 Report from Sustainability Committee Chair from the meeting on 28 October 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/11/21/16 Report from Systems & Partnerships Committee Chair from the meeting on 28 October 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/11/21/17 Report from Audit Committee Chair from the meeting on 14 October 2021

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

17.2 Jon advised the Board that the Committee had reviewed the Internal Audit plan and agreed a revised plan in light of Covid and winter pressures. It was noted that one internal audit report in respect of the review into the Trust's Mental Health Act compliance processes was received which identified some improvements which the Trust has accepted and implementation would be reported back to the Committee during the year supported by oversight at the Quality Committee.

17.3 The Committee received an update from the External Auditors Grant Thornton and the Local Counter Fraud Specialist in addition to a very encouraging benchmark report in respect of tender waivers, Jon explained that having very few tender waivers is the sign of a well-run organisation and legacy Trust WSHFT was one of the best in the country.

17.4 It was noted that the Trust had received the annual Health and Safety reports for the former BSUH and former WSHFT, Jon advised that the Committee was recommending both reports to the Board for noting.

17.5 Jon advised the that the Committee had also received a presentation in relation to the new Datix IQ system which led onto a broader discussion on risk and governance of the new combined Trust in respect of the new committee structure, as such the Committee has asked that a suite of information be brought to the next meeting giving the Committee oversight of the effectiveness of the Trust's revised governance processes, allowing it to consider this information to aid the Committee in highlighting the areas of good practice for inclusion in the Trust's year end Annual Governance Statement.

17.6 The Board **NOTED** the Chairs Report from the Audit Committee and **NOTED** the Annual Health and Safety Report for former Trusts Brighton and Sussex University Hospitals and Western Sussex Hospitals NHS Foundation Trust.

TB/11/21/18 Report from Charitable Funds Committee Chair from the meeting on 12 October 2021

18.1 Lizzie Peers, Chair of the Charitable Funds Committee, presented the report from the Committee meeting held on 11 October 2021.

18.2 Lizzie explained to the Board that the Committee had received updates from both BSUH Charity and Love your Hospital Charity for quarter 2. The Annual Report and Accounts for both Charities were presented with the External Auditors in attendance, Lizzie advised that both charities were provided with an unqualified Audit opinion.

18.3 Lizzie encouraged those members of the Board not members of the Charitable Funds Committee to read both Annual Reports, highlighting that they provide a fantastic overview of the work of the charities, the work with partners of the charities including the League of Friends across all hospital sites and the incredible support received from the public over the last year.

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

TB/11/21/19 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 Glen highlighted that throughout the meeting the issues in respect of the current increased risk being experienced by the Trust in a number of areas, including the uncertainty within the H2 framework and the increased pressure on workforce had been discussed. The Board was asked if it felt that any of the current risks were understated or required further review by the Executive.

19.3 Alan McCarthy commented that the discussion during the meeting suggested that the Board was of the opinion that the current level of risk is above where we would like it to be.

19.4 Lucy Bloem concurred that she would be very supportive of the risks being reviewed as she felt that currently they are understated in terms of the level risk.

19.5 Dame Marianne Griffiths commented that other than the Sustainability risks which are in all probability scored correctly, a review of the other BAF risks is required so that the BAF is more reflective of the current risk landscape being experienced across the whole of the system.

19.6 **ACTION:** Executive to review current stated risks on the BAF to be brought back to the next Board for endorsement. **Executives**

TB/11/21/20 Company Secretary

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

20.2 The Board was advised that the Trust is required to receive reports on learning from deaths. The Board was reminded that the detail of these reports 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. It was noted that the Quality Committee received and reviewed these reports at its meeting on the 26 October 2021 and the outcome of the learning is tracked through the updates received by the Board as part of the Integrated Performance Report. Appendix 1 relates to

reviews covering Royal Sussex County and Princess Royal Hospitals. Appendix 2 relates to reviews covering St Richards and Worthing Hospitals.

20.3 Glen advised the Board that the Trust had now concluded the elections for public governors which saw three new governors elected, Lindy Tomsett for Chichester, Maggie Gormley also for Chichester and Hazel Heron for East Sussex and out of area. Elections for two staff governors had also conclude with Amelia Palmer elected for Worthing and Southlands and Joanne Norgate for St Richard's. Glen also extended the thanks of the Board to those governors leaving the Trust, staff governors Ryan De-Vall and Anna Mathew and public governors Les Wilcox and Stuart Fleming.

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

TB/11/21/21 OTHER BUSINESS

21.1 There was no other business to discuss.

TB/11/21/22 Questions from Members of the Public

22.1 The Board received two questions in advance of the Board meeting from a Mr John Gooderham who asked, "Will the Board give a progress report, on the provision of a satellite radiotherapy unit at St Richard's Hospital, as announced by the Western Sussex Hospitals NHSFT Board at its meeting 5 years ago, in November 2016?"

22.2 Pete Landstrom explained that as previously explained, that whilst the Boards of both legacy Trusts Western Sussex Hospitals and Brighton and Sussex Hospitals have always confirmed that they support the opportunity to site a radiotherapy unit at St Richards Hospital, any provision of cancer radiotherapy cannot be seen in isolation of the wider cancer and oncology services supporting it. In May this year in response to the same question, Dame Marianne Griffiths explained that it was not solely in the gift of the Trust to make that decision. In addition, the impact of the Covid pandemic on all services, and the national focus and priorities for capital and other resources on responding to pandemic and now recovery and winter, has meant that no further progress has been made. Once the immediate pressures and winter is over the Trust remains committed to developing our clinical strategy for Cancer services and as part of that the provision of Radiotherapy.

22.3 In response to Mr Gooderham's second question, "Will the Board give a progress report, on the provision of the operational helipad on the Thomas Kemp Tower at the Royal Sussex County Hospital, as announced by the BSUH NHS Trust Board 10 years ago, in July 2011 and due for completion 4 years ago, in October 2017?"

22.4 Pete explained that as the Board has previously updated, the 3Ts build has been impacted and delayed as a result of both Covid and the availability of materials and workforce following the UK leaving the EU. However, Pete advised that he was very pleased to confirm that the Trust's main contractor handed over the helipad and the Thomas Kemp tower at the end of October in line with the agreed refreshed timescales. The Trust will now undertake a period of work to support commissioning which will commence in January and will be concluded by the end of March 2022, at which point all operational checks and approvals required will be completed for the helipad to become operational. We envisage that the helipad will therefore be operational next year in line with completion of the supporting Stage 1 3Ts infrastructure.

TB/11/21/23 **Resolution into Board Committee**

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

TB/11/21/24 The Chair formally closed the meeting

TB/11/21/25 **DATE OF NEXT MEETING**

25.1 It was noted that the next Board Meeting would take place at 10.00 on Thursday 03 February 2022 via Microsoft Teams Broadcast.

Tanya Humphrys
Board & Committee Administrator
04 November 2021

Signed as a correct record of the meeting

………………………………………………. Chair

……………………………………………….. Date

MATTERS ARISING

AGENDA ITEM: 4

Meeting	Minute Ref	Action	Person Responsible	Deadline	Status
04 November 2021	**TB/11/21/19.6**	**Board Assurance Framework:** Executive to review current stated risks on the BAF to be brought back to the next Board for endorsement.	Executive	**Completed**	*BAF reviewed by Executive Team and included at item 18.*

CEO Board Report

Dame Marianne Griffiths

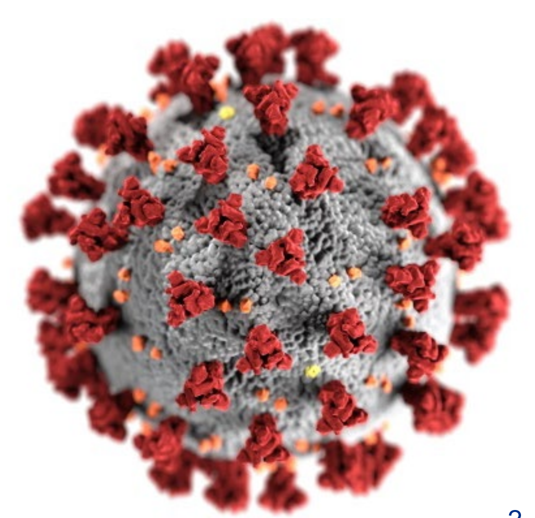
February 2022

News

We are currently caring for 140 patients* with Covid-19 in our hospitals, with 2 in critical care

- Royal Sussex County Hospital: **42** (including 2 in ITU)
- Princess Royal Hospital: **29** (0 in ITU)
- Worthing Hospital: **36** (0 in ITU)
- St Richard's Hospital: **33** (0 in ITU)

*Correct as of 25/01/22



Omicron and the winter surge

- Since January 2022 we have been seeing significant and ongoing pressures on our A&E departments with high demand and challenges managing flow.

- We have also seen unprecedented delays in discharges due to a lack of capacity across our local NHS and social care services, combined with a high number of staff absent due to Covid, which is putting further pressure on the number of available inpatient beds.

- We currently have 260 patients in our hospitals who are medically ready for discharge. We have 332 staff absent due to sickness.

Our response…

We have introduced a range of new measures to ensure it maintains safe services for patients as pressures on hospitals continue to rise.

- Postponing some less urgent clinical work and reallocating staff as required to support essential services. We will do this in close consultation with clinical leaders
- Senior leaders will be working with teams across the hospitals and with system partners to review capacity, patients and to escalate issues and plan safe discharges
- Postponing some planned procedures in order to create space for patients needing urgent care.
- Developing detailed surge plans and asking for additional support at a national level to be able to staff additional clinical areas.
- Standing down non-essential meetings to maximise the number of colleagues available to work in clinical roles.

Visitor Information

During this time, visiting in our hospitals remains restricted to keep patients and staff safe. Our messaging for patients and their families continues to be:

- Attend any planned outpatients appointments (alone if possible)
- Take a lateral flow test before attending to ensure they do not have Covid
- Wear a surgical mask at all times and maintain a 1m social distance
- Nominate just one person to be their visitor while they are in hospital

Collaborative working

Vaccination clinics

- Working with Sussex Health and Care Partnership we are providing walk-in Covid vaccination services across Worthing, St Richard's and Royal Sussex County Hospitals.
- Colleagues, patients and the public can receive their first, second or booster doses without booking.

A new ED volunteering scheme

- Non-clinical colleagues have been volunteering in emergency departments to help ease some of the pressures.
- Tasks include making cups of tea, reassuring confused patients, answering phones and restocking supplies

Mandatory vaccinations

We have taken a number of actions in anticipation of the mandatory vaccination law for health and care workers ahead of the 1 April:

- We have written to all colleagues for whom we don't have a complete vaccination number, both by email and post
- We have produced and issued a toolkit for leaders to manage conversations with their teams
- We are arranging a dedicated vaccination briefing to answer questions
- We are working on an updated set of FAQs based on the most commonly raised questions
- We have made information available on the intranet
- We have extensively shared the link to the vaccination status form, including guidelines for how to complete it

STARs Awards Launch

Our annual STARs Awards have returned for staff and volunteers who embody the ideals of our Patient First programme.

Nominations opened on 17 January for five weeks and staff and patients can nominate a colleague or team via our intranet and website. Nominees will be automatically entered into a prize draw with one draw per week (prizes sourced by our Trust charities).

New categories include:

- Clinical Team of the Year
- Support Service Team of the Year
- Environmental Sustainability Champion

The awards ceremony will take place on Wednesday 25 May 2022 at Worthing Assembly Hall, which we will report on via our communications channels and showcase our winners.

News highlights

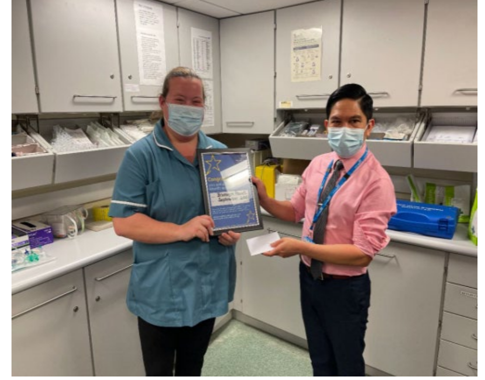
NHS
University Hospitals Sussex
NHS Foundation Trust

BBC South East feature – Critical Care

Our critical care department featured on BBC South East as part of their special reports about the pressures NHS staff are facing. The video highlights how extraordinarily hard our colleagues are working to care for the high volumes of patients we are seeing.

First UHSussex Star of the Month

Healthcare Assistant Bronwyn Powell from Worthing, was the first UHSussex Star of the Month. Bronwyn was nominated by a member of the public who noticed the wonderful kindness she showed to a patient while she was on her break. Congratulations to everyone who was nominated – more than 100 in the opening month! Bronwyn won £100 and a special gift.



Green surgery team nationally recognised for sustainable healthcare project

A UHSussex general surgery team has been nationally recognised for an innovative sustainable healthcare project. Competing against four other surgical teams in the UK, their work looked at reducing the number of blood tests a patient needs before an operation; saving patient time, money and reducing the Trust’s carbon footprint.

News highlights

Creative workshops continue at satellite sites

Our creative wellbeing workshops hosted at our four main sites in the summer, continued their travel to our smaller locations thanks to funding from BSUH Charity and Love Your Hospital. Staff reported how beneficial they found the workshop.

Reopening of chapel space at Princess Royal Hospital (PRH)

The Onward Arts and Chaplaincy teams hosted a special event, to celebrate the reopening of the renovated chapel space at PRH. The improvements began in 2020 thanks to kind donations to BSUH Charity, which funds Onward Arts at four of our hospitals. The space now incorporates images of nature, artificial plants, new furniture and carpet, and soft lighting, providing a calming space for staff, patients and their loved ones to reflect and rest in.

UHSussex in green inhaler project

A study by Trust clinicians found that if patients on one respiratory ward changed the inhaler they were using, their collective carbon footprint could reduce by about 90% in one year. The findings have been presented nationally, and a working group is being set up and a medicine clinical fellow appointed to reduce MDI prescribing at UHSussex.

CQC - update

The CQC issued a Warning Notice which identified four areas that the Trust was required to make significant improvements in by 3 December 2021:

- Safe storage and administration of medicines in maternity
- Safe, secure and contemporaneous medical records in maternity across the trust
- Infection prevention and control in surgery at RSCH
- Assessing and responding to risk

It also identified a further two areas that required significant improvement by 29 April 2022:

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

Investing in patient care

Refurbished Theatres at the Princess Royal Hospital:

- All the theatres in the main building at PRH have been completely refurbished over the last two years. The final touches to the work are being completed now.

Community Diagnostic Hub at Southlands Hospital:

- A mobile CT scanner and MRI will be set up in the coming months to improve imaging services at the hospital as soon as possible. At the same time designs are being drawn up for a permanent Community Diagnostics Centre at Southlands. Work on site for the permanent centre will start later in the year.

New CT Scanner at St Richards Hospital:

- Preparatory work for the new CT scanner starts this month. The new scanner will help ensure the quality and robustness of imaging services for patients coming to St Richard's. It will be delivered towards the end of February and will come into use later in the spring.

Investing in patient care

New Urgent Treatment Centre at the Royal Sussex County Hospital:

- The new UTC will improve patient flow throughout the Emergency Department at RSCH and will be complete within eight weeks. The interior of the building is being fitted out at the moment.

New Chemotherapy Medical Day Case Unit at Worthing Hospital:

- The new unit will be almost twice the size of the existing department and allow staff to care for more patients in a much better environment. Work on it start on 24th January and will complete towards the end of 2022.

Thank you to all staff involved in making these improvements possible.

Their hard work, goodwill and willingness to work flexibly allows everyone to benefit from these projects.

Any questions?

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	6-10	Meeting:	Trust Board	Meeting Date:	3 February 2022
Report Title:	**Integrated Performance Report – Quarter 3 2021/22**				
Sponsoring Executive Directors:	Marianne Griffiths, William Roche, Maggie Davies Pete Landstrom, Karen Geoghegan and David Grantham				
Author(s):	Marianne Griffiths, Rob Haigh, Maggie Davies, 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 3 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.

Integrated Performance Report

February 2022

Contents

Structure of the report

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

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

Patient First Strategy Deployment Framework

True North

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

3-5 Years
Specific Metrics

Breakthrough Objectives

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

Horizon : 0-1 Year
Specific Metrics

Changes delivered through the Front Line

Corporate Projects

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

Horizon : 0-1 Year
Task and Finish Projects

Central Oversight and Support / Resources

Strategic Initiatives

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

Horizon : 1-3 Years
Programmes of Work

Will Create sub-Projects and Improvement Efforts

Patient First True North

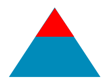
Patient

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 reduce the number of all harms categorised as 'low' or 'moderate' by 10%	**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

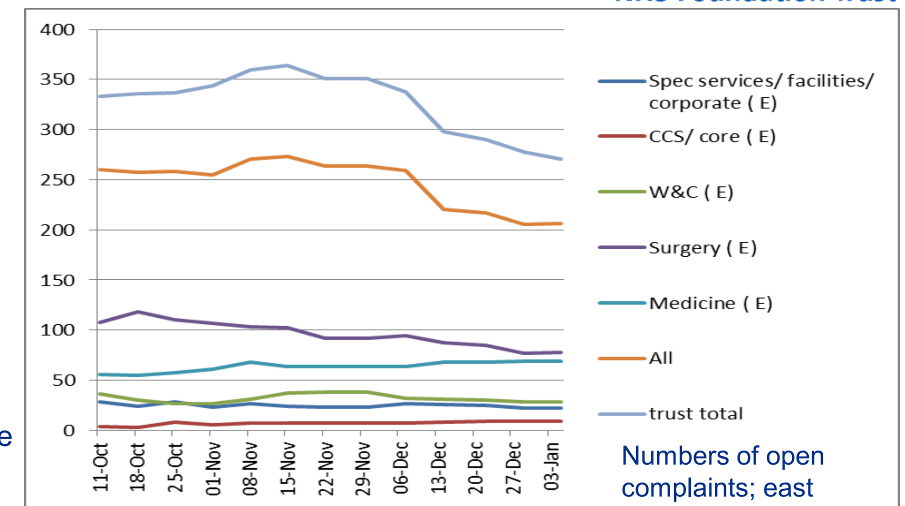
Patient

Integrated Performance Report Section

Patient: Key performance headlines

Key metric: 95% of patients have a good or better experience of care

- Based on FFT data, the significant majority of patients (>90%) are satisfied that they have a good or better experience
- Although there are increased levels of concerns (for example, PALS concerns increased from 1135 in Q2 to 2,659 in Q3, and complaints have increased from >100 in Q2 20/21 and 355 in Q2 21/22 to 396 in Q3 in 21/22) there has been a steady reduction in the number of open complaints, including where the backlog was most significant – the teams have worked exceptionally hard to achieve this.
- In the context of operational pressures there is reduced compliance with target of 65% complaints completed within 25 days.
- Dissatisfaction in A&Es is reducing (FFT data) and satisfaction levels in all touch points, (except inpatient in the east) is above the national average.
- Themes in negative patient feedback continue to relate to waiting (on site and for treatment), clinical treatment, communication and staff behaviours. Waiting is the priority change programme under the breakthrough objective programme.



Numbers of open complaints; east

Complaints	Currently open as at 11th Jan 2022		New Oct 21		New Nov 21		New Dec 21		Closed in 25 days (target 65%)*	
	W	E	W	E	W	E	W	E	W	E
	61	216	55	74	49	106	38	74	71%	37%
PALS	New Oct 21		New Nov 21		New Dec 21		New Total UHS for Q3		Compliments	
	W	E	W	E	W	E			W	E
	409	518	443	544	314	431	2,659		143	311

'There is literally nothing you could have done better. Throughout my whole experience, each one of you has made me feel comfortable & helped me to feel "normal"'

'Staff shortages & busy times meant people often left me for a long time. I felt like I could have benefited from updates even just to say there is no change as emotionally I felt a little hopeless and forgotten

FFT • (average for Q3)	ED response rates*		ED satisfaction rates*		Inpatient response rates*		Inpatient satisfaction*		Maternity response rates*		Maternity satisfaction*		Outpatient: response rates*		Outpatient: satisfaction*	
	W	E	W	E	W	E	W	E	W	E	W	E	W	E	W	E
	12.1%	19.7%	78.3%	79.3%	13.3%	24.3%	97.6%	91.5%	22.0%	31.6%	96.8%	92.5%	NA	NA	98.3%	93.7%
National Ave Oct 21			75%				94%				89%				93%	

*these are measured differently on each side of the trust currently but will be standardised in Q4. Includes The Alex and Sussex Eye Hospital

Themes: What we do well for many patients

Patients who experience and report their positive experiences of care do so around a number of dominant themes:

- Treatment by staff, characterised by kindness, dedication, efficiency
- Clarity of explanation and involvement, including of waits and in decision making
- Attention to basic needs such as refreshments and supplies

Reporting of compliments is dependent on clinical divisions recording, collating and sharing the compliments they receive. As such, identifying, sharing, celebrating and building on excellent experiences can be strengthened by encouraging service leaders to record and share their plaudits. Service leaders are regularly reminded to share plaudits so they can be formally logged for validation purposes and learning.

Top plaudit: treatment by staff, attention to basic needs, kindness.

Q3 Compliments	West
Medicine	43
Surgery	33
Women and Child Health	40
Core Services	23
Corporate	3
Facilities & Estates	1
CCS	
Specialist	
Other	
Totals	143

Top plaudit: staff attitude, friendly and welcoming environment, clinical care.

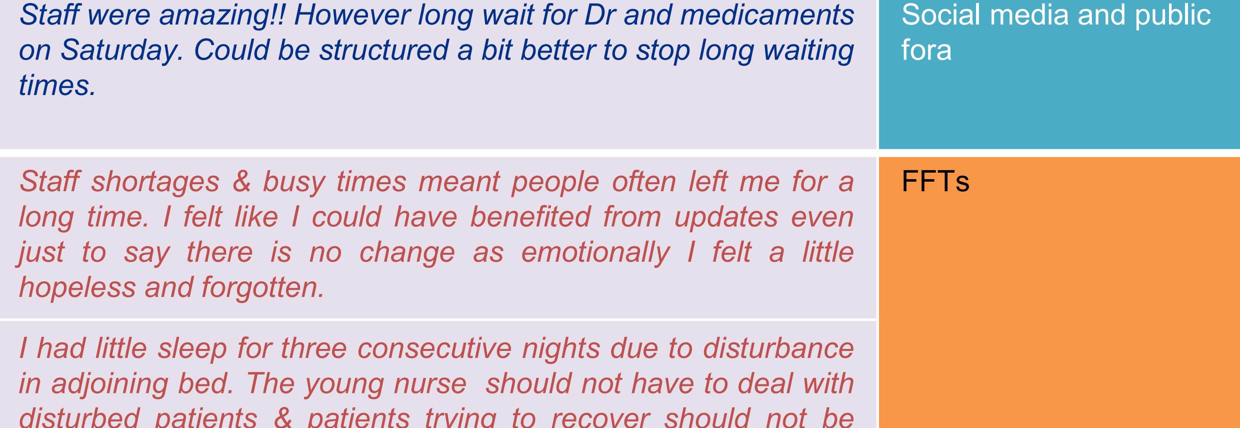
Q3 Compliments	East
Abdominal Surgery and Medicine	44
Acute Floor	42
Cancer	28
Cardiovascular	15
Central Clinical Services	3
Childrens Services	13
Critical Care / ICU	1
Facilities and Estates	2
Head and Neck	11
Musculo Skeletal	14
Neurosciences and Stroke Services	5
Speciality Medicine	22
Various	3
Womens Services	94
Totals	311

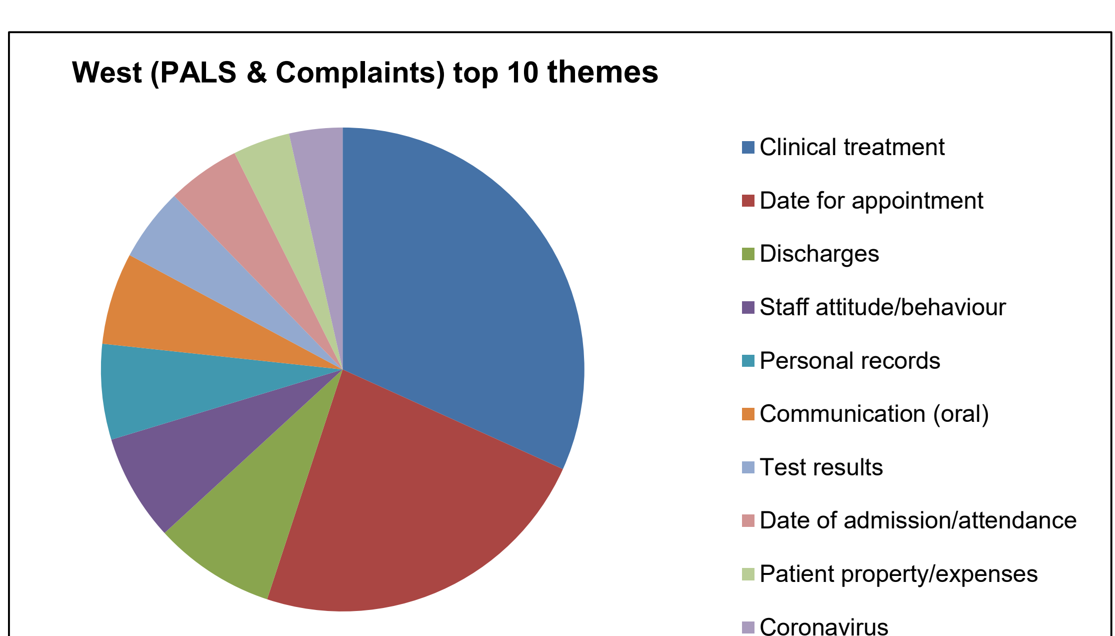
Examples from patient feedback	
I was seen quickly and with compassion. The doctor whilst not able to work out what was wrong sent off for a number of tests, he has kept me informed of the results after I left A & E. I have felt looked after and am appreciating his efforts.	FFT
Totally amazing caring, in the face of constant pressure and demands. Nursing is such high standard, food good. And every person, house keeping, HCA, cleaners, and of course doctors make you feel you`re the only one - that is an achievement and testament to them and St Richards.	
Thank you to the doctor who was absolutely amazing and always has a smile which puts you at ease and always does his best to make you better. Yo u will never know what a difference you make.	Plaudits
A clean, bright, comfortable environment with a great team working seamlessly together. All in all it was an incredibly impressive experience.	
We are acutely aware of how busy your staff are working in difficult times dealing with staff shortages alongside being in a pandemic but they still remain caring and have an obvious passion for their difficult jobs.	
The two staff members in the recovery ward were real diamonds. They explained everything to me in detail and nothing was too much trouble. They didn't seem stop working. They had a wonderful sense of humour and created a very relaxed atmosphere in the ward. The theatre staff were brilliant and very efficient.	Public fora and social media

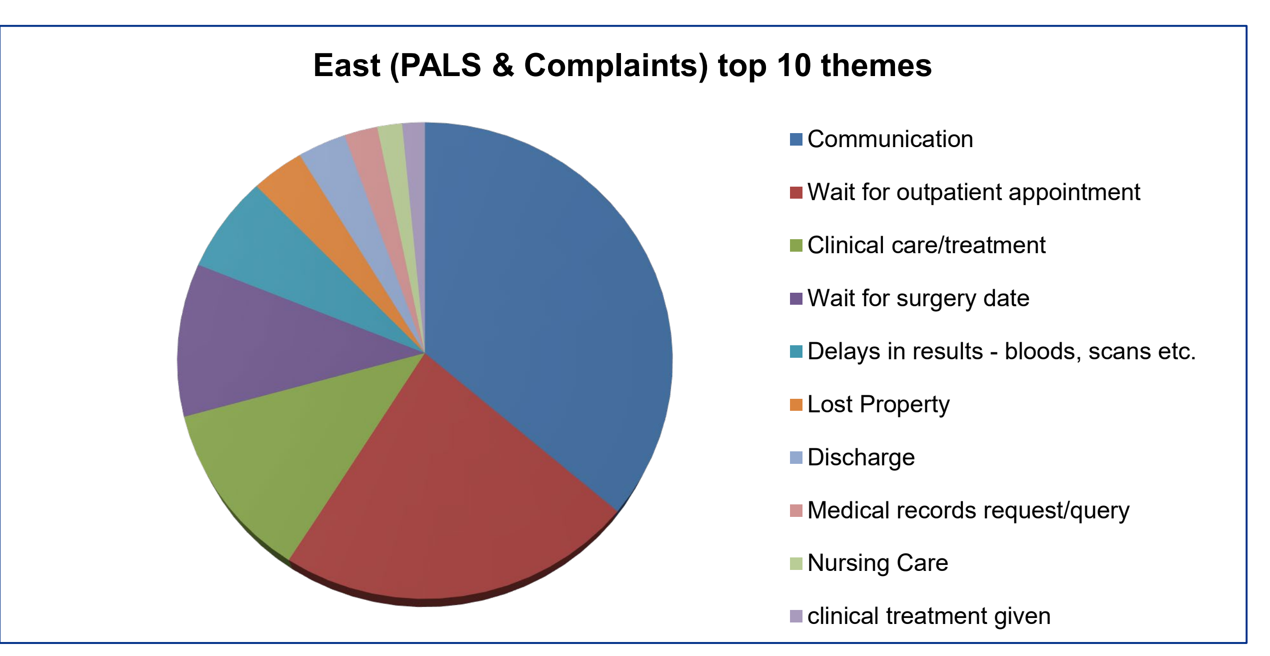
Themes: Where patient experience could be improved

Across PALS, complaints and other engagement sources there are themes which present opportunities for action at scale. These are in relation to:

- **Waits** for interventions/ appointments
- **Waits** on arrival for treatment – including strengthening communication to manage expectations and waits
- Issues relating to **clinical treatment**
- Addressing **staff behaviours and engagement** through management







Quality

Integrated Performance Report Section

Focus of this section

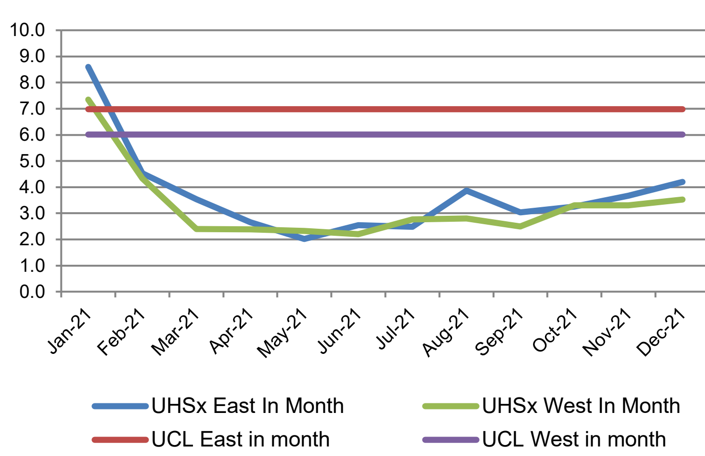
1) HSMR True North is to receive a 10% reduction in crude mortality

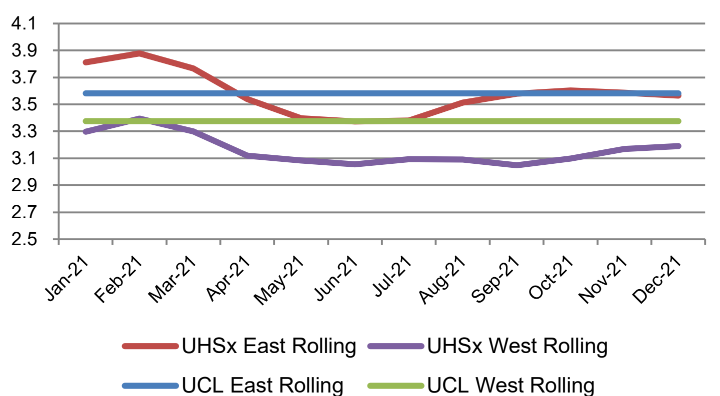
2) Patient Safety True North is ‘Zero harm occurring to our patients when in our care’, with a target to reduce the number of all harms categorised as ‘low’ or ‘moderate’ by 10%. This target has been met for all harms from July to September 2021

Crude Mortality

The UHSx in-month crude mortality rates were 4.2% and 3.52% in the East and West respectively for December and have a rising trend.

The rolling 12-month crude mortality rates are 3.57% and 3.19% respectively up to and including December. Current rates are comparable to those seen pre-pandemic.





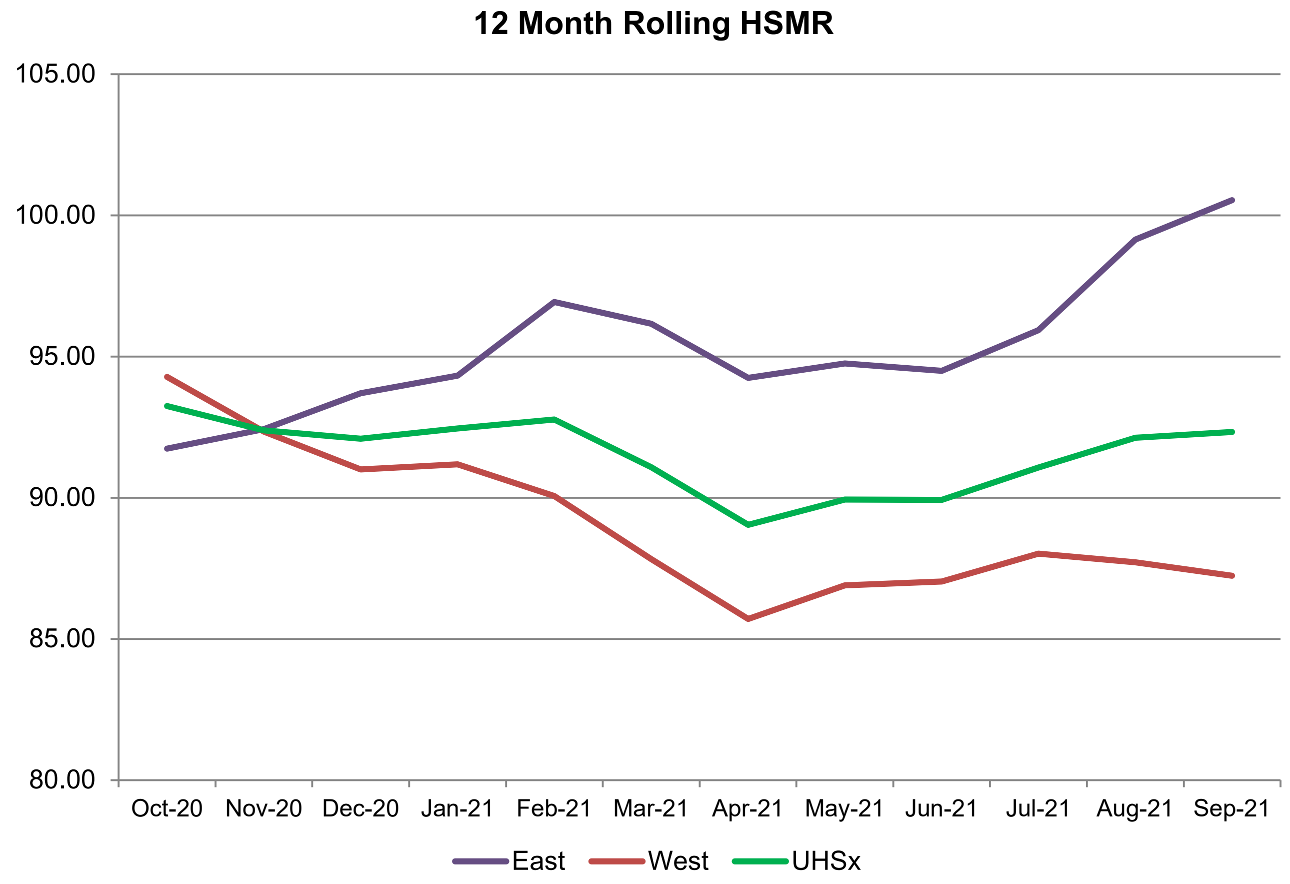
Crude Mortality

Covid Deaths Within 28 Days of a Positive Test

HSMR

- Data for the UHSx HSMR (east) was interrupted following merger due to problems at NHS Digital. The flow of information was restored late in 2021.

- The UHSx 12 month rolling HSMR is 93.9 up to and including October 2021. There is a rising HSMR in the east that is driven by the RSCH site. The HSMR in the west is stable

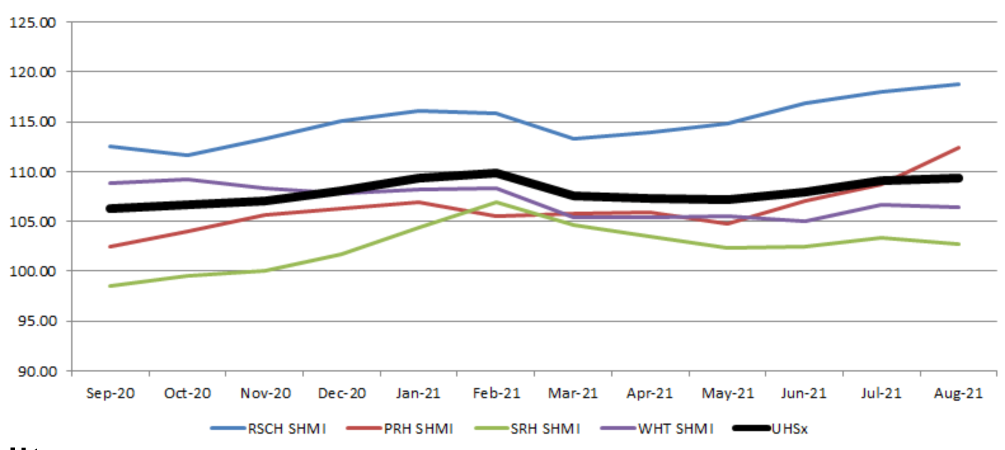


SHMI

Data for the UHSx HSMR (east) was interrupted following merger due to problems at NHS Digital. The flow of information was restored late in 2021.

With the restoration of the data, a rise in the SHMI has become apparent with a high USHx SHMI of 109 up to and including August 2021 data with a significant variation between sites. The site-specific values for the SHMI are 102 (SRH), 106 (W), 112 (PRH) and 118 (RSCH) respectively.

The SHMI includes deaths up to 30 days following discharge that are not included in the HSMR and the observed deaths within 30 days of discharge exceed the expected on all four sites with in-hospital deaths exceeding the expected on the RSCH site.



Crude Mortality

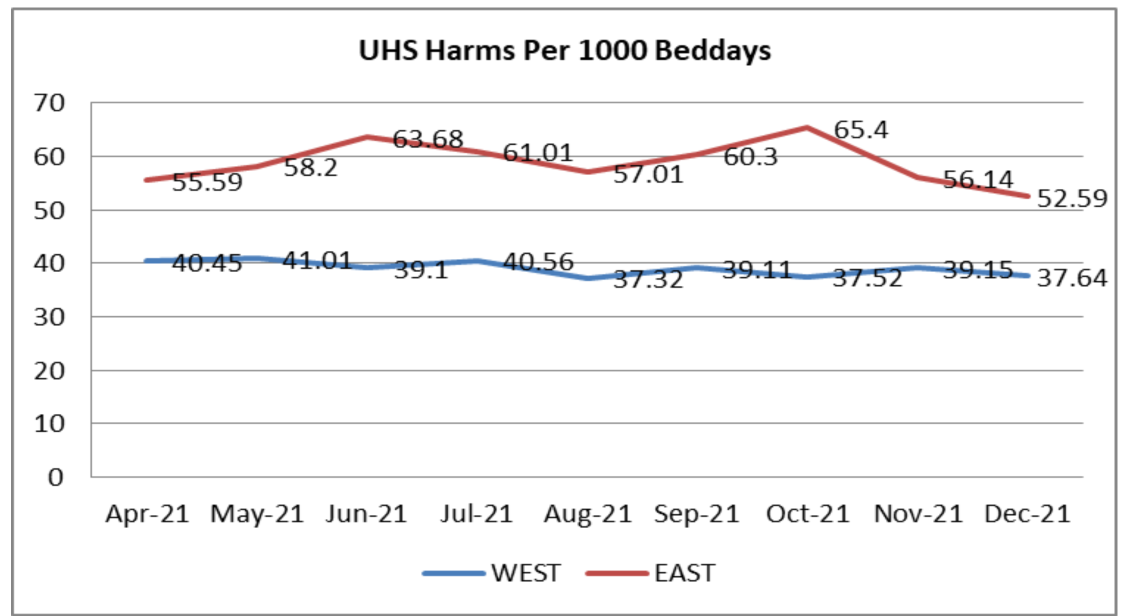
In view of the high UHSx SHMI, a mortality review group chaired by the CMO has been convened to explore underlying causes for the raised metrics. This will include external analysis from Healthcare Evaluation Data (HED).

Patient Safety

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

The **Quality True North** for harm at UHSussex is '*Zero harm occurring to our patients when in our care',* with a target to reduce the number of **all harms** categorised as 'low, moderate, severe harm and death' by 10%.

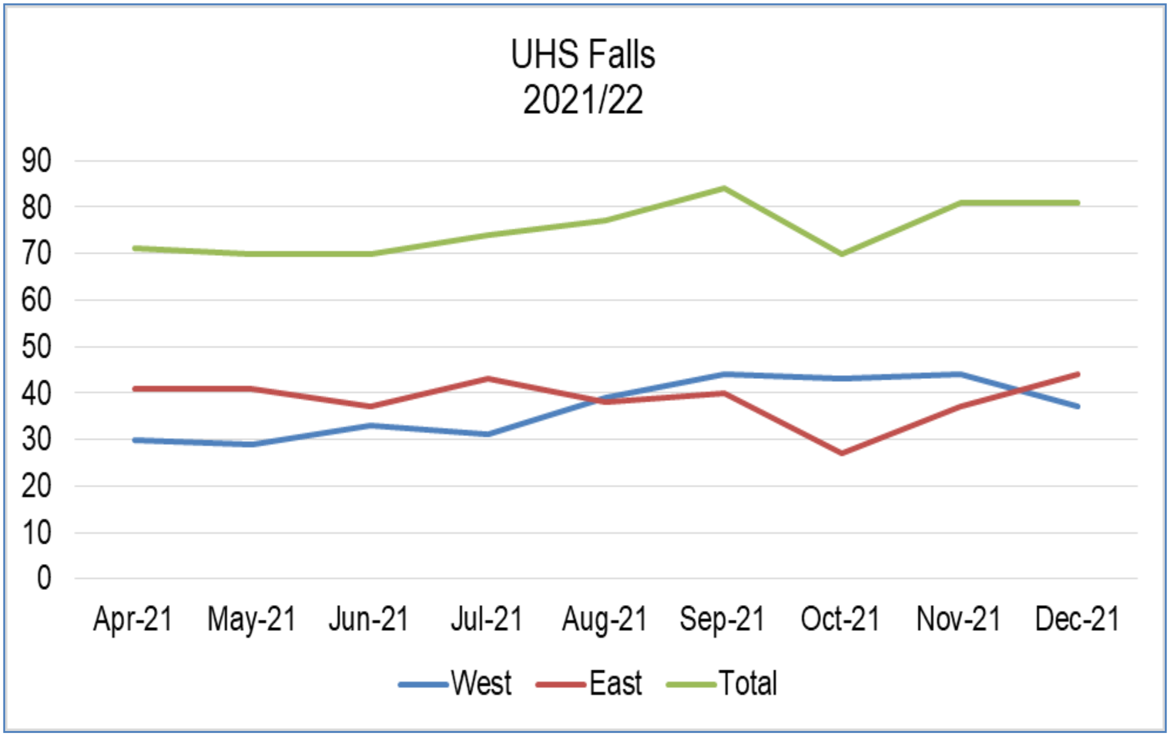
The reduction per 1000 occupied bed days is detailed in Figure 1.



Site variables are due to

- Differences in reporting cultures
- Incidents versus 'issues'
- Multiple 'categories on incident reporting system leading to double reporting/duplication
- Demographic IPC reporting
- Outdated version of DATIX - now implementing RLDATIX IQ

Avoidable Harm– Key Metrics: Falls



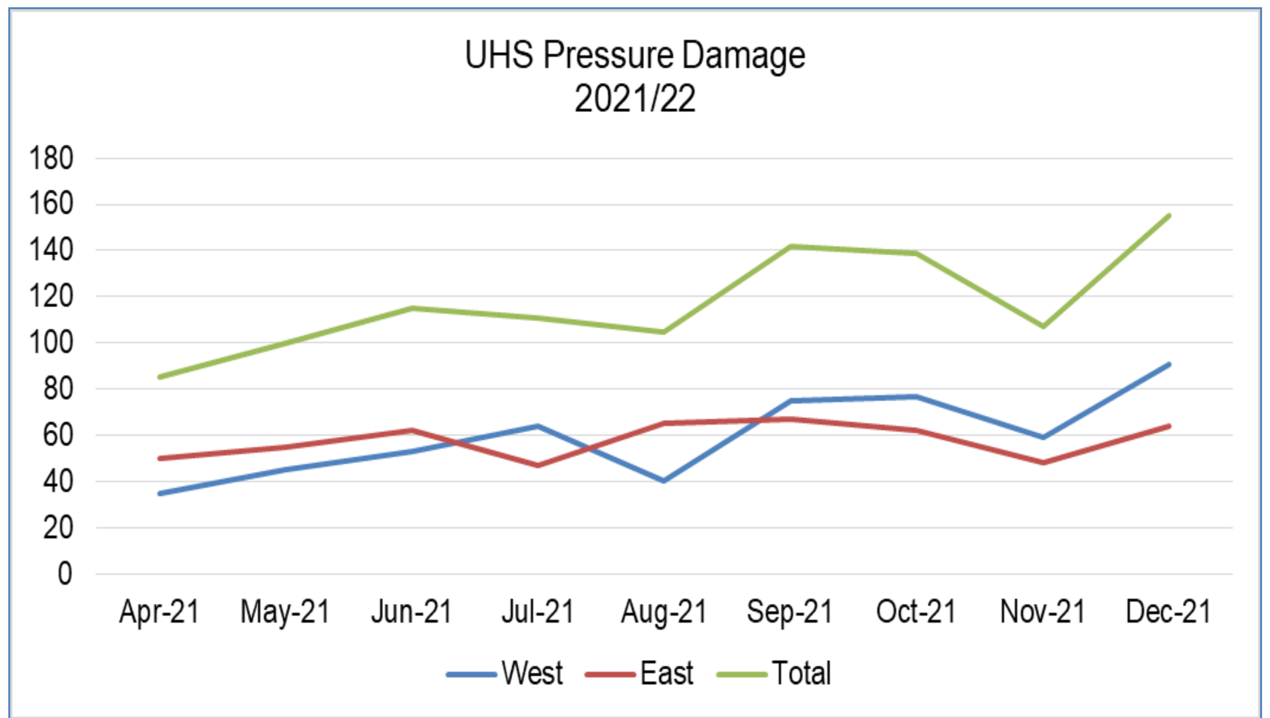
West: Falls rate per 1000 bed day December 2021 = 5.33; rolling 12 month average 5.04 (National falls rate 6.63)

- Serious harm falls reduced compared to previous 2 months
- Higher proportion of witnessed falls resulting in no harm, showing positive efforts of staff and good reporting culture
- Staffing pressures and additional ward areas open leading to challenges with completing required assessments and maintaining Baywatch.
- Baywatch theme of the week in month for daily huddle discussions
- AARs have highlighted recurring theme of significant delay in x-ray post falls; Working group set up to try to resolve the process issues.
- Risk identified re correct bathroom equipment use. Alert cascaded to all matrons for urgent action and audit planned for January 2022.
- Requested additional support to help cover ward Baywatch observation needs and comfort rounds.
- Training continues for all new HCAs and OSN programme to help support best practice awareness.

East: Falls rate per 1000 bed days December 2021 = 4.42; (rolling 12 month average 3.6). (National falls rate 6.63)

- Reported falls have increased since last month by 10%, this data now includes Critical Care and Maternity which were previously excluded
- Unwitnessed and toilet related continues as a theme.
- Postural blood pressure assessment not regularly measured in at risk patients
- Baywatch protocol not always being adhered to leading to Baywatch theme of week actioned
- Falls themes shared and discussed at Harm Free Care Group
- Weekly falls reports now being circulated to ward teams
- Harm Free Care Nurse Specialist now teaching falls prevention to HCAs and accelerated preceptorship
- Falls reduction programme in targeted areas with high falls rate (L8AW) and Acute Floor

Avoidable Harm– Key Metrics: Pressure Damage

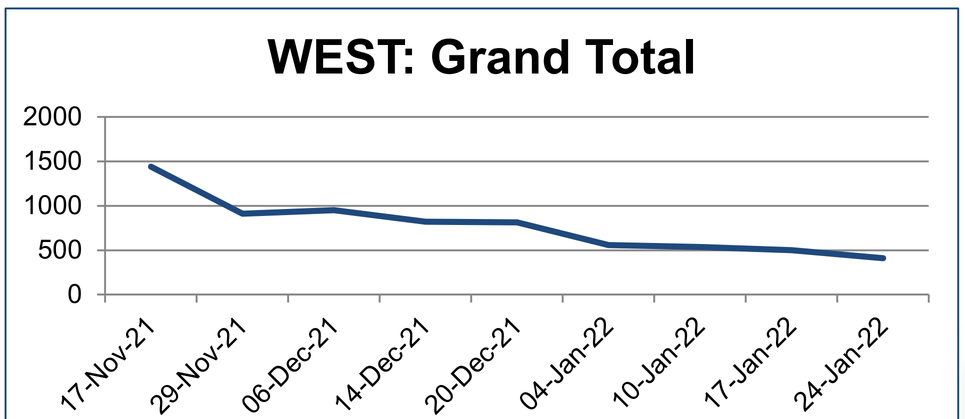


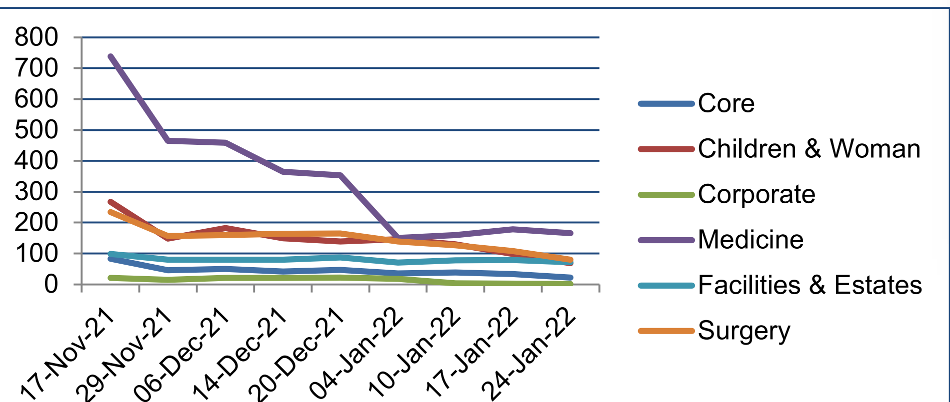
West: Pressure Ulcer Rate in December 2021 = 2.02 patients with Cat 2 and above ulcers per 1000 bed days	East: Pressure Ulcer Rate in December 2021 = 1.44 patients with Cat 2 and above ulcers per 1000 bed days
• Increase in reported in pressure damage in month, reflecting the extreme system pressures and presenting frailty of patients. Worthing reporting continues to be higher than SRH; Sacral and moisture related ulcers a key theme; Heel deep tissue injuries also remain an area of concern. • Cross cover TVCNS support in place, using photography and virtual review where no other option and the vascular team have supported review of patients where able. • TVN team to focus teaching on identifying patients at risk of pressure/ moisture related skin breakdown and implementing appropriate care. • All induction-training sessions continued in month, despite challenges.	• Acquired Pressure Damage has remained static this month with a reduction in the bed day rate despite increased frailty of inpatient population. • Increase in reported incidents in Critical Care which is being reviewed. • Learning from incidents presented and discussed at Harm Free Care Group • Harm Free Care Nurse Specialist to introduce pressure damage training and deconditioning awareness. • Weekly PD report now being circulated to ward teams with themes and trends.

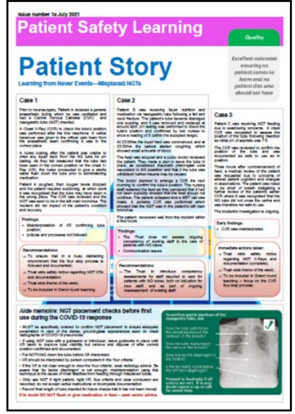
Incident Management and Learning

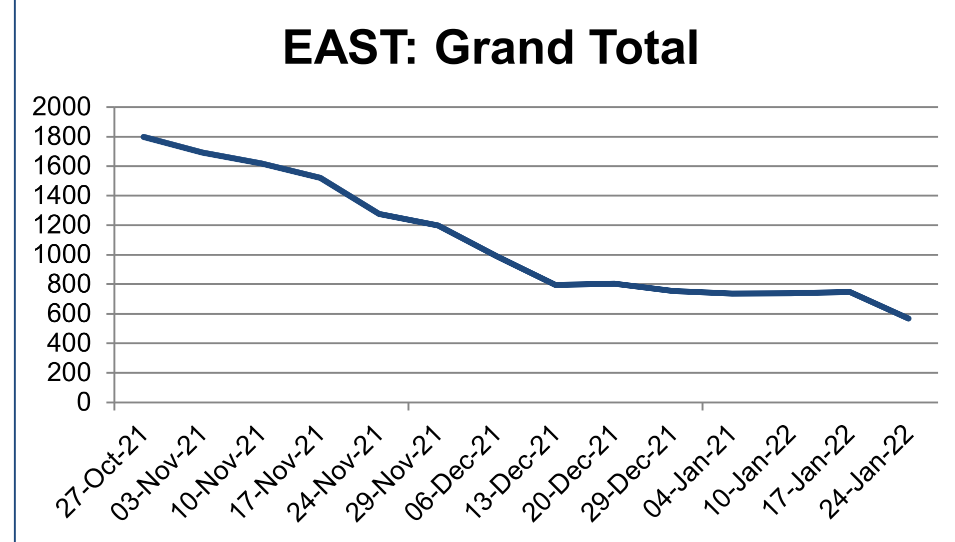
Improvement trajectory:
Investigation, review and closure of all no/low harm incidents (within 20 working days) Jan= 71% reduction in open incidents

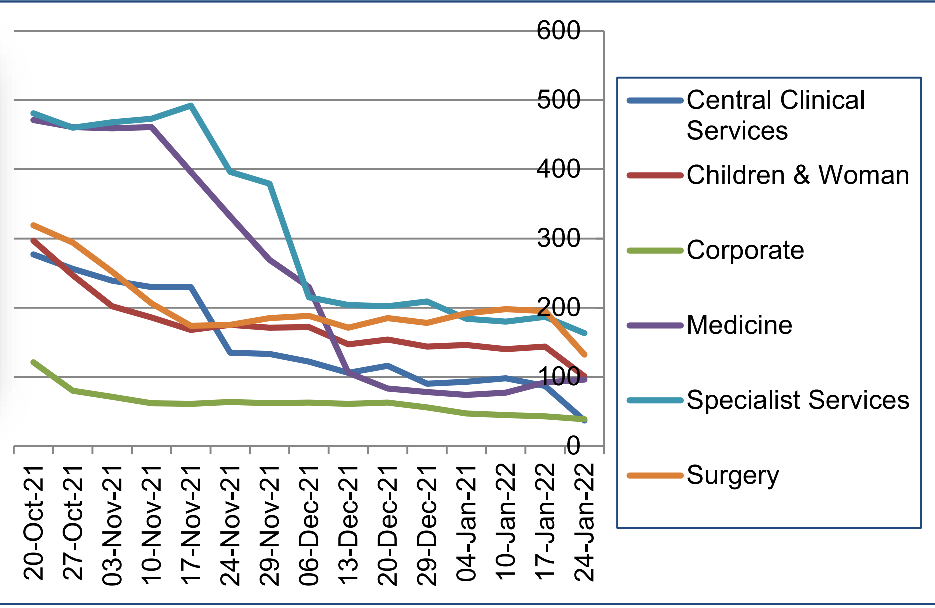
- Staff feedback
- Thematic learning via governance forums and safety huddles
- Patient Story (working with patients/families)







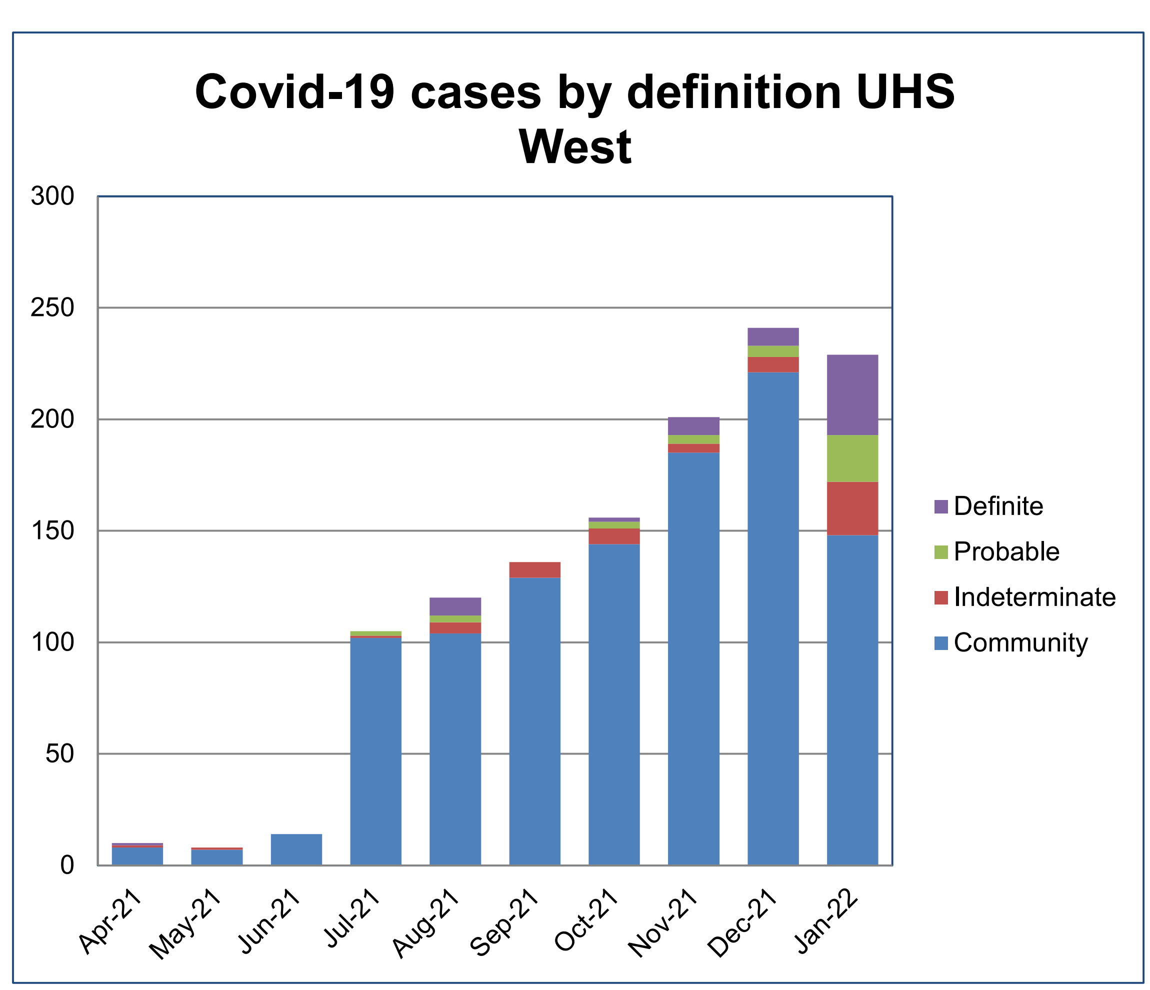


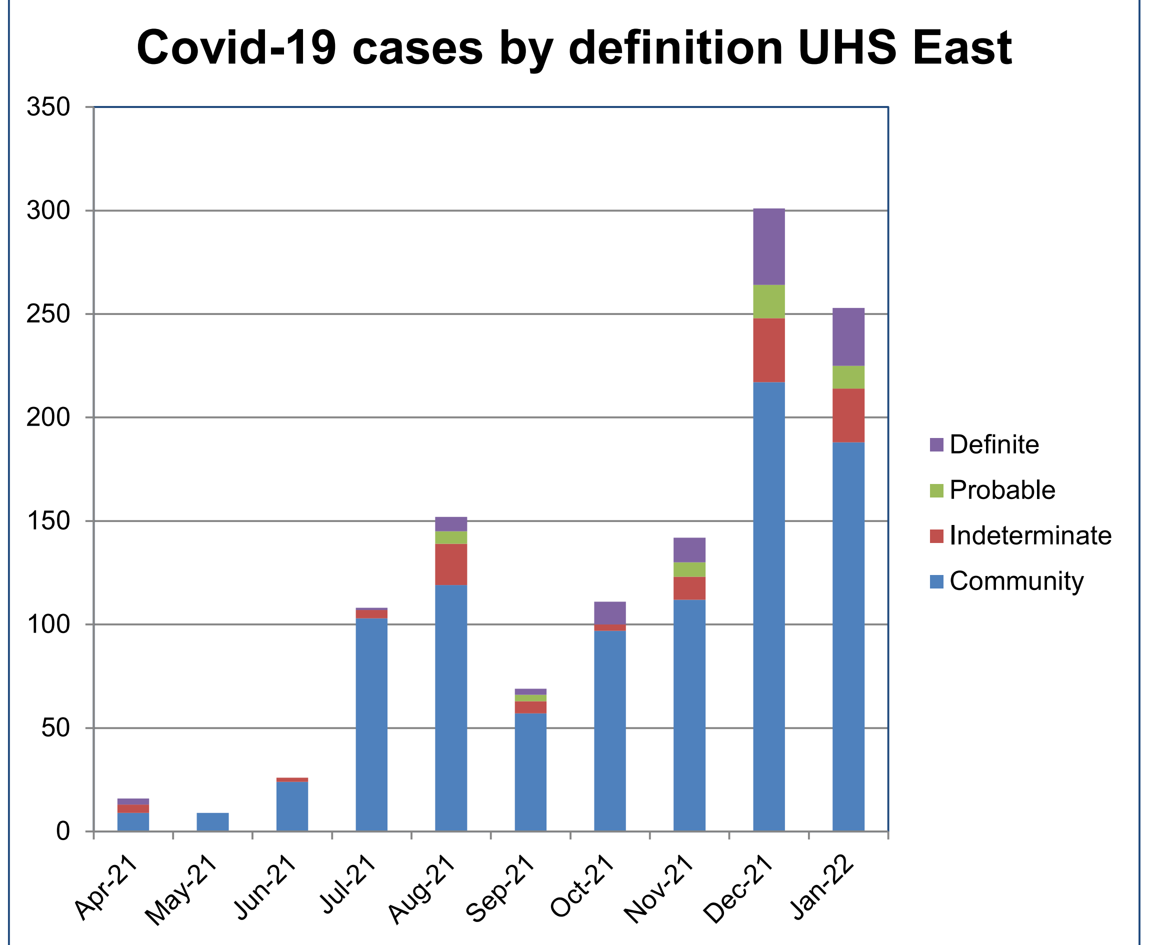


Improvement actions (harm reduction)

- Analysis of all reported patient safety incidents (site, division, service, ward) continues month on month.
- Implementing RLDATIX IQ risk and incident management and assurance system.
- Targeted focus on reduction of low/moderate harms (falls and pressure damage) Falls and pressure damage are noted as top 2 themes in reported harms (moderate/low).
- Post pandemic, learning identified that factors such advanced age and frailty, sex, ethnicity and weight are strong predictors of adverse outcomes, harms and mortality for older people hospitalised because of acute illness.
- Patients who are medically fit/ready for discharge but experience a delay to discharge due to the continuity of community care are at increased risk of harm.
- RTT harm reviews indicate the potential for increased low harm reporting, early identification of at risk groups and patient categorisation.

Infection Prevention and Control – COVID-19

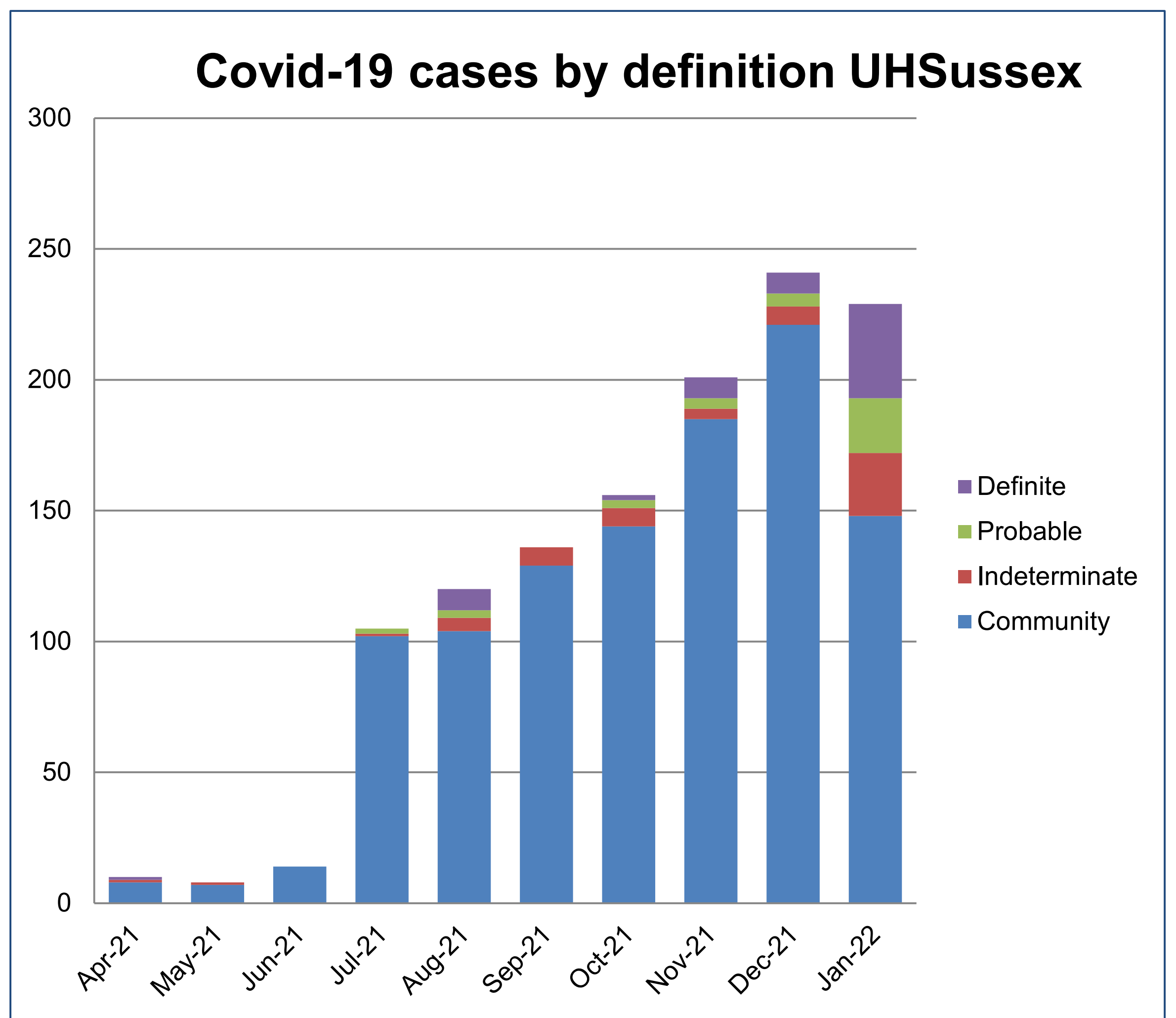




Infection Prevention and Control COVID - 19

- Covid-19 has caused the biggest pandemic for over 100 years leading to the death of millions of people across the world.
- The UK saw a further (4th) wave in December 2021 caused by the Omicron variant which caused cases to soar nationally
- Omicron appears to be (for most vaccinated people) a milder disease and as such, although there are a lot of cases, these have not translated into as many ITU admissions or deaths.
- The wave of Omicron is made more challenging as many people with it remain asymptomatic. In some cases the index could not be identified immediately; patients are screened on admission and at days 3, 5 and 7, but by the time the result is known they may have exposed other patients.
- There has been significant bed pressures caused by the need to isolate cohorts of patients if they are exposed to another patient who tests positive.
- Changes in national guidelines have been made in early January 2022 to reduce isolation times for positive and exposed patients and it is anticipated that this will lead to an improvement in bed capacity across all sites.
- It is recognised that airborne transmission plays a role in infection. The trust has several areas of old estate which have poor ventilation; and while efforts have been made to avoid using these areas, this is not always possible.
- As a result of lessons learned, there has been a focus on the hierarchy of controls, in particular, ventilation. Mitigation has been attempted with the use of air scrubbing devices, which HEPA filter the air to reduce airborne transmission.
- The IPC team have been working closely with Estates to secure machines and advise correct placement to support with ventilation issues in our older buildings.

Infection Prevention and Control

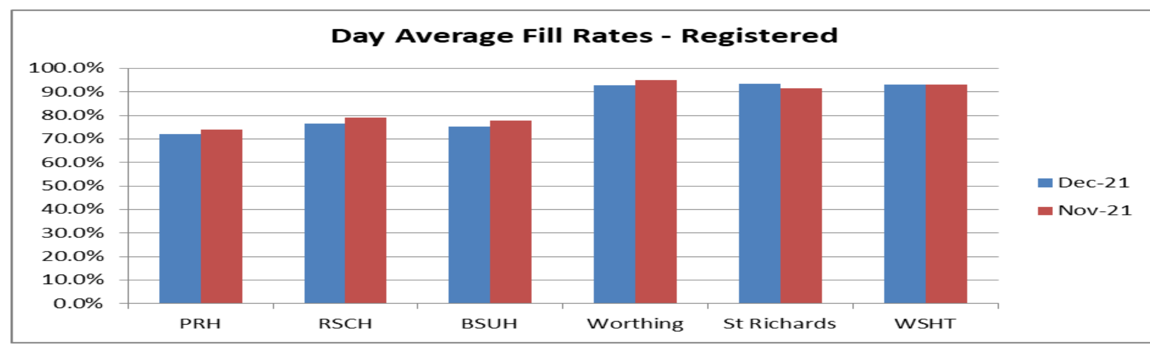


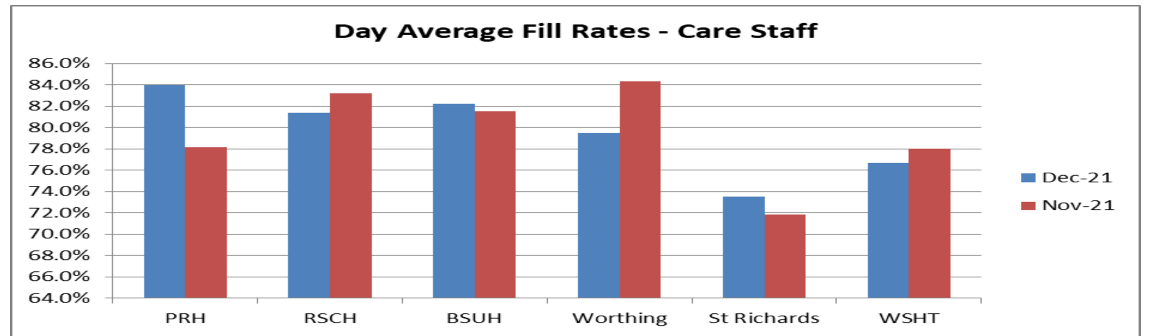
- There have been a total of 44 outbreaks since October 2021; 22 in East ,and 22 on West
- Numbers peaked in December
- Most cases originated from the community
- Patients in ITU have been largely unvaccinated or not fully vaccinated
- In one case an unvaccinated patient and their visitor who both refused to wear a mask were the cause of a significant outbreak on the acute floor
- Visiting has been maintained as much possible, with a request for lateral flow test and mask compliance.

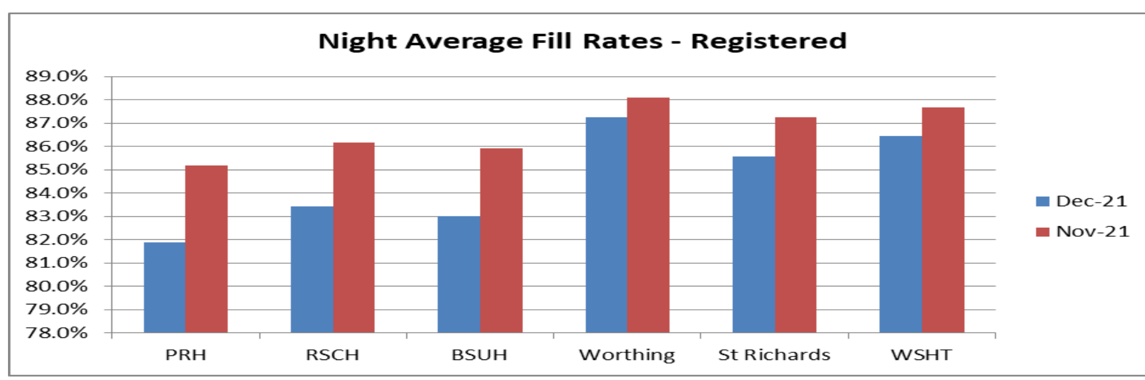
Safer Staffing

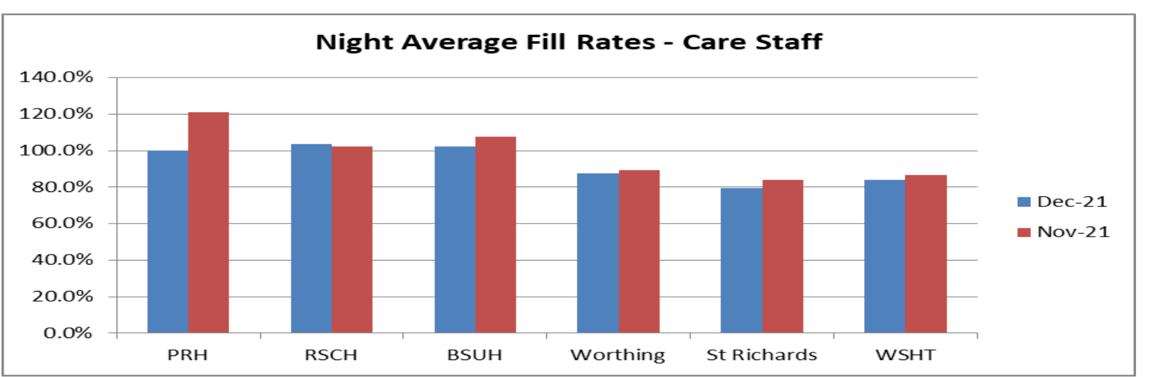
- During December 2021, we have seen an increase in the number of staff off sick related to COVID-19. In addition, the Trust had to open additional areas to support the increasing demand for hospital beds. Both of these have impacted our fill rates for registered and unregistered staff.
- In response to fluctuations in staffing levels, staffing huddle is held at least twice a day to ensure that areas with challenged staffing levels are supported. Unmitigated staffing shortfalls are escalated to the Director of Nursing.
- The overall fill rate in the East is lower compared to the West , however, the Care hours per patient day (CHPPD) is 8.7 overall which is above the peer and national median scores of 8.3 and 8.1, respectively.
- The Trust overall CHPPD during December 2021 is 7.85, an improvement from the CHPPD reported during November 2021 (7.30).
- A bonus scheme was introduced in December 2021 for four months to encourage nursing colleagues to work additional shifts during the winter months when demand for our services intensifies.
- Recruitment is on going on a regular basis both domestically and internationally.

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









	DAY				NIGHT				CHPPD					
	Fill Rate - Registered		Fill Rate - Care Staff		Fill Rate - Registered		Fill Rate - Care Staff		Registered		Care		Overall	
	Nov-21	Dec-21	Nov-21	Dec-21	Nov-21	Dec-21	Nov-21	Dec-21	Nov-21	Dec-21	Nov-21	Dec-21	Nov-21	Dec-21
PRH	73.9%	72.0%	78.2%	84.0%	85.2%	81.9%	121.1%	99.9%	3.75	4.42	3.33	3.81	7.07	8.23
RSCH	79.2%	76.5%	83.2%	81.4%	86.2%	83.4%	102.3%	103.4%	4.87	5.45	3.31	3.45	8.18	8.90
BSUH	***77.7%***	***75.3%***	***81.5%***	***82.2%***	***85.9%***	***83.0%***	***107.6%***	***102.3%***	4.51	5.14	3.31	3.56	7.83	8.70
Worthing	95.1%	93.0%	84.4%	79.5%	88.1%	87.3%	89.2%	87.4%	3.88	3.97	3.03	3.04	6.91	7.01
St Richards	91.4%	93.5%	71.9%	73.5%	87.3%	85.6%	84.0%	79.5%	4.02	4.12	2.68	2.56	6.70	6.69
WSHT	***93.2%***	***93.2%***	***78.0%***	***76.7%***	***87.7%***	***86.5%***	***86.8%***	***83.9%***	3.95	4.05	2.85	2.81	6.80	6.86
UHSussex	**85.0%**	**81.9%**	**79.7%**	**79.8%**	**86.7%**	**84.3%**	**97.3%**	**94.5%**	4.22	4.64	3.08	3.21	7.30	7.85

People

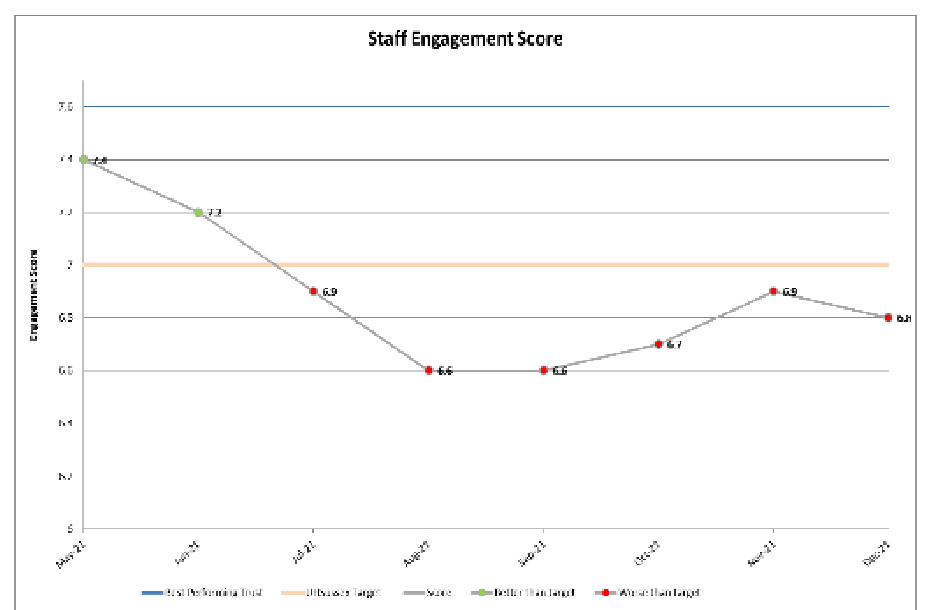
Integrated Performance Report Section

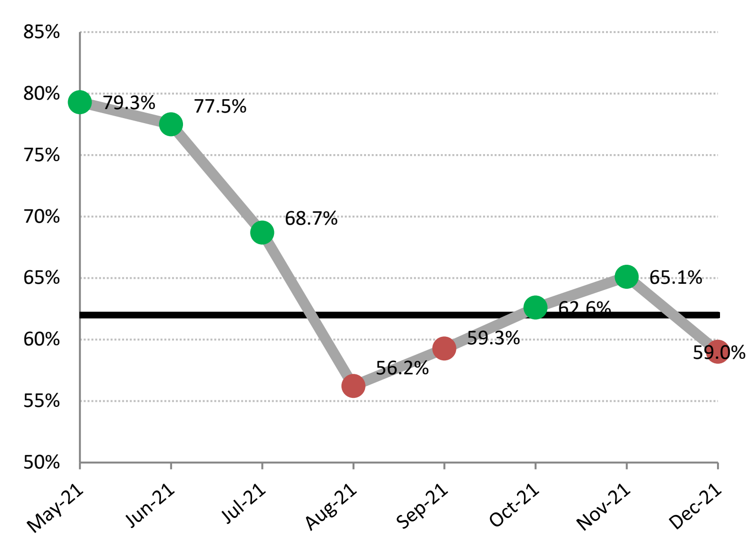
Focus of this section

- True North - Performance against Staff Engagement Target
- Breakthrough Objective – Becoming the best place to work
- People Strategic Initiative – Leadership, Culture, Development
- People Corporate Project – Electronic Workforce Deployment
- People Key Performance Indicators – Data and Commentary

People True North

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. The latest staff engagement score and recommendation of the Trust as a place to work:





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

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

Key Actions:

The Breakthrough Objective focuses on Divisional activities to address the lowest scoring areas. These are on-going and specific priorities which have been developed at local team level which will support the Trust aim using PFIS.

Activities in Flight - East

Division	Activity	Date
Facilities & Estates	**Security** - Follow up sessions booked with all shifts to identify root cause and agree priorities for counter measures **Traffic Security** –initial session booked with the traffic team **Porters** – 2nd day scheduled to shadow porters **Catering** – Further session scheduled in order to engage with more colleagues in the service **Housekeeping** – Sessions held with colleagues and priorities identified. Support to be provided on implementing counter measures	• 17th/24th/25th Jan , 1st Feb • 24th Jan • 12th Jan • 10th Feb • End of Jan
Surgery	**Level 9a**- Call held with Nursing team, DLN, HRBP, PFIS lead and CI PM to discuss and agree next steps and support required. Separate call held with CI PM and PD team to discuss specific actions relating to BTO. 3 initial sessions scheduled with colleagues to discuss issues and to support implementation of counter measures **Main Theatres** – Attended morning training session to discuss V&B in more depth and to establish colleagues desired outputs. CI PM and Kaizen BP, to hold session to agree set of principles to follow in Theatres, also approached to hold session with international recruits to give an introduction V&B's	• 14th/20th/21st Jan • 17th Jan/ 16th Feb
Women and children	**Maternity**- 3 listening sessions have taken place and chaired by members of the Exec team, which were attended by 17 colleagues. Actions have been assigned.	• Ongoing
Medicine	**A&E** – Feedback given on issues raised with colleagues to Matron and Ward Manager and follow up day booked to identify root causes and establish priorities for A&E colleagues **SHAC** – Initial sessions held in all services, follow up sessions taking place to establish root causes and to agree priorities with colleagues **ARU** – Initial feedback given to Ward Manager and Matron and initial discussions taken place with colleagues. Further session booked to discuss issues in more detail in order to identify root cause and agree priorities with colleagues	• 10th Jan • 26th Jan • 20th Jan
Specialist Services	**Major Trauma** – Delays due to BCI & supporting other services, so waiting for go head to commence **Nursing Theatre** –Delays due to BCI & supporting other services so waiting for go head to commence **Cardiac** -Delays due to BCI & supporting other services so waiting for go head to commence	• TBC • TBC • TBC
Central clinical services	**Senior medical staff imaging** – Ongoing activity being led by the DDO **Medical records** – Sessions held to understand issues and feedback given to Ops Manager, further sessions scheduled with colleagues in order to identify real root cause and offer support on implementing improvements . Ops have already introduced some counter measures as a result of the sessions **Clinical Reception** – Initial session held and time scheduled in ENT and Main OPD Receptions to observe some of the issues that have been raised by colleagues and follow up sessions to identify root cause scheduled **Oncology/Radiographers** – Follow up sessions held with Band 7's to agree next steps. Priorities are visibility of leaders and to understand the reason why clinics over run at RSCH. CI PM to follow journey from initial referral through to CT to appointment (in all 3 sites).	• Ongoing • 25th/26th/31st Jan • 19th Jan • 21st Jan 3rd/ 4th Feb

Activities in Flight- West

Division	Activity	Date
Facilities & Estates	**Domestics** – Follow up session booked with colleagues to identify root cause and establish priorities **Housekeeping** –initial session booked with colleagues ***Hostesses*** –Follow up session booked with Worthing colleagues , initial session now scheduled for SR colleagues	• 2nd Feb • 20th Jan • 27th Jan/2nd Feb
Surgery	**Ophthalmic Clinic** – Initial discussions held with colleagues and fed back to leads. Further session to be held to identify root cause. Additional session to be held to ensure maximum coverage. Matron to provide dates **ITU /Theatres/DSU** –The division is mindful of the need to approach root cause sessions with care based on the learnings from Theatres (East). In preparation of the root cause sessions taking place, actions have been put in place	• TBC • TBC
Women and children	**Howard and Blue Fin** – Continue to agree approach for staff engagement in safe and sensitive way with HoN **SCBU** – Staff Engagement agreed as a Driver Metric so A3 being mobilised with the Team **Community Midwifery** – Staff Engagement agreed as a Driver Metric so A3 being mobilised with the Team	• Ongoing • Ongoing • Ongoing
Medicine	**Specialist Admin (Worthing)** - SDR held and agreed Staff Engagement is a watch metric **Specialist Admin (Worthing)** - SDR held and agreed Staff Engagement is a watch metric	• Ongoing support when required
Core	**Outpatients** – A3 being progressed with Team as PFIS unit **Radiotherapy** – Initial session held with colleagues in SR, 1-2-1 calls held with colleagues in WTG. Follow up sessions to be held to identify root cause and priorities. Reached out to colleagues to establish desired process for next steps (Group or 1-2-1's) **Physiotherapy** – 11 services in total, all Root Cause sessions in flight or scheduled, supporting 2 sites with the counter measure phase. Call held with the Interim HoT's to feedback initial feedback and actions taken away	• Ongoing • End of Jan • Ongoing

People Strategic Initiate
Progress Update

January 2022 Summary Position:

- A review has taken place of the Leadership, Culture and Development Strategic Initiative to refresh project deliverables, project charters and ultimately inform programme plans.
- The SI has been developed under three key workstreams, focussing on long-term strategic and OD focused pieces of work, requiring delivery over more than 1 year. These workstreams are (a) Health and Wellbeing, (b) Leadership Skills and (c) Integrated Education and Development. New project charters have been developed for each of these workstreams and are continued being finalised with lead SROs through a series of meetings, which will include agreement of key deliverables and top level timelines to ensure detailed plans can developed to drive forward these workstreams.
- There is ongoing discussion on an EDI specific fourth workstream being identified with work on this in January. Any proposal will be brought through the executive committee and people committee with a Board Seminar on race equality plans expected on 2 March.

RAG	Workstream	Comments
	Governance	Continued refresh of programme governance underway, including working with Exec Lead and SROs re the setting of workstream deliverables through individual workstream charters. SROs currently reviewing charters for key deliverables and top level timelines. A programme risk register has been completed to identify any programme risks.
	Leadership Skills	**Workstream Lead – Nick Groves** Key actions: • 'Voice of the Customer' survey of all staff 8a and above required to identify the training leaders would like to see in a leadership curriculum completed and reported. • Responses being reviewed, with themes identified to inform programme of work and leadership offerings. • Individual workstream charter to be reviewed and ratified to support onward development of project plans.
	Health & Wellbeing	**Workstream Lead – Abbi Denyer** • Individual workstream charter to be developed for onward development of project plans. • Improved use of data to understand pressures and areas for improvement, to establish an evidence base to take forward initiatives and be able to measure improvement outcomes. • Focus on the need to raise awareness and responsibility for self and others health and wellbeing • Continue to develop models to support flexible working • Support for winter and keeping well • Use of wellbeing steering group to support integration of interventions • Delay in first meetings of H&W steering group due to operational pressures
	Integrated Education & Development	**Workstream Lead – Martyn Clark** Review project charter, timelines and key deliverables. On-going work on drafting the UHSX Trust Integrated Education and Development Strategy. Key aims: 1. To develop and publish a UHSussex Integrated Learning & Development Strategy, to both deliver and raise standards of education and learning 2. Develop a robust system to regularly review training needs Exec paper on initial design and focus for integrated education has been prepared and discussions with HEE as a stakeholder also planned. Some delay in establishing IE steering group (Education Board) due to operational pressures.

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 replaced multiple electronic workforce systems and reduced reliance on non-automated processes with no standardised methods to ensure effective deployment of the substantive and bank workforce and improve operational workforce reporting. The work is ongoing in 2022-23 with a business case for funding. A benefits stocktake of benefits realised was presented to the People Committee in January. These included staff satisfaction, reduced admin, increased self rostering.

90%+ staff are on a eRoster	**Baseline Figs in Brackets**
% Nursing , AHP & Pharmacy on an eRoster	EAST: 62% (35%) WEST: 92% (94%) **TRUST: 73% (64%)**
% Non-clinical staff on an eRoster	EAST: 36% (21%) WEST: 90% (91%) **TRUST: 59% (33%)**
% Nursing eRosters issued 6 weeks in advance	EAST: 44% (21%) WEST: 47% (38%) **TRUST: 45% (26%)**

Project KPI link to NHSE/I targets.

Stable working patterns, timely issuing of rosters and up to date Job plans support UHSx to improve staff engagement

Trend and trajectory charts have been developed and a roster performance dashboard.

People headlines

16,054 WTE posts
14,683 WTE in post
1,370 vacancy (8.5%)

Sickness 4% (4.5% in month)
Turnover 8.5%

Appraisal (non-medical) 75%
Medical 31%

STAM 82% (ave)

More people joined than left in last 12 months except in July 2021

Latest staff engagement 6.3%
Recommendation 59%

People Committee Scorecard - UHSx

December 2021

	Key Performance Indicator	Target	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Trend
	True North - Engagement		7.1	7.3	7.3	7.3	7.1	7.4	7.2	6.9	6.6	6.6	6.7	6.9	6.8	
	Breakthrough - Place to work (included in some of the surveys)		76.47%	85.71%	84.81%	83.41%	84.02%	79.72%	77.45%	68.70%	56.22%	59.27%	62.63%	65.13%	59.02%	
	Survey Responses		1,426	2,399	2,410	2,114	2,069	2,058	1,632	633	268	586	415	461	384	
Workforce Capacity	FTE - Budgeted		15,620.91	15,700.40	15,703.12	15,684.49	15,916.00	15,915.64	15,880.63	15,878.60	15,909.50	15,984.96	16,017.54	16,021.05	16,053.74	
	FTE - Substantive contracted		14,224.28	14,292.17	14,383.60	14,387.58	14,468.75	14,420.36	14,406.04	14,456.34	14,866.65	14,613.69	14,658.54	14,645.01	14,683.37	
	FTE - Substantive contracted variance from Budget		1,396.63	1,408.23	1,319.52	1,296.91	1,447.25	1,495.28	1,474.59	1,422.26	1,042.85	1,371.27	1,359.00	1,376.04	1,370.37	
	Vacancy Factor (Substantive contracted FTE)		8.94%	8.97%	8.40%	8.27%	9.09%	9.40%	9.29%	8.96%	6.55%	8.58%	8.48%	8.59%	8.54%	
	Vacancy Factor HCA Band 2 (Substantive contracted FTE)		-	-	-	-	6.92%	6.35%	5.27%	5.17%	7.55%	10.13%	12.85%	14.03%	13.59%	
	Vacancy Factor Nurse Band 5 (Substantive contracted FTE)		-	-	-	-	21.14%	21.44%	20.61%	19.47%	19.80%	18.29%	16.52%	15.18%	13.47%	
	Spend - Bank as a % of total staffing		8.97%	9.73%	9.49%	6.08%	7.39%	10.51%	6.81%	7.92%	7.70%	5.43%	7.02%	7.60%	8.78%	
	Spend - Agency as a % of total staffing		3.46%	2.96%	3.38%	1.98%	3.43%	3.05%	2.85%	3.46%	3.44%	2.86%	3.10%	3.28%	3.18%	
	Substantive Headcount		16,203	16,316	16,350	16,379	16,419	16,435	16,452	16,377	16,479	16,508	16,521	16,618	16,586	
Workforce Efficiency	Absence - Sickness (12 month)		-	-	-	4.04%	3.87%	3.81%	3.81%	3.82%	3.90%	3.92%	4.00%	4.04%		
	Absence - Sickness in month		4.07%	4.45%	4.00%	3.40%	2.87%	3.48%	3.90%	4.09%	4.44%	4.13%	4.98%	4.66%		
	Absence - Maternity in month		2.24%	2.28%	2.30%	2.16%	2.01%	2.14%	2.14%	2.10%	2.13%	2.13%	2.07%	1.99%		
	Absence - Special, Study & Other Leave in month		-	-	-	8.23%	7.20%	7.28%	7.67%	8.33%	7.81%	8.08%	8.44%	8.36%		
	Absence - Total in month		-	-	-	13.79%	12.08%	12.90%	13.70%	14.52%	14.38%	14.35%	15.49%	15.01%		
	Sickness - Short Term (< 28 days)		1.64%	2.06%	1.53%	1.56%	1.40%	1.73%	1.87%	1.99%	2.08%	1.97%	2.54%	2.42%		
	Sickness - Long Term (>= 28 days)		2.44%	2.39%	2.47%	1.84%	1.47%	1.74%	2.03%	2.10%	2.36%	2.17%	2.44%	2.24%		
	Sickness - Stress in month		1.02%	0.98%	1.03%	0.84%	0.65%	0.85%	0.98%	1.04%	1.13%	0.96%	1.07%	1.03%		
	Sickness - Gastro Intestinal in month		0.30%	0.28%	0.29%	0.19%	0.21%	0.31%	0.32%	0.31%	0.34%	0.34%	0.34%	0.32%		
	Sickness - Other Musculoskeletal in month		0.38%	0.36%	0.31%	0.32%	0.34%	0.46%	0.48%	0.43%	0.49%	0.38%	0.44%	0.41%		
	Sickness - Cough, Cold & Flu in month		0.20%	0.28%	0.20%	0.18%	0.16%	0.16%	0.16%	0.20%	0.22%	0.35%	0.76%	0.70%		
	Sickness - Back in month		0.24%	0.20%	0.22%	0.20%	0.19%	0.22%	0.27%	0.25%	0.27%	0.27%	0.22%	0.20%		
	Episodes - New sickness episodes in month		-	-	-	2,103	1,889	2,076	2,251	2,372	2,381	2,541	3,442	3,133		
	Episodes - On-going sickness episodes in month		-	-	-	506	506	536	542	666	688	676	793	682		
	Episodes - Total sickness episodes in month		-	-	-	2,609	2,395	2,612	2,793	3,038	3,069	3,217	4,235	3,815		
	Maternity - Number of staff on maternity leave		-	-	-	430	399	430	424	410	423	413	412	392		
	Turnover - Trust (12 month)		-	-	-	9.97%	9.84%	9.81%	9.80%	9.59%	9.37%	8.87%	8.71%	8.56%	8.58%	
	Turnover - Medical & Dental (12 month)		-	-	-	16.09%	17.44%	17.56%	15.65%	14.07%	14.06%	14.06%	13.94%	13.60%	13.59%	
	Turnover - Nursing & Midwifery (12 month)		-	-	-	9.05%	8.93%	8.89%	8.92%	8.59%	7.98%	7.44%	7.03%	6.49%	6.31%	
	Turnover - Scientific, Therapeutic & Technical (12 Month)		-	-	-	10.19%	9.64%	9.31%	9.31%	9.31%	8.88%	8.24%	8.45%	8.57%	8.57%	
	Turnover - Admin, Clerical & Estates (12 months)		-	-	-	8.84%	8.69%	8.73%	9.05%	9.15%	9.31%	9.11%	9.07%	9.43%	9.56%	
	Turnover - Support Staffing (12 months)		-	-	-	11.00%	10.68%	10.70%	10.73%	10.61%	10.65%	9.66%	9.51%	9.10%	9.32%	
	Stability %		-	-	-	-	89.16%	89.07%	88.79%	92.1%	88.3%	88.4%	88.1%	87.9%	87.1%	
Training and Development	% of appraisals up to date (All Staff)	90%	-	-	-	-	75.4%	76.3%	75.2%	73.83%	73.72%	71.45%	68.84%	69.34%	69.34%	
	% of appraisals up to date (Medical staff)	90%	-	-	-	-	29.1%	30.1%	29.7%	31.36%	30.95%	30.43%	29.01%	29.56%	31.15%	
	% of appraisals up to date (excl Medical staff)	90%	78.21%	74.58%	73.63%	76.53%	81.81%	82.8%	81.67%	80.01%	79.96%	77.48%	74.70%	75.23%	75.02%	
	STAM Weighted Average	90%	84.96%	84.28%	82.38%	84.90%	82.81%	83.3%	84.24%	83.81%	83.64%	82.74%	82.63%	82.30%	82.64%	
	% In Date - Fire	90%	84.58%	84.02%	82.32%	85.20%	83.46%	85.1%	84.27%	82.32%	82.41%	80.31%	79.78%	79.47%	80.00%	
	% In Date - Infection Control (Role Specific)	90%	83.40%	83.14%	81.12%	84.13%	82.48%	84.4%	83.73%	81.54%	81.45%	79.67%	79.64%	79.34%	79.94%	
	% In Date - Back Training (Role Specific)	90%	87.80%	85.77%	83.65%	85.12%	80.53%	69.1%	71.12%	73.23%	74.38%	75.19%	75.92%	76.18%	76.88%	
	% In Date - Child Protection (Role Specific)	90%	89.93%	89.99%	88.98%	90.20%	87.62%	88.6%	87.92%	87.46%	86.71%	86.03%	86.08%	85.19%	85.47%	
	% In Date - Information Governance	90%	83.14%	82.43%	79.15%	82.21%	80.61%	82.7%	82.08%	80.25%	80.19%	78.06%	76.88%	77.49%	78.13%	
	% In Date - Adult Protection	90%	81.70%	84.83%	84.54%	85.11%	84.90%	86.9%	87.64%	88.46%	88.62%	88.44%	88.75%	88.27%	88.41%	
	% in Date - Equality & Diversity	90%	92.92%	92.45%	91.06%	92.00%	89.54%	91.0%	90.83%	90.46%	89.52%	88.80%	88.54%	88.06%	88.48%	
	% in Date - Health & Safety	90%	89.28%	88.66%	87.20%	89.70%	87.20%	89.4%	94.74%	94.37%	94.25%	93.87%	93.87%	93.52%	93.51%	
	% in Date - Resus	90%	63.95%	57.83%	53.31%	62.56%	62.12%	67.5%	71.37%	72.22%	70.89%	70.01%	69.91%	68.57%	68.14%	
Capacity	Starters	-	143	210	182	182	185	130	151	121	576	251	249	210	137	
	Leavers	-	124	118	153	152	122	95	105	129	438	140	173	100	118	
COVID*	Absence		267	695	501	491	169	59	89	274	244	157	169	170	165	
	Vaccination % First Dose		-	81.31%	85.98%	88.78%	89.51%	89.65%	89.65%	89.65%	89.65%	89.65%	89.65%	89.65%	89.65%	
	Vaccination % Second Dose		-	-	-	65.36%	84.09%	86.23%	86.23%	86.23%	86.23%	86.23%	86.23%	86.23%	86.23%	
	Clinically Extremely Vulnerable		20	320	336	403	115	10	11	9	10	12	12	11	5	

Workforce KPIs - Commentary

Current Performance	Response / Actions Planned
Turnover • 8.5% and relatively stable	Breakthrough work with Divisions Follow up work to listening events in Maternity and Surgery (East) Culture review of Theatres (East) Planned scrutiny of Surgery culture Commissioned support from NHS Elect and Edgecumbe for those areas. Action on health and wellbeing with ‘winter plan’ interventions.
Sickness Absence • Covid absence has been challenging over the Omicron wave but appears to be reducing • Annual sickness generally is stable at around 4% but with seasonal escalation in December.	Review of the management of long covid absence has been completed and this is now being managed in line with Trust policy. New Health & Wellbeing at Work Policy launched October with support and guidance training in place for managers. Ongoing provision of health and wellbeing initiatives such as mental health first aid training, wellbeing webinars, wellbeing workshops. There is a greater focus on ‘in-reach’ for teams that cannot easily access resources. Psychological support offering has been strengthened with dedicated psychologist time for some areas. Extra winter funding has been obtained to provide ‘healthy snack box’ support for staff in areas where it is hard to take a break or access food and refreshment. Review of future H&WB offers and new H&W steering group.

Workforce KPIs - Commentary

Current Performance	Response / Actions planned
Appraisal 75% non-medical 31% medical	A new Development Appraisal format has launched and is being piloted in several areas. It combines Welfare Appraisal with restoration of 'performance' aspects of traditional appraisal and staff development. A supporting training video and updated guidance has been developed. Although uptake/compliance of Appraisal rate remains very challenging given operational pressures, data is circulated monthly with follow up support provided. There has been specific focus on the areas inspected by the CQC.
STAM 82% (average)	STAM continues to be provided largely online, except where face-to-face teaching and/or assessment is required (following risk assessment). Compliance remains challenging in some subjects and many Divisions given operational pressures. STAM compliance reports are now being circulated to Divisions twice per month to encourage their management of uptake and have been re-formatted to help identify staff who need to be supported to achieve compliance. There have been additional 'on the ward' training sessions and a particular focus on maternity and surgery. Capacity to provide moving and handling training has been increased. Resus training sessions have also been stepped up. The new improvement board is monitoring the response to the CQC comments on training compliance.
Vacancy 8.5%	Recruitment and retention initiatives are focusing on the nursing workforce, midwifery and key medical workforce (ED and medicine). 47 international B5 nurses were recruited directly to start employment with the Trust in mid-November, and a further cohort of 25 international B5 nurses via an agency route are commencing employment between November 2021 – January 2022. The Trust has agreed a package of support and incentives to recruit additional midwives with the additional 'Ockenden' funding to expand the establishment. There is early planning to secure different supply routes of international doctors to support gaps in training rotations where UK recruitment / assignment of trainee doctors is unsuccessful. This would partner with overseas hospitals and organisations to provide use these opportunities for training. The immigration and other issues are being worked through.

Sustainability

Integrated Performance Report Section

Sustainability Summary

- Throughout 2021/22, the Trust has operated under two interim financial frameworks, with the last quarter's performance following the H2 financial framework. The H2 allocations differ from the H1 framework; an increased efficiency requirement, a reduction in some income flows and a significant change in income recovery for elective activity.

- The intention of the framework, for individual organisations within the Sussex ICS, was to deliver a breakeven position; whilst restoring services to reduce the backlog and delivering financial targets. At the end of Q3 the Trust's financial performance met the target of breakeven.

- One key change in the H2 framework was the creation of the £1bn Elective Recovery Fund (ERF) and a new Targeted Investment Fund (TIF).

- The revised ERF arrangement, was significantly different in complexity, construct and application. Due to operational pressures, the Trust is not expecting to earn additional ERF in H2 at the same level as in H1.

- The Trust has however been able to secure significant additional funding to support elective recovery activity. This equates to £17m revenue and £5m capital.

Sustainability True North – Financial Plan

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

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

- As at the end of Q3, I&E performance remains on plan with sufficient cash balances to meet financial commitments to year end. The Capital programme is £13.6m behind plan, driven in part through late funding confirmation and supply chain challenges.

- Despite significant operational pressures, there was no further slippage in the value of efficiencies delivered to date, with performance remaining £4.6m less than target.

Sustainability Key Financial Metrics

			G
I&E £k	**YTD Plan**	**YTD Actual**	**Variance**
Income	(964,730)	(966,944)	2,214
Operating Costs	948,860	951,599	(2,739)
Finance Costs	15,736	14,972	764
Performance Adjustments	134	373	(239)
Overall performance	0	0	0

The Trust continues to report a breakeven Financial I&E performance in line with the submitted H2 plan. The Trust is earning more income than planned offset by additional expenditure on workforce premium and insourcing activity.

The Trust is forecasting a year-end breakeven position.

			G
Cash £k	**YTD Plan**	**YTD Actual**	**Variance**
	45,261	48,160	2,899

The cash balances are in line with the plan and relate to the opening cash position of the new Trust, rather than in year performance.

The cash forecast for the remainder of the year will continue to be reviewed and updated to reflect the timing of future cash flows.

			A
Capital £k	**YTD Plan**	**YTD Actual**	**Variance**
3T's Scheme	63,569	57,671	(5,898)
Operational Schemes:			
Internally Funded	32,189	29,813	(2,376)
Externally Funded	12,997	7,679	(5,318)
Overall performance	108,755	95,163	(13,592)

Expenditure on the 3T Stage 1 construction is on track. Expenditure on high value 3T's capital equipment has bene ordered but delivery is in 2022/23.

The operational capital forecast remains to deliver the plan. Some schemes have slipped but completion is still expected by March 2022.

			A
Efficiency £k	**YTD Plan**	**YTD Actual**	**Variance**
	18,744	14,106	(4,638)

Tactical scheme delivery is ahead of plan. There are a number of variations at a scheme level, where delivery has been impacted by operational pressures, and for which mitigations have been identified and are being finalised. The forecast outturn is in line with the year-end plan. Delivery of planned levels of productivity has been challenging due to pressures on urgent emergeny care

Sustainability-Forward look to 2022/23

- The draft planning guidance and associated consultations were circulated on 24th December 2021 by NHSE/I. The intent being to return to more recognizable contracting arrangements, with a move away from interim block arrangements.

- The Trust will continue to have a financial performance breakeven requirement for 2022/23.

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

  - 2021/22 H2 baseline will be annualised;
  - Recurrent adjustments will be made for health inequalities, maternity and growth of 4.1%
  - National efficiency requirement of -1.66%
  - A convergence adjustment towards Finance Improvement Trajectory targets is applied; Sussex System this -0.9%
  - Covid-19 funding reduced by 57%

- There will be additional funding via Elective Recovery Fund but requires activity levels at 104% above 19/20 value.

- Capital funding is a 3 year allocation

- The draft plan is due on 17th March 2022 and a final plan due on 28th April 2022.

- Whilst the Trust is awaiting receipt of final guidance & Trust financial allocations; planning meetings, budget setting, development of efficiencies and creation of a draft financial envelope for 2022/23 are progressing.

Sustainability - Financial Risks

There a number of risks that may impact delivery of our financial targets in Q4:

- Ability to protect elective capacity and increase our restore and recover activities; due to non-elective and COVID operational pressures.
- The application of the H2 financial framework, impacts the Trust's ability to secure additional funds equivalent to the cost of elective restoration activities.
- Global supply chain challenges and the construction market may impact the delivery of the capital plan
- Late notification of additional funding for capital schemes in 2021/22, which need to be spent before 31st March 2022, risks expenditure falling into a different financial year from receipt of the income; and
- Due to the ongoing COVID-19 pandemic, the Trust is continuing to operate in a challenging environment with high levels of uncertainty and associated impacts.

Sustainability - Actions & Recommendations

There are no actions required of the Board.

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

- The Quarter 3 performance financial performance including I&E, cash management, capital and efficiency delivery.

- 2022/23 draft financial plans will be submitted in March. The key risks to achievement of the breakeven target are the impact of operational pressures on the Trust's ability to deliver the efficiency programme, protect elective capacity and secure funding to support elective recovery.

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

Systems & Partnerships

Integrated Performance Report Section

Systems & Partnerships Summary Q3

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

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

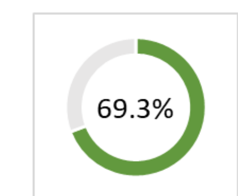
- The overall Trust performance against these measures at the end of Quarter 3 2021/22 has deteriorated, with significantly increased pressure on operational services as a result of ongoing Covid impacts, and wider system challenges against these targets.

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

Performance Summary Q3

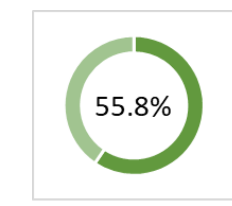
True North and NHS Constitutional Targets

A&E



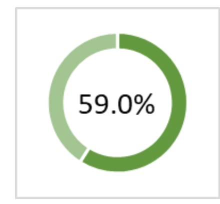
- Overall the combined Trust treated 69.3% of patients within 4 hours of attending all A&E departments. UHS West achieved 70.7% and UHS East achieved 68.0%. National performance also deteriorated and was 73.3%.
- There was continued pressure on Trust emergency departments in particular with increases in long length of stay patients as a result of constrained flow, exacerbated by the Omicron Covid-19 wave.

RTT



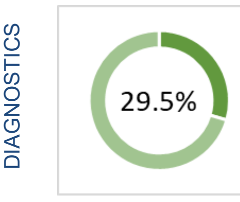
- The combined Trust has 55.8% of patients waiting longer than the target 18 weeks at the end of December. UHS West achieved 54.7% and UHS East achieved 56.7%. National performance was 65.5%.
- The total number of patients waiting for elective treatment at the Trust is 104,496, of whom 286 were waiting over 104 weeks at the end of December. Despite operational pressures the 104 week patient numbers have continued to decrease in line with the Trust's recovery trajectory to have no patients waiting at the end of March.

CANCER



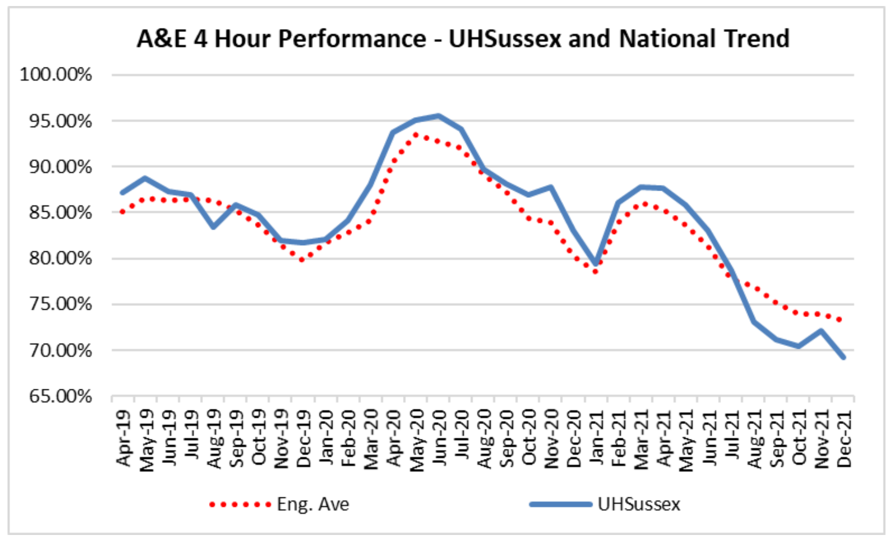
- Overall 59.0% of patients who commenced cancer treatment were treated within 62 days. UHS West was 56.5% and UHS East achieved 62.7%. National performance was 67.5%.
- There has been an increase in over 62 and 104 day prospective waits in December, although those numbers have reduced in over the January period as recovery plans have started to impact.

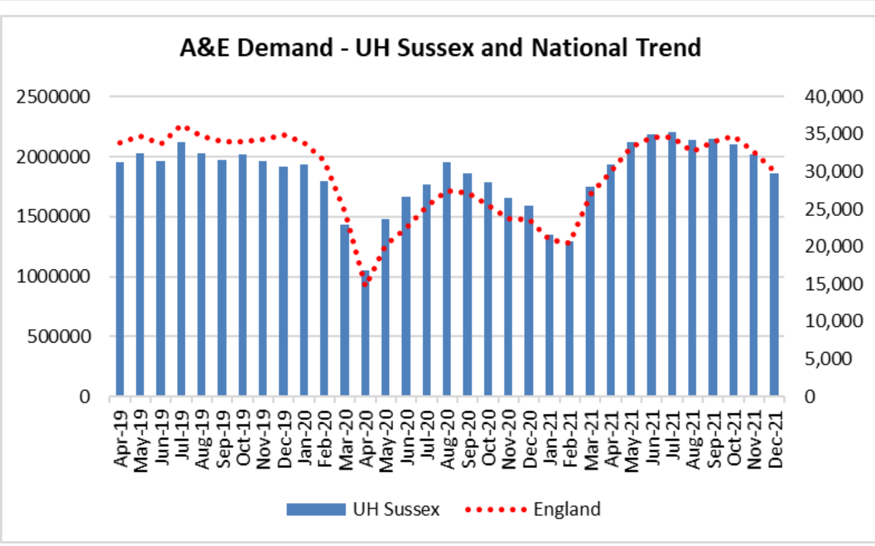
DIAGNOSTICS



- Overall the combined Trust had 29.5% of patients waiting more than 6 weeks for a diagnostic against a 1% target. UHS West achieved 35.1% and UHS East achieved 21.3%.
- This is a worsening of +4.8% since Nov-21 as a result of Christmas, Covid-19 related staff absences and emergency pressures.

A&E Performance Summary Q3





- A&E 4hr performance was 69.3% Dec-21 and 76.8% YTD, and was -4.0% below the national 4hr performance of 73.3% with a greater and sustained decline in performance than seen nationally over the last 5 months.

- To ensure patient safety, the time to triage, treatment and mean waiting times are key areas of focus for the Emergency Department teams. Despite the challenges outlined, the time for triage and treatment of patients improved in December.

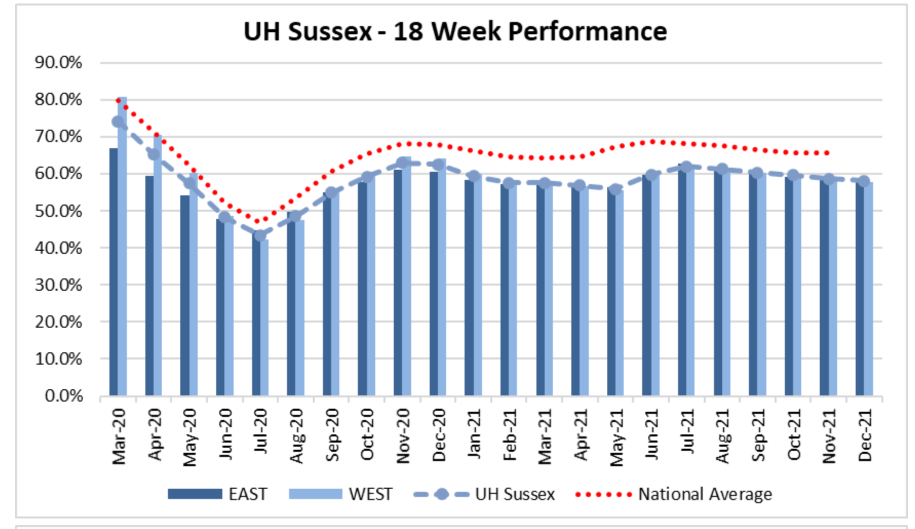
UHSussex	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Time to Triage (mins):	15.8	17.7	18.8	21.9	21.5	22.9	23.6	21.7	18.9
Time to Treatment (mins):	83.6	91.4	99.8	109.5	113.0	115.8	109.8	106.6	102.5
Mean Waiting Time (mins):	199.3	203.9	210.3	230.6	254.4	261.7	271.4	273.0	275.0

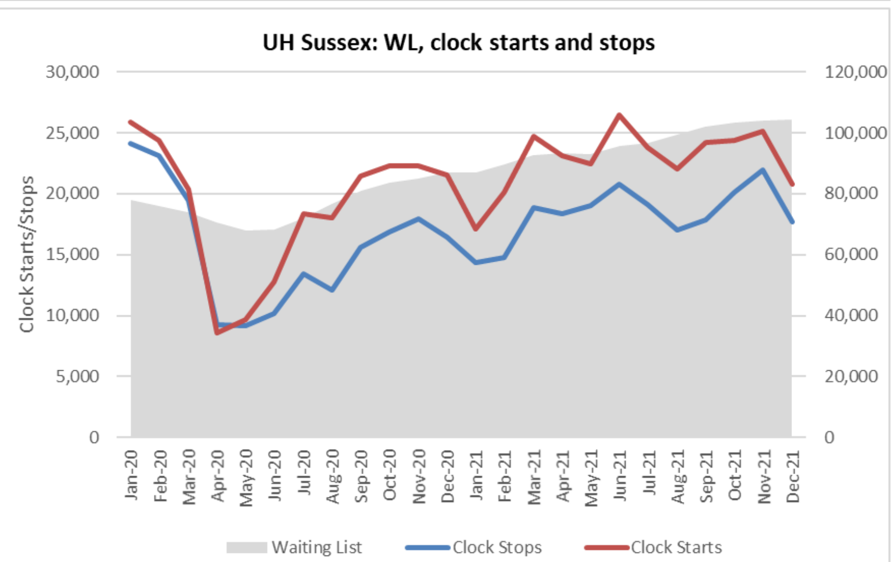
- Whilst there has continued to be high levels of emergency demand, complicated by the continued 'red/green' pathway split within both the emergency departments and wider hospitals, the main driver for the challenges has been the inability to create flow out of the Emergency Departments and admit patients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

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

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

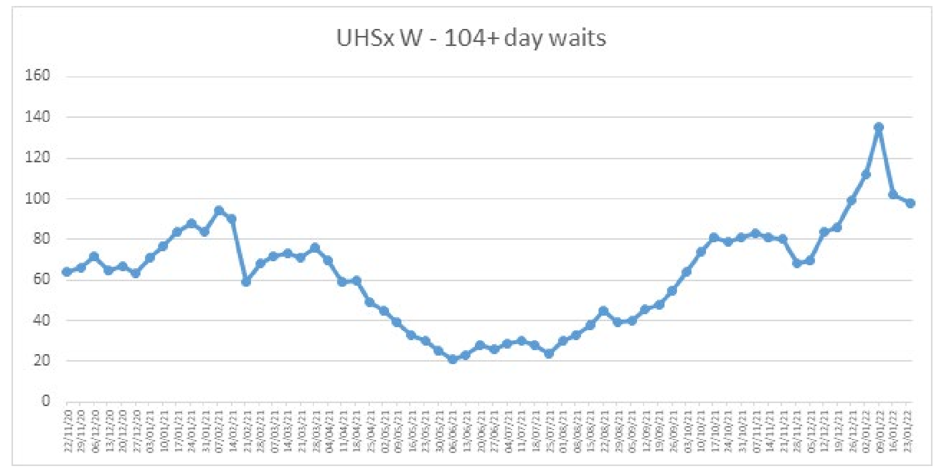
RTT Performance Summary Q3

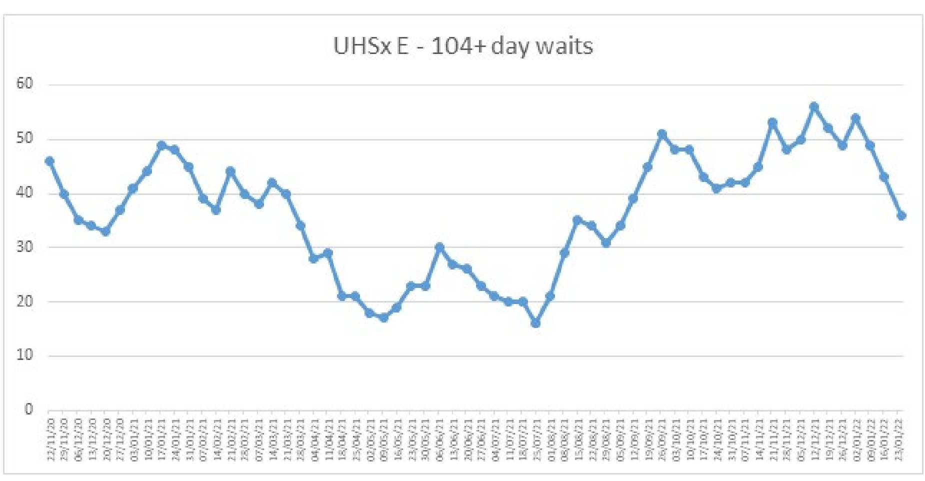




- RTT 18 weeks performance was 55.8% Dec-21, and there were 7,031 patients waiting over 52 weeks, compared to 6427 end Nov-21, an increase of 604 but in line (+11 higher) than the Trust’s forecast recovery trajectory.
- The National and local focus is on ensuring that no patients wait longer than 104 weeks by the end of March.
- Despite the operational pressures, good progress has continued to be made treating the longest waiting patients, and at the end of December there were 286 patients waiting over 104 weeks.
- The Trust has comprehensive plans supported by use of the Independent Sector and the cohort of patients requiring treatment by the end of March (who would otherwise wait longer than 104 weeks) has reduced by 1,111 (-60%) since the end of September to 649 currently.
- There were 20,773 RTT clock starts in December, whilst the Trust commenced 17,730 definitive treatments. The Trust has continued to perform well against the national elective activity targets, but the ongoing difference in demand (clock starts) to capacity (clock stops), means that the total waiting list was is now 104,496 patients, although the pace of increase has slowed significantly over Q3 as a result of the recovery plans.

Cancer Performance Summary Q3





- Cancer 62 day cancer treatment targets were not met in November with 59.0% starting treatment in under 62 days. UHS West was 56.5% and UHS East achieved 62.7%. National performance was 67.5%.

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
62 Day Perforamance	68.1%	65.4%	69.6%	68.6%	63.4%	61.6%	60.3%	59.0%	
28 Day FDS	70.7%	72.8%	72.1%	67.4%	66.0%	63.6%	65.5%	62.1%	
>62 Day Waits	267	301	329	372	529	574	573	605	719
>104 Day Waits	64	62	63	62	80	125	130	138	192

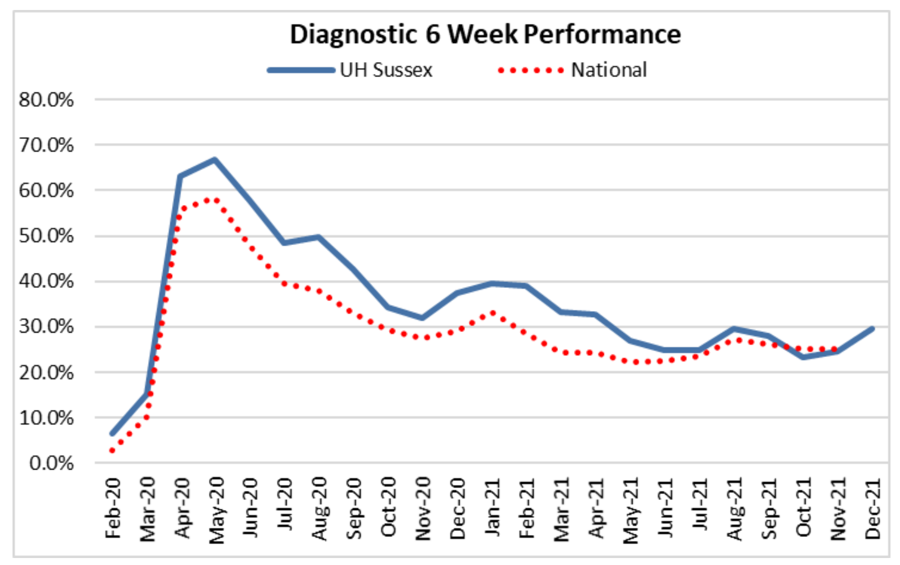
- At the end of December the Trust had 719 patients waiting > 62 days for cancer treatment compared to the improvement trajectory of 257. There were 192 patient waiting > 104 days.

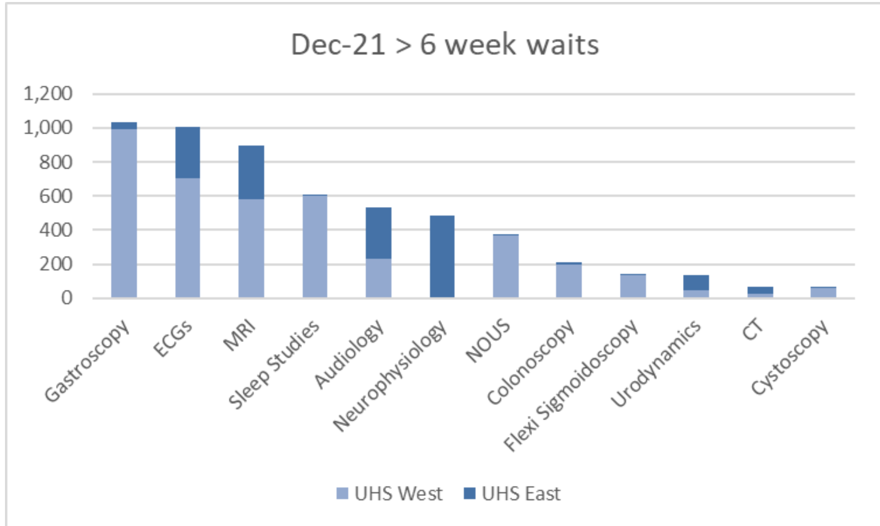
- The numbers of patients potentially waiting over 104 days increased in December, particularly in UHSussex West, whereas UHSussex has continued to improve week on week over the last month.

- The Trust performance has worsened against the new 28 Day Faster Diagnosis Standard in Quarter 2, with performance at 62.1% due to capacity constraints particularly in the skin anatomical site. National performance was 71.3%.

- The key driver for this has been the significant increases in cancer referrals over the last quarter, with volumes +6.6% above 2019 levels UHSussex East, and +21% UHSussex West.

Diagnostic Performance Summary Q3





- UHSussex diagnostic performance against the 6 week target deteriorated in December with 29.5% of patients waiting longer than 6 weeks for a diagnostic at the end of December. National performance was 25.0%.
- Performance was most challenged in the West with 35.1% of patients waiting longer than 6 weeks for a diagnostic at the end of December, a -7% deterioration from the previous month. This was as a result of the impact of emergency pressures and Covid-19 with both workforce constraints in key specialist diagnostic areas, and the impact of having to utilise areas such as Endoscopy and Cardiac Physiology to support inpatient surge capacity.
- Imaging, ECGs (Echocardiograms), and Neurophysiology have been most impacted by workforce constraints. High emergency pressures have also resulted in significantly higher demand for imaging services in particular.
- Positively, as some of the surge areas have been able to be de-escalated over the January period, clinical areas have been able to restart and increase diagnostic activity. In addition plans are underway to expand capacity with Independent Sector to support clearance of the backlogs.
- Some areas such as colonoscopy and non-obstetric ultrasound have now returned to compliance over the last month.

Summary and Forward Look Q4

- Although Q3 has been significantly challenged, there has been good progress in progressing a number of the Trust plans to address the continued pressures.

- Within Emergency care, work has continued with Sussex ICS partners to focus on both alternatives to A&E attendance, and in January the Trust has 'gone live' with the additional phone-based UTC capacity which will enable increased clinical capacity in the departments to treat patients attending.

- Similarly there have been multi-agency focused discharge improvement efforts to try and reduce the numbers of patients who can be discharged to other care settings (MRD patients), although to date this work has not yet been able to sustain a decrease. This work will continue in Q4, and is being prioritised Nationally as well as locally.

- The elective and cancer recovery plans are well developed and currently the Trust is ahead of its planned trajectories. This enable the potential risks within them to be closely managed and early identification of mitigations to ensure that as many long waiting patients are treated as possible.

- The key risk remains the operational pressures relating to emergency demand and the impact of Covid-19 on the capacity and workforce across all areas of delivery.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	11	Meeting:	Board	Meeting Date:	February 2022
Report Title:	Patient Committee Chair report to Board				
Committee Chair:			Jackie Cassell, Committee Non Executive Chair		
Author(s):			Jackie Cassell, Committee Non Executive Chair		
Report previously considered by and date:					

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

Implications for Trust Strategic Themes and any link to BAF risks		
Patient	✓	Assurances in relation to risks 1.1 and 1.2
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 25 January and was quorate as it was attended by seven Non-Executive Directors, the Chief Nurse, the Chief Medical Officer, the Deputy Chief Executive and Managing Director and the Chief People Officer. In attendance were the Director of Experience, Engagement and Involvement, the Director for Improvement and Delivery and the Director of Communications and Engagement.

The Committee received its planned items including the reports on the respective Patient First Trust North, Breakthrough and Strategic Initiative, the quarter 3 patient experience report, an update on the Trust work within the area of health inequalities and the Trust's recent focus on complaints. The Committee also considered the BAF risks for which it has assigned oversight.

Key Recommendation(s):

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

The Committee following a detailed discussion agreed to recommend to the Board that risk 1.1 within the BAF for which it has oversight is fairly represented.

The Committee agreed to recommend to the Board it considers having a dedicated session on the Trust's approach to health equality improvements and to determine where the Trust's priorities should be.

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
Patient Committee	**25 January 2022**	**Jackie Cassell**	yes	no
			✓	☐

Declarations of Interest Made

There were no declarations of interest made

Assurances received at the Committee meeting

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

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

The Committee **RECEIVED** the quarter 3 report on the patient experience feedback and the actions taken as a result of this feedback. The Committee **NOTED** that the Trust has received a strong feedback score through FFT where patients have reflected a good or better experience. These scores are above the national comparisons in all areas except for inpatient satisfaction within the east sites which is 2.5% lower than the national average. The Committee discussed the dominant plaudit and improvement area and the actions being taken through the "you said we did" updates. The Committee recognised the work undertaken through the Trust's "with you" project which has seen the enhanced use of technology to allow patients to keep in touch with their families during their inpatient stay. The Committee **ENDORSED** the work being undertaken to secure more engagement and the Trust's recognition that whilst technology has a role to play that equally important is the personal work to remove barriers to enable patients to have an easy route to give feedback. The Committee **NOTED** the report by the Director of Experience, Engagement and Involvement and the data within the report and was **ASSURED** that the Trust remains committed to listening to all feedback and acting where improvements are required.

The Committee **RECEIVED** the update on the delivery of the Trust's Breakthrough objective, this being the area where improvement actions will have the largest positive impact on the True North. The Committee was updated on the data analysis undertaken to determine the key priorities for improving the experience of those patients waiting. These include enhancing patient communication during the period of waiting, improvement to the hospital environment they are waiting in, the deployment of staff within our waiting rooms to enable timely support to be offered to those waiting and also the information provided to our patients including that provided as they leave or progress through their pathway. The Committee **NOTED** this update and recognised that further information on the outcome of these actions will flow through the strategy deployment reports to the next meeting.

The Committee **RECEIVED** a report on the Strategic Initiative from the Director for Delivery and Improvement. The Committee **NOTED** the work undertaken and planned across each of the programme pillars. The Committee **NOTED** the senior support being provided to the divisions to engage with the PFIS programme. The rhythm of divisional strategy deployment meetings has restarted in this month (January 2022). The Committee through the report was **ASSURED** that the Trust has a structured set of actions and support mechanism for staff to be engaged with the Patient First programme and methodology.

The Committee **RECEIVED** an update on the assigned Corporate Project from the Director for Delivery and Improvement. This project is focused on ensuring the learning and improvement from the recent inspection

is cascaded across the Trust. The Committee **NOTED** that many of these activities were about enhancing the Trust's routine "business as usual" processes. The expectation is that this project would naturally conclude as the Trust's systems and processes mature and provide the evidence these improvements are sustained. The Committee recognised the overlap with the work of the Quality Committee who receive reports and information to demonstrate the sustained delivery of our improvements.

Committee Activity

The Committee **RECEIVED** a presentation on the work being undertaken in respect of the partnership working being undertaken by the Trust with the ICS in respect of health inequalities. The Committee **NOTED** the work being undertaken at a system level and were reminded of the system work on the Waiting Well project which the Trust's work within the breakthrough objective on waiting dovetails with. The Trust through the Director of Experience, Engagement and Involvement, is actively engaging with a number of system partners on the area of improving health equality. The Committee **NOTED** the explicit reference to heath equality within the Terms of Reference of the Patient Experience and Engagement Group which gives structured oversight for both our work in this area how that work links to the activity within the wider system.

The Committee **RECEIVED** a report from the Director of Experience, Engagement and Involvement on the outcome of the work by the Trust on the enhanced focus being provided on dealing with complaints. This work has seen an increase in the Trust's delivery of responses within its target response time, but **NOTED** that work continues to achieve the consistent level of high quality and timely responses it seeks to give to all complainants. The Committee **NOTED** the revised support and oversight model adopted allowing the team to offer more resilient support to the respective divisions as they respond to and learn from complaints. The Committee **AGREED** that the pursuit of transformational change is right but that the immediate focus needed to remain on the resolution of the older open complaints. The Committee **NOTED** that from October 2021 the number of complaints being responded to exceeded the number received giving confidence that the effort being applied is working but there remains more work to do to conclude swiftly the older complaints.

The Committee **RECEIVED** a report from the Director of Patient Experience and Engagement on the Trust's revised structures of the patient team and how these structures will support the Trust's ambition that every contact with and by and patients is positive, and ensuring that where this does not happen we cascade the learning to revised ways of working. The Committee **ENDORSED** the approach to protect within this revised structure a focus on the strategic element of proactive work to improve our patient's experience.

The Committee **RECEIVED** an update on the work of the Patient Experience and Engagement Group and how this will support the Patient Committee as this meeting will provide key oversight for the national surveys coupled with a schedule of improvement actions. The Committee asked that reporting from this group be made direct to the Committee thus allowing the Committee to have greater visibility of the work of the Group

ICS Update

The Committee **NOTED** there was nothing further to update the Committee on specifically outside of the presentation received on health inequalities. The Committee **AGREED** to recommend to the Board that the Board considers having a dedicated session on the Trust's approach to health equality improvements and where its priorities should lie in the short term.

RISK

The Committee had a discussion on the BAF and the respective risks it has assigned oversight for these being risks 1.1 and 1.2. The Committee **AGREED** that the current score for risk 1.1 was fairly stated and that the information received within the meeting supported this. The Committee debated the new risk 1.2 and **AGREED** that whilst this is an issue there should be further work to determine the nature of the associated risk and its current and target scores.

Actions taken by the Committee within its Terms of Reference	
The Committee **APPROVED** the revised Breakthrough Objective Charter. The Committee **AGREED** to recommend the quarter 4 score for BAF risks 1.1 to the Board. The Committee **AGREED** that there is an issue in respect of health inequalities but that further work is needed in order to be in a position to determine the actual risk and its associated likelihood and impact.	
Items to come back to Committee (Items the Committee keeping an eye on outside its routine business cycle)	
The Committee sought further information on the complaints process transformational A3 at its next formal committee meeting in April 2022.	
Items referred to the Board or another Committee for decision or action	
Item	**Date**
The Committee following a detailed discussion agreed to recommend to the Board that risk 1.1 within the BAF for which it has oversight is fairly represented. The Committee agreed to recommend to the Board it considers having a dedicated session on the Trust's approach to health equality improvements and to determine where the Trust's priorities should be.	To Board 3 February 2022

Agenda Item:	12	Meeting:	Board	Meeting Date:	3 February 2022
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 25 January 2022 and was quorate as it was attended by five Non-Executive Directors, the Chief Nurse, the Chief Medical Officer and the Chief People Officer. In attendance were the Trust's Medical Director for the west, the Director of Patient Safety, the Chief Operating Officer for the east, the Director of Strategy and Planning 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, the developing quality scorecard, the maternity scorecards including the national Ockenden report metrics, reports covering SIs and the respective learning and the duty of candour audit outcomes, the learning from deaths report, the report from the Committee's respective reporting group and the Board Assurance Framework. The Committee also received an update on the progress being made in respect of the Internal Audit actions relating to mental health act compliance.

Key Recommendation(s):

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

The Board is asked to **NOTE** the Committee recommendation in respect of BAF risks 4.1 and 4.2 for which it has oversight, that the scores for start of quarter 4 are fairly represented.

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
Quality Committee	**25 January 2022**	**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, and Strategic Initiative.

The Director of Patient Safety and Learning provided an update on the True North in relation to harms. The Committee **NOTED** the developed dashboard in respect of the oversight of reported incidents requiring action. The Director of Patient Safety and Learning ASSURED the Committee on the Trust's processes for ensuring learning is captured and shared in respect of incidents. The Committee **NOTED** that further detail on these processes is provided within the report on incidents provided to this Committee. The Committee **NOTED** the progress with the actions supporting the delivery of the Trust North. The Committee received an update from the Director of Patient Safety and Learning on the associated breakthrough objective aligned to the True North on Harm. The Committee was updated on the data analysis undertaken to determine the key priorities for reducing the level of harm whilst maintaining a strong reporting culture. The Committee **NOTED** this update and recognised that further information on the outcome of these actions will flow through the strategy deployment reports to the next meeting.

The Medical Director west took the committee through the True North on Mortality, whilst the True North metric is for crude mortality the Committee NOTED that the Trust also tracks both HSMR and SHMI performance allowing the Trust to have a three dimensional view of mortality. The Committee recognised the lag in data provision from NHS Digital following their need to remap BSUH data post the merger. Following its receipt of the data the Trust has identified a small number of areas for further investigation in respect of both its HSMR and SHMI data. The Trust's action plan was considered and the Medical Director **ASSURED** the Committee that the initial review of the data had not identified any specific diagnostic group causing any concern. The Committee noted that the reporting of the delivery of these action will flow into the routine reporting through the strategy deployment updates.

The Chief Operating Officer for the east provided an update on the Outpatient Transformation Corporate Project. The Committee **NOTED** that progress had been slow over the last few months but **NOTED** that there had been a month on month improvement within the project as specialities joined the programme. The Committee was updated on the impact the latest national planning guidance will have on this project. The Committee NOTED the interrelationship with the reporting on this project and the routine reporting that flows to the Trust's Systems and Partnership Committee.

The Director of Strategy and Planning provided an update on the Strategic Initiative in relation to the Trust's clinical strategy. The Committee **NOTED** that the progress had like the Corporate Project been slower than planned. The Committee **NOTED** the work planned to show within the Strategy the linkages to the key

developments within the Trust over the forthcoming years and how the Strategy is aligned to the Trust established clinical operating model.

Committee Activity

The Committee **RECEIVED** reports in respect of the Trust's maternity services for all four of its maternity units, which included the Okenden data sets. The Committee considered each of the dashboards, with the Trust's Medical Director west providing information across each of the domains of; learning from any deaths or incidents where the medical Director cross referred to the information within the incident and learning from deaths reports; training which had seen an improved positon in respect of staff undertaking their training and the voice of the patient where the Committee was reminded that information in respect of the Trust's friends and family rates and resultant actions are reported to the Patient Committee. The Committee **NOTED** the information within the reports and the associated dashboards. The Chief Nurse informed the Committee that at a future meeting then a stocktake of the Trust's progress against the initial Okenden report national recommendations would be brought to a subsequent meeting giving a further layer of assurance to that within the dashboards as this stocktake will also be informed by a desktop review of the Trust's evidence undertaken by the LMNS.

The Committee **RECEIVED** an update on the developed quality dashboard. The Committee considered the breadth of indicators at both a Trust and supporting hospital level. The Chief Medical Officer explained how the dashboard will support the focus of the activity of Committee's key reporting group Quality Governance Steering Group. The Committee reviewed the indicators and suggested a small number of areas where further indicators could be added as the dashboard is developed. The Committee **AGREED** that this dashboard would be used to report to the Committee with the priority being to focus on the establishment of robust processes to capture the underlying data to enable the reports to be fully populated through an efficient process where the data quality is assured. The Committee **NOTED** the intent that the dashboard would be considered annually to allow for its iterative development to be aligned to any changes within the external oversight or reporting requirements placed on the Trust.

The Committee **RECEIVED** reports in respect of the learning being drawn from reported incidents within quarter 2 and was **ASSURED** over the Trust's focus on learning. The Trust **NOTED** the processes applied to audit the data within the report and thus allowing the Committee to be **ASSURED** over the Trust's compliance with the duty of candour. The Committee **NOTED** the linkage between this report and the update on the breakthrough objective. The Committee considered the processes of learning against the low and no harm incidents especially with the category of medication incidents. The Committee **AGREED** given the breath of this category of incidents that the QGSG look at the processes applied for the sharing of learning between divisions.

The Committee **RECEIVED** the Trust's learning from deaths report for quarter 3 of 2021/22 noting that whilst the report was for the whole Trust the information offers analyses across the hospital sites of St Richards, Worthing and Southlands and Royal Sussex County and Princess Royal. The Committee was **ASSURED** over the progress made with undertaking structured judgement reviews where initial medical examiner investigation recommended that this process be applied to seek out learning and **NOTED** there remained low levels of poor care being identified. The Committee **NOTED** the cross speciality learning that had flowed from the mortality panel discussions and the Medical Director west provided examples of changes made. The Committee **NOTED** the work in progress to expand the acute support for learning from deaths to other sectors, including primary care and hospices and the Medical Director confirmed that we are engaged with this programme locally.

The Committee **RECEIVED** an update on the Trust's CQC action plan by the Chief Nurse, recognising that within the Patient Committee meeting earlier that day assurance was provided over the developed improvement programme that supports this work. The Chief Nurse confirmed that future updates will provide assurance that the actions taken have been sustained along with the Trust's actions against the workforce improvements required by April. The Committee **NOTED** this update.

The Committee **RECEIVED** an update from the Chief Medical Officer and Medical Director west on work of the Quality Governance Steering Group (QGSG) at its December meeting. The Chief Medical Officer provided an update on the QGSG meeting that took place yesterday and the plan to adapt the focus of this group going forward to better support the Quality Committee with attention on the quality dashboard metrics and the undertaking of routine deep dive into quality matters where cross divisional learning or analysis would be beneficial. The Committee **NOTED** there were no matters which the Group was seeking Committee support or action.

The Committee **RECEIVED** a report from the Medical Director west in respect of the progress against the Trust's developed improvement actions following an Internal Audit over the Trust's processes for mental health act compliance. The Committee **NOTED** this progress and the remaining actions being undertaken in partnership with the mental health trust to enhance the Trust's application of its designed processes of internal control within this area.

ICS Update

The Committee **NOTED** that within this area there was nothing that required the Committee to take action on. The Committee was updated on the work being undertaken with the ICS on the development of a system wide quality oversight process which would allow greater focus on the balance of system risks.

RISK

The Committee reviewed the BAF risks it has oversight for, and **AGREED** that that score for risks 4.1 and 4.2 were fairly stated based on the information received at the meeting.

Actions taken by the Committee within its Terms of Reference

The Committee **AGREED** the developed quality dashboard.

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

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

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

The Committee would receive a complementary report to the routine Maternity Dashboards from the Chief Nurse in respect of a stocktake of the Trust's progress against the initial Okenden report national recommendations.

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

Item	Date
The Committee recommended to the Board that the risk within the BAF for which it has oversight is fairly represented.	To Board 3 February 2022
The Committee asked given the breath of the category of medication incidents that the QGSG look at the processes applied for the sharing of learning between divisions.	To QGSG in February 2022

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Quality Committee	22 December 2021	Joanna Crane	✓	☐

Declarations of Interest Made

There were no declarations of interest made

Assurances received at the Committee meeting

The Committee meeting on the 22 December was structured to receive the legacy annual reports for BSUH and WSHFT for 2020/21 in relation to Infection Prevention and Control and the Adult and Children's Safeguarding. The meeting also received on behalf of the Board the monthly maternity dashboards and associated reports along with an update in respect of the CQC actions, a report from the Chair of the Quality Governance Steering Group (QGSG) in resect of its meeting in November and a verbal update from the QGSG meeting held on the 20 December (noting the formal report will be provided to the January Quality Committee), and a presentation in respect of the Trust's harm review processes for those patients waiting.

2020/21 BSUH and WSHFT Infection and Prevention Control Annual Reports

The Associate Director of Infection and Prevention Control Annual Report took the Committee through the highlights of the 2020/21 which are included within the respective annual reports. The Committee noted the levels of infections in the year, noting that 2020/21 had been impacted by Covid but like other Trust's saw a reduction in other infections such as MRSA and e-coli, but noted that whilst a reduction in C-Difficile was seen at BSUH there was a very small increase at WSHFT but this level was still lower than prior years.

The Committee was informed of the changed requirements for surveillance and reporting of other infections during 2021/22.

The Committee was reminded of the actions taken in respect of managing Covid through the various waves and the changing guidance and information available during the year. The Trusts' were compliant will all the requirements and undertook investigations to ensure learning was applied early to improve processes. The Trust engaged with patient's families where they unfortunately died of Covid, ensuring that open and candourous conversations were had about their patient's care. Risk assessments have been undertaken and continue to be reviewed updated as circumstances change or advice changes as more information become available.

Pat reminded the Committee of the changes to the Team which will see the Team move forward on developing wider surveillance and support in respect of infection prevention and control processes.

The Committee was informed that within the surge plans for this most recent covid wave the lessons from the learning from the prior waves has been incorporated whilst noting that these do bring some operational challenges focusing on safety is in line with our risk appetite.

The Committee **APPROVED** the reports for reporting to the Trust Board and their placement on our website subject to some minor typographical changes.

2020/21 BSUH and WSHFT Adults' Safeguarding Annual Reports

The Nurse Director took the Committee through the respective reports and reminded the Committee on the work the Trust and that of the partner organisations in respect of safeguarding through the local safeguarding boards. The Committee was informed of the increased numbers of referrals across all sites, but recognised that there were significant differences in the profile of these between the two legacy Trusts.

The Committee noted the respect Trusts' involvement engagement with the relevant safeguarding reviews. In respect of the legacy BSUH processes they had been subject to an internal audit which provided overall a positive opinion. The Committee was informed of the action taken in respect of these audits recommendation and informed that these actions were weaved into the priorities for 2021/22 which will ensure these are applied across the whole Trust.

The Committee was informed on the potential changes to the relevant codes of practice and the Trust is working to determine our response and changes our services.

The Committee noted the work being undertaken to develop the process for UHSussex and the development of business case for a consistent approach for the provision of support within all of the Trust's Emergency Departments to bring the best approach from the legacy Trust's

The Committee **APPROVED** the reports for reporting to the Trust Board subject to some minor typographical changes.

2020/21 BSUH and WSHFT Children's Safeguarding Annual Reports

The Nurse Director took the Committee through the respective reports and reminded the Committee on the work the Trust and that of the partner organisations in respect of safeguarding through the local safeguarding boards. The Committee was informed of the variations within the referrals recognising that there were significant differences in the profile of these between the two legacy Trusts. The Committee recognised that Covid has had an impact on the ability for children to be seen with many interactions having to be made virtually.

The Committee discussed the actions being taken by the Trust and within the system given there has been an increase with children experiencing mental health issues which is putting increased pressure on the respective organisations.

The Committee was informed of the priorities for 2021/22 and as with the Adult reports there are plans in place for a consistent approach for the provision of support across the enlarged Trust. The Committee was updated by the Chief Nurse on the investments made to support the safeguarding team to allow them to rise to the challenges expected going forward.

The Committee **APPROVED** the reports for reporting to the Trust Board subject to some minor typographical changes. Noting the issue of resourcing will be flow through the respective business cases processes.

Maternity

The Trust Medical Director introduced an update from the Service leads in respect of the Maternity Dashboards recognising that the Trust is reflecting on feedback from the LMNS of extra data that could be added.

The Committee considered the respective data and received information on the reported incidents and the key metrics. The Committee noted the actions being undertaken in respect of the CNST requirements and noted that these actions overlap with wider Ockenden actions. The Committee received information on the improving delivery of staff training which will see improved metrics reported in the next report with investments made in the resources to support the delivery of training. The Committee noted that whilst recruitment continue and staff vacancies rates is low there remain pressures on staff and has seen suspension of the continuity of carer to enable the resources to used flexibility to meet needs. The Committee was updated that there are planned changes to the Maternity Voices (the voice of our service users) will see a strategic overview supported by newly formed four local voice chairs to enable local matters to be discussed and actioned on to enhance services to be reflective of any local demographic differences.

The Chief Nurse updated the Committee on the work being taken to support the service to progress with the delivery of their improvement actions especially in respect of listening and supporting our staff especially in respect of delivering training more flexibly.

The Committee **NOTED** this update and was **ASSURED** over the actions being taken to learn and improve from the metrics included within the dashboard. The Committee **NOTED** the planned development of the dashboard to broaden this to include matters such as inequalities.

CQC

The Chief Nurse provided an update on the actions taken and engagement with the CQC in respect of the presentation of evidence of the actions taken.

QGSG

The Deputy Chief Medical Officer took the Committee through the report on outcome of the meeting of the November and provided an update on the meeting held on the 20 December. The Committee was informed over the progress made to standardise the divisional and respective key supporting group reporting. The Committee was informed over the work undertaken to reduce the levels of outstanding incident investigations and complaints.

The Trust Medical Director updated the Committee on the focus the harm review processes for waiting patients. The process maintains its focus on cancer patients waiting over 104 week patient and the review of patients who are waiting more than 104 weeks or P2 waiting over 52 weeks. They also consider those patients on those pathways where time to treatment is expected to be below 12 months (Vascular, Cardiac, Neurosurgery) but where patients are waiting longer than desirable and the processes cover patients within the ED pathway looking at those waiting longer than 12 hours or involved in ambulance handovers taking more than 60 minutes. The Committee **NOTED** that these processes had commenced and these will be reported within the developing quality score card.

Actions taken by the Committee within its Terms of Reference

The Committee **APPROVED** to the Board the respective 2020/21 annual reports for both legacy Trusts of BSUH and WSHFT in respect of Infection Prevention and Control and Adult's and Children Safeguarding.

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

Given the nature of the meeting there were no specific matters over those planned for the next scheduled meeting within its cycle of business that it asked to return to the January meeting.

Items referred to the Board or another Committee for decision or action	
Item	**Date**
The Committee recommended to the Board that they receive the summary presentations for the legacy Trust's Annual Reports in support of the Committee's Recommendation of their approval by Board.	

Director of Infection Prevention and Control, Annual Reports 2020-21

Introduction

- This presentation gives an overview of the Director of Infection Prevention and Control Team annual reports of the legacy Western Sussex Foundation Trust, and Brighton and Sussex University Hospitals NHS Trust for 1 April 2020 to 31st March 2021.
- This is the last such report as following their merger in April 2021to become University Hospitals Sussex, there will one report going forward.
- The DIPC annual report is a statutory report that is required to be published on the Trust public website.
- The reports give an overview of activity undertaken throughout the year and detail performance against certain key metrics monitored by NHSE/I.
- The year 2020-21 was severely impacted by the global pandemic of COVID-19 which posed a major challenge in managing safe patient care.

Highlights for BSUH

- There were a total of 70 *Clostridioides difficile* Infection against a trajectory of 76. This was a 7.9% reduction on the year before.
- There were two cases of post-48 hours Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia.
- Gram-negative blood stream infections (BSI) caused by *Escherichia coli*, and *Klebsiella* species were lower than the previous year. There was a slight increase in *Pseudomonas* BSI.
- The Trust experienced outbreaks of CoVid-19 similar to all other hospitals in the country
- Significant teaching and support was given to ensure staff understood how to safely use personal protective equipment
- There were no outbreaks of influenza, respiratory syncytial virus or Norovirus.

CDI by Category April 2019 to March 2021

Month	Cdiff HOHA	Cdiff COHA	Cdiff COIA	Cdiff COCA
Apr-19	4			11
May-19	3			8
Jun-19	6			19
Jul-19	4			9
Aug-19	4	1	1	12
Sep-19	4	3	0	7
Oct-19	12	4	1	2
Nov-19	5	1	1	5
Dec-19	6	2	0	3
Jan-20	5	1	0	3
Feb-20	0	1	3	3
Mar-20	0			1
Apr-20	3	2	1	2
May-20	1	0	1	2
Jun-20	3	1	1	3
Jul-20	4	1	0	8
Aug-20	3	0	1	5
Sep-20	5	2	0	6
Oct-20	4	3	2	2
Nov-20	4	7	0	3
Dec-20	4	3	2	3
Jan-21	5	1	0	4
Feb-21	5	1	0	8
Mar-21	4	4	1	5

CDI HAI April 2019 to March 2021

Baseline calculated on 2019 to 2020 data

18
16
14
12
10
8
6
4
2
0

Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21

HAI Total
Target
Mean
UCL 3σ

MRSA BSI totals April 2019 to March 2021

MRSA Hospital onset   MRSA Community onset

Month	MRSA Hospital onset	MRSA Community onset
Apr-19	1	2
May-19	0	
Jun-19	2	0
Jul-19	1	1
Aug-19	0	1
Sep-19	1	0
Oct-19	0	
Nov-19	1	0
Dec-19	0	1
Jan-20	0	
Feb-20	1	1
Mar-20	1	0
Apr-20	0	
May-20	0	1
Jun-20	1	1
Jul-20	0	
Aug-20	0	
Sep-20	0	1
Oct-20	0	2
Nov-20	1	0
Dec-20	0	
Jan-21	0	1
Feb-21	0	1
Mar-21	1	0

E. coli total cases April 2019 to March 2021

Baseline calculated on April 2019 to March 2020 values

45
40
35
30
25
20
15
10
5
0

Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21

Total cases | Mean | UCL 3σ | LCL 3σ

Hospital-Onset E. coli April 2019 to March 2021

Baseline calculated on April 2019 to March 2020 data

9
8
7
6
5
4
3
2
1
0

Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21

Hospital onset cases — Mean — UCL 3σ

Highlights for WSFT

- There were a total of 38 *Clostridioides difficile* Infection against an internal trajectory of 64. This was a slight increase on 32 the previous year.
- There were no cases of post-48 hours Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia.
- Gram-negative blood stream infections (BSI) caused by *Escherichia coli* reduced by 13% on the previous year. There were 49 hospital acquired cases, a reduction from 60 the previous year.
- The Trust experienced outbreaks of CoVid-19 similar to all other hospitals in the country
- Significant teaching and support was given to ensure staff understood how to safely use personal protective equipment
- There were no outbreaks of influenza, respiratory syncytial virus or Norovirus.

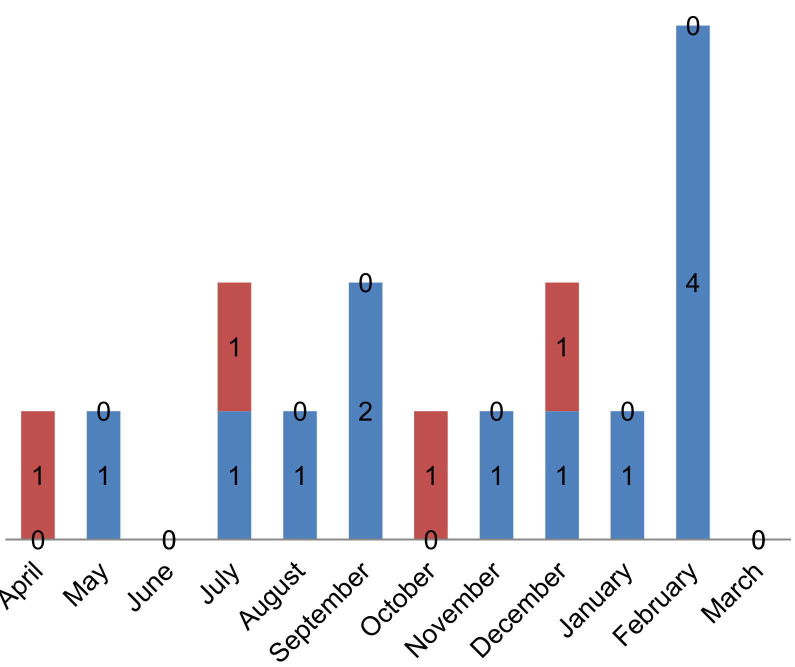
Attributable C. difficile Infection

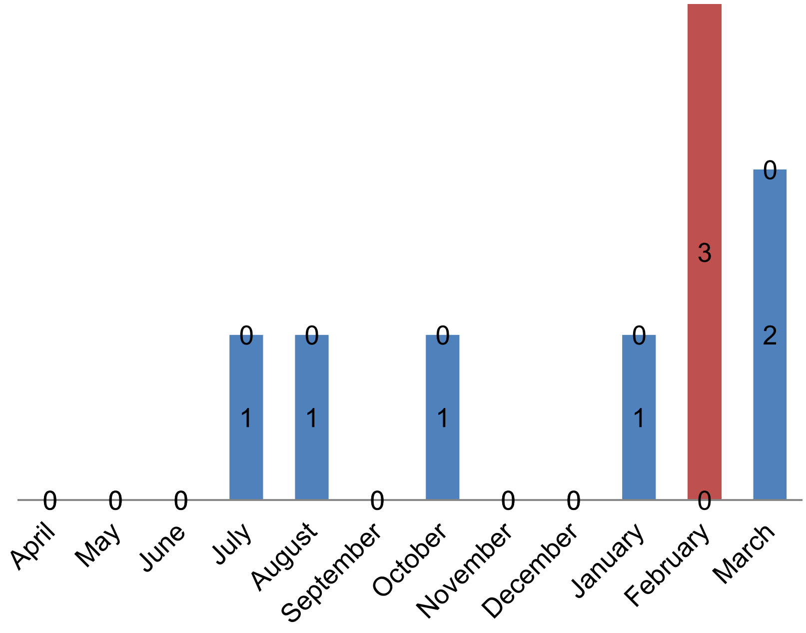
	April	May	June	July	August	September	October	November	December	January	February	March
Worthing	1	2	3	0	2	4	3	0	1	1	1	1
SRH	0	0	1	2	3	2	3	2	4	1	1	0

Attributable *E.coli* infection

Month	Worthing	SRH
April	3	0
May	0	0
June	0	5
July	2	2
August	1	2
September	6	2
October	1	3
November	2	3
December	3	4
January	0	4
February	1	2
March	3	0

Other gram negatives





Joint Working during Covid

- The Infection Prevention Teams at BSUH and WSFT have been working under the guidance of the DIPC through much of the pandemic
- Management of COVID-19 was essentially similar in both legacy Trusts
- Bronze, Silver and Gold Tactical meetings were held to coordinate management of the pandemic.
- Outbreaks have been managed through daily outbreak meetings and support from IPCT to clinical areas

COVID-19

Definitions

- Positive PCR results were categorised in order to enable identification of hospital acquired infection:
- **Community-Onset** – First positive specimen date less than 2 days after admission to the Trust
- **Hospital-Onset Indeterminate Healthcare-Associated** – First positive specimen date 3-7 days after admission to the Trust
- **Hospital-Onset Probable Healthcare-Associated** - First positive specimen date 8-14 days after admission to the Trust
- **Hospital-Onset Definite Healthcare-Associated** – First positive specimen date 15 or more days after admission to the Trust
- An outbreak has occurred where there are two or more test-confirmed or clinically suspected cases of COVID-19 among individuals (for example patients, health care workers, other hospital staff and regular visitors, for example volunteers and chaplains) associated with a specific setting (for example bay, ward or shared space), where at least one case (if a patient) has been identified as having illness onset after 8 days of admission to hospital.'

Outbreak Management

Where new outbreaks were considered to have occurred, the following processes were put in place, in order to mitigate the potential risk of spread of infection:

- Existing patients in bay remain in situ
- Bay closed to admissions
- Exposed patients were screened every day for 14 days while in hospital
- Observe remaining patients for symptoms
- Swab/isolate if new onset of respiratory symptoms
- If suspected patient is negative, and COVID-19 not clinically suspected – open bay and affected patient can remain on ward area
- If suspected patient is COVID-19 positive, isolate bay contacts for 14 days from last contact

Covid-19 Outbreaks

- At BSUH there were 12 outbreaks retrospectively identified in wave one and 40 in wave two.
- At WSHT there were 4 outbreaks retrospectively identified in wave one and 26 in wave two
- All measures were employed as advised by PHE and NHSE, supported by appropriate internal communication strategies, Infection Prevention and Control Team (IPCT), Ways of Working Team, Human Resources (HR), Occupational Health (OH), Pathology, and the Clinical Advisory Group.
- Work included:
  - advising, training and supporting the Trust with implementing guidance as it came out from Public Health England, NHS improvement and NHS England
  - supporting training in use of PPE
  - undertaking of screening and fit testing as well as providing reassurance to staff.
- For each outbreak, a Post Infection Review (PIR), Root Cause Analysis (RCA) process was put in place.
- Structured Judgement Reviews were carried out for patient deaths where acquisition of Covid-19 was definetely or probably hospital acquired.
- Duty of candour was carried out where required.
- Meetings were convened with key attendees and a PIR tool was developed to direct and document the reviews and resulting actions.

Learning from the outbreaks

- Inadequate ventilation was considered to be the most significant factor in the spread of nosocomial Covid-19 infection throughout Wave two
- Specific areas including the Barry building and wards at Princess Royal Hospital were identified as having poor ventilation.
- Early issues with testing led to some delays in identification of positive patients.
- Multiple patient specialties increased the number of staff in some wards
- Shared toilets and facilities in some areas
- Wards with high numbers of patients with low cognition (e.g. delirium, dementia, brain injury) meant that patients did not always understand social distancing
- Wearing face masks was encouraged for patients but not all patients could tolerate or comply
- Reduced access to staff rooms to enable social distancing.

Moving Forward

- The teams continue to support the newly formed Trust in tackling the on-going COVID-19 pandemic, and using learning from previous waves.
- The teams have been recognised for their hard work during the pandemic
- The IPC Teams from the legacy trusts are working more closely together under the direction of the new Associate DIPC
- A process is in place to review structure of the team to strengthen and improve IPC provision
- Future annual reporting will be in the form of a joint report with clear data against trajectories, audit plan and annual work plan.
- New trajectories have been set for the Trust to include MRSA, CDT, *E.coli, Klebisella sp* and *Pseudomonas aeruginosa.*
- Auditing will be rolled out on the 'Perfect Ward' app across the whole trust
- Areas for future work streams identified for 2021-22, include SSI prevention, ANTT, oral care and improving hydration as part of national *E.coli* reduction targets

I've had my flu jab
PROTECTS YOU, YOUR FAMILY AND PATIENTS FROM THE FLU

- Annual Report -
Infection Prevention & Control
2020-2021

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Infection Prevention and Control Annual report 2020/2021

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2 Executive Summary

2.1 This is the annual report of the Brighton and Sussex University Hospitals NHS Trust Infection Prevention and Control Team for 1 April 2020-31st March 2021. This is the last such report as the BSUH Trust has merged with Western Sussex NHS Foundation Trust from 1st April 2021 to become University Hospitals Sussex.

2.2 It should be noted that there was an international pandemic (Covid-19) during this period that required a change in IPC focus for the Trust. There were no set trajectories for alert organisms. The Trust was also operating an incident governance structure with bronze, silver and gold meetings that could review new Covid-19 guidance and make decisions in a more timely fashion.

2.3 There were a total of 70 *Clostridioides difficile* Infection against no set trajectory. However this was a 7.9% reduction on the year before.

2.4 There were two cases of post-48 hours Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia. There were 34 cases of post-48 hours Meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia.

2.5 There were no identified issues with contamination of blood cultures.

2.6 Gram-negative blood stream infections (BSI) caused by *Escherichia coli*, and *Klebsiella* species were lower than the previous year. There was a slight increase in *Pseudomonas* BSI.

2.7 The trust was heavily affected by the Covid-19 pandemic, which put significant pressure of beds and staffing. There were twelve outbreaks of Covid-19 retrospectively identified in wave one and forty in wave two. Key areas for learning were identified to enable changes for further waves. This included spreading out staff for breaks or office use, improving ventilation and effective use of PPE including introduction of fluid resistant surgical masks in all hospital areas.

2.8 The cleaning standards monitoring team continued to undertake audits, with some initial exceptions in Covid-19 high risk areas which were deemed inaccessible to all but essential staff. Results were discussed at Facilities and Estates huddles, with reports to The Trust Infection Prevention and Control Committee.

1.9 During this period the Perfect ward auditing programme was implemented across Brighton and Sussex University Hospitals. This is an app based programme which allows data collection on a tablet device or phone. The app correlates all results giving a consistent indicator of progress across the trust.

2.10 The Infection Prevention and Control Team undertook an audit of bed spacing in relation to Covid-19 to ensure safe management of patients. An audit of commodes was also undertaken with results fed back directly and communicated by email.

2.11 All face to face teaching was suspended due to the Covid-19 pandemic. Staff were enabled to undertake training, including donning and doffing personal protective equipment, via the IRIS e-learning platform and videos on the Trust intranet, supported by the IPC team in the clinical environments. The national infection prevention and control e-learning tools were utilised and aligned with the Skills for Health Competency framework.

2.12 Surgical site surveillance was undertaken on total knee replacements for 3 months, with no infections reported in this category.

2.13 The Water Safety Group continued to meet during this period, via Microsoft Teams platform to review water microbiology results and discuss actions.

2.14 The ventilation steering group continued to meet during this time and the Trust continued with the operating theatre upgrade programme. There was a focus on identification of ventilation levels in clinical areas as part of the Covid-19 exposure management.

2.15 Antimicrobial Stewardship - The Covid-19 pandemic and staff vacancy had a slight negative impact on antimicrobial usage on the previous year. The Antimicrobial pharmacy post is now filled.

2.16 There were no outbreaks of influenza, respiratory syncytial virus or Norovirus. This may have been a valuable side effect of the pandemic infection prevention restrictions across the UK. The Trust experienced outbreaks of Covid-19 similar to all other hospitals in the country.

2.17 The infection prevention and control team has inputted into the 3Ts stage one construction and were involved in capital projects for new builds and refurbishments.

2.18 Despite the pressures of the pandemic, the Trust was able to access personal protective equipment (PPE) for its staff throughout. Government guidance was followed and incorporated into standard operating procedures and policies through a multi-disciplinary ‘Clinical Advisory Group’ (CAG).

2.19 Staff uptake of Covid vaccination has been good across the trust at around 80%.

3 Introduction

The purpose of this report is to assure the patients, public, staff, the Trust Board of Directors, Governors and Clinical Commissioning Group (CCG) that the system of Health Care Associated Infection (HCAI) management meets its obligations with regard to patient safety and clinical governance. It is also to reassure that best practice is followed as identified in the Hygiene Code and Care Quality Commission underpinning national and local guidance and provide assurance that the Trust remains compliant with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (Department of Health, 2015).

Investment in, and support of infection prevention and control remains both necessary and cost effective and will be a big focus for the newly merged University Hospitals Sussex Trust in order to maintain patient safety .

4 Infection Prevention and Control Team (IPCT)

- The Director of Infection Prevention and Control (DIPC) is the Executive Chief Nurse.
- The BSUH IPCT comprises:
- WTE Band 8d (seconded post)
- WTE Band 8b (vacant)
- WTE Band 8a
- WTE Band 7
- 2.6 WTE Band 6
- 0.8 WTE Band 4 (vacant - administrative support)
- WTE Band 3 (admin and audit)

There is approximately 0.2 PA of medical cover as Infection Control Doctor (ICD) and Deputy Director of Infection Prevention and Control (DDIPC). Previously this post was held by the substantive Head of Nursing for IPC. Recruitment to this post has been challenging and the team is being supported by the secondment of the Head of Nursing for Medicine..

The IPCT covers 8.00am – 5pm daily with out-of-hours advice being given by the microbiology on-call service.

5 Infection Prevention and Control Governance Structure

The Trust Infection Control Committee became the Trust Infection Prevention Committee (TIPC). There were less frequent meetings during this period, mainly due to the Covid-19 pandemic and that the Trust was running a responsive incident structure with frequent bronze, silver and gold meetings that revised the governance structure with more timely review of new guidance and timely actions.

TIPC reports to the Trust Board as per Figure 1.

The main purpose of TIPC is to provide strategic direction to the Trust's management of infection prevention and control (IPC) activity.

TIPC provides assurance that the system of Health Care Associated Infection (HCAI) management is via a detailed framework to ensure the Board meets its obligations with regard to patient safety and clinical governance. It is also to ensure that best practice is followed as identified in the Hygiene Code and Care Quality Commission underpinning national and local guidance.

At TIPC there is representation from each division (Medicine, Surgery, Women & Children, Corporate, Facilities & Estates, and Consultant in Communicable Disease Control; Public Health England and Community partners).

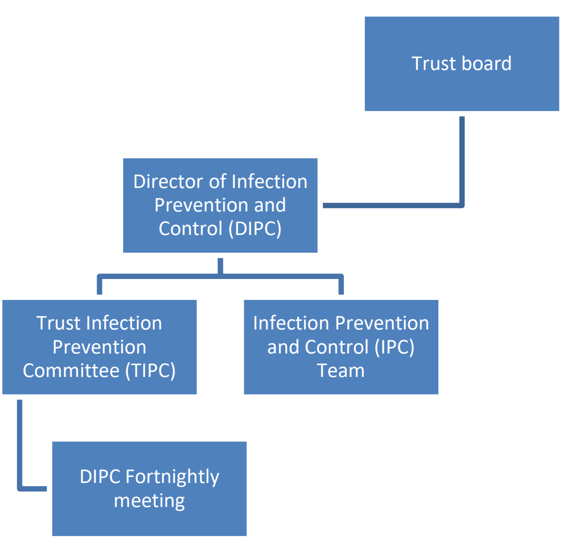


Figure 1 IPCT reporting lines

During this period there was also a fortnightly IPC meeting chaired by the Lead IPC Nurse with DIPC and DDIPC support. The fortnightly IPC meeting reported to TIPC as per Figure 1 above.

6 Summary of performance 2020-21

6.1 *Clostridioides difficile* Infection (CDI)

There were 70 cases of CDI during this period; broken down into 45 hospital-onset healthcare associated and 20 community onset healthcare associated. Inpatient cases were reviewed by the IPCT during ward reviews. Root cause analyses (RCA) were undertaken on some cases balanced with the Covid-19 workload. Results of RCAs were presented at the bi-monthly TIPC.

There was no actual target was set for 2020-21. The previous target had been set at 76, and the actual number for 2019-20 was 76, so this represented a 7.9% decrease.

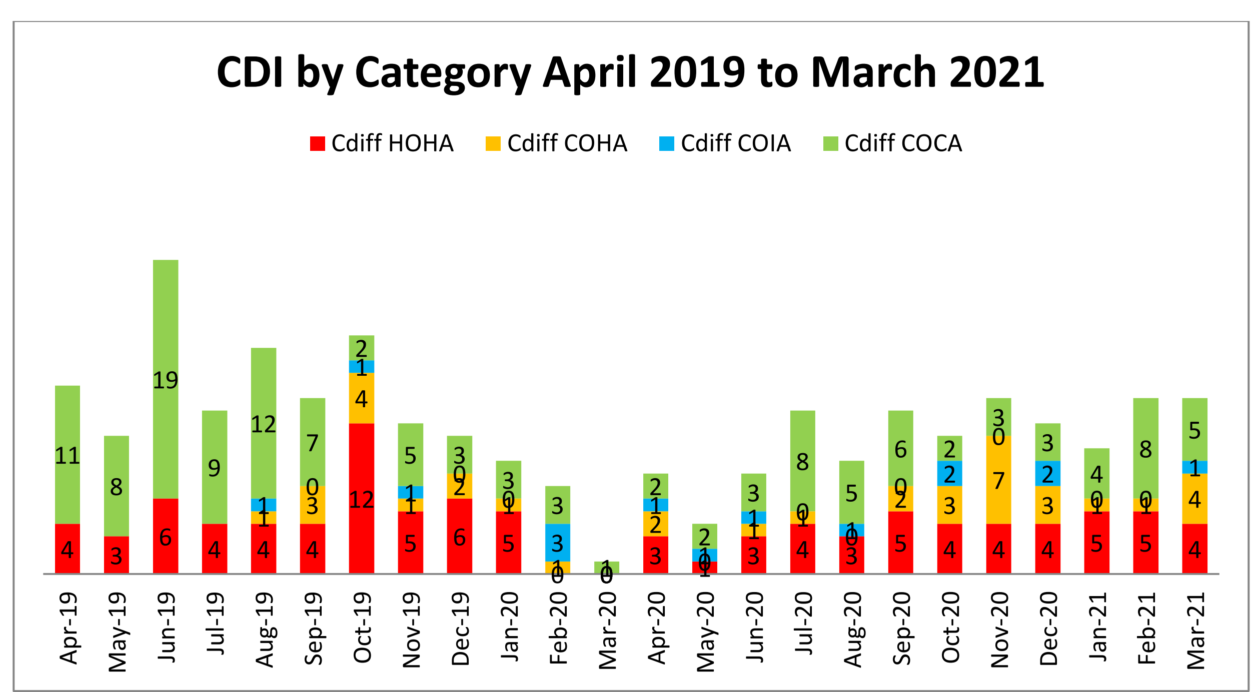


Chart 1: CDI by Category

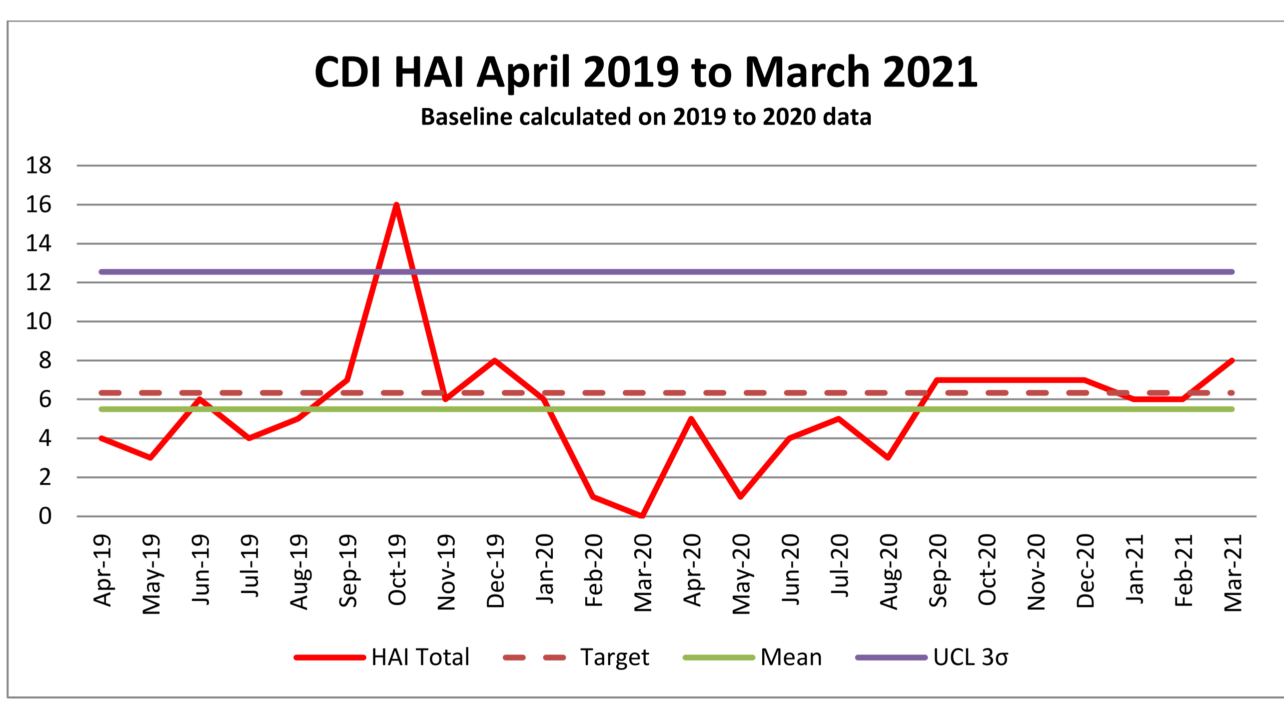


Chart 2: CDI Statistical process control chart

6.2 Methicillin-resistant *Staphylococcus aureus* (MRSA) Blood stream infections (BSI)

There was a 67% reduction of hospital-onset cases from six in 2019/20 to two during this period 2020/21. There was no RCA completed due to pandemic pressures.

There was an increase of community cases from four in 2019/20 to six in 2020/21.

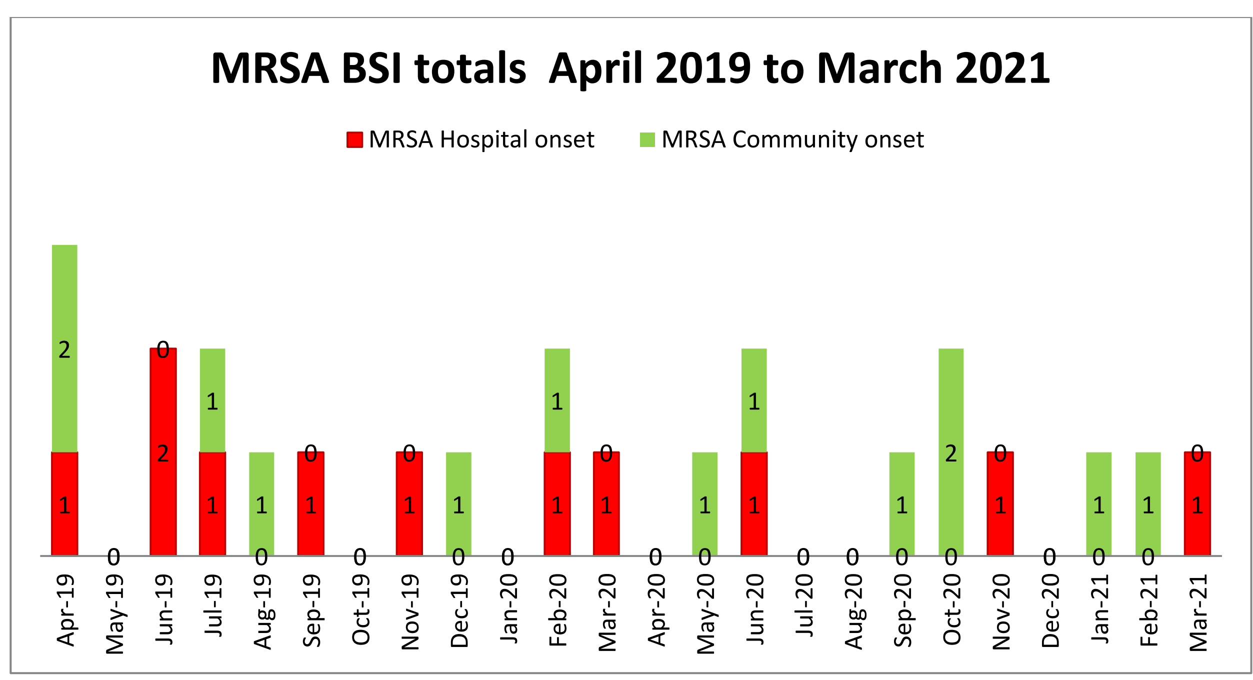


Chart 3: MRSA BSI totals

6.3 Methicillin-susceptible *Staphylococcus aureus* (MSSA) BSI

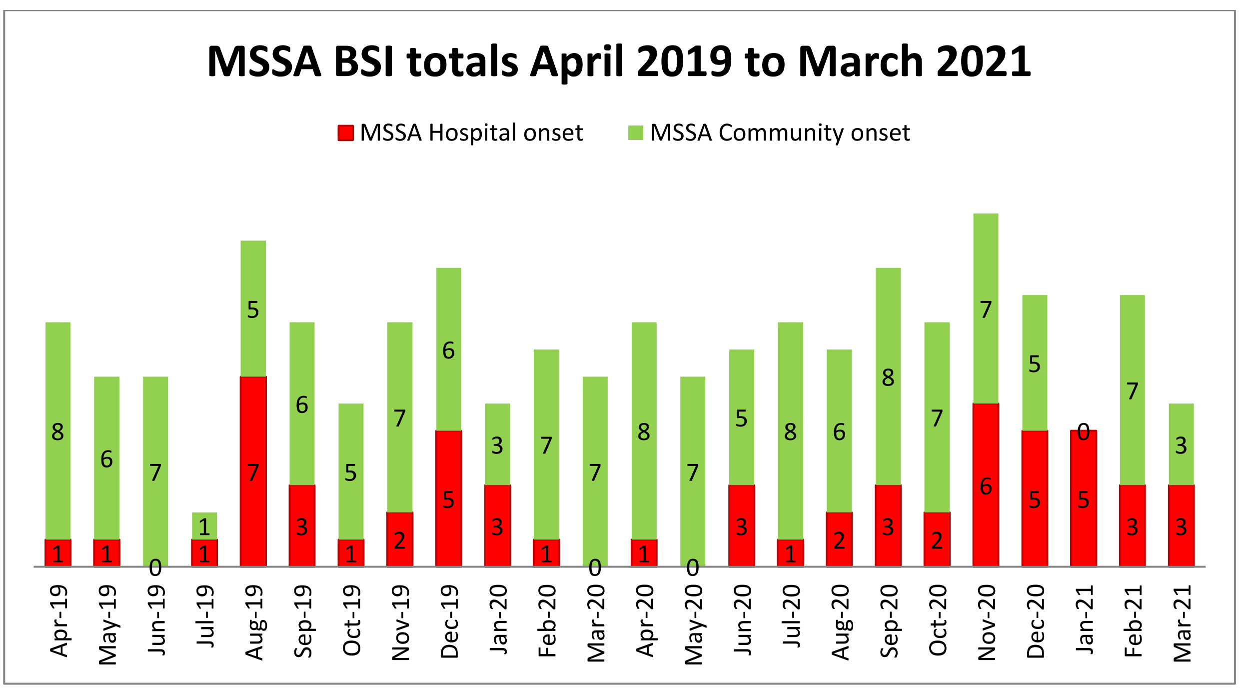


Chart 4: MSSA BSI totals

There was an increase of hospital-onset MSSA from 25 in 2019/20 to 34 in 2020/21

Due to the Covid-19 workload it was not possible to undertake post infection reviews on all the hospital onset cases, however, all in-patients with MSSA BSI had input from the microbiology team with regard identifying the likely source of infection and associated treatment.

6.4 *E.coli* bacteraemia

In 2019/20 the Trust had a total of 287 *Escherichia coli* blood stream infections (40 Hospital-onset) that reduced by 14% to 247 (29 Hospital-onset) during 2020/21.

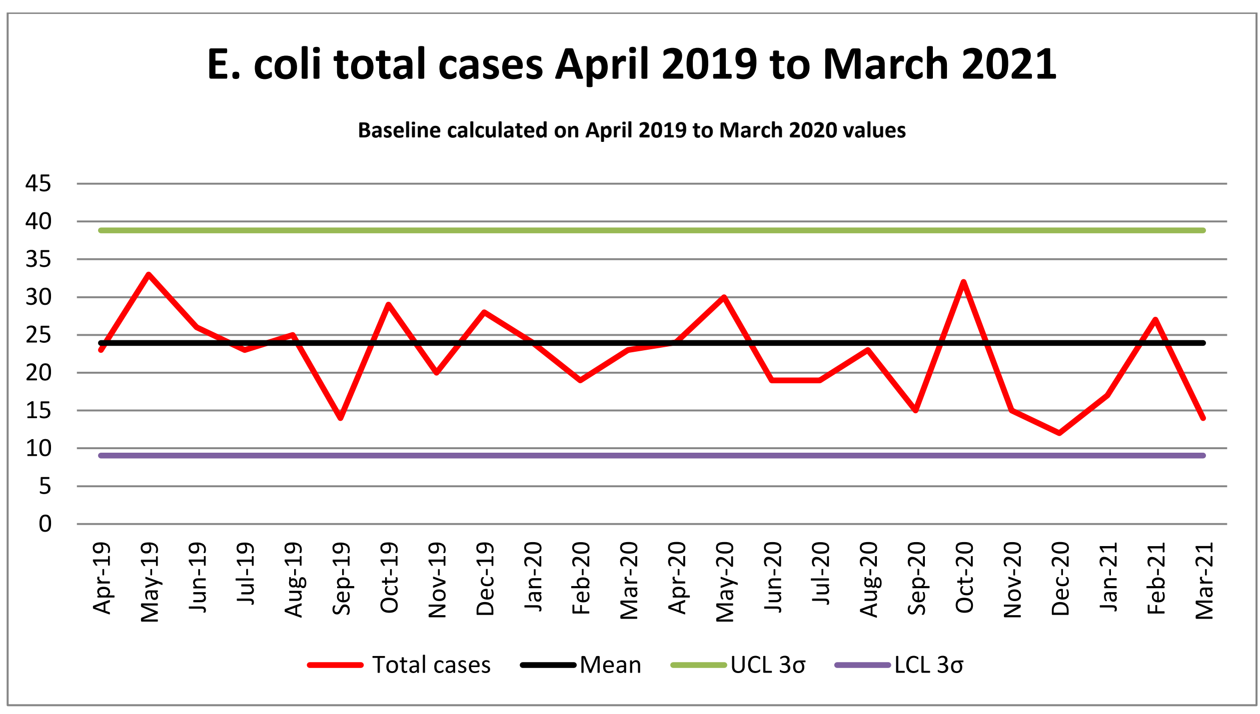


Chart 5: *E.coli* totals Statistical process control chart

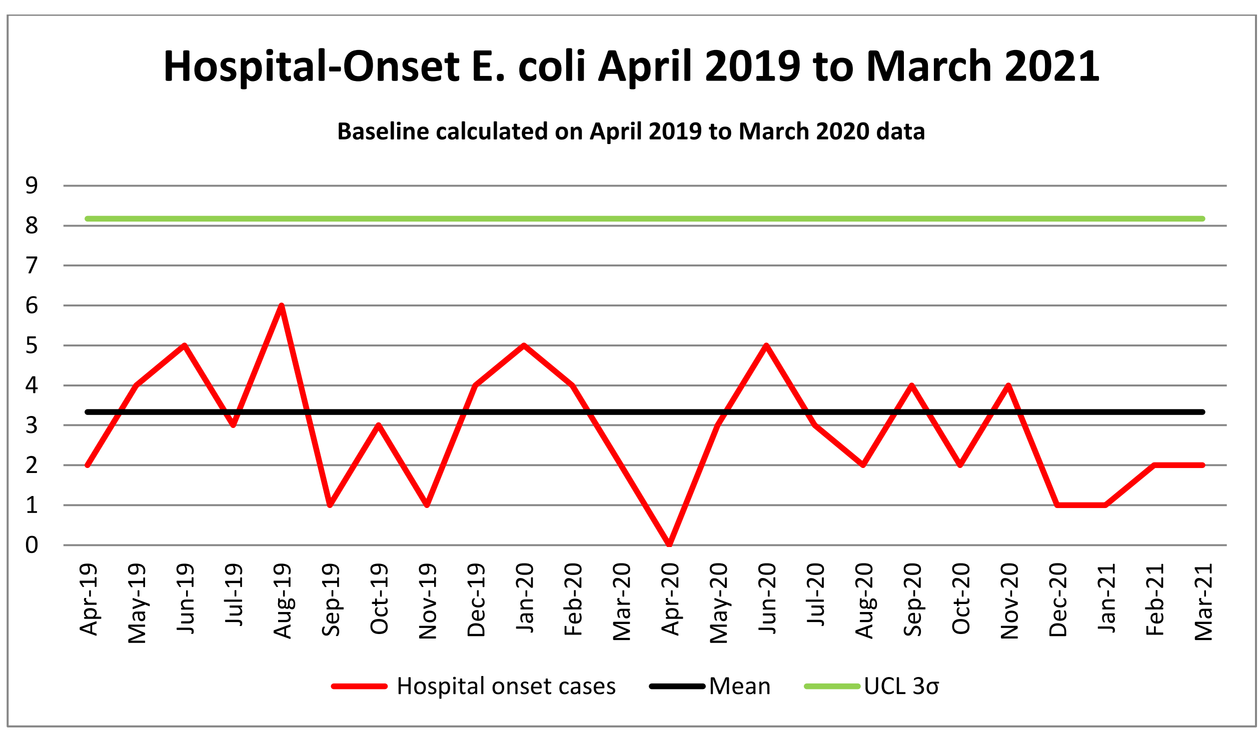


Chart 6: E.coli hospital-onset totals Statistical process control chart

6.5 *Pseudomonas aeruginosa* Bacteraemia

There were 15 cases of hospital-onset Pseudomonas aeruginosa BSI in 2019/20 and a slight increase to 19 in 2020/21.

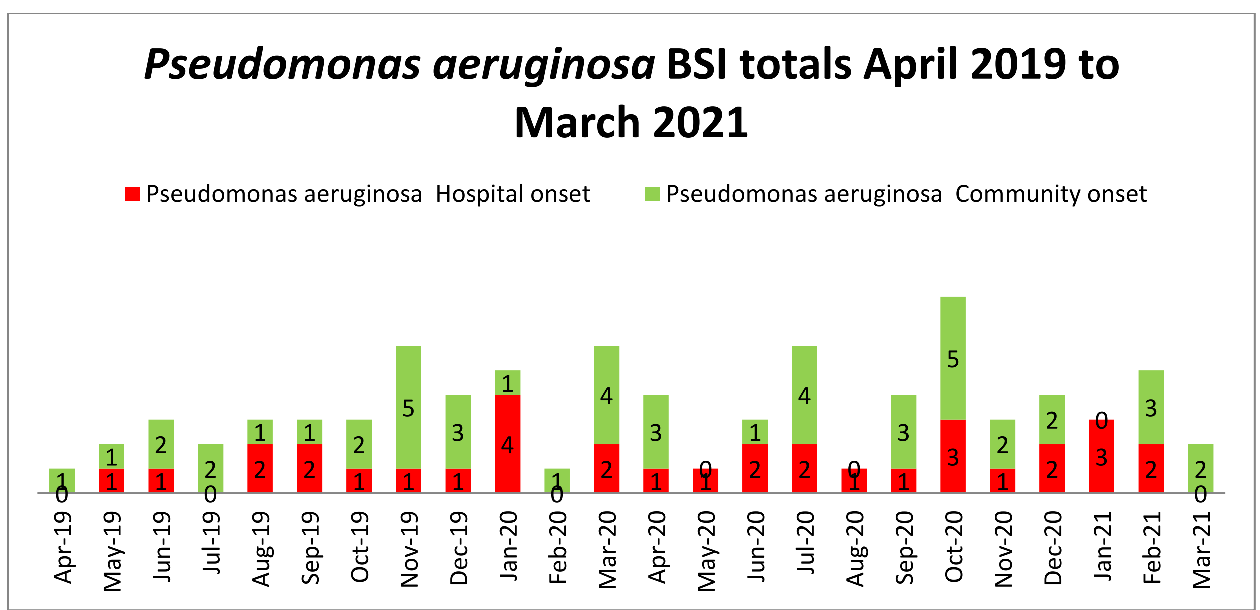


Chart 8: *Pseudomonas aeruginosa* BSI totals

6.6 *Klebsiella* species Bacteraemia

There was a 31% reduction of hospital-onset *Klebsiella spp.* BSI with 29 in 2019/20 and 20 in 2020/21.

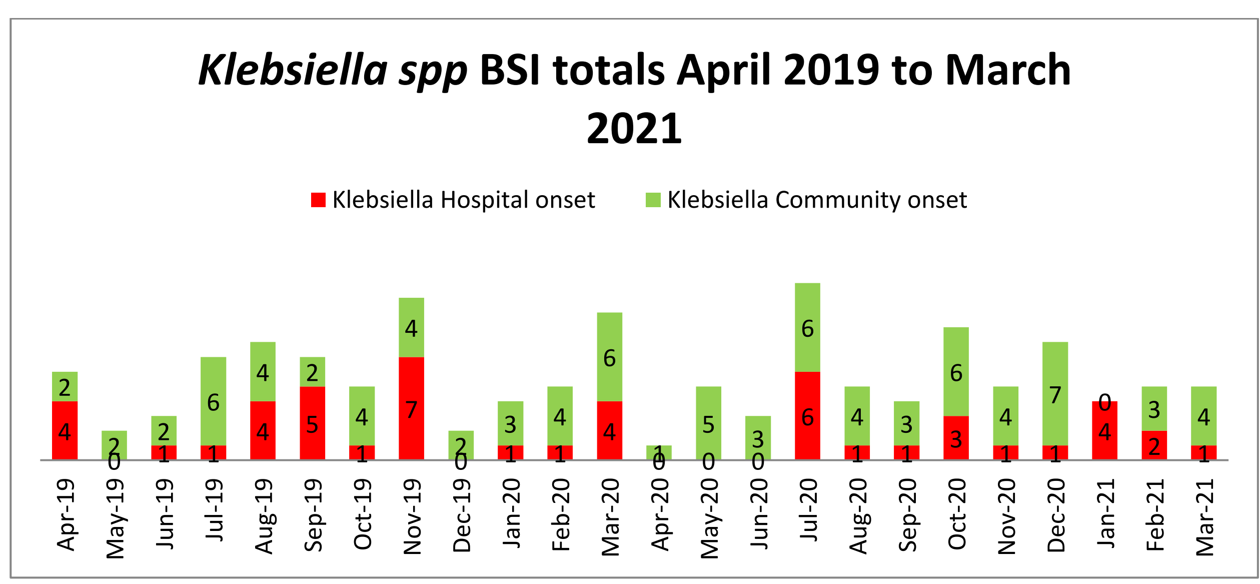


Chart 8: *Klebsiella spp* BSI totals

Although post infection reviews were not undertaken on all cases, all in-patients with BSI had reviews conducted by the Microbiology/ Infectious Diseases teams to identify the likely source of infection and appropriate treatment .

7 Auditing and Teaching

7.1 Main IPC Audits – Hand hygiene, PPE use bed spacing and commodes

With the focus being on the Covid-19 pandemic, the IPCT supported with related audits. These included support for staff to ensure correct use of PPE and hand hygiene. There was also a bed spacing audit. In some areas the beds were not always two metres apart and removal of beds had to be risk assessed with the operational pressure on the Trust and the need to admit patients for acute care.

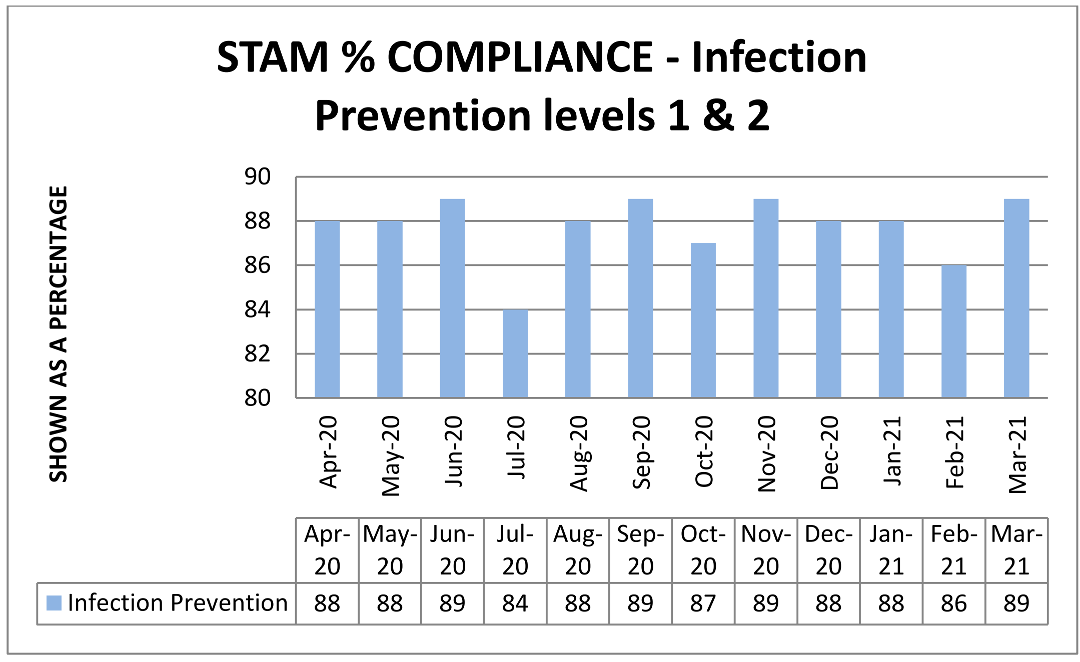
The IPCT undertook a Trust-wide audit of commodes in April 2020 and July 2020. Results were fed back at the time and any deficiencies addressed. We continue to reinforce the importance of commode cleanliness, and have promoted sporicidal disinfection wipes for commodes.

During this period the monitoring team continued to audit against the national cleanliness standards. Issues were rectified in-line with the standards and a follow up audit conducted

'Perfect ward' was also introduced across the trust. This app based audit tool allows 'real time' reporting on a digital platform that can be easily accessed and shared.

7.2 Teaching

All face to face teaching sessions were suspended in-line with national Covid-19 guidance and IPC teaching/ education was hosted on the Trust IRIS platform and Trust Intranet. Staff could undertake IPC mandatory training via The National e-learning module. Videos demonstrating donning and doffing of personal protective equipment were also available on the Trust intranet. Figure 2 (below) shows monthly compliance with IPC training and Figure 3 (below) the compliance at end of fiscal year (March 2021) with 84% (clinical) and 95% (non-clinical) staff.



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Infection Prevention	88	88	89	84	88	89	87	89	88	88	86	89

Figure 2. IPC statutory and mandatory performance April 2020 – March 2021

	Level 2 (Clinical)	Level 1 (non-clinical)
Total numbers to train	5848	2981
Number in date on 31st March 2021	4889	2836
Number out of date on 31st March 2021	959	145
Compliance by subject	**84%**	**95%**

Figure 3. Numbers and percentage of staff in date with IPC mandatory training. March 2021

8 Surgical Site Surveillance

During this period the Trust attempted to undertake the mandatory requirement to undertake one period of surveillance in an orthopaedic module. This was conducted in quarter one (April 2020 – June 2020) with a focus on Total Knee replacements. Unfortunately there were only 4 patients operated on at this time as operating was curtailed by the pandemic. There were no infections noted.

There is no dedicated SSI team at BSUH and the work pressure on the IPCT due to the pandemic, did not allow a further period of surveillance. Going forward a plan to involve the surgical division in this process will be explored to give assurance that all processes are being followed correctly.

9 COVID-19

9.1 Background

Covid-19 has presented the biggest health challenge across the globe in living memory and the single most disruptive pandemic infection since the 1918 Spanish Flu. With well over 260 million cases and 5 million deaths worldwide, economic disruption and normal life curtailed for much of 2020/21. It has posed a logistical challenge to keep patients and staff safe whilst maintaining essential care for patients.

Covid-19 first emerged on 31st December 2019 in Wuhan a province of China. During February 2021, the Trust was the first in the country to identify a patient with this new novel disease later referred to as Covid-19.

The routes of transmission for Covid-19 are through the eyes, nose, and mouth. This can be due to breathing in contaminated air, especially if near someone who is symptomatic with a cough expelling droplets, as well as through self-inoculation of the eyes, nose, or mouth because of contaminated hands. There is no evidence of Covid-19 being transmitted via blood, wounds, or surgery.

Covid -19 is the disease caused by a human coronavirus called SARS CoV2. It was named because of its similarity to the SARS virus seen in 2003, but unfortunately this virus is far more transmissible among humans. Early efforts to control the virus centred on travel to affected areas, however this was not effective, and numbers began to rise in the UK in March 2020, peaking in April 2020, and tailing down in early summer. During this time, the UK was put into national lockdown with restrictions on activity including essential travel only, closure of shops restaurants and pubs. In early summer, the country came out of lockdown and started to learn to live with various restrictions to minimise risk of picking up the virus which was still circulating. Introduction of face coverings was made mandatory in all health care premises and on public transport from 15th June 2020.

In the early Autumn of 2020, the number of cases started to rise again, and a 'mini lockdown' was established in November 2020, however schools remained open and there was not a strict 'stay at home' order. Cases continued to rise as Christmas approached and restrictions were re-imposed on the 19th December with a full lock down from the 6th January 2021. This lockdown continued through to June, with a planned gradual easing of restrictions starting with schools re-opening in March, shops in April and bars and restaurants in May. The gradual programme for easing restrictions was in response to concerns from advisors at Public Health England (PHE) regarding the need to monitor the number of cases at each phase. At the end of the first lockdown, services had resumed within a matter of a few weeks, and it was seen that numbers, though lower, had not reduced adequately. This led to the decision to put approximately five weeks between the various stages of opening up after the second full lockdown. Numbers had come down significantly in the UK by end of March 2021, however it should be noted that there are increases in other countries, including many of our European neighbours and a significant outbreak in India. The opening up of services has been further complicated by the emergence of several 'variants of concern' including the UK, Alpha (originating in Kent) variant and the Delta (originating in India) variant. This has led to a delay in the Government roadmap for reopening of all services.

Nationally and internationally, efforts to control the pandemic have focussed on several areas which have been introduced at different points in time as we developed a better understanding of the disease. Guidance in the UK has come centrally from the government advised largely by PHE and NHS England (NHSE) including sub committees Scientific Advisory Group for Emergencies (SAGE) and New and Emerging Respiratory Virus Task Group (NERVTAG).

Initiatives during the pandemic have included:

- Social distancing to create a physical barrier to stop disease transmission.
- Isolation of affected people and their contacts
- Appropriate use of personal protective equipment (PPE)
- Cleaning and improved hygiene to reduce contaminated surfaces.
- Hand hygiene to reduce the risk of transferring virus from contaminated surfaces to one's face.
- Use of face coverings to reduce transmission when in company of others.
- Segregated patient pathways for those at high, medium, and low risk of infection
- Improved ventilation and fresh air as the virus transmits less readily outdoors.
- Vaccination of the population
- Identification of variants of concern and isolation of carriers.
- Travel restrictions

9.2 Minimising the risk of spread of Covid-19 within BSUH

Minimising the risk of spread of Covid-19 to patients and staff remained a central focus during the pandemic. In order to identify patients being admitted into hospital with pre-existing Covid-19 infection, all patients admitted for any reason were immediately tested for Covid-19.

Strict designated patient pathways were put in place. Routes through the hospital - corridors, lifts and access points, as well as wards and departments were divided into 'red' and 'green' to enable 'cohorting' (grouping patients together in areas):

Red areas were designated for patients with Covid-19 infection confirmed by PCR swab testing, or suspected infection (seen on abnormal chest x-ray or scan results).

Green areas were designated for patients with no Covid-19 symptoms, and a negative Polymerase chain reaction (PCR) test result.

By cohorting patients in this way, the spread of the infection was minimised.

9.3 Determining nosocomial infection

In any patients in which the result was negative, the patients were re-screened by PCR testing at repeated intervals throughout their stay.

Positive PCR results were categorised in order to enable identification of hospital acquired infection:

Community-Onset – First positive specimen date less than 2 days after admission to the Trust

Hospital-Onset Indeterminate Healthcare-Associated – First positive specimen date 3-7 days after admission to the Trust

Hospital-Onset Probable Healthcare-Associated - First positive specimen date 8-14 days after admission to the Trust

Hospital-Onset Definite Healthcare-Associated – First positive specimen date 15 or more days after admission to the Trust

9.4 Outbreak definitions and guidance (Wave Two)

Public Health England (PHE) applied the following definitions when referring to outbreaks:

'2 or more test-confirmed or clinically suspected cases of COVID-19 among individuals (for example patients, health care workers, other hospital staff and regular visitors, for example volunteers and chaplains) associated with a specific setting (for example bay, ward or shared space), where at least 1 case (if a patient) has been identified as having illness onset after 8 days of admission to hospital.'

Where new outbreaks were considered to have occurred, the following processes were put in place, in order to mitigate the potential risk of spread of infection:

- Existing patients in bay remain in situ
- Bay closed to admissions
- Exposed patients were screened every day for 14 days while in hospital
- Observe remaining patients for symptoms
- Swab/isolate if new onset of respiratory symptoms
- If suspected patient is negative, and COVID-19 not clinically suspected – open bay and affected patient can remain on ward area
- If suspected patient is COVID-19 positive, isolate bay contacts for 14 days from last contact

Up to date guidance on managing outbreaks was available via the online portal 'Microguide' on the Trust intranet, where all Trust staff can access the most recent and relevant clinical information.

9.5 Transmission of Covid-19 infection

Wave one

According to the evidence available at the time of Wave one, the COVID-19 virus was primarily considered to be spread by droplet transmission and contact routes (things that had been touched). Guidance on prevention measures focussed on wearing masks, keeping a two metre distance, and reducing indoor occupancy to reduce transmission.

Wave two

A significant difference was emerging at the time of Wave Two, with the increasing evidence that Covid-19 could be spread from one person to another by (much finer) airborne particles (aerosols). Airborne spread became increasingly recognised as being a significant factor, and awareness was growing to the risks this posed for transmission. The importance of ventilation was beginning to become apparent.

9.6 Outbreaks

Systems and processes – BSUH outbreak management

When the infection prevention and control (IPC) team were alerted to a potential cluster/ outbreak of Covid-19 infection (through surveillance, and being alerted by clinical staff), a standardised process was followed in order to make a plan of action to minimise further spread and patient harm.

A proforma (checklist – see appendix 4) was completed for each outbreak to document the actions, and to ensure:

- The outbreak was confirmed by IPC specialists in accordance with latest PHE guidance
- Patient management was in place without delay
- Decisions to close wards was made along with a full risk assessment
- The appropriate bodies were notified (internally and externally)
- Contact tracing was in place for patients and staff
- IPC precautions and environment checks were in place in the ward areas affected (e.g. hand hygiene/increasing housekeeping measures/PPE available and in use etc.)
- Assurance of adherence to prevention measures (audits of compliance)

Following this, for each outbreak, a multidisciplinary (MDT) Outbreak Control Meeting was promptly convened and held weekly, to which the following personnel were in attendance:

Ward outbreaks – BSUH

Twelve outbreaks were retrospectively identified in wave one and forty in wave two.

Within BSUH all these measures were employed as advised by PHE and NHSE, supported by appropriate internal communication strategies, Infection Prevention and Control Team (IPCT), Ways of Working Team, Human Resources (HR), Occupational Health (OH), Pathology, and the Clinical Advisory Group. Work included advising, training and supporting the Trust with implementing guidance as it came out from Public

Health England, NHS improvement and NHS England; supporting training in use of PPE, undertaking of screening and fit testing as well as providing reassurance to staff.

For each outbreak, a Post Infection Review (PIR), Root Cause Analysis (RCA) process was put in place. (PIRs and RCAs are conducted in order to identify potential contributory factors for infections outbreaks, for there to be rapid learning, so that mitigations can be put in place as soon as possible).

Meetings were convened with key attendees and a PIR proforma tool was completed, to direct and document the reviews and resulting actions.

It should be noted that there was no nationally recommended standardised tool/proforma. This was escalated to the wider system and NHS England and Improvement via the Head of Infection Prevention & Control South East Region, and the IPC team developed a PIR proforma local to BSUH.

It was recognised that with no standardised PIR tool, there was a potential for variation in the quality and accuracy of a locally developed proforma, and the Trust sought advice and guidance from a Nurse Consultant familiar with IPC and research methodology when developing their PIR proforma.

9.7 Learning from the outbreaks

Following the PIR RCAs, it was not usually possible to confirm the direct cause of transmission from the 'index case' (the first person identified in a chain of infection).

Inadequate ventilation was considered to be the most significant factor in the spread of nosocomial Covid-19 infection throughout Wave two.

Though not considered to be directly causal, in the 38 outbreaks that were reviewed, there were some areas of learning which were identified in the areas where outbreaks occurred:

- It was noted that high levels of staff training and good hand hygiene & PPE compliance were identified in all areas with outbreaks.
- There were reduced staff numbers due to sickness and vacancies, and this was considered to have an impact on asymptomatic screening. PCR testing of patients and checking results was not always undertaken in a timely manner, which meant delayed identification of, and action taken, following positive results.
- Following confirmation of outbreaks, increased, targeted staff screening identified staff that were asymptomatic and had a positive PCR result. (Staff screening with twice weekly lateral flow testing was also in place).
- Multiple patient specialities were being cared for on some wards. This meant increased numbers of staff from different medical teams entering the ward.
- Limited facilities on some wards meant that a higher number of patients were sharing toilet facilities and showers than recommended.
- Wards with high numbers of patients with low cognition (e.g. delirium, dementia, brain injury) found that the patients often moved around areas and approached staff, not always understand social distancing, which meant that patient contact was not always be able to be minimised. Due to the safety of the patients it was not possible to draw the curtains between patients and they were unable to consistently comply with infection prevention measures.

- Wearing face masks was encouraged for patients, and in particular when moving away from their own bed space. Not all patients could tolerate or comply with mask wearing.
- Reduced access to staff rooms. Dayrooms were sometimes used for staff breaks while patients were also present (social distancing was maintained, but mask wearing not possible while eating and drinking).

9.8 Specific findings in areas of high outbreak

There were some areas where a 'deep-dive' found more specific learning. Towards the end of Wave two, the Trust identified from outbreak data, that the following three areas within the Trust were being disproportionately affected:

- 22 of the 38 outbreaks occurred at PRH. This was of particular concern as PRH is the smaller of the two main Trust hospitals, with 14 inpatient areas compared to 33 at RSCH.
- 6 outbreaks were on Twineham ward (PRH) – the outbreaks were recorded in November (x1), December (x1), February (x2) and March (x2).
- 11 outbreaks occurred in seven of the nine wards in the Barry Building (RSCH)

Twineham Ward - PRH

Following confirmation of the 5th outbreak on Twineham ward, the Chief Nurse (and DIPC), requested full closure of the ward for an extended length of time, in order to try and identify the causes for the higher number of outbreaks in that area, and to attempt to break the cycle of infection.

Twineham ward is a large ward with 39 beds comprising of six bays, with five or six beds in each, and four single side rooms. The patient bays are all along one side of a long corridor, and all outside/window facing. On the other side of the corridor (with no external windows), are the single rooms, and other facilities such as the ward physio gym, clean and dirty utility rooms, storage and kitchen.

The specific findings were:

- The ward did not have a Manager at the time and this meant that there was no consistent leadership, though the Matron was present on the ward on a daily basis to support the team.
- Large numbers of staff due to the size of the ward. During the day there are approximately 24 staff members from the nursing, therapy, medical and housekeeping teams around the ward. Many of the team members were required to visit other wards and this may have contributed to the spread of infection.
- There were reduced staff numbers due to sickness and vacancies which meant that staff were redeployed from other areas and hospitals (from Brighton to PRH) to work in the ward, and a higher than usual reliance on bank and agency nurses. These staff were less familiar with the ward practices, and this may have led to reduced compliance with expected infection control standards.
- The ward was repurposed due to bed pressures. Prior to November 2020, Twineham ward specialised in the care of orthopaedic patients. From November 2020 to March 2021, it became exclusively an acute medical ward to accommodate the high numbers of patients requiring hospitalisation due to either Covid-19 infection, or other acute medical condition.
- Limited natural ventilation (windows and doors):

- The outbreak was in the peak of winter (December/January). Although ventilation within the ward was encouraged, patients would often ask for the windows to be closed due to feeling the cold.
- Mandatory window restrictors in place prevent hospital windows from being opened more than a very small gap
- Doors to each bay and room were kept closed in line with recommendation

The PHE guidance document on ventilation referenced the barriers to natural ventilation: *'any actions to improve ventilation should not compromise other aspects of safety and security (for example, avoid propping open fire doors), and should consider other consequences such as health and wellbeing impacts from thermal discomfort'.*

Barry building wards - RSCH

The Barry Building houses some of the oldest wards of the Trust estates, and seven of the nine wards experienced 11 outbreaks in Wave two. The Barry Building will be due for demolition on completion of the 3T's project building.

Along with the other common themes, the following was found from the PIR RCAs:

- The geography of two of the wards meant that patients from one ward had to pass through another ward to get to the patient lifts if they needed to be transferred for any reason (e.g. to attend the x-ray department).
- Maintaining social distancing in the office was challenging due to multi professional groups being required to work on the ward reviewing patients.
- It was not always possible to maintain a distance of two metres or more between bed spaces due to the need for bed capacity and the ward space available.
- Limited hand washing facilities on the ward, with basins in the middle of the bay. This meant that PPE 'doffing' (taking off) occurred in the middle of the bay (hand gel was available on all beds and in areas of congregation).
- In one case, the patient identified as the index case was leaving the ward regularly and mixing with patients/staff and the general public, and could not be encouraged to comply with the requirement to remain isolated.
- It was difficult to transfer patients with altered cognition (acute dementia) to a single room once they had been identified with a positive test result, as they required 1:1 observation and specialist dementia care.
- When a number of patients with dementia tested positive, for their safety, it was agreed to cohort the patients in one end of the ward in an area that was segregated using a screen.
- The cohorted patients also used a separate toilet/shower facility, and signage at the entrance to the area explained that it was a high risk area and appropriate PPE was provided at the entrance should staff need to go in to the area.

9.9 Engineered ventilation

The extended closure of Twineham ward provided an opportunity to examine the wards mechanical ventilation, as this could not be conducted in the vents above the beds while patients were present.

Results showed that there was no air movement at all in the vents on Twineham ward and the Barry Building. Unknown previously, it was discovered that the ventilation system on Twineham ward is designed to be dependent on open doors and windows for it to function. This meant that the guidance for closed doors between the vents and the open windows could have inadvertently caused the mechanical ventilation to malfunction, and the only ventilation available was from the windows within the individual bays.

The PHE guidance on airborne transmission noted that '*in poorly ventilated rooms the amount of virus in the air can build up, increasing the risk of spreading COVID-19, especially if there are lots of infected people in the room. The virus can also remain in the air after an infected person has left',* and that *'open windows can only dilute air within two metres within a building unless there is a through draught.'*

There is currently no definition for a 'poorly ventilated' room, or what constitutes adequate ventilation to prevent airborne transmission of Covid-19.

The PHE ventilation guidance acknowledges that 'for some existing and older buildings, ventilation systems may not have been designed to meet current standards and additional mitigations may be needed'.

This review considers that airborne transmission (from an index patient to other patients in the bay, and then to other patients in the ward), is likely to have been a contributory factor for the Twineham Ward outbreak.

The investigation was told that the cost of retro-fitting Twineham ward ventilation system is likely to be prohibitive. The Facilities and Estates department have completed an investigation into the ventilation system on Twineham ward and are currently appraising options.

The Barry Building is due for demolition as part of the Trust '3Ts' development and the replacement building will be fitted with modern ventilation systems.

At the time of this investigation report(June 2021), PHE published revised infection prevention and control guidance which advised that organisations undertake risk assessments in-line with the 'hierarchy of controls'(the most and least effective methods of prevention of infection Figure 4), to mitigate potential transmission of Covid-19. As a result of these assessments, staff have been advised that they can now wear FFP3 respirators in 'red' areas. This has been implemented in the RSCH Barry building and PRH Twineham ward.

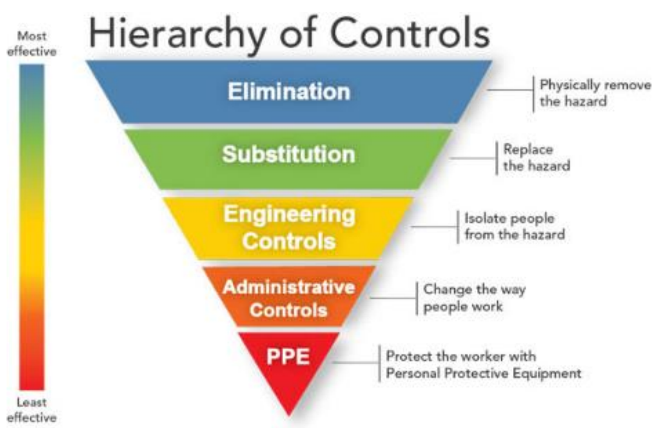


Figure 4: Hierarchy of controls

9.10 Learning from deaths from COVID-19 (Nosocomial)

Guidance was introduced in June 2020 to help Trusts identify whether the deaths of patients who died with Covid-19 were due to nosocomial infection. The following definition was applied:

'*A probable or definite hospital-onset healthcare associated COVID-19 infection is a patient safety incident and should be reported and responded to according to the trust's existing policies.* A probable or definite hospital-onset healthcare associated COVID-19 infection death is defined as; *the death of a patient who has a positive specimen result where the swab was taken within 28 days of death and/or COVID-19 is cited on either Part 1 or Part 2 of the death certificate (i.e. the death resulted from a COVID-19 clinically compatible illness with no period of complete recovery between the illness and death)*; *and the COVID-19 infection linked to the death meets the definition of 'probable' or 'definite' hospital-onset healthcare associated infection (see above)*'.

It was confirmed that 96 patients died with a hospital onset healthcare associated COVID-19 at BSUH.

In any patient for whom COVID-19 was recorded as a cause of death on part 1 of the death certificate, a mortality review was conducted. This was conducted by senior clinicians who reviewed the care pathways that the patients followed, including the medical and nursing care that they received.

If nosocomial infection was confirmed using PHE guidance/criteria, and the cause of death was recorded as COVID-19 on part 1 of the death certificate, the duty of candour process was followed. Families were contacted and offered support by senior clinical staff under the direction of the CNO and Director of Patient Safety. Following initial contact, they were sent a Duty of Candour letter.

All families are offered a copy of the final report, and an opportunity to discuss their loved ones individual care with a face to face meeting (socially distanced). The Trust acknowledges how challenging this may be during such an immensely difficult and sad time.

9.11 Quality Improvement (QI)

During both wave one and wave two of the pandemic; a number of QI initiatives to support the IPC pandemic work plan have been implemented.

IPC Team Support and assurance

The IPC team, microbiology team and the materials management team (distributing stocks of PPE) implemented a support service to clinical staff. The IPC team provided ward visits to support staff directly, and supported the clinical operational meetings (Bronze and Silver command), and the Clinical Advisory group.

Specialist nursing staff were redeployed from the Practice Development team to provide secondary support to the IPC team with FFP3 respirator FIT testing, PPE advice and management,

Throughout the pandemic the Trust has actioned, implemented and monitored all Public Health Guidance and whilst the challenge of this changing (sometimes daily) this was always adhered to and communicated out via the staff intranet, global communications, staff briefings and via huddles.

BSUH invited external reviews from specialist IPC nurses from Sussex Commissioners (Clinical Commissioning Groups) and NHS Improvement/ NHS England. The external reviewers submitted their written feedback to the Trust (which was good overall in relation to IPC measures), and their recommendations and suggestions were included into an action/improvement plan. These actions fed into the Board Assurance Framework (BAF).

9.12 Decontamination and cleaning

A continued and sustained focus on the decontamination and cleaning regimes of the clinical areas continued throughout the Wave two in line with Trust and PHE guidance, with increased frequency of 'infectious deep cleans' carried out.

9.13 NHSE Infection Prevention and Control Board assurance Framework (IPC BAF)

The IPC BAF (published May 2020) is a framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting.

NHSE have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection, which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others and to co-operate with employers to ensure compliance with health and safety requirements. Each of the 10 criteria (key lines of enquiry) has a subset of headings requiring evidence and assurance.

10 Water Safety Group

Despite the challenges faced by the Trust during its response to the COVID-19 emergency, the multi-disciplinary Water Safety Management Group (WSMG) continued to meet remotely, although at a reduced frequency. With the help of Omnia-Klenz, one of the Trust's water safety contractors, significant progress has been made in the development and roll-out of more comprehensive water temperature monitoring arrangements, deploying remote temperature sensors at strategic parts of the water systems across the RSCH and PRH estates. This has provided greater assurances of water safety and also helped to identify circulatory issues which can now be addressed. Microbiological sampling of the water systems has also been adjusted to provide a more risk-based approach, targeting areas of greatest concern, i.e., focusing on high-risk patient areas and higher-risk outlets, such as patient showers.

In March 2021, and in response to the isolation of a multi-drug resistant Pseudomonas aeruginosa from a patient catheter specimen of urine in Royal Sussex County Hospital L5 ITU, extensive environmental

monitoring was undertaken and the bacterium was traced to a sluice hopper in the dirty utility room. Infection Prevention and Control convened a sub-group of the WSMG to explore potential routes of contamination and to devise a programme of remedial actions to address the issue. This included replacement of the sluice hopper and the development of revised cleaning procedures in the dirty utility room. The situation was logged on DATIX and Trust risk register, and monitored via a documented risk assessment report prepared and updated by IPC and the Trust's Risk Management Department.

11 Specialist Ventilation Group

The specialist ventilation group met frequently throughout 2020/21. It is a multi-disciplinary, productive group which monitor, measure and action air quality within the Trust. A theatre shut down plan, for the Brighton and Princess Royal Hospitals has ensured all theatre suites have been validated and returned to use with minimal disruption to hospital service. The Authorising Engineer (ventilation) for these sites is Paul Jameson of IOM.

Estates serviced and re validated 29 operating theatres, four endoscopy suites and three cardiac catheter laboratories during this time

During this time, and in relation to the pandemic, ventilation assessments were undertaken and specialist

12 Antimicrobial Stewardship

12.1 Antibiotic consumption

Standard contract target for 2020/21 is a 2% reduction in use from the 2018 baseline (DDD per 1000 admissions). For 2020/21 UHSussex East had a reduction of 3.6%. The usage was significantly impacted by the 1st and 2nd COVID-19 wave. The usage was highest in March and April 2020 with a significant reduction from May to November. There was a second peak in December to January reflecting the second COVID-19 wave. This data does not reflect business as usual due to the pandemic and the impact this has had on acute admissions and elective work.

12.2 AWaRe (Access, Watch, Reserve) category use

The target is greater than 55% to be from the Access category. At UHSussex East we have not met this target. Our reserve antibiotic use increased in 2020/21, this is likely due to COVID-19. The UK 5-year National Action Plan published in 2019 set a target of 10% reduction in the use of drugs in the Reserve and Watch categories.

2020-21 financial year by quarter	Access	Watch	Reserve
April - June 2020	52.3%	44.2%	3.5%
July – September 2020	48.1%	48.7%	3.2%
October - December 2020	49.2%	47.2%	3.7%
January - March 2021	51.7%	45.1%	3.1%

By financial year	Access	Watch	Reserve
2020/21	50.2%	46.4%	3.3%
2019/20	54%	44%	2%
2018/19	52%	46%	2%

12.3 Carbapenem prescribing

For 2021/21 there was a significant increase in carbapenem usage at 153 DDD per 1000 admissions increased from 102 DDD per 1000 admissions in 2019/20 and 111 DDD per 1000 admissions in 2018/19. The most significant increase was in December and January, coinciding with the second COVID-19 wave.

12.4 Vaccination update COVID-19 and Influenza

For 2020/21 the flu vaccine uptake in staff was 80%, this is above the 70% target.

On the 7th December UHSussex East commenced the COVID-19 vaccine programme at the Royal Sussex County Hospital site. This was the first day that the vaccine was available in England. As an Annex 1 site UHSussex East, was required to vaccine their own workforce and support neighbouring trusts. From the 7th of December there was vaccine hubs for both staff and patients. In March UHSussex East was commissioned to provide the regional Sussex Vaccine Allergy Service.

The uptake of the COVID-19 vaccine is approximately 92% in staff.

12.5 ASG meeting

From October 2020 to the end of February 2021 and Lead Pharmacist Clinical Infection and AMS post was vacant. For this reason and the COVID-19 pandemic there was only three ASG meetings in June, July and September.

An IV to Oral antibiotic switch poster was approved and displayed in treatment rooms across UHSussex East to encourage doctors to review and switch to oral antibiotics.

12.6 Guidelines

The following guidelines where updated in line with new NICE guidance; community acquired pneumonia, hospital acquired pneumonia, cellulitis and leg ulcer. The acute exacerbation bronchiectasis guidance was updated in line with NICE and BTS Guidance.

Guidance for COVID-19 was produced for steroids, remdesivir and IL-6 inhibitors.

13 Outbreaks/Incidents (Excluding Covid-19)

13.1 Norovirus/ D&V

During this time, the Trust did not have any outbreaks of diarrhea and vomiting that resulted in ward closure. The Trust did not have any outbreaks of Norovirus.

13.2 Influenza and other respiratory viruses (not Covid-19)

The Trust had no outbreaks of influenza or respiratory syncytial virus (RSV) during this period. There were no cases of influenza. It has been theorised that IPC measures and influenza vaccination may have prevented this. There is also the possibility of viral displacement theory with many people being exposed to/ infected with Covid-19 that displaced other respiratory pathogens.

13.3 Multi-drug resistant (MDR)/ Carbapenemase-producing non-Enterobacterales Gram negative rods: (CPE) Pseudomonas aeruginosa producing VIM carbapenemase

In February a patient was found to be colonised with a MDR CPE *P. aeruginosa,* that was also found in the dirty utility 'sluice hopper' The Trust has previous experience with this organism and it has been well published that these organisms can reside in drains including sluice hoppers and macerators. The patient came to no harm and no other patients were found to be carrying the organism and extensive screening was undertaken. As a precaution the sluice hopper was changed and a robust cleaning schedule put in place along with reinforcement of Infection Prevention and Control practices.

14 Capital Projects and 3Ts

The infection prevention and control team undertook routine visits to the 3Ts stage one construction site to review completed rooms. It is anticipated that commissioning will start from November 2022 and the IPCT will significantly input into this handover/ sign-off process.

The team were also consulted about capital projects including refurbishments and new builds.

15 Conclusion

2020-21 was an exceptionally busy time for the whole BSUH Trust. The IPCT, supported by the Head of Nursing for Medicine, played an instrumental part in supporting safe patient care through the most challenging period ever in the National Health Service's history.

The importance of an adequately supported, educated and resourced IPCT has been demonstrated to be vital to the smooth operational running of the organisation and the maintenance of patient safety and experience.

The merger with Western Sussex NHS Foundation Trust will strengthen the resources going forward and will play a significant part in continued improvements for patient care as we emerge from the pandemic.

16 Future priorities

Further investment in IPC nursing resource is required, to allow adequate IPC Nursing cover for Royal Sussex County and Princess Royal hospitals.

Improvements in ventilation are required on both sites. Barry building needs short term remedial as due for demolition in 2023. The wards at Princess Royal require a substantial retrofitting of appropriate ventilation which should be prioritised with the Estates Team according to clinical risk.

Explore provision of a data analyst to help with analysis of data and identification of future strategic direction. This will reduce the amount of nursing time spent processing data, reduce duplication of effort and allow more effective use of IPC nursing time to make improvements to patient care.

Invest in an infection prevention IT programme to allow more efficient handling of results, recording of information and communication to clinical teams.

Explore an implement a programme for SSI surveillance that will allow participation from the surgical teams. This will allow SSI work to be directed to identified need and allow improvement to be embedded within the division.

Continue to work with the estates and facilities team to introduce the new National Standards of Cleanliness across the organisation.

Develop the relationships with the IPC Nursing team at Western Sussex as the newly formed Trust develops to allow an aligned and consistent cross site approach to Infection prevention and control.

Western Sussex Hospitals

NHS Foundation Trust

- Annual Report -
Infection Prevention & Control
2020-2021

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Infection Prevention and Control Annual report 2020/2021

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1 Executive Summary

1.1.1 This is the report of the Western Sussex Hospitals NHS Foundation Trust Infection Prevention and Control Team for 1 April 2020-31st March 2021. This is the last such report as WSHFT Trust has merged with Brighton and Sussex University NHS Foundation Trust from 1st April 2021 to become University Hospitals Sussex.

1.1.2 It should be noted that there was an international pandemic (COVID-19) during this period that required a change in IPC focus for the Trust. There were no set trajectories for alert organisms. The Trust was also operating an incident governance structure with bronze, silver and gold meetings that could review new COVID-19 guidance and make decisions in a more timely fashion

1.1.3 There were 40 cases of hospital-onset or hospital-associated *Clostridioides difficile* in WSHFT against a maximum objective of 64. Of these 15 were deemed to have lapses in care by the executive-led RCA panel. The main issues were the environment, sampling and hand hygiene.

1.1.4 *C. difficile* Trust action plan was formulated following a multi-disciplinary workshop in April 2018 but wasn't actively used during this year due to pandemic pressures.

1.1.5 There were 0 cases of post-48 hours MRSA bacteraemia.

1.1.6 There were 26 cases of post-48 hours MSSA bacteraemia.

1.1.7 Contaminated blood cultures are continuing to be monitored as we are seeing high rates, in particular from the Emergency Departments.

1.1.8 Carbapenemase-producing Enterobacteriaceae (CPE) are not increasing dramatically in this area but there is a sustained increase in other Gram-negative bacteraemias.

1.1.9 Pressures from the pandemic meant that it was not possible to undertake environmental audits in all clinical wards and departments, however 95 of 127 were completed with feedback to the relevant areas.

1.1.10 Despite the pressures of the pandemic, the Trust was able to access personal protective equipment (PPE) for its staff throughout. Government guidance was followed and incorporated into standard operating procedures and policies through a multi-disciplinary 'Clinical Advisory Group' (CAG).

1.1.11 Despite COVID-19 pandemic constraints, the Water Safety Group continued to be active with frequent meetings discussing testing and maintenance of water. The Infection Prevention Team has attended as many water safety group meetings as possible throughout the year but recognise the pandemic work has taken priority. There are a number of outlets being managed for Legionella and/or *Pseudomonas aeruginosa.* These outlets, that have tested positive, have had a point-of-use water filter applied and estates remedial action planned to identify and rectify the root cause.

1.1.12 Antimicrobial Stewardship is monitored by the antimicrobial pharmacists and consultant microbiologists. We achieved 3 of the 4 CQUINS despite the targets being very difficult due to our previously tight control making it more difficult to decrease use further.

2 Introduction

2.1.1 The purpose of this report is to reassure the patients, public, staff, the Trust Board of Directors, Governors and Coastal West Sussex Clinical Commissioning Group (CCG) that the system of Health Care Associated Infection (HCAI) management meets its obligations with regard to patient safety and clinical governance. It is also to reassure that best practice is followed as identified in the Hygiene Code and Care Quality Commission underpinning national and local guidance and provide assurance that the Trust remains compliant with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (Department of Health, 2015).

2.1.2 Investment in infection prevention and control remains both necessary and cost effective.

2.1.3 This report aims to capture this extraordinary year highlighting the challenges for the Trust and IPCT during a pandemic; the scale of which the NHS has never seen before. The IPCT and microbiologists were pivotal in every area of the hospitals guiding and advising on all aspects of infection prevention, infection management and outbreak control.

2.1.4 It will not be possible to capture in it's entirely the enormity of what was achieved but it will be very clear that without the dedication and hard work of the teams it would have been less.

2.1.5 Managing the pandemic was clearly achieved alongside traditional IPC work but it will be divided into routine and COVID-19 work for the sake of this report.

2.2 IPCT

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

2.2.2 The WSHFT IPCT comprises:

- 1 WTE Band 8b (seconded to 8c due to pandemic pressures)
- 1.8 WTE Band 7
- 2.2 WTE Band 6
- 0.8 WTE Band 4 Secretarial support

Please see **Appendix 1** for further details on structure.

2.2.3 There is approximately 1PA of Infection Control Doctor (ICD) time. This is due to the inability to recruit to the vacant microbiology post. Previously (before 2015) there was 4PA of ICD time but this was reduced when the post-holder resigned and the post was withdrawn.

2.2.4 The IPCT covers 8.30am – 5pm daily with out-of-hours advice being given by the microbiology on-call service. IPCT have an on-call rota during the winter months (Jan – March) which was used during the Outbreaks. However in March 2020 this was continued due to the pandemic and therefore the 3 senior members of the team worked 1 in 3 weekends throughout the year.

2.2.5 The seven day service that was started in response to the COVID-19 pandemic in February 2020 was continued for the rest of the year.

2.3 Infection Prevention and Control Governance Structure

2.3.1 The Trust Infection Prevention Committee (TIPC) meets quarterly and is chaired by the DIPC. Two of the meetings were delayed due to the pandemic but all 4 meetings were held over the year.

2.3.2 TIPC reports to the Trust Board as per Figure 1.

2.3.3 TIPC terms of reference are to be found in **Appendix 2**. The main purpose of TIPC is to provide strategic direction to the Trust's management of infection prevention and control activity.

2.3.4 TIPC provides assurance that the system of Health Care Associated Infection (HCAI) management is via a detailed framework to ensure the Board meets its obligations with regard to patient safety and clinical governance. It is also to ensure that best practice is followed as identified in the Hygiene Code and Care Quality Commission underpinning national and local guidance.

2.3.5 At TIPC there is representation from each division (Medicine, Surgery, Women & Children, Corporate, Facilities & Estates, Consultant in Communicable Disease Control, Public Health England and Community partners).

2.3.6 The Infection Prevention Operational Group (IPOG) meets monthly and is chaired by the Lead IP&C Nurse/Deputy Director IPC.

2.3.7 IPOG reports to TIPC as per Figure 1 above.

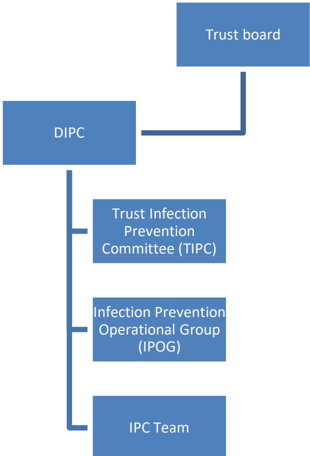
2.3.8 IPOG terms of reference are to be found on the intranet within Infection Prevention and Control Management Arrangements Policy Version 4.

2.3.9 The main purpose of IPOG is to provide a high level management forum to ensure senior managers keep abreast of pertinent issues relating to IP&C and participate in effecting necessary change throughout the organization in a timely manner.

2.3.10 In 2020/2021 only 2 IPOG meetings were cancelled due to operational pressures.

2.3.11 Information from both IPOG and TIPC meetings are fed back via divisional leads. In addition the IP&C team feedback relevant information every month to the Sister & Matron meetings/team huddles.

Figure 1 IPCT reporting lines



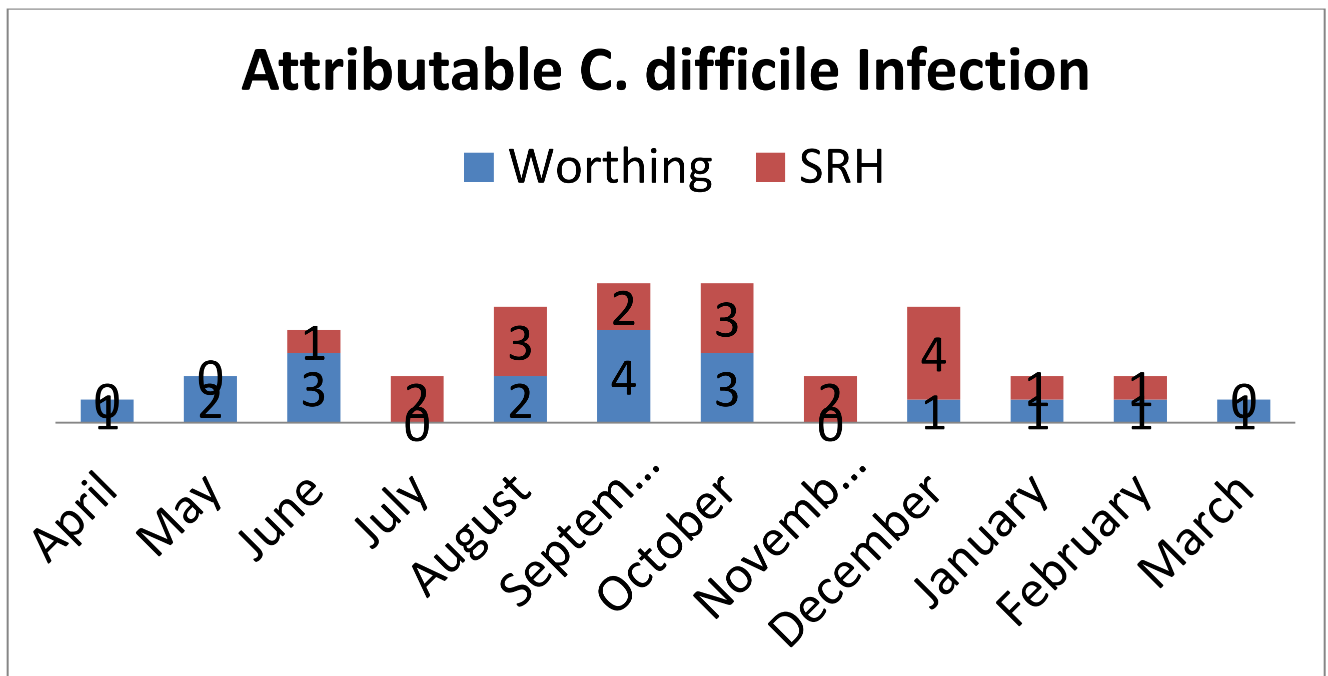
3 Summary of performance 2020/21

3.1 *Clostridioides difficile* Infection (CDI)

3.1.1 There were 40 cases of CDI against a maximum allowed of 64 with 35 cases in 2019/20 and 32 cases in 2018/19. All hospital-onset or hospital-associated cases undergo a rapid review and any with non-compliances are reviewed by an executive-led (or their representative) RCA panel to establish whether there was any potential lapse in care which could either have led to the case, or increase the risk of further cases (for example by delayed isolation of the patient).

3.1.2 We continued to use the CDI action plan from 2018/19.

3.1.3 There were 15 RCA's where a lapse in care was identified. Of these 11 were at Worthing Hospital and 4 at St Richard's hospital. The reasons for lapses were broadly similar and the difference between the two sites can be explained by the lack of side rooms and extreme pressure on beds, which was exacerbated by the pandemic. A common theme in lapses was an inadequate standard of clinical cleaning which was due to extremely poor staffing levels and the high nursing needs of the patients during the surges.



Graph 1 Attributable *C.difficile* infection by hospital site.

3.2 Methicillin-resistant *Staphylococcus aureus* (MRSA)

3.2.1 There was 1 pre-48 hours MRSA bacteraemia and no trust-acquired MRSA bacteraemias. Due to the low incidence within the locality a full PIR was not required.

3.2.2 Whilst 0 post-48 hour MSRA bacteraemias WSHFT continue to be proactive by continuing methods to reduce blood culture contamination rate, specifically within A&Es. In addition, proactive monitoring of appropriate adherence to MRSA decolonisation suppression therapy.

3.2.3 More than 56000 MRSA screens were completed over the year which equates to nearly 5000 screens a month.

3.3 Methicillin-susceptible *Staphylococcus aureus* (MSSA)

3.3.1 Due to the increased work load we were not able to review all Gram-negative bacteraemias and post-48 hour MSSA bacteraemias with an RCA. As agreed in the Annual programme for last year if there were >5 per month then they would be investigated.

3.3.2 There were 26 cases of post-48 hours MSSA bacteraemia, compared to 19 in 2019/20.

3.3.3 Of these 6 had Root Causes Analysis carried out. This is far lower than we would have hoped but due to staff shortages and pandemic pressures it was not possible to allocate more time for RCAs.

3.3.4 In January 2021 a cluster of MSSA infections and bacteraemias was noticed in Intensive Care in Worthing hospital. On further scrutiny it was noted that there were also a higher than expected number of sputa returned with MSSA. Of the eight patients identified, 6 samples were available for further testing (samples from non-sterile sites are not routinely stored). These were sent to the reference laboratory for typing. None of the six returned as matches. However, prior to this result IPCT thoroughly investigated the current procedures in ITUs on both sites and made multiple recommendations. With the result it was clear there was no cross-contamination but the opportunity was taken to look at other potential causes such as line care and tracheostomy care.

3.3.5 During this time period there were 78 non-Trust cases (pre-48 hours) an increase from 64 in 2019/20. The Trust IPCT no longer carries out RCAs on these cases.

3.3.6 The actions in the MRSA action plan are also relevant for MSSA bacteraemias in particular the decolonisation of patients and antimicrobial stewardship.

3.4 Contaminated blood cultures

3.4.1 There has been a high rate of contaminated blood cultures for many years. A new method of collating data has been instigated in the laboratory in January 2020. The results were compared with traditional methods of counting and although not identical were felt to be a good proxy.

3.4.2 The large spike in contamination seen in January 2021 is in part to do with the second wave of COVID-19 and associated PPE use. Significantly more samples were taken that month than usual. The particularly low level of contamination seen in December is more likely due to Locum staff in Microbiology not recording the cases than due to a real drop.

BC contaminants	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Total number of BC	1099	910	1055	1093	1188	1051	1119	1130	1177	1614	1211	1144	13791
Total positive	180	138	147	191	191	172	203	187	182	299	212	165	2267
Number of contaminants	49	49	44	63	66	58	56	50	62	151	63	62	773
Percentage of total	4.5	5.4	4.2	5.8	5.6	5.5	5	4.4	5.3	9.4	5.2	5.4	5.475
Percentage of positives	27.2	35.5	29.9	32.9	34.6	33.7	27.6	26.7	15.5	51	29.7	37.6	31.825

3.5 Gram-negative bacteraemias

3.5.1 There has been growing scrutiny over Gram-negative bacteraemias over the past few years. During the 17/18 year mandatory reporting of *Klebsiella spp.* and *Pseudomonas aeruginosa* came into effect, as well as the previously reported *E. coli* bacteraemia data.

3.5.2 The government launched an initiative in April 2017, to reduce Gram-negative infections by 50% by 2021.

3.5.3 In 18/19 the total count of *E. coli* bacteraemias was 343 representing a reduction of 13.8% since 17/18 and 17.9% since the initiative begun. This is a significant achievement especially when results are compared with neighbouring Trusts. However this trend was reversed in 19/20 with 420 cases.

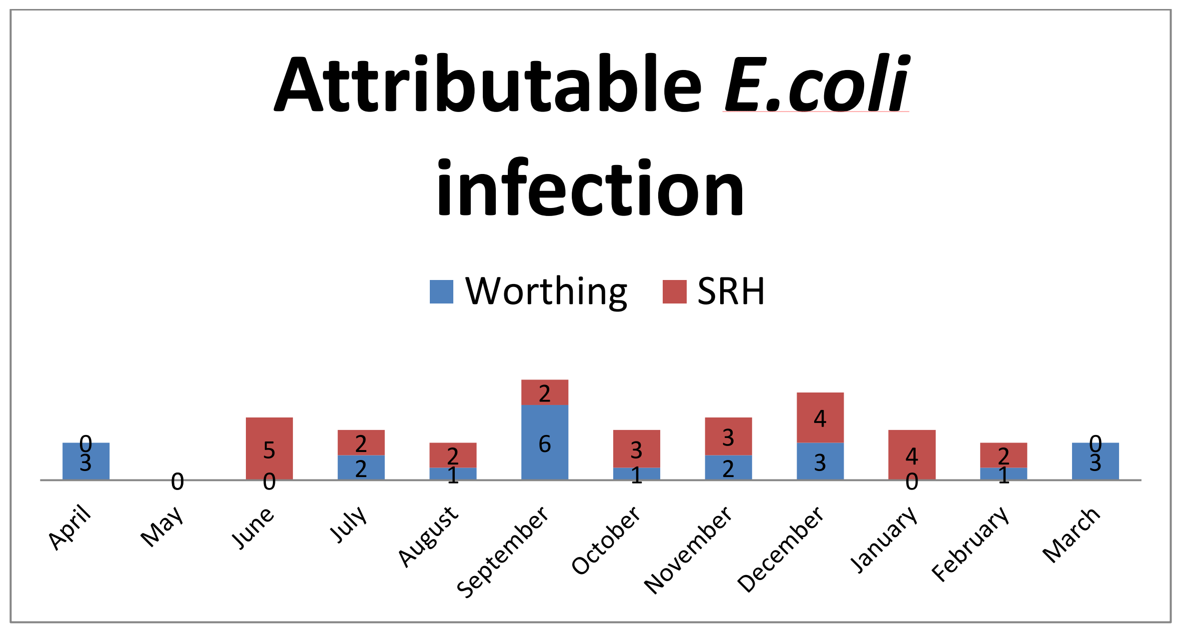
3.5.4 In 20/21 there were 366 *E. coli* bacteraemia cases in total. This represents a reduction of 13%. This can't be easily explained but it is likely to be due to a lower number of admissions due to the pandemic rather than a real reduction.

3.5.5 Overall there has been a 12.4% reduction in *E. coli* bacteraemias since the initiative was started in 2017 against a target of 50% which is disappointing. However, during this time the average rate in England went up not down.

3.5.6 There was a modest reduction in the number of hospital-acquired bacteraemias – down from 60 to 49 cases across site. This may be due to the reduced number of operations during the year.

3.5.7 There was a slight rise in the number of hospital-acquired *Klebsiella spp.* bacteraemias of which there were 16. Previously they fell from 24 in 2017/18 to 13 in 2018/19 and then 12 in 2019/20.

3.5.8 The number of hospital-acquired *Pseudomonas aeruginosa* bacteraemias remained low with 9 recorded across site. In previous years the count has gone from 12 in 2017/18 to 16 in 2018/19 and then to 15 in 2019/20. There were 46 community onset cases compared to 57 in the previous year.



3.5.9 Multi-resistant Gram-negative organisms are also becoming an increasing problem nationally. To date we have seen no bacteraemias caused by Carbapenemase-Producing Enterobacteriaceae (CPE) but have seen a few on clinical or screening specimens for example Gram-negative screen or urine samples.

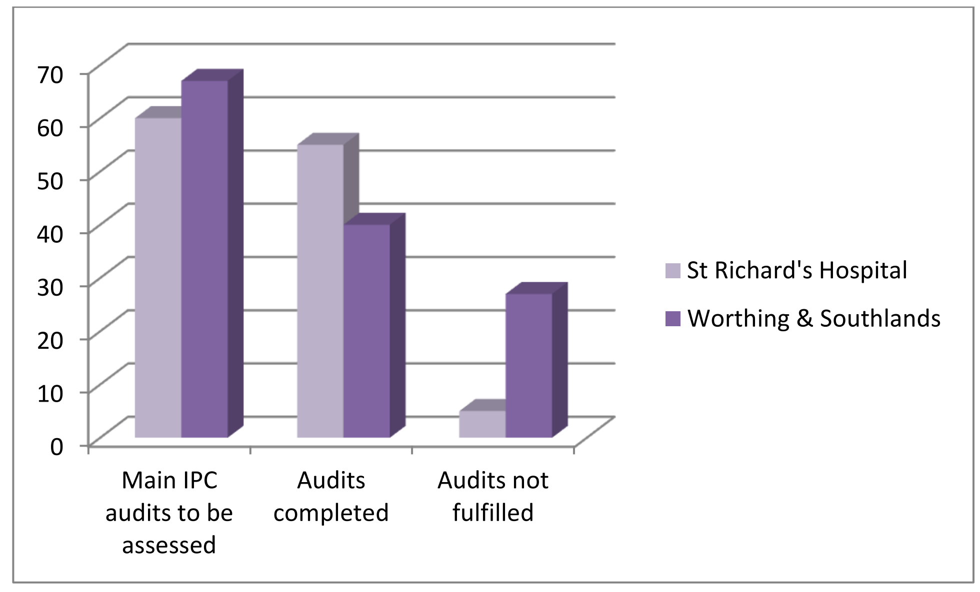
3.5.10 All patients who have received in-patient care abroad or outside of our immediate region are required to be isolated on admission until they have a negative Gram-negative screen. 429 screens were carried out during the year.

3.6 Surveillance, Auditing and Teaching

3.6.1 **Main IPC Audits**

- Similar to previous years, IPCT have strived to undertake at least one main audit in every clinical/operational area across all 3 sites. This has been exceptionally challenging during 2020/21 due to acute pandemic pressures and prioritisation of clinical COVID-19 workload.
- In total 95 out of 127 main audits were performed during 2020/21. The team were extremely pleased to have audited this many areas under the exceptional circumstances of last year. St Richard's had additional audit support from a retired IPC specialist nurse who returned as an audit nurse. This was so valuable and allowed consistent monitoring and reporting despite the pandemic. Worthing did not have any additional audit support however they had other staff members offer support for fit testing and staff swabbing .
- Each main audit takes approximately one hour to observe practice and review the environment. This does not include the Infection prevention team's time to collate findings, write the audit report, send and review the action plan. In total, each audit takes a minimum of 2 hours.

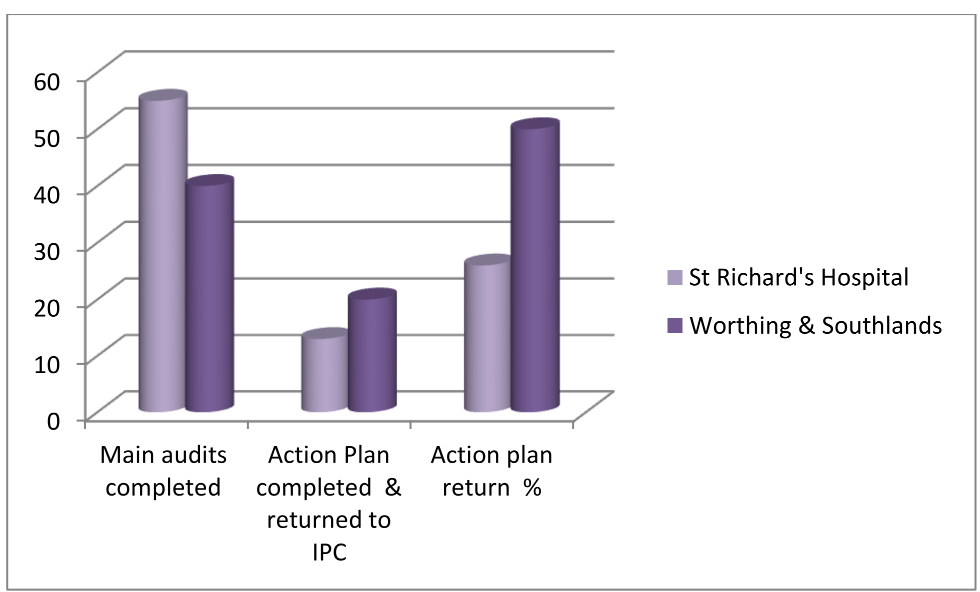
Figure 2 Main IPC Audits Totals



- There were 32 areas (5 SRH, 21 Worthing and 6 Southlands) that did not receive a main IPC audit within the year. These areas will be a priority for 2021/22.
- The twelve clinical areas that did not have audits within 2019/20 had audits completed as a priority within 2020/21.

- Once again the return rate, for departments to send back completed action plans, has been poor and IPCT escalated this to IPOG to try to improve compliance. The audit cycle includes closing the audit loop and IPCT must be sent the completed action plans to provide evidence of noting the recommendations and resolving the non-compliances.

Figure 3 - Audit action plan return rate



- With the pressures on the IPCT it is not going to be possible to put in extra measures to improve compliance until the workforce has increased to match the work demand.

3.6.2 **Main audit trends**

- Condition of the environment as several clinical areas not cleanable.
- Floor replacement needs priority in specific areas (SRH surgical wards).
- Corridor and bay floors need scrubbing.
- Cleanliness of tables and lockers.
- Over full used laundry bags.
- Incorrect waste segregation.
- Ward kitchens not fit for purpose.
- Cluttered bays/bedsides – this problem has increased over the last year due to cessation of visiting during the pandemic. Relatives were unable to take things home.

Whilst the audit non-compliances have been identified as trends, a detailed focused multi-disciplinary approach has reduced risk by implementing certain actions. IPOG discuss themes and work towards mitigating risks with clinical support. The IPC team attend Sister/Matron meetings to

discuss/problem solve emerging trends and the matrons support these actions within each clinical area. Catering teams have been instrumental in implementing standards of cleanliness for lockers and tables and all team members have been retrained in how to perform this task effective and consistently. The estates team have supported the launch of a rolling fan cleaning programme which will reduce risk of infection to our patients, visitors and staff.

3.6.3 **Spot check audits**

Spot check audits are a quick 15 minute review of a clinical area that can help support or change practice within the clinical environment. These have been utilised to investigate any highlighted concerns and are a useful tool to re-audit an area after a poor audit outcome or observation. They are implemented as a multi-disciplinary team approach, with matrons and facilities team members, to ensure all aspects of clinical areas are reviewed. Despite the pandemic, the IPCT have strived to ensure all clinical areas had a monthly spot check completed and allowed for comparison and trend analysis. This hasn't always been possible and the IPCT have had to cancel a number of spot checks during COVID-19 wave 1 & wave 2. The pass benchmark has remained at 85% however if any bodily fluids were found then it was an instant fail, regardless of the score.

In 2020/21 385 spot checks were completed across the Trust. Whilst this is a significant decrease from the previous year (604), the IPCT were exceptionally pleased to have reviewed so many areas over St Richard's and Worthing hospital. The number of failures remain disappointing with 171 (336 2019/20) spot checks failing to achieve 85% or above. All non-compliances were communicated to the wards/facilities/estates for immediate action. Non-compliances to best practice were discussed at monthly IPOG meetings by the division representatives. There are a variety of areas which contributed to the failed spot checks. Commodes, lockers/tables and environmental dust all featured.

We have been working closely with Facilities and Estates as well as the wards to improve the cleaning. We have asked our colleagues to be extra vigilant and increased communications by using the 'Theme of the Week' for useful topics. Following the safety cross audit we have nominated commode champions who are tasked with reviewing commode 3 times a day on their ward. This is an embedded process and now a standard piece of clinical task allocation.

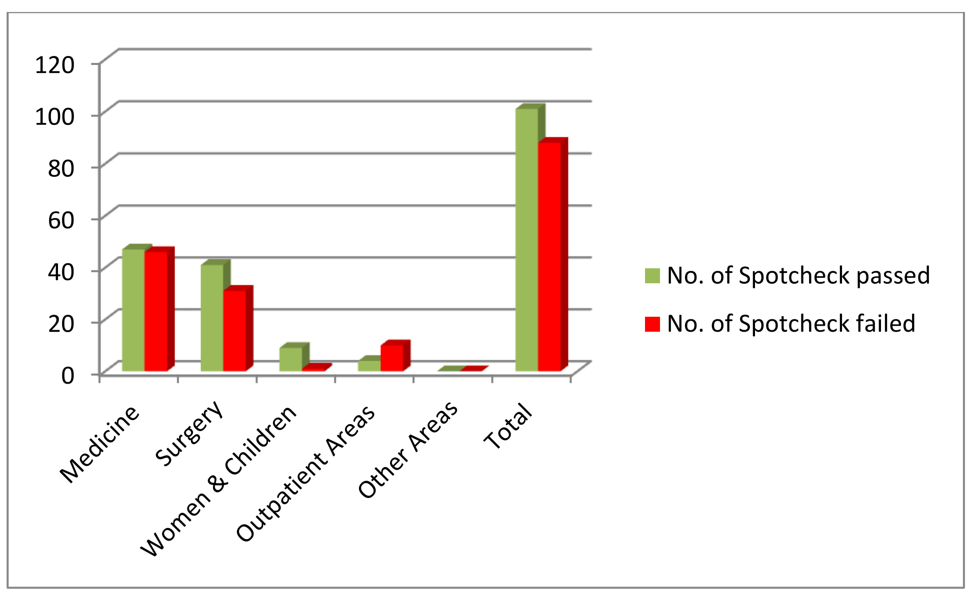
St Richard's hospital spot check data

Figure 4 -St Richard's Spot check audits

Divisions	Spotcheck planned within 12 months	No. of Spotchecks completed within 12 months	No. of Spotcheck passed	No. of Spotcheck failed
Medicine	168	93	47	46
Surgery	168	72	41	31
Women &	84	10	9	1

Children				
Outpatient Areas	156	14	4	10
Other Areas	132	0	0	0
Total	**708**	189	101	88

Figure 5 - St Richard's spot checks passed/fail per division

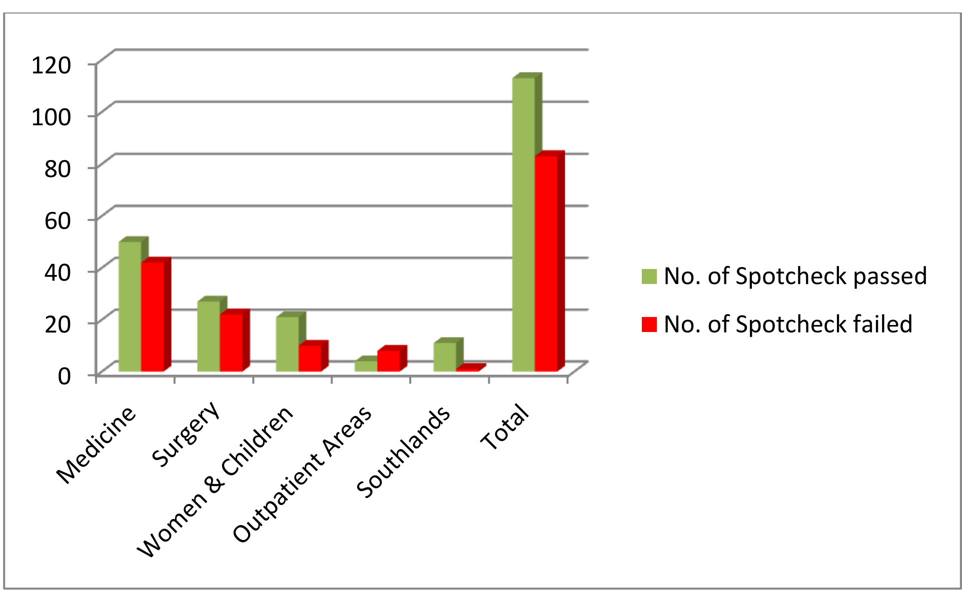


Worthing hospital spot check data

Figure 6 - Worthing Hospital Spot check audits

Divisions	Spotcheck planned within 12 months	No. of Spotchecks completed within 12 months	No. of Spotcheck passed	No. of Spotcheck failed
Medicine	216	92	50	42
Surgery	96	49	27	22
Women & Children	72	31	21	10
Outpatient Areas	12	12	4	8
Southlands	96	12	11	1
Total	**492**	196	113	83

Figure 7 - Worthing Hospital spot checks passed/fail per division



3.6.4 **Safety Thermometer Audit**

The safety thermometer audit ceased April 2020. Urinary catheter insertion and continuing catheter care high impact intervention audits are monitored monthly, via patient track data and reported to IPOG.

3.6.5 **Vascular Access Device Audit**

Historically the team has struggled to perform these bi-monthly vascular access device audits. Restarting the audits was unachievable during 2020/21 due to the pandemic and sickness /early retirement of a senior IPC nurse within the small IPCT.

We are expecting the IV team to take on the majority of these audits going forwards.

3.6.6 **Commode Audit**

Each month a commode audit was undertaken by IPCT. This has expanded to include the assessment of all bedpans, shower chairs and raised toilets seats, as these were often found contaminated during spot check audits. These results are included in the IPC monthly report for IPOG and discussed at Sister Meetings. The commode audits were also reviewed at each *Clostridioides difficile* root cause analysis meeting throughout 2020/21. The highlighted area in yellow on Figure 8 were areas of high incidence and required follow up and re-audit.

Figure 8 - Monthly cleanliness audit of commodes, raised toilet seats, shower chairs and bed pans.

Clean √	SRH				Worthing			
Contaminated X	Commode	RTS	S.Chairs	Bedpans	Commode	RTS	S.Chairs	Bedpans
April	Not Completed	Due to COVID-19			Not Completed	Due to COVID-19		
May	Not completed	Due to COVID-19			67 √ 3 X	5 √ 1 X	24 √ 3 X	73 √ 0 X
June	61 √ 1 X	14 √ 1 X	14 √ 0 X	79 √ 0 X	72 √ 6 X	9 √ 4 X	17 √ 0 X	65 √ 1 X
July	59 √ 4 X	14 √ 6 X	1 √ 0 X	73 √ 0 X	65 √ 6 X	10 √ 0 X	14 √ 2 X	67 √ 1 X
Aug.	65 √ 5 X	10 √ 3 X	3 √ 0 X	89 √ 1 X	65 √ 3 X	3 √ 0 X	11 √ 1 X	67 √ 1 X
Sept.	64 √ 5 X	5 √ 1 X	3 √ 0 X	85 √ 0 X	Partial completion – will combine with October 20			
Oct.	54 √ 7 X	19 √ 4 X	18 √ 4 X	61 √ 2 X	70 √ 1 X	3 √ 1 X	27 √ 0 X	81 √ 0 X
Nov.	63 √ 4 X	21 √ 2 X	14 √ 0 X	75 √ 1 X	58 √ 4 X	5 √ 0 X	10 √ 0 X	71 √ 1 X
Dec.	52 √ 5 X	19 √ 10 X	22 √ 1 X	68 √ 0 X	Not completed	Due to COVID-19		
Jan.	Not Completed	Due to COVID-19			Not Completed	Due to COVID-19		
Feb.	57 √ 6 X	41 √ 4 X	64 √ 4 X	62 √ 1 X	56 √ 21 X	9 √ 6 X	36 √ 9 X	58 √ 6 X
March	52 √ 10 X	22 √ 14 X	41 √ 2 X	63 √ 3 X	57 √ 10 X	8 √ 7 X	22 √ 6 X	65 √ 1 X
TOTALS								

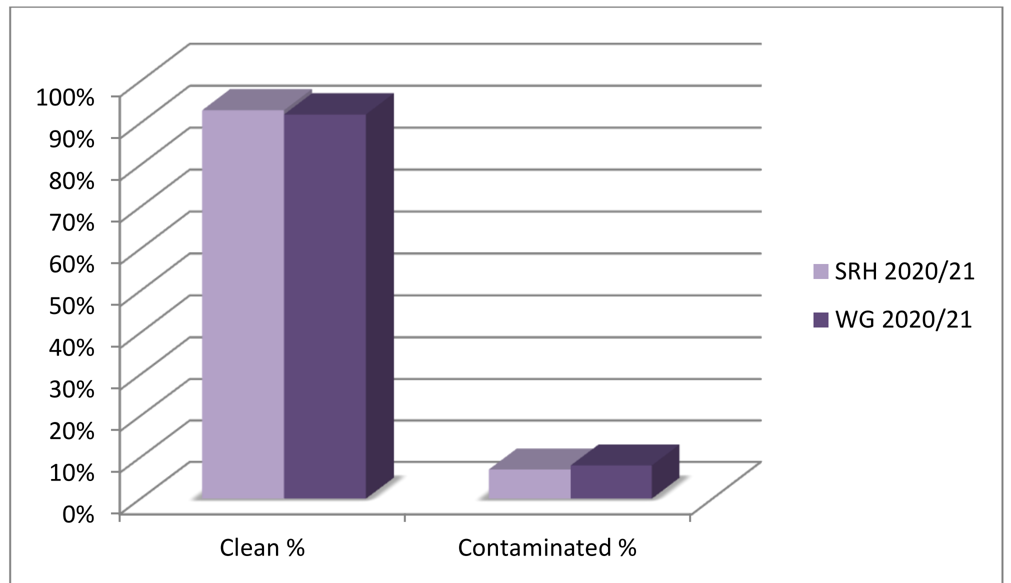
Figure 9 - Monthly cleanliness annual scores 2020/21

SRH 2020/21	Clean	Contaminated	%	WG 2020/21	Clean	Contaminated	%
Commodes	527	47	92%	Commodes	510	54	90%
Raised toilet seats	165	45	76%	Raised toilet seats	52	19	73%
Shower Chairs	180	11	94%	Shower Chairs	161	21	88%
Bedpans	655	8	99%	Bedpans	547	11	98%
Total	1527	111	93%	Total	1270	105	92%

Figure 10 - Overall cleanliness annual scores 2020/21

Overall Percentage	Clean %	Contaminated %
SRH 2020/21	93%	7%
WG 2020/21	92%	8%

Figure 11 - Overall cleanliness annual scores 2020/21



3.6.7 **Technical Cleaning Audits**

In addition to the routine cleaning schedule, ward side-rooms and bays were deep "infectious cleaned". This was implemented when a patient who poses an infectious risk has been moved from a bed space or discharged and prior to another patient being allocated that bed space. Infectious cleans are supplemented with vaporised hydrogen peroxide (VHP) (*Bioquell*®) for additional environmental disinfection as directed by IPCT. The use of Bioquell has increased during 2020/21 with the focus on environmental cleaning due to COVID-19. The annual deep clean programme, whilst most areas have been deep cleaned and Bioquelled, the maintenance and estates work hasn't been fulfilled due to capacity and pandemic prioritisation. Further Bioquell machines were purchased to support the increased need for enhanced cleaning.

3.6.8 See **Appendix 3** - Technical cleaning scores for the three hospitals

3.6.9 **Patient Led Assessment of the Care Environment (PLACE**)

PLACE visits ceased at the beginning of the year in line with the pandemic national lock down 'stay at home' guidance. All PLACE strategy and clinical visits were cancelled and will be reviewed once lock down and COVID-19 measures have been lifted within the healthcare environment.

3.6.10 **Teaching**

The decision to cancel IPC face to face training was in line with the pandemic COVID-19 guidance to reduce transmission risk and ensure staff were as safe as possible whilst at work. The senior IPC nurse made a recording for the updated on line IPC teaching module and this has been evaluated by trust staff members favourably. The video didn't cover COVID-19 in detail as little was known, within the early few months, about the novel coronavirus.

The table below shows the Infection control training figures for 2020/21 taken from the monthly board report. The percentages below reflect the challenges within workforce numbers, patient capacity/acuity and prioritisation of pandemic work within the hospitals.

Figure 12 - IPC teaching figures March 2020 to March 2021

	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Infection Control	85.4%	81.9%	78.0%	79.2%	79.5%	79.0%	78.1%	78.4%	79.4%	80.6%	79.9%	77.9%	80.2%

3.7 SSI

***note, no surveillance was undertaken April to June 2020**

Surgery	Inpatient/ readmission rate 20/21	National Benchmark	Total 20/21 incl. Superficial	National Benchmark
THR SRH & Worthing	0.8% 2/233	0.3%	0.8% 2/233	0.8%
TKR	1.1% 2/170	0.3%	1.7% 3/170	1.2%
Breast SRH	0.8% 1/124	0.6%	6.4% 8/124	2.9%
Breast Worthing	0% 0/145	0.6%	8.2% 12/145	2.9%
Large Bowel SRH	8.6% 17/197	8.4%	10.1% 20/197	10.4%
Large Bowel Worthing	12.3 19/154	8.4%	13.6 21/154	10.4%

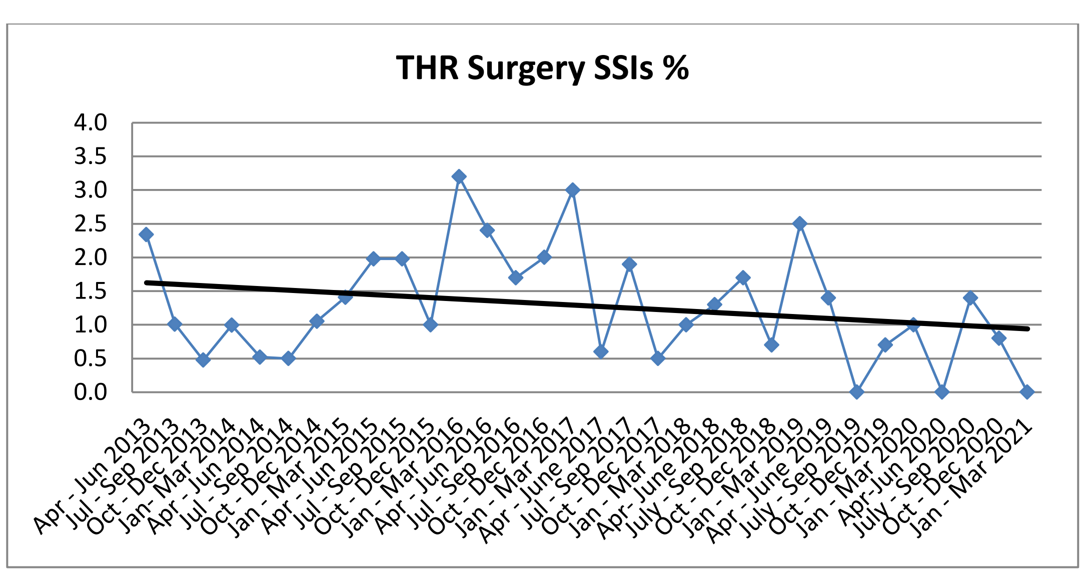
Actions to reduce SSI rates are monitored through the Trust Infection Prevention Operational Group and Committee and SSI Team work within Surgical Division. Surveillance is undertaken as part of PHE Surgical Site Infection Surveillance Service. Mandatory SSI surveillance involves 1 quarter per annum of an Orthopaedic category. However, UHSFT West participates in SSI surveillance of Total Hip replacement, Total Knee Replacement, Large Bowel and Breast surgery. Unfortunately due to COVID 19 Pandemic and suspension of elective surgery the data for April to June 2020 – Q2 calendar year. In-patient and readmission rates are reported in line with PHE reporting. Post discharge surveillance is routinely undertaken by the SSISS nurses to ensure an accurate rate of infection. All infections are discussed with the surgical teams involved and IP Consultant and agreed before submitting the data to PHE.

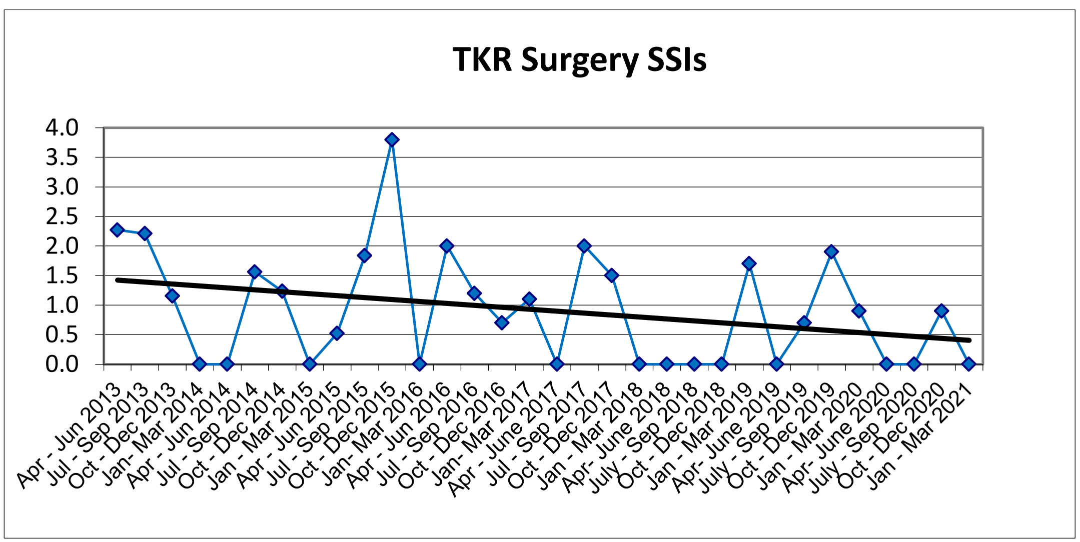
Orthopaedics

Quality Standards agreed have been incorporated into the Chichester & Worthing Enhanced Recovery Pathway (CWERP) document. These are based on NICE Quality standard [QS49] October 2013 and include aspects of the patients' pathway pre, peri- and post-operatively including basic aspects of skin preparation, prophylactic antibiotic management, normothermia, asepsis, surgical environment and wound management. The standards will be routinely audited for all THR and TKR CWERP patients and this data will be taken to CWERP Committee.

As inpatient/readmission post-operative infections are identified a SWARM process is initiated to ensure a full RCA is completed and that the MDT is involved. The RCA's are presented to an executive led panel and also discussed at the Trauma & Orthopaedic Clinical Governance meetings for more appropriate peer review.

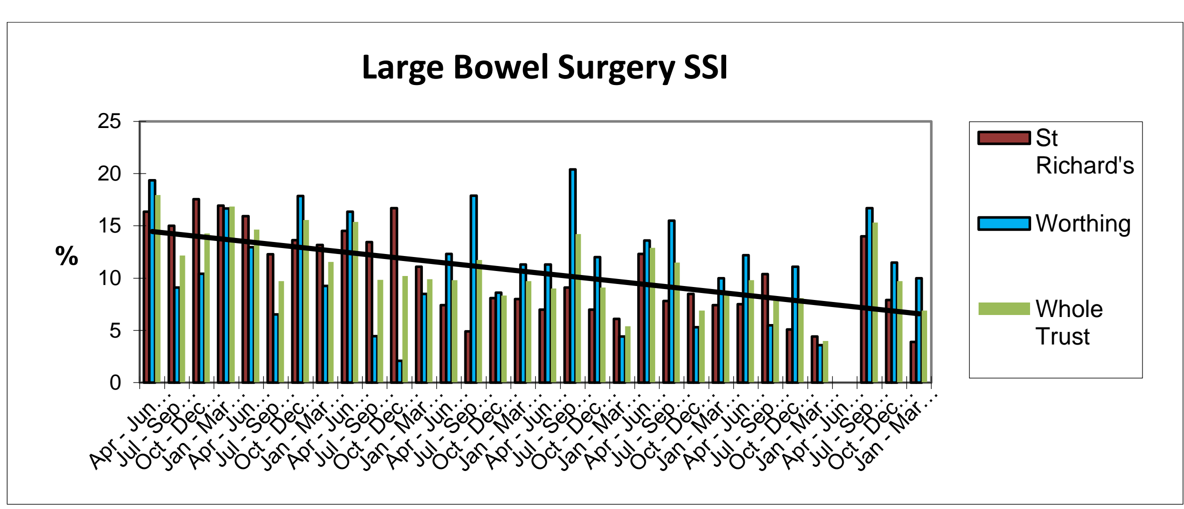
All actions are on-going however a theme which requires some further intervention following the RCA's and auditing is recording of temperatures peri-operatively.





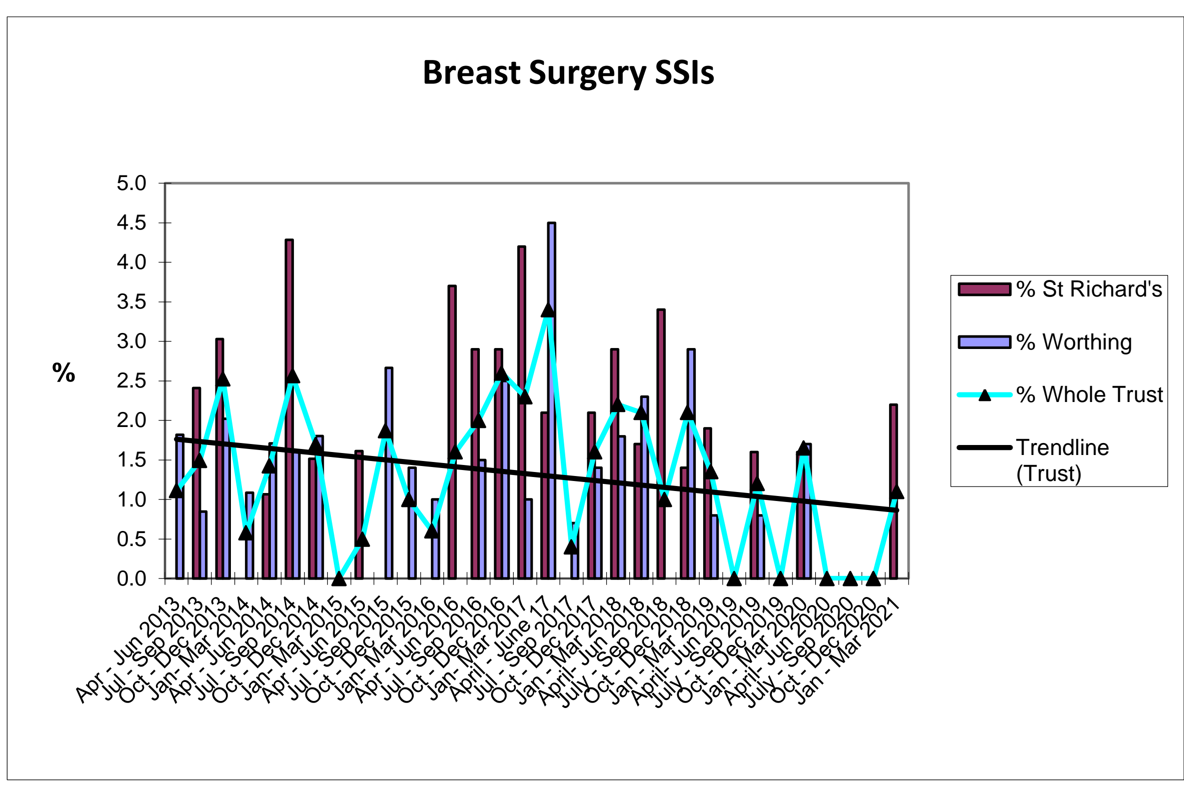
Colorectal

Organ space infections include anastomotic leaks. There is continued use of pre-operative bowel preparation and oral neomycin for hemicolectomy cases as standard across the Trust. Division to look at re auditing the quality standards for colorectal,to provide assurance regarding use of drapes and decolonisation that appeared as a theme in Oct-Dec 2020.



Breast

The Breast Department is aligned to the Core Division and monitored through their Governance channels but is included here as part of the overarching SSI data.
This is a low participation category. Breast surgery data not collected for Q1 & Q2
An RCA of each infection undertaken by the breast team and reviewed at clinical governance meetings. The breast team are included in the overarching SSI work across the Divisions.



3.8 Water Safety Group

3.8.1 The water safety group, whilst a multi-disciplinary, productive group which monitor, measure and action water within the Trust, were under added pressure throughout 2020/21. Due to COVID-19 pandemic pressures the meetings weren't quorate and the Authorised Engineer (Water) was not appointed.

3.8.2 Over 2020/21 2 water safety group meetings were cancelled due to operational issues and a lack of attendees.

3.8.3 All positive water sample results are discussed at the monthly meeting and estates team members discuss immediate actions and planned remedial work. In addition the water safety group includes Worthing's Hydrotherapy pool and in 2017 a separate Hydrotherapy pool sub-group was initiated. This sub-group generated a hydrotherapy pool policy and a separate pool procedure manual. Both water safety group and hydrotherapy pool meetings are minuted with the addition of a comprehensive action plan that is revisited every month.

3.8.4 The number of water samples sent off site for testing during 2020/21 was a staggering 6000 samples. All these sample results were reviewed, logged and any remedial action required initiated.

3.8.5 The Water safety group monitor 'Keep it hot, keep it cold, keep it moving' analogy. Water temperature is critical to ensure waterborne pathogens don't have the environment to thrive and replicate. An external company (Biochemica) conduct water temperature checks on a monthly basis on select outlets across all 3 sites. Any concerns on incorrect water temperature have a works ticket raised and estates will investigate and rectify.

3.8.6 Temperatures of any outlet tested for *Pseudomonas aeruginosa* or *Legionella* spp. are also recorded and investigated if they fall below standard.

3.8.7 A vast amount of dead leg removal and remedial work has occurred on all trust sites during 2020/21 and this is evidenced by the significant drop in *Legionella* spp. and *Pseudomonas aeruginosa* outlet failures. If waterborne pathogens are detected in a sample then immediate action is taken to apply a point-of-use filter on the water outlet to ensure it can continue to be used without risk. The removal of blind ends are identified during the investigative remedial work and removed accordingly.

3.9 Specialist Ventilation Group

3.9.1 The specialist ventilation group are a multi-disciplinary, productive group which monitor, measure and action air quality within the Trust, and were under added pressure throughout 2020/21. The COVID-19 pandemic pressures resulted in the meetings not being quorate and the Authorised Engineer (Ventilation) was not appointed. There were frequent changes to guidance with regards to ventilation requirements within clinical areas (positive to negative air pressure).

3.9.2 Over 2020/21 2 specialist ventilation operational groups were cancelled due to operational issues and a lack of attendees.

3.9.3 Estates service and re-validate 26 operating theatres, 2 endoscopy suites, 2 Aseptic suites, 3 Catheter Labs and 10 isolation rooms every year. Not every theatre passed the environmental audit or microbiological air sampling first time, however root cause analysis investigations were carried out. The learnings helped improve processes and procedures when revalidating theatres.

3.9.4 Isolation rooms at St Richard's Hospital are a main concern for the ventilation group. They have not been validated since pre-COVID-19. Efforts have been made to maintain air handling units (AHU) to the standard of their previous validation however patient capacity, acuity and lack of estates workforce has contributed to not revalidating the ventilation within these rooms. This concern has been escalated.

3.9.5 Baseline ventilation data for all sites is 77% compliant – shortfalls: Isolation rooms at SRH & 6 monthly AHU servicing at Southlands/Worthing. The 6 monthly work has been completed and is awaiting documentation to support the governance of the process.

3.10 Antimicrobial Stewardship

3.10.1 NHS Standard Contract: Antibiotic consumption reduction

Standard contract target for 2020/21 was a 2% reduction in total antimicrobial use from the 2018 basline, results in the below table (to be finalised July 2021).

NHS Standard Contract	Current performance	Comments
2% reduction in DDDs than calendar year total 2018	-1.83%	Target not achieved quite but very close – final figure reported. We recognise the effects of COVID-19 influenced these results and were skewed due to significantly different admission patterns this year. (Total usage down 32%). FP10 data delayed by up to 3/12.

3.10.2 Year on year additional monitoring

This monitoring is not mandated in the national contract but is collected by NHSE and displayed on PHE Fingertips website.

2020-21

Target	Current performance	Comments
Maintain carbapenem usage (no increase)	+44.8% compared to 19/20 usage	Total use only increased by 7% but hospital activity much reduced so +44% appears worse. Predominant increase: ITU patients (COVID-19, greater use with activity, antibiotics linked to long stay and long intubation). Micro ward round to ITUs continued and use of carbapenems discussed.
Use of 'Access' antibiotics > 55%)	59.6%	Good. WHO AWaRe categories – 'Access' group is the narrow spectrum antibiotics.

3.10.3 COVID-19 and ASG

Pharmacy team members have supported 2 COVID-19 vaccination hubs with both vaccinators and technical support. This has been a significant workforce pull alongside the clinical and dispensing functions. This had an impact on other antimicrobial stewardship work.

We have created and agreed much COVID-19 guidance in 20/21, which has been shared on MicroGuide and the intranet such as policies for using drugs such as remdesivir, steroids, tocilizumab and also our position on using antibiotics in COVID-19. We subsequently noticed high use of antibiotics in these patients in summer 2020 and then spent a considerable amount of time stewarding these antibiotics asking clinicians to review the need for any antibiotics in COVID-19 confirmed patients – unless there was evidence of secondary bacterial infection. We were also visiting/virtually visiting 'red' COVID-19 ward areas daily asking if any guidance is needed.

3.10.4 Influenza update

As attached below is an audit report from a trainee pharmacist at Worthing Hospital. This audit looked into the reasons for low uptake of inpatient vaccination this year. Results for numbers of prescriptions made for inpatients as below, and within report much more information with results from questionnaires on staff beliefs given out to all wards at Worthing Hospital to different members of the MDT.

Flu vaccines confirmed administered	107
Number of different patients prescribed ‘flu vaccine	148
Total prescriptions made (100 duplicates for the non-administered)	248

Pharmacy continued to support the staff influenza vaccination programme and also undertook a quality improvement project to recognise barriers and take action to increase inpatient influenza vaccination.

3.10.5 ASG meetings

These were suspended during COVID-19 but have restarted in April 2021.

3.10.6 AMS

Antimicrobial stewardship at WSHT is maintained via surveillance using electronic prescribing and medicines administration (EPMA) drug charts. An automated report of all patients on antibiotics is emailed to each antimicrobial pharmacist and microbiologist on a daily basis. This is filtered and interpreted to undertake targeted review of patients on the daily clinical ward round with the Microbiology consultants. Particular focus is made on patients commenced on restricted antibiotics or prolonged courses of antibiotics whose regimen we feel can be stewarded.

3.10.7 CQUINs

CQUINs were suspended for the rest of 2020/21. Confirmed that these will be NOT activated in 2021/22 Q1 or Q2.

National CQUIN requirements have all been suspended however we continue to ensure we are keeping these in mind and reporting to the above groups. We are still monitoring on a monthly basis the antimicrobial total usage with regards to the 2% annual reduction target, whilst also monitoring carbapenem and AWaRe category use (as per previous AMS CQUINs) – these data are also being fed into the PHE Fingertips website. We remain outliers for performing very well for these categories too. We remain around 60% use when the average for KSS area and England is below 50% for the ‘Access’ group. For carbapenem use we generally use around 20 DDDs per 1000 admissions, whereas the average for KSS area is 35-40 and England 65-70.

4 Outbreaks/Incidents

4.1.1 This year has been dominated by COVID-19. Following the first two major waves reviews were written by the Head of Clinical Governance and Patient Safety. For brevity the entire reviews are not included in this report.

4.1.2 Testing for COVID-19 was initially a challenge as there was no test, and then there was very limited testing capacity as the samples had to be sent away. By March 2020 we had limited testing capacity on-site but only had capacity to test symptomatic patients. Over time capacity increased until we were testing all admissions regardless of symptoms and all negative patients were rescreened on days 3 and 5 and then weekly during admission. The workload from this screening had a huge impact on both the laboratory and the wards where screening had to be undertaken.

4.1.3 All positive samples were sent away to a National reference laboratory for genotypic sequencing. This information would have been helpful in distinguishing a true outbreak from multiple unrelated infections due to the very high community prevalence of COVID-19. Unfortunately the results were not returned in a timely fashion and when they were the level of detail made further interrogation futile. The vast majority of patients in Wave 2 had the Alpha (previously known as Kent) Variant.

4.1.4 Based on the results of testing, previous known contacts and clinical scenario patients who required admission were placed in designated red zones for likely COVID-19 or green zones for asymptomatic beds. Patients with a mixed clinical picture or indeterminate test results were placed in side-rooms where possible. This put a huge pressure on side rooms.

4.1.5 Some patients presented with a clinical picture of COVID-19 but testing remained negative despite multiple samples including sputum samples. CT scans were sometime used which showed typical features of COVID-19 which had not been seen previously. These patients were treated with the 'Treat As Positive' pathway and again ideally placed in a side room although this was not always possible.

4.1.6 Staffing was very challenging during the year. Prior to mass testing being available staff who were symptomatic or had a household member who was symptomatic were required to self-isolate for initially 14 days, and later 10 days. This severely impacted the number of staff available to work and particularly during January 2021 affected which wards could be used.

4.1.7 Vaccination first became available in this Trust late December 2020. Initially staff were given two vaccines at 3 weeks apart but following a National mandate this was changed to 12 weeks by early January 2021.

4.1.8 Daily COVID-19 control meetings which had started in early March 2020 subsequently became Bronze IPC meetings. These meetings gave a Sit Rep and also discussed pressing issues such as cleaning protocols, PPE use and ward changes.

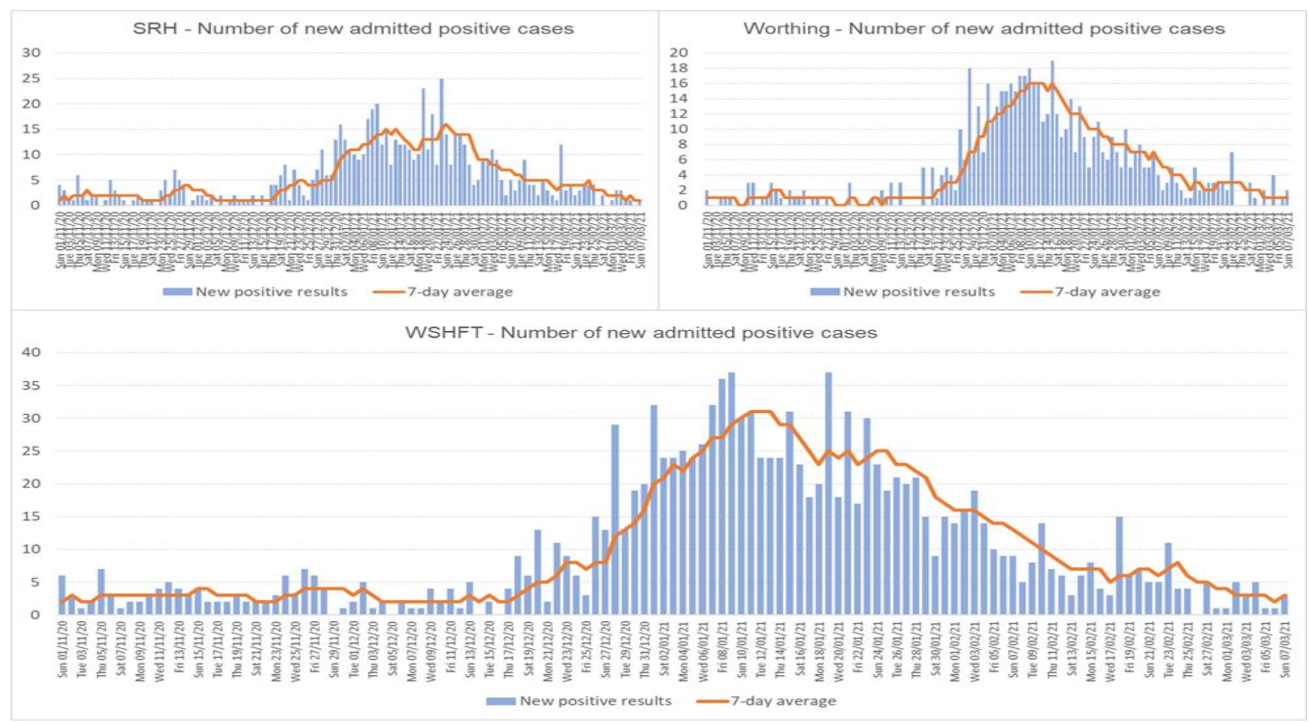


Figure 13 - New Positive COVID-19 cases from November 2020 to March 2021

4.1.9 Outbreaks were declared when there were two or more cases linked in time or place and one of them was described as probably or definitely Hospital Acquired infection as per PHE guidance. All outbreaks were discussed in daily meetings with PHE and CCG delegates invited. Outbreaks were closed internally 14 days after the last positive, and externally 28 days. All patients in the outbreak area were placed on an enhanced swabbing routine, which was restarted with each new case identified. All staff, including visiting staff eg porters, therapies etc were also screened after declaration of the outbreak.

4.1.10 Following all outbreaks a root cause analysis (RCA) investigation was completed, led by the IPC teams and hospital matrons, with a consequent panel review to analyse the lessons learned and action required. All outbreaks were reported nationally as per protocol.

4.1.11 Additionally each patient who had sadly died (having definitely or probably acquired COVID-19 in hospital and had COVID-19 recorded as cause of death on part 1a of the death certificate) had an in depth mortality review of both the medical and nursing care provided, and the patient pathways followed. Following completion of all the reviews, a designated panel of experts was convened, and each patient's care pathway was discussed with input from the senior nursing team, the infection prevention and control team, medical examiners and the microbiologist. The duty of candour process was also followed with support for families being provided by the medical examiners, heads of nursing and hospital matrons.

Table 1- COVID-19 Wave 1 nosocomial increased incidence/declared outbreaks

Ward/Area	Date of Outbreak Declaration	Total no pt.
Broadwater	**07.04.2020**	16
Buckingham	**12.05.20**	16
Eastbrook	**29.06.20**	10
Chiltington	**16.07.20**	13

Table 2 - COVID-19 Wave 2 nosocomial increased incidence/declared outbreaks

Ward/Area	Date of Outbreak Declaration	Total no pt.	C	I	P	D	Staff	Int closure
Castle	08.09.20	9	1	4	3	1	1	28.09.20
Buckingham	18.09.20	5	0	0	4	1	1	05.10.20
Coombes	18.09.20	2	0	0	1	1	3	05.10.20
Chiltington	23.09.20	4	0	1	1	2	0	06.10.20
Ashling	02.11.20	5	0	0	3	2	10	23.11.20
Petworth	24.11.20	6	3	0	0	3	3	11.12.20
ACU	17.12.20	4	0	1	2	1	7	18.01.21
Lavant 1	17.12.20	4	0	0	0	4	1	12.01.21
Middleton	26.12.20	30	0	1	11	18	16	12.02.21
Clapham	27.12.20	4	0	2	2	0	10	18.01.21
Chiltington	05.01.21	2	0	0	0	2	0	18.01.21
Castle	06.01.21	5	0	1	2	2	3	27.01.21
Selsey	06.01.21	11	0	2	2	7	12	08.02.21
Lavant 2	07.01.21	11	0	1	7	3	5	11.02.21
Wittering	08.01.21	15	0	5	7	3	13	10.02.21
Bosham	12.01.21	13	0	5	0	8	8	01.02.21
Brooklands	15.01.21	8	0	2	4	2	0	29.01.21
Erringham	19.01.21	6	0	1	4	1	1	04.02.21
Eastbrook	20.01.21	4	0	2	2	0	3	15.02.21
Eartham	21.01.21	12	0	3	5	4	4	15.02.21
Staff Transport service	22.01.21	0	0	0	0	0	9	05.02.21
Chilgrove	28.01.21	13	1	5	2	6	3	16.03.21
Ditchling	10.02.21	3	0	0	2	1	0	25.02.21
Clapham	13.02.21	6	0	1	4	1	1	08.03.21
Boxgrove	18.02.21	6	0	2	2	2	3	22.03.21
Ford	04.03.21	5	1	2	2	0	0	26.03.21
26 Stand alone >8 days	N/A	25					N/A	N/A

NHSEngland COVID-19 categories

C = Community-Onset; positive specimen date <=2 days after hospital admission or hospital attendance;

I = Hospital-Onset Indeterminate Healthcare-Associated; positive specimen date 3-7 days after hospital admission;

P = Hospital-Onset Probable Healthcare-Associated; positive specimen date 8-14 days after hospital admission;

D = Hospital-Onset Definite Healthcare-Associated; positive specimen date 15 or more days after hospital admission.

5 Future priorities

Further investigation of ventilation systems should be undertaken and plans progressed for any required improvements.

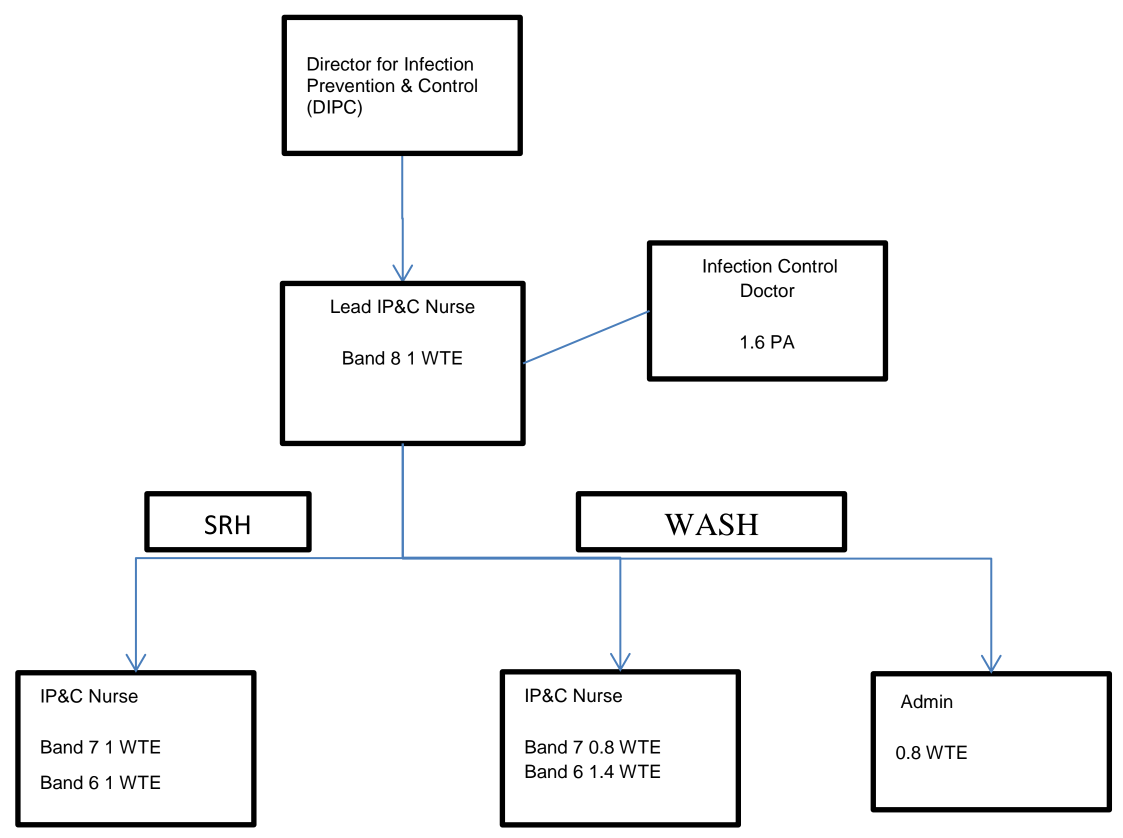
Explore provision of a data analyst to help with analysis of data and identification of future strategic direction. This will reduce the amount of nursing time spent processing data, reduce duplication of effort and allow more effective use of IPC nursing time to make improvements to patient care.

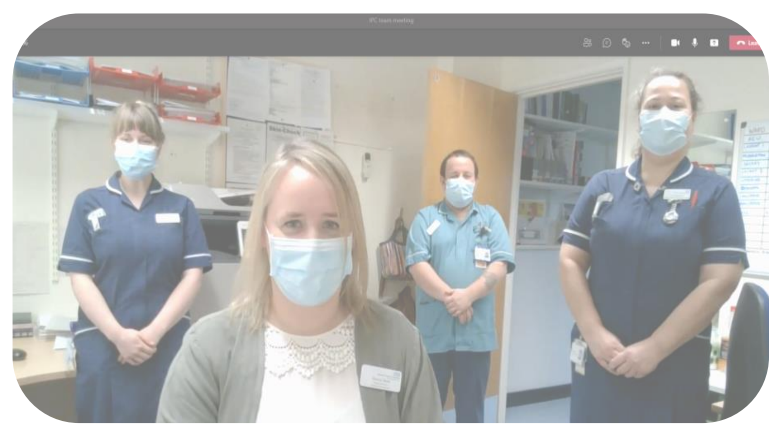
Invest in an infection prevention IT programme to allow more efficient handling of results, recording of information and communication to clinical teams.

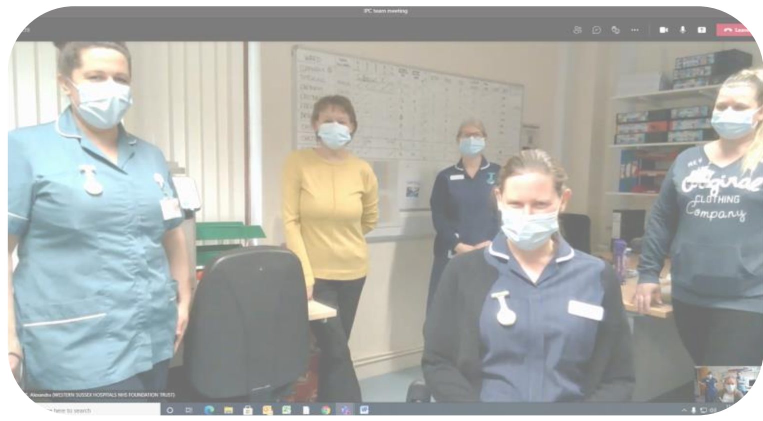
Continue to work with the estates and facilities team to introduce the new National Standards of Cleanliness across the organisation.

Develop the relationships with the IPC Nursing team at Western Sussex as the newly formed Trust develops to allow an aligned and consistent cross site approach to Infection prevention and control.

Appendix 1 Infection Prevention & Control Team Structure







Appendix 2 TERMS OF REFERENCE Trust Infection Prevention and Control Committee (TIPC)

Membership

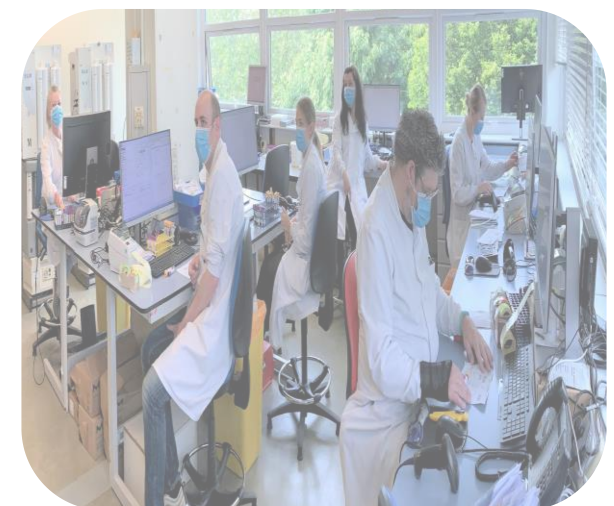
WSHFT Chief Nurse / DIPC (Chair)

Deputy Chief Nurse (Deputy Chair)

Medical Director

Infection Prevention & Control Doctor / Consultant Microbiologist

Lead Infection Prevention & Control Nurse



Infection Prevention & Control Team

Surgical Surveillance Team

Antimicrobial Pharmacist

Decontamination Lead

Heads of Nursing - Medicine

Heads of Nursing - Surgery

Head of Nursing - Women & Children

Consultant in Communicable Disease Control

Occupational Health Manager

CCG Infection Prevention & Control Lead Nurse

SCFT Nurse representative

Associate Director of Facilities

Associate Director of Estates

Medical representation from each Division

Corporate DDO/Services Lead

Nominated Non-Executive Director

The group will be chaired by the Director of Infection Prevention and Control or deputy. Other members of staff may be invited if appropriate.

2. In attendance

2.1 Other members of Trust staff, including other Executive Directors, may be invited to attend to present and/or discuss particular items on the Agenda. The Trust Chair (if not the nominated Chair or member of the Committee) and Chief Executive have the right to attend any meeting of the Committee as desired.

3. Purpose

3.1 To provide strategic direction to the Trust's management of infection prevention and control activity.

3.2 To ensure that the system of Health Care Associated Infection (HCAI) management is via a detailed framework to ensure the Board meets its obligations with regard to patient safety and clinical governance. It is also to ensure that best practice is followed as identified in the Hygiene Code and Care Quality Commission underpinning national and local guidance.

4. Duties

To ensure the purpose is met, the group is responsible for the following:

4.1. To agree the annual Infection Prevention & Control programme, review the progress of the programme and assist in its effective implementation. Regular reports will be received on:

- Outbreaks of infection in any part of the Trust's premises
- Surgical wound site surveillance modules
- Audit results as part of national or local surveillance
- Relevant external and national reports

4.2 To advise on the most effective use of resources available for implementation of the programme.

4.3 To implement, audit and review policies on all aspects of infection prevention and control.

4.4 To monitor compliance with action plans and infection prevention and control standards as specified by the Department of Health and/or external bodies.

4.5 To draw the attention of the Chief Executive and Director of Infection Prevention and Control to any serious problems or potential hazards relating to infection prevention and control and patient safety.

4.6 To provide support, guidance and advice to the Infection Prevention and Control Team.

4.7 To inform itself on HCAI trends, improvements and areas of concern.

4.8 To provide a core of personnel to form an Outbreak Control Team (OCT) when directed by the Infection Control Doctor (ICD) or DIPC.

4.9 To ensure effective implementation of a plan for the management of outbreaks in the hospital and monitor its implementation.

4.10 To exchange minutes and information from the PHE and the CCG, ensuring that appropriate action is undertaken.

4.11 To ensure that risk assessments are undertaken with regard to the infection prevention and control team.

4.12 To promote and facilitate the education of all Trust staff in infection prevention and control practice and procedures.

4.13 To receive and agree an annual report and infection prevention and control programme, including plans for surveillance. This should be submitted for acknowledgement to the Trust Board.

4.14 To encourage communication among the different disciplines involved to share difficulties, successes and ideas in the management of infection prevention and control.

4.15 To receive and act upon reports from the Antimicrobial Stewardship Group

5. Quorum

5.1 The Quorum will consist of 10 members, of whom at least 4 must be the following (or their nominated representatives):

DIPC/Deputy Chief Nurse (Chair)

IP&C Doctor

Lead IP&C Nurse

Representative of each Division (Medicine, Surgery, Women & Children, Corporate)

Facilities & Estates

A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.

6. Frequency of meetings

6.1 The group will meet quarterly. The formal meetings will meet the above objectives.

7. Minutes and Reporting

7.1 Agendas and briefing papers should be prepared and circulated in sufficient time for Committee Members to give them due consideration.

Distribution of minutes: TICC committee members and Trust Board.

7.2 Minutes of Committee meetings should be formally recorded and distributed to Committee Members within 1 month of the meetings. Subject to the approval of the Chair, the Minutes will be submitted to the Trust Board at its next meeting and may be presented by the Committee Chair.

7.3 An annual report from the Committee to the Trust Board will be produced to demonstrate the Committee's discharge of its duties. This report will be presented to the Trust Board within the second quarter of the financial year.

7.4 The Committee will report directly to the Trust Board.

8. Conduct of Business

8.1 The conduct of business will conform to guidance set out in the Trust Board Standing Orders, unless alternative arrangements are defined in these Terms of Reference.

Author: Maggie Davies Director of Infection Prevention & Control **Signed ……………….**

Date approved June 2019 **Date for review June 2022**

Appendix 3 - Technical cleaning scores for the three hospitals

St Richard's Hospital

Technical Cleaning Scores - Year 2020-21											
Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
		99%	99%	99%	99%	99%	100%	99%		98%	98%
		99%	99%	99%	99%	99%	99%	99%		97%	98%
		99%	0%	0%	96%	99%	97%	98%		0%	94%
		100%	0%	0%	100%	95%	100%	95%		0%	82%

Worthing Hospital

Technical Cleaning Scores - Year 2020-21											
Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
		98%	98%	98%	98%	98%	98%	98%		98%	98%
		96%	96%	95%	96%	95%	95%	95%		97%	98%
		93%	89%	89%	91%	85%	85%	88%		0%	94%
		0%	87%	87%	79%	0%	75%	86%		0%	82%

Southlands Hospital

Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
			98%	98%	98%	98%	98%	98%		98%	98%
			97%	98%	98%	98%	98%	98%		97%	98%
			93%				87%			0%	94%
			88%				80%			0%	82%

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Trust Board Annual Safeguarding Children and Adults Reports for 2020-21

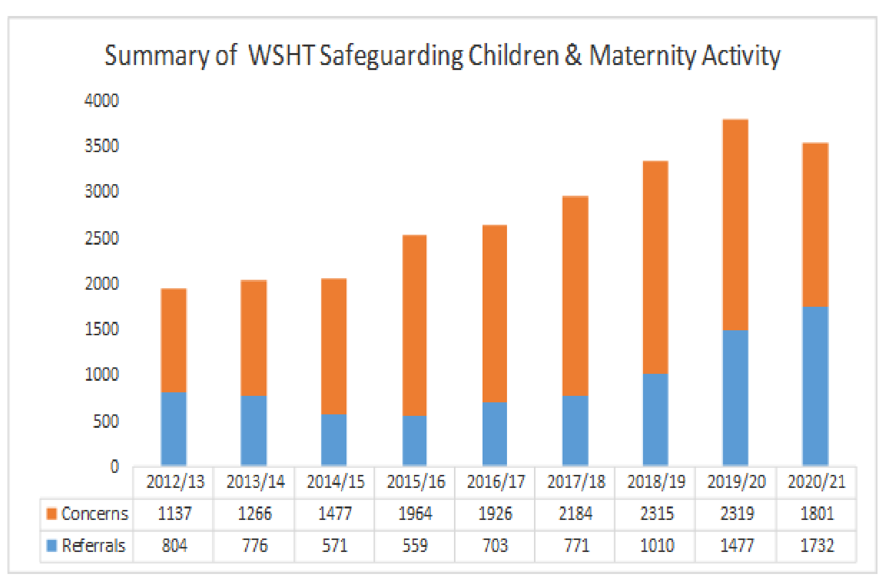
Introduction

- The Safeguarding Annual reports for 2020-21 will be presented as four separate reports, two for each legacy Trust (one for Children and one for Adult safeguarding).
- The Safeguarding Annual reports provide an opportunity to reflect on where we need to focus our efforts in the year ahead (2021-22) and celebrate our achievements in 2020-21. The Trust faced a lot of challenges over the last year but the safeguarding teams continue to deliver the safeguarding service and minimise the disruption caused by COVID-19 pandemic.

NHS
University Hospitals Sussex
NHS Foundation Trust

Children’s Safeguarding Activity

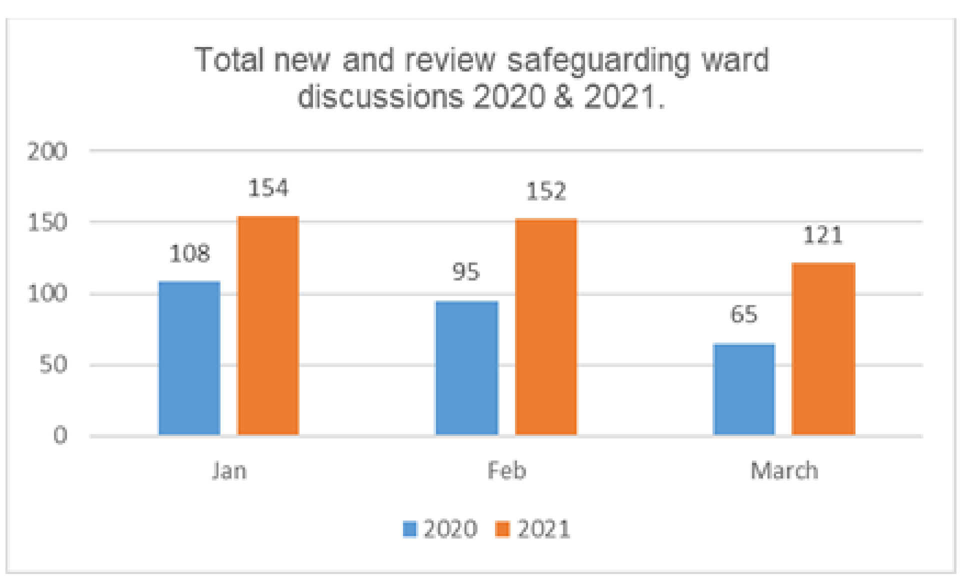
WSHT



	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Concerns	1137	1266	1477	1964	1926	2184	2315	2319	1801
Referrals	804	776	571	559	703	771	1010	1477	1732

Safeguarding concerns have reduced but referrals to children’s social care has increased despite reduction in Emergency Department attendance (20,477 for 2020-21 and 29,114 for 2019-20).

BSUH



There is a significant increase in the number of safeguarding discussions during 2021 compared to 2020.

Children's Safeguarding Key Messages

WSHT

- WSHT continues to address the issues around safeguarding children and promoting their welfare but the complexity of work has increased.
- Internal governance arrangements and statutory requirements for safeguarding children and child protection are met and monitored.
- The impact of the COVID-19 pandemic for children, young people and families and our community is becoming apparent.
- There is an increase in children waiting in our hospitals for a specialist mental health or local authority care placement to become available within the system.
- Sharing the message to new parents and families.

BSUH

- BSUH continues to address the issues about safeguarding children and promoting their welfare but the diversity of work has widened.
- Safeguarding activity across the organisation is increasing, demonstrated by a significant increase in the information being shared, referrals, concerns and daily contact through the safeguarding office and team.
- The number of young people presenting with mental health issues is rising.
- The Trust audit of Section 11 of the Children Act 2004 (HMSO 2004) undertaken in 2020 meets most of the requirements, demonstrating a safe service, acknowledging and addressing the challenges relating to safeguarding children

Children's Safeguarding Priorities for 2021-22

WSHT

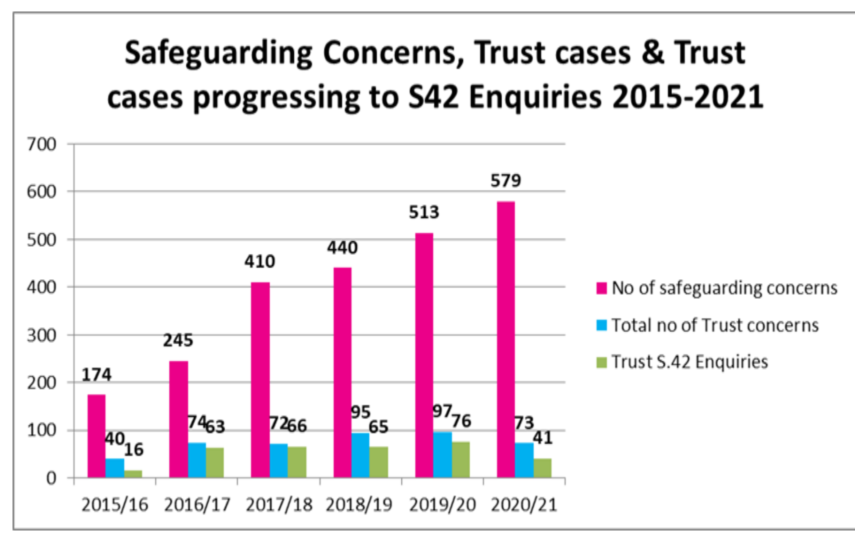
- Develop integrated working for safeguarding children within the newly formed UH Sussex.
- Continue to work towards implementation of Liberty Protection Safeguards (LPS).
- Transitional safeguarding; develop pathways alongside adult safeguarding team to support vulnerable young people transitioning to adult services.

BSUH

- Business case to increase workforce capacity to respond to the rising workload relating to children and young people safeguarding.
- Work towards integrated working to improve services for safeguarding children.
- Work towards the implementation of Liberty Protection Safeguards (LPS).
- Review of the Named Midwife post to meet the statutory requirement.

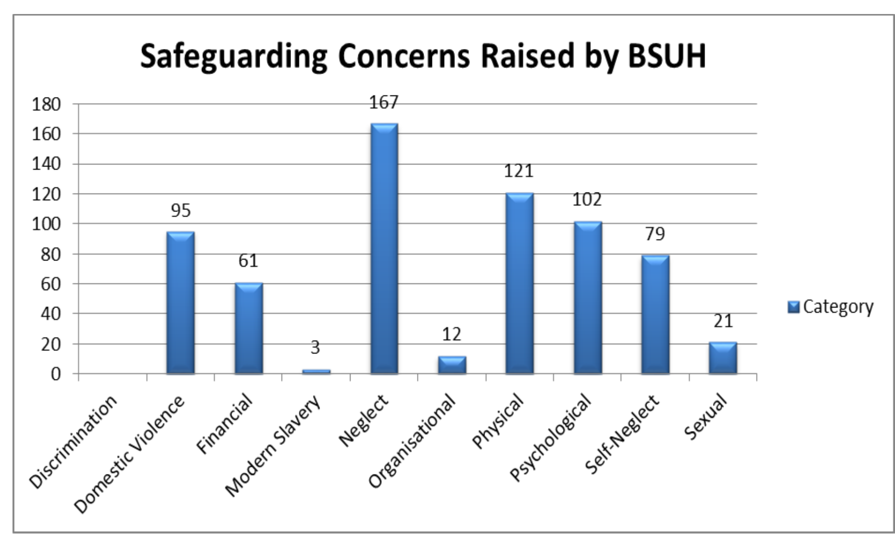
Safeguarding Adults Activity

WSHT



The table above clearly demonstrates that year on year, activity has continued to increase, in particular the activity relating to Deprivation of Liberty Safeguards.

BSUH



Throughout 2020-21, BSUH raised 661 safeguarding concerns, a significant increase from the previous year's total of 418 safeguarding concerns raised.

Safeguarding Adults Key Messages

WSHT

- Successful delivery of the Trust-wide transition of new safeguarding concerns process with the WSCC safeguarding.
- Protocols and training for staff relating to domestic violence concerns (for adults without children) to ensure robust communication pathways were delivered.
- The year has seen an increase in reporting, both of safeguarding concerns and requests for DoLS authorisations.
- Timely investigations to ensure no section 42 backlog despite pressures attributed to the COVID-19 pandemic.

BSUH

- The number of safeguarding concerns and application for DoLS has increased.
- Opportunity to review our existing processes through internal audit.
- Opportunity to introduce a blended learning and training approach to support safeguarding training due to restriction on face to face training.

Safeguarding Adults Priorities for 2021-22

WSHT

- Implementation of full review of Safeguarding, MCA and Prevent Training in order to develop an aligned UH Sussex training plan.
- Preparation for and implementation of LPS in line with legislative requirements.
- Strengthening of partnership and engagement with SAB and associated activity.
- Working towards an integrated safeguarding service for UH Sussex.

BSUH

- Implementation of Level 3 Safeguarding training.
- Implementation of the action plan in response to internal audit recommendations.
- Completion of the SAB bi-annual safeguarding self-assessment and peer challenge event.
- Preparation for and implementation of LPS in line with legislative requirements.
- Working towards an integrated safeguarding service for UH Sussex.

Thank You

Agenda Item:	12.3	Meeting:	Trust Board of Directors	Meeting Date:	3.2.2022
Report Title:	Safeguarding Adults Annual Report 2020-21				
Sponsoring Executive Director:			Chief Nurse		
Author(s):			Jo Henderson – Lead Nurse for Safeguarding Adults		
Report previously considered by and date:			Safeguarding Strategy Committee 9.12.2021 Quality Committee 22.12.2021		

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	☐
Link to Trust Strategic Themes:			
Patient Care	✓	Sustainability	✓
Our People	✓	Quality	✓
Systems and Partnerships	✓		
Any implications for:			
Quality			
Financial			
Workforce			
Link to CQC Domains:			
Safe	✓	Effective	✓
Caring	✓	Responsive	✓
Well-led	✓	Use of Resources	☐

Communication and Consultation:

Safeguarding Strategy Committee.

Executive Summary:

BSUH Trust Board has overarching leadership of Safeguarding Adults within its hospitals. It has a duty to ensure the systems and processes are in place to embed a culture whereby safeguarding is everyone's business. This report provides an overview of the multifaceted scope of safeguarding adults and the wide range of activity taking place within BSUH to safeguard its most vulnerable patients.

This report illustrates how BSUH continues to work closely with its partners across the local community to ensure the principles of safeguarding underpin core practice alongside the values and beliefs of the organisation.

One of the key purposes of safeguarding is to improve not only the care of the individual involved but also to learn from our mistakes to improve practice and the care of other patients. Equally it is important to recognise and share where good practice has taken place. This report highlights the key themes identified in the concerns raised in order to identify areas for improvement.

Whilst face to face training was discontinued as a result of social distancing requirements during the pandemic, training for staff remains a priority to ensure they have the necessary skills and knowledge to recognise and respond to safeguarding concerns.

Implementing the principles of the Mental Capacity Act (2005) is core to safeguarding the voice of our vulnerable patients. An increasingly high number of patients are subject to Deprivation of Liberty Safeguards. BSUH works closely with the relevant local authorities to ensure these are proportionate

and in accordance with legislation. The Mental Capacity Amendment Act (2019) introduces revisions to DoLS and the Board will need to review the implications of the new Liberty Protection Safeguards (LPS) and make provision for the implementation of these.
As a result of the pandemic the implementation date was delayed to 1 April 2022 however the Code of Practice is yet to be published.

Key Recommendation(s):

1. Review of training and development of a blended approach to improve compliance in line with intercollegiate document.
2. Development of integrated policies and systems to ensure robust governance arrangements following the merger.
3. Audit of MCA and review of roles/ requirements in preparation for LPS.
4. A review of the team structure to ensure sustainability of safeguarding function – currently inequitable structure across the two merged organisations.

Safeguarding Adults Annual Report (BSUH) 2020-21

Annual Report to the Board of Directors – January 2021

Safeguarding Adults including Prevent, Mental Capacity Act and DoLS /LPS

1. Introduction and Executive Summary

The Care Act (2014) provides the statutory framework for safeguarding adults. Sections 42 – 47 of the Act set out the legal duties and responsibilities in relation to safeguarding. Key responsibilities lie with Local Authorities, working in partnership with the Police and NHS.

The Care Act safeguarding duties apply to an adult who:

- Has needs for care and support (whether or not the local authority is meeting any of those needs),
- Is experiencing, or at risk of, abuse or neglect,
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about working in partnership to support people to make decisions about the risks they face in their own lives and protecting those who lack the mental capacity to make those decisions.

Making Safeguarding Personal (MSP) is the national approach to safeguarding adults with the aim of ensuring the response to safeguarding is person led and outcome focused. The key principle is to engage with the adult in a way which supports and empowers them to make choices and have control about how they live their lives.

The Annual Report provides an overview of safeguarding activity within BSUH from 1 April 2020 to 31 March 2021. The report illustrates how the Safeguarding Adults team within BSUH continued to work closely with its partners across the local community to ensure the principles of safeguarding underpin core practice alongside the values and beliefs of the organisation; thereby ensuring the Trust is fulfilling its duties and responsibilities with regard to the welfare of those who come into its care.

One of the key purposes of safeguarding is to improve not only the care of the individual involved but also to learn from our mistakes to improve practice and the care of other patients. Equally it is important to recognise and share where good practice has taken place. This report highlights the key themes identified in the concerns raised in order to identify areas for improvement.

Whilst face to face training was discontinued as a result of social distancing requirements during the COVID-19 pandemic, training for staff remains a priority to ensure they have the necessary skills and knowledge to recognise and respond to safeguarding concerns.

Implementing the principles of the Mental Capacity Act (2005) is core to safeguarding the voice of our vulnerable patients. An increasingly high number of patients are subject to Deprivation of Liberty Safeguards. This report provides assurance that BSUH works closely

with the relevant local authorities to ensure these are proportionate and in accordance with legislation.

The Mental Capacity Amendment Act (2019) introduces revisions to DoLS and the Board will need to review the implications of the new Liberty Protection Safeguards (LPS) and make provision for the implementation of these.

The report identifies that there has been an increase in allegations against staff. The Board should be assured that BSUH has the appropriate policies and procedures in place whereby allegations against people in positions of trust are responded to in a way that is proportionate and transparent. Unless the allegation is deemed to be a criminal offence, the focus of a safeguarding enquiry involving individual staff is not to be punitive but to seek to understand the circumstances that may have led to the allegation being made; to identify individual learning outcomes but also where learning can be shared across clinical areas to improve practice.

2. Safeguarding Adults in BSUH

The Safeguarding Adults agenda is a key component of Patient Safety in BSUH. The team consists of X 1.0 WTE Band 8a Lead Nurse for Safeguarding Adults who reports directly to the Deputy Chief Nurse. In addition they are supported by X 1.0 WTE Band 7 Safeguarding Adults /Mental Capacity Act Lead Educator and a 0.67 WTE Band 4 Safeguarding Adults Team Administrator. A previous 0.54 WTE Band 7 Safeguarding Nurse vacancy has been removed following a restructure elsewhere within Quality and Safety which historically holds the budget for safeguarding adults. The Safeguarding Adults team work across all BSUH sites.

Affiliated to the team is a Health Independent Domestic Violence Advocate (HIDVA), working on site at RSCH. The role is commissioned by the CCG who provide funding to RISE (Brighton and Hove domestic abuse charity) to provide support to ED /Maternity/Sexual Health. In addition 2.8 WTE Learning Disability Liaison Nurses work across BSUH and are employed by Sussex Partnership NHS Foundation Trust and Sussex Community NHS Foundation Trust.

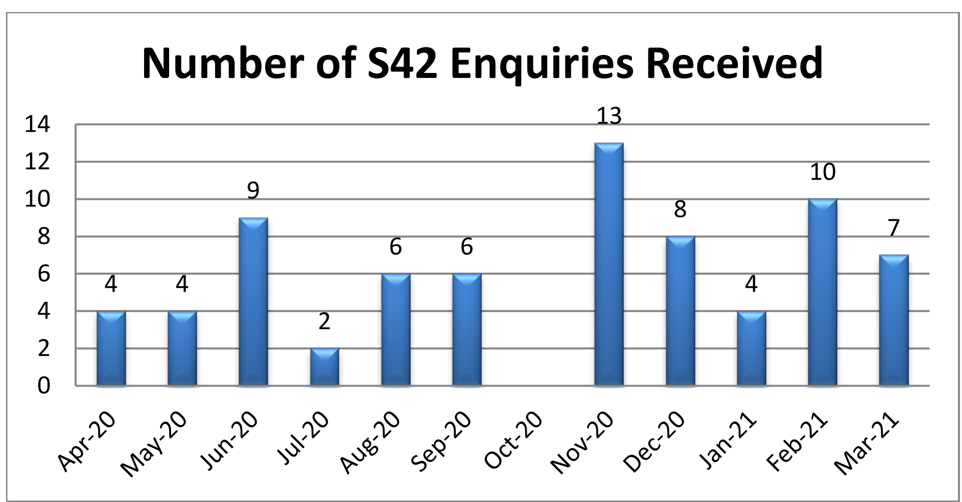
The BSUH Safeguarding Steering Group meets on a quarterly basis, bringing together Safeguarding Children, Safeguarding Adults, Prevent, MCA and DoLS, Domestic Violence, Learning Disabilities, Dementia and Mental Health. The steering group is chaired by the Chief Nurse and there is attendance from all the clinical divisions as well as external partners. In line with the clinical governance structure, this steering group reports to the Patient Safety Group. The Lead Nurse Safeguarding Adults participates in both the Patient Experience Group and Patient Safety Group which provides improved escalation of safeguarding and sharing of learning.

The Chief Nurse is a member of both the Brighton and Hove and West Sussex Safeguarding Adults Boards (SAB) and the Safeguarding Team members actively participate in sub committees of both SABs. The Lead Nurse Safeguarding Adults also represents BSUH at the Brighton and Hove Prevent Board.

Safeguarding Activity April 2020 to March 2021 - Section 42 Enquiries

As part of their statutory duties, The Care Act requires local authorities to make enquiries or ensure others do so, when they believe that an adult is subject to, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to stop or prevent abuse or neglect, and if so, by whom.

For the period 1 April 2020 to 31 March 2021 the team received 73 Section 42 “Causing others to undertake enquiry” whereby concerns were raised regarding the care provided by BSUH. Each Section 42 enquiry relates to an individual adult although may include more than one category of harm or abuse.



In line with The Care Act, allegations of harm or abuse are raised as one of more of the following categories:

- Neglect or acts of omission
- Physical
- Sexual
- Emotional/Psychological
- Domestic
- Financial
- Discriminatory
- Modern Slavery
- Organisational
- Self-neglect

As with previous years, the majority of Section 42 enquiries received regarding the care provided by BSUH fell into the category of ‘Neglect or acts of omission’. A review of the underlying themes within the safeguarding concerns raised can be seen below. Multiple themes may relate to one Section 42 enquiry.

Themes

9

A comparison with the safeguarding concerns received last year shows that discharge continues to be an on-going area of concern. However, there is a reduction from last year where 44 Section 42 enquires relating to discharge were received. This in part may be due to the changes in both legislation and processes relating to discharge implemented in response to the COVID-19 pandemic.

However, concerns involving poor communication as a theme increased from 9 the previous year to 15 this year. There is no doubt that national lockdown and COVID-19 restrictions on visiting had an impact on the anxiety felt by families and the sense of isolation from their loved ones during the pandemic. Equally, demands on staff were unprecedented. Ward staff have worked hard to learn from the safeguarding enquiries and in many cases have taken them as an opportunity to review and improve their own process such as identifying a named person on the ward round from the MDT who will make contact with specific relatives that day; improving discharge planning documentation to aid communication. A Transformational Lead for Discharge has also been appointed.

There has been an increase in safeguarding allegations raised against individual staff. These have ranged from allegations of inappropriate restraint, inappropriate touching of a potentially sexual nature as well as verbal abuse and rough handling. BSUH has a ‘Managing Safeguarding Allegations Against People in Positions of Trust’ policy and continues to work in partnership with Adult Social Care and Sussex Police with regard to all allegations raised against individual members of staff. After a period of investigation none have resulted in any formal action from Sussex Police, however where appropriate, further action has been taken in line with BSUH Investigation and Disciplinary policies.

Learning from Safeguarding Adult Reviews

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

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

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

The Brighton and Hove SAB commissioned SAR James – James was a 42 year old man who suffered a brain injury in 2010 which led to him developing significant care and support needs and subsequently coming into contact with a range of statutory and non-statutory agencies when he returned to independent living. James experienced many issues which impacted on his engagement with services including substance misuse, self-neglect, financial abuse, exploitation and fluctuating ability to make capacitated decisions following his brain injury. James was admitted to RSCH in 2019 following a cardiac arrest linked to drug use and subsequently died shortly after this.

Key learning points highlighted in SAR James include the need to improve the knowledge and skills for practitioners undertaking Mental Capacity Assessments with adults with an ABI, to fully explore their ability to use and weigh and demonstrate the 'how' or executive functioning as part of the assessment.

The full SAR report is published on the SAB website. In addition, the SAB also produced a learning briefing for professionals that was shared with all SAB partners:

Internal Audit

The Internal Audit review of Adult Safeguarding took place in February 2021. This was completed by BDO LLP - The purpose of the audit was to assess whether there is a strong, integrated and sustainable culture of safeguarding vulnerable adults with effective governance, leadership, strategic and operational working.

The conclusion of the report was as follows:
Overall, we identified four findings relating to the Trust's controls for adult safeguarding. Whilst there are policies and procedures in place to provide guidance to staff for safeguarding adults key responsibilities as to the role of the Board lack sufficient detail.

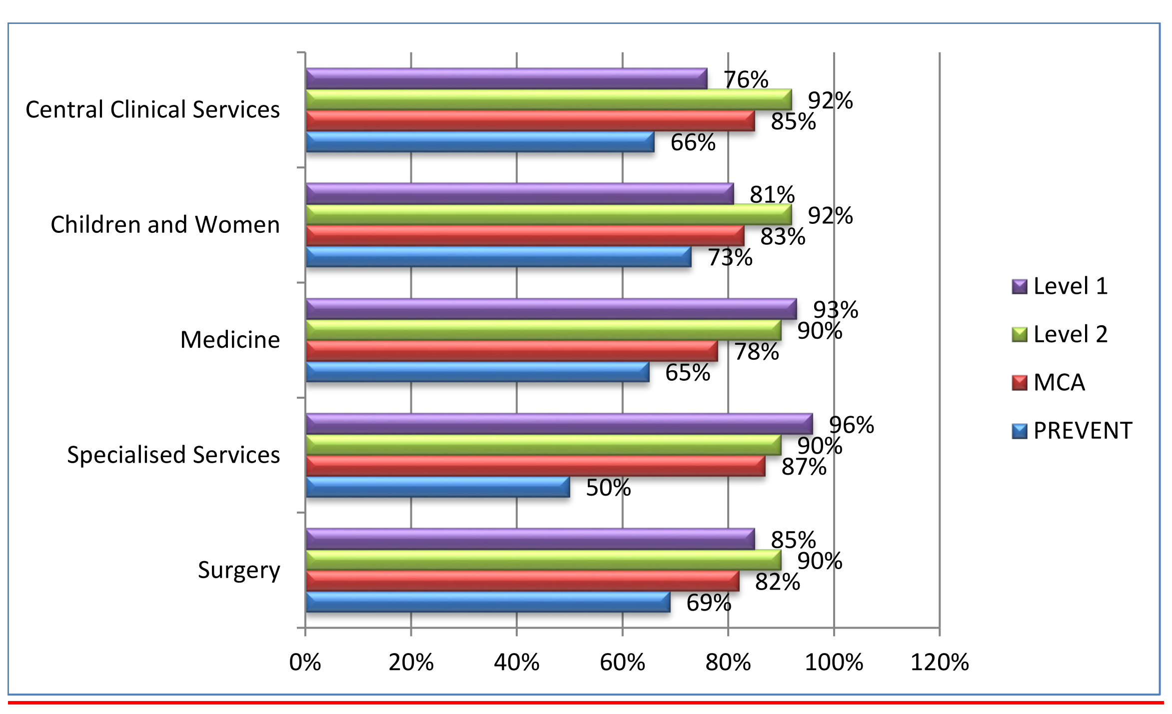
Additionally we noted instances where there was insufficient documentation of the actions to be implemented to better safeguard adults going forward. This led to our final assessment of moderate assurance over the control design and moderate assurance over the control effectiveness.

Three of the recommendations were rated moderate risk (amber) and 1 rated as low risk (green). There were no high risk (red) recommendations. The action plan highlighted in response to the recommendations included the following:

- Safeguarding Adults polices to be refreshed as part of the merger between BSUH and WSHFT to ensure practice in relation to both raising concerns and completing safeguarding enquiries across all sites is in line with Local Authority processes.
- Planned implementation of monthly safeguarding review meetings with ward leaders/matrons to review safeguarding concerns and development of action plans. Divisional summaries to be presented at quarterly safeguarding committee.
- More detailed safeguarding level 3 blended learning currently in development – to include focus on completing section 42 enquiries /managing allegations against staff /supporting vulnerable patients with complex needs – best interest decision making etc.
- Monthly divisional safeguarding to include training compliance – sent to Heads of Nursing/ Safety & Quality leads to be shared at divisional governance meetings.
- Divisional training compliance included in safeguarding updates for safeguarding committee.
- To strengthen partnership and engagement with the West Sussex SAB following the merger.

Training

Divisional compliance as at March 2021



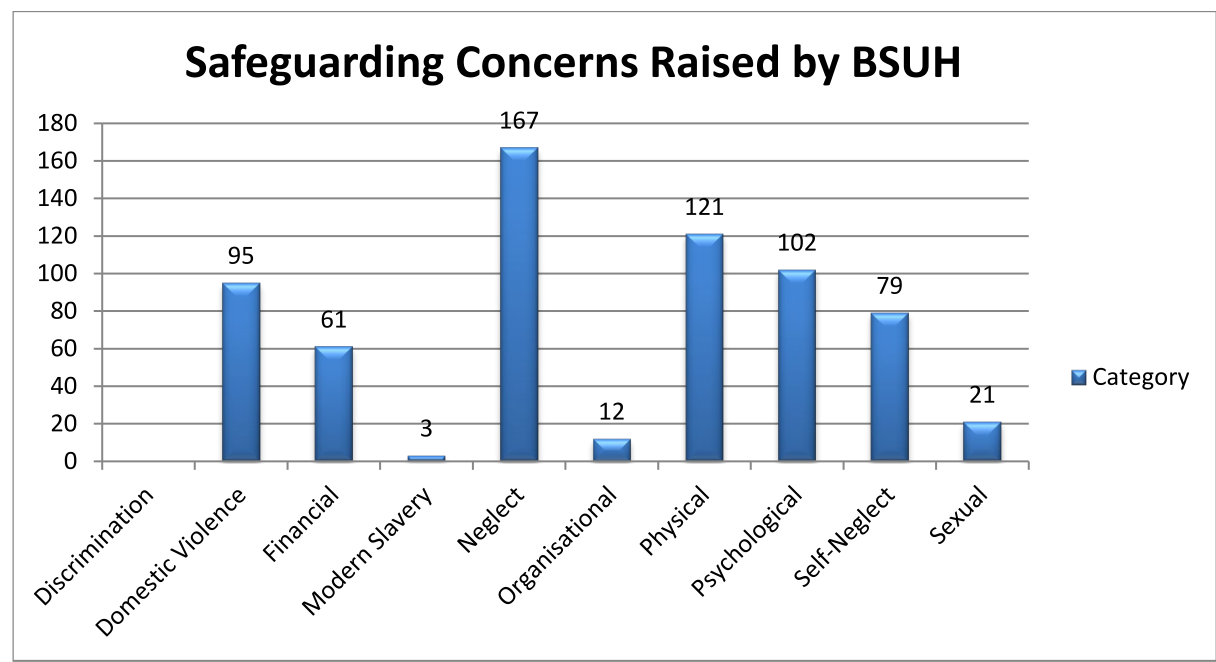
As part of the Trust response to COVID-19, face to face training was discontinued in order to maintain safety of staff in line with social distancing requirements. As a result, e-learning modules have been/are being developed. The Safeguarding Adults/ MCA Education Lead, with support from the Trust IRIS team, has developed and updated Level 1 and Level 2 e-learning which meets the national and professional requirements of both Skills for Health and the RCN Intercollegiate document.

Level 2 includes the requirements for Mental Capacity Act training although a stand -alone module is being finalised. Level 3 modules available on IRIS:

- Prevent L3 national e-learning
- Domestic Abuse e-learning

Both modules contribute to overall level 3 requirements.

The purpose of training is to share learning from safeguarding to improve patient care and also to give staff the knowledge and skills to recognise concerns and report these appropriately. Staff have a duty to safeguard patients in the wider community as well as within our hospitals. One measure of the impact of training can be reflected in wider safeguarding activity.



Throughout 2020 – 21 BSUH raised 661 safeguarding concerns, a significant increase from the previous year's total of 418 safeguarding concerns raised. An emerging theme of safeguarding throughout the COVID-19 pandemic both nationally and locally has been the significant increase in calls to domestic abuse helplines. This has also been reflected in the increased number of safeguarding concerns raised by BSUH relating to domestic violence and abuse when compared to the previous year figures of 45 safeguarding concerns.

3. Prevent

Prevent is one of four strands in the Government's counter terrorism strategy, CONTEST. The revised strategy was launched by the Home Secretary in June 2018 and reinforces safeguarding at the heart of Prevent; to ensure children or adults vulnerable to any form of radicalisation are supported as they would be if at risk from exploitation from a range of other harms such as criminal exploitation, gangs and sexual exploitation.

Brighton and Hove remains a priority city in accordance with the Home Office classification of risk. The Deputy Chief Nurse is the Trust Prevent lead and BSUH is represented at the Brighton and Hove Prevent Board by the Lead Nurse Safeguarding Adults.

Prevent has continued to remain an area of focus throughout the pandemic. Social isolation and the impact on mental health has the potential to increase vulnerability to exploitation. Whilst lockdown has resulted in a reduction in travel capabilities, on-line grooming and radicalisation via social media and gaming sites have continued to grow.

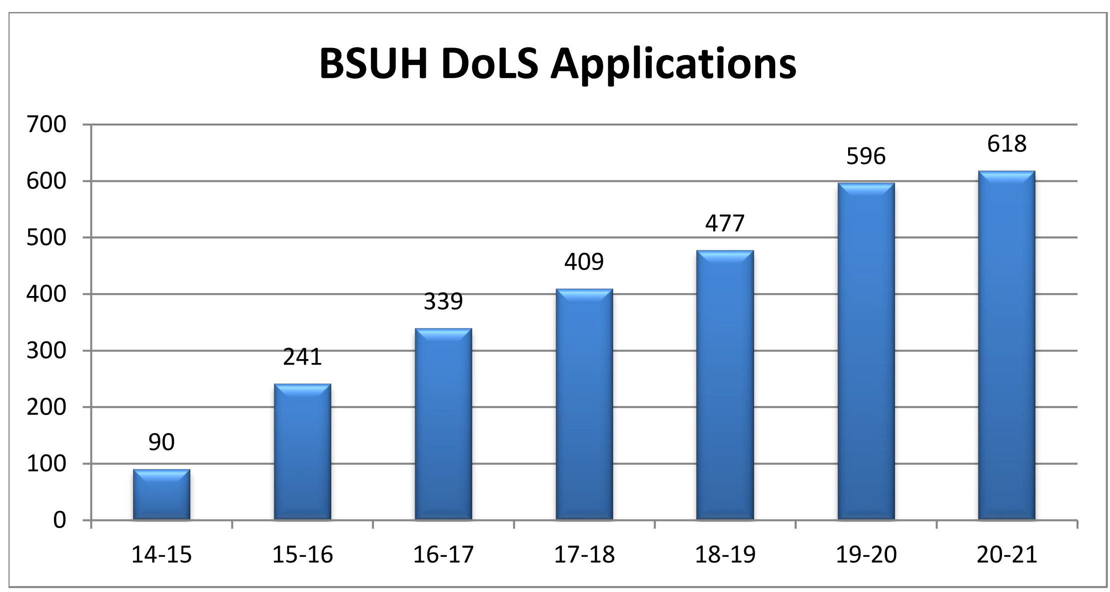
Following the terrorist attack in Forbury Park, Reading in June 2020, #WeStandTogether - Communities across Brighton & Hove stand together as One Voice was a message of solidarity shared with all partners along with a reminder that the terrorist threat level remained 'substantial' meaning an attack is likely.

Prevent training is included as mandatory training requirements for staff working in BSUH. Level 1 and Level 2 basic Prevent awareness are included as part of core Safeguarding Adults training as well as referenced in Safeguarding Children training. Home Office approved Prevent Level 3 e-learning for NHS trusts has been developed and is available on IRIS. As a result, BSUH has seen a significant improvement in the training compliance reported to NHSE.

4. Mental Capacity Act and DoLS

Deprivation of Liberty Safeguards (DOLS) activity 2020 - 21

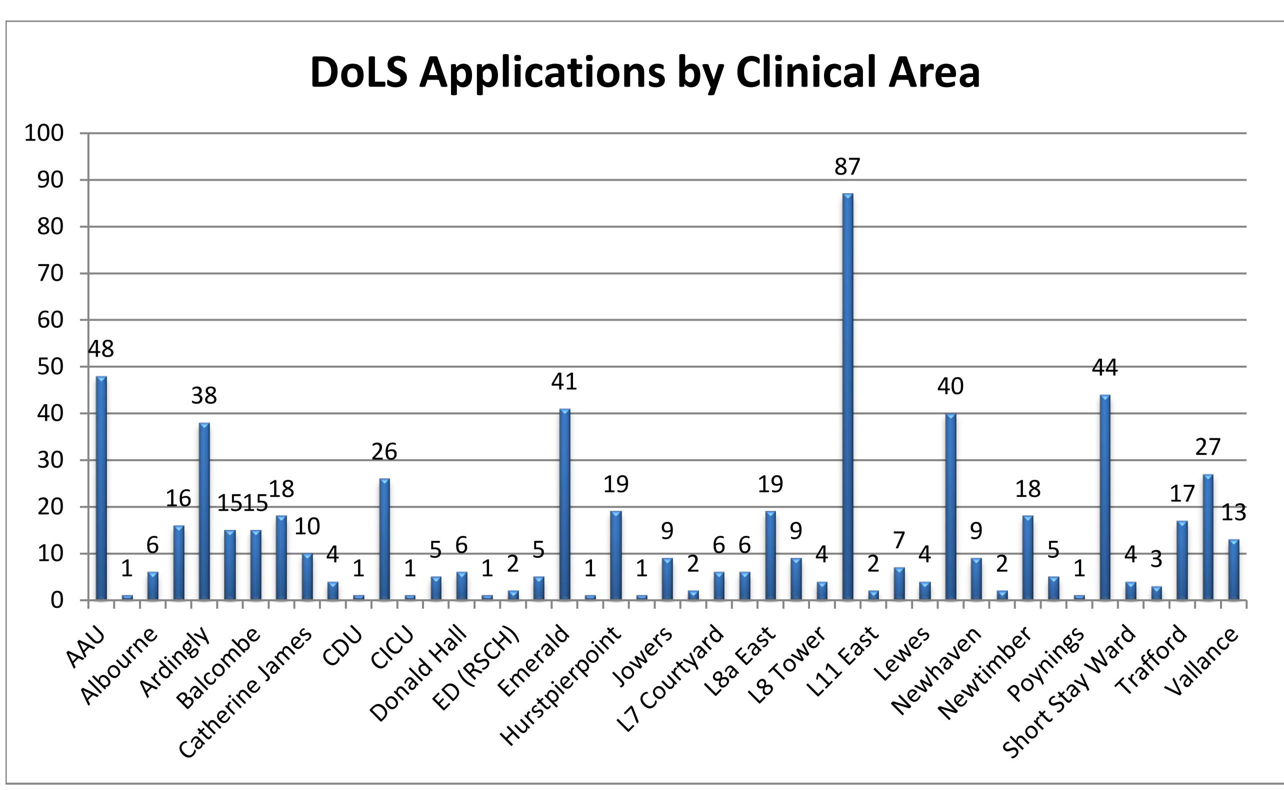
In line with the national trend, BSUH continues to see a year on year increase in the number of DoLS applications submitted to the local authorities for authorisation. DoLS processes were streamlined during the COVID-19 pandemic. In addition the hospital experienced a reduction in non-COVID-19 related hospital admissions therefore, whilst there continued to be a year on year increase, this was proportionately lower than previous year on year increases. The Safeguarding Team continues to monitor the DoLS applications made by BSUH and the impact of the return to pre-COVID-19 requirements for DoLS and the return of non-COVID-19 admission activity.



The Mental Capacity (Amendment) Bill was introduced to the House of Lords in July 2018. The Bill seeks to replace DoLS with a new scheme called **Liberty Protection Safeguards (LPS)**. The implementation date of October 2020 was delayed due to COVID-19 and is currently planned for implementation from 1 April 2022. Publication of the LPS Code of Practice, which will underpin the implementation, remains overdue.

Nonetheless, the Trust needs to consider the implications of the new roles within LPS and the responsibilities for assessing/authorising and monitoring which will fall to BSUH particularly in light of the above figures.

DoLS applications by clinical area April 2020 - March 2021



5. COVID-19

Some of the impact of COVID-19 has already been highlighted throughout this report.

In recognition of the unprecedented demands faced by partner agencies as a result of COVID-19, the majority of SAB and subgroup meetings were suspended. However, the Safeguarding Team worked hard with limited resources to maintain BSUH's statutory safeguarding function. The decision was made not to redeploy the Safeguarding Team to clinical areas and they continued to work across BSUH, providing support to staff and patients in clinical practice.

The Safeguarding Team maintained regular links with the CCG safeguarding leads as part of the system calls to support safeguarding governance across health partners throughout the pandemic; sharing trends and emerging themes.

The increase in partner agencies working remotely from home had a significant impact on the work undertaken by the team who remained present in the hospital. The Lead Nurse Safeguarding Adults worked closely with the Dementia Specialist Lead Nurse, supporting the care of complex patients and often undertaking mental capacity assessments in relation to discharge that would previously have been undertaken by colleagues in Adult Social Care. Whilst the Care Act was suspended and new discharge legislation implemented to support the impact of COVID-19 on Health and Adult Social Care, the Mental Capacity Act did not change. Ensuring the principles of MCA and best interest decision making continue to be implemented has, at times, proved challenging.

The HIDVA also worked remotely throughout the pandemic which resulted in many of the concerns relating to domestic abuse being referred directly to the Safeguarding Team rather than the HIDVA.

6. Safeguarding Adults Priorities for 2021 – 22

The Safeguarding priorities for 2021-22 need to be considered against the background of the on-going impact of COVID-19 and also the merger between BSUH and WSHFT from 1 April 2021.

- Implementation of Level 3 Safeguarding training.
- Implementation of the action plan in response to internal audit recommendations – outstanding actions: updating and merging relevant policies and development of level 3 safeguarding training.
- Completion of the SAB bi-annual safeguarding self –assessment and peer challenge event.
- Preparation for and implementation of LPS in line with legislative requirements.
- Strengthening of partnership and engagement with SAB and associated activity.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	12.4	Meeting:	Trust Board of Directors	Meeting Date:	3.2.2022
Report Title:	Safeguarding Adults Annual Report (WSHT) April 2020-March 2021				
Sponsoring Executive Director:			Chief Nurse		
Author(s):			Frank Ungani- Trust Senior Lead for Safeguarding Adults		
Report previously considered by and date:			Safeguarding Strategy Committee 9.12.2021 Quality Committee 22.12.2021		

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	✓	
Sustainability	✓	
Our People	✓	
Quality Improvement	✓	
Systems and Partnerships	✓	

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

Communication and Consultation:

Executive Summary:

The Safeguarding Annual Report provides an opportunity to reflect on where we need to focus our efforts in the year ahead (2021/2022) and celebrate our achievements in 2020-21. The trust faced a lot challenges over the last year caused by COVID-19, but the safeguarding adults team managed to minimise disruption to safeguarding provision and service provision.

The 2020-21 annual report provides the Trust Board with:

- An overview of the local, regional and national context of safeguarding
- An overview of safeguarding practice within the Trust
- The adults Safeguarding team activities, achievements and progress during 2020-21 to develop a culture that puts safeguarding at the centre of all care delivery.
- Assurance that the Trust is meeting its statutory obligations and the required national standards with regard to safeguarding adults.
- 2021-2022 challenges, future priorities and work plans for the safeguarding adults team to demonstrate continuous improvement on the arrangements currently in place.

The priorities set for this year were as follows:

PRIORITY 1 - Deliver successful Trust wide transition of new safeguarding concerns process with the WSCC safeguarding hub-Delivered.

PRIORITY 2 - Deliver training plan to achieve compliance with the Intercollegiate Requirements for Safeguarding Training levels-Partially delivered.

PRIORITY 3 - Deliver the Mental Capacity Act action plan developed in response to the 2019/20 DoLS audit and NICE standard gap analysis-Partially delivered.

PRIORITY 4 - To review and update the MHA policies and procedures and complete assurance audit of section 5(2) and Section 132 reading of rights documentation-Partially completed.

PRIORITY 5 - To review protocols and training for staff relating to domestic violence concerns (for adults without children) to ensure robust communication pathways-Delivered.

Conclusions

This has been another busy year for the Safeguarding Adults Team. The team celebrate the successful change to direct referrals to the WSCC safeguarding hub. The team also ensured that despite significant operational pressures the matrons across the Trust were supported to undertake timely investigations to ensure no section 42 backlog.

The year has seen an increase in reporting, both of safeguarding concerns and requests for DoLS authorisations, which is positive evidence of increased awareness by teams.

The focus of our improvement work will be on the quality of the safeguarding concern referrals and the DoLS requests and ensuring staff are trained to the appropriate level for their role. The audits conducted in 2021 will guide the development of future training programmes.

Additionally, the priorities below respond to the identified and growing challenge of care for patients with complex mental health needs and the merger between BSUH and WSHFT from 1st April 2021.

- Implementation of full review of Safeguarding, MCA and Prevent Training in order to develop an aligned UH Sussex training plan.
- Implementation of the MHA action plan in response to internal audit recommendations.
- Completion of the SAB bi-annual safeguarding self –assessment and peer challenge event
- Preparation for and implementation of LPS in line with legislative requirements
- Strengthening of partnership and engagement with SAB and associated activity.

• Develop and Implement Domestic Violence Support Improvement Plan. • Transitional safeguarding is to be reviewed and opportunities for joint working explored.
Key Recommendation(s):
The Board is required to APPROVE

Annual Report
Safeguarding Adults
April 2020 to March 2021

Prepared By

Frank Ungani - Trust Senior Lead for Safeguarding Adults

Lisa Ekinsmyth - Quality Matron

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1. Introduction and Executive Summary

The Safeguarding Annual Report provides an opportunity to reflect on where we need to focus our efforts in the year ahead (2021/2022) and celebrate our achievements in 2020-21. The Trust faced a lot challenges over the last year caused by COVID-19, but the Safeguarding Adults Team managed to minimise disruption to safeguarding provision and service provision. The organisation became University Hospitals Sussex NHS Foundation Trust from the 1 April 2021 and the former Western Sussex Hospitals NHS Foundation Trust is referred to as UHSussex (West). UHSussex continues to recognise and adhere to the principle that safeguarding is everyone's business.

The Safeguarding Adults Team has been working collaboratively and restoratively with the Safeguarding Children Team and our partner agencies to "think family" and protect all those at risk of harm, abuse or neglect.

The Annual Safeguarding Adults Report provides an update on safeguarding adults' activity within historically Western Sussex Hospitals Foundation Trust from 1 April 2020 - 31 March 2021 and compares this with the available activity data from the local authority.

The report also includes an update on training provision and on activity in relation to the Mental Capacity Act (Deprivation of Liberty Safeguards requests) and Mental Health Act detentions.

This report provides a declaration of assurance that the Trust is fulfilling its duties and responsibilities in relation to promoting the welfare of adults and their families or carers who come into contact with our services.

The 2020-21 Annual Report provides the Trust Board with:

- An overview of the local, regional and national context of safeguarding.
- An overview of safeguarding practice within the Trust.
- The Adults Safeguarding Team activities, achievements and progress during 2020-21 to develop a culture that puts safeguarding at the centre of all care delivery.
- Assurances that the Trust is meeting its statutory obligations and the required national standards with regard to safeguarding adults.
- 2021-2022 challenges, future priorities and work plans for the Safeguarding Adults Team to demonstrate continuous improvement on the arrangements currently in place.

The Care Act 2014 delivered the legislation which governs safeguarding activity. Safeguarding duties apply to an adult aged 18 or over who:

- has needs for care and support (whether or not the local authority is meeting any of those needs) and is experiencing, or at risk of, abuse or neglect; and as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

2. Governance and Accountability Arrangements

2.1 The Safeguarding Adults Team at WSHFT

The Safeguarding Adults Team consists of an executive lead and team working to support clinical wards and departments across sites as follows:

Maggie Davies	Chief Nurse and Executive Lead for Safeguarding Adults and Looked after Children and Prevent Lead
Annie Blackwell	Trust Senior Lead for Safeguarding Adults (1.0 WTE)
Monique Devlin	Safeguarding Nurse Specialist (0.8 WTE)
Carolyn Marskell	Mental Capacity Act Lead (0.9 WTE)
Marianna Wilmott	Team Administrator (0.57 WTE)

The wider remit for adult safeguarding also includes the delivery of the Trust Dementia and Learning Disability work streams. The responsibility for the planning and delivery of the Dementia Strategy is held by the Matron for Dementia who historically has been reporting to the Trust Senior Lead for Adult Safeguarding.

Improving the care of patients with learning disability is currently led by the Matron for Quality through the Trust Learning Disability and Autism Strategy meeting (which reports into the Trust Safeguarding Operational Group).

2.2 Role & Responsibility of the West Sussex Safeguarding Adults Board (WSSAB)

The Care Act 2014 sets out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect. One of the local authorities duties set out by the Care Act 2014 is the establishment of Safeguarding Adults Boards that consist of the local authority, NHS and police, which will develop, share and implement a joint safeguarding strategy.

The focus is on personalised and outcome focused care with an emphasis on making adult safeguarding ‘personal’. Adults should therefore be seen as experts in their own lives and safeguarding means working ‘with the adult’ and not a process that is done to or for an adult.

The main objective of a Safeguarding Adults Board is to assure itself those local safeguarding arrangements and partners act to help and protect adults in its area who meet the criteria set out in the care Act 2014.

The Care Act 2024 states that a Safeguarding Adults Board (SAB) has three core duties:

- It must publish a strategic plan for each financial year that sets out how it will meet its main objective and what the members will do to achieve this. The plan must be developed with local community involvement and the SAB must consult the local Healthwatch organisation. The plan should be evidence-based and make use of all available evidence and intelligence from partners to form and develop its plan.
- It must publish an annual report detailing what the SAB has done during the year to achieve its main objective and implement its strategic plan and what each member has done to implement the strategy as well as detailing the findings of any Safeguarding Adults Reviews and subsequent action.
- It must conduct any Safeguarding Adults Reviews in accordance with Section 44 of the Act.

In addition to the statutory requirements, the West Sussex Safeguarding Adults Board (WSSAB) has the following aims:

- The Board strives to make sure that the voices of adults with care and support needs, their families and their carers are heard.
- The Board sets the strategic direction for safeguarding.
- To have effective processes in place to prevent and respond to abuse and neglect.
- To raise awareness of the importance of safeguarding through publicity campaigns.

In March 2020 the WSSAB temporarily postponed some of the subgroup meetings in recognition of the pressures for the Partnership due to the pandemic. This decision was revisited in June 2020 when all meetings fully resumed. With the support of our Partners, WSSAB continued progressing all workstreams to safeguard adults in West Sussex. In January 2021, once again, the board reduced the frequency of some subgroup meetings. However, all work has continued to be progressed with oversight and sign off by key Partners. This has ensured continuation, as far as possible, to the vital work to protect adults at risk of abuse and neglect and ensure compliance with the Care Act.

The WSSAB has a number of subgroups. The Safeguarding Adults Team attend the Learning and Policy (formerly called Learning and Development) subgroup and the Quality and Performance subgroup. The Trust Senior Lead for Safeguarding Adults attends the

Quality and Performance subgroup and the Safeguarding Adults Nurse Specialist attends the Learning and Policy subgroup.

The WSSAB receives assurance of each organisation's performance through an assurance document.

Western Sussex Hospitals Foundation Trust was represented on this Board by Nursing Director, Dr Maggie Davies and Annie Blackwell/Lisa Ekinsmyth Trust Senior Lead for Safeguarding Adults.

2.3 NHS Professionals Forum

This forum has been in operation since 2007 in a variety of formats. Currently this is a meeting open to all safeguarding adults professionals within the NHS across Sussex.

Meetings are held quarterly and are informal in nature, enabling safeguarding professionals to recommend practice changes or improvements to the Safeguarding Adults Boards, discuss cases, issues and share knowledge and experience.

During the COVID-19 pandemic these meetings were held weekly as a means for safeguarding professionals working in health to be able to share experiences and support one another during business continuity. These meetings are currently being held on a monthly basis.

Western Sussex Hospitals NHS Foundation Trust is represented at these meetings by the Trust Senior Lead for Safeguarding Adults.

2.4 The Adult Safeguarding Operational Group (WSHFT)

The Adult Safeguarding Operational Group used to meet quarterly. Since the merger with our colleagues in Brighton and Hove the meeting is now held bi-monthly. The structure of the meeting now follows the Children's safeguarding teams meeting and has an overlap period to discuss issues relevant to both teams including; transitional safeguarding and domestic abuse.

The overall purpose of the Safeguarding Adults Operational Group is to monitor the implementation and effectiveness of the Trust's safeguarding adults processes, compliance with the requirements of the Care Act and Making Safeguarding Personal.

- To ensure compliance with the duties placed on NHS and Foundation Trusts in accordance with Home Office Prevent Duty guidance.
- To monitor the implementation of the Mental Capacity Act to ensure compliance with the principles of the Act and best interest decision making.

- To monitor the process by which patients are detained to the Trust under Deprivation of Liberty Safeguards and also the Mental Health Act.
- To receive updates on Trust safeguarding cases, identify any themes and to triangulate and share the learning from safeguarding concerns which link with complaints, inquests, legal claims and clinical and non-clinical incidents.
- To receive quarterly safeguarding exception reports and identify any issues which require escalation to the Safeguarding Strategy Committee.
- To monitor safeguarding and MCA action plans and escalate any issues which cannot be resolved at an operational level.
- To receive summary reports from Safeguarding Adults Reviews which the Trust has contributed to and to disseminate the learning from these reviews.
- To recommend to the Trust Quality Committee policy & practice changes that are required as a result of learning from safeguarding investigations.
- To act as a link between WSHFT and both the Brighton and Hove and West Sussex Safeguarding Adults Board (SAB) and its subgroups and to disseminate information from these groups to staff within the Trust.
- To act as a link between WSHFT and the local Prevent Board and to disseminate information in accordance with Counter Terrorism Police information sharing classifications.
- To monitor local and national safeguarding developments and to recommend to the Trust Quality Committee (via the Safeguarding Strategy Committee) those policy changes that are required as a result of these developments.
- To receive an annual report for safeguarding adults.
- To receive internal and external audit reports and monitor recommendations and associated action plans.

2.5 Adults & Children's Safeguarding Strategy Committee (WSHFT)

The Safeguarding Strategy Committee meets quarterly. The purpose of the Committee is as follows:

- Ensure there are mechanisms in place to alert staff to safeguarding policies and procedures.
- Ensure relevant staff have appropriate training in relation to national safeguarding requirements for both adults and children (i.e. Intercollegiate Guidance 2018) and the clinical divisions are able to demonstrate compliance.
- Scrutiny of the training strategy in line with local and national learning opportunities available.
- To consider progression of annual report development.

- Ensure dissemination of information from local Safeguarding Children's Board and Safeguarding Adults Board.
- Review any new guidance and set the direction for safeguarding strategy.
- Identify, monitor and ratify guidelines and procedures, making recommendations on changes aligned to national best practice. These will then be deemed ready for ratification at the Quality and Risk Committee and onward cascade into the organisation.
- To consider audit recommendations, taking forward any action points through relevant fora eg patient safety.

The Executive Lead is the Chief Nurse Dr Maggie Davies. The meeting is attended by the Safeguarding Leads for Adults and Children and by the Adults and Children's Safeguarding Doctors. The Safeguarding Leads have been advised that sufficient assurance has been received regarding the governance of the committee and the escalation of any outstanding concerns.

3. Review of the Year

3.1 Safeguarding Adults Board Developments (2020-2021)

The Safeguarding Adults Board has recently published their annual report for the period 2020-21. This included the following local developments:

- Supported and worked with East Sussex and Brighton & Hove Safeguarding Boards to create a:
  - Pan-Sussex Information Sharing Protocol;
  - Pan-Sussex Adult Death Protocol;
- Reviewed and updated all published documents to meet the Accessibility Standards' deadline of September 2020.
- Updated the Terms of Reference for all Subgroups.
- Reviewed Memberships of all Subgroups.
- Further developed the Threshold Guidance, to include information related to COVID-19.
- Established Board representation for GP service, Ford Prison, Gatwick Immigration Centre and the Department for Work and Pensions.
- Included case studies at Board meetings to ensure the voice of the user is heard.
- As part of the Board's Communication and Engagement Strategy, initiated a Service User Engagement Task and Finish group. This is led by our Healthwatch Partner and our Lay Person to reach community groups in order to promote what safeguarding is and how to refer.

3.2 CQC Regulation 13-Safeguarding Service Users from Abuse and Improper Treatment

The Trust continues to adhere to the CQC regulations for the "Fundamental Standards of Care". As part of the Fundamental Standards the CQC introduced Regulation 13 - Safeguarding Service Users from Abuse and Improper Treatment. The regulation sets out the clear requirements for providers to ensure the safety of their service users by ensuring adherence to the following:

- Systems and processes must be established and operated effectively to prevent abuse of service users.
- Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of any allegation or evidence of such abuse.
- Care or treatment of the service users is provided in the way set out in the regulation.
- A service user is not deprived of their liberty for the purpose of receiving care or treatment without lawful authority.
- Restraint of the service user is only undertaken in accordance with the requirements of the regulations.

The Safeguarding Adults Team has continued to provide evidence to the Compliance Team on a regular basis to demonstrate our compliance with these regulations. The data supplied includes policies as well as data on safeguarding cases, the number of DoLs authorisation requests and numbers approved and the number of people detained under the Mental Health Act.

3.3 West Sussex Safeguarding Adults Policy and Procedures.

A review of the Sussex Safeguarding Adults Policy and Procedures was finally completed and the new, electronic policy and procedures were published in June 2018. For the first time, this is only available electronically to facilitate regular updates. The Trust's Safeguarding Policy has been updated to reflect the changes to the Sussex Safeguarding Adults Policy and Procedures.

As described above, WSCC adopted a significant change in approach to their referral processes during 2019 with the launch of a new hub, a single point of referral for adult safeguarding concerns. This hub receives direct online referrals from professionals and members of the public which the team then triages, making the decision regarding whether the threshold for section 42 investigation is met. WSHFT has now successfully adopted this direct referral approach, implementing this change from September 2020.

3.4 West Sussex County Council Safeguarding Activity

West Sussex County Council is the lead agency for safeguarding and has a duty to record all safeguarding activity on behalf of the multi-agency partnership and the West Sussex Safeguarding Adults Board. Concerns from agencies are usually raised using the online form and are screened by West Sussex Adults Care Point and decisions are made regarding action required. The local authority extracts data from the West Sussex County Council's 'Mosaic' system and this is included in the Department of Health returns.

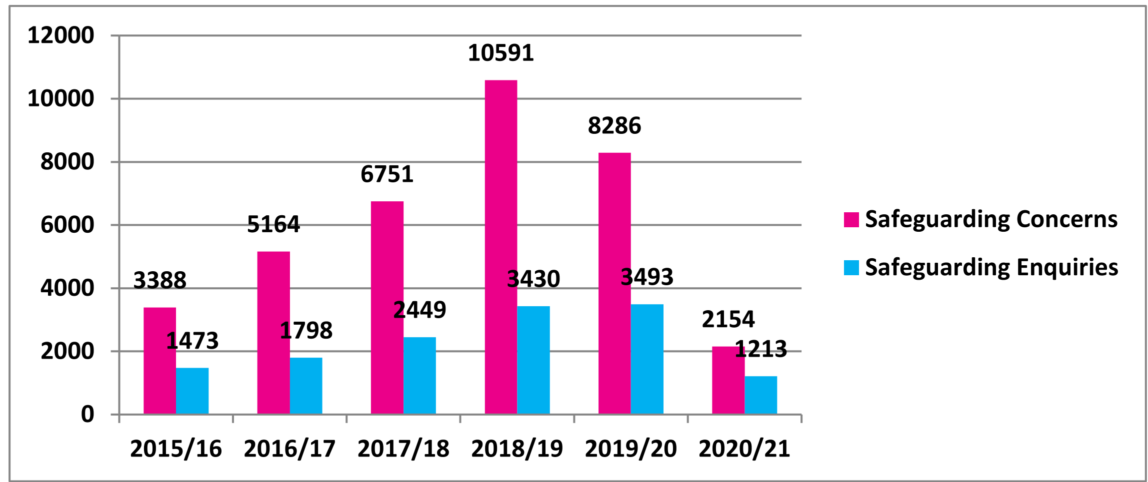
Previous years have seen the Department of Health making amendments to the way data is recorded and reported in West Sussex. This change, together with the additional categories of abuse introduced by the Care Act (self-neglect, modern slavery and domestic abuse) has meant that it has been difficult to make direct year on year comparisons.

The data given below is taken from the West Sussex Safeguarding Adults Board's Annual Report 2020-21, which is the most recent data available currently. The Safeguarding Adults Board Annual Report contains data on both the total number of safeguarding concerns and the number of concerns which become safeguarding enquiries (also known as Section 42 enquiries).

Figure 1 illustrates the total number of safeguarding concerns received by West Sussex County Council and the number of concerns which became safeguarding enquiries in the last five years.

The figures in the graph illustrate that there has been a significant decrease in the number of safeguarding concerns received over the course of 2020/21. This is understood to be due to the implementation of the online safeguarding referral form and Threshold Guidance. This reflects more appropriate referrals being made.

Figure 1 – West Sussex County Council Safeguarding Adults Activity 2015-2021



In the previous year, 2019/20, there were 8,286 concerns received. Of these 3,493 proceeded to a Section 42 Enquiry. This represents a conversion of 42.2% of safeguarding concerns proceeding to a Section 42 Enquiry.

This year, 2020/2021, there were 2,154 concerns received. The number of concerns reported each month has ranged between 122 to 238. Of the 2,154 concerns raised 1,213 proceeded to a Section 42 Enquiry, this represents a conversion rate of 56.3%. The number of safeguarding concerns reported to WSCC is fewer this year. This lower number is attributed to a change in the way in which WSCC receive and record concerns. Prior to the implementation of the Safeguarding Hub, all incoming concerns were recorded on a safeguarding concern form. However, a referral stage has now been added. A referral may lead to a safeguarding concern or another work pathway such as a care act assessment. The total number of referrals received in 2020/21 was 7,390.

The WSSAB also commissions Safeguarding Adults Reviews; details of these can be found in section 4.4 of this report.

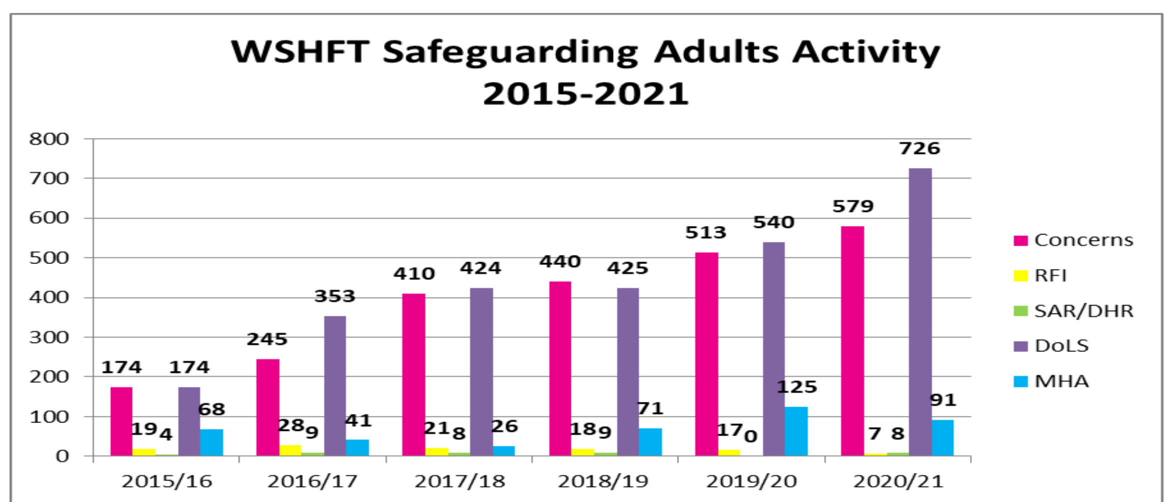
4. Trust Safeguarding Adults Activity

4.1 Trust Safeguarding Adults Team Activity

The Safeguarding Adults Team's activities include safeguarding casework, Safeguarding Adults Reviews (SARs), monitoring and logging all Deprivation of Liberty Safeguards (DoLs) and informing the Care Quality Commission (CQC) of the outcomes as well as the recording of those patients detained to WSHFT under the Mental Health Act.

Figure 2 details the WSHFT Safeguarding Adults Team's main areas of activity over the last six years. This includes data on all safeguarding concerns: external (community-based) concerns raised by Trust staff; concerns raised about Trust care, Safeguarding Adults Reviews (SARs) and "Requests For Information" (RFI) to inform external safeguarding enquiries. Under the Care Act, the Trust is required to respond to such requests for information to inform safeguarding enquiries. Data on the non-safeguarding aspects of the team's work (the number of Deprivation of Liberty Safeguards (DoLS) authorisation requests and data on Mental Health Act detentions to WSHFT) is also included.

Figure 2: Comparison of all Safeguarding activity within WSHFT 2015-2021.



This table clearly demonstrates that year on year, activity has continued to increase, in particular the activity relating to Deprivation of Liberty Safeguards.

Activity will be continually reviewed in order to determine any adjustments to the team structure that may be needed in order to support this increasing workload.

Making Safeguarding Personal (MSP) – The team continue to encourage and reinforce the importance of making safeguarding personal in training and in any contacts with clinicians. The need for consent regarding concerns being raised is discussed in training as well as considering the importance of capacity and coercion in terms of raising adult safeguarding concerns. The Safeguarding Adults Board has developed an MSP toolkit which is available on their website, with links from our staffnet pages for clinical staff to access.

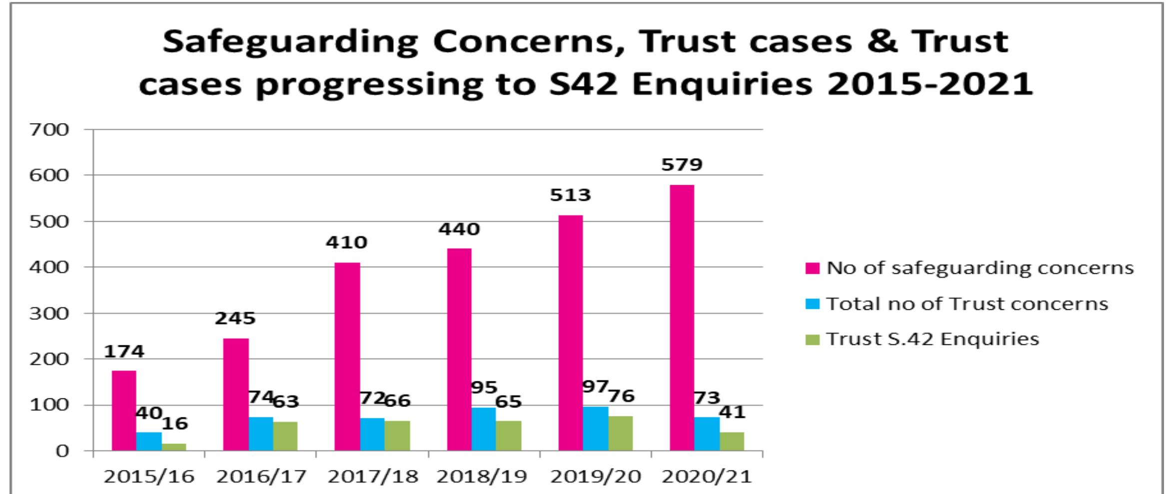
4.2 Trust Safeguarding S42 Enquiries

This year the total number of concerns raised was 579. Of these, 73 were related to Trust care and 41 (7.08% of total concerns) became Section 42 enquiries. This figure is half of the data from the previous year. The remaining cases were either deemed for information gathering only and did not progress to full enquiries or were logged as quality issues and escalated via our internal incident review processes.

This follows a review by the local authority of the process by which the safeguarding concerns are managed. Those cases which relate to quality are now removed from the safeguarding process.

Figure 3 shows the data for the last 6 years for the number of safeguarding concerns received by WSHFT and includes both concerns about issues related to care in the community (external cases) and Trust care. In 2020-21, 56% of trust cases progressed to S42 enquiries.

Figure 3: Trust safeguarding concerns progressing to S42 enquiries

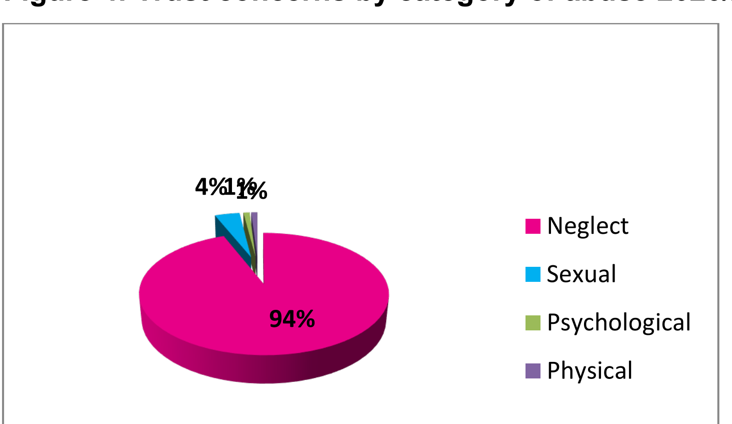


4.3 Types of harm in Trust cases

The Care Act cites 10 categories of abuse or harm, and all Trust concerns are logged as being one of these categories. Analysis of the detail for Trust safeguarding concerns indicates that the top two concerns were the same as last year: Neglect was the largest category with Sexual the second largest. Psychological Harm and Physical abuse were equal third.

Figure 4 illustrates top 4 categories of harm.

Figure 4: Trust concerns by category of abuse 2020/21



The “Neglect” category covers a wide range of concerns, from pressure damage to problems with discharges and issues with medication.

94% of neglect cases were linked to discharge. The common themes being lack of information, packages of care not being arranged and medication errors. The underlying most common threat is communication. This aligns itself with our patient experience feedback theme from surveys and complaints. It is expected that the Trust plans for a breakthrough discharge improvement programme will deliver a positive reduction in concerns raised.

The 1 Physical and 1 Psychological concerns were patient on patient incidents; one patient pulled out another patients NG tube and the psychological concern involved a patient verbally abusing another patient.

The sexual abuse cases included 3 concerns of sexual abuse by members of staff. All such cases are thoroughly investigated with full involvement of the police. No further action has been taken in any of the cases.

4.4 Safeguarding Adults Reviews (SAR)

The Safeguarding Adults Team received 4 Summary of Involvement (SOI) requests regarding Domestic Homicide Reviews (DHR) during 2020/2021. No requests were received for Safeguarding Adults Reviews.

Information was provided for the DHR panel; for one we were asked to complete an Information Management Review which will be reflected on in the 2021/2022 report. The panel acknowledged that the lack of hospital IDVA was a potential area of improvement.

Another of the SOI did, in the end, not become a DHR because the alleged perpetrator was acquitted. This meant that there was not an actual homicide to be reported on.

During 2020/21 WSCC received 6 referrals for SAR, 3 which met the criteria for review; there were also a further 3 open reviews. All 6 reviews progressed during this year had been referred by WSCC Social Care and were all regarding concerns about neglect or acts of omission. WSHFT received one “Summary of Information”(SOI) and full contact information has been provided by WSHFT to inform consideration for a SAR undertaken by WSCC. Although the review did not involve the experience of care by our services, the requested information supported the review of physical presentation of the patients on arrival to our care. The Safeguarding Adults Team also received requests in relation to 2 Domestic Homicide reviews during quarter 1.

Following receipt of a SAR report by the Trust in Quarter 3 of 2019/20 relating to Adult P, the Trust submitted their action plan in response to the learning from the SAR during Q 2 of 2020/2021.

The two key actions for the Trust related to:

- Develop a more robust approach to information sharing between organisations.
- Improved provision of discharge information.

The progress of this action plan is being monitored at the Trust operational group, learning from all WSCC SARs will be shared via ASOG.

Themes from the reviews by WSCC this year which provide helpful learning include:

- Person-centred approaches and making safeguarding personal.
- Health optimisation.
- Recognising and working with cases of self-neglect.
- Assessing and managing risks, including conducting risk assessments.
- Knowledge and implementation of the Mental Capacity Act.
- Safeguarding practice including implementation of the Care Act 2014.
- Multi-agency working and information sharing.
- Staff management and supervision.
- Professional curiosity.
- Partnership working including with the private and voluntary sector, housing, and GPs.
- Identifying unusually low or high levels of reporting of accidents, incidents and safeguarding concerns.
- Promote and sustain whistleblowing and the raising of safeguarding concerns in care services.
- Increase customer and family members' understanding of quality and "what good look like" in care homes.

4.5 Domestic Violence Referrals

The change in the delivery of domestic violence support within West Sussex continues to be a challenge and there continues to be no domestic violence advisor on site.

There was a short pilot at Worthing A&E of a domestic violence worker from WORTH services based in the department, however this was discontinued at the start of the COVID-19 outbreak and has not recommenced.

Work has continued to develop a business case for a Harm Reduction Worker, who would work with those experiencing domestic abuse but also frequent users of A&E services and

the homeless for example. However, to date this case has not been successful. The concerns in relation to a lack of access to specialist support on site have been added to the Risk Register this year.

The Safeguarding Adults Team are unable to attend the MARAC (Multi-Agency Risk Assessment Conference) meetings and have previously supported the work of MARAC by supplying related health information on specific individuals to the meetings in each area. However, there has been no capacity to be able to continue with this due to increased activity. The Child Protection Team Administrator continues to support the provision of information on behalf of the Trust. A full review of the domestic violence workload is required as part of the review of the team structure to ensure that this important and increasing work stream is appropriately supported.

4.6 Prevent Agenda

Prevent is the government's anti-radicalisation strategy and Prevent continues to sit within safeguarding. Although WSHFT is deemed to be a low risk area, in the last year we have been required to submit data on Prevent referrals and training to NHS England.

There remains a requirement for Prevent Level 3 training (previously referred to as WRAP - Workshop Raising Awareness of Prevent) to be completed by specific staff groups, with the data being reported to NHS England on a quarterly basis.

This year, the Level 3 training has been available online as e-learning and this has been encouraged as WSHFT does not have an accredited WRAP trainer. There have been no Prevent referrals this year.

5. Safeguarding Adults Training

There was a significant change in safeguarding adults training requirements in August 2018 with the publication of the intercollegiate document on Adult Safeguarding: Roles and Competencies for Health Care Staff. This sets out 5 levels of safeguarding training; the required level is determined by the job role.

All WSHFT job roles and safeguarding adults training requirements have been reviewed and the new levels identified. Work continues to ensure that the workforce reports accurately reflect the training level required for each staff member. The intercollegiate document confirms that the expectation is that all staff will have met their required training level by 2021. The last year has seen an increasing use of the E-learning for Health safeguarding adults modules available to staff via ESR.

The need for remote teaching opportunities caused by COVID-19 has led to a full review of the training challenge. During 2020/21, the achievement of the requirement for compliance

with the Intercollegiate document was a key objective. The Team worked closely with clinical leads to deliver a significant improvement in training compliance as shown in the table below (target for all levels = 85%).

Safeguarding Training Level	Staff Trained Q2	Staff Trained Q4
Level 1	**97.6%**	**99.5%**
Level 2	**58%**	**78.5%**
Level 3	**47.6%**	**67%**
Level 4	**100%**	**100%**

Further work is required to review the designation of various staff groups in relation to both Safeguarding and standalone Prevent and MCA training. MCA awareness training is currently included within the existing safeguarding sessions. However it is recognised that more in depth stand- alone training is needed. During the COVID-19 pandemic training moved towards remote or e-learning. The team have made two videos for practitioners requiring level 2 training. Level 1 continues to be delivered by the booklet. For those requiring level 3, we have utilised the e-learning for health online training. The team have also developed an interactive workshop which is delivered via Teams for practitioners to attend.

6. Mental Capacity Act Activity

Work continues to deliver training on assessing mental capacity and best interest decision making to support all staff groups to feel more confident; numerous bespoke sessions in different departments and disciplines have been delivered and these have been well received.

Complex situations continue to require a more individualised approach and there remains a constant stream of cases bought to the Mental Capacity Act Leads attention. Advice and support in these cases are provided directly to practitioners to navigate them through the process and ensure that patients' rights are upheld and that the legal framework is followed.

As described in section 5, a key objective for the coming year will be to review the current training needs analysis and to deliver mandated standalone MCA training across all staff groups in line with the legacy BSUH approach.

6.1 Deprivation of Liberty Safeguards (DoLS)

As seen in Figure 2, there has been a steady increase in the number of Deprivation of Liberty Safeguards (DoLS) authorisation requests being made over the last 6 years.

In 2020/21, there was a 34% increase in the number of DoLS applications from 2019/20.

No patient assessed by the WSCC DoLS team in 2020/21. This was due to the large number of DoLS authorisation requests being received by the DoLS team from across the county and challenges brought by the COVID-19. The DoLS team have reviewed their processes but acute hospitals continue not seen as a priority area.

The low rate of assessments by the DoLS Team has been raised at the NHS Safeguarding Professionals meeting as an area of risk and is also on the Trust's Risk Register.

In order to mitigate the risk of patients being detained unlawfully, the MCA Lead has developed a "Weekly DoLS Review" sticker. This is a coloured sticker which documents whether the patient still lacks capacity to consent to care and treatment, whether the patient is still being treated in their best interests and in the least restrictive way and whether the DoLS team have been updated. The stickers are used as evidence that the need for a DoLS has been reviewed, even though the DoLS team have not been out to assess. Figure 4 illustrates the DoLS referrals by site in 2020/21.

Figure 4: WSHFT DoLS Referrals 2020/21

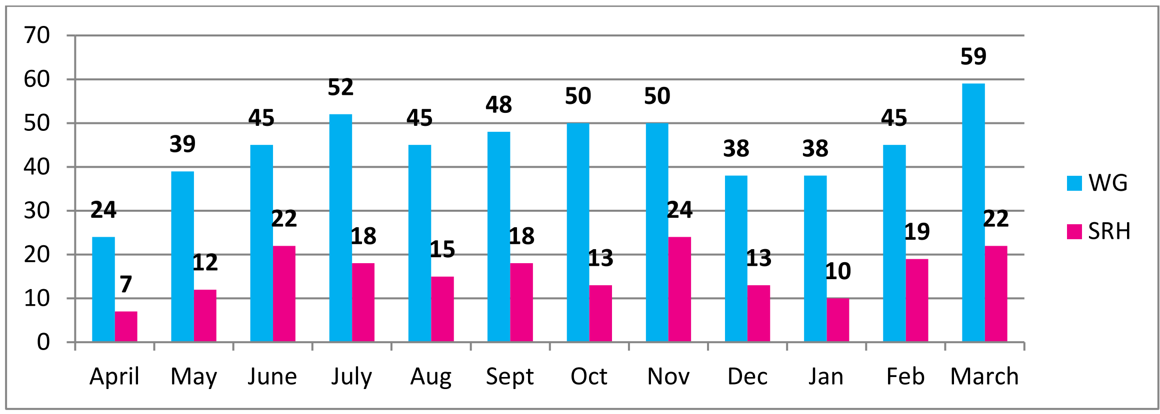
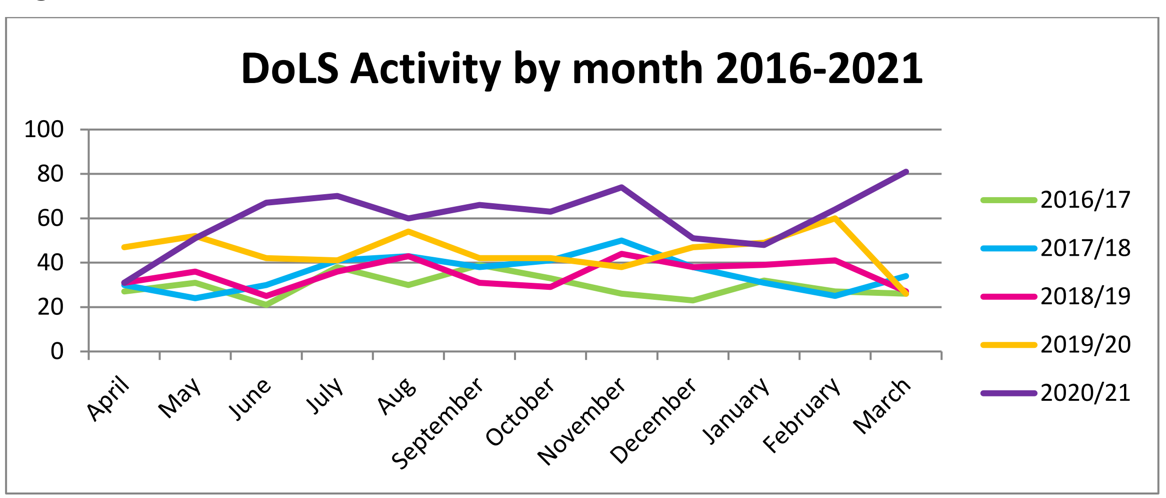


Figure 5: WSHFT DoLS Referrals 2016-21



As seen in figure 5, the referrals continue an upward trend with the exception of March 2019 where the exceptional circumstance of COVID-19 led to a large reduction in hospital bed use and the rapid discharge of those patients who would normally generate need for DoLS. There remains a large discrepancy in DoLS numbers between the sites as shown in figure 4. A key objective for the coming year is to undertake work to more fully understand the reasons for this difference and put in place any required remedial actions.

6.2 The future of DoLS

The Mental Capacity (Amendment) Bill was passed in law in May 2019. It replaces the Deprivation of Liberty Safeguards (DoLS) with a scheme known as Liberty Protection Safeguards (LPS). Implementation had been due in October 2020, but has now been delayed for implementation until April 2022.

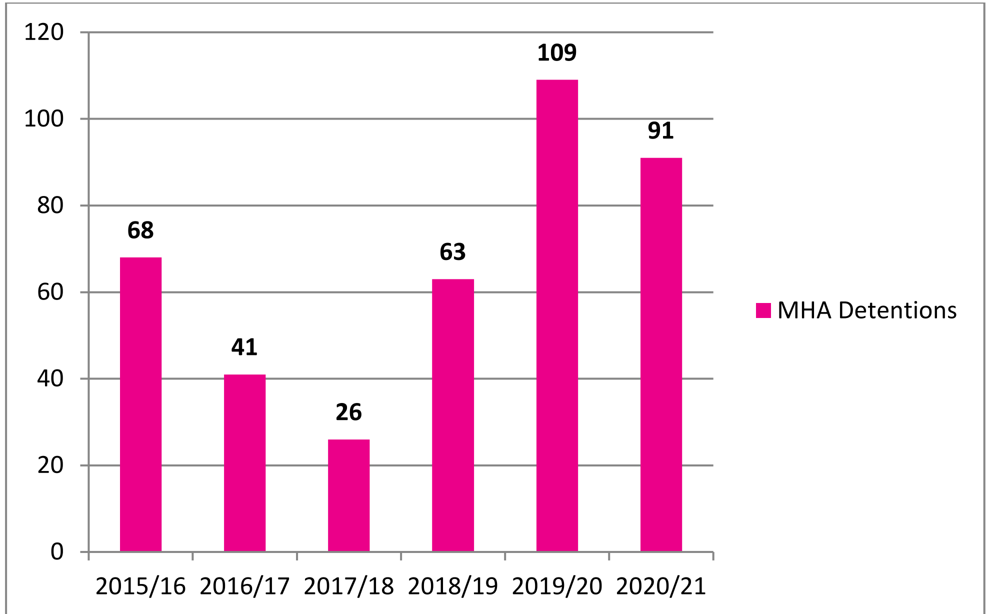
Under the LPS scheme the responsibilities placed upon the "responsible body" (the Trust) have changed significantly. The changes will impact upon process and will undoubtedly require additional training and resources in order to meet the requirements. The revised Code of Practice for both the Mental Capacity Act and Deprivations of Liberty are anticipated for early 2022 and this will hopefully give further clarity regarding the expectations being placed upon the responsible bodies. In the interim, all providers are being urged to continue to improve upon staff knowledge and application of the Mental Capacity Act and Deprivation of Liberty Safeguards.

7. Mental Health Activity

WSHFT has a contract with Sussex Partnership NHS Foundation Trust for the administration of the Mental Health Act (MHA) process. This includes the management of the legal papers associated with those patients detained to the Trust under the MHA as well as admin support when patients appeal to a Tribunal against their detention. In addition, the contract includes the delivery of training to staff on the mental health act.

The below chart shows the increase in the number of patients detained to WSHFT between 2015-2021.

Figure 6 – MHA Activity 2015-2021



7.1 MHA Section 5(2) Audit

We continue to work with our SPFT colleagues to try to improve the process by which detentions are reported and to facilitate the correct completion of the section papers. The SPFT MHA team delivered training to our key teams, including the site team and children's wards during this year. This is particularly important due to the continued increase in under 18s being detained to the Trust under a section. The policies and guidance have also been refreshed by our SPFT partners. The increasing challenge in providing the appropriate care for patients across our wards held under section remains a significant concern for the Trust. Due to ongoing concerns a full audit of the processes is planned for July 2021 with the expectation of a number of recommendations to help inform the alignment of policies for the new organisation.

8. Learning Disability Activity

The most recent Learning Disability Peer Reviews took place in February 2020. This was the seventh year that the Peer Review had been undertaken and was the first time the review was conducted across all 3 sites. Due to the second COVID-19 wave in January 2021, there was no onsite Peer review visits during this year. However the Trust continued work on the recommendations from the previous review and also the feedback from the annual NHSI Benchmarking exercise of the Learning Disability Improvement Standards.

The report's main recommendation was to embed the use of the available tools and resources across wards and departments and to put in place an action plan for delivery of

training to all Trust staff. The Action plan for delivery of improvements is monitored through the Learning Disability Steering group.

8.1 Learning Disability Meetings

From April 2019, a refreshed LD Strategy Group was set up, co-chaired with SCFT with the following purpose:

- To monitor the implementation of the Learning Disability Improvement Standards from NHSI.
- To monitor the action plan developed following the Learning Disability Peer Reviews.
- To receive updates and recommendations from the Learning Disability reviews undertaken as part of the LeDeR programme.
- To recommend areas for service development to the Safeguarding Strategy Committee by exception reporting.
- To plan and monitor actions to deliver NICE guidelines relevant to LD.

Despite the significant operational pressures this group continued to meet throughout this year and has been praised by local commissioners as an example of best practice.

The core value for this group is to embed the Ask – DO – LISTEN approach to care:

- **ASK** people with a learning disability, autism or both, their families and carers for their opinion and concerns about treatment.
- **LISTEN** to all involved and show respect to those opinions and concerns.
- **DO** something about it and work in partnership with us.

8.2 Learning Disability Reviews (LeDeR)

The Trust is actively supporting the nation-wide LeDeR review programme. Although WSHFT does not have any LeDeR reviewers, the Learning from Death Manager works closely with external reviewers providing assistance in their review of cases. Under this programme, the death of anyone with a learning disability is referred for a possible review. The CCG lead for LeDeR programme attends both the LD strategy meeting and the End of Life and Mortality Board to ensure communication of learning from the reviews and to receive assurance of the Trust's improvement work in response.

9. Review of this year's priorities

The priorities set for this year were as follows:

PRIORITY 1:

Deliver a successful Trust wide transition of new safeguarding concerns process with the WSCC safeguarding hub.

OUTCOME:

- Delivered: the Trust successfully implemented the change to direct electronic referrals to the WSCC safeguarding hub. This required close working with the WSCC team leads and a full communication campaign. In order to ensure proactive action for any issues relating to this change, the hub leads were invited to the regular safeguarding operational group and review of hub referrals is a standing item for this meeting. The hub reports no issues with the transition.

PRIORITY 2:

Deliver a training plan to achieve compliance with the Intercollegiate Requirements for Safeguarding Training levels**.**

OUTCOME:

- Partially Delivered: the Trust compliance with safeguarding training requirements has improved considerably this year as described in section 5. A further review of content of training, delivery of stand-alone MCA training and also review the staff groups who require level 3 safeguarding, MCA and Prevent training forms a key priority for the coming year. This will be undertaken in conjunction with colleagues from legacy BSUH to form an aligned and future proof UHSussex approach to safeguarding adults

PRIORITY 3:

Deliver the Mental Capacity Act action plan developed in response to the 2019/20 DoLS audit and NICE standard gap analysis.

OUTCOME:

- Partially Delivered: Audits completed with outcomes fedback to the Adult Safeguarding Operational Group. The MCA lead has developed a full training plan and is working with clinical leads across specialisms to improve the compliance with best practice for MCA.

PRIORITY 4:

To review and update the MHA policies and procedures and complete assurance audit of section 5(2) and Section 132 reading of rights documentation.

OUTCOME:

- Partially Completed. The policies and procedures have been updated. The planned audit was pushed back to July 2021. This has now been completed by our Trust Auditors and a full Trust action plan is in development.

PRIORITY 5:

To review protocols and training for staff relating to domestic violence concerns (for adults without children) to ensure robust communication pathways**.**

OUTCOME:

- Delivered. The team has updated the flow charts and undertaken a full awareness campaign for frontline staff including theme of the week and attendance at huddles. There is also recognition of the need for additional support for this important and growing work stream.

10. Priorities for 2021-22

This has been another busy year for the Safeguarding Adults Team. The team celebrates the successful change to direct referrals to the WSCC safeguarding hub. The team also ensured that despite significant operational pressures the matrons across the Trust were supported to undertake timely investigations to ensure no section 42 backlog.

The year has seen an increase in reporting, both of safeguarding concerns and requests for DoLS authorisations, which is positive evidence of increased awareness by teams.

The focus of our improvement work will be on the quality of the safeguarding concern referrals and the DoLs requests and ensuring staff are trained to the appropriate level for their role. The audits conducted in 2021 will guide the development of future training programmes.

Additionally, the priorities below respond to the identified and growing challenge of care for patients with complex mental health needs and the merger between BSUH and WSHFT from 1 April 2021.

- Implementation of full review of Safeguarding, MCA and Prevent Training in order to develop an aligned UH Sussex training plan.
- Implementation of the MHA action plan in response to internal audit recommendations.

- Completion of the SAB bi-annual safeguarding self –assessment and peer challenge event.
- Preparation for and implementation of LPS in line with legislative requirements.
- Strengthening of partnership and engagement with SAB and associated activity.
- Develop and Implement Domestic Violence Support Improvement Plan.

11. Appendix A-Link to West Sussex Safeguarding Board Annual Report 2020/21

https://www.westsussexsab.org.uk/media/2dqix1f4/2020-21-wssab-annual-report.pdf

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	12.5	Meeting:	Trust Board of Directors	Meeting Date:	3.2.2022
Report Title:	Safeguarding Children Annual Report (BSUH) April 2020-March 2021				
Sponsoring Executive Director:	Chief Nurse				
Author(s):	Debi Fillery - Nurse Consultant for Safeguarding Children and Young people				
Report previously considered by and date:	Safeguarding Strategy Committee 9.12.2021 Quality Committee 22.12.2021				

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	✓	
Sustainability	✓	
Our People	✓	
Quality Improvement	✓	
Systems and Partnerships	✓	

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

Communication and Consultation:

Safeguarding children Named professionals have completed the report to comply with the statutory guidance to safeguarding children.

Executive Summary:

The Safeguarding Annual Report provides details of how BSUH responds to the statutory requirements, national guidance and events and outlines the safeguarding achievements from 2020 – 2021 and the priorities for 2021 - 2022. Failure to comply with the legal requirements of safeguarding children could risk the Trust's registration with the Care Quality Commission.

This paper demonstrates that:

1. BSUH continues to address the issues about safeguarding children and promoting their welfare but the diversity of work has widened.
2. The internal governance arrangements and statutory requirements for safeguarding children and child protection are met & monitored.
3. The Trust audit of Section 11 of the Children Act 2004 (HMSO 2004) undertaken in 2020 currently meets most of the requirements, demonstrating a safe service, acknowledging and addressing the challenges relating to safeguarding children. However, actions relating to Looked after children need strengthening.

4. The CQC action plan from 2019 is progressing, & is due to be completed in Sept 2021.
5. Systems, processes and policies are constantly under review to ensure that they comply with local and national guidance including learning from serious case reviews.
6. The training figures for all eligible staff have improved, but are affected by the COVID-19 pandemic.
7. Partnership Working continues to be strong as BSUH is represented by the Named Nurse & Doctor at key strategic groups both internally and externally.
8. Safeguarding activity across the organisation is increasing, demonstrated by a significant increase in the information being shared, referrals, concerns and daily contact through the safeguarding office and team. The number of young people presenting with mental health issues is rising.

Priorities for 2021-22:

1. Seek approval for the safeguarding children team business case in order to respond to the rising workload and give parity with Worthing/Chichester side of the new UHSx Trust.
2. Refinement of new CDOP processes and review of the Looked after children standards.
3. Assessment of the impact of COVID-19, especially in September 2021 when the children return to school.
4. Review of transitional safeguarding and exploration of joint working.
5. Liberty Protection Safeguards (LPS) need to be developed once the statutory guidance is published.
6. The merger with the legacy Western Sussex Hospitals NHS Foundation Trust will provide opportunities to review and improve services for safeguarding children.

Key Recommendation(s):

The Board is required to APPROVE

Annual Report

Safeguarding Children
and
Looked after Children

April 2020 - March 2021

Author: Debi Fillery, Nurse Consultant Safeguarding Children and Young People

Child Protection and Safeguarding Children
Annual Report to the Board

April 2020- 2021 + COVID-19 update

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Introduction

The Safeguarding Annual Report provides details of how BSUH responds to the statutory requirements, national guidance and events and outlines the safeguarding achievements from 2020–2021 and the priorities for 2021-2022.

BSUH adheres to the standard that the '*welfare of children is paramount'* as defined by the Children Act 2004 and follows the principles that care should be child centred, co-ordinated and is *everyone's responsibility* as indicated in 'Working Together' 2018.

The Safeguarding Children Team provide specialist and expert safeguarding training, advice, support and supervision to all Trust employees to fulfil their safeguarding responsibilities and duties on a wide range of safeguarding issues affecting the unborn, children and young people and their families and carers.

Safeguarding includes the early identification and/or prevention of harm, exploitation and abuse by using national guidelines, local multi-agency procedures and by disseminating 'lessons learnt' and promoting best practice from serious incidents to improve future service development for patients and staff.

The team strive to ensure all safeguarding processes are robust, effective and responsive to emerging local and national needs & enables achievement of the safeguarding standards. In doing so, the Trust discharges its responsibility for Board-level assurance, scrutiny and challenge of safeguarding practice within the Trust, in line with the statutory requirements of The Children Act (1989), Section 11 of The Children Act 2004, and Working Together to Safeguard Children (2018).

COVID-19 has had an impact on the nation and over the past year children have been affected in many different ways depending on their age and circumstances. Some children are hidden and are not being seen in person, due to the changes in how professionals are working, which will affect recognition and disclosure of abuse. It is therefore vital that every contact counts. Locally it is anticipated that the impact of potentially stressful family situations may cause a surge of safeguarding issues once the regulations are relaxed and children are reviewed at school and other settings. Attendances of young people at emergency departments is already indicating that there is a rise in presentations due to mental health issues.

BSUH Named Professionals are working across the network to plan for this possibility and will need to be supported to cope with any surge in activity.

Key Messages for the Board:

Purpose:
The BSUH Trust Board has the overarching leadership with respect to safeguarding children and child protection & this report provides the Trust Board with an overview of the local, regional and national context of safeguarding and of safeguarding practices within the Trust.

The report highlights how the statutory duties are fulfilled any areas of potential risk related to safeguarding children.
Failure to comply with the legal requirements of safeguarding children could risk the Trust's registration with the Care Quality Commission.

Corporate Objective:
BSUH must ensure a culture exists where safeguarding is everybody's business and ensure that there are robust systems in place and the best and safest care is given to safeguard our most vulnerable patients (children and adults, including those with learning disabilities).

This paper demonstrates that:

1. BSUH continues to address the issues about safeguarding children and promoting their welfare but the diversity of work has widened.
2. The internal governance arrangements and statutory requirements for safeguarding children and child protection are met & monitored.
3. The Trust audit of Section 11 of the Children Act 2004 (HMSO 2004) undertaken in 2020 currently meets most of the requirements, demonstrating a safe service, acknowledging and addressing the challenges relating to safeguarding children. However actions relating to Looked after children needs strengthening.
4. The CQC action plan from 2019 is progressing, & is due to be completed Sept 2021.
5. Systems, processes and policies are constantly under review to ensure that they comply with local and national guidance including learning from serious case reviews.
6. The training figures for all eligible staff have improved, but are affected by COVID-19.
7. Partnership Working continues to be strong as BSUH is represented by the Named Nurse & Doctor at key strategic groups both internally and externally.

It is also recognised that:

1. Safeguarding activity across the organisation is increasing, demonstrated by a significant increase in the information being shared, referrals, concerns and daily contact through the safeguarding office & team. The number of young people presenting with mental health issues is rising.
2. The safeguarding children team business case is seeking approval to respond to the rising workload.
3. The new CDOP processes needs refining
4. There are Looked after children standards still to be met
5. The impact of COVID-19 is still to be assessed but the network feel services may be challenged in September 2021 when the children return to school.
6. Transitional safeguarding is to be reviewed and opportunities for joint working explored.
7. Liberty protection Safeguards (LPS) need to be developed once the statutory guidance is published.
8. The merger with WSHFT will provide opportunities to review and improve services for safeguarding children.

Contextual Summary of Issues during 2020-21

Local context

BSUH provides hospital services for the local geographical area and have some tertiary services for patients across the South east. There are four A&E departments. The 'Royal Alexandra Children's Hospital (RACH) cares for 45,000 children every year and the Care Quality Commission rated it as '*outstanding*'.

The latest annual safeguarding children report produced by Brighton and Hove suggests that the City population is estimated to be 295,300 in 2020. Between 2017 and 2030 the population is expected to rise by 8.1%. This projected growth is higher than projected population increases in the South East of 7.3% and England: 6.6%).

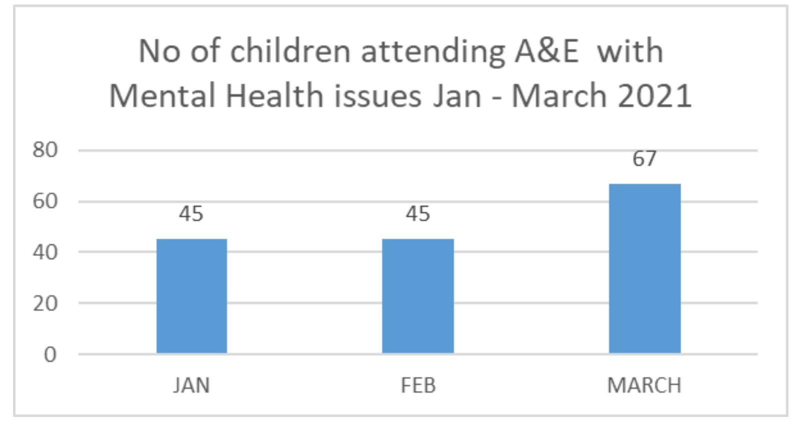
The latest data estimates indicated that 16% of the B&H population are aged 0-15 years.

Ethnicity estimates indicate that 21% of children and young people aged 0-15 years are from BME groups. 16% of the city's residents were born outside of the UK, of which 40% were born in the EU.

Between 11% and 15% of the population aged over 16 is estimated to be lesbian, gay or bisexual.

The 'Working in partnership across Sussex report' (2019) suggests Brighton & Hove ranks within the most deprived areas in England. With higher rates of hospital admissions for self-harm of children aged 10-24, and alcohol misuse compared with the rest of England.

Quarter	Sept 2010	Sept 2011	Sept 2012	June 2013	June 2014	June 2015	June 2016	June 2017	June 2018	June 2019	Feb 2020
Total children with a CP Plan in B&H	411	395	340	300	328	385	381	380	**370**	**326**	**331**
B&H per 10,000	88	85	N/A	59.9	59.9	57.1	74.7	74.2	**72.1**	**63.5**	**64.5**
National average per 10,000	N/A	36	N/A	37.8	37.9	42.1	42.9	43.1	**43.3**	**43.7**	**43.7**
Statistical neighbour						44.4	42.1	45.3	**49.8**	**40.4**	**40.4**
League table (n=152)			8th	15th	24th	33rd	25th	10th	**17th**	**25th**	**24th**



The number of child protection medicals has fallen and there is a general consensus of opinion that this is due to children not being seen by professionals due to COVID-19.

	2016/17	2017/18	2018/19	2019/20	2020/21
CP medicals	109	112	112	111	71

The number of women disclosing FGM remains small, all were over 18 yrs of age.

BSUH Disclosures	2014	2015	2016	2017	2018	2019	2020
	22	26	22	13	13	14	21

BSUH is part of the Safeguarding Partnership arrangements which replaced the LSCB in Sept 2019. This is in response to the recommendations of the Children and Social Work Act 2017. The partnership priorities are:

1. Partnership Engagement and Accountability
2. Violence and Exploitation
3. Reducing neglect
4. Mental Health and Emotional Health/Wellbeing

In July 2020 BSUH took part in the Partnership 2020 bi annual section 11 audit and challenge event producing an action plan which is being be monitored via the safeguarding committee. The main issues for development relate to care for 'looked after children', monitoring the work of the independent domestic violence advocate/advisor and monitoring and improving safeguarding training.

Serious case reviews are now overseen by the Child Safeguarding Practice Review Panel (the Panel). https://learning.nspcc.org.uk/media/2589/child-safeguarding-practice-review-panel-annual-report-2020-summary.pdf

The Panel received 482 serious incident notifications between 1 Jan and 31 Dec 2020, relating to 514 children.

- The majority of children were either under one (35%) or aged 15-17 (30%).
- Domestic abuse featured in 42% of incidents.
- Parental mental health was still an issue.
- In 16% of cases the child experienced mental ill-health.
- 18% of incidents featured parental alcohol misuse.
- 24% featured parental drug misuse.
- 34% of non-fatal incidents and 35% of fatal incidents mentioned neglect.
- 60% of incidents reported to the Panel, the child protection system had previously identified the children as vulnerable.

Locally BSUH was involved with partnership working related to:

- 1 rapid review.
- 2 commissioned practice reviews which should be completed in 2022.
- A legacy case which was published anonymously.
- A local legacy learning review.

The local learning, which has been incorporated into the training sessions, relates to:

- Recognition and response to neglect.
- Considering Black, Asian and diverse cultures within assessments and across systems.
- Safeguarding Children affected by family drug and alcohol use.

In addition, the need for adult services to consider the impact of adult issues on children and young people is vital, ie 'think family', see various reminders and newsletters during 2020.

The Sussex initiative to help prevent abusive head trauma (ICON) is an evidence based programme highlighting the simple message making up the ICON acronym. https://iconcope.org/for-professionals/

I Infant crying is normal and it will stop
C Comfort methods can sometimes soothe the baby and the crying will stop
O It's OK to walk away if you have checked the baby is safe and the crying is getting to you
N Never ever shake or hurt a baby

BSUH has responded to the research which points to persistent crying in babies being a potential trigger for some parents/care givers to lose control and shake a baby. It also shows that around 70% of babies who are shaken are shaken by men. So the initiative has been incorporated into the midwifery 'badgernet' IT system to ensure that male caregivers are given the opportunity as well as all other parents/caregivers to have information about crying and how to cope with a crying baby.

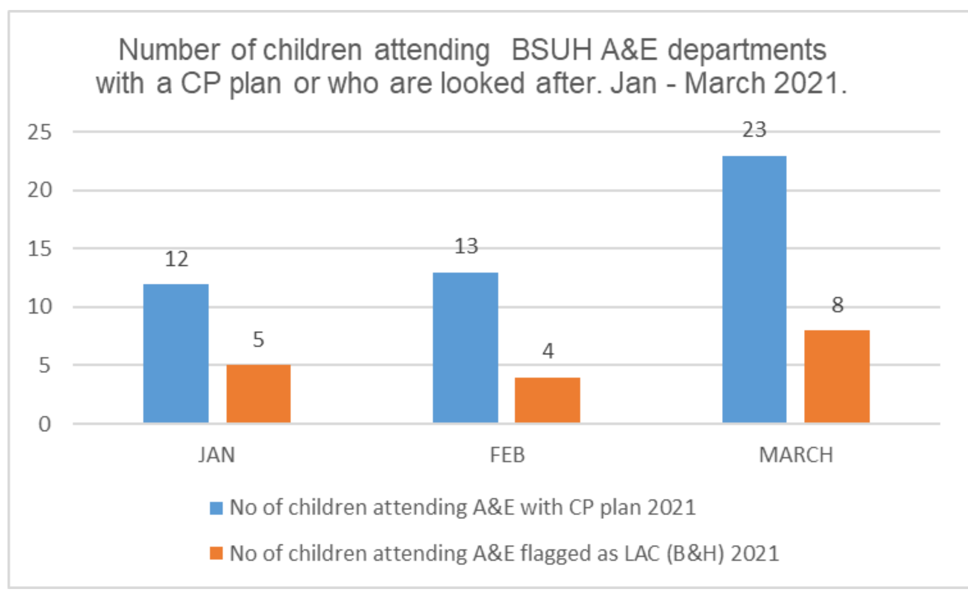
Looked after children (LAC) recommendations

A child who has been in the care of their local authority for more than 24 hours is known as a looked after child. Looked after children are also often referred to as children in care, a term which many children and young people prefer.

Research suggests that when looked after children are compared with children in the general population, they tend to have poorer outcomes in a number of areas such as educational attainment and mental and physical health. In addition, there is data to show that Looked after children will have experienced adverse childhood events and will have poor long term adult health outcomes.

BSUH treats all children as individuals to ensure they are in line with the statutory recommendations in the 'Promoting the health and wellbeing of looked after children' report (2015 DfE DOH) to address these health inequalities. The most recent section 11 report has emphasised the need to consider the vulnerability of looked after children and as such bi-monthly assurance documents are provided for the CCG.

As mentioned in the previous annual report, BSUH was given permission to flag all Brighton & Hove young people who are looked after on Symphony & Medway to add a further layer of information sharing to inform clinician decision making. East and West Sussex have not given BSUH the information necessary to flag the young people from those areas.



Corporate Responsibilities and Statutory Leads during 2020-21
Child Protection / Safeguarding Children workload

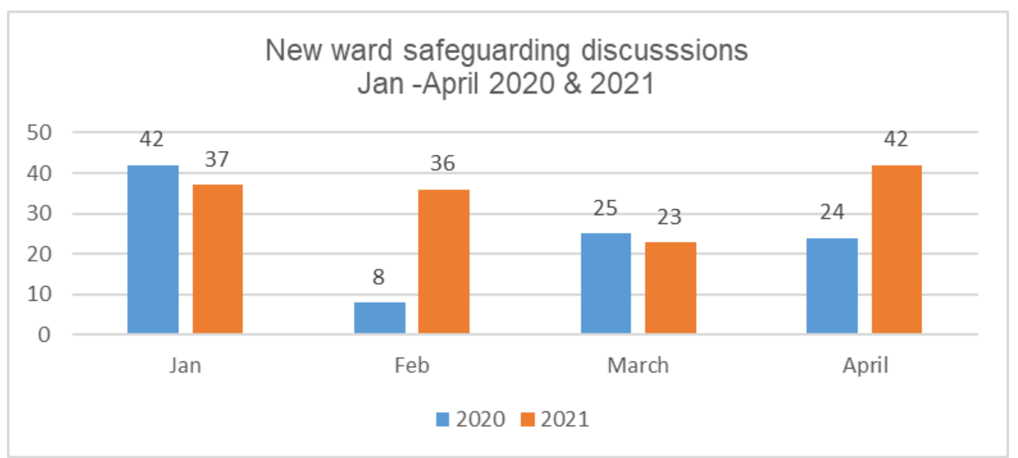
Working together (2018) stipulates that each Health Trust must have **a Named Nurse and Doctor and a Named Midwife** if providing midwifery care. Funding, supervision and support should be given to ensure they can fulfil their child welfare and safeguarding responsibilities effectively. Currently the Named Midwife role required 0.2WTE extra and a business is being developed to increase the team staffing levels to adhere to the statutory requirements and address the increasing workload.

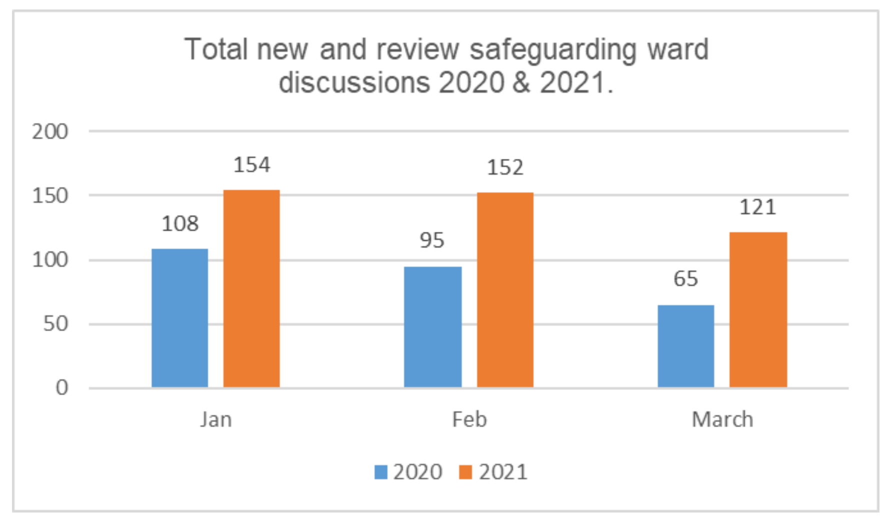
BSUH Safeguarding Named Professionals		WTE
Corporate Responsibility	The Chief Executive	
Lead Director	Chief Nurse	
Named Doctor	Consultant paediatrician	4pa
Named Nurse	Nurse Consultant Safeguarding Children & Young People	1.0
Safeguarding nurse	Job share currently (0.6+0.4WTE)	1.0
Liaison Nurse		0.72
Named Midwife	Community midwifery matron	0.2
Safeguarding Midwife	Midwife Band 7	1.0
Safeguarding Midwife	Midwife Band 6 (from Oct 2020)	1.0

The expected outcomes of the safeguarding children service are to:

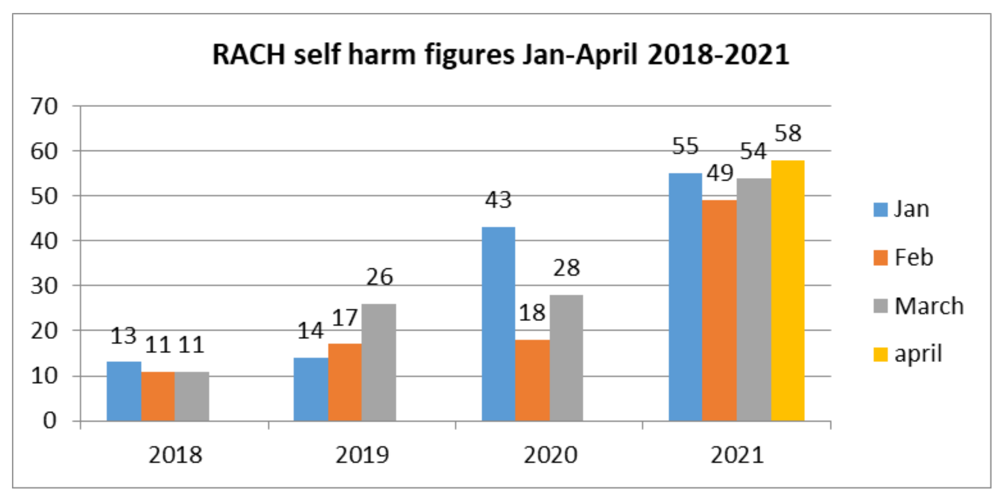
- Facilitate the development of a confident, informed workforce in relation to their role and responsibility to children, young people and adult welfare and safeguarding matters
- Improve outcomes for children, young people and adults
- Reduce risk to children, young people, adults, visitors and staff

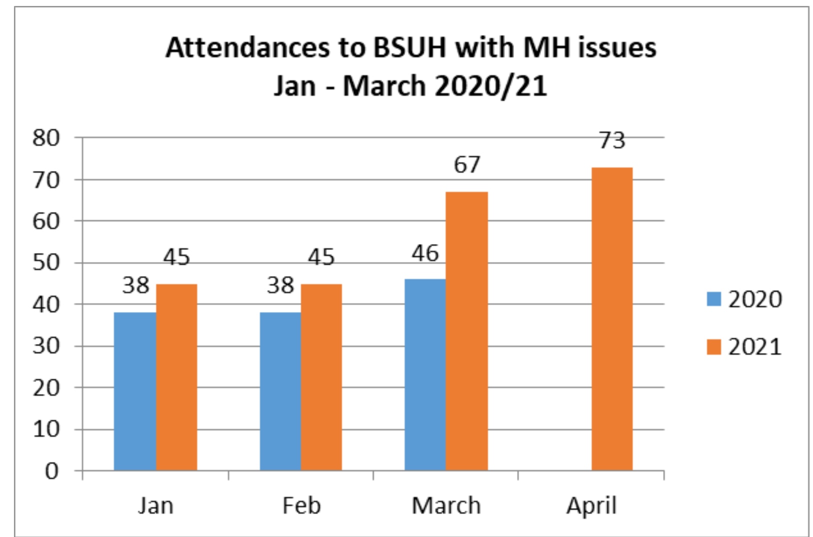
The RACH daily ward round continues to ensure advice and co-ordination of care is available. As can be seen from the chart below the number of children with new safeguarding issues is rising.





The number of young people with self-harm and mental health issues has risen during COVID-19. The safeguarding team works closely with the paediatric mental health liaison service based at RACH which was set up in 2015.





The **We Can Talk** training has been introduced to RACH staff & is developed directly in response to the views, experiences and needs of young people and those working in acute hospital settings.

The BSUH safeguarding children newsletter highlights issues relating to children and mental health.

Clinical Governance and Multi-Agency Working during 2020-2021

The BSUH Safeguarding Children Steering Group

Meets quarterly   Chair: Lead Director - Chief Nurse

1. Ensures internal governance arrangements are in place and effective and reports to the Board once a year. There are reports to the quality & assurance committee & the CCG assurance group quarterly.
2. Works towards completing the BSUH safeguarding action plan.
3. Maintains and monitors the Section 11 audit with evidence available electronically and updated as required.
4. Addresses & disseminates learning from Government strategic documents, SCR & audit.

Policies & guidance introduced or updated

1. The safeguarding learning and development strategy was updated.
2. Paediatric on line clinical guidance is available via microguide.
3. The safeguarding children web page is up to date with links to various resources.
4. Most other policies are due to be updated in 2022. These will be part of the integrated working within the new merged Trust.

Audits undertaken

Partnership notes audit x 2 (Sexual abuse and BME) The maternity documentation audit x 3. Self-harm Audit of Injuries June 2020- August 2020 Ward discussion overview	Training evaluation Child referral form quality audit 2020 PRH attendance (MH) 2020. PRH under 18 audit 2020.

Projects undertaken in 2020/21

- Consolidation of the Pan Sussex initiative to prevent abusive head trauma(ICON).
- Maternity badgernet IT system introduced (Feb 2021).
- The PANDA safeguarding children section where specific read only action plans can be stored to ensure these are available for clinical staff (went live in July 2020).
- An electronic safeguarding children referral form has been developed on PANDA (went live July 2020).
- The paediatric wards introduced a 'tapestry' app to enable photos to be shared safely with parents if unable to visit their children in hospital due to COVID-19.

Safeguarding Supervision

- There have been no changes to the process of Supervision due to lack of capacity.
- There has been no serious incident in this timeframe.
- The Named Doctor, Nurse & safeguarding Midwife continue to fulfil their statutory role by offering supervision on a case by case basis & to those with complex caseloads.
- The Named professionals receive supervision from the designated professionals.
- The named doctor organises a weekly peer review meeting to discuss child protection medicals promoting consensus, learning and best practice.
- The monthly updates and newsletter produced by the Named Nurse should be disseminated to the Directorate teams via their quality and safety meetings.

Training

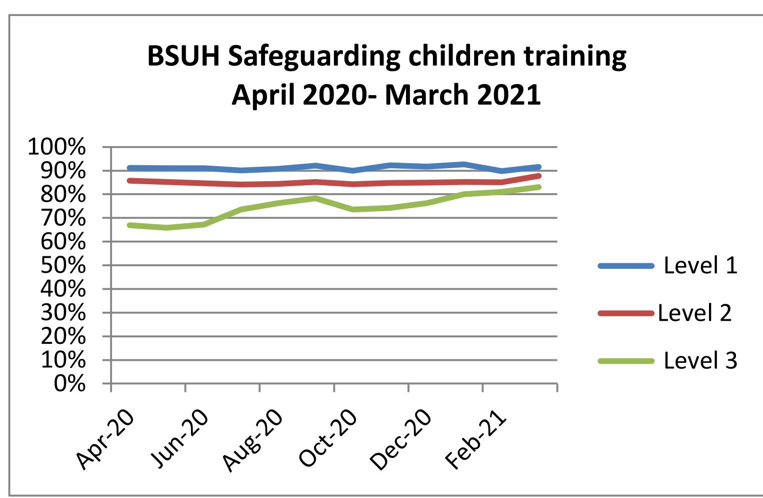
The Trust continues to demonstrate on-going commitment to safeguarding training ensuring all staff receive the required levels of safeguarding training under guidance of the Intercollegiate Document for Safeguarding Children (RCPCH 2019).

www.rcn.org.uk/professional-development/publications/pub-007366

All staff need some level of statutory safeguarding children training.

1. Level 1 (At induction & All non-clinical staff) requires 3 yearly update.
2. Level 2 (All clinical staff who see adults) requires 3 yearly update
3. Level 3 (All clinical staff who see children **and unscheduled care - PRH A+E**) require annual update

COVID-19 has meant that training has been delivered differently, via video, 'teams' plus a comprehensive on line quiz. The compliance levels have fluctuated but are reasonable given the current pressures on staff.



- An online D session has been uploaded to IRIS (designed by the HIDVA)
- The midwifery team have uploaded short video information relating to learning from incidents and cases.
- The named nurse has produced various posters and newsletters highlighting learning.

Communication and IT

- Information sharing between the Trust and the community health visitors and school nurse moved to an electronic solution in May 2020. However this proved to be a challenge for the receiving team and BSUH was asked to revert to the paper system.
- The need to ensure safeguarding instructions regarding specific information sharing has been considered in the light of a data breach. This was thoroughly investigated. Action taken has been to ensure staff get written confirmation from social workers when dealing with complex cases.
- The PANDA development team completed the safeguarding children section where specific read only action plans can be stored to ensure these are available for clinical staff. (went live in July 2020).
- An electronic safeguarding children referral form went live on PANDA in July 2020.

External Regulation and Inspection by Partnership, Care Quality Commission (CQC), Commissioners (CCG) and JTAI (Joint targeted area inspections).

The bi-annual S11 audit & actions were repeated in May 2020. The Trust were not invited to a challenge event but were asked to expand on 3 aspects only.

1. How the Trust intend to develop safeguarding services in your acute settings which enable and ensure appropriate support for this vulnerable cohort of children and young people.
2. How the Trust ensures training on child sexual exploitation is robust.
3. How are you utilising your IDVA service under COVID-19 conditions and how has the increase in reported domestic abuse impacted your services?

The CQC undertook a safeguarding inspection in July 2019. The safeguarding committee has oversight of the action plan which should be completed in Sept 2020.

The CCG quarterly exception reports continue to be discussed bi-monthly. The issues relate to staffing of the safeguarding team, training figures, services for looked after children.

No JTAI inspections were conducted in B&H during 2020/21.

Partnership working

- The Named Nurse and Named Doctor represent the Trust at the B&H Partnership Board meetings and various sub groups contributing to the various quality initiatives.
- The Named Nurse links to West Sussex and East Sussex Local Safeguarding Children Boards via the Designated Nurses and Designated Doctors for Child Protection.
- The Named Nurse attends the health sub group of the West Sussex Partnership.
- The BSUH Named professionals attended the local network of health professionals to exchange information related to COVID-19.

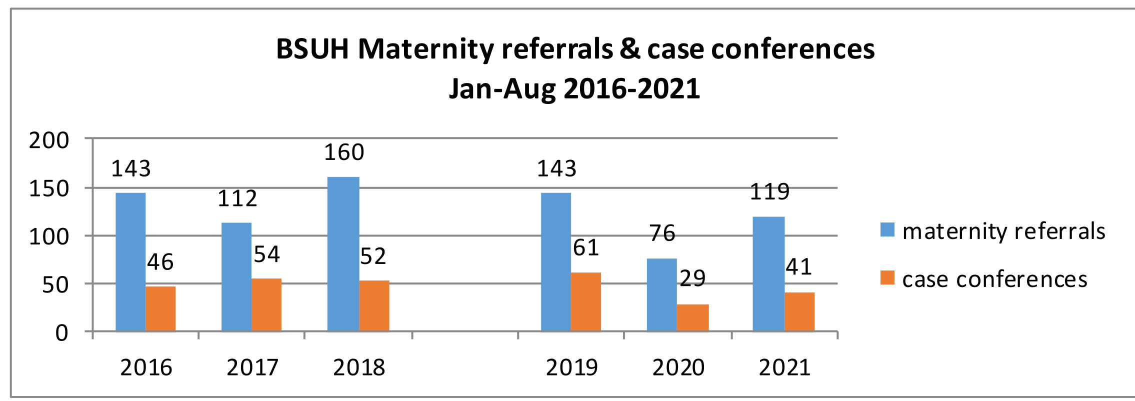
Reports written by the Named Nurse & contribution include:

1. Contribution to 2 B&H audits.
2. Contribution to serious case review x 3.
3. A BSUH safeguarding update to contribute to the LSCB annual report.

Maternity Report

Achievements and Progress in relation to Maternity 2020-21

- At BSUH the Named Midwife role is combined with the community midwifery manager's post. 0.2WTE is allocated to the Named MW role a deficit of 0.2WTE and therefore does not fully meet the statutory requirements.
- The safeguarding midwife maintains clinical oversight for all the maternity cases. The service has acknowledged increasing complexity of cases and introduced an additional band 6 post in Sept 2020 to support the service.
- During the COVID-19 pandemic, the safeguarding team worked within the hospital supporting the midwives and ensuring good communication with some of the multi-agency teams who were working from home.
- COVID-19 initially meant that maternity bookings were conducted over the phone or by 'teams' and home visits were reduced, however in 2021 this has reverted back to face to face sessions.
- COVID-19 affected the number of referrals and case conferences in 2020 but it is increasing again in 2021, so the improved safeguarding midwife staffing is being used to improve supervision of cases and training opportunities such as video learning.



- The new COVID-19 arrangements meant that some online family court cases were held on the wards. The safeguarding team had to ensure the families and staff were supported during this emotional time and confidentiality was maintained.
- The introduction of 'Badgernet' in February 2021 has improved the opportunity to gather information about social issues & to review the risks at 28 & 36 weeks gestation. The documentation will be audited and the results will be fed back to the maternity team.
- The FGM figures continue to suggest that B&H does not have a large population of women who are victims of FGM. All the women who disclosed were over 18 and had the FGM performed when they were children in their own country.
- The Level 3 safeguarding and domestic abuse training compliance has fluctuated over the year but remains between 84-86%. An online quiz and targeted videos were devised to help staff keep up to date when face to face training was impossible due to COVID-19 restrictions.
- The ICON programme related to reducing the incidents of abusive head trauma has been part of the maternity work/training programme in 2020/21.
- The CQC action plan following the visit in 2019 has been completed in relation to midwifery. Audits will be required in 2021/22 to ensure the learning and processes have been embedded.

Maternity Action plan 2021-2022

- The statutory named midwife role & support network to be monitored to ensure it fulfils its statutory purpose.
- To continue to monitor and audit the pre-birth safeguarding workload and make recommendations as required (ongoing).
- To audit the safeguarding aspects of care embedded within the Badgernet IT system.
- To monitor the ICON programme and ensure it remains a high profile aspect of maternity care.
- The 2019 CQC actions related to midwifery are completed and further audits will be required in 2021/22 to ensure the learning and processes have been embedded.

Domestic Violence and Abuse Report (DVA)

The Refuge service for victims of domestic abuse states that:

- 'Anyone forced to change their behaviour because they are frightened of their partner or ex-partner's reaction is experiencing abuse'.
- 'Domestic abuse can happen to anyone, regardless of age, background, gender, religion, sexuality or ethnicity. However, statistics show most domestic abuse is carried out by men and experienced by women'.
- 'Domestic abuse is never the fault of the person who is experiencing it.'

- ‘Domestic abuse is a crime.’

The Crime Survey for England and Wales showed that 1.6 million women and 757,000 men had experienced domestic abuse between March 2019 and March 2020, with a 7% growth in police recorded domestic abuse crimes

Between April and June 2020, there was a 65% increase in calls to the National Domestic Abuse Helpline, when compared to the first three months of that year.

In total, between the start of the COVID-19 restrictions in England and Wales on 23 March 2020 and 31 March 2021 there were 215 deaths in 208 incidents reported to Domestic Homicides Project . These included domestic homicides, child deaths, unexplained deaths, and suspected victim suicides with a known history of domestic abuse. This is slightly higher than the previous year (152) but in line with the 15-year average (Home Office police-recorded homicide data[5]).

Looking at individual cases and thematic impacts the project found: -

- COVID-19 has acted as an escalator and intensifier of existing abuse in individual cases.
- Victims have been less able to seek help or advice.
- Victims’ access to on-going support or help with caring responsibilities or mental or physical health conditions have been reduced.
- Children and adults have been made more ‘invisible’ to services through home-schooling and homeworking.
- Both victims’ and suspects’ ability to manage mental ill-health and drug/alcohol dependencies have been reduced by the pandemic.
- COVID-19 has not ‘caused’ domestic homicide, but it seems to have been weaponised by some abusers as both a new tool of control over victims and – in some cases – as an excuse for domestic abuse and even homicide.

In January 2021, a scheme was launched with participating pharmacies called the ‘Ask for ANI scheme’ (Action Needed Immediately) to help survivors. Pharmacies were encouraged to display material to let survivors know that trained staff are available to offer a safe and private space, with the option to call the police or other support services if needed.

The Domestic Abuse Act 2021, comes into force on 29 April 2021, aiming to strengthen measures to protect victims of domestic abuse and address the behaviour of perpetrators.

In April 2021 the HIDVA service will be managed by Victim Support service not RISE.

Health IDVA update

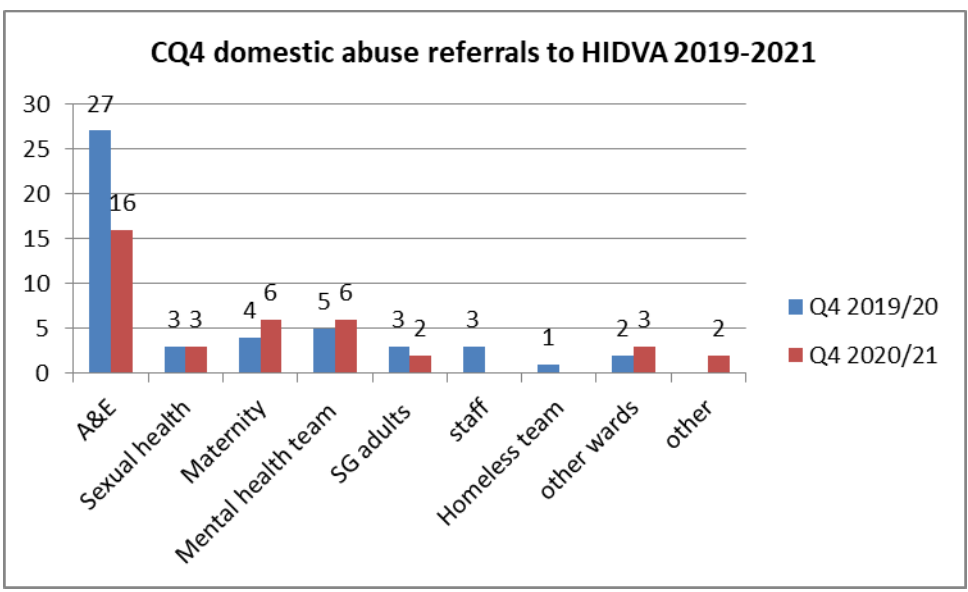
COVID-19 affected everyone’s working practices with some support staff and services working from home.

A&E attendance figures fluctuated but initially seemed lower than usual and it is likely that victims of domestic abuse may have been avoiding A&E out of fear of being infected by the virus. Unfortunately, it is very likely that while being in lock down with their abusers, victims also felt unable to come to a place previously seen as safe and supportive.

While working remotely HIDVA was less able to complete a meaningful piece of work with referred patients while they were still in A&E or Short Stay Ward as there is no mobile phone signal.

When patients return to their homes where abusers are present it is unsafe for HIDVA to call and for the victims to engage safely and meaningfully. As a result, her visibility and support for staff plus face to face engagement with victims was reduced.

TOTAL number of referrals to HIDVA service 4th quarter 2021 – 38 (Q3 – 55)



Although the safeguarding training had to be on line the HIDVA designed a programme which staff could access to keep themselves up to date. In addition the safeguarding team are still incorporating domestic abuse within the adult and children safeguarding training. There is information on the BSUH web site.

Victims of domestic abuse can include members of staff who should feel confident to seek help from the safeguarding team, their managers, occupational health dept, and the HELP service.

There continues to be a BSUH 'top 10 tips' leaflet about domestic abuse to help staff and a posters indicating how COVID-19 can impact on domestic abuse.

Flagging of victims of domestic abuse by using a blue teardrop (replacing the red triangle) was introduced in 2019/20 and is proving to be a successful alert.

The safeguarding team continue to provide information to the Multi-agency Risk Assessment Committee (MARAC) in order to support safety planning and therefore safeguard victims.

Domestic Abuse Action plan 2021-2022

- To continue to support the domestic abuse strategic agenda.
- To work with the new provider of DV services in B&H (Victim support) to ensure a smooth transition and prevent any loss of quality service. The CCG will be part of this process due to the shared funding arrangements.
- To review and continue the BSUH commitment to the B&H MARAC.
- The domestic abuse training needs to continue and be reviewed to ensure it is up to date and consistent with any changes introduced by the new *Domestic Abuse Act 2021.*
- To monitor the flagging system for those people who are discussed at MARAC.

Key Issues for BSUH 2020-2021 and Action Plan for 2021–2022

Safeguarding is everyone's business irrespective of role or position & BSUH will continue to promote the welfare of children & young people seen within the Trust and by working in the multi-agency arena. Children will continue to be a high priority.

In 2020/21 the continuing impact of COVID-19 will require specific attention to ensure a positive and cohesive response to any increase in safeguarding activity. The named professionals are already well linked to local and national networks to help facilitate this work but the increase in workload will need to be factored into safeguarding staffing levels & the business case.

How young people transition between services and from child to adult services is important especially for those who are autistic or have special needs. The Trust needs to contribute to multi-agency planning to ensure this group of young people are supported to smoothly negotiate this significant part of their lives.

Given the rise of young people attending the hospital with self-harming behaviour, mental health issues and/or eating issues, the links with services who can support these young people is vital. In addition, the number of young people who are admitted to the wards for prolonged periods of time waiting for a specific placement which meets their individual needs is rising. Strategic involvement in county and country wide discussions about service commissioning and provision is crucial.

The Liberty Protection Safeguards (LPS), which the Government plan to introduce in April 2022, will provide protection for people aged 16 and above who are or who need to be deprived of their liberty in order to enable their care or treatment and lack the mental capacity to consent to their arrangements.

Currently, when a 16 or 17-year-old needs to be deprived of their liberty, an application must be made to Court of Protection. Under the Liberty Protection Safeguards, Responsible Bodies can authorise the arrangements without a Court order. This will deliver more proportionate decision-making about deprivation of liberty and minimise potential distress and intrusion for young people and their families.

The safeguarding team have been involved with the LPS Steering Group, led by the CCG, however specific guidance has not been forthcoming from the Government yet.

https://www.gov.uk/government/publications/liberty-protection-safeguards-factsheets/liberty-protection-safeguards-what-they-are

The merger with Western (WSHFT) will also provide opportunities and these will be explored during the year. The existing close working relationships will be useful as a basis for further developments.

The Safeguarding children committee action plan will respond to additional issues which arise throughout the year.

1. To ensure safeguarding children is a high priority within the new trust arrangements.
2. To ensure the business case for strengthening the safeguarding team and ensuring parity across the new Trust is quickly presented for approval by the Board.
3. To continue to plan and respond to safeguarding issues raised by the COVID-19 pandemic
4. To participate in the Liberty Protection Safeguards initiative.
5. To participate in Partnership and monitoring arrangements eg section 11 review.
6. The LAC Named Nurse role in UHSx East needs to be clarified and strengthened.
7. To continue to have Directorate assurance & evidence that 'safeguarding children' is discussed and that staff are aware of their role and responsibilities.
8. To update any safeguarding policies which become out of date in 2021-22.

9. To continue to raise awareness and embed the skills and knowledge around learning relating to safeguarding children, based on evidence from the Child Safeguarding Practice Review Panel.
10. To complete the audit programme.
11. Continue and complete the work itemised in the Safeguarding Children & Young People Committee action plan.
12. To ensure the maternity action plan is addressed and the named midwife role is increased and embedded.
13. To ensure the domestic abuse action plan is addressed and that the HIDVA service is supported.

Debi Fillery
Nurse Consultant Safeguarding Children and Young People
March 2021 and reviewed in November 2021

Appendices

Action plan update 2020/21	BSUH safeguarding declaration.
action plan update 2021.docx	safeguarding decleration 2020.doc

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	12.6	Meeting:	Trust Board of Directors	Meeting Date:	3.2.2022
Report Title:	Safeguarding Children Annual Report (WSHT) April 2020-March 2021				
Sponsoring Executive Director:			Chief Nurse		
Author(s):			Catherine Coppard - Lead and Named Nurse for Safeguarding Children		
Report previously considered by and date:			Safeguarding Strategy Committee 09.12.2021 Quality Committee 22.12.2021		

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	✓	
Sustainability	✓	
Our People	✓	
Quality Improvement	✓	
Systems and Partnerships	✓	

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

Communication and Consultation:

The author has completed the report in consultation with the named professionals for safeguarding children, the members of the safeguarding operational group and the divisional head of nursing for women and children.

Executive Summary:

The Safeguarding Annual Report provides details of how WSHT responds to the statutory requirements, national guidance and events and outlines the safeguarding achievements from 2020 – 2021 and the priorities for 2021 - 2022.

This paper demonstrates that:

1. WSHT continues to address the issues around safeguarding children and promoting their welfare but the complexity of work has increased.
2. The internal governance arrangements and statutory requirements for safeguarding children and child protection are met & monitored.
3. The Trust audit of Section 11 of the Children Act 2004 undertaken in 2020 demonstrates a safe service whilst acknowledging the challenges relating to safeguarding children and areas requiring

strengthening which include; arrangements for Looked after children, safer recruitment practice on the shortlisting/ interview panel and domestic abuse support within the hospital.

4. Systems, processes and policies are continuously reviewed to ensure that they comply with local and national guidance including learning from children's safeguarding practice reviews.
5. Evidence that the public health message ICON – coping with crying message is being shared and recognition and response to neglect has improved in practice and continues to be monitored.
6. Information sharing and enabling practitioners to use their professional curiosity and have those difficult conversations with children and families in response to concerns when raised; remains a key focus of quality improvement work.
7. Overall 90.4% of staff have completed their mandatory safeguarding children training which demonstrates a 5% annual reduction during the Covid pandemic.
8. Partnership Working continues to be an important focus of work for the safeguarding team.
9. The youth worker, a new role at WSHT has started to have a notable impact on supporting the safeguarding of children and young people.

And the report also identifies improvement work and the wider challenges faced within the system;

10. The impact of the COVID-19 pandemic for children, young people and families and our community is becoming apparent and there is evidence of a post lockdown surge and an increase in disclosures of abuse and referrals to children's social care, reflecting the challenges experienced by children, young people and families.
11. There is increasing complexity and demand within the system particularly for young people requiring specialist mental health placements. There were 17 children and young people detained during the year under the mental health act, compared to 12 children the previous year.
12. There is an increase in children waiting in our hospitals for a specialist mental health or local authority care placement to become available within the system. This has created significant challenges for children, young people, families and staff involved and remains on our risk register.
13. Funding for hospital independent domestic violence/ abuse advisors as part of a trust wide domestic abuse strategy is required.

Key Recommendation(s):

The Board is required to APPROVE

Annual Report

Safeguarding Children &

Looked after Children

April 2020 - March 2021

Prepared by:

Catherine Coppard

Named Nurse for
Safeguarding Children

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1. INTRODUCTION AND EXECUTIVE SUMMARY

The welfare of children is paramount' as defined by the Children Act 2004 and guided by the following principles, safeguarding children should be;

- a child centred approach.
- a coordinated approach; safeguarding children is everyone's responsibility.
- early help is beneficial and it is better to offer early help to children and families as early as possible, before issues escalate and become more damaging.
- effective information sharing between practitioners and local organisations and agencies enables the safeguarding of children.

(Working Together 2018)

This report defines the structures and processes for safeguarding children and looked after children and how these relate to wider safeguarding children arrangements within the Western Sussex Hospitals NHS Foundation Trust (WSHT) which includes Worthing and Southlands Hospitals, St Richards Hospital Chichester and Sexual Health services in West Sussex. The report also reviews WSHT children's safeguarding and looked after children activity and outlines relevant safeguarding children guidance, policy and priorities for the forthcoming year.

The organisation became University Hospitals Sussex NHS Foundation Trust from the 1st April 2021 and the former WSHT is referred to as UHSussex (West).

As required by Section 11 of The Children Act 2004, WSHT fulfils its statutory duty by promoting a culture where safeguarding is everyone's business and ensuring practice issues are identified and addressed by having effective safeguarding arrangements in place to safeguard vulnerable children. These arrangements include:

- Safeguarding structures including the following statutory designated roles; Executive Lead, Named Doctor, Named Nurse & Named Midwife for Safeguarding Children.
- Arrangements for Looked after children including Named Doctor lead for Looked after children.
- Governance & Accountability; including learning from serious incidents and child safeguarding practice reviews.
- A culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services.
- An environment where staff feel able to raise concerns 'Freedom to speak up' and a culture that enables safeguarding and promoting the welfare of children.
- Escalation policies for staff to follow when safeguarding concerns are not being addressed within the organisation or by other agencies.
- Arrangements for information sharing.
- Safe recruitment practices and policies including when to obtain a criminal record check.
- Clear policies for dealing with allegations against people working with children.
- Supervision and support and effective safeguarding training arrangements.
- Working in partnership with other agencies.

Key messages for the Board:

- The impact of the COVID-19 19 pandemic for children, young people and families is becoming apparent and there is evidence of a surge post lockdown and an increase in disclosures of abuse.
- Referrals to children's social care have increased, reflecting the challenges experienced by children, young people and families.
- There is increasing complexity and demand within the system particularly for young people requiring specialist mental health placements. There were 17 children and young people detained during the year under the mental health act, there were 12 children the previous year.
- There is an increase in children waiting in hospital for a specialist mental health, eating disorders or local authority care placement to become available within the system. This has created significant challenges for children, young people, families and staff involved. This remains on our risk register.
- There have been 5 serious incidents relating to children in hospital. Four of these serious incidents relates to those children waiting for a specialist placement to become available within the system (This is the first year serious incidents have been included in the annual report).
- The Section 11 Audit was completed in June 2020. The arrangements for looked after children have since been strengthened but outstanding actions include; requirement for improved domestic abuse support in the hospitals at WSHT; and requirement to strengthen recruitment ensuring all recruitments have a trained staff member in safer recruitment practice on the shortlisting/ interview panel.
- Information sharing and enabling practitioners to use their professional curiosity and have those difficult conversations with children and families in response to concerns when raised; remains a key focus of quality improvement work.
- The Youth worker, a new role at WSHT commenced May 2021 and has started to have a notable impact on supporting the safeguarding of children and young people.
- Overall 90.4% of the staff have completed their mandatory safeguarding children training, required level for their role. Compliance remains challenging for front line staff, particularly medical and nursing staff, impacted further by the COVID-19 pandemic. The safeguarding team continue to work with specialities to support training compliance and by delivering a blended safeguarding training programme.
- Evidence that ICON – coping with crying public health message is being shared and recognition and response to neglect has improved in practice and continues to be monitored.
- The number of allegations against staff which have been managed are recorded for the first time in this annual report.
- This report also identifies improvement work and the wider challenges faced within the system.

2. GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS

The Department for Education (DfE) is responsible for child protection and safeguarding children, and sets out policy, legislation and statutory guidance on how the children's safeguarding system should work.

In compliance with the Children Act 2004 (section 11) WSHT has statutory responsibilities to co-ordinate and ensure the effectiveness of what is done for the purposes of safeguarding and promoting the welfare of children. It remains the responsibility of organisations to develop and maintain quality standards and assurance, to ensure appropriate systems and processes are in place and to embed a safeguarding culture within the organisation through mechanisms such as safe recruitment processes including use of vetting and barring, staff induction, effective training and education, patient experience and feedback, critical incident analysis, risk assessments and risk registers, reviews and audits, annual staff appraisal and revalidation of professional staff. It is also important to be aware of the role of external regulators such as CQC, Ofsted and JTAI (Joint Targeted area inspections) in monitoring safeguarding systems within organisations and the role of the West Sussex Safeguarding Children Partnership (WSSCP) in coordinating improvements locally.

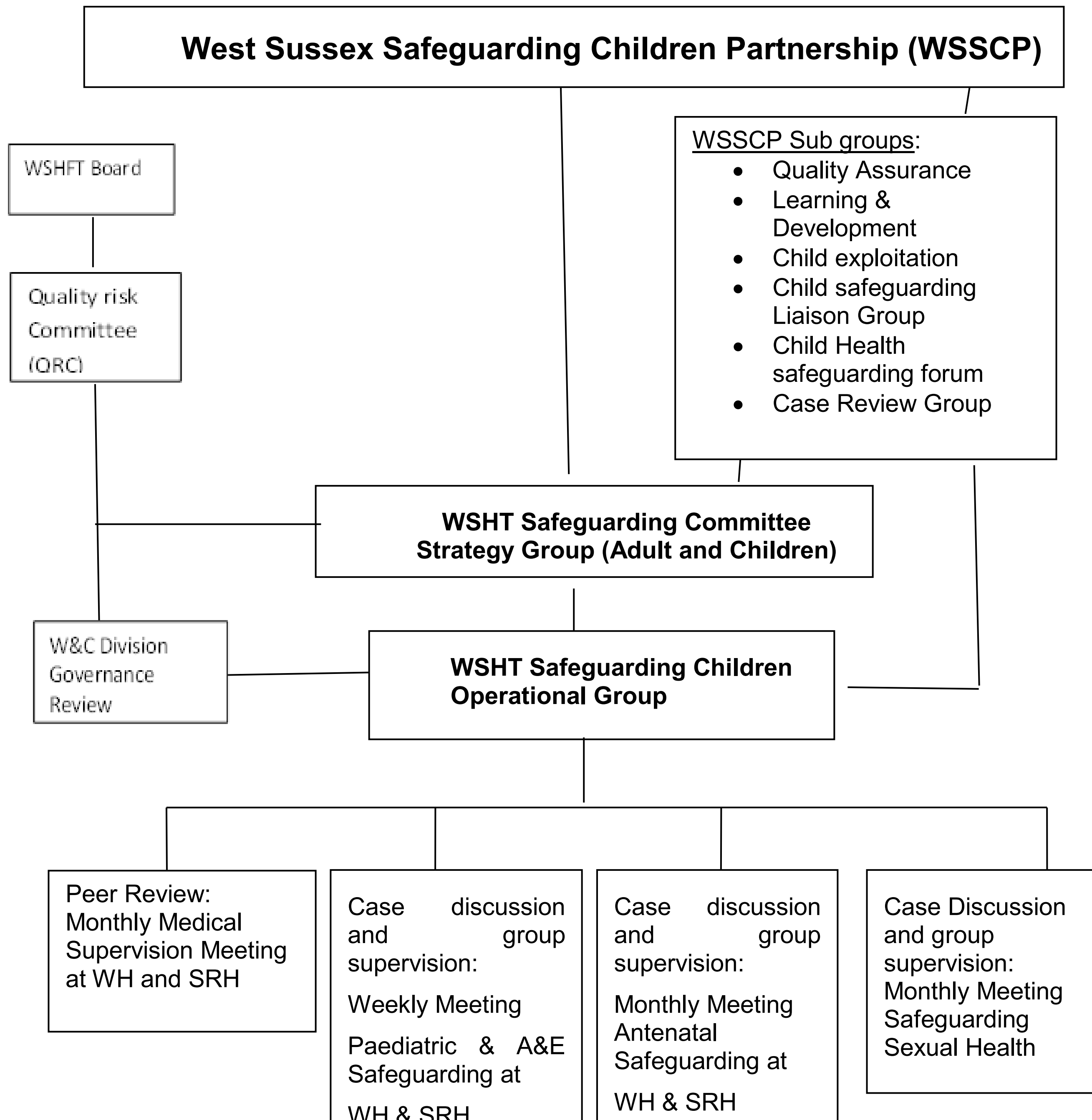
Quarterly exception reports are provided to the safeguarding strategic committee, Women & Children Division, Sussex commissioners and WSSCP. The section 11 audit, which outlines WSHT compliance to our statutory obligations, was undertaken June 2020 and reviewed June 2021.

2.1 **WSHT Safeguarding Children**

The Children's Act 2004 placed 'a requirement on each health provider to appoint named professionals to take the professional lead for safeguarding children within the organisation and to advise all staff employees, on awareness and processes related to child protection and safeguarding children.'

Maggie Davies	Chief Nurse & Executive Lead for safeguarding and looked after children and (*Prevent Lead*)
Catherine Coppard	Lead Nurse & Named Nurse Safeguarding Children
Rowena Remorino/Emily Charkin (SRH) Pauline Shute/Lucy Killian (WH):	Named Doctors for Safeguarding Children
Janetta Milea	Named Doctor for Looked after children
Gail Addison	Named Midwife and (*FGM lead*)
Vicki White/Janine Peach	Specialist Safeguarding Nurses
Clare Hosking & Sarah Barwick	Specialist Safeguarding Midwives
Kathy Walker/Dee Warner Vicki Warren/	Safeguarding and liaison nurses
Jo Fanning	HR Lead and Allegations manager
Helen McCutchan	Sexual Health Matron & (*CSE Lead*)
Helen Milne	ED Consultant (WH)
Liz Cheshire	ED Consultant (SRH)

2.2 **WSHT Safeguarding Children Structure**



2.3 **Role of the West Sussex Safeguarding Children's Partnership (WSSCP)**

West Sussex Safeguarding Children Partnership (WSSCP) formed June 2019, places a duty on three lead partners: Police, Clinical Commissioning Groups and the local authority to agree local arrangements to work together to safeguard children.

WSSCP Business Plan Practice and overarching priorities for 2020/21:
1. Neglect
2. Child exploitation
3. Ensure effective multi-agency safeguarding practice
4. Lead and consolidate effective partnership arrangements
5. Revise and embed a learning and Improvement Framework

The named professionals and safeguarding team are active members of the WSSCP and subgroups and continue to ensure the focus is on quality and embedding learning into practice.

2.4 **WSHT Safeguarding Children Meetings**

2.4.1 **Safeguarding children case discussion meetings;**

- Weekly Meeting Paediatric & A&E Safeguarding at WH & SRH
- Monthly maternity meeting
- Monthly sexual health meeting

These well attended weekly multi-disciplinary meetings provide an invaluable forum for case discussion, information sharing, decision making, resolution, group supervision and learning. Integrated working is strengthened when Child and Adolescent Mental Health Service (CAMHS) A&E liaison are able to attend the children's meetings, however due to operational pressures their attendance has significantly reduced over the year, especially on the SRH site. At the monthly antenatal meetings; perinatal

mental health practitioners, health visitors, are also invited. In order to strengthen safeguarding arrangements pre- birth, the pre-birth assessment social workers within West Sussex, are also invited.

2.4.2 **Peer Review: Weekly and Monthly Medical Supervision Meeting;**
Chaired by the named doctor on each site, these are well attended by consultant pediatricians and named nurse. The purpose of these meetings, are to;

- Promote a culture of learning and professional support, drawing on the existing evidence base relevant to child abuse.
- Provide assurance that practitioners meet a measure of standard and are therefore more reliable in their practice.
- To reduce professional isolation and improve sharing of best practice with discussion of complex patients in a challenging but supportive way.
- To provide a regular documented review of practice as expected by the judiciary, GMC and RCPCH.

2.4.3 **Safeguarding Children's Operational Group;**
The Group meet quarterly and are responsible for the effective operational implementation and performance of the safeguarding children framework within the Trust. More specifically the group;

- Ensure there are mechanisms in place to alert staff to safeguarding policies and procedures.
- Ensure there is sufficient safeguarding training to enable staff to carry out their duties to safeguard children.
- Communicate and disseminate WSSCP and sub group information and guidance, including relevant serious case reviews through existing divisional structures.
- Ensure dissemination of relevant national information and guidance.
- Monitor and identify when guidelines require updating, making recommendations on changes aligned to national best practice. These will then be deemed ready for divisional ratification at the divisional governance meeting and onward cascade through divisions and the WSHT safeguarding strategic group.
- To consider the annual audit plan and recommendations, taking forward any actions through relevant forums.
- Track progress on any serious case reviews or action plans.
- Monitor additional actions and learning needs identifying learning events as required.

2.4.4 **Safeguarding Committee (Strategic Group)**

This integrated adults and children's safeguarding group meet quarterly and is responsible for assuring the effective implementation and performance monitoring of the safeguarding framework within the Trust, adhering to statutory requirements; Section 11 of the Children Act 2004 and 2010 and The Care Act 2014 and national frameworks; Safeguarding children, young people and adults at risk in the NHS: Safeguarding Accountability and Assurance Framework (NHS England, July 2019)**.**

More specifically the purpose is to;

- Report mechanisms are in place and to provide assurance to the CCG through the annual assurance and quarterly exception reports.
- Ensure there are mechanisms in place to alert staff to Safeguarding policies and local procedures.
- Monitor the quality of training and compliance, ensuring relevant staff have appropriate training in accordance with the Intercollegiate guidance (RCN 2019).
- Monitor the quality of safeguarding practice.
- Scrutiny of safeguarding processes; including training and information sharing.
- Oversee the provision and development of the annual safeguarding report.

- Monitor the dissemination of information from the WSSCP and subgroups, including relevant serious case reviews.
- Review any new guidance and set the direction for the safeguarding strategy.
- Identify, monitor and ratify safeguarding policy, making recommendations on changes aligned to national best practice. These are then ratified at the Quality and Risk Committee, and onward cascade into the organisation.
- To consider audit recommendations, taking forward any actions through relevant forum e.g. Patient Safety.
- Review of safeguarding team structures and ability to discharge statutory responsibilities.

Quarterly reports are provided to the Sussex commissioners, safeguarding strategic committee, W&C Division, West Sussex Safeguarding Children Board Partnership (WSSCP).

3 REVIEW OF THE YEAR: 2020-21

3.1 Evaluation of progress against priorities set in the annual report 2020

Priority: 2020-21	Progress	Status
1. Safeguarding information leaflets for children and families outlining process and investigations where there are safeguarding concerns	Leaflets explain safeguarding progress and investigations and available on the safeguarding page on the trust staffnet for practitioners to provide child and family in certain circumstances	Completed
2. Audit of children who 'do not attend'/ 'was not brought' to hospital appointments	Monthly audit embedded into safeguarding checks led by the children's safeguarding team The practitioners guide to managing 'was not brought' was updated in consultation with practitioners and shared in June 2021 and available on staffnet	Completed
3. Embedding ICON public health message and Safe sleeping into practice and sharing Dadpad details	ICON embedded into maternity, children's and A&E services ICON has become embedded within practice. This was a challenge during the pandemic particularly in maternity when partners could not attend appointments. However, message is now shared at booking and discharge and at key points during the pregnancy and again during the postnatal period at home. Information on how to access to Dadpad given at booking & well-advertised around all clinical areas. This ICON message is repeated during the neonatal period for parents of infants under 6 months of age, when attending	Completed

	A&E and paediatrics. A safe sleeping campaign was also shared during the year.	
4. Appoint to new posts for children's safeguarding Team	New staff were in post from February 202, following the successful business case in September 2020 nursing establishment was increased by 1.65 wte (across the bands; 8b, 6 & 3 posts)	Completed
5. Audit of safeguarding processes in A&E	Safeguarding children's team undertake daily review of children's A&E attendances in accordance with safeguarding processes There is evidence of exceptional practice in difficult circumstances but also quality issues identified during daily checks of A&E attendances on a daily basis. Evidence shows the safeguarding team are following up on a working daily basis. There is a need to collate evidence of compliance with processes in A&E via a monthly audit to be developed to capture the themes of quality issues and monitor improvement.	In progress
6. Section 11 Audit	Completed June 2020 and updated June 2021 The outstanding actions are as follows; • Standard 1 and 3: lines of accountability and governance structures for the services provided for Looked after Children need to be reflected within the organisation • Standard 2: Children's Safeguarding Policy requires renewal by 2022 • Standard 6: Safer recruitment-requirement to ensure all recruitments have a trained staff member in safer recruitment practice, on the shortlisting/ interview panel • Standard 9: Recognition and	In progress

	response to risk for domestic abuse - requires improvement	
7. Improve Integrated working within WSHT and partner agencies	There is evidence that multi -agency working with system partners to improve services and keep children safe is rooted into practice, in particular for those children and young people in need whom attend hospital with mental health issues, self-harm, eating disorders and challenging behaviour or have disabilities or are looked after children. The ability to have virtual meetings has supported this. Communication and information sharing is complex and access to relevant information in a timely manner can be problematic due to the various systems and access levels, used by each of the agencies involved. Work to improve communication and information sharing continues between those key areas; A&E, UTC, Children's wards and CDC and agencies involved; WSHT, SCFT, SPFT, IPC.	In progress
8. Quality; ensure the Child Protection Medical service delivery standards (RCPCH 2020) are met.	WSHT does not have a clinical photography service. A business case in consultation with the clinical photography service at the Brighton hospital to be developed to support the Child protection medical service at WSHT by improving the quality of photography for child protection medicals undertaken. St Richards Hospital Site due to the limited resource and significant challenges no longer provide a full child protection medical service but continue to provide medicals via a managed rota, for children under 1 year and those requiring acute medical attention. Commissioners were informed August 2021	In progress

9. Improve the training compliance for medical staff to above 95%	A challenging year due to the pandemic; currently 75% of all medical staff trained at the required level compared to 78.8% in 2020 A new strategy has been developed which includes a blended approach of; film for levels 1, and film, webinar and workbook for level 2 and 3 being rolled out for all training The safeguarding team would benefit from administrative and technologist support to coordinate and deliver the safeguarding training programme	In progress
10. Specialist domestic abuse support (Hospital Independent domestic abuse advisor- HIDVA) required for WSHT	Staff Survey March 2021 - 70% of respondents felt that having a domestic abuse professional based in the hospital would 'definitely' help. This was even higher amongst respondents working in A&E (78%) and Maternity departments (76%) Discussions held with Safeguarding leads in the CCG and local domestic abuse services (WORTH) NHSE have provided £14,000 to support HIDVA funding for year ending 2022	In progress

3.2 National and Local Context, Guidance, Reviews and Policy changes

3.2.1 Local Context

Within West Sussex 20% of the total population are children and young people

Table 1

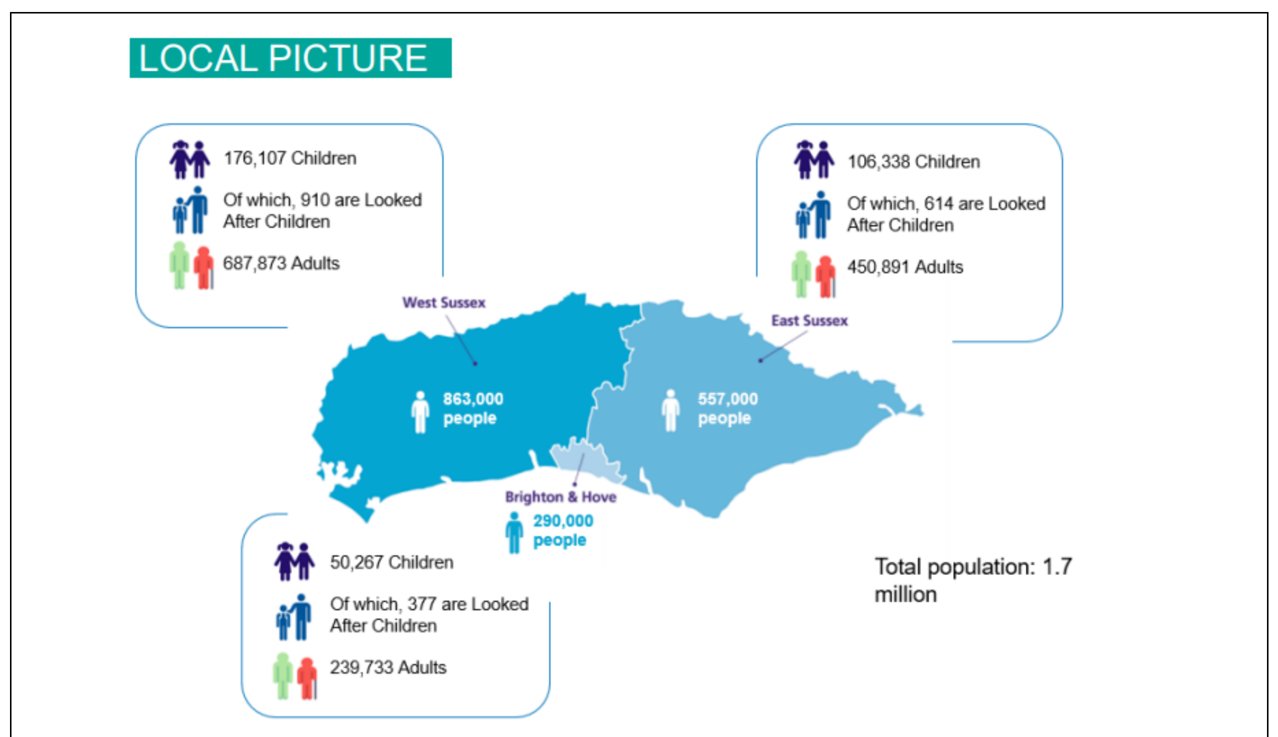
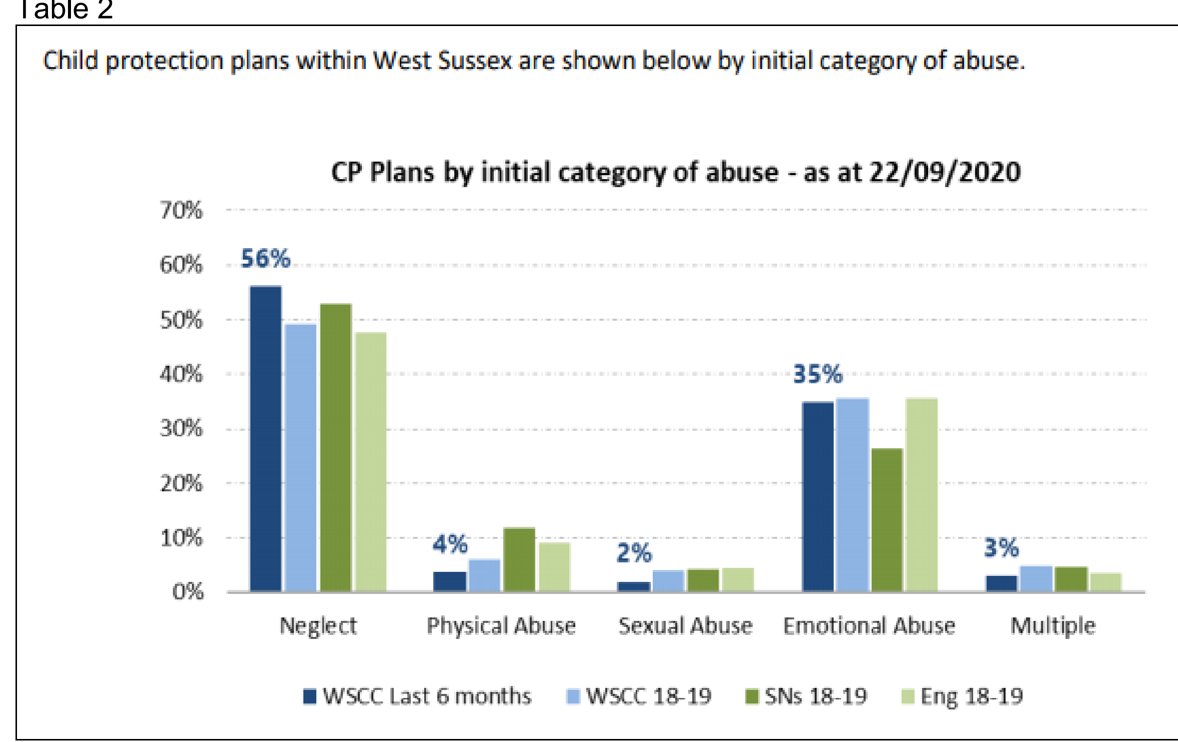


Table 2



Annual Report WSSCP August 2020

West Sussex Children's services are on a journey of improvement following 2019 inspection when services were found to be 'inadequate'. The report stated there were 'Critical weaknesses in how agencies identify and respond to neglect across the service' and 'accumulating concerns about the neglect children have experienced are not always recognised or understood, resulting in a lack of assertive action and to some children experiencing profound and potentially long-term consequences'.

WSHT have been actively engaging with children's social care and relevant partners in particular with the Neglect improvement work and with information sharing related to contextual safeguarding. There is evidence that recognition and response to neglect is recognised and responded to within our services.

3.2.2 **Impact of COVID-19 pandemic**

The damaging impact of the COVID-19 pandemic on children, especially vulnerable children is of great concern and is being felt within our services. There were 2.2 million children in England living in households affected by one or more of the following family issues: domestic abuse, parental drug and/or alcohol dependency, and severe parental mental health issues, before the crisis struck. (Children's Commissioner, 2020) The risk factors of abuse and neglect have been exacerbated by the coronavirus pandemic whilst the support services which would usually identify and respond to these concerns, for periods of time have during periods of lockdown have been unable to see children and families in person. Services were therefore advised to monitor and be prepared for a surge of safeguarding concerns related.

In maternity services visiting restrictions impacted on the woman's pregnancy journey, and for some periods during the pandemic partners were not allowed to attend scans, antenatal appointments or stay on the postnatal ward for longer than one hour. There has been a noticeable increase over the year of families disclosing; increased stress, financial pressures, mental health issues and or experiencing domestic abuse. The reasons for increased disclosures of domestic abuse are thought to relate to the social isolation experienced during lockdown led to an increase in domestic abuse (Women's Aid 2020) but also practitioners report it was easier to enquire about domestic abuse when seeing the woman on their own during restrictions.

There has been increase in complexity, parental anxiety and children presenting with eating disorders, mental health issues or challenging behaviour. There has been an increase in detainments and challenges in finding a suitable placement for children needing specialist placement. There are increasing challenges in the system but also on the children's wards and resulted in some children being almost 'stranded' having long waits on the ward until a suitable placement was available.

COVID-19 has brought about changes to the way we work. Virtual working has aided the development of virtual networks and partnership working. There have also opportunities to attending virtual safeguarding training and seminars and share learning and best practice with colleagues within the safeguarding community.

3.2.3 Transitional Safeguarding

Transitional safeguarding is an approach to safeguarding adolescents and young people, recognising transition is a journey and every young person will experience this journey differently. It is a needs led personalised approach recognising the harms associated with sexual and criminal exploitation and the impact of control and coercion on young people.

Bridging the gap: Transitional Safeguarding and the Role of Social Work with Adults briefing paper- (Holmes and Smale 2018) calls for the need for change in practice across systems involving all agencies to safeguard young people and young adults (mid-teens - mid 20's). Young people whom are autistic or have learning needs are particularly vulnerable in this age group. Although children's and adult safeguarding systems are governed by distinct statutory frameworks, this should not prevent work to ensure young adults, whom need help to be safe and healthy, receive that help. Having capacity and making unwise decisions is not consenting to abuse (Bridging the Gap Holmes & Smale 2018)

The team were fortunate to attend a virtual seminar on Transitional Safeguarding earlier in the year. Opportunities of joint working are being explored locally with our colleagues and partners involved in adult safeguarding to ensure vulnerable young people receive the help and support they require, to be safe and healthy.

3.2.4 Contextual Safeguarding

Safeguarding has evolved and its scope has expanded significantly over the last few years from a mainly intra-familial abuse model to a more complex model. Safeguarding

against extra-familial abuse, including; complex abuse, child exploitation and online abuse, also need to be considered. Consideration of extra familial abuse has created new challenges requiring new ways of working and a whole system approach through partnership working with a variety of agencies. The specific needs of adolescents and their vulnerabilities are also increasingly recognised. The children's safeguarding team share local information relating to youth violence and concerns of exploitation, with police as part of operation signal.

3.2.5 Safeguarding young people with mental ill health and challenging behaviour

Safeguarding children and young people, admitted to the children's wards at WSHT with significant mental health issues including self-harm; eating disorders and challenging behaviour, are of great concern. There has been a noticeable increase number of children and young people attending and some admitted to hospital accompanied by police under a section 136 of the Mental Health Act. There has also been an annual increase in children and young people being detained under the Mental Health Act.

There are increasing numbers of children admitted to the ward with extreme mental and emotional distress and requiring chemical, physical or mechanical restraint to keep them safe. The ward takes measures to keep the child/young person safe and ensure good communication with child, young person and family and multi-agency partners involved in the child's care. Risk assessment are undertaken and safety measures (by any agency involved including the police) can include; 1:1 supervision, removal of items which are a risk including ligature risks, chemical restraint, physical restraint and on occasions if accompanied by police under a section 136; mechanical restraint. These measures and situations necessary to keep the child safe involve depriving the child/young person of their liberty and are seen as a safeguarding concern. This can be extremely distressing situation for the child/young person and family as well as for those staff caring for them, including security staff who on occasions, become involved in keeping the child and young person safe whilst in hospital. There is further work at a national safeguarding level to consider how the harm from such incidents is classified and how to influence the system change required. Locally, a system wide multi-agency learning event led by the Executive Director of Children, Young People and Learning Services was held in September 2020, to share learning from such incidents and to review pathways.

Nationally, there has been an increase number of young people with acute and long-term physical and mental ill health problems, accessing health services and this situation has intensified further with the impact of the measures to contain the spread of COVID-19, on the health and wellbeing for some young people, now being realised (National Child Mortality Database, 2020). Challenges within the system to meet the demand and availability of specialist placements for ongoing care especially for children with mental health issues and eating disorders, are being experienced. This system wide problem can lead to some children remaining in general children's wards whilst awaiting a mental health, eating disorder or therapeutic placement for their ongoing specialist care needs. These concerns are escalated within the safeguarding system on a frequent basis.

It is recognised that the role of a Youth worker to support young people within A&E and hospitals is beneficial as reported by Waring and Marshall (2021) in 'They make stuff lighter- youth workers in hospital setting'. We are fortunate to have a youth worker within our organisation now working with us who supports children in hospital and further expansion of this role within the services provided, particularly A&E, would be beneficial.

3.2.6 Liberty Protection Safeguards (LPS)

LPS will apply for young people from age 16 years and it will be 'everyone's business' and not just the responsibility of a named professional. If arrangements are proposed for enabling care or treatment of a person (aged 16+) that give rise to a deprivation of liberty (constant supervision & control and not free to leave); the responsible body will be responsible.

Liberty Protection Safeguards (LPS) which, was expected to be implemented in April 2021 has been further delayed and the statutory guidance is awaited.

The children's safeguarding team have been contributing to the LPS Steering Group, led by the CCG, alongside WSHT MCA lead, and self- assessment is progressing.

3.2.7 Domestic abuse support

Disappointedly, we have still been unable to secure funding for a hospital independent domestic violence advisor (HIDVA) within the organisation, despite many efforts. This issue continues to remain on the risk register and an area of high priority. Discussions have been held with the CCG and local community domestic abuse support services and also raised as an issue of concern within the local safeguarding partnerships.

The impact of the pandemic and the recommendations outlined in the pre- pandemic report by Safelives (2016) 'A Cry for health- why we must invest in domestic abuse services in hospitals', clearly states why we should have a HIDVA would be beneficial in supporting patients, children and families and staff working within WSHT, whom are experiencing domestic abuse.

Along with our adult colleagues, we will revisit this priority, which will include developing a new business case, with the support of the designated nurses within the CCG. The safeguarding teams will continue to provide some support and training within the hospital for domestic abuse, however it is recognised more specialist support and increased capacity for this important work, is acutely needed.

A domestic abuse staff survey was undertaken in collaboration with Safelives, Worth and the Children's safeguarding team in March 2021. The headline findings from a response rate of 331 respondents mainly from A&E, maternity, sexual health services and paediatrics are as follows;

- Discomfort around asking questions, not knowing how to ask questions and having no one to seek advice from were all listed as top reasons for staff not asking patients about abuse –implying a need for improved training / specialist presence within the services provided by WSHT

- Over a 5th of front line staff (22%) have never asked patients about possible abuse

- Overall, 70% of respondents across all departments and roles, felt that having a domestic abuse practitioner based in the hospital would 'definitely' help them ask questions about possible domestic abuse or sexual abuse. This figure was higher amongst professionals working in Maternity and A&E.

To support staff in enquiring about domestic abuse during virtual consultations, a brief guidance for safe enquiry for 'virtual' settings such as online or via the telephone. The guidance sets out five simple steps to help identify and respond to people who might be at risk and was adapted for our maternity services but can be applied to all services which use routine enquiry, as well as services using clinical enquiry.

3.2.8 Local Reviews: Child Safeguarding Practice Review (CSPR)

A child safeguarding practice review (CSPR) is a multi-agency case review carried out by the local safeguarding children partnership (LSCP). When a child dies, or is seriously harmed, the practice of all agencies involved with the child and family and of working together is reviewed to reflect on what protection and support was offered. Child

safeguarding practice reviews (formerly known as serious case reviews) are divided into:

Local reviews – where safeguarding partners consider that a case raise issues of importance in relation to their area.

National reviews – where the Child Safeguarding Practice Review Panel considers that a case raises issues which are complex or of national importance. The Panel may also commission reviews on any incident(s) or theme they think relevant.

Working Together to Safeguard Children (2018)

All child safeguarding practice reviews should:

- reflect the child's perspective and the family context
- be proportionate to the circumstances of the case
- focus on potential learning
- establish and explain the reasons why the events occurred as they did.

(Child Safeguarding Practice Review Panel, DfE 2019)

Details of the reviews WSHT have been involved in can be seen in Table 3 below.

Table 3 West Sussex SCR/CSPR Reviews with WSHT involvement (2020/21)

Full details of the published reviews can be found via https://www.westsussexscp.org.uk/reviews/west-sussex				
Child/ref	Date TOR agreed	Review Type	Summary	Status
Avocet	12/19	LCSPR	Themed learning event Feb 2021	Published Feb 2021
C	08/18	NCSPR	NAI Themed learning event Feb-May 2021	In progress
K	09/18	NCSPR	National panel included in a thematic review for under 1's with NAI Bruise protocol and professional curiosity Themed learning event Feb-May 2021	In progress
Brambling	03/20	LCSPR	Contextual safeguarding transition/trauma informed care Learning event planned for 2021	Published March 2021
SCR N	07.09.16	SCR	Themed learning event Feb-May 2021	Publication still awaited
SCR T	17.10.17	SCR	Abusive Head Trauma	Published 2020

SCR U	20.04.18	SCR	NAHI. Themed learning event Feb-May 2021	Published Sept 2020
SCR V	07.03.18	SCR	Neglect and Perplexing illness/Fabricated and Induced illness Themed learning events Feb- July 2021	Published Sept 2020
SCR W	24.04.19	SCR	Neglect	Published 2020
TK-D	2020	LCSPR/D HR combined review	Domestic Homicide	In progress
Deena	2018	Learning review	Child Exploitation	In progress

Actions from the reviews are monitored by WSSCP and WSHT Safeguarding committee. The publication of some of these reviews was delayed due to court proceedings; however, improvement plans and shared learning are in progress or have been completed. Some of these cases also required some staff to attend court hearings in the family courts and in some cases criminal courts. The children's safeguarding team and trust legal team have supported staff through this process.

Table 4: Identified Themes from Practice Reviews in West Sussex;

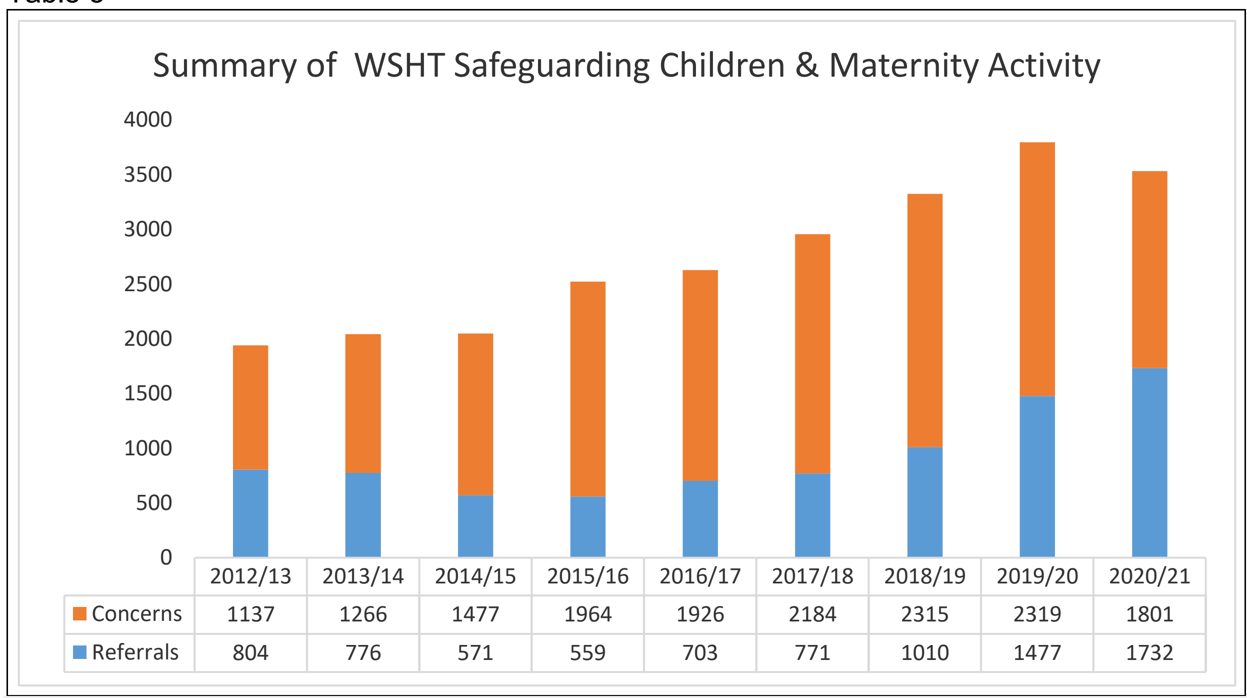
Summary	Common Risk Factors / Vulnerabilities	Learning
Babies who have sustained non accidental injuries over the past three years	• Very young babies • Young parents • Late presentation in pregnancy • Parental Domestic Abuse • Parental Mental Health • Parental Substance Misuse • Premature baby • Parents care leavers	• GP involvement in CP processes • Multi agency Information sharing (including across county borders) and escalation • Sharing of information between health agencies eg: maternity/perinatal MH/GP • Support for care leavers • Role of other professionals • Engaging fathers and including in risk assessments • Risks of domestic abuse and in conjunction with parental mental health issues

Summary	Common Risk Factors / Vulnerabilities	Learning
Children who have suffered chronic neglect impacting on their physical, emotional and psychological development	• Parental Domestic Abuse • Parental Mental Health • Parental Substance Misuse • Parental Learning Disability • Children not brought to appointments/non engagement of parents with health services • Neglect co existing with other forms of abuse eg Sexual abuse • Transition of health care from children to adult services • Optimism of parental compliance	• Information sharing between agencies eg: schools/health/CSC/substance misuse services • Sharing of information between health agencies eg: diabetes specialist services/GP/School nurse • Being proactive in seeking the voice and understanding the lived experiences of children • Understanding that females can be perpetrators of CSA • Importance of using chronologies to understand emerging pattern of neglect • Risk assessment should be rooted in child development ie: impact

Summary	Common Risk Factors / Vulnerabilities	Learning
Children who have been subject to Criminal or Sexual Exploitation	• Neglect • Parental Substance and Alcohol Misuse/Domestic Abuse • Looked after Children • Children who have suffered Adverse Childhood Experiences (ACEs) • Children groomed into county lines • Children excluded from school	• Information sharing between agencies eg: schools/health/CSC/substance misuse services/police/sexual health services • Being proactive in seeking the voice and understanding the lived experiences of children • Early Help response to CSE • Avoid victim blaming (eg : lifestyle choice etc) • Cultural competence • Escalation process, addressing disagreements between agencies • Understanding Trafficking • Contextual safeguarding • Supporting whole family

3.3 WSHT Children and Maternity Safeguarding Activity:

Table 5



	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Concerns	1137	1266	1477	1964	1926	2184	2315	2319	1801
Referrals	804	776	571	559	703	771	1010	1477	1732

Activity Data for 20/21;

- **20,477 children's A&E attendances** (WH: 11,901, SRH: 8,576) compared to 29,114 the previous year. These attendances were reviewed by the safeguarding & liaison team as per procedures.
- **Referrals to children's social care** has increased; despite a significant drop in A&E attendances, referrals to children's social care have increased which reflects the increase in number of higher level safeguarding concerns and complex cases which meet the threshold for referral to children's social care
- **Safeguarding concerns** have reduced; however, this appears to be proportionate to the overall reduced number of hospital attendances in the year. The children's safeguarding team have an internal process for review safeguarding concerns which may not meet threshold for a referral to children's social care but require review to consider the outcome and action required may result in information sharing, health support for the child and family or escalating to a referral to children's social care

For full details of concerns and referrals please refer to Appendix 1 Table 8

- **Principle reason for safeguarding concern or referral** see Table 6 for maternity and for children Appendix 1-Table 9
- **Detainments of children in hospital** under the Mental Health Act have increased;
  2018/19 - 6
  2019/20 - 10
  2020/21 - 17 (WH- 10 SRH 7)
- **Allegations management**: 4 referrals
- **Serious Incidents involving children**: 5

Table 6: Maternity Safeguarding Data 2020-21

Maternity - Annual SG activity (referrals & concerns) 2020-21 (*4424 women gave birth/4470 babies born*)	**Worthing**	**SRH**
Mental health	214	71
Known to social care	98	64
Domestic Abuse	64	39
Looked after children	40	10
Concealed/late booking	21	22
Substance misuse	38	24
Other	33	25
Total	**508**	**255**

3.4 **Looked after Children Service Update**

Worthing Child Development Centre (CDC) is part of WSHT and provides two appointment slots per week for statutory health assessments for Looked after children in West Sussex. These health assessments include; initial health assessments (IHA), review health assessments (RHA) for under 1 year olds and adoption medicals. There have been on-going challenges within West Sussex to ensure health assessments are completed within the statutory timescales. However, developments early 2021 have led to the development of an interim 'Virtual Hub Model' for the delivery of looked after children health assessments in West Sussex. The 'virtual hub' is managed by Sussex Community Foundation Trust (SCFT) and has been developed to help maximise clinic capacity and referrals for statutory health assessment appointments for Looked after children. The service support co-ordinator within the 'virtual hub' oversees the IHA tracker and CDC appointment trackers and coordinates appointments, cancellations and non-attendance of appointments and works with the local authority and providers of Looked After Children services to understand and help unblock current barriers to timely referrals or completion of IHAs.

It is however recognised that there are some continued barriers which are being addressed;

- Capacity issues; the number of children requiring a health assessment in the local Worthing area exceeds the number of available appointments.
- The Worthing CDC currently has limited capacity provides two appointments per week (usually on a set day). Capacity at Worthing is limited and due to other clinics, is not able to flex to meet demand.
- Some carers of Looked after children are reluctant to travel further distance for a health assessments eg from Worthing to Crawley CDC.
- SCFT doctors do not have access to WSHT electronic patient health records (Evolve) which creates additional challenges.
- WSHT CDC staff have read-only access to SCFT electronic patient health records (SystemOne) however are unable to make direct referrals via the system or upload assessments, therefore correspondence relies on secure email.

Evidence of good practice; improvements are being made following as per recommendations from an audit of initial health assessments in early 2020. The Safeguarding Children's Nurse Specialist with experience in looked after children's nursing will be providing advice and support at the IHA clinic particularly for those children over 13 years old. In addition, it had been identified that there was a need for written resources for the older age group therefore health promotion leaflets have been provided to the CDC for this age group to be used alongside the information that is already being given.

Where there are safeguarding concerns relating to a looked after child they will be discussed through our safeguarding processes and structures.

3.5 Unexpected Child Deaths

Within the trust the statutory child death review process arrangements have been reviewed in accordance with national guidance and new arrangements are now in place from April 2020 with the support from an administrator from September 2020. A memorandum of understanding has been agreed for working together and information sharing.

The sharing of learning from these deaths related to safeguarding is managed through the child death arrangements and feedback provided to WSHT.

There were sadly 7 unexpected child deaths between April 20 - end of March 2021 and for four of these children and young people, there were safeguarding concerns. The unexpected child death process was followed as part of the statutory child death process and reviewed by the Child death overview panel (CDOP).

3.6 Safeguarding Children Training and Supervision

3.6.1 Training Compliance

Table 7: WSHT Children's Safeguarding Training Data

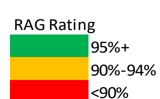
Child Protection Training Figures as at 09/06/2021

Child Protection Training by Division

Division	ALL WSHT STAFF (Excluding Bank)			MEDICS ONLY			NON MEDICS		
	Heads	Total Up To Date	% Up To Date	Heads	Total Up To Date	% Up To Date	Heads	Total Up To Date	% Up To Date
Core Services	1604	1554	96.9%	66	59	89.4%	1538	1495	97.2%
Corporate	737	702	95.3%	62	46	74.2%	675	656	97.2%
Facilities & Estates	654	645	98.6%	0	0	-	654	645	98.6%
Medicine	2144	1817	84.7%	311	221	71.1%	1833	1596	87.1%
Surgery	1396	1202	86.1%	286	224	78.3%	1110	978	88.1%
Women & Children	791	703	88.9%	132	93	70.5%	659	610	92.6%
Total	7326	6623	90.4%	857	643	75.0%	6469	5980	92.4%

Child Protection Training by Level Required

Level Required	ALL WSHT STAFF (Excluding Bank)			MEDICS ONLY			NON MEDICS		
	Heads	Total Up To Date	% Up To Date	Heads	Total Up To Date	% Up To Date	Heads	Total Up To Date	% Up To Date
Level 1	2603	2567	98.6%	7	7	100.0%	2596	2560	98.6%
Level 2	3798	3268	86.0%	668	509	76.2%	3130	2759	88.1%
Level 3	924	788	85.3%	182	127	69.8%	742	661	89.1%
Total	7325	6623	90.4%	857	643	75.0%	6468	5980	92.5%



Child Protection By Staff Group

Staff Group	Heads	Total Up To Date	% Up To Date
Add Prof Scientific and Technic	257	236	91.8%
Additional Clinical Services	1451	1311	90.4%
Administrative and Clerical	1418	1386	97.7%
Allied Health Professionals	439	419	95.4%
Estates and Ancillary	618	608	98.4%
Healthcare Scientists	166	163	98.2%
Medical and Dental	857	643	75.0%
Nursing and Midwifery Registered	2120	1857	87.6%
Total	7326	6623	90.4%

Training has been significantly impacted over the year due to impact of the pandemic. The overall safeguarding children training compliance remains below the high target WSHT set. The safeguarding team have had to transform their delivery of training over the year to a model of virtual webinars, films and workbook assessments. With limited time, administrative resource and technological support, this has been challenging and required a significant amount of time and resource from the safeguarding team and named professionals to develop and modify following staff feedback.

The team are currently about to update the films for delivering core content for level 1, 2 and 3 and update the webinar and assessment and workbook content for the forthcoming year. A safeguarding booklet has also been developed for staff and available via staffnet. The training content has also been expanded in accordance with the intercollegiate guidance for looked after children.

Safeguarding Children's training and Looked after Children's roles and competencies for healthcare staff are defined in accordance with the respective Intercollegiate Guidance (RCN 2019 and RCPCH 2020). Named professional roles have had the opportunity to attend virtual seminars and conferences which has supported their knowledge and development for level 4 safeguarding training.

Virtual Training in Allegations Management was delivered by the local authority designated officer and received by staff in HR and safeguarding children's team.

3.6.2 Safeguarding Supervision

Supervision has been strengthened further during the year with the development of virtual supervision groups for specialist nurses and allied health professionals. This offer will also be extended to some of our colleagues working within the integrated child development centre at Worthing Hospital.

Safeguarding supervision is provided in accordance with the framework outlined in the Safeguarding policy. Group supervision is available for practitioners at the weekly and monthly safeguarding case discussion meetings or monthly peer review. Supervision is also available on a 1:1 basis. Supervision is now also offered on a more regular basis to specialist nurses, virtual fracture clinic and the multidisciplinary children's chronic pain team.

Named professionals receive supervision quarterly by designated safeguarding professionals and the safeguarding nurses and midwives receive supervision from the named professionals.

3.7 Audit

The following audits have been completed during the year;

Non-attendance of appointments are audited on a monthly basis by the maternity and children's safeguarding teams as part of our action plan for the WSSCP neglect strategy. The 'Was not brought/Did not attend (DNA)' pathways were also relaunched during the year with involvement of the practitioners working with children and families.

ICON- coping with crying babies and preventing abusive head trauma public health message was audited between November 2020 and June 2021 as part of a quality improvement project by a speciality trainee doctor in the Worthing A&E. Undertaking the audit was made challenging as it coincided with the second wave of the pandemic. Findings indicated:

- 90% staff felt confident discussing coping with crying strategies with parents.
- Improvement in sharing the ICON message was evident following the second cycle of auditing in the period.
- Need to continue to share the message with carers within A&E when presenting with a baby under 6 months.

4. CONCLUSIONS AND PRIORITIES FOR THE FORTHCOMING YEAR

This annual report outlines the achievements and challenges for 2020-2021 and priorities for the forthcoming year.

Safeguarding at WSHT is supported by an experienced and cohesive team in a supportive environment. Increasing the safeguarding children's nursing establishment by 1.65 wte following the first lockdown in 2020, has certainly helped to support safeguarding in practice, as the surge of demand post lockdowns is felt. The new role of the youth worker at WSHT, commencing in 2021, has also been a strength in supporting safeguarding in practice at WSHT. It is hoped, going forward, this role can be extended further, within the new UHSussex.

The Section 11 Audit was completed in June 2020 and the arrangements for looked after children have since been strengthened including the statutory services which are delivered from the Child development centre at Worthing hospital.

Information sharing and enabling practitioners to use their professional curiosity and have those difficult conversations with children and families in response to concerns when raised; has been a key focus of quality improvement work and will continue to remain so. Evidence that ICON – coping with crying public health message is being shared and recognition and response to neglect continues to improve in practice. This report also identifies improvement work and effective multi agency networking during challenging times.

Overall 90.4% of the staff have completed their mandatory safeguarding children training, required level for their role, delivered using a blended and 'virtual' approach during the pandemic. It is recognised however that compliance remains challenging for front line staff, particularly medical and nursing staff. The safeguarding team continue to work with specialities to support training compliance and by delivering a blended safeguarding training programme.

The challenges however have been felt. The effects of the pandemic, the complexity of concerns and the significant challenges within the system, has made it challenging for safeguarding children and young people and families, in practice. The number of safeguarding concerns reaching the higher threshold for referral to children's social care have increased, this is despite an overall reduction in attendances to hospital during the year of children and young people.

One particular area of concern is for children and young people presenting with significant mental ill health including self- harm and eating disorders, or challenging behaviour. There have also been significant challenges within the system, with children and young people waiting in WSHT for a specialist mental health, eating disorders or care placement. As a result of these challenging situations, there has been a notable increase in incidents and episodes of restraint this year. These extremely difficult situations are impacting on children, families and staff, and rely on dynamic and robust partnership working, to manage. These concerns are seen as a systemic safeguarding issue and are being experienced nationally and are escalated regularly to the commissioners and NHS England and also discussed within our networks and partnerships.

There are outstanding actions following the Section 11 audit which include; requirement for improved domestic abuse support in the hospitals at WSHT; and requirement to strengthen recruitment ensuring all recruitments have a trained staff member in safer recruitment practice on the shortlisting/ interview panel.

Integrated working with partner agencies brings benefits however poses new challenges at the boundaries of working together. Access to relevant patient information in a dynamic system is challenging. Further integration of electronic records and access to relevant health information and integration of referral pathways would be advantageous and support working together to safeguard children in those areas where there is integrated working with partner agencies.

Overall, improving processes, effective partnership working and a supportive culture, with staff clear of their safeguarding responsibilities, supports the safeguarding of children. Progress continues in the development of training, communication and information sharing processes within WSHT and between partner agencies. Furthermore, the safeguarding team continue to share learning and endeavour to embed effective safeguarding practice throughout the whole Trust. The team also actively contributes and participates to the collaborative work of the WSSCP in order to find new ways of working and continually improve the quality of the safeguarding service.

The child safeguarding priorities for the newly formed UHSussex (west) for 2021-22 are outlined below.

4.1 **Priorities**

1. **Complete S11 audit standards** and any outstanding actions from June 2020 which includes; securing **domestic abuse support** for a hospital independent domestic violence advisor (HIDVA) and **safer recruitment** practice.

2. **Develop Integrated working for safeguarding children within the newly formed UHSussex.**

3. **Develop the safeguarding champion role** to ensure there is best practice for all our service areas. Supported by the safeguarding team, champions in a variety of ways and as part of their day-to-day roles, will share safeguarding best practice through signposting and sharing knowledge, role-modelling best practice, and; giving others the confidence to do the same in their work.

4. **A&E safeguarding children audit**; agree format for monthly data collection with A&E and embed into current safeguarding processes.

5. **Develop a protocol for the management of substance use in pregnancy**; in partnership with multi agency partners, with the aim to improve multi agency communication and improve outcomes for women & families.

6. **Improve Integrated working with partner agencies within** the CDC, UTC, A&E and CAMHS Liaison service, through agreed governance arrangements in particular for information sharing, joint safeguarding training and improved access to relevant health information.

7. **Transitional safeguarding**; develop pathways alongside adult safeguarding team, to support vulnerable young people transitioning to adult services.

8. **Improve safeguarding data monitoring for harmful incidents** Classification of harmful incidents related to restraints and managing challenging behaviour of children whilst they are in hospital to be improved with the release of the updated incident reporting system (datix) within the trust.

9. **Liberty Protection Safeguards** continue to work towards implementation.

5. GLOSSARY OF TERMS

CCG	Clinical Commissioning Group-Sussex Commissioners
CDC	Child Development Centre
CIN	Child in Need Plan
CPP	Child Protection Plan
CQC	Care Quality Commission
CSPR	Child Safeguarding Practice Review
DFE	Department for Education
FGM	Female Genital Mutilation
HCP	Healthy Child Programme (health visitors & school nurses)
HIDVA	Hospital Independent domestic violence advisor
IHA	Initial Health Assessment for looked after children
IPC	Innovations in Primary Care
LCSPR	Local Child Safeguarding Practice Review
LSCP	Local Safeguarding Children's Partnership
MCA	Mental Capacity Act
MHA	Mental Health Act
NCSPR	National Child Safeguarding Practice Review
NHSE/I	National Health Service England and NHS improvement
NICE	National institute of clinical effectiveness
SCFT	Sussex Community Foundation Trust (community services)
SPFT	Sussex Partnership Foundation Trust (mental health services)
SCR	Serious case review
UHSussex	University Hospitals Sussex NHS Foundation Trust
UTC	Urgent Treatment Centre
WSHT	Western Sussex Hospitals NHS Foundation Trust
WSSCP	West Sussex Safeguarding Children Partnership

Appendix 1 - Safeguarding Children Activity 2020-2021

The following data details safeguarding activity per area within WSHT and is based on the number of safeguarding concerns raised and referrals to children's social care.

Table 8

St Richards Hospital (SRH) Children's Social Care Referral: 2020/21

Department		Q1 Apr - Jun	Q2 Jul - Sept	Q3 Oct - Dec	Q4 Jan - Mar	Total Referrals 2020/21
Maternity	168	32	43	42	44	161
Paediatrics	74	12	24	18	14	68
A & E	388	102	95	130	123	450
Sexual Health	1	1	1	0	0	2
Children's Safeguarding Team	18	2	16	28	17	63
Other	16	13	0	0	4	17
	665				**TOTAL Referrals**	**761**

St Richards Hospital (SRH) Safeguarding Concern: 2019/20

Department		Q1Apr - Jun	Q2 Jul - Sept	Q3 Oct - Dec	Q4 Jan - Mar	Total Concerns 2020/21
Maternity	119	32	23	24	14	93
Paediatrics	84	19	32	26	27	104
A & E	614	136	171	104	119	530
Sexual Health	13	2	1	0	0	3
Children's Safeguarding Team	19	2	12	8	3	25
Other	36	4	5	5	2	16
	885				**TOTAL Concerns**	**771**

SRH Total Safeguarding Activity 2020/21: 1,532

Worthing Hospital (WH) Social Services Referral: 2020/21

Department	Total Referrals 2019/20	Q1Apr - Jun	Q2 Jul - Sept	Q3 Oct - Dec	Q4 Jan - Mar	Total Referrals 2020/21
Maternity	207	39	48	55	45	187
Paediatrics	51	20	19	26	20	85

A & E	429	111	128	133	101	474
Sexual Health	58	4	5	4	7	20
Children's Safeguarding Team	54	16	19	27	51	113
Other	13	9	7	2	7	87
	812				**TOTAL Referrals**	**966**

Worthing Hospital (WH) Safeguarding Concern: 2020/21

Department	Total Concern 2019/20	Q1 Apr - Jun	Q2 Jul - Sept	Q3 Oct - Dec	Q4 Jan - Mar	Total Concerns 2020/21
Maternity	299	58	88	78	77	301
Paediatrics	117	38	30	43	27	138
A & E	886	116	122	101	56	395
Sexual Health	57	4	12	6	13	35
Children's Safeguarding Team	26	4	13	10	33	60
Other	49	7	6	5	0	91
	1,434				**TOTAL Concerns**	**1,020**

Worthing Total Safeguarding Activity 2020/21: 1,986

Crawley Safeguarding Forms Completed: 2020/21

Dept. Crawley Sexual Health	Total 2019/20	Q1Apr - Jun	Q2 Jul - Sept	Q3 Oct - Dec	Q4 Jan - Mar	Total 2020/21
Referrals	10	0	1	3	1	5
Concerns	40	3	4	3	0	10

Crawley Total safeguarding activity 2020/21: 15

Table 9

Children's Safeguarding Concern and Referral Data				
Principal Concern (Excludes maternity Safeguarding Data)	**Year**	**SRH**	**WH**	**Crawley**
THINK FAMILY Household Dysfunction & Adult Issues: drug/alcohol misuse/ domestic/poverty /mental health/ housing/ young carer/teenage pregnancy	20/21	187	267	
	19/20	195	328	<5
	18/19	174	358	<5
Child Mental Health & Emotional Health; anxiety, challenging behaviour, anger management, bullying, self-harm, mental health, eating disorders, online abuse	20/21	366	471	<5
	19/20	330	639	<5
	18/19	261	533	<5
Child Physical: including perplexing cases, FII, unexplained bruise, injuries, assault, dog bite	20/21	97	122	
	19/20	145	169	
	18/19	117	218	
Child Sexual Abuse; CSA, CSE, FGM	20/21	8	13	
	19/20	9	9	<5
	18/19	10	23	<5
Risky Behaviour; including drug/alcohol problems, vulnerable, exploitation	20/21	121	134	14
	19/20	155	271	46
	18/19	118	341	59
Neglect Concerns; including; parenting concerns/ DNA /attachment/supervision/preventable accident/NEET	20/21	307	469	
	19/20	428	347	
	18/19	207	362	
Child Protection Medical (Worthing CP medicals include acute and community CDC)	20/21	40	83	
	19/20	44	96	
	18/19	24	86	

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	13	Meeting:	Board	Meeting Date:	3 February 2022
Report Title:	People Committee Chair report to Board				
Committee Chair:			Patrick Boyle, Committee Non Executive Chair		
Author(s):			Patrick Boyle, Committee Non Executive Chair		
Report previously considered by and date:					

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

Implications for Trust Strategic Themes and any link to BAF risks		
Patient	☐	
Sustainability	☐	
People	✓	Assurances in relation to risks 3.1 – 3.4
Quality	☐	
Systems and Partnerships	☐	

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

Communication and Consultation:

Executive Summary:

The People Committee met on the 26 January 2022 and was quorate as it was attended by four Non-Executive Directors, the Chief Executive, the Chief People Officer, the Deputy Chief Executive and Managing Director, the Chief Nurse and the Chief Medical Officer.

In attendance were the Director of Integrated Education, the Director of Workforce Planning and Deployment, Director of Medical Education, the Nursing Director and senior members of the HR and Wellbeing team.

The Committee received its planned items including the reports on the respective Patient First Trust North, Breakthrough Objective, Strategic Initiative and Corporate Project, Staff Survey progress, the health and wellbeing strategy update, workforce performance reports, the GMC annual report and the Annual Gender Pay Gap and the Annual Equality Report along with update on the work of the ICS people committee and the Trust's 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** that the Committee after careful consideration of the continued pressures facing staff agreed the risk scores for BAF risks 3.1 to 3.4 are fairly stated for the start of quarter 4.

The Board is asked to **NOTE** the Committee's recommendation to approve the Annual Gender Pay Gap reports at the snapshot date of 31 March 2021 for BSUH and WSHFT along with the combined BSUH and WSHFT Annual Equality Report for 2020/21.

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
People Committee	**27 October 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 Chief People Officer provided an update on the True North in respect of staff engagement. The Committee **NOTED** the various of processes that enable the Trust to listen to its staff. The Committee recognising that as the national staff survey is undertaken once a year that the Trust uses the pulse survey feedback which is received more frequently to monitor staff engagement. The Committee **NOTED** that there were complementary staff listening events that have been undertaken and was **ASSURED** by the Chief People Officer and Managing Director that these will continue.

The Chief People Officer discussed the actions being taken in respect of the Breakthrough objective to increase the number of staff who would recommend the organisation as a place to work. The Committee **NOTED** the impact of operational pressures the Trust has been dealing with but despite this there have been a reasonable level of action being taken supported by the positive use of Patient First to secure staff engagement with the identified improvements.

The Chief People Officer presented an update on the Trust's Strategic Initiative and recognised the underpinning report on health and wellbeing is was also considered at this meeting. The Committee **NOTED** the actions being taken and **RECEIVED** a more detailed update on those actions planned within integrated education which was presented by the Director of the Integrated Education. Based on the update provided the Committee was **ASSURED** over the actions taken to understand and develop the Trust's integrated education strategy. The Committee endorsed the development of a fourth workstream pillar within this project aligned to the Trust's inclusion value and looked forward to the receipt of the developed project charter at a future meeting.

In respect of the Corporate Project, the Director of Workforce Planning and Development presented an update on this project and its deployment with a specific focus on the benefits realisation tracker and the initial benefits data. The Committee **NOTED** the breadth of benefit metrics developed and through the data provided was **ASSURED** of the early benefits delivered so far. The Committee **AGREED** that the oversight of the benefit delivery of this project is maintained and reported regularly to the Committee.

Committee Activity

The Committee **RECEIVED** an update on the Trust's staff health and wellbeing initiatives and their alignment to the support the delivery of the People Breakthrough Objective and True North. The Committee was **ASSURED** through this information that these activities were both reactive to the known pressures but also were being developed proactively through the work of the wellbeing steering group to enable staff

health and wellbeing support to be weaved into the Trust's ways of working. The Committee **NOTED** the multi-faceted approach to staff support and the close working relationships with the Charity in respect to the use of locally and nationally donated charitable funds allowing a number of the wellbeing projects to be accelerated.

The Committee **NOTED** the developed workforce dashboard. Through the update provided by the Chief People Officer the Committee **NOTED** the Trust's performance across the core metrics of recruitment, retention, appraisals, training and engagement. The Committee **AGREED** that within future reports gerater information should be included the activity being taken to address the areas for improvement as identified from the workforce metrics. The Committee **NOTED** the pressure on staff and the impact this is having on the Trust's levels of compliance with its targets for staff training and appraisals.

The Chief People Officer provided an update on the role the People Steering Group will play in co-ordinating the oversight of information flowing from the various formally established sub groups to the Committee. The Committee **NOTED** the Steering Group's in support of the regularising the reporting from the respective groups to this Committee. The Committee NOTED the Chief People Officers assurance that the groups will start to provide formal reports to the Committee over the forthcoming year.

The Committee **RECEIVED** the Trust's Annual GMC survey report and the respective Guardian of Safe Working reports. The Committee noted the cohorts of staff contributing to the respective reports were different and they covered differing timeframes. The Committee **NOTED** the themes identified within the Annual GMC survey report and those within the respective Guardian of Safe Working reports and was **ASSURED** that these would be considered within the respective Committee reporting groups. The Committee **AGREED** that the quality aspects of the improvement themes be referred to the Quality Committee for information and respective consideration.

The Committee **RECEIVED** the Annual Gender pay gap reports at the snapshot date of 31 March 2021 for the former BSUH and WSHFT Trusts. The Committee discussed the key differences the data within the reports identity. The Committee **NOTED** that there is work being undertaken which was planned as part of the post merger work to consider the progress being made with the harmonisation of pay and the review of the strategies employed by the Trust to recruit and promote female staff. The Committee was **ASSURED** through the update provided by the Chief People Officer and the Equality and Diversity senior manager that the report was complaint with the Trust's statutory reporting requirements and therefore **RECOMMENDED** this report to the Board for approval.

The Chief People Officer provided the Committee with an update on the Trust's recent Equity, Diversity and Inclusion activity and presented the 2020/21 Annual Equality Report which had been produced as a combined report covering BSUH and WSHFT. The Committee NOTED this report and NOTED that the oversight for the use of this data to inform the Trust's equality and diversity actions would be provided by the respective Committee reporting Group. The Committee was **ASSURED** through the update provided by the Chief People Officer and the Equality and Diversity senior manager that the report was complaint with the Trust's statutory reporting requirements and therefore **RECOMMENDED** this report to the Board for approval.

<u>ICS Update</u>

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

RISK

The Committee reviewed the BAF risks it has oversight for, and **AGREED** the quarter four score for risks 3.1 to 3.4 as stated in the BAF. The Committee agreed based on the reports received at the meeting and the summary provided within the report by the Chief People Officer that for these risks, they continue to correctly reflect the pressures on the Trust's workforce along with the context of the wider risks impacting on Trust and the workforce.

Actions taken by the Committee within its Terms of Reference

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

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

The benefits realised from the corporate project form part of the routine reporting to this Committee.

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 to the Board that after careful consideration of the continued pressures facing staff that the risk scores for BAF risks 3.1 to 3.4 are fairly stated for the start of quarter 4. The Committee recommended to the Board the approval of the Annual Gender Pay Gap reports at the snapshot date of 31 March 2021 for BSUH and WSHFT along with the combined BSUH and WSHFT Annual Equality Report for 2020/21.	To Board 3 February 2022

Agenda Item:	13.1	Meeting:	Trust Board	Meeting Date:	03/02/2022
Report Title:	Annual Gender Pay Gap Report 2021 – Legacy WSHFT & BSUH				
Sponsoring Executive Director:			David Grantham, Chief People Officer		
Author(s):			Simon Anjoyeb, Deputy Head of Inclusion		
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 Gender Pay Gap (GPG) reports for legacy BSUH & WSHFT shows the difference in average hourly pay and bonus payments between men and women.

This is the fifth Gender Pay Gap (GPG) report Brighton & Sussex University Hospitals (BSUH) and Western Sussex Hospitals NHS Foundation Trust (WSHT) has produced following the introduction of the requirement in March 2017. This is the final report for legacy BSUH & WSHFT following the merger with BSUH to form University Hospitals Sussex NHS Foundation Trust.

Key Recommendation(s):

The Board is asked to approve this report for publication on the Trust website by the 30 March 2022.

Gender Pay Gap Report

(31 March 2021 snapshot)

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- Average bonus gender pay gap as a mean average 4
- Average bonus gender pay gap as a median average 4
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What is the gender pay gap report?

Gender pay reporting legislation requires employers with 250 or more employees from April 2017 to publish statutory calculations every year showing how large the pay gap is between their male and female employees. There are two sets of regulations. The first is mainly for the private and voluntary sectors (taking effect from 5 April 2017) and the second is mainly for the public sector (taking effect from 31 March 2017). Employers will have up to 12 months to publish their gender pay gaps.

The results must be published on the employer's website and a government website. They must, where applicable, be confirmed in a written statement by an appropriate person, such as a chief executive. While employers may already be taking steps to improve gender equality and reduce or eliminate their gender pay gap, this process will support and encourage action.

Gender pay reporting is different to equal pay - equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman.

The gender pay gap shows the difference in the average pay between all men and women in a workforce. If a workforce has a particularly high gender pay gap, this can indicate there may a number of issues to deal with, and the individual calculations may help to identify what those issues are.

The NHS terms and conditions of service handbook contain the national agreements on pay and conditions of service for NHS staff other than very senior managers and medical staff.

Job evaluation (JE) enables jobs to be matched to national job profiles or allows trusts to evaluate jobs locally, to determine in which Agenda for Change pay band a post should sit.

The gender pay gap indicators

An employer must publish six calculations showing their:

- Average gender pay gap as a mean average
- Average gender pay gap as a median average
- Average bonus gender pay gap as a mean average
- Average bonus gender pay gap as a median average
- Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment
- Proportion of males and females when divided into four groups ordered from lowest to highest pay.

BSUH workforce context – 31/03/21

The current gender split within the overall workforce is 71.1% female and 28.9% male (Headcount). The breakdown of proportion of females and males in each

banding by Headcount:

Band	Male	Female
Apprentice	-	-
Band 1	30.3%	69.7%
Band 2	35.1%	64.9%
Band 3	26.4%	73.6%
Band 4	21.0%	79.0%
Band 5	20.6%	79.4%
Band 6	18.0%	82.0%
Band 7	22.2%	77.8%
Band 8a	32.9%	67.1%
Band 8b	34.8%	65.2%
Band 8c	37.5%	62.5%
Band 8d	57.1%	42.9%
Band 9	56.2%	43.8%
Medical	50.3%	49.7%
Ad-Hoc	36.4%	63.6%

Results for BSUH – 31 March 2021 snapshot

Average gender pay gap as a mean average

Overall

	Male	Female	% Difference
Mean hourly rate	£20.51	£17.25	15.9%

Agenda for Change and Medical

	Male (AfC)	Female (AfC)	% Difference
Mean hourly rate	£15.01	£15.68	-4.5%
	Male (Medical)	**Female (Medical)**	**% Difference**
	£38.03	£32.80	13.8%

Average gender pay gap as a median average

Overall

	Male	Female	% Difference
Median hourly rate	£15.66	£15.66	0.0%

Agenda for Change and Medical

	Male (AfC)	Female (AfC)	% Difference
Median hourly rate	£12.71	£14.96	-17.7%
	Male (Medical)	Female (Medical)	% Difference
	£36.73	£29.57	19.5%

Average bonus gender pay gap as a mean average

	Male (Medical)	Female (Medical)	% Difference
Mean bonus payment	£18,013	£10,605	41.1%

Average bonus gender pay gap as a median average

	Male (Medical)	Female (Medical)	% Difference
Median bonus payment	£12,919	£5,545	57.1%

Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment

Male proportion receiving bonus	Male medical staff overall	% diff	Female proportion receiving bonus	Female medical staff overall	% diff
16.9%	50.2%	-33.3%	7.4%	49.8%	-42.4%

Proportion of males and females when divided into four groups ordered from lowest to highest pay

	Male	Female
Lower (Q1)	31.6%	68.4%
Lower middle (Q2)	27.7%	72.3%
Upper middle (Q3)	20.3%	79.7%
Upper (Q4)	37.8%	62.2%

Publication of data

This report will be submitted to the People Committee and approved at the Trust Management Board. The Trust is required to publish information and make it accessible on the Trusts website. The published information is uploaded to the government website with a written statement confirming the calculations are accurate. This must be signed by an appropriate senior person, such as a Director or Chief Executive.

Organisations are required to provide written narrative with their calculations to support understanding of why a gender pay gap is present. This should explain what the organisation intends to do to reduce or eliminate the gender pay gap. For reporting purposes submitted data is rounded up to one decimal place.

Actions to take forward

The Trust is committed to ensuring an equitable workforce and this paper highlights the gender pay gap data as of 31 March 2021. Towards the end of 2019/20 and 2020/21 and in response to the COVID-19 pandemic, delivery of the proposed actions agreed in 2019 were delayed.

Actions have been delayed to the next reporting period. In view of Western Sussex Hospitals merging with Brighton Sussex University Hospitals from 1 April 2021 the ongoing collaboration, shared expertise, advice and guidance provided by the Equality, Diversity and Inclusion team at BSUH will support continuous gender pay progression and focus to:

- Establish a joint WSHT/BSUH gender pay working group lead by relevant stakeholders including the Trust's Medical Directors and provide regular progress reports to the merged Diversity Matters Steering Group.
- Undertake a review of the local and national CEA applications to ensure both female and male employees feel able, are encouraged and confident to apply and outcomes treated fairly.
- Seek confirmation on the detail available in the ESR Business Intelligence (BI) template report to understand the breakdown of local and national CEA.
- Monitor applications of Trust policies such as flexible working. Record the number of applications and outcomes on ESR, produce an quarterly report for the gender pay gap working group.
- Develop improved career pathways for all lower paid staff, linked to the annual welfare process.
- Ensure all staff have fair and equitable access to all leadership & management development opportunities.
- Review how well the Trust manages women's career progression after an employment break such as maternity.

Gender Pay Gap Report (31 March 2021 snapshot)

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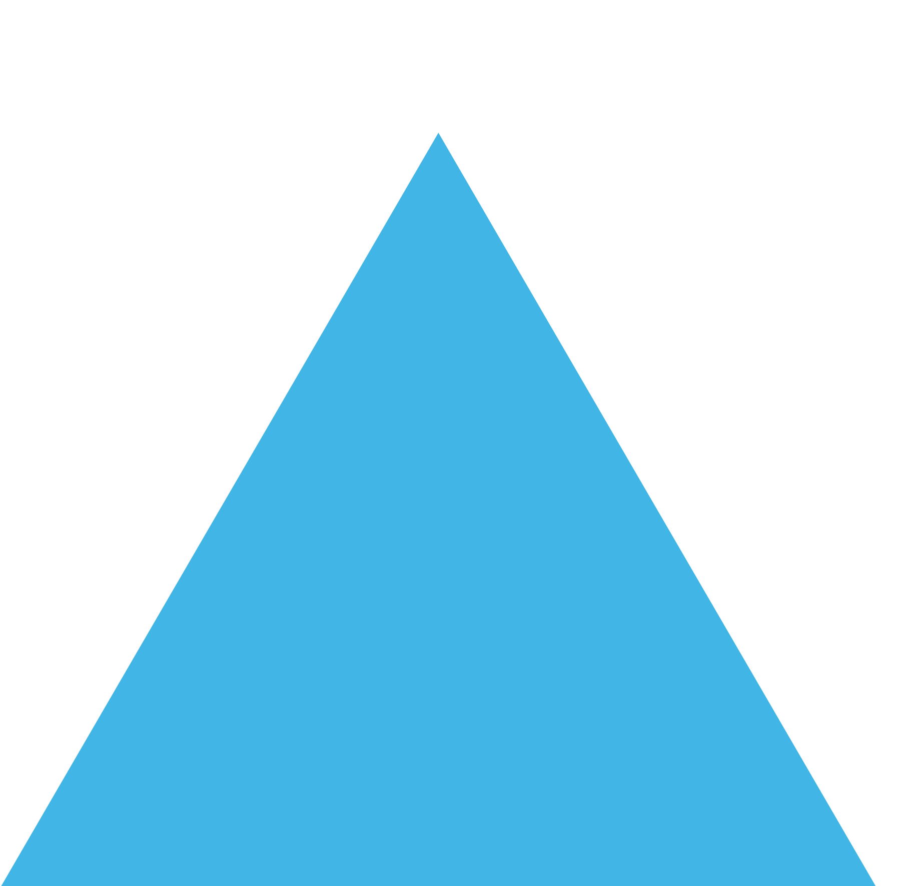

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Introduction

Gender Pay Gap (GPG) reporting shows the difference in average hourly pay and bonus payments between men and women. This is the fifth Gender Pay Gap (GPG) report Western Sussex Hospitals NHS Foundation Trust (WSHT) has produced following the introduction of the requirement in March 2017.

In April 2021 Western Sussex University Hospitals Foundation NHS Trust and Brighton and Sussex University Hospitals NHS Trust merged to form University Hospitals Foundation NHS Trust. This will be the last report that the legacy organisations will be reporting as separate NHS Trusts.

All Public Sector organisations listed in Schedule 2 of The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 are subject to the mandatory GPG reporting requirements, if they have more than 250 employees under a contract of employment. This includes all staff under Agenda for Change, Medical & Dental and Very Senior Managers (VSM).

Data relating to the pay period in which the snapshot date of 31 March 2021 is required, with full publication on 30 March 2022 and annually thereafter. Organisations are required to maintain data on their websites for three years in order to show progress made.

The legislation requires the Trust to report and publish six basic calculations:

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

The pay period is a snapshot of the gross hourly pay rate of all employees, excluding bank workers on the 31 March 2021 and includes the following elements:

- Basic pay including other allowances
- Paid leave, including annual leave, sick leave, maternity, paternity, adoption or parental leave (except where an employee is paid less than usual because of being on leave)
- Bonus pay (if paid in the pay period) i.e.: VSM bonus or Clinical Excellence Award (CEA)

All posts are banded through the Agenda for Change (AfC) job evaluation process which determines the banding of the role, therefore this should ensure consistency in terms of equality. Job evaluation evaluates the content and specifics of the job and

not the actual post holder. AfC makes no reference to gender or any other personal characteristic of existing or potential job holders. The report does not include:

- Overtime pay, waiting list initiatives (WLI), expenses, value of salary sacrifice schemes, benefits in kind, redundancy pay and tax credits.

Purpose

GPG reporting shows the difference in average hourly pay and bonus payments between men and women. WSHT are required to analyse the information to identify any underlying root causes for GPG and put in place remedial actions to address and mitigate this. The results will be used to assess:

- the level of gender equality
- the balance of male and female employees in each of the four salary range quartiles
- how effectively talent is being maximised and rewarded

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

Analysis

Gender mean and median - hourly pay gap

The tables below shows the mean and median hourly rates for male and female employees in the Trust and the actual gap in monetary and percentage terms in in both 2020 and 2021.

There is a 19.79% (19.17% in 2020) difference in favour of male employees when using the mean hourly rate; this is a increase of 0.62% on the 2020 figures.

This however, moves to 2.91% in favour of male employees when the median hourly rate is used. This was 1.18% in favour of male employees in 2020. The mean figure is more indicative measure.

Data obtained for the 2021 snapshot has been provided by staff group and pay banding. This shows outliers in the gender pay gap in favour of male employees of 16.31% (15.81% in 2020) for Medical and Dental staff and 22.90% (19.08% in 2020) Administration and Clerical. When reviewing the 2021 snapshot data these staff groups are to be reviewed further as a priority.

As part of the Agenda for Change contract refresh during the previous reporting period the pay band transition from band 1 to band 2 evidences that there are 3 times more women in band 2. This is impacting on the pay medium, compared to

pay band 1 where the numbers of male to female are comparative. There is however a -£0.12 difference (-1.09%) paygap in favour of female.

Gender	Mean Hourly Rate 2020	Mean Hourly Rate 2021
Male	£19.71	£20.51
Female	£15.93	£16.45
Difference	£3.78	£4.06
Pay Gap	19.17%	19.79%

Gender	Median Hourly Rate 2020	Median Hourly Rate 2021
Male	£14.33	£15.07
Female	£14.17	£14.63
Difference	£0.16	£0.44
Pay Gap	1.18%	2.91%

Gender mean and median – bonus pay gap

The tables below includes Medical and Dental employees who received a Clinical Excellence Award (CEA) and Very Senior Managers (VSM) who received a bonus. There is a general reduction in the gap in median, which is a positive decrease

Gender	Mean Bonus Pay 2020	Mean Bonus Pay 2021
Male	£12,308.88	£11,629.48
Female	£7,072.63	£6,225.23
Difference	£5,236.25	£5,404.25
Pay Gap	42.54%	46.47%

Gender	Median Bonus Pay 2020	Median Bonus Pay 2021
Male	£8,818.67	7,690.80
Female	£3,019.68	3,015.97
Difference	£5,798.69	4,674.83
Pay Gap	65.75%	60.78%

Note: The 2019 Local Clinical Excellence Awards (LCEA) round was paused and payments incorporated into the 2020 LCEA round. Payments have been applied equally amongst all eligible consultants and paid in February 2021. Part time staff will receive the same amount as full-time colleagues. It is a fair assumption that pausing the LCEA round will have a bearing on the overall median bonus data. The

2020 snapshot will exclude the 2021 National CEA which closes for applications in mid-March 2021.

Proportion of male and female receiving a bonus payment

A total of 123 (121 in 2020) employees in the Trust received a bonus payment; this is shown as a percentage of the overall workforce. The reported data is comparable to that in 2020 (data in brackets)

.Gender	Employees Paid Bonus (% of this group)	VSM Staff Paid Bonus	Medical & Dental and Staff Paid Bonus	% of WSHT Workforce
Male	81, 65.9% (82, 68.3%)	5 (1)	76 (81)	3.59% (4.62%)
Female	42, 34.1% (39, 31.7%)	7 (2)	35 (37)	0.60% (0.69%)

Proportion of male and female staff in each quartile band

The Trust is required to rank every employee by rate of pay on the 31 March 2021 (not by pay banding). The data has been presented in 4 equal quartiles in the table below. The reported data is comparable to that in 2020 and is also in line with the national NHS scene (data in brackets).

Quartile	Female	Male	Female %	Male %
1 (Lower)	1474	471	75.8% (76.2%)	24.2% (23.8%)
2(Lower Middle)	1513	433	77.8% (77.6%)	22.2% (22.4%)
3 (Upper Middle)	1610	337	82.7% (83.1%)	17.3% (16.9%)
4 (Top)	1331	617	68.3% (68.9%)	31.7% (31.1%)

Publication of data

This report will be submitted to the People Committee and approved at the Trust Management Board. The Trust is required to publish information and make it accessible on the Trusts website. The published information is uploaded to the government website with a written statement confirming the calculations are accurate. This must be signed by an appropriate senior person, such as a Director or Chief Executive.

Organisations are required to provide written narrative with their calculations to support understanding of why a gender pay gap is present. This should explain what

the organisation intends to do to reduce or eliminate the gender pay gap. For reporting purposes submitted data is rounded up to one decimal place.

Actions to take forward

The Trust is committed to ensuring an equitable workforce and this paper highlights the gender pay gap data as of 31 March 2021. Towards the end of 2019/20 and 2020/21 and in response to the COVID-19 pandemic, delivery of the proposed actions agreed in 2019 were delayed.

Actions have been delayed to the next reporting period. In view of Western Sussex Hospitals merging with Brighton Sussex University Hospitals from 1 April 2021 the ongoing collaboration, shared expertise, advice and guidance provided by the Equality, Diversity and Inclusion team at BSUH will support continuous gender pay progression and focus to:

- Establish a joint WSHT/BSUH gender pay working group lead by relevant stakeholders including the Trust's Medical Directors and provide regular progress reports to the merged Diversity Matters Steering Group.
- Undertake a review of the local and national CEA applications to ensure both female and male employees feel able, are encouraged and confident to apply and outcomes treated fairly.
- Seek confirmation on the detail available in the ESR Business Intelligence (BI) template report to understand the breakdown of local and national CEA.
- Monitor applications of Trust policies such as flexible working. Record the number of applications and outcomes on ESR, produce an quarterly report for the gender pay gap working group.
- Develop improved career pathways for all lower paid staff, linked to the annual welfare process.
- Ensure all staff have fair and equitable access to all leadership & management development opportunities.
- Review how well the Trust manages women's career progression after an employment break such as maternity.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	13.2	Meeting:	Trust Board	Meeting Date:	03/02/2022
Report Title:	Annual Equality Report 2021 – legacy BSUH & WSHFT				
Sponsoring Executive Director:			David Grantham, Chief People Officer		
Author(s):			Simon Anjoyeb, Deputy Head of Inclusion		
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:

University Hospitals Sussex NHS Foundation Trust recognises that its workforce and patients are core to achieving its business and social responsibilities. This report aims to help demonstrate progress in delivering the best possible inclusive healthcare services. The report will help show that the Trust has a valued, reflective workforce that is meeting the communities' needs.
As one of the largest employers in the local health economy and a significant public sector service provider, the Trust is duty bound by legislation to ensure everyone receives a fair and equitable service, promoting a culture of active inclusion.

The contents of this report will help to demonstrate how compliant the Trust is with several national, legislative, NHS specific and regulatory drivers.

The reporting period for this document is 1st April 2020 to 31st March 2021; during this time, Brighton and Sussex University Hospitals NHS Trust (BSUH) was under a shared management contract with Western Sussex Hospitals NHS Foundation Trust (WSHT). Subsequently, on the 1st April 2021, both Trusts merged to form University Hospitals Sussex NHS Foundation Trust. This report is the last that will look at BSUH and WSHT as separate entities.

Key Recommendation(s):

The Board is asked to approve this report for publication to the Trust website by the 30 March 2022.

Annual Equality Report 2020-2021

Produced by the Equality Team, published January 2022

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Introduction

University Hospitals Sussex NHS Foundation Trust recognises that its workforce and patients are core to achieving its business and social responsibilities. This report aims to help demonstrate progress in delivering the best possible inclusive healthcare services. The report will help show that the Trust has a valued, reflective workforce that is meeting the communities' needs.

As one of the largest employers in the local health economy and a significant public sector service provider, the Trust is duty bound by legislation to ensure everyone receives a fair and equitable service, promoting a culture of active inclusion. The Equality Act 2010 specifically states that people should not be treated unfavourably because of:

- their age
- any disabilities they may have
- their ethnic background or race
- their gender (sex is the characteristic listed in the act)
- their gender identity (gender reassignment is the characteristic listed in the act)
- their marital status
- if they are pregnant or recently had a baby
- any religion or beliefs they may have
- their sexual orientation

These nine attributes are known as protected characteristics.

The contents of this report will help to demonstrate how compliant the Trust is with several national, legislative, NHS specific and regulatory drivers that include:

- Equality Objectives – a requirement set by the Equality Act 2010, Public Sector Equality Duty
- Care Quality Commission – The Fundamental Standards (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014)
- Equality Act 2010 – including the Public Sector Equality Duties
- Equality and Human Rights Commission – Codes of Practice
- Human Rights Act 1998
- NHS Constitution
- The Trust's Patient First Programme – This is a programme to deliver improvements for both patients and staff

The NHS Interim People Plan and the NHS People Plan also sets out the commitment to Equality, Diversity and Inclusion, stating that: "It is not enough for the

NHS merely to continue to champion the idea of inclusion and diversity. We must recognise our shortcomings in this area and listen to the experience of those who face exclusion and marginalisation to understand how to advance equality and diversity better. We need to develop leaders who have the knowledge, skills and behaviours to create and sustain cultures of compassion and inclusion…."

The reporting period for this document is 1st April 2020 to 31st March 2021; during this time, Brighton and Sussex University Hospitals NHS Trust (BSUH) was under a shared management contract with Western Sussex Hospitals NHS Foundation Trust (WSHT). Subsequently, on the 1st April 2021, both Trusts merged to form University Hospitals Sussex NHS Foundation Trust. This report is the last that will look at BSUH and WSHT as separate entities.

BSUH is an acute hospital-based across two main sites: the Royal Sussex County Hospital in Brighton and the Princess Royal Hospital in Haywards Heath. The Brighton campus includes the Royal Alexandra Children's Hospital and the Sussex Eye Hospital. The Haywards Heath campus includes Hurstwood Park Regional Centre for Neurosciences and the Sussex Orthopaedic Centre. The Trust also provides services in Brighton General Hospital, Lewes Victoria Hospital, Bexhill Renal Satellite Unit, Hove Polyclinic, Park Centre Breast Care, Goodwood Court Medical Centre and Worthing Hospital.

WSHT has three main sites. 24-hour emergency care, acute medical care, maternity and children services operate from St. Richard's Hospital in Chichester and Worthing Hospital in the centre of Worthing. Southlands Hospital in Shoreham-by-Sea specialises in day-case procedures and diagnostics, outpatient appointments. It is home to our purpose-built ophthalmology centre for eye patients. The Trust also provides a wide range of satellite services across West Sussex in community settings.

As a public sector organisation, we monitor decisions that could unfairly affect any particular protected characteristic of staff, carers, volunteers, patients and their families.

Towards the end of 2019/20 – the COVID-19 pandemic hit the world and presented all organisations with unprecedented circumstances. As a result, there has been an impact on delivering some of the objectives covered within this reporting period. The effect of the pandemic and restoration of services is still being felt in health and social care.

Who benefits from this report?

Those who use or have an interest in our services

Collecting and analysing data allows the Trust to see if it is meeting both corporate and equality objectives. The data helps demonstrate if services delivered are safe, effective and of high quality. The data can also highlight areas where the Trust needs to improve and open the door to inclusive and collaborative engagement with relevant stakeholders.

This report can be helpful to those who use our services, local charities and commissioners to review any barriers to access or outcomes. Publishing this report is essential to demonstrating transparency, acting as an enabler to communicate how we tackle inequity. It also acts as a lever to improve quality.

Those who work within the Trust

Attracting, developing and retaining a diverse and reflective workforce are essential to delivering responsive and inclusive services. Having such a workforce encourages the Trust to develop and deliver services that understand the complex needs of the diverse communities it serves. National research suggests that the degree to which an organisation's workforce represents community demography drives a positive patient experience. (Why Organisational and Community Diversity Matter: Representativeness and the Emergence of Inclusivity and Organisational Performance, King et al., 2011).

Response to COVID-19/Coronavirus Pandemic

The impact of the global pandemic was visible and felt across the world. Within healthcare in the UK, significant changes were made in how services were delivered and accessed.

To meet the demands from the pandemic, the Trust implemented several changes across the board. Some of the changes made during this period included:

- Improving the risk assessment process for both departments and individuals; enabling effective judgements on the best ways to protect our staff and services. All staff has had an individual risk assessment.
- The introduction of risk assessment advisory panels. The independent panels review complex individual risk assessments and provide advice and solutions to issues.
- Commissioning SignLive British Sign Language services, allowing BSL users to communicate with hospital staff effectively (both in-person and remotely).
- Widespread use of 'virtual clinics' both telephone and video conferencing.
- Widespread working from home practices.
- Promotion and expansion of staff health and wellbeing services.

- Bronze, silver and gold COVID-19 command centres – to make trust wide decisions on issues affecting capacity and flow in services.
- COVID-19 Workforce taskforce – to help address questions and resourcing of departments.

Since the beginning of the pandemic, national guidance changed throughout; the Trust worked hard to ensure that it was compliant and delivering effective services for both patients and staff.

Vision statement

Equality, Diversity and Inclusion at Brighton and Sussex University Hospitals NHS Trust and Western Sussex Hospitals NHS Foundation Trust

Our vision is for equality, diversity and inclusion to be a 'golden thread' running through and central to how we work together to provide sustainable, high-quality patient-centred care for all people we serve.

Our vision intends to provide a focus and vision for delivering and developing all our services.

Our patients and service users:

1) Have confidence their individual needs and beliefs are taken seriously, and they are treated with dignity and respect.
2) Know their individual life chances and wellbeing are enhanced by the Trust's commitment to equality, diversity and inclusion.
3) Are happy to choose to use and recommend the organisation.

Our staff:

1) Feel valued and fairly treated in an organisation that really cares.
2) Knows the Trust as an organisation that people want to come and work for, stay with and thrive. Because of its commitment to equality, diversity and inclusion.
3) Are proud to work in an open and inclusive organisation.

Our communities:

1) Assured the Trust engages with the diverse communities based on mutual interest and respect.
2) Confident the Trust is active in tackling inequality, making services accessible, solving problems, delivering solutions and being willing to learn.
3) The Trust is responsive to the challenges faced by people with diverse needs and communicates appropriately.

Our organisation:

1) Lives its values consistently across all sites in the organisation.
2) Demonstrates long-term, consistent commitment to equality, diversity and inclusion for the people it serves.
3) Is a positive, innovative and 'can do' place to be.

What are the Equality Objectives for the Trusts?

The Equality Act 2010 places specific duties on public sector organisations. Part of the specific duties is setting measurable objectives and goals that demonstrate how the organisation meets these needs or takes steps to improve equality.

The objectives and goals are live from 2019 to 2022.

Below is a summary of the objectives:

The following objectives apply to Brighton and Sussex University Hospitals NHS Trust and Western Sussex Hospitals Foundation NHS Trust:

1. Aim to have the workforce's declared equality monitoring data as a minimum of 90% across the board.

2. Review the disparity of experiences from the NHS Staff Survey. The review is currently under the Human Resources work stream. Work is also being undertaken as part of WRES and WDES with respective action plans to address the highlighted issues.

3. Review recruitment and selection process and training to identify areas of practice and unconscious bias.

4. Engage with patients to encourage greater trust with patient monitoring exercises.

What is the Trust doing to further the inclusion agenda?

The Trust undertakes a wide range of work, projects and activities to support the inclusion agenda to benefit patients and the workforce. Below is a summary of some of the key highlights during 2020/21.

Diversity Matters Steering Group (DMSG) and Diversity Matters Group (DMG)

The Deputy Chief Executive/Chief Medical Officer (George Findlay) chairs the BSUH group, the Chief Executive (Dame Marianne Griffiths) chairs the WSHT group. The groups provide a valuable forum to discuss issues that impact equality and inclusion in the Trust for both staff and patients.

DMSG and DMG also provide governance for action plans (such as the NHS equality standards: Workforce Race Equality Standard and Workforce Disability Equality Standard. Gender Pay Gap Reports, and the Stonewall Workplace Equality Index) and relevant policies and guidelines. The steering group reports to the Trust Executive Committee and the Trust Board.

Gender Pay Gap Reporting

All large employers must publish their pay data and compare differences for men and women. Gender pay gap reporting helps demonstrate if disparities or inequalities exist that need to be addressed on an organisational level.

The reports highlight some disparities in both workforces exist. A working group has been formed to examine the issues and have developed action plans.

To see the 2020 and previous reports, please go to:

Go to the latest BSUH Gender Pay Gap Report
Go to the latest WSHT Gender Pay Gap Report

NHS England Equality Standards

The Trust has participated in the Workforce Race Equality Standard (WRES) since 2015. The WRES looks at several factors that help demonstrate race equality within the Trust processes and services for staff. The core areas that investigated in the standard are:

- Representation in the general workforce
- Recruitment
- Entry into the disciplinary process
- Access to non-mandatory and CPD training
- Experiencing bullying, harassment or abuse
- Provision of equal opportunities and career progression and development
- Representation in the Board

The Trusts use data and information from the NHS Staff Survey, Electronic Staff Records, local employee relations and recruitment databases.

For BSUH reports, please go to the BSUH equality, diversity and inclusion pages
For WSHT reports, please go to the WSHT equality, diversity and inclusion pages

The Workforce Disability Equality Standard (WDES) was mandated in the NHS Standard contract in April 2018, with implementation in April 2019. The standard aims to demonstrate fairness within services using standardised data available to all NHS Trusts; the standard will also highlight areas for improvement. This standardisation of data allows NHS Trusts to compare the experiences of disabled and non-disabled staff in several areas that impact staff. Specific working groups (formed of Trust staff) look at issues raised within the standard.

The areas that the standard looks at include:

- Workforce representation
- Recruitment
- Entrance into formal capability processes
- Experiences of discrimination, harassment and abuse
- Provision of equal opportunities and career progression and development
- Feeling pressured to come into work when not feeling well enough to perform duties
- Satisfaction of staff in terms of valuing work and contribution
- Reasonable adjustments
- Engagement of disabled staff
- Representation of disabled staff in the Board.

For BSUH reports, please go to the BSUH equality, diversity and inclusion pages
For WSHT reports, please go to the WSHT equality, diversity and inclusion pages

NHS England has released the Sexual Orientation Monitoring Standard; the standard will look at sexual orientation monitoring for patients. This standard has been implemented within the Trust. It ensures appropriate standardised ways of recording the sexual orientation of patients/service users (over 16 years of age) in NHS services and some social care elements.

To find further information about the standard, please go to NHS England's Sexual Orientation Monitoring Standard page

The Inclusion Team

The Trusts has a dedicated Inclusion team:

- Head of Inclusion (key areas of responsibility include Race and Workforce Race Equality Standard
- Deputy Head of Inclusion (key areas of responsibility include service improvement, disability, and the Workforce Disability Equality Standard
- Race Equity Lead (key areas of responsibility REAL Strategy)
- Project and Office Manager

The team enables the organisation to benefit from their expert advice for both staff and patients.

Due Regard Assessments

The assessment is a process where policies and practices (and anything else that would affect our workforce, patients or service delivery) are reviewed. The review ensures they will not unfairly impact groups protected by the Equality Act 2010. The assessments also ensure that any opportunity to promote equality is taken.

Freedom of Information Request

The Freedom of Information Act 2000 helps to promote transparency within public services. The Inclusion team assists in completing a number of requests, mainly focusing on interpretation and translation.

Staff Conferences

BSUH did not hold any staff conference events during 2019/20.

Staff Networks and Groups

Disabled Staff Network (RSCH) and Disability Forum (WSHT)

The Disability Staff Network (DSN) was formed in 2019 and is a growing community of about 100 members. Marce Quinn leads the network, and Vickie Johnson is the secretary.

The DSN provides a safe space for members to discuss issues that are affecting them. There is a wide range of different NHS staff in the network, including people with disabilities, long-term health conditions and those that support someone with a disability or long-term health condition. The network also provides a space for members to share and highlight ideas that could improve the everyday working lives of disabled staff in the Trust.

During 2020/21, the DSN realised that many additional challenges were facing disabled staff in the Trust caused by the pandemic. Some of these challenges include changes in personal and working circumstances, new ways of working and reasonable adjustments, the working environment, a growing sense of isolation, widespread use of facemasks and a decrease in mental health for some members. These topics and more have been discussed in the network's meetings.

In response to the pandemic (and the restrictions placed on the organisation), the DSN moved from monthly to fortnightly meetings held over Microsoft TEAMS. As a result, there has been a greater level of support offered to network members. Moving to online meetings has helped more members from over a large geographical area to attend meetings regularly.

Some of the highlights from 2020/21:

- The network has arranged for various guest speakers to discuss many different interesting topics that impact disabled people. The inclusion of guest speakers has provided learning opportunities for members
- After the implementation of the Trust's Health Passport, the network is supporting the promotion and use to disabled staff
- Continuing support and advice for staff – including isolation barriers many disabled staff have experienced
- Closer collaboration and involvement of staff from both Brighton and Sussex University Hospitals NHS Trust and Western Sussex Hospitals NHS Foundation Trust – with plans to merge the groups

- Supported an increase of staff declaring their diversity data
- Both the network's lead and secretary are active members of the Trust's Workforce Disability Equality Standard Working Group and have helped shape and deliver improvements for disabled staff.
- The DSN Lead and Dame Marianne Griffiths, CEO, have regular meetings to discuss network members' issues and other general disability issues. The meetings play an important opportunity for support and sharing information and learning.

What the network is looking forward to in 2021/22:

- Planning a Disability Staff Network Staff Conference for 2022)
- Campaigning for a Disability Leave Policy
- Launching 'The Game'- a fun educational tool to improve the understanding of disability issues
- Completing the merger with the WSHT Disability Group.

Disability Forum

The Disability Forum has been active throughout 2020-21, providing a mechanism to ensure disabled people have a voice within the Trust. One of the key objectives is to ensure that monitoring systems and processes are put in place to support disabled people are fit for purpose. This group is also involved in our policy development to ensure issues relating to disability are taken into account. The Forum has been active in supporting the Workforce Disability Equality Standard (WDES) action plan for the Trust.

The Disability Forum will be merging with the Disabled Staff Network in 2021-22; in the meantime, stronger links have been drawn between the two groups.

LGBTQ+ Networks

The network helps support the organisation and improve the experiences of LGBTQ+ staff, volunteers and allies. With a vast membership base at all levels across the organisation, the network plays a vital role as an agent for change.

During 2020/21, some activities the network usually undertakes was put on hold due to the restrictions caused by the ongoing pandemic. However, the network responded by enabling the engagement of its members through several creative methods. For example:

- Regular newsletters – to inform members of relevant news and information about LGBTQ+ issues on a Trust, regional or national level
- Virtual meetups, e.g. virtual coffee drop-ins and Valentine's Day events
- Virtual LGBTQ+ book and discussion club events
- Continuing social media presence (why not take a look at the network's Twitter page?)

Some key highlights for the network during 2020/21 include:

- Prides scheduled to take place in the summer of 2020 were either cancelled or moved to a digital format. The network developed a Prides video to take part in the Brighton Digital Pride, focusing on the history of Stonewall and what Prides means to Trust staff.
- Following on from the success of the networks 'Journey to True North: Follow the Yellow Brick Road' board game, this has now been digitised and can be played on Microsoft Teams.
- Work was undertaken to merge the BSUH and WSHT networks – in preparation for this, a joint network survey was sent to members to identify the key priorities moving forward.
- The network has participated in a range of research projects.
- Undertaken a project to be used as an educational tool to improve the understanding of lived experiences.
- Connecting network members with LGBTQ+ prospective job applicants to mentor them through the NHS/Trust application process.
- The Network worked with the BSUH Directorate of Education and Knowledge and Brighton Medical School to run six education seminars on a range of topics that impact LGBTQ+ people. You can view the seminars on the Network's YouTube channel.

In 2021/22, the network is looking forward to:

- Participation in Prides events in the summer of 2021 – both digital and in-person
- Participation in the NHS Rainbow Badge pilot award scheme; the scheme is designed to look at several factors impacting LGBTQ+ equality and provides an award based on evidence.
- The network designed a new LGBTQ+ pin badge for staff and will be rolling these out during 2021/22.

The SOAR BAME Network

The network was launched at RSCH in September 2020, while at WSHT, the Black Asian and Minority Ethnic (BAME) Network, formerly Celebrating Cultures, was launched in August 2020. Both Networks agreed to join under the banner SOAR,

BAME Staff Network. Fadzai Fadairo Leads at the East, and Patience Mugawazi Leads at the West.

SOAR stands for Safe space, Opportunity, equity and empowerment, Amplify voices, Re-dress the balance. The network aims to provide a safe space for people to share any concerns and provide support or sign posting to appropriate services. Through shared learning and lived experience, the network offers a platform and aspire to achieve racial equity for our members and the wider BAME staff groups.

Currently, there are about 150 members, including individuals who are our non-BAME allies. There is also an additional team of BAME volunteers across both the East and West, offering support to staff for issues relating to the pandemic and also Mental Health First Aid to those who require it.

During 2020/21, SOAR BAME Network has faced many challenges, not least the disproportionate effect of Covid on BAME people but also the impact from George Floyd's killing and the ensuing Black Lives Matter protests. Against this backdrop, we have been part of important conversations around risk assessment early equitable access to the Covid vaccine for BAME staff whilst addressing the issues around vaccine hesitancy.

All of the meetings have taken place over MS Teams due to the restrictions necessitated by the pandemic. Despite interactions being primarily virtual, it has not lessened the impact and value of conversations had. Some of the highlights and achievements over the past year include:

- BAME Volunteers embedded at East and West
- Allies Network launched at the West
- A high COVID vaccine uptake amongst our BAME staff
- Mental Health First Aid Training (West)
- Participation in National Inclusion Week

The network has exciting events planned to celebrate Black History Month to engage with all our staff within the Trust.

The main focus is to grow our Network membership through various events, including webinars and discussions throughout the year. The network will host a Wellbeing Day in the New Year (COVID permitting), celebrating the Trust’s staff, rolling out new branding, and increasing our social media presence to engage with a broader audience. The network identifies that workforces’ needs and the challenges they face differ greatly across groups and recognise that various approaches are needed to achieve these goals to be equitable.

Workforce Race Equality Working Group

As a consequence of the May 2018 Race Equality Conference, an initially small (10) group of staff responded to our Chief Executive's 'call to action' to help us improve

the data surrounding WRES. The working group was formed in June 2018 and has met monthly devised a Partnership and Engagement Plan 2018 – 2021, which the Trust Board has fully supported, and this is in part our WRES Action Plan. The main areas of focus are:-

- Recruitment
- Communication
- Education and Training

Members of the working group felt that concentrating on these issues would have the most significant positive impact on our BME workforce.

Workforce Disability Equality Standard Working Group

The group was established to look at the data and information from the annual WDES data; the group also helps produce an action plan to address the inequity that the data highlights. The group reports to the Diversity Matters Steering Group, which provides oversight and governance on the action plan delivery.

The action plan covers three financial years and contains actions that seek to address:

- Declaration rates
- Supporting disabled staff
- Education and training

Information to support the workforce and patients

The Inclusion team has produced or made available a wide range of information that promotes good practice to assist staff and patients. The team are also happy to discuss issues or concerns that staff or patients may have about inclusion issues in the Trust.

Examples of this information can be found on the Trust's website. You can also contact the Inclusion Team by emailing uhsussex.equality@nhs.net for BSUH or uhsussex.western.equality@nhs.net for WSHT.

Recruitment

The Trust is currently reviewing its recruitment processes to ensure fairness and equity are considered throughout. The Inclusion Team was involved in the recruitment merger group and provided advice on an integrated recruitment process for the new organisation (University Hospitals Sussex NHS Foundation Trust).

Training

The Inclusion team have facilitated several general and specialised training sessions. Training helps ensure the workforce are aware of their responsibilities under equality legislation and to be able to meet a wide range of needs.

Inclusion as a topic features in the Trust's Corporate Induction and Statutory and Mandatory Training programmes.

The pandemic and the restrictions around social distancing has restricted the ability to deliver face-to-face training. At present, most training activity is via e-learning or over Microsoft Teams.

Service Improvements and other initiatives

NHS Accessible Information Standard

NHS England launched the standard in July 2016; however, in the lead-up, the Inclusion team provided information and support to the workforce to ensure they could consistently meet the requirements in the standard. The standard introduces checks to ensure that NHS Trusts can consistently meet patient communication needs caused by disability. For more information about the standard, please visit NHS England's Accessible Information Standard page.

The workforce has access to a range of interpretation and translation services, hospital communication books and a Learning Disabilities Liaison Team. The Inclusion team have also provided support by purchasing and distributing Sonido personal listening devices to a number of wards and departments, distributing

hospital communication books (this provides a pictorial way of communicating) to wards and departments, and purchasing the 'Recite Me' system, which has helped to improve the accessibility of the Trust's website.

The Trusts has implemented the 'Browsealoud' system to increase the accessibility of the external website. The contract came to an end during 2017/18; after evaluating all the options, the Trust has signed a new agreement for the 'Recite Me' system. The new system has the same functionality as the previous one, adding some important additional functions. These functions benefit people with sensory impairments and help people with learning disabilities/difficulties and overseas language speakers.

You can find further information about the Recite Me website accessibility tool in the accessibility section of the Trust websites.

Overseas and Communication Support

The Trust undertook a nine-month procurement process with other NHS partners in the local area. The NHS partners procured a range of overseas and communication support services that will meet the needs of the local population. Undertaking this process as a group enables the Trust to secure high-quality services and solutions whilst enjoying the benefits of economy of scale.

The contracts went live in July 2018; the providers under this citywide agreement are:

- Action Deafness – British Sign Language and all other communication Support
- Language Line – Telephone Interpreting and all translation support
- Sussex Interpreting Services – Face-to-face overseas interpreting
- Vandu Language Services – Face-to-face overseas interpreting

From March 2020, the Trust went live with SignLive British Sign Language remote services. The service enables virtual interpreting using video conferencing and BSL users to contact the hospital via the switchboard (and departments) telephone (via an interpreter). During this period, Sussex Interpreting Services and Vandu expanded their services to include video conferencing, which the Trust has used to facilitate patient appointments.

The Inclusion team has undertaken some targeted engagement work with clinical divisions to provide ward/department based solutions to meet their patient's needs.

This engagement includes producing patient information, graphical tools and equipment to aid clear communication.

The Trusts are in the process of commissioning a system called Cardmedic. Cardmedic is a system developed with colleagues across BSUH and Western and led by Rachel Grimaldi. It has been designed to translate medical information and questions into multiple languages to share information with patients and involve them in their care. The system is available on a tablet or phone. Cardmedic is continuously updated to include many medical procedures and modes of communication (language and formats). The system has proved so successful that it is now becoming available to other organisations.

Across both Trusts, electronic tablets and mobile phones were purchased through charitable funding to support patients in contacting their families when visiting was restricted or challenging during the pandemic. These devices enabled a wide range of contact and communication support. The tablets were also used to install remote interpretation services, some with transcription services; this boosted access to one of our vaccination hubs where remote BSL interpretation was needed.

At WSHT, through engagement with the Love Your Hospital charity, clinicians on ITU undertook a project to purchase in-ear headphones for use with electronic tablets and mobile phones. The headphones help support patients wearing C-PAT hoods for their treatment which are noisy and difficult to hear clearly. The use of the in-ear headphone meant that background noise was reduced, and communication with clinical colleagues and others became clearer.

WSHT purchased ten listening devices; the devices are available from the PALS service (Chichester and Worthing) and can be used in clinics, wards and any location where a patient or relative with slight hearing loss may benefit from more precise communication. These devices help amplify sounds and allow for a clearer conversation without the need for voices or speech to be raised. The devices are beneficial when additional PPE may add to difficulties in communication. BSUH distributed these types of devices previously to wards and departments on a request basis.

Engagement with Patient Experience

The Patient Experience Team (including the PALS and Complaints teams) undertake a wide range of activities to understand patients' experience while using hospital services and engage with those who interact with our services. There is always a strong focus on improving patient experience by working with feedback and departments.

During the pandemic, there was a need to change the focus from responding to patient feedback to actively creating positive experiences. So examples of this work include:

- Facilitating communications between patient and their families when there were strict visiting restrictions. The Team provided patients without a means to communicate with their family access to a mobile phone with Skype and Facetime
- Heart for the dying and the bereaved – providing matching pairs of handmade hearts to be shared between dying patients and loved ones
- Letters/messages to loved ones – relatives and friends unable to visit could write to or call the PALS team; the team would print or transcribe the message and ensure that quick and safe delivery to the patient
- The NHS Complaints process was suspended in April 2020; the PALS and Complaints teams were redeployed to departments. The redeployed staff worked in various areas and used their skills and experience to support communications with patients and loved ones.
- 'Thinking of you' messages – many local schools and parish groups in West Sussex have written in to support and lift the spirits of patients who were more isolated by sending in messages or drawings

Other activities undertaken to support patients include:

- Using patient feedback to identify learning opportunities throughout the organisation and divisional teams
- Promoting action on feedback using 'You said, we did…' boards
- Collating plaudits (positive feedback) from patients, relatives, etc. and sharing with relevant teams and individuals. In 2020/21, there were 1,210 plaudits received in BSUH and 839 in WSHT.
- Run the Patient Experience and Engagement Quality Management Groups (PEEG) from this group; there is a clear escalation to Quality Assurance Committee if it is needed
- The Chief Nurse is the Executive Lead for Patient Experience
- Monitor patient satisfaction through the Friends and Family Test (FFT)
- Support and analyse the National Patient Surveys within the Trust
- Engagement activity, e.g. supporting the 3Ts (Trust redevelopment) wayfinding focus groups and engagement event; that was attended by 50 members of the public, Healthwatch, Clinical Commissioning Groups (CCG) and Possibility People
- Strengthening partnership with commissioners, NHS providers, local authorities and community and voluntary sector to improve coordinated care and communication across the Sussex Integrated Care System
- The WSHT Patient Experience Team is taking specific action relating to a Healthwatch report detailing the experiences of nearly 600 patients, carers and staff about hospital discharge during the pandemic.
- During 2020/21, the BSUH received 2,371 informal and 2,004 formal concerns, which were either resolved immediately or progressed to be investigated. In WSHT, 373 formal complaints were received; recording of

informal enquires was suspended to enable more focus on themes emerging from patient concerns.

The Learning Disability Liaison Team (LDLT)

The LDLT provides specialist nursing guidance and advice to people with learning disabilities and their families and staff. The team help with planned and emergency admissions, outpatient appointments and hospital discharge.

The teamwork with hospital staff to ensure that the healthcare that they deliver is person-centred by:

- aiding and teaching communication skills using specialist techniques or tools
- help staff understand the patient's needs and preferences
- look at reasonable adjustments within the environment, treatment plans or timing of appointments
- for patients that have capacity, the team ensure the patient understands planned treatment, expectations of them for their treatment/care plan and consent
- advocate for patients and their carers or family
- help coordinate treatment and ongoing care
- provide reassurance to the patient and their family or carers
- promote the use of the 'Hospital Passport' and 'Hospital Communication Book' where appropriate.

In addition to ward-based work, the LDLT can also educate staff to help raise the standards for patients with learning disabilities in Trust premises.

The LDLT can be contacted by telephoning 01273 664975 or by email LDLTreferral@sussexpartnership.nhs.uk (BSUH) or telephoning 07785 516155 (Worthing Hospital) or 07901520940 (St. Richard's Hospital, Chichester).

Changing Places

The Trust continues to provide Changing Places facilities, with the venue at Southlands Hospital open and being used; the facility at Worthing Hospital will open soon. The new 3Ts (redevelopment) facility at the Royal Sussex County Hospital will also have a Changing places facility as part of its design.

A Changing Places can help and promote independence for people with profound and multiple learning disabilities or physical disabilities such as spinal injuries, muscular dystrophy and multiple sclerosis. These groups often need extra equipment and space to use the toilets safely and comfortably.

Going home packs for vulnerable patients

The Hospital Charity funded going home packs for patients who are leaving the hospital and are vulnerable. The patients could be returning to their homes without anyone to buy initial food supplies (e.g. milk, bread, etc.). The catering teams have been putting together a 'Going Home Pack' containing these essential food items for patients to take home. Wards can request a pack for their patients; the pack is given to the patient on discharge. The scheme has been significant during the pandemic where it might have been more difficult for someone else to do that first amount of shopping.

Pin badges for baby loss awareness

Each year as part of Baby Loss Awareness Week, WSHT holds a remembrance service to allow parents a chance to come together. Due to the restrictions of COVID, it was not possible to do this. So the team who support awareness week approached the Love Your Hospital Charity and arranged for Baby Loss awareness pin badges to be sent to parents as a way of showing that the team was thinking of them and that they continued to be there to offer support.

Freedom to Speak Up Guardian

The Freedom to Speak Up Guardian is here to provide support and advice to staff if they are worried about something they think may affect the quality or safety of patient care or is a risk to our Trust. The Freedom to Speak Up Guardian provides advice on how to raise concerns effectively and guidance on how the Raising Concerns Policy and process works.

The Freedom to Speak Up Guardian works alongside trust leadership teams to support the organisation in becoming a more open and transparent workplace where all staff are actively encouraged and enabled to speak up safely.

HELP Service – Health, Employee, Learning and Psychotherapy

The HELP service provides staff with confidential support, counselling and psychotherapy for a range of issues: work-related concerns, stress management to relational issues, employment difficulties or following critical/ traumatic events, to personal issues affecting the individual staff member. HELP also provides specialist EMDR (Eye Movement Desensitisation and Reprocessing) trauma therapy for staff with stressful or traumatic experiences. HELP also delivers Mental Health Awareness Training and HOT Debrief Training to Managers and staff.

During 2019/20, the service undertook the following activities to help support staff:

- Supporting staff: 1-2-1 therapeutic support: face to face / on MST / phone sessions
- BAME COVID Debriefs – focused on supporting our BAME colleagues during the pandemic (the impact of COVID19 on BAME staff – reflecting on how the Trust supported staff, shared information specific to BAME staff, the difficulties of redeployment, shielding, lockdowns, isolation
- HELP promotes equality, diversity, and inclusion in its hosting and training honorary psychotherapists from University (on placement)
- HELP involved in SOAR (BAME) staff network – producing quarterly newsletter – via Victoria Fernandes and Glenn Roarke, Fadzai Fadairo, Babs Harris
- 20 Debriefs around the Trust – a debrief is a way of providing emotional and psychological support to staff in a group setting, shortly after a traumatic or major incident
- Two hot debrief training sessions – this trains teams to perform a debrief when there is a traumatic or major incident
- Thirteen workshops - stress management and mindfulness workshops
- Mental Health Awareness training to improve knowledge and reduce stigma. The first pilot of this training has been completed, and a second pilot is planned. This training will be available to all managers
- The HELP Service has involvement and engagement with WRES - Workforce Race Equality Standards and WDES Workforce Disability Equality Standards, Learning and Development and the LGBTQ+ Network and acts as organisational allies for these protected characteristics.
- HELP Service recruitment and expansion has diversity awareness and inclusion at the forefront
- Mindfulness workshops delivered to teams within the Trust
- The service has developed several resources for staff, including managing anxiety, depression, grief and trauma hand-outs
- Designed a community resource, with contact numbers, for staff who want to access BME/ BAME/ LGBTQ + and disability groups.

Occupational Health Services

Occupational health services are available to all staff, but the delivery of the services are different in BSUH and WSHT.

At BSUH:

The in-house Occupational Health (OH) offers a range of services are delivered by qualified professionals (nurse specialists, clinic nurses, a physiotherapist and a locum consultant), including:

- Health screening before or on commencement of employment
- Fitness for work assessments and advice
- Advice on workplace adjustments due to injury, illness or disability
- Advice on the applicability of the Equality Act 2010 concerning disability
- Work-related vaccination and blood taking service
- Sharps/splash assessment
- Moving and handling training and advice
- Physiotherapy for injuries caused by or affecting work
- Ergonomic workplace assessments for staff with injury or disability
- Health surveillance, including skin assessments

Inclusion

- The vaccination service is available at both RSCH (St Mary's site) and PRH
- Consultations take place face-to-face, phone or video
- The OH department is wheelchair accessible
- Alternative venues can be arranged on a case by case basis
- Hearing induction loop in OH department
- Correspondence can be provided in a larger font
- Interpreting and translation services can be requested
- Equality impact statements are completed for all OH policies

Data Protection

Occupational Health Services processes personal and health data in line with the Data Protection Act 2018; as per our Privacy Statement, you can find more information on the Occupational Health Services page.

The Data Protection Act 2018 allows staff to view or receive a copy of their records.

Confidentiality
Information held in staff OH records will only be passed to a third party with the individual's consent. In exceptional circumstances, OH can breach confidentiality, e.g., withholding information would have a safety implication. All OH staff are bound by both BSUH Trust and a local confidentiality agreement.

Further information about Occupational Health Services is available on the Trust's info-net or by contacting Occupational Health Services directly.

At WSHT:

Team Prevent UK Ltd provides the Employee Health and Wellbeing Service. The Trust works together with Team Prevent to implement a healthy leadership culture to ensure that our employees receive early support in the event of illness or injury and encourage better health and wellbeing.

The Employee Health and Wellbeing Service aims to protect and promote employees' health. Ensuring employees are working in a healthy environment and encouraging them to take responsibility for their health and wellbeing, both inside and outside work.

The Employee Health and Wellbeing Team are specialists in assessing fitness for work and have a responsibility to both the employer and the employee. They are required to provide fair and impartial advice based on evidence and clinical opinion.

The Employee Health and Wellbeing Team will be involved in the following:

- Medical conditions which may affect work or may be affected by work
- Fitness for work including reasonable adjustments and rehabilitation programmes if necessary
- Health surveillance relevant to an individual's work, for example, skin surveillance, respiratory screening, hand-arm vibration and sight testing (job-specific)
- Immunisation and vaccination programmes
- Needlestick injuries
- Advising on workplace risks including sharps/contamination incidents and liaising with Health and Safety and Infection Control Teams
- Proactive health education and engagement and wellbeing initiatives

Consultations with the Employee Health and Wellbeing Team can be held face-to-face in the clinic or by telephone or video consultation. There is significant evidence to show that telephone and video consultations are an efficient and effective way of delivering healthcare. By utilising this service, waiting times, travel times, and costs are reduced, and employees can access advice quickly and conveniently.

Improvements to staff health and wellbeing offer

Project Wingman

Project wingman has seen staff from the airline industry come together to offer volunteer support to hospital staff by creating incredible 'first-class lounges'. The lounges provide somewhere for staff to take a break from their work and have someone to look after them with a hot drink, and provide an additional listening ear for staff to decompress and take a moment before returning to work. Project Wingman teams in their everyday work have training in supporting people in stressful situations, and this service has been incredibly highly thought of and used by staff across the Trust.

Support for newly recruited international staff at WSHT

Welcome packs were created for newly recruited arriving overseas staff required to self-isolate. The staff were not able to immediately go shopping for supplies. Packs contained ingredients for meals and comfort provisions such as coffee, tea and biscuits. The welcome packs were highly thought of and funded through the Love Your Hospital Charity.

Risk Assessment Advisory Panel

Both BSUH and WSHT have panels running since May 2020 in response to the COVID-19 pandemic. The panels help support managers and staff with individual risk assessments; they provide expert advice on complex issues or where a staff member is identified as a high risk.

This assessment and panel helped ensure a proper Trustwide undertaking of COVID-19 Risk Assessments and that both managers and staff understood what was needed to work safely during the pandemic.

The Risk Assessment Advisory Panel which comprised of the following expertise:-

- HR Representatives
- Paediatric Consultant
- Medical Director
- Occupational Health
- Cardiac Consultant
- Deputy Chief Nurse
- Head of Inclusion

Expertise from other areas is called upon as is required. This group has met every week since they were formed.

To support the risk assessment process, a trustwide produced and published a video involving staff from BSUH and WSHT. Staff shared the purpose and benefits of undertaking COVID risk assessments. The video was aimed at both managers and

staff and helped share the benefits of the assessments and the opening up of positive conversations.

Interpretation and Translation Services

During 2020/21, the Trust utilised a range of interpretation and translation services to meet the communication needs of our patients. In this section, we will highlight what was spent by the Trust.

In Brighton and Sussex University Hospitals NHS Trust:

British Sign Language, Braille and other communication support

Activity	Number of sessions or jobs	Method of delivery	Cost
British Sign Language	330	Face-to-face	£36,220.00
British Sign Language	226	Remote (online)	£ 9,825.60
Braille and other communication support	7	Transcription and translation	£ 657.43

Overseas Languages

Activity	Number of sessions or jobs	Method of delivery	Cost
Overseas language interpretation	2,312	Face-to-face	£175,630.81
Overseas language interpretation	2,720	Remote (online and telephone)	£ 73,839.68
Overseas language translation	84	Translation	£ 21,792.45

During 2020/21, there were interpreting sessions that counted as a late cancellation:

- British Sign Language – 56 sessions cancelled, costing £5,890
- Overseas Language – 1,251 sessions cancelled, costing £52,199.65

The top 10 languages that required interpreter support were:

1. Arabic (1,710 sessions)
2. Bengali (515 sessions)
3. British Sign Language (458 sessions)
4. Portuguese (408 sessions)
5. Spanish (381 sessions)
6. Farsi (353 sessions)
7. Romanian (313 sessions)
8. Polish (274 sessions)
9. Russian (238 sessions)
10. Albanian (236 sessions)

Western Sussex Hospitals NHS Foundation Trust

Recording of interpretation and translation services does not follow the same processes as BSUH. The overall spend for these services was £16,350.67. Post-merger, all interpretation and translation will be monitored under the same processes.

Recite Me Website Accessibility Toolbar

Both Trusts use the Recite Me toolbar to help improve the accessibility of our web pages for all the users to the website.

For further details about Recite Me and other accessibility features of our websites:

For BSUH, please go to the BSUH website accessibility page
For WSHT, please go to the WSHT website accessibility page

During 2020/21, the BSUH website:

Had the Recite Me Toolbar loaded 15,709 times by 5,268 unique users. During the web sessions that the toolbar has assisted, a total of 37,360 features were used; these include:

- Screen reader function (in English and overseas languages) 35,111 times
- Translation of written text on web pages 2,331 times
- Style changing function 1,152 times
- Text only mode 146 times
- Dictionary 61 times
- Ruler 48 times
- Magnifier function 43 times
- Preferences function 31 times
- Screen mask function 28 times
- Download web pages into an audio format 9 times.

The Trusts' Workforces

This section will review the BSUH and WSHT workforces through various datasets. The data is taken from multiple systems, including Electronic Staff Records (ESR, integrated human resources and payroll system, TRAC (recruitment system), and other local databases.

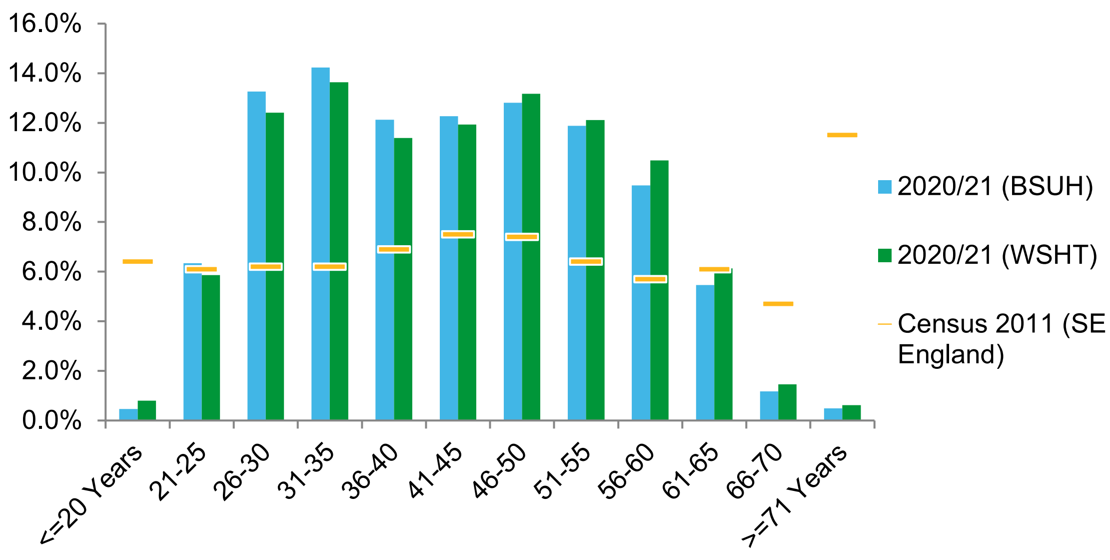
It was impossible to break down gender identity and pregnancy and maternity during the reporting period. The ESR system either does not collect the information or cannot report on a range of employee activity.

Age

Representation of staff within the workforce broken down by age

Age Range	<=20 Years	21-25	26-30	31-35	36-40	41-45	46-50
2019/20 (BSUH)	0.6%	5.8%	13.8%	13.4%	12.5%	12.8%	12.5%
2020/21 (BSUH)	0.5%	6.3%	13.3%	14.2%	12.1%	12.3%	12.8%
2019/20 (WSHT)	0.9%	6.1%	12.1%	13.0%	11.4%	12.3%	13.3%
2020/21 (WSHT)	0.8%	5.9%	12.4%	13.6%	11.4%	11.9%	13.2%
Census 2011 (SE England)	6.4%	6.1%	6.2%	6.2%	6.9%	7.5%	7.4%

Age Range	51-55	56-60	61-65	66-70	>=71 Years
2019/20 (BSUH)	12.1%	9.7%	5.0%	1.2%	0.5%
2020/21 (BSUH)	11.9%	9.5%	5.5%	1.2%	0.5%
2019/20 (WSHT)	12.2%	10.4%	6.2%	1.4%	0.7%
2020/21 (WSHT)	12.1%	10.5%	6.1%	1.5%	0.6%
Census 2011 (SE England)	6.4%	5.7%	6.1%	4.7%	11.5%



Observations

- There is generally no correlation between the BSUH or the WSHT workforces compared to the 2011 Census for South East England. Only in age groups 21-25 and 61-65 for both Trusts does the workforce reflect the census data. It should be noted that the Census 2011 looks across the whole population and not those of working age.
- The majority of both workforces are aged 26-60.
- Compared to WSHT, BSUH has a larger proportion of staff aged 21-45.
- Compared to BSUH, WSHT has a larger proportion of staff aged 46-71+ and under 20 years of age.
- Compared to the previous year, there have not been any significant changes in the representation of any age group in either BSUH or WSHT's workforce.

Breakdown of age by pay banding

The items in bold highlight where there is a great representation of that particular group compared to the representation in the overall workforce

BSUH

Pay Band	<=20 Years	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	>=71 Years
Band 1	0.0%	1.1%	5.6%	7.9%	**16.9%**	**19.1%**	11.2%	**15.7%**	7.9%	**11.2%**	1.1%	**2.2%**
Band 2	**1.6%**	**8.4%**	9.9%	12.3%	10.9%	11.6%	11.0%	**13.2%**	**10.4%**	**7.9%**	**1.7%**	**1.2%**
Band 3	**1.0%**	**7.7%**	11.8%	9.8%	11.9%	10.8%	11.4%	**12.0%**	**12.2%**	**8.6%**	**2.1%**	**0.8%**
Band 4	**0.9%**	**6.3%**	12.4%	11.1%	**12.3%**	6.9%	11.2%	**13.2%**	**12.9%**	**10.0%**	**2.2%**	**0.6%**
Band 5	0.0%	**13.0%**	**18.7%**	**16.7%**	9.9%	8.7%	10.2%	9.1%	9.0%	3.8%	0.6%	0.3%
Band 6	0.0%	3.1%	**14.8%**	**16.3%**	11.7%	**14.8%**	**15.1%**	**11.9%**	7.4%	3.9%	0.8%	0.3%
Band 7	0.0%	0.6%	5.6%	**14.3%**	**16.1%**	**16.2%**	**16.7%**	**14.9%**	**11.0%**	4.0%	0.6%	0.0%
Band 8a	0.0%	0.0%	3.9%	6.6%	**12.8%**	**15.9%**	**24.8%**	**20.5%**	9.3%	4.7%	**1.6%**	0.0%
Band 8b	0.0%	0.0%	1.8%	2.7%	**15.2%**	**17.0%**	**18.8%**	**22.3%**	**12.5%**	**8.9%**	0.9%	0.0%
Band 8c	0.0%	0.0%	0.0%	5.0%	7.5%	**17.5%**	**17.5%**	**17.5%**	**30.0%**	5.0%	0.0%	0.0%
Band 8d	0.0%	0.0%	0.0%	0.0%	4.8%	9.5%	**14.3%**	**28.6%**	**33.3%**	**9.5%**	0.0%	0.0%
Band 9	0.0%	0.0%	0.0%	6.3%	0.0%	**25.0%**	**25.0%**	**25.0%**	**12.5%**	**6.3%**	0.0%	0.0%
Directors	0.0%	0.0%	0.0%	9.1%	0.0%	0.0%	**63.6%**	**18.2%**	9.1%	0.0%	0.0%	0.0%
Medical & Dental - Consultant	0.0%	0.0%	0.0%	2.0%	**15.7%**	**24.5%**	**23.9%**	**16.0%**	**11.7%**	4.3%	**1.6%**	0.2%
Medical & Dental - Middle Grade	0.0%	0.0%	1.8%	1.8%	**14.5%**	**14.5%**	**21.8%**	**16.4%**	**20.0%**	**7.3%**	**1.8%**	0.0%
Medical & Dental - Training	0.0%	**9.6%**	**35.0%**	**32.6%**	**12.6%**	6.6%	2.2%	0.9%	0.4%	0.0%	0.1%	0.0%
Local Scale	0.0%	0.0%	0.0%	0.0%	**100.0%**	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Observations

- Greatest representation within pay bands/grades: bands 1-4 staff aged: 26-65, bands 5-7 staff aged 21-60, bands 8a-b staff aged 36-60, bands 8c-9 staff aged 41-60, directors 46-55, consultants (medics) 36-55, middle grade (medics) 46-60 and trainee (medics) 26-35.
- Bands/grades where age groups have a greater representation than overall workforce representation (for that group): under 20 bands 2-4, 21-25 bands 2-5 and trainee (medics), 26-30 bands 5-6 and trainee (medics), 31-35 bands 5-7 and trainee (medics), 36-40 bands 1, 4, 7-8b and all medical and dental grades, 41-45 bands 1, 6-8c, consultants (medics) and middle grade (medics), 46-50 bands 6-9, directors and all medical grades, 51-55 bands 1-4, 5-9, directors, consultants (medics) and middle grade (medics), 56-60 bands 2-4, 7, 8b-9, consultants (medics) and middle grade (medics), 61-65 bands 1-4, 8b, 8d-9 and middle grade (medics), 66-70 bands 2-4, 8a, consultants (medics) and middle grade (medics) and 71+ bands 1-4.

WSHT

Pay Band	<=20 Years	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	>=71 Years
Band 1	9.8%	9.8%	4.9%	12.2%	12.2%	12.2%	7.3%	7.3%	9.8%	12.2%	2.4%	0.0%
Band 2	2.7%	6.9%	8.9%	11.0%	11.0%	11.2%	11.4%	11.8%	13.1%	8.8%	2.2%	0.9%
Band 3	0.6%	8.2%	11.5%	12.3%	9.4%	10.1%	11.7%	12.3%	12.0%	8.2%	2.4%	1.4%
Band 4	0.2%	6.7%	9.6%	10.4%	7.8%	9.2%	13.7%	14.9%	16.1%	8.2%	2.0%	1.2%
Band 5	0.0%	8.8%	19.5%	17.7%	10.3%	9.8%	11.7%	9.2%	7.6%	4.3%	0.9%	0.3%
Band 6	0.0%	3.6%	12.6%	15.9%	13.4%	14.9%	14.7%	11.6%	8.1%	4.1%	0.8%	0.3%
Band 7	0.0%	0.7%	5.1%	9.9%	12.7%	16.9%	19.3%	18.4%	10.7%	5.4%	0.7%	0.3%
Band 8a	0.0%	0.0%	4.8%	8.9%	10.7%	19.6%	19.6%	13.7%	14.9%	7.7%	0.0%	0.0%
Band 8b	0.0%	0.0%	2.8%	7.0%	11.3%	5.6%	23.9%	28.2%	18.3%	2.8%	0.0%	0.0%
Band 8c	0.0%	0.0%	0.0%	3.3%	3.3%	20.0%	20.0%	23.3%	26.7%	3.3%	0.0%	0.0%
Band 8d	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	12.5%	12.5%	62.5%	0.0%	12.5%	0.0%
Band 9	0.0%	0.0%	0.0%	0.0%	0.0%	28.6%	28.6%	14.3%	0.0%	28.6%	0.0%	0.0%
Directors	0.0%	0.0%	0.0%	4.8%	0.0%	14.3%	19.0%	23.8%	19.0%	9.5%	4.8%	4.8%
Medical & Dental - Consultant	0.0%	0.0%	0.0%	2.5%	15.2%	17.7%	21.7%	20.6%	11.8%	6.8%	2.8%	0.8%
Medical & Dental - Middle Grade	0.0%	0.7%	28.7%	34.7%	17.9%	7.2%	5.1%	3.0%	1.2%	0.9%	0.2%	0.2%
Medical & Dental - Training	0.0%	39.8%	50.0%	5.9%	0.8%	2.5%	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%

Observations

- Greatest representation within pay bands/grades: bands 1-4 staff aged: 31-60, bands 5-7 staff aged 26-55, bands 8a-b staff aged 41-60, bands 8c-9 staff aged 41-60, directors 41-55, consultants (medics) 36-60, middle grade (medics) 26-40 and trainee (medics) 21-30.
- Bands/grades where age groups have a greater representation than overall workforce representation (for that group): under 20 bands 1-3, 21-25 bands 1-

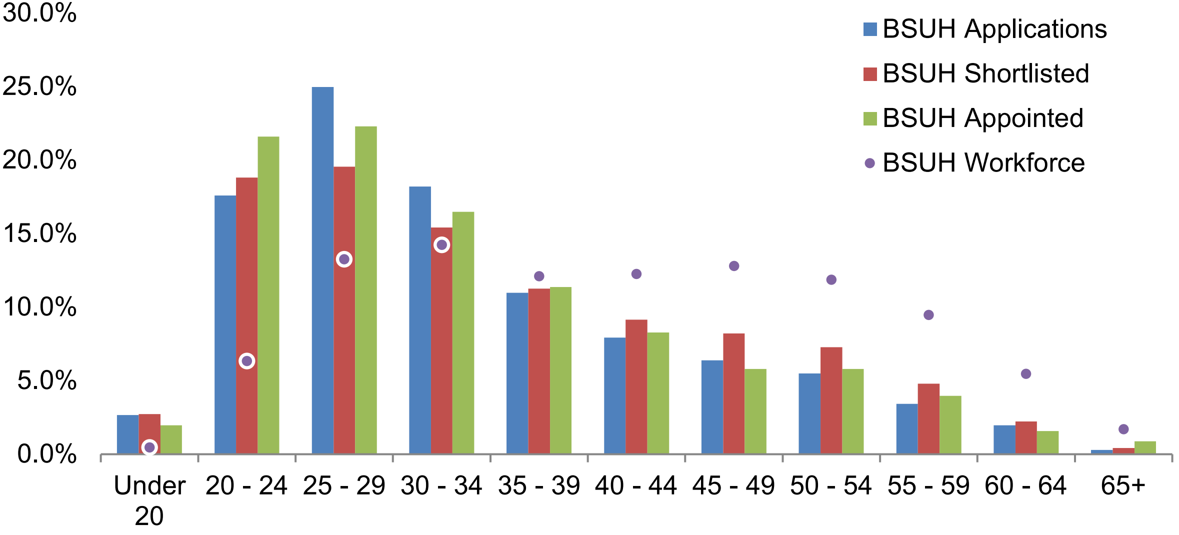
5 and trainee (medics), 26-30 bands 3, 5-6, middle grade (medics) and trainee (medics), 31-35 bands 5-6 and middle grade (medics), 36-40 bands 1, 6-7, consultant (medics) and middle grade (medics), 41-45 bands 1, 6-8a, 8c, 9, directors and consultants (medics), 46-50 bands 4, 6-8c, 9, directors and consultants (medics), 51-55 bands 4-5, 7-9, directors and consultants (medics), 56-60 bands 2-4, 8a-8d, directors and consultants (medics), 61-65 bands 1-4, 8a, 9 and directors, 66-70 bands 1, 3, 8d, directors and consultants (medics). 71+ bands 2-4, directors and consultants.

Breakdown of age in recruitment processes

the data compares the three stages of recruitment compared to the workforce representation within the organisation.

BSUH

Age Band	Applications	Shortlisted	Appointed	Workforce
Under 20	2.7%	2.7%	2.0%	0.5%
20 - 24	17.6%	18.8%	21.6%	6.3%
25 - 29	25.0%	19.6%	22.3%	13.3%
30 - 34	18.2%	15.4%	16.5%	14.2%
35 - 39	11.0%	11.3%	11.4%	12.1%
40 - 44	7.9%	9.1%	8.3%	12.3%
45 - 49	6.4%	8.2%	5.8%	12.8%
50 - 54	5.5%	7.3%	5.8%	11.9%
55 - 59	3.4%	4.8%	4.0%	9.5%
60 - 64	2.0%	2.2%	1.6%	5.5%
65+	0.3%	0.4%	0.9%	1.7%
Not stated	0.1%	0.1%	0.0%	

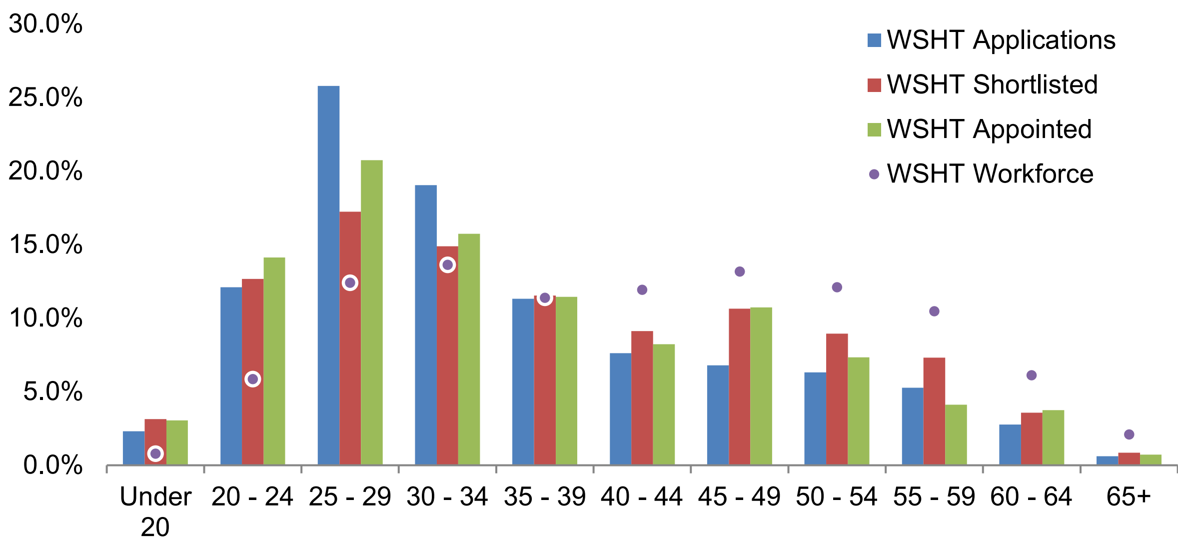


Observations

- When reviewing the representation of candidates through all stages of recruitment to the workforce representation, there is a higher representation of candidates aged <20 to 34 but a lower representation of candidates aged 35+.
- When comparing groups progression from appointment to shortlisting stage; a decrease in representation can be seen in 25-34 and 45-49, broadly similar representation: <20, 35-39 and 60+ and lastly an increase can be seen in 20-24, 40-44 and 50-59.
- When comparing progression from shortlisting to appointment stage, a decrease in representation can be seen in <20 and 40-64, broadly the same representation: 35-39. Lastly, an increase can be seen in 20-34 and candidates aged 65+.
- There does not appear to be any groups that have seen a significant advantage or disadvantage through the Trust's recruitment processes. There has been a moderate advantage for candidates aged 65+.

WSHT

Age Band	Applications	Shortlisted	Appointed	Workforce
Under 20	2.3%	3.1%	3.0%	0.8%
20 - 24	12.1%	12.7%	14.1%	5.9%
25 - 29	25.8%	17.2%	20.8%	12.4%
30 - 34	19.1%	14.9%	15.7%	13.6%
35 - 39	11.3%	11.5%	11.4%	11.4%
40 - 44	7.6%	9.1%	8.2%	11.9%
45 - 49	6.8%	10.6%	10.7%	13.2%
50 - 54	6.3%	8.9%	7.3%	12.1%
55 - 59	5.3%	7.3%	4.1%	10.5%
60 - 64	2.8%	3.6%	3.8%	6.1%
65+	0.6%	0.8%	0.7%	2.1%



Observations

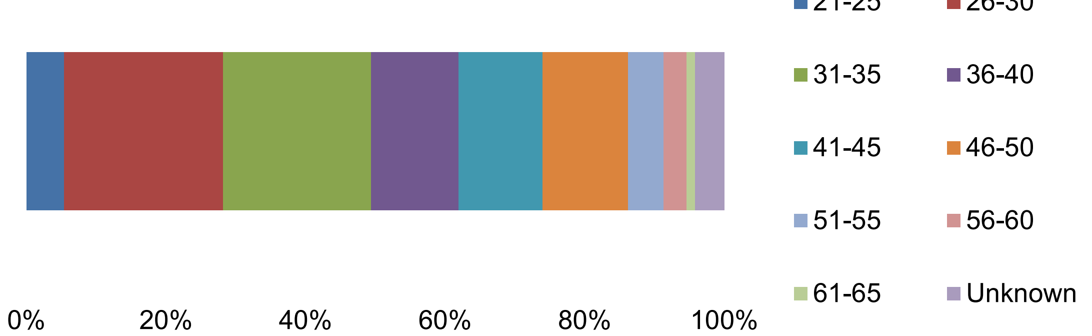
- When comparing to the overall workforce representation, the following groups can see an overall greater representation <20-34, groups with a broadly similar representation 35-39, and the groups with a lower representation are candidates aged 40+.
- Comparing progression from application to shortlisting stage, groups that have a decrease in representation are those aged 25-34, groups that have a broadly similar representation are those aged 35-39, and those with, and an increase can be seen in those aged <20-24 and 40+.
- Comparing progression from shortlisting to appointment stage, groups that have a decrease in representation are those aged 40-44 and 50-59, groups that have a broadly similar representation are those aged <20, 35-39, 45-49 and 60+. Age groups with increased representation can be seen in those aged <20-34.
- Overall, it would appear that those aged 45-49 appear to benefit from the Trust's recruitment processes, whilst those age groups between 25-29 may experience a disadvantage.

Uptake of non-mandatory training or continuing professional development

BSUH

Age Band	Number of staff attending training	% of staff attending training	Representation in the workforce
21-25	18	5.4%	6.3%
26-30	76	22.8%	13.3%
31-35	71	21.3%	14.2%
36-40	42	12.6%	12.1%
41-45	40	12.0%	12.3%

46-50	41	12.3%	12.8%
51-55	17	5.1%	11.9%
56-60	11	3.3%	9.5%
61-65	4	1.2%	5.5%
Unknown	14	4.2%	
Total	334	100.0%	



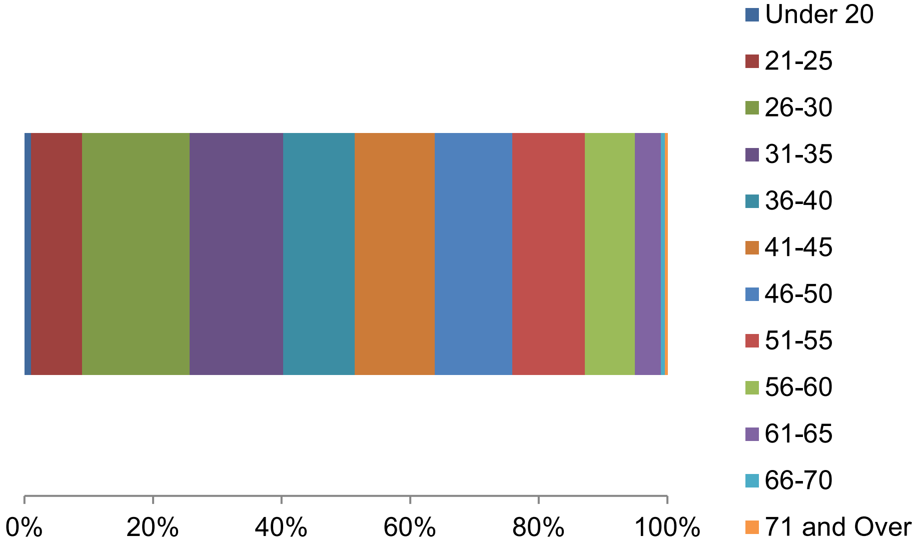
Observations

When comparing those that attended training to the workforce representation:

- those aged 26-35 have a higher than expected representation,
- those aged 36-50 has a broadly similar representation, and
- those aged 21-25 and 51+ have a lower than expected representation.

WSHT

Age Band	Number of staff attending training	% of staff attending training	Representation in the workforce
Under 20	28	1.0%	0.8%
21-25	219	8.0%	5.9%
26-30	458	16.7%	12.4%
31-35	398	14.5%	13.6%
36-40	305	11.1%	11.4%
41-45	342	12.5%	11.9%
46-50	330	12.0%	13.2%
51-55	310	11.3%	12.1%
56-60	212	7.7%	10.5%
61-65	112	4.1%	6.1%
66-70	17	0.6%	1.5%
71 and Over	10	0.4%	0.6%
Total	2741	100.0%	



Observations

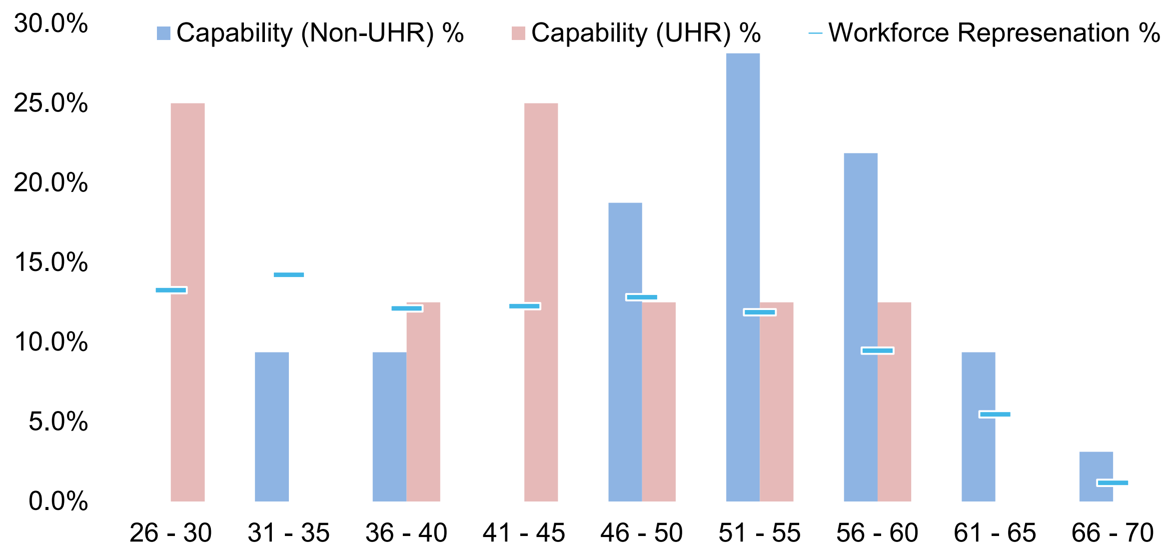
When comparing those that attended training to the workforce representation:

- those aged 21-35 and 41-45 have a higher than expected representation,
- those aged <20 and 36-40 has a broadly similar representation, and
- those aged 46+ have a lower than expected representation.

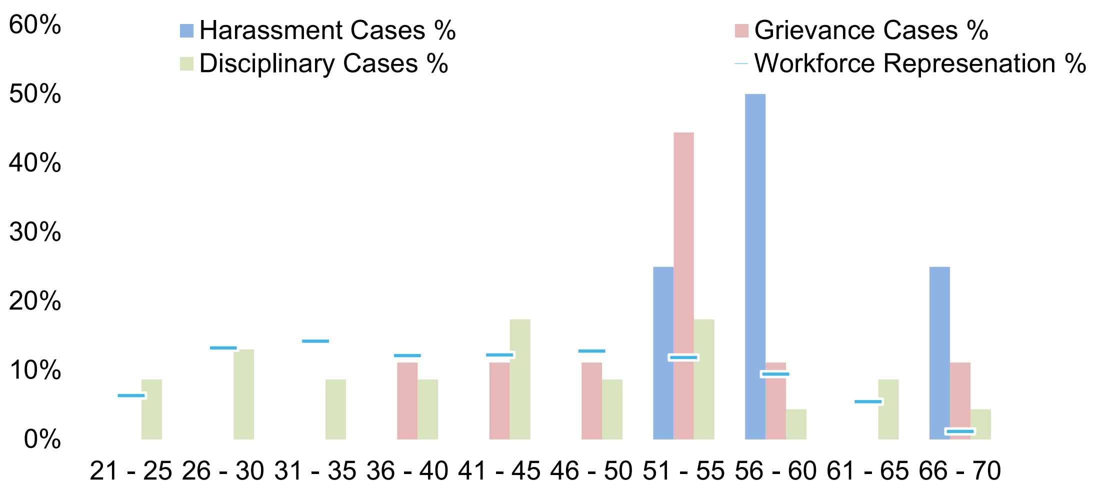
Employee relations processes broken down by age

BSUH

Age Band	Capability (Non-UHR)	Capability (Non-UHR) %	Capability (UHR)	Capability (UHR) %	Workforce Representation %
26 - 30	0	0.0%	2	25.0%	13.3%
31 - 35	3	9.4%	0	0.0%	14.2%
36 - 40	3	9.4%	1	12.5%	12.1%
41 - 45	0	0.0%	2	25.0%	12.3%
46 - 50	6	18.8%	1	12.5%	12.8%
51 - 55	9	28.1%	1	12.5%	11.9%
56 - 60	7	21.9%	1	12.5%	9.5%
61 - 65	3	9.4%	0	0.0%	5.5%
66 - 70	1	3.1%	0	0.0%	1.2%
Total	**32**	**100%**	**8**	**100%**	

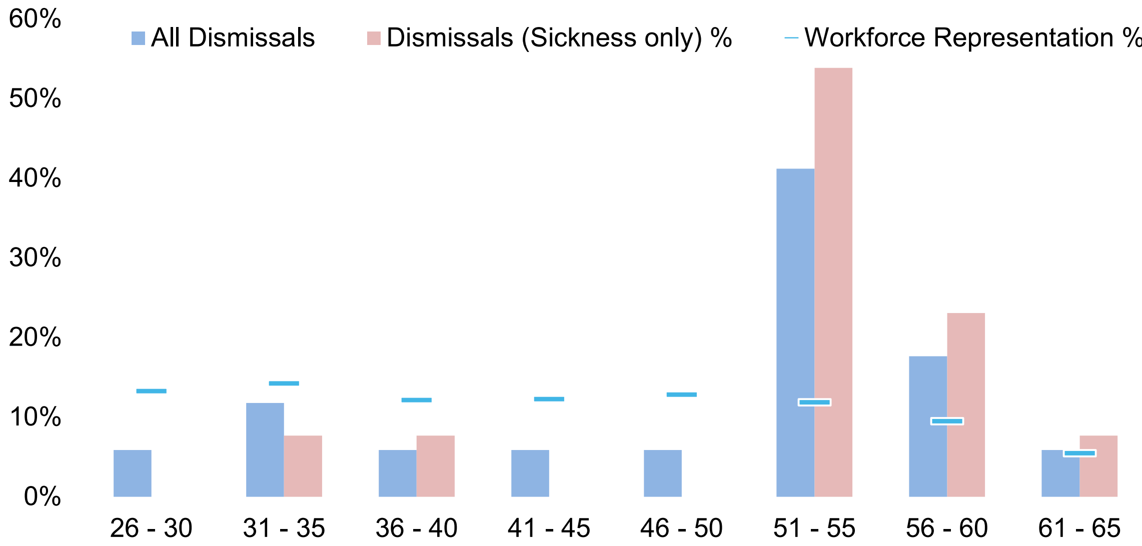


Age Band	Harassment Cases	Harassment Cases %	Grievance Cases	Grievance Cases %	Disciplinary Cases	Disciplinary Cases %	Workforce Representation %
21 - 25					2	9%	6.3%
26 - 30					3	13%	13.3%
31 - 35					2	9%	14.2%
36 - 40			1	11%	2	9%	12.1%
41 - 45			1	11%	4	17%	12.3%
46 - 50			1	11%	2	9%	12.8%
51 - 55	1	25%	4	44%	4	17%	11.9%
56 - 60	2	50%	1	11%	1	4%	9.5%
61 - 65					2	9%	5.5%
66 - 70	1	25%	1	11%	1	4%	1.2%
Total	**4**	**100%**	**9**	**100%**	**23**	**100%**	



Age Band	All Dismissals	All Dismissals %	Dismissals (Sickness only)	Dismissals (Sickness only) %	Workforce Representation %

26 - 30	1	6%	0	0%	13.3%
31 - 35	2	12%	1	8%	14.2%
36 - 40	1	6%	1	8%	12.1%
41 - 45	1	6%	0	0%	12.3%
46 - 50	1	6%	0	0%	12.8%
51 - 55	7	41%	7	54%	11.9%
56 - 60	3	18%	3	23%	9.5%
61 - 65	1	6%	1	8%	5.5%
Total	**17**	**100%**	**13**	**100%**	



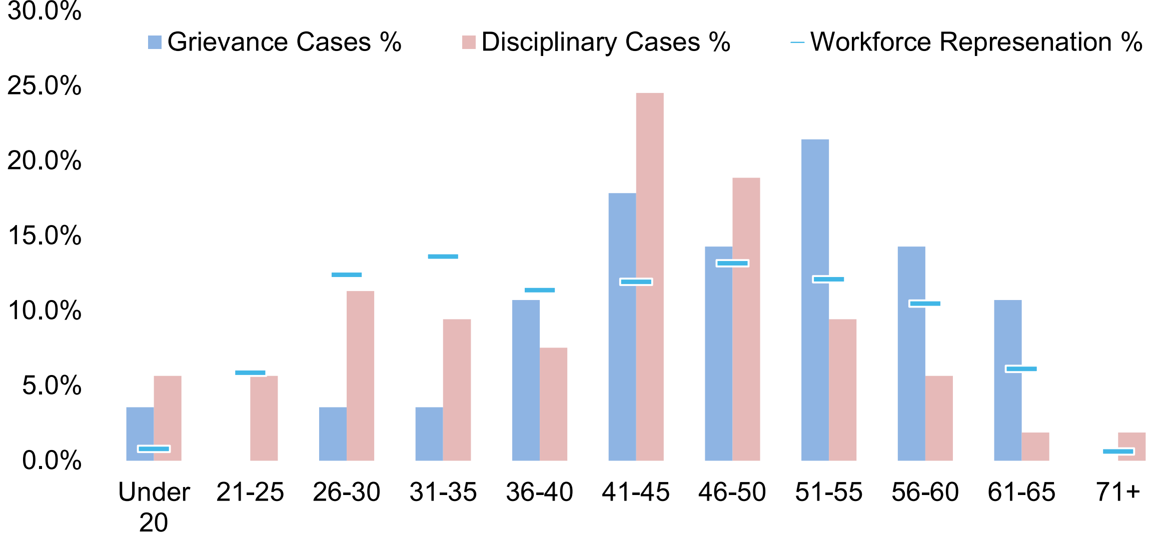
Observations

When comparing representation in employee relation process to overall workforce representation:

- Those most likely to be impacted by capability (non-underlying health reasons) are staff aged 46+, staff that are least likely to be impacted are staff aged <20-45.
- Those most likely to be impacted by capability (underlying health reasons) are staff aged 26-30 and 41-45. Those least likely to be impacted <20-25 and those aged 61+.
- Groups most likely to be impacted by harassment cases are 51-60 and 66-70.
- Groups with a higher representation in grievances 51-60 and 66-70, staff aged 36-50 have either a broadly similar or lower representation.
- Groups with a higher representation in disciplinary processes include 21-25, 41-45, 51-55 and 61-70. All other groups are either not represented or have a lower than expected representation.
- Those aged 51-65 appear to have a higher representation in dismissals; all other groups are either not represented or have a lower than expected representation.

WSHT

Age Band	Grievance Cases	Grievance Cases %	Disciplinary Cases	Disciplinary Cases %	Workforce Representation %
Under 20	1	3.6%	3	5.7%	0.8%
21-25			3	5.7%	5.9%
26-30	1	3.6%	6	11.3%	12.4%
31-35	1	3.6%	5	9.4%	13.6%
36-40	3	10.7%	4	7.5%	11.4%
41-45	5	17.9%	13	24.5%	11.9%
46-50	4	14.3%	10	18.9%	13.2%
51-55	6	21.4%	5	9.4%	12.1%
56-60	4	14.3%	3	5.7%	10.5%
61-65	3	10.7%		1.9%	6.1%
71+			1	1.9%	0.6%
Total	**28**	**100%**	**53**	**100%**	



Observations

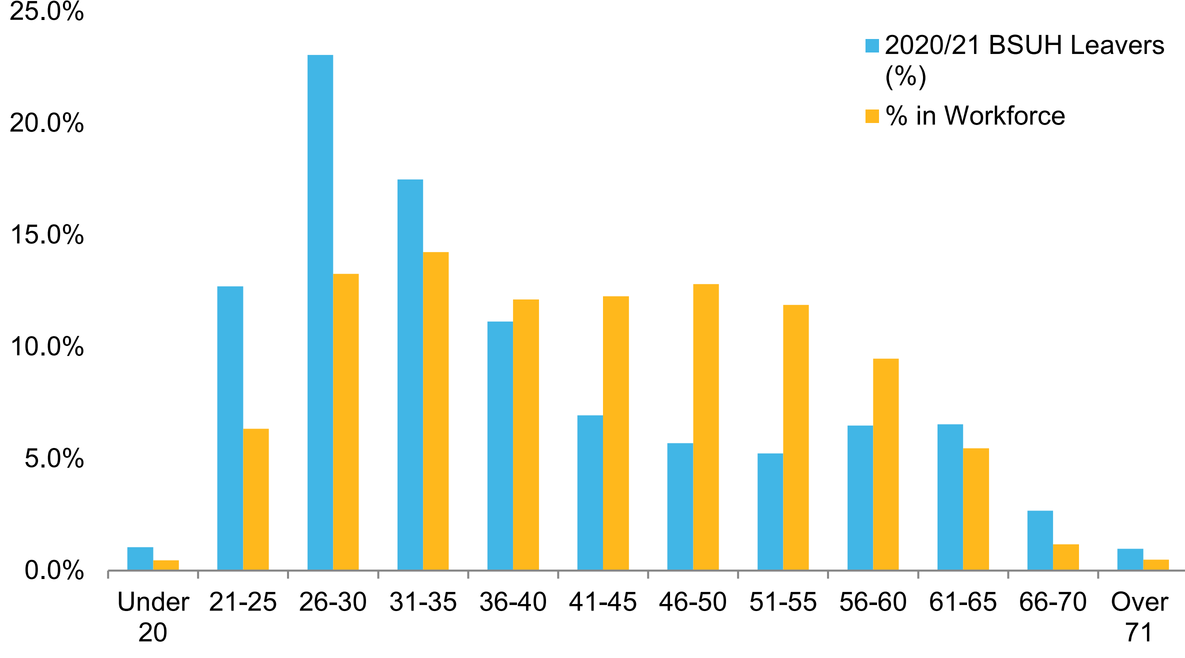
Compared to the overall representation in the workforce:

- Those aged <20 and 41-65 have a higher than expected representation in grievance cases; all other groups are either not represented or have a lower than expected representation.
- Those aged <20 and 41-50 and 71+ have a higher than expected representation in disciplinary cases; all other groups are either not represented or have a lower than expected representation.

Leavers broken down by age

BSUH

Age Band	2020/21 BSUH Leavers	2020/21 BSUH Leavers (%)	Number in Workforce	% in Workforce
Under 20	16	1.0%	41	0.5%
21-25	194	12.7%	563	6.3%
26-30	352	23.1%	1177	13.3%
31-35	267	17.5%	1263	14.2%
36-40	170	11.1%	1075	12.1%
41-45	106	6.9%	1088	12.3%
46-50	87	5.7%	1137	12.8%
51-55	80	5.2%	1054	11.9%
56-60	99	6.5%	841	9.5%
61-65	100	6.5%	485	5.5%
66-70	41	2.7%	104	1.2%
Over 71	15	1.0%	44	0.5%
Grand Total	**1527**	**100.0%**	**8872**	**100.0%**

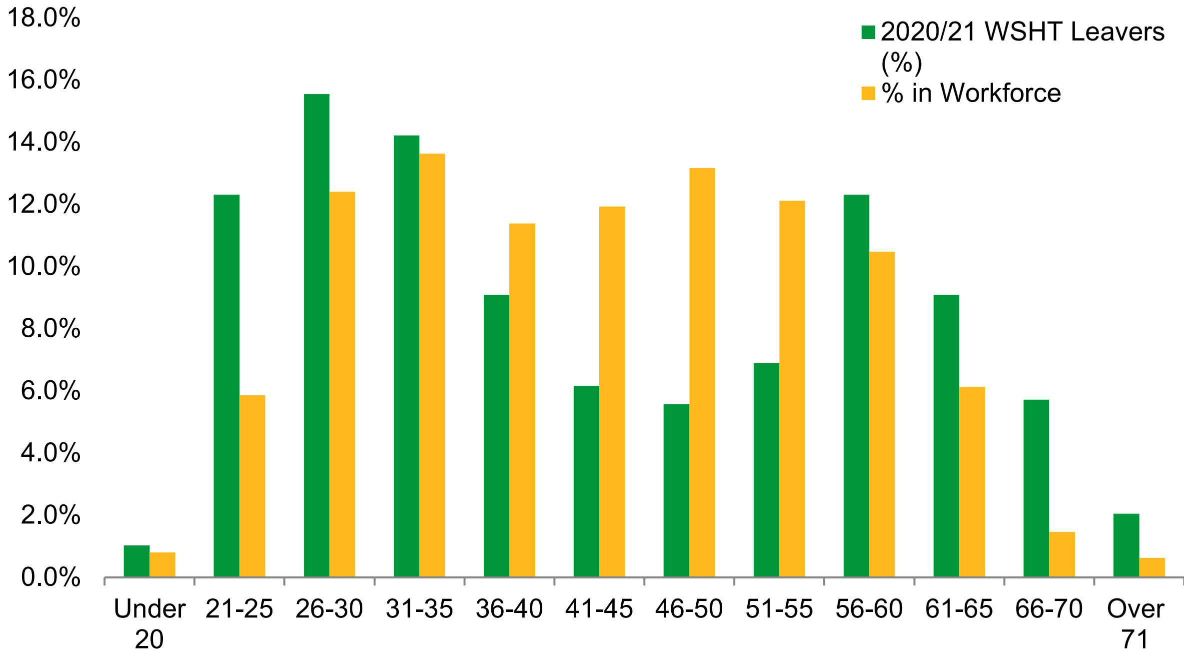


Observations

- Proportionally, more staff aged <20-35 and 61+ are leaving the organisation than the overall workforce representation.

WSHT

Age Band	2020/21 WSHT Leavers	2020/21 WSHT Leavers (%)	Number in Workforce	% in Workforce
Under 20	7	1.0%	60	0.8%
21-25	84	12.3%	441	5.9%
26-30	106	15.5%	933	12.4%
31-35	97	14.2%	1025	13.6%
36-40	62	9.1%	856	11.4%
41-45	42	6.2%	897	11.9%
46-50	38	5.6%	990	13.2%
51-55	47	6.9%	911	12.1%
56-60	84	12.3%	788	10.5%
61-65	62	9.1%	461	6.1%
66-70	39	5.7%	110	1.5%
Over 71	14	2.1%	47	0.6%
Grand Total	**682**	**100.0%**	**7519**	**100.0%**



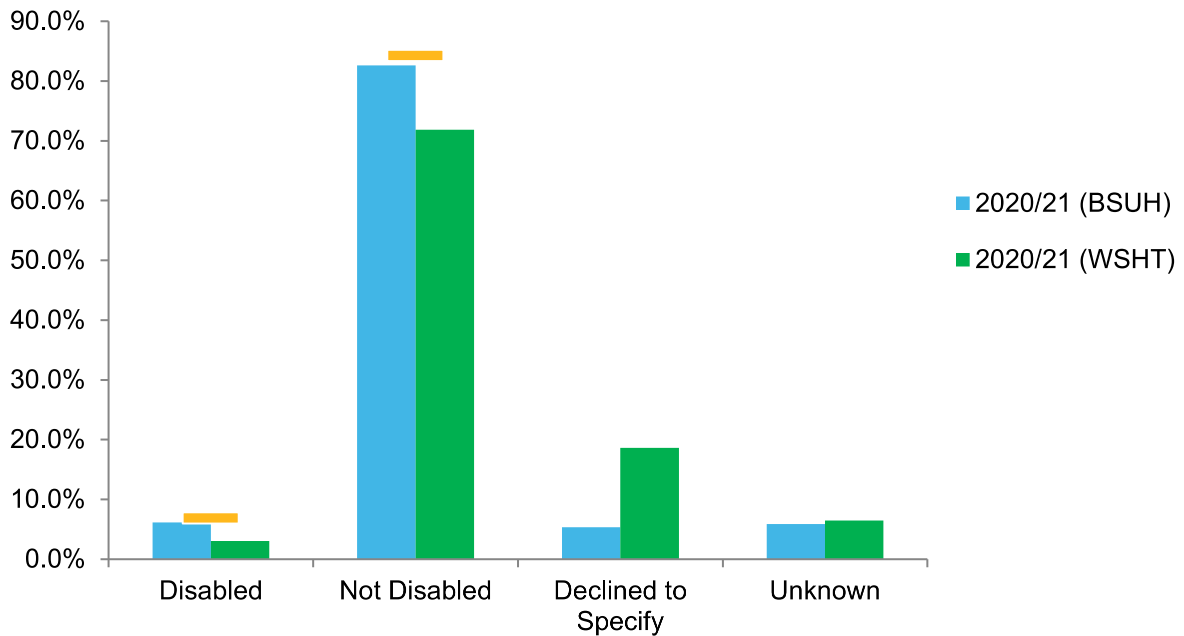
Observations

- Proportionally, more staff aged <20-35 and 56+ are leaving the organisation than the overall workforce representation.

Disability

Representation of staff within the workforce broken down by disability

	Disabled	Not Disabled	Declined to Specify	Unknown
2019/20 (BSUH)	6.3%	80.3%	6.3%	7.1%
2020/21 (BSUH)	6.2%	82.6%	5.3%	5.9%
2019/20 (WSHT)	2.9%	69.3%	20.7%	7.1%
2020/21 (WSHT)	3.1%	71.8%	18.6%	6.5%
Census 2011 (SE England)	6.9%	84.3%		



Observations:

- BSUH Workforce:
  - Overall has a slightly lower representation of disabled people in the workforce than the 2011 Census data.
  - Approximately 11% of staff have chosen not to declare, or their disability status is unknown.
  - Compared to the previous year, there has been a slight decrease in percentage points of disabled staff; there has been an increase in non-disabled staff and a decrease where the disability is unknown.
- WSHT Workforce:
  - There is a lower representation of disabled people in the workforce compared to the 2011 Census data.
  - Approximately 25% of staff have chosen not to declare, or their disability status is unknown.

- Compared to the previous year, there has been an increase in staff declaring their disability status and a decrease where the disability status was unknown.

Breakdown of disability by pay banding

the items in bold highlight a greater representation of that particular group than the workforce representation.

BSUH

Pay Band	Disabled	Not Disabled	Prefer not to Say	Unknown
Band 1	16.9%	83.1%	0.0%	0.0%
Band 2	7.6%	84.9%	3.7%	3.8%
Band 3	8.6%	82.9%	2.5%	**6.0%**
Band 4	7.2%	84.0%	3.1%	5.7%
Band 5	6.3%	85.2%	3.2%	5.3%
Band 6	4.9%	81.0%	4.7%	9.3%
Band 7	5.2%	83.5%	3.2%	8.2%
Band 8a	6.6%	82.9%	3.1%	7.4%
Band 8b	9.8%	83.0%	1.8%	5.4%
Band 8c	2.5%	85.0%	7.5%	5.0%
Band 8d	9.5%	66.7%	9.5%	14.3%
Band 9	12.5%	75.0%	6.3%	6.3%
Directors	0.0%	54.5%	45.5%	0.0%
Medical & Dental - Consultant	1.0%	73.8%	23.9%	1.2%
Medical & Dental - Middle Grade	1.8%	58.2%	36.4%	3.6%
Medical & Dental - Training	4.2%	81.5%	8.8%	5.5%
Local Scale	0.0%	100.0%	0.0%	0.0%

Observations

- Compared to the overall workforce representation, disabled staff have a higher than expected representation in bands 1-5, 8a-b and 8d-9. It appears that there is a lower than expected representation of disabled staff in bands/grades 6-7, 8c, directors and all medical grades.
- Staff have declined to specify their disability status is particularly noticeable in director-level posts and medical consultants and middle grades.
- Staff whose disability status is unknown (i.e. a blank field) is throughout the workforce.

WSHT

Pay Band	Disabled	Not Disabled	Prefer not to Say	Unknown
Band 1	12.2%	43.9%	22.0%	22.0%
Band 2	3.4%	71.6%	16.6%	8.4%
Band 3	2.9%	78.5%	12.8%	5.7%
Band 4	4.5%	73.5%	17.1%	4.9%
Band 5	2.7%	67.8%	22.7%	6.8%
Band 6	3.2%	76.0%	15.8%	4.9%
Band 7	2.4%	72.8%	17.5%	7.3%
Band 8a	2.4%	78.6%	14.3%	4.8%
Band 8b	5.6%	74.6%	16.9%	2.8%
Band 8c	0.0%	70.0%	20.0%	10.0%
Band 8d	0.0%	50.0%	50.0%	0.0%
Band 9	0.0%	71.4%	28.6%	0.0%
Directors	0.0%	71.4%	28.6%	0.0%
Medical & Dental - Consultant	1.4%	65.9%	22.8%	9.9%
Medical & Dental - Middle Grade	1.6%	68.1%	28.2%	2.1%
Medical & Dental - Training	6.8%	58.5%	34.7%	0.0%

Observations

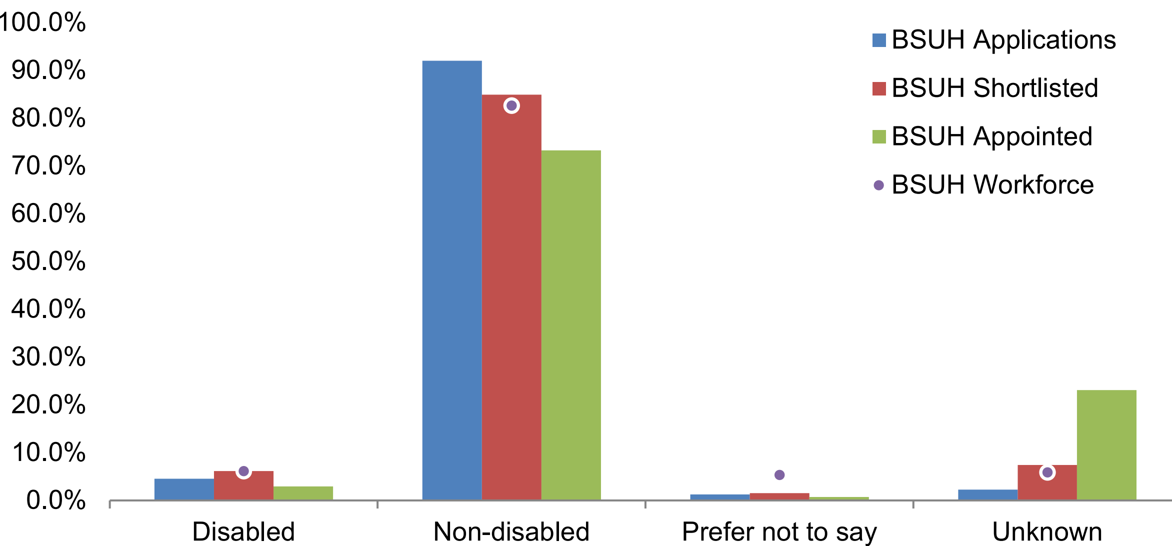
- Compared to the overall workforce, there is a fair to good representation of disabled staff in bands 1-6, 8b and medical trainees. There is a lower than expected representation of disabled staff in 7, 8a, 8c-9, directors, medical consultants, and middle grade.
- A high proportion of senior management and medical staff have declined to specify if they have a disability. There are also spots throughout the organisation where the disability status is unknown.

Breakdown of disability in recruitment processes

The data compares the three stages of recruitment compared to the workforce representation within the organisation.

BSUH

Disability Status	Applications	Shortlisted	Appointed	Workforce
Disabled	4.5%	6.1%	3.0%	6.2%
Non-disabled	92.0%	84.9%	73.2%	82.6%
Prefer not to say	1.3%	1.5%	0.7%	5.3%
Unknown	2.3%	7.4%	23.1%	5.9%
Total	100.0%	100.0%	100.0%	100.0%

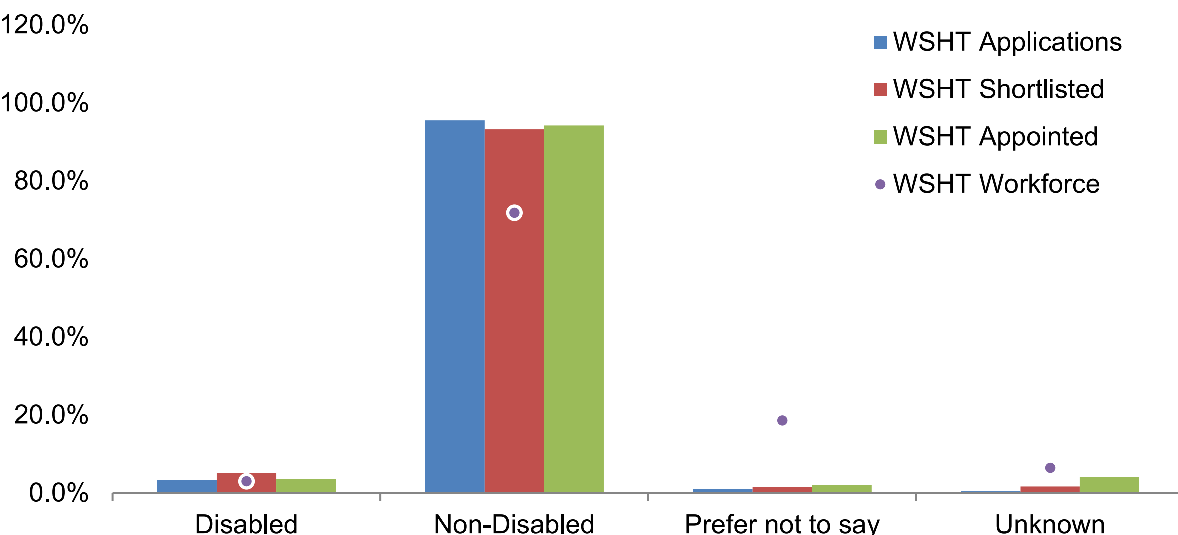


Observations

- Compared to the workforce representation, disabled candidates are well represented at the shortlisting stage but have a proportionally lower number of applicants and appointments.
- There are a low number of candidates who have declined to declare their disability status that has been appointed. When moving throughout the recruitment stages, the representation of candidates whose disability status is unknown disproportionately grows.
- From the application to shortlisting stage, there is a large proportion of disabled candidates. This growth in representation could be helped by the guaranteed interview scheme that the Trust operates. There is a lower proportion of disabled candidates from shortlisting to the appointment. The appointment representation is lower than the overall representation in the workforce.

WSHT

	Applications	Shortlisted	Appointed	Workforce
Disabled	3.4%	5.2%	3.7%	3.1%
Non-Disabled	95.5%	93.3%	94.3%	71.8%
Prefer not to say	1.1%	1.5%	2.0%	18.6%
Unknown	0.5%	1.7%	4.0%	6.5%
Total	100.0%	100.0%	100.0%	100.0%



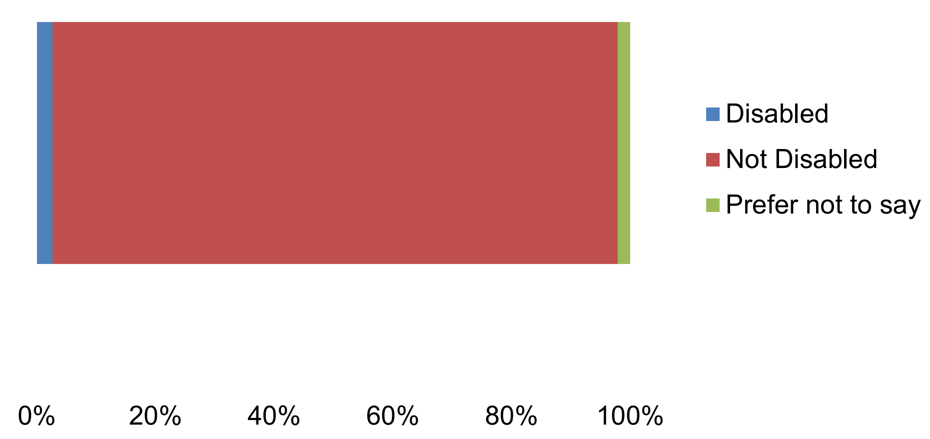
Observations

- Compared to the workforce representation, disabled applicants have a high representation throughout all stages of recruitment.
- The overall declaration of disability is high in the recruitment processes.
- From the application to the shortlisting stage, there is a greater representation of disabled candidates; this could be helped by the guaranteed interview scheme operated by the Trust. From shortlisting to the appointment stage, there is a reduction of disabled candidates; however, the overall appointment of disabled candidates remains greater than the overall workforce representation.

Uptake of non-mandatory training or continuing professional development

BSUH

Disability Status	Number of staff attending training	% of staff attending training	Workforce Representation
Disabled	9	2.7%	6.2%
Not Disabled	318	95.2%	82.6%
Prefer not to say	7	2.1%	5.3%
Unknown	0	0.0%	5.9%
Grand Total	334	100.0%	100.0%

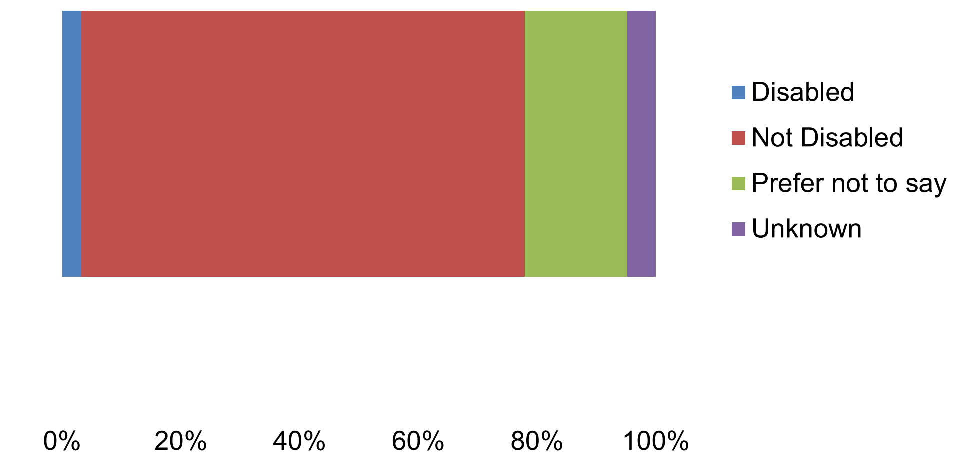


Observations

- There is a lower proportion of disabled staff undertaking non-mandatory/CPD training than the overall workforce representation.

WSHT

Disability Status	Number of staff attending training	% of staff attending training	Workforce Representation
Disabled	90	3.3%	3.1%
Not Disabled	2045	74.6%	71.8%
Prefer not to say	474	17.3%	18.6%
Unknown	132	4.8%	6.5%
Grand Total	2741	100.0%	100.0%



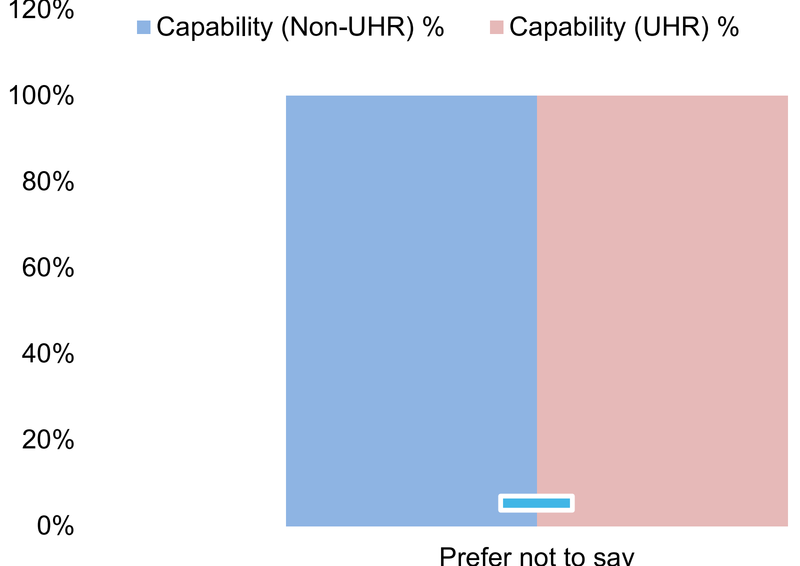
Observation

- There is a slightly higher proportion of disabled staff undertaking non-mandatory/CPD training than the overall workforce representation.

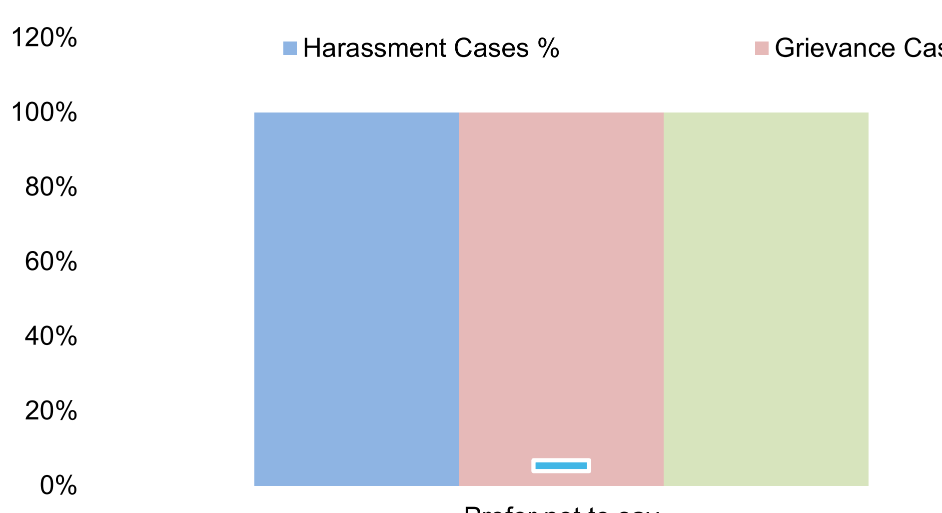
Employee relations processes broken down by age

BSUH

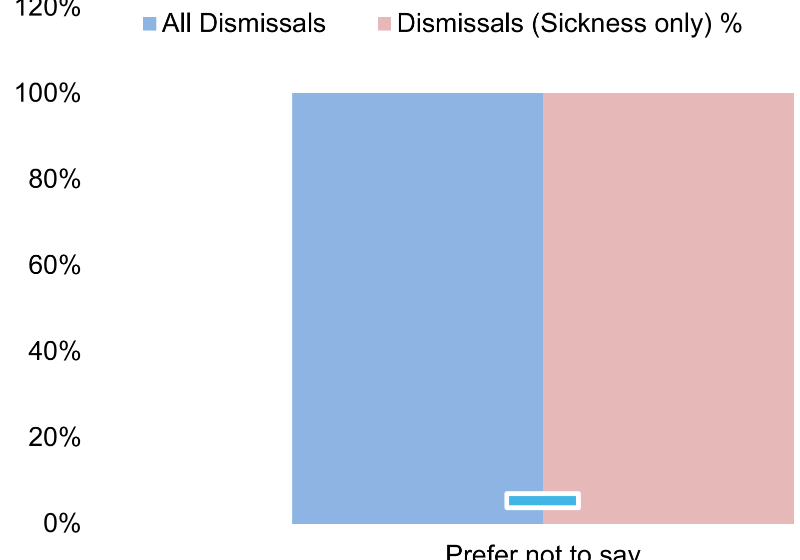
Disability Status	Capability (Non-UHR)	Capability (Non-UHR) %	Capability (UHR)	Capability (UHR) %	Workforce Representation %
Prefer not to say	32	100%	8	100%	5.3%
Total	**32**	**100%**	**8**	**100%**	



Disability Status	Harassment Cases	Harassment Cases %	Grievance Cases	Grievance Cases %	Disciplinary Cases	Disciplinary Cases %	Workforce Rep %
Prefer not to say	4	100%	9	100%	23	100%	5.30%
Total	**4**	**100%**	**9**	**100%**	**23**	**100%**	



Disability Status	All Dismissals %	All Dismissals	Dismissals (Sickness only)	Dismissals (Sickness only) %	Workforce Representation %
Prefer not to say	17	100%	13	100%	5.30%
Total	**17**	**100%**	**13**	**100%**	

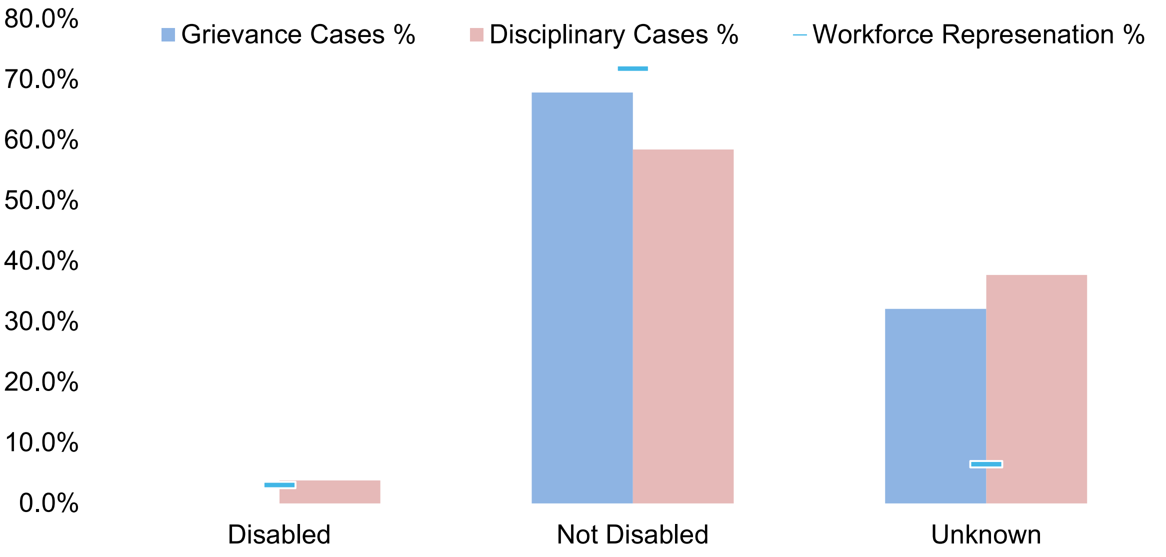


Observations

- In all employee relations procedures/processes, all staff that have been subject to them have declined to provide their disability status.

WSHT

Disability Status	Grievance Cases	Grievance Cases %	Disciplinary Cases	Disciplinary Cases %	Workforce Representation %
Disabled		0.0%	2	3.8%	3.1%
Not Disabled	19	67.9%	31	58.5%	71.8%
Unknown	9	32.1%	20	37.7%	6.5%
Total	**28**	**100%**	**53**	**100%**	



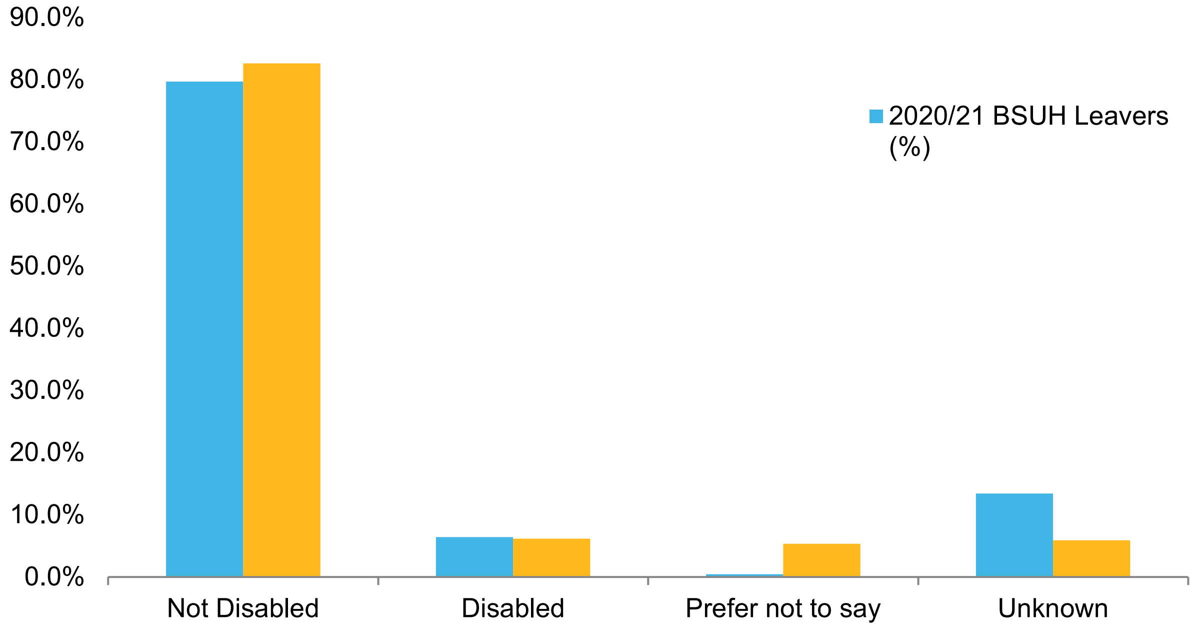
Observations

- Disabled staff were not involved in grievance cases, but there was a slightly higher representation of disabled staff in disciplinary processes than the overall workforce representation.

Leavers broken down by disability

BSUH

Disability Status	2020/21 BSUH Leavers	2020/21 BSUH Leavers (%)	Number in Workforce	% in Workforce
Not Disabled	1217	79.7%	7331	82.6%
Disabled	98	6.4%	547	6.2%
Prefer not to say	7	0.5%	473	5.3%
Unknown	205	13.4%	522	5.9%
Grand Total	**1527**	**100.0%**	**8873**	**100.0%**

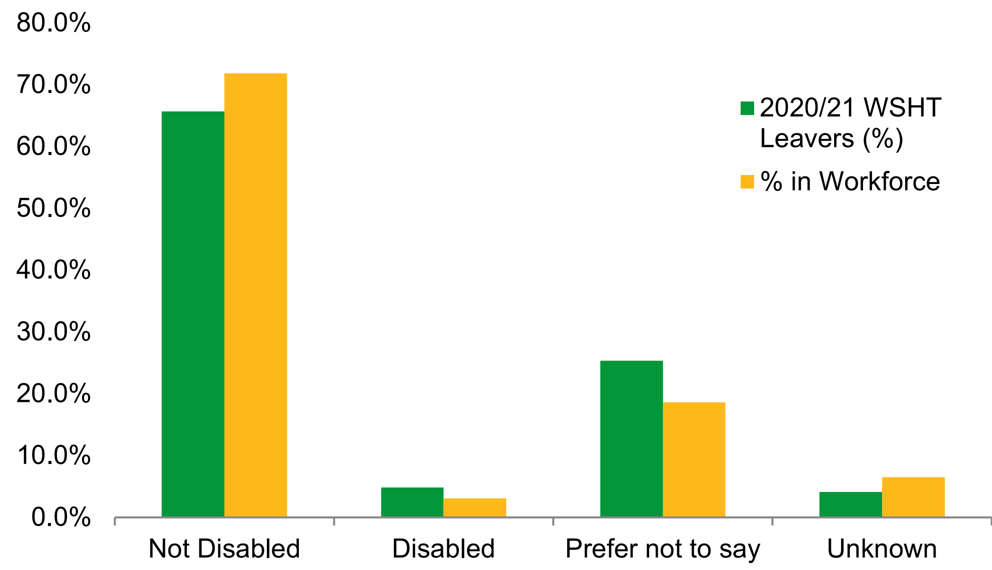


Observations

- A proportionate number of disabled staff have left the organisation compared to the overall workforce representation.
- There is also a high proportion of staff whose disability status is unknown that have left the organisation. This group of staff may impact the future overall disability representation of the workforce.

WSHT

Disability Status	2020/21 WSHT Leavers	2020/21 WSHT Leavers (%)	Number in Workforce	% in Workforce
Not Disabled	448	65.7%	5401	71.8%
Disabled	33	4.8%	230	3.1%
Prefer not to say	173	25.4%	1401	18.6%
Unknown	28	4.1%	487	6.5%
Grand Total	**682**	**100.0%**	**7519**	**100.0%**



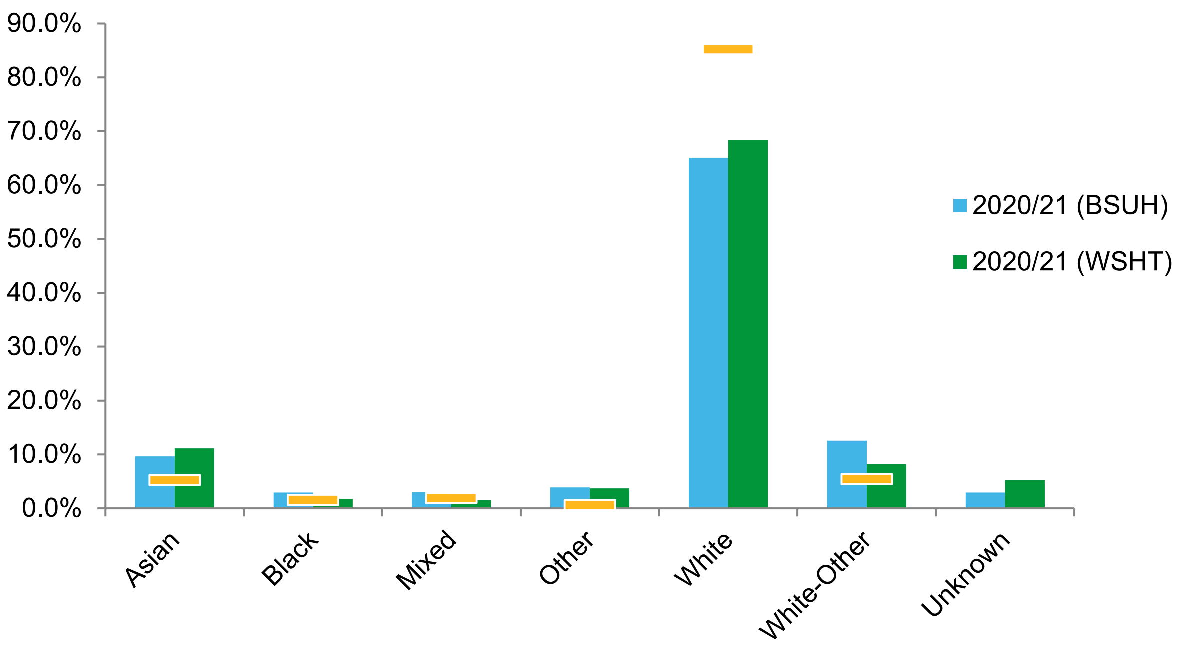
Observations

- A proportionate number of disabled staff are leaving the organisation compared to the overall workforce representation.
- A high proportion of leavers are staff that have declined to specify their disability status have left the organisation.

Ethnicity

Representation of staff within the workforce broken down by ethnicity

Ethnicity	Asian	Black	Mixed	Other	White	White-Other	Unknown
2019/20 (BSUH)	9.1%	2.9%	2.6%	3.9%	65.5%	12.8%	3.3%
2020/21 (BSUH)	9.6%	2.9%	3.0%	3.9%	65.1%	12.6%	2.9%
2019/20 (WSHT)	9.7%	1.9%	1.4%	3.7%	68.7%	8.6%	6.1%
2020/21 (WSHT)	11.1%	1.8%	1.5%	3.7%	68.4%	8.2%	5.3%
Census 2011 (SE England)	5.2%	1.6%	1.9%	0.6%	85.2%	5.4%	



Observations:

- Overall the workforce representation for most ethnic groups is greater than the 2011 Census data; this excludes white for BSUH and white and mixed heritage groups for WSHT.
- Compared to the previous year, there have not been significant changes in the ethnicity profiles of the workforces. WSHT has seen an increase of more than 1% of Asian staff.

Breakdown of ethnicity by pay banding

Items in bold highlight where there is a great representation of that particular group compared to the representation in the overall workforce

BSUH

Pay Band	Asian	Black	Other	Mixed	White	White-Other	Unknown
Band 1	6.7%	**7.9%**	**4.5%**	**6.7%**	19.1%	**47.2%**	**7.9%**
Band 2	**10.2%**	**2.9%**	**3.9%**	**3.2%**	58.1%	**19.9%**	1.8%
Band 3	6.2%	2.8%	3.6%	**3.0%**	**71.7%**	11.4%	1.3%
Band 4	4.8%	**3.6%**	1.5%	2.1%	**77.7%**	8.1%	2.2%
Band 5	**12.6%**	**3.8%**	**6.3%**	2.5%	58.5%	**14.3%**	2.1%
Band 6	6.9%	2.3%	**4.5%**	1.9%	**70.1%**	12.1%	2.3%
Band 7	4.7%	1.8%	1.6%	2.8%	**81.9%**	6.0%	1.2%
Band 8a	4.3%	2.3%	1.9%	**3.1%**	**83.7%**	3.5%	1.2%
Band 8b	2.7%	2.7%	0.0%	0.9%	**87.5%**	4.5%	1.8%
Band 8c	0.0%	**5.0%**	0.0%	0.0%	**87.5%**	5.0%	2.5%
Band 8d	0.0%	**4.8%**	0.0%	**4.8%**	**81.0%**	9.5%	0.0%
Band 9	0.0%	**6.3%**	0.0%	0.0%	**81.3%**	0.0%	**12.5%**
Directors	9.1%	0.0%	0.0%	0.0%	54.5%	0.0%	**36.4%**

Medical & Dental - Consultant	21.3%	2.5%	3.7%	3.7%	54.6%	11.2%	3.1%
Medical & Dental - Middle Grade	21.8%	5.5%	10.9%	9.1%	32.7%	16.4%	3.6%
Medical & Dental - Training	18.3%	3.0%	4.2%	5.8%	47.4%	9.2%	12.1%
Local Scale	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%

Observations

When comparing to the overall workforce representation:

- Asian staff have a good representation in bands/grades 2, 5, directors and all medical roles. There is a lower than expected representation in bands 1, 3-4, 6-8b, and there is no representation in bands 8c-9.
- Black staff have a good representation in bands/grades 1-6a, 8a-9, and all medical roles. There is a lower than expected representation in 7 and no representation in directors.
- Mixed heritage staff have a good representation in bands/grades 1-3, 5, 7-8a, 8d and all medical roles. There is a lower than expected representation in bands 4, 6 and 8b; there is no representation in bands 8c, 9 and directors.
- Other ethnicity staff have a good representation in bands/grades1-3, 5-6 and all medical grades. There is a lower than expected representation in 4, 7 and 8a and no representation in 8b-9 and directors.
- White staff are generally well represented in all bands, in bands/grades 1, 2, 5, directors and all medical grades.
- White-Other staff have a good representation in 1, 2, 3, 5-6 and middle-grade doctors. There is a lower than expected representation in 4, 7-8d and medical consultants and trainees; there is no representation in band 9 and directors.
- There is a disproportionately high number of staff whose ethnicity is unknown in band 9, directors and all medical grades.

WSHT

Pay Band	Asian	Black	Other	Mixed	White	White-Other	Unknown
Band 1	4.9%	2.4%	0.0%	2.4%	65.9%	19.5%	4.9%
Band 2	9.5%	1.0%	3.1%	1.0%	67.7%	12.5%	5.1%
Band 3	8.9%	1.3%	2.8%	0.8%	76.7%	6.4%	3.1%
Band 4	2.4%	1.0%	1.4%	1.6%	86.5%	4.9%	2.0%
Band 5	20.6%	1.9%	7.2%	2.1%	53.1%	6.5%	8.5%
Band 6	6.2%	1.7%	4.4%	1.4%	75.0%	6.9%	4.5%
Band 7	4.2%	0.9%	1.8%	0.9%	82.5%	5.2%	4.5%

Band 8a	4.2%	1.8%	0.6%	0.6%	82.7%	6.0%	4.2%
Band 8b	0.0%	1.4%	0.0%	0.0%	95.8%	1.4%	1.4%
Band 8c	0.0%	0.0%	0.0%	0.0%	93.3%	3.3%	3.3%
Band 8d	12.5%	0.0%	0.0%	0.0%	87.5%	0.0%	0.0%
Band 9	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%
Directors	4.8%	0.0%	0.0%	0.0%	71.4%	0.0%	23.8%
Medical & Dental - Consultant	17.5%	2.8%	2.5%	2.3%	56.1%	13.8%	5.1%
Medical & Dental - Middle Grade	24.5%	7.2%	5.1%	3.5%	43.1%	8.4%	8.2%
Medical & Dental - Training	20.3%	1.7%	0.8%	4.2%	66.1%	2.5%	4.2%

Observations

When comparing to the overall workforce:

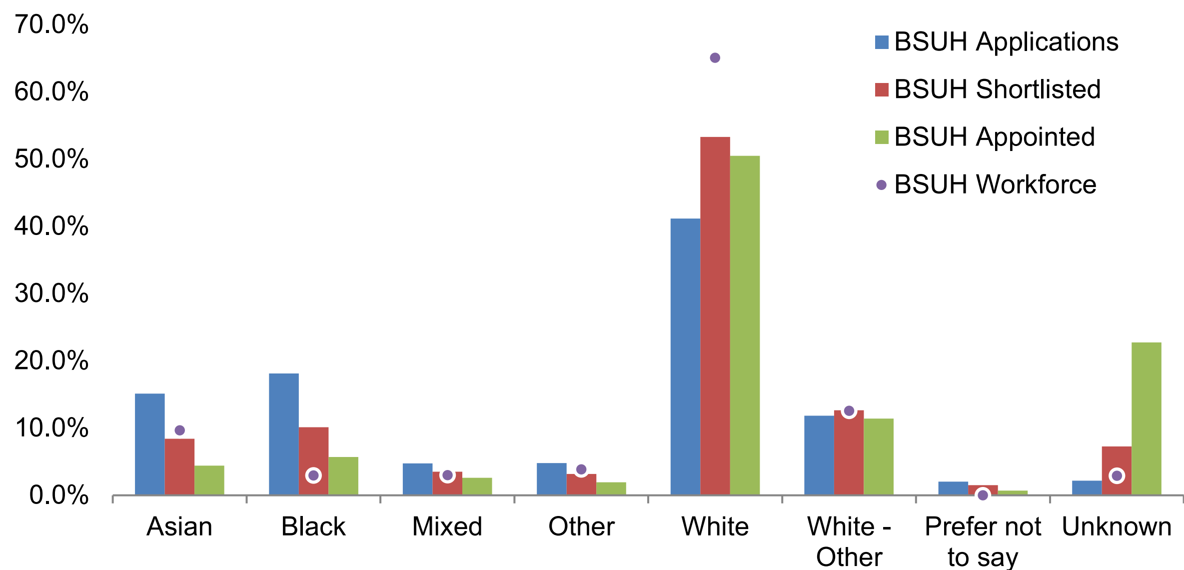
- Asian staff have a higher than expected representation in bands 5, 8d and all medical grades. There is a lower than expected representation in bands 1-4, 6-8a and directors; there is no representation in bands 8b-c and 9.
- Black staff have a good representation in 1, 5-6, 8a and all medical grades. There is a lower than expected representation in 2-4, 7 and 8b; there is no representation in bands 8c-9 and directors.
- Mixed heritage staff have a good representation in 1, 4-6 and all medical grades. There is a lower than expected representation in bands 2-3 and 6-8a; there is no representation in bands 8b-9 and directors.
- Other ethnicity staff have a good representation in 5-6 and medical middle grade. There is a lower than expected representation in bands/grades 2-4, 7-8a, medical consultants and trainees; there is no representation in bands 8b-9 and directors.
- White staff generally have a good to higher than expected representation in most bands except in bands five and all medical roles.
- White-Other staff have a good representation in bands/grades 1-2 and medical consultant and middle grades. There is a lower than expected representation in bands 3-8c; and no representation in 8d-9 and directors.
- There are a disproportionately high number of directors where their ethnicity is unknown.

Breakdown of ethnicity in recruitment processes

The data compares the three stages of recruitment compared to the workforce representation within the organisation.

BSUH

	Applications	Shortlisted	Appointed	Workforce
Asian	15.1%	8.4%	4.4%	9.6%
Black	18.1%	10.1%	5.7%	2.9%
Mixed	4.7%	3.5%	2.6%	3.0%
Other	4.8%	3.2%	2.0%	3.9%
White	41.2%	53.3%	50.5%	65.1%
White - Other	11.8%	12.7%	11.4%	12.6%
Prefer not to say	2.0%	1.5%	0.7%	0.0%
Unknown	2.2%	7.3%	22.7%	2.9%
Grand Total	100%	100%	100%	100.0%

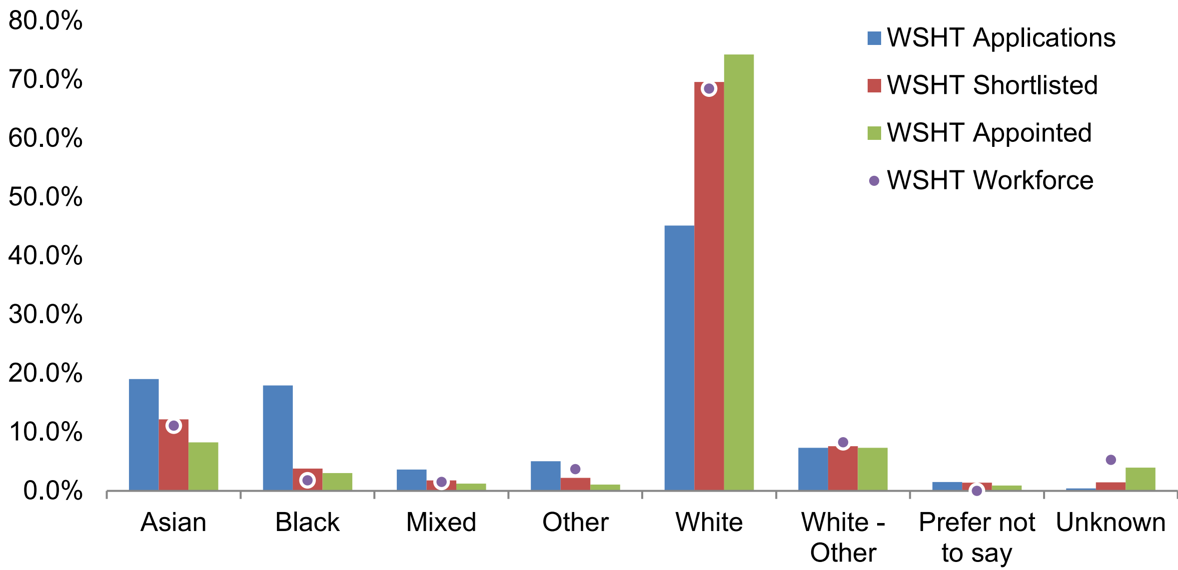


Observations

- Compared to the overall workforce representation, for the majority of the minority groups, there is a larger than expected representation at the application stage. When progressing through to shortlisting and appointment, there is a progressive drop. This is particularly pronounced in Asian and Black candidates.
- There is a lower representation for white candidates throughout all stages of recruitment, but the representation progressively increases.
- White-Other candidates are relatively in line and consistent with the workforce representation throughout all stages of recruitment.
- There is a disproportionately high number of candidates where their ethnicity is not known that have been appointed.

WSHT

Ethnicity	Applications	Shortlisted	Appointed	Workforce
Asian	19.0%	12.2%	8.2%	11.1%
Black	17.9%	3.8%	3.0%	1.8%
Mixed	3.6%	1.8%	1.3%	1.5%
Other	5.0%	2.2%	1.1%	3.7%
White	45.1%	69.6%	74.2%	68.4%
White - Other	7.4%	7.6%	7.3%	8.2%
Prefer not to say	1.5%	1.4%	0.9%	0.0%
Unknown	0.4%	1.5%	3.9%	5.3%
Total	100.0%	100.0%	100.0%	100.0%



Observations

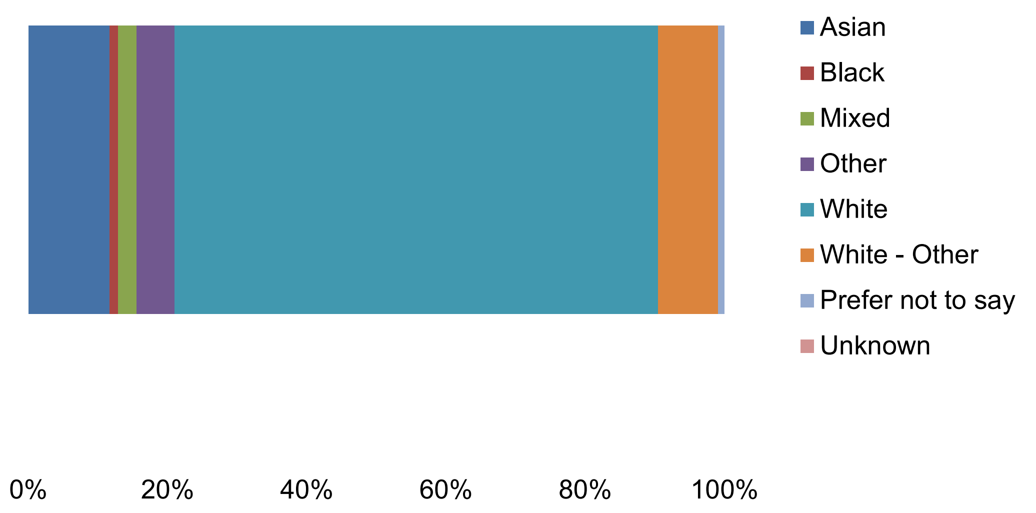
- Compared to the overall workforce representation, for most minority groups, there is a large representation at the application stage. However, when progressing to shortlisting and appointment stages, there is a progressive drop in representation. The drop is quite pronounced in Asian, Black and Other ethnicity groups.
- For White candidates, there are proportionally fewer applicants at the application stage than the overall workforce representation; as candidates progress through to shortlisting and appointment stages, the proportion of white candidates increases (greater than the overall workforce representation).

- For White-Other candidates, the representation at all stages in recruitment is slightly lower than the overall workforce representation; however, the representation remains relatively consistent through the recruitment stages.

Uptake of non-mandatory training or continuing professional development

BSUH

Ethnicity	No. of staff attending training	% staff attending training	Workforce representation
Asian	39	11.7%	9.6%
Black	4	1.2%	2.9%
Mixed	9	2.7%	3.0%
Other	18	5.4%	3.9%
White	232	69.5%	65.1%
White - Other	29	8.7%	12.6%
Prefer not to say	3	0.9%	
Unknown			2.9%
Grand Total	334	100.0%	

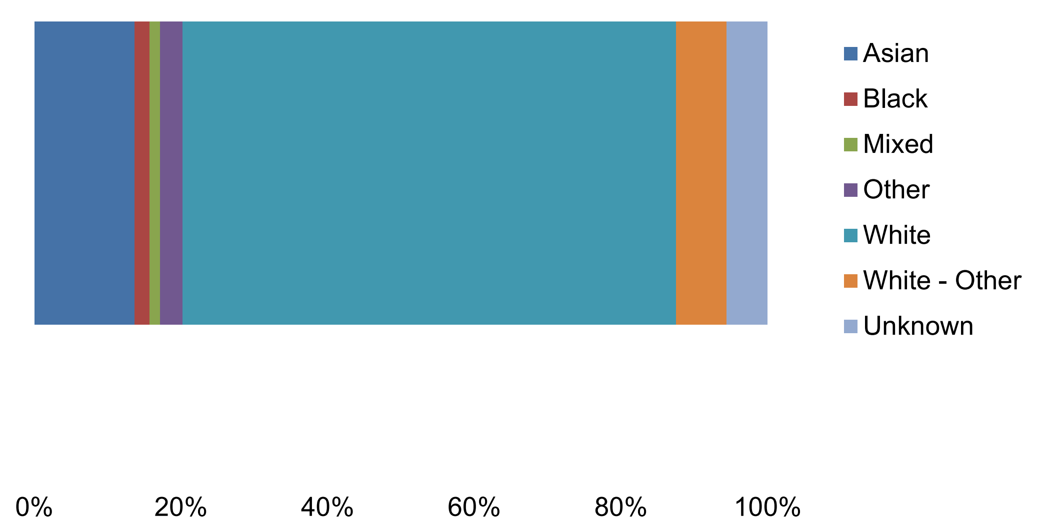


Observations

- Asian, Mixed, other ethnicities, and White staff have an equal or greater representation in training than the overall workforce representation.
- Black and White-Other have a lower representation in training compared to the overall workforce representation.

WSHT

Ethnicity	No. of staff attending training	% staff attending training	Workforce representation
Asian	375	13.7%	11.1%
Black	56	2.0%	1.8%
Mixed	40	1.5%	1.5%
Other	82	3.0%	3.7%
White	1847	67.4%	68.4%
White - Other	189	6.9%	8.2%
Unknown	152	5.5%	5.3%
Grand Total	2741	100.0%	



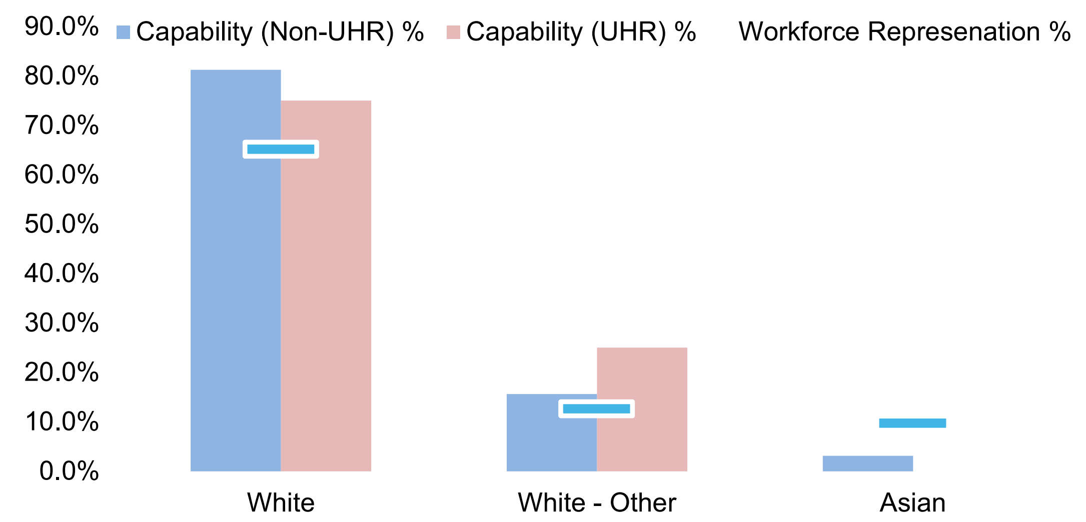
Observations

- Asian, Black, and mixed heritage staff have an equal or higher representation in training compared to the overall workforce representation.
- Other ethnicities and white staff have a close representation compared to the overall workforce representation.
- White-Other has a lower representation in training compared to the overall workforce representation.

Employee relations processes broken down by ethnicity

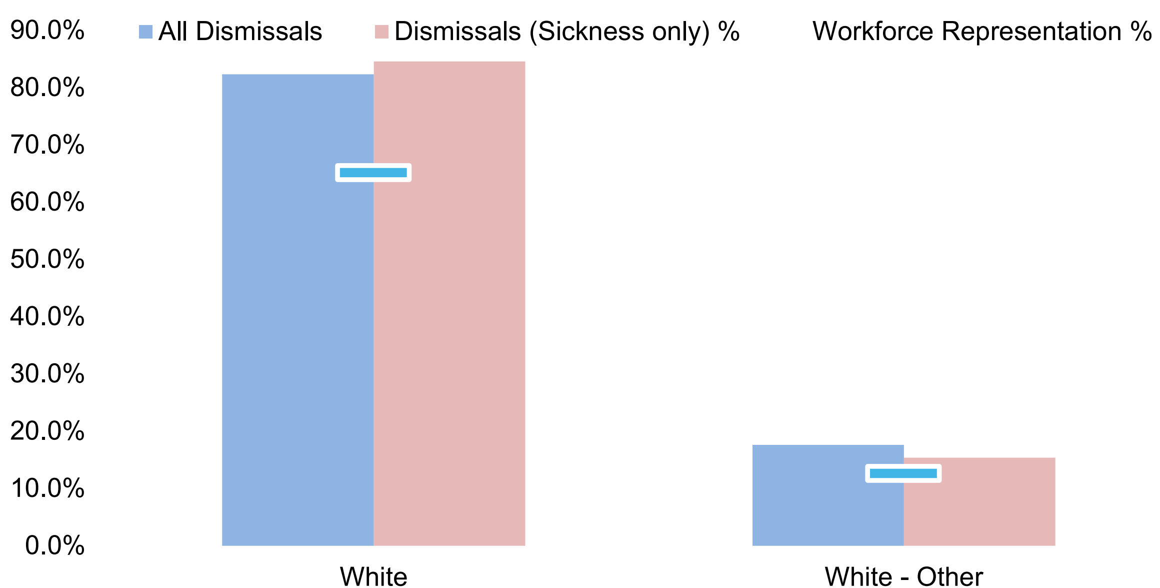
BSUH

Ethnicity	Capability (Non-UHR)	Capability (Non-UHR) %	Capability (UHR)	Capability (UHR) %	Workforce Representation %
White	26	81.3%	6	75.0%	65.1%
White - Other	5	15.6%	2	25.0%	12.6%
Asian	1	3.1%			9.6%
Total	**32**	**100.0%**	**8**	**100.0%**	



Ethnicity	Harassment Cases	Harassment Cases %	Grievance Cases	Grievance Cases %	Disciplinary Cases	Disciplinary Cases %	Workforce Representation %
Black					1	4.3%	2.9%
White	4	100.0%	9	100.0%	13	56.5%	65.1%
White - Other	0	0.0%	0	0.0%	9	39.1%	12.6%
Total	**4**	**100.0%**	**9**	**100.0%**	**23**	**100.0%**	

Ethnicity	All Dismissals %	All Dismissals	Dismissals (Sickness only)	Dismissals (Sickness only) %	Workforce Representation %
White	14	82.4%	11	84.6%	65.1%
White - Other	3	17.6%	2	15.4%	12.6%
Total	**17**	100.0%	**13**	100.0%	

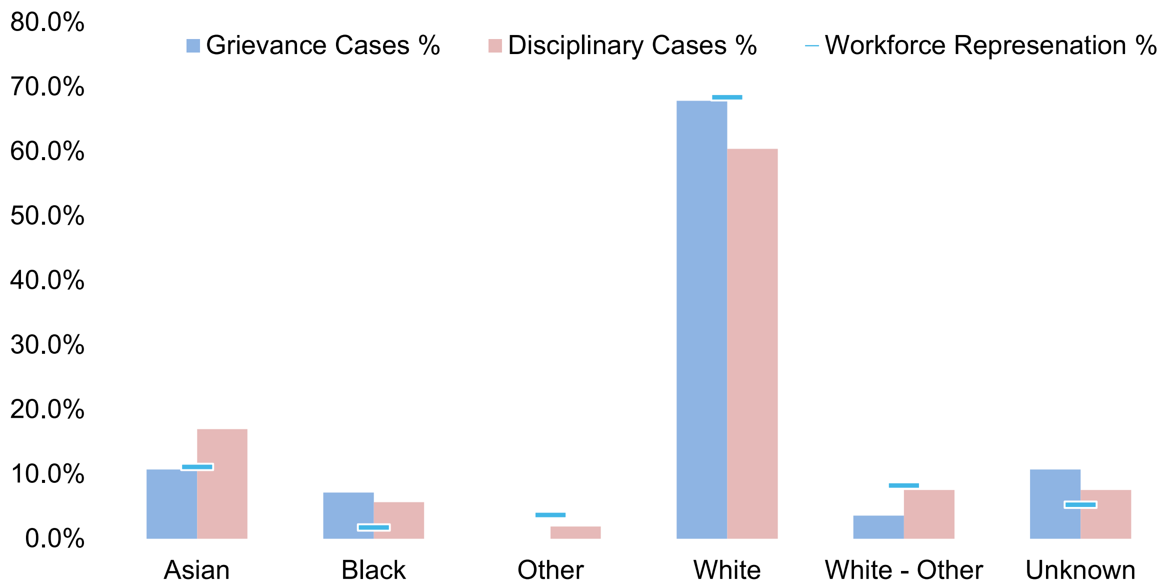


Observations

- White and White-Other staff has a higher than expected representation in all capability processes.
- White staff have a higher than expected representation in harassment and grievance cases. White-Other and Black staff have a higher than expected representation in disciplinary cases.
- White and White-Other staff has a higher than expected representation in dismissals.

WSHT

Ethnicity	Grievance Cases	Grievance Cases %	Disciplinary Cases	Disciplinary Cases %	Workforce Representation %
Asian	3	10.7%	9	17.0%	11.1%
Black	2	7.1%	3	5.7%	1.8%
Other			1	1.9%	3.7%
White	19	67.9%	32	60.4%	68.4%
White - Other	1	3.6%	4	7.5%	8.2%
Unknown	3	10.7%	4	7.5%	5.3%
Total	**28**	**100%**	**53**	**100%**	



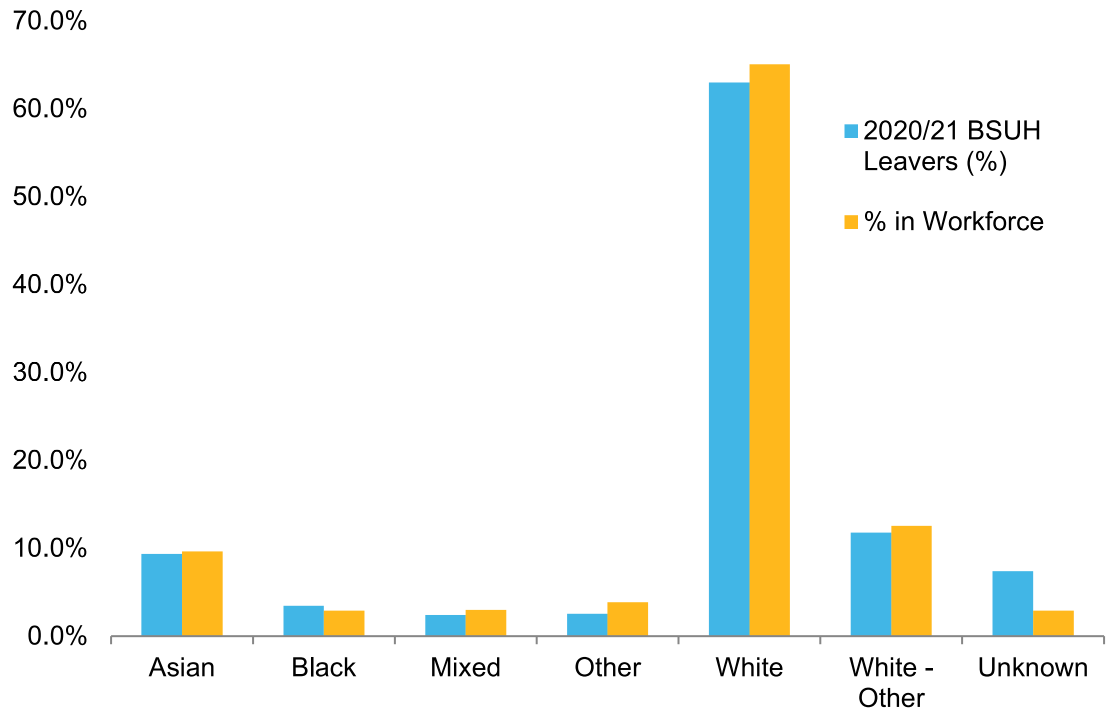
Observations

- Black staff have a higher than expected representation in disciplinary and grievance cases, while Asian staff have a higher than expected representation in disciplinary cases.
- All other declared groups' representation is lower than their overall workforce representation.

Leavers broken down by ethnicity

BSUH

Ethnic Category	2020/21 BSUH Leavers	2020/21 BSUH Leavers (%)	Number in Workforce	% in Workforce
Asian	143	9.4%	856	9.6%
Black	53	3.5%	260	2.9%
Mixed	37	2.4%	266	3.0%
Other	39	2.6%	343	3.9%
White	962	63.0%	5775	65.1%
White - Other	180	11.8%	1115	12.6%
Unknown	113	7.4%	258	2.9%
Grand Total	**1527**	**100.0%**	**8873**	**100.0%**

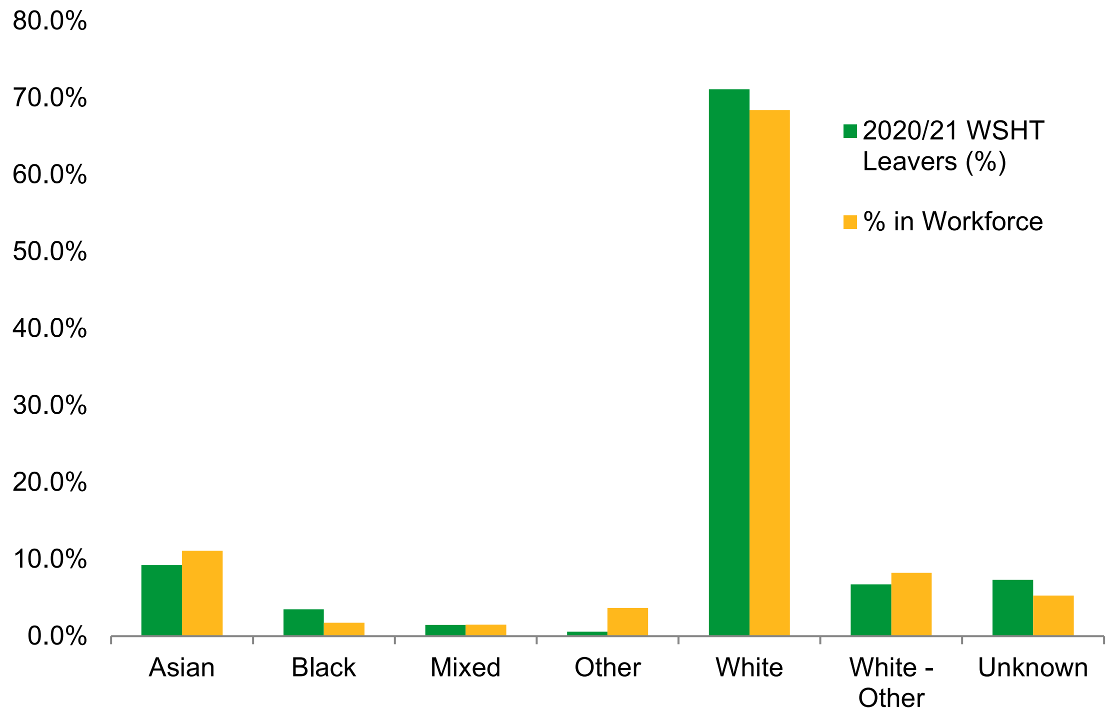


Observations

- A higher number of black staff are leaving the organisation when compared to the overall workforce representation.
- Leavers in all other declared groups are lower than the overall workforce representation.
- A higher proportion (compared to overall workforce representation) of staff whose ethnicity is unknown has left the organisation.

WSHT

Ethnic Category	2020/21 WSHT Leavers	2020/21 WSHT Leavers (%)	Number in Workforce	% in Workforce
Asian	63	9.2%	835	11.1%
Black	24	3.5%	133	1.8%
Mixed	10	1.5%	113	1.5%
Other	4	0.6%	277	3.7%
White	485	71.1%	5143	68.4%
White - Other	46	6.7%	620	8.2%
Unknown	50	7.3%	397	5.3%
Grand Total	**682**	**100.0%**	**7518**	**100.0%**



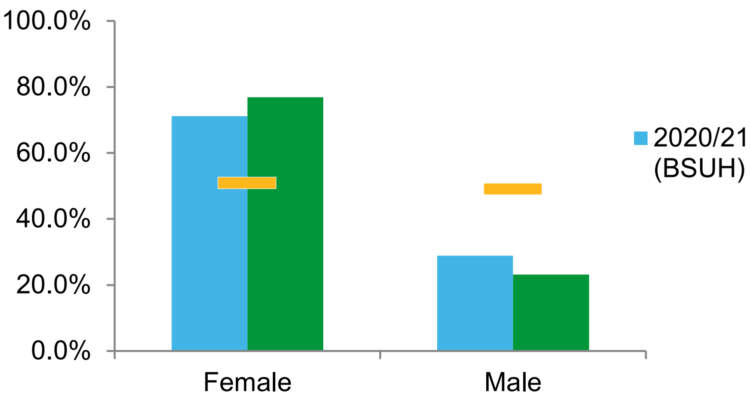
Observations

- Black and White staff have a higher representation in the leavers data compared to their overall workforce representation.
- All other declared groups have an equal or lower representation in the leavers data compared to their workforce representation.
- A high proportion of unknown ethnicity staff has left the organisation compared to the overall workforce representation.

Gender

Representation of staff within the workforce broken down by gender

	Female	Male
2019/20 (BSUH)	71.5%	28.5%
2020/21 (BSUH)	71.1%	28.9%
2019/20 (WSHT)	77.0%	23.0%
2020/21 (WSHT)	76.9%	23.1%
Census 2011 (SE England)	50.9%	49.1%



Observations:

- Neither BSUH nor WSHT's workforces reflect the 2011 Census data, but the gender profile broadly aligns with the national NHS workforce data.
- There have not been any significant changes to the BSUH or WSHT gender profile compared to the previous year.

Breakdown of gender by pay banding

The items in bold show where a greater representation of that particular group than representation in the overall workforce

BSUH

Pay Band	Female	Male
Band 1	69.7%	**30.3%**
Band 2	64.9%	**35.1%**
Band 3	**73.6%**	26.4%
Band 4	**79.0%**	21.0%
Band 5	**79.4%**	20.6%
Band 6	**82.0%**	18.0%
Band 7	**77.8%**	22.2%
Band 8a	67.1%	**32.9%**
Band 8b	65.2%	**34.8%**
Band 8c	62.5%	**37.5%**
Band 8d	42.9%	**57.1%**
Band 9	43.8%	**56.3%**
Directors	63.6%	**36.4%**
Medical & Dental - Consultant	41.5%	**58.5%**
Medical & Dental - Middle Grade	45.5%	**54.5%**
Medical & Dental - Training	55.3%	**44.7%**
Local Scale	0.0%	**100.0%**

Observations

- There is a fair to good representation of female staff in bands 1-8b. There is a lower than expected representation from 8c-9, directors and all medical grades than the overall workforce representation.
- Female staff have the highest representation in bands 3-7.
- Male staff are well represented in bands 1-3, 8a-9, directors and medical grades. Apart from bands 3-7 (lower than expected), male staff have a higher than expected representation than the overall workforce.

WSHT

Pay Band	Female	Male
Band 1	56.1%	**43.9%**
Band 2	75.8%	**24.2%**
Band 3	**79.1%**	20.9%
Band 4	**86.3%**	13.7%
Band 5	**84.2%**	15.8%
Band 6	**86.7%**	13.3%
Band 7	**83.3%**	16.7%
Band 8a	70.2%	**29.8%**
Band 8b	66.2%	**33.8%**
Band 8c	76.7%	**23.3%**
Band 8d	**87.5%**	12.5%
Band 9	57.1%	**42.9%**
Directors	52.4%	**47.6%**
Medical & Dental - Consultant	35.8%	**64.2%**
Medical & Dental - Middle Grade	53.8%	**46.2%**
Medical & Dental - Training	62.7%	**37.3%**

Observations

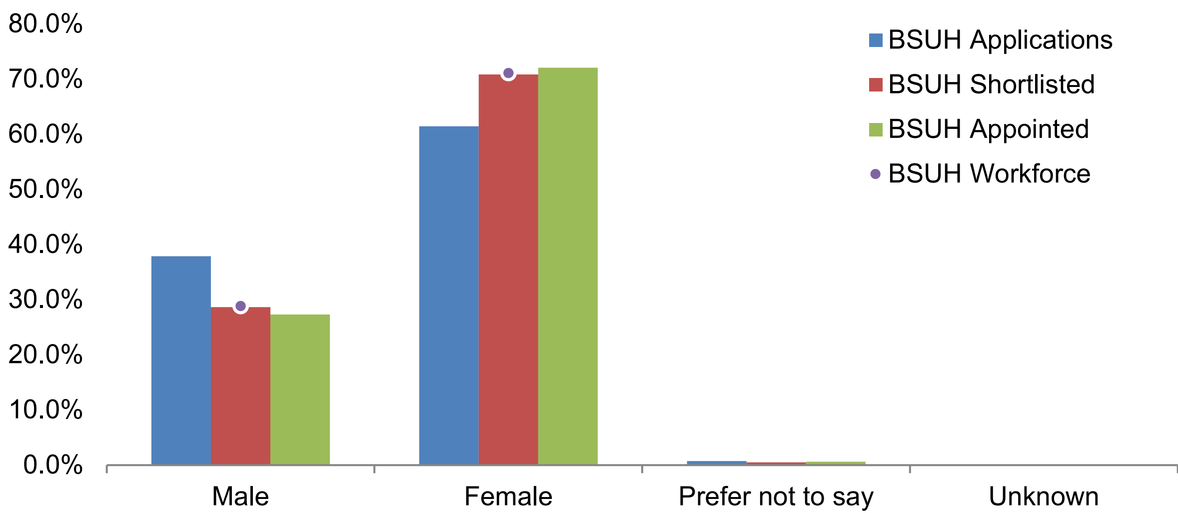
- There is a good representation of female staff in bands 2-7 and 8c-d. For all other bands, female staff have a lower than expected representation than the overall workforce.
- Female staff have a higher than the overall workforce representation in bands 3-7 and 8d.
- Male staff have a larger than expected representation (than the overall workforce representation) in bands 1-2, 8a-c, 9, directors and all medical grades. In all other bands, male staff have a lower representation than expected.

Breakdown of gender in recruitment processes

The data compares the three stages of recruitment compared to the workforce representation within the organisation.

BSUH

Gender	Applications	Shortlisted	Appointed	Workforce
Male	37.9%	28.7%	27.3%	28.9%
Female	61.4%	70.8%	72.0%	71.1%
Prefer not to say	0.7%	0.5%	0.6%	
Unknown	0.0%	0.0%	0.0%	
Total	100.0%	100.0%	100.0%	

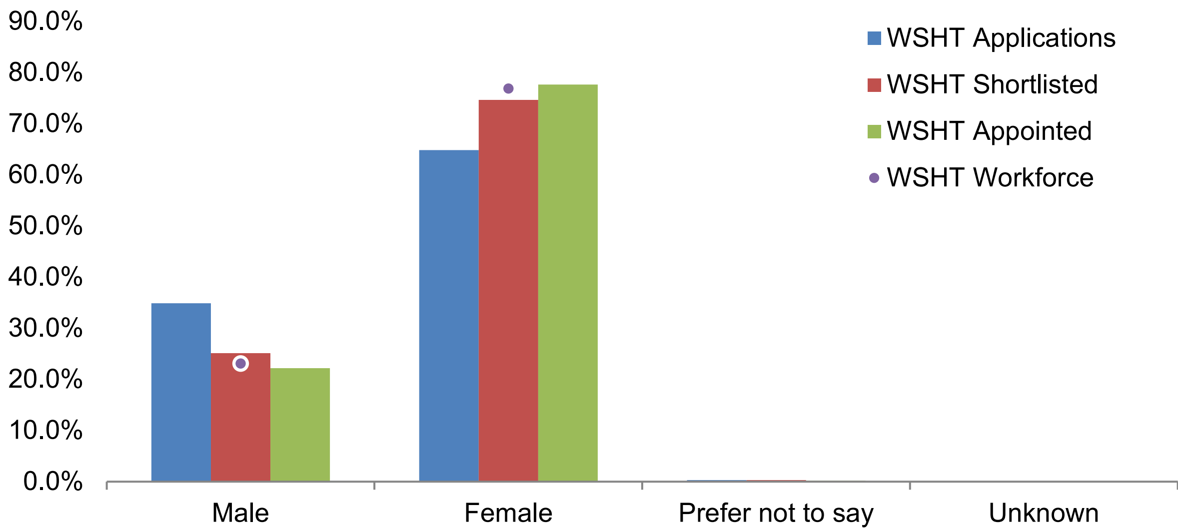


Observations

- There is a greater proportion of male candidates (than the overall workforce representation) at the application stage. However, at shortlisting and appointment stages, the representation of male candidates are broadly in line with the overall workforce representation.
- There is a lower representation of female applicants at the application stage than in the overall workforce representation. However, at shortlisting and appointment stages, the representation of female candidates is broadly in line with the overall workforce representation.
- The overall conversion throughout the recruitment process may suggest that male candidates may suggest that they experience a disadvantage; the opposite is true for female candidates.
-

WSHT

Gender	Applications	Shortlisted	Appointed	Workforce
Male	34.9%	25.1%	22.2%	23.1%
Female	64.8%	74.6%	77.6%	76.9%
Prefer not to say	0.3%	0.3%	0.2%	
Unknown	0.0%	0.0%	0.0%	
Total	100.0%	100.0%	100.0%	



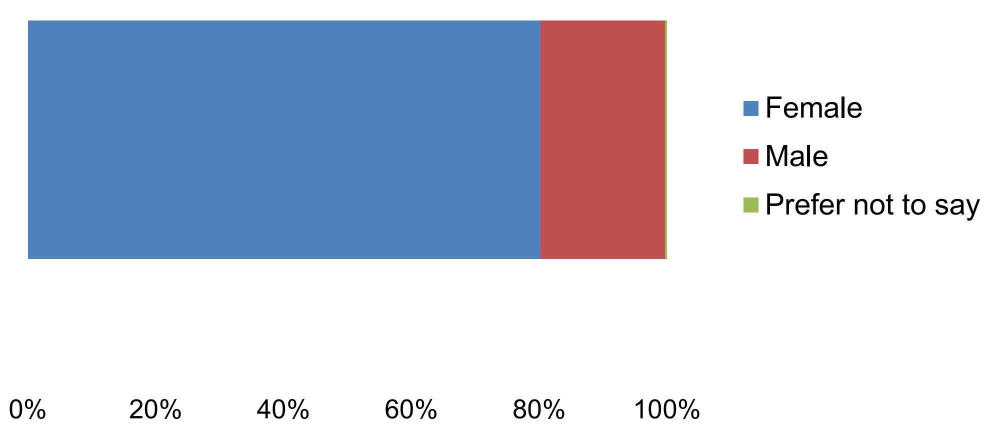
Observations

- There is a greater proportion of male candidates (than the overall workforce representation) at the application stage. However, at shortlisting and appointment stages, the representation of male candidates are broadly in line with the overall workforce representation.
- There is a lower representation of female applicants at the application stage than in the overall workforce representation. However, at shortlisting and appointment stages, the representation of female candidates is broadly in line with the overall workforce representation.
- The overall conversion throughout the recruitment process may suggest that male candidates may suggest that they experience a disadvantage; the opposite is true for female candidates.

Uptake of non-mandatory training or continuing professional development

BSUH

Recorded Gender	Number of staff attending training	% staff attending training	Workforce representation
Female	268	80.2%	71.1%
Male	65	19.5%	28.9%
Prefer not to say	1	0.3%	
Grand Total	334	100.0%	100.0%

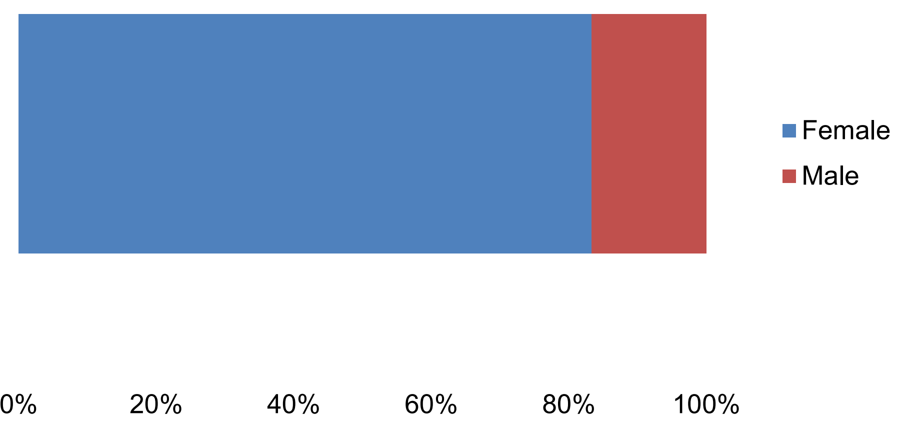


Observations

- A higher proportion of female staff has undertaken non-mandatory/CPD training than the overall workforce representation; the opposite is true for male staff.

WSHT

Recorded Gender	Number of staff attending training	% staff attending training	Workforce representation
Female	2285	83.4%	76.9%
Male	456	16.6%	23.1%
Grand Total	2741	100.0%	100.0%



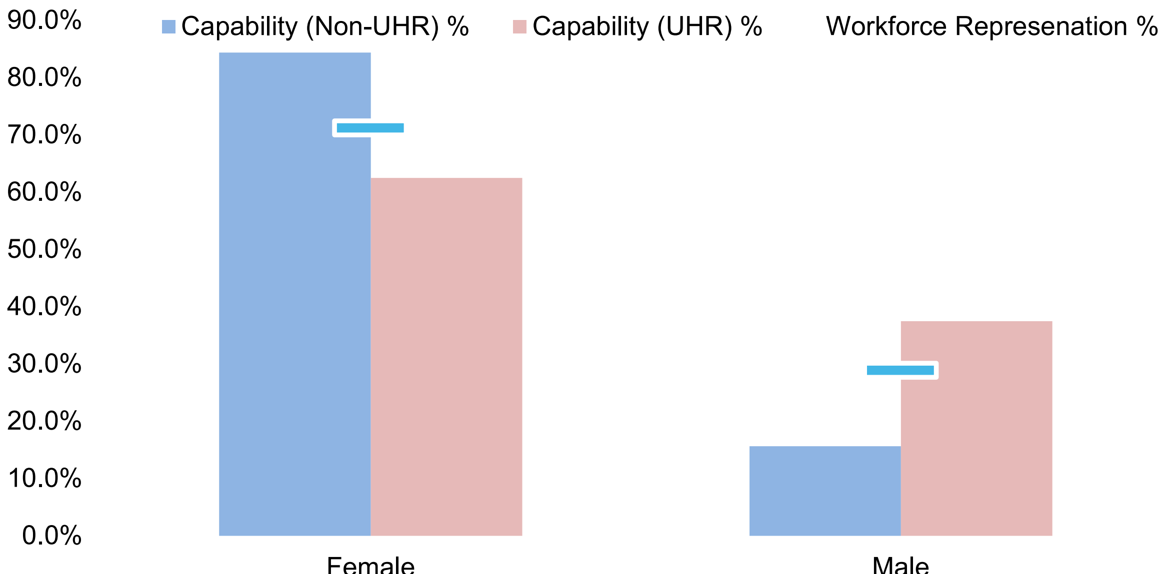
Observations

- A higher proportion of female staff has undertaken non-mandatory/CPD training than the overall workforce representation; the opposite is true for male staff.

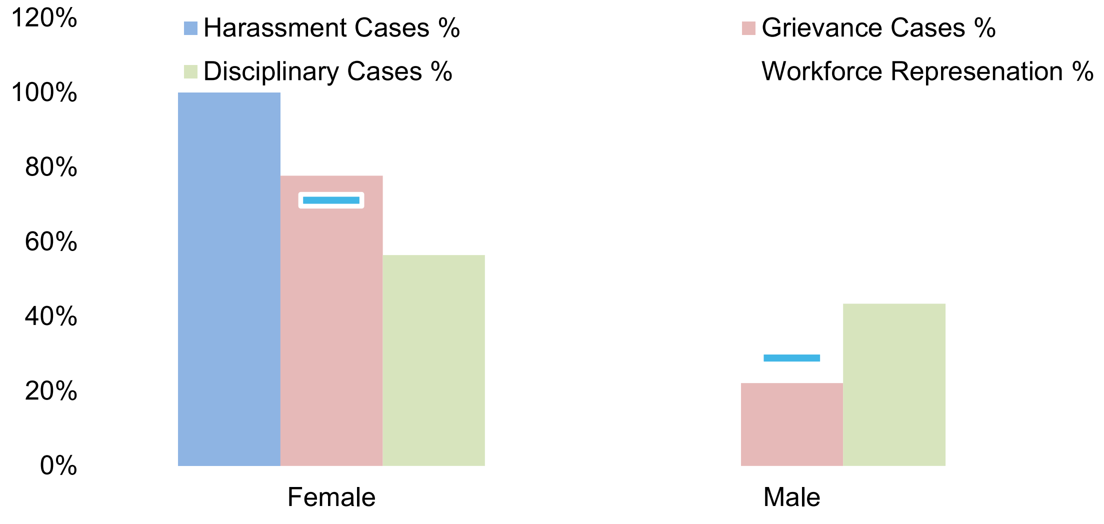
Employee relations processes broken down by gender

BSUH

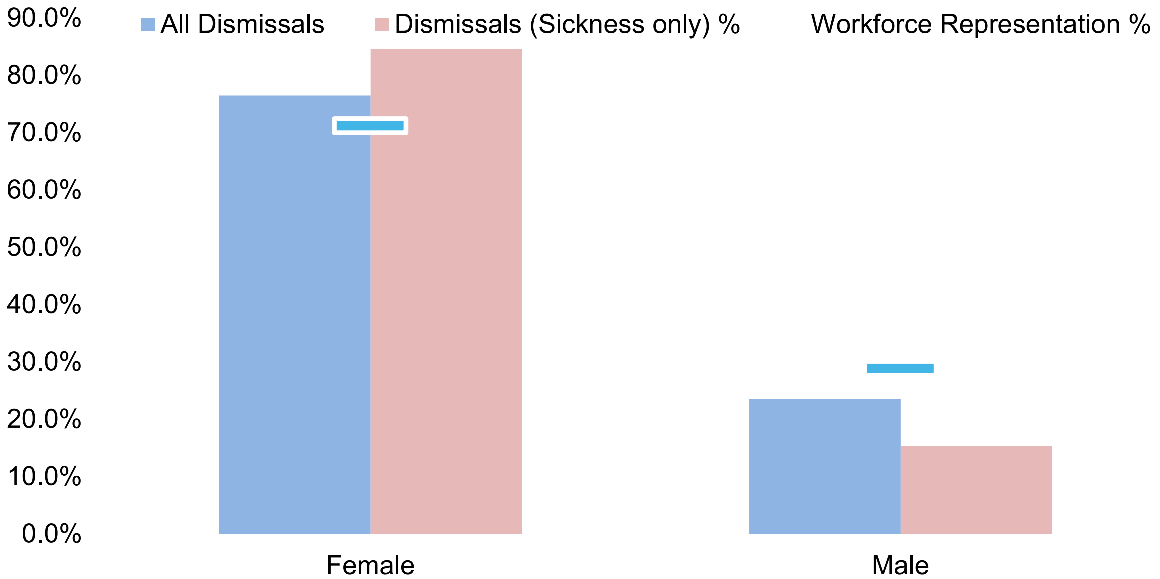
Recorded Gender	Capability (Non-UHR)	Capability (Non-UHR) %	Capability (UHR)	Capability (UHR) %	Workforce Representation %
Female	27	84.4%	5	62.5%	71.1%
Male	5	15.6%	3	37.5%	28.9%
Total	**32**	**100%**	**8**	**100%**	



Recorded Gender	Harassment Cases	Harassment Cases %	Grievance Cases	Grievance Cases %	Disciplinary Cases	Disciplinary Cases %	Workforce Representation %
Female	4	100.0%	7	77.8%	13	56.5%	71.1%
Male	0	0.0%	2	22.2%	10	43.5%	28.9%
Total	**4**	**100.0%**	**9**	**100.0%**	**23**	**100.0%**	



Recorded Gender	All Dismissals	All Dismissals %	Dismissals (Sickness only)	Dismissals (Sickness only) %	Workforce Representation %
Female	13	76.5%	11	84.6%	71.1%
Male	4	23.5%	2	15.4%	28.9%
Total	**17**	**100.0%**	**13**	**100.0%**	



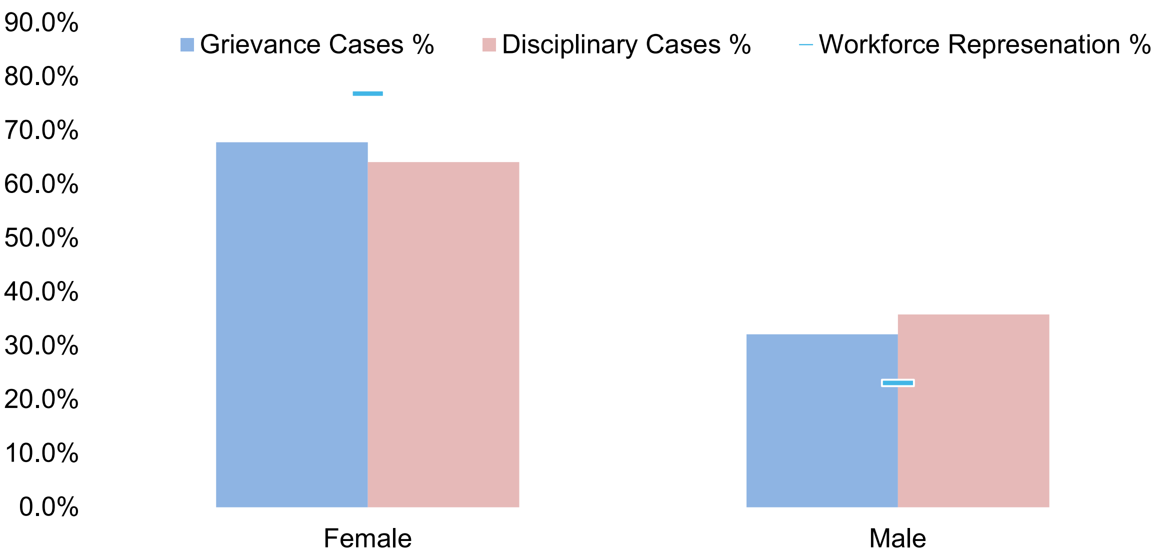
Observations

Compared to the overall workforce representation

- Female staff have a higher than expected representation in capability (non-underlying health reasons), but male staff have a higher than expected representation in capability (underlying health reasons).
- Female staff has a higher than expected representation in harassment cases, while male staff have a higher representation in disciplinary cases.
- Grievance cases are broadly in line with the overall workforce representation.
- In dismissals, both male and female staff representation broadly aligns with the workforce. But in dismissals relating to sickness, women have a higher than expected representation.
- Men have a lower representation than that of all dismissal processes.

WSHT

Recorded Gender	Grievance Cases	Grievance Cases %	Disciplinary Cases	Disciplinary Cases %	Workforce Representation %
Female	19	67.9%	34	64.2%	76.9%
Male	9	32.1%	19	35.8%	23.1%
Total	**28**	**100%**	**53**	**100%**	



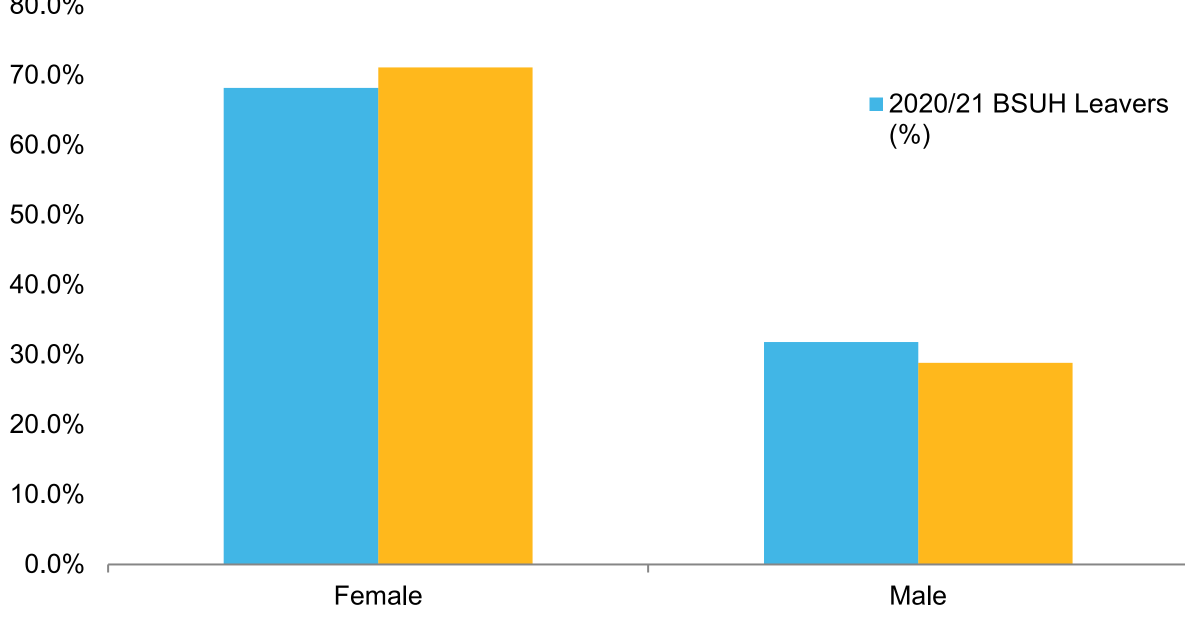
Observations

- In both grievances and disciplinaries, male staff have a higher than expected representation, and the opposite is true for female staff.

Leavers broken down by gender

BSUH

Recorded Gender	2020/21 BSUH Leavers	2020/21 BSUH Leavers (%)	Number in Workforce	% in Workforce
Female	1041	68.2%	6312	71.1%
Male	486	31.8%	2561	28.9%
Grand Total	1527	100.0%	8873	100.0%

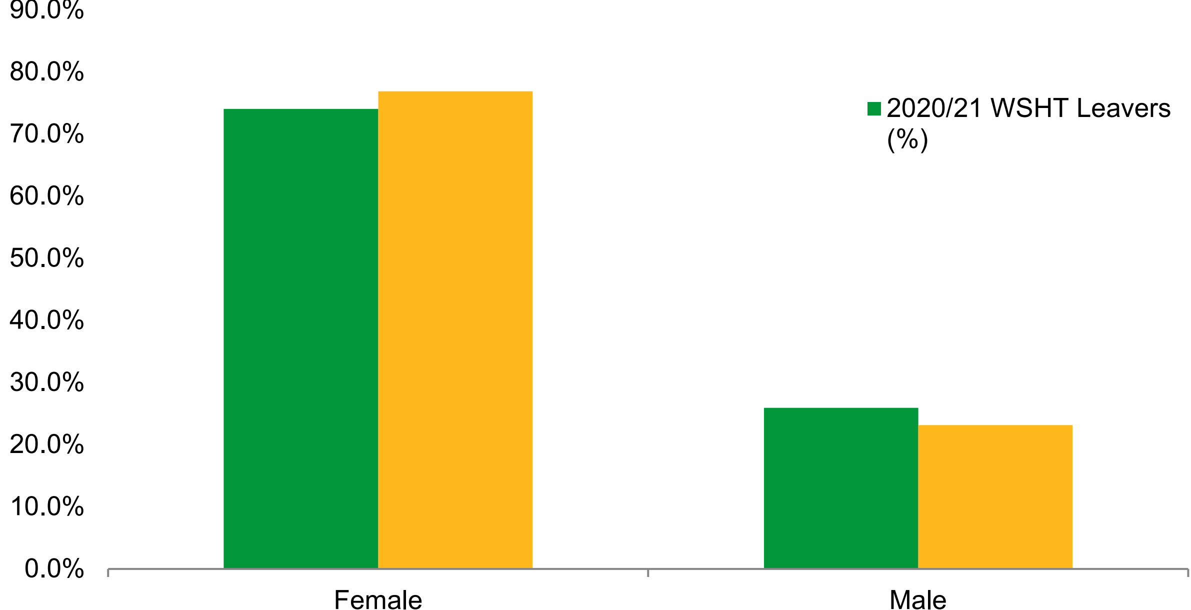


Observations

- Male and female staff that have left the organisation is broadly in line with the workforce representation.

WSHT

Recorded Gender	2020/21 WSHT Leavers	2020/21 WSHT Leavers (%)	Number in Workforce	% in Workforce
Female	505	74.0%	5780	76.9%
Male	177	26.0%	1739	23.1%
Grand Total	**682**	**100.0%**	**7519**	**100.0%**



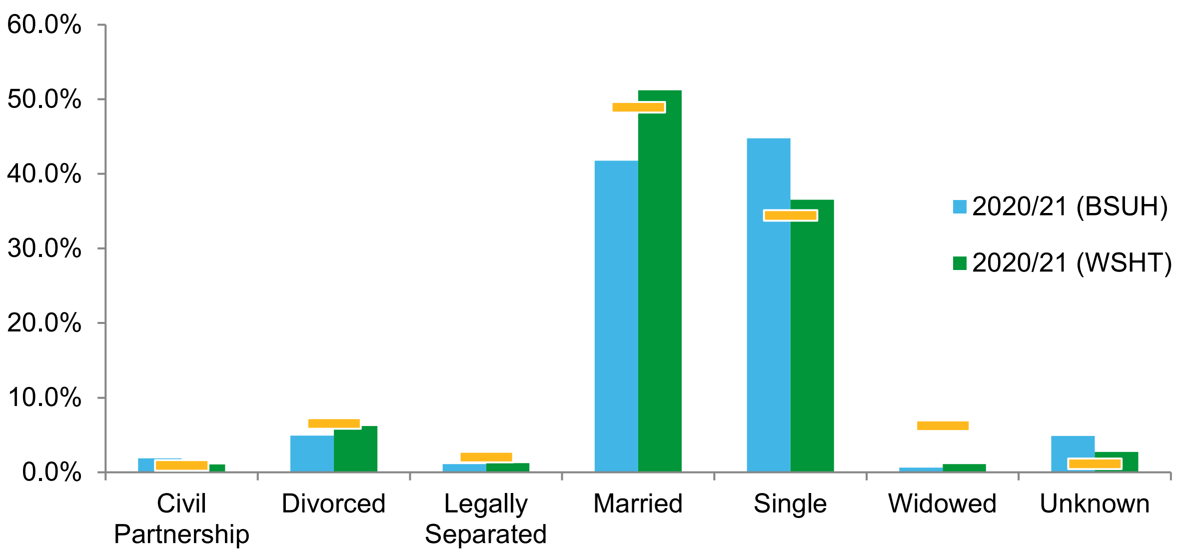
Observations

- Male and female staff that have left the organisation is broadly in line with the workforce representation.

Marital Status (Marriage and Civil Partnership)

Representation of staff within the workforce broken down by marital status

	Civil Partnership	Divorced	Legally Separated	Married	Single	Widowed	Unknown
2019/20 (BSUH)	1.5%	4.7%	1.2%	42.9%	45.1%	0.7%	4.0%
2020/21 (BSUH)	1.9%	4.9%	1.1%	41.8%	44.8%	0.6%	4.9%
2019/20 (WSHT)	1.0%	6.4%	1.3%	52.5%	35.0%	1.1%	2.7%
2020/21 (WSHT)	1.1%	6.2%	1.2%	51.2%	36.5%	1.1%	2.7%
Census 2011 (SE England)	0.9%	6.5%	2.0%	48.9%	34.4%	6.2%	1.1%



Observations:

- There is a greater representation of staff in a civil partnership compared to the 2011 Census data.
- There is a lower representation of married staff than the 2011 Census data in the BSUH workforce but higher in WSHT.
- There has been an increase in staff representation in a civil partnership and a decrease in married staff from the previous year.

Breakdown of marital status by pay banding

The items in bold show a greater representation of that particular group compared to the representation in the overall workforce

BSUH

AFC Banding	Civil Partnership	Divorced	Legally Separated	Married	Single	Widowed	Unknown
Band 1	**2.2%**	**5.6%**	**1.1%**	28.1%	**51.7%**	**1.1%**	**10.1%**
Band 2	**2.8%**	**5.8%**	**1.5%**	37.3%	44.2%	**1.2%**	**7.2%**
Band 3	**2.3%**	**7.8%**	**1.3%**	41.3%	42.0%	**0.9%**	4.4%
Band 4	1.6%	**8.4%**	**1.5%**	39.8%	43.6%	**0.9%**	4.2%
Band 5	1.5%	4.3%	**1.3%**	34.9%	**54.1%**	0.2%	3.8%
Band 6	1.7%	4.1%	**1.4%**	**44.2%**	44.4%	0.5%	3.7%
Band 7	**2.0%**	**5.6%**	0.4%	**49.2%**	38.4%	0.4%	4.1%
Band 8a	**1.9%**	**6.6%**	0.8%	**53.9%**	29.5%	**1.2%**	**6.2%**
Band 8b	0.0%	0.9%	**2.7%**	**48.2%**	38.4%	**2.7%**	**7.1%**
Band 8c	**2.5%**	**7.5%**	**2.5%**	**42.5%**	35.0%	0.0%	**10.0%**

Band 8d	4.8%	0.0%	9.5%	66.7%	9.5%	0.0%	9.5%
Band 9	0.0%	18.8%	0.0%	56.3%	18.8%	0.0%	6.3%
Directors	0.0%	0.0%	0.0%	63.6%	36.4%	0.0%	0.0%
Medical & Dental - Consultant	1.4%	1.0%	0.0%	70.6%	22.9%	0.4%	3.7%
Medical & Dental - Middle Grade	0.0%	7.3%	0.0%	63.6%	23.6%	0.0%	5.5%
Medical & Dental - Training	1.3%	0.5%	0.3%	28.4%	64.2%	0.0%	5.2%
Local Scale	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%

Observations

- There is a greater representation compared to the overall staff workforce representation in a civil partnership in bands 1-3,7-8a and 8c-d; there is a fair representation in bands 4-6, medical consultants and trainees. In all other bands/grades, there is no representation.
- There is a greater representation than the overall workforce of married staff in bands 7-9, directors and medical consultants and middle-grade doctors. All other bands/grades have a low to fair representation.

WSHT

AFC Banding	Civil Partnership	Divorced	Legally Separated	Married	Single	Widowed	Unknown
Band 1	2.4%	0.0%	0.0%	41.5%	51.2%	2.4%	2.4%
Band 2	1.4%	7.5%	1.4%	49.5%	35.6%	1.8%	2.8%
Band 3	1.4%	9.8%	1.3%	45.7%	37.8%	1.5%	2.5%
Band 4	1.6%	9.6%	2.4%	49.2%	32.9%	1.2%	3.1%
Band 5	0.6%	5.0%	1.0%	45.0%	45.7%	1.2%	1.5%
Band 6	1.1%	4.5%	1.2%	55.2%	35.1%	0.6%	2.3%
Band 7	0.9%	8.4%	1.3%	60.1%	24.9%	0.9%	3.4%
Band 8a	1.8%	7.7%	2.4%	60.1%	25.6%	0.0%	2.4%
Band 8b	1.4%	5.6%	0.0%	76.1%	12.7%	0.0%	4.2%
Band 8c	3.3%	10.0%	0.0%	70.0%	16.7%	0.0%	0.0%
Band 8d	0.0%	12.5%	12.5%	75.0%	0.0%	0.0%	0.0%
Band 9	0.0%	14.3%	0.0%	57.1%	28.6%	0.0%	0.0%
Directors	0.0%	4.8%	4.8%	76.2%	9.5%	0.0%	4.8%
Medical & Dental - Consultant	0.0%	1.4%	0.3%	81.1%	13.2%	0.0%	3.9%
Medical & Dental - Middle Grade	0.2%	0.2%	0.0%	44.1%	51.3%	0.0%	4.2%
Medical & Dental - Training	0.0%	0.8%	0.0%	2.5%	89.8%	0.0%	6.8%

Observations

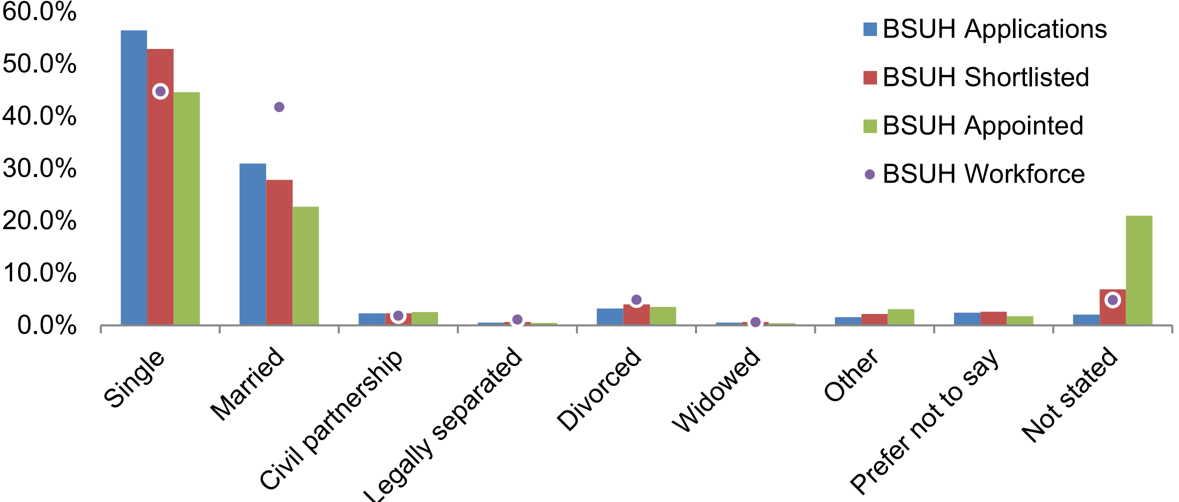
- There is a greater representation than the overall workforce of staff in a civil partnership in bands 1-4, 6 and 8a-c; there is a fair representation in bands 5, 7 and middle-grade doctors. All other bands/grades have no staff representation in a civil partnership.
- There is a good representation of married staff across all bands/grades, except with medical trainees.
- The majority of (very) senior managers are married.

Breakdown of marital status in recruitment processes

The data compares the three stages of recruitment compared to the workforce representation within the organisation.

BSUH

Marital Status	Applications	Shortlisted	Appointed	Workforce
Single	56.4%	52.9%	44.6%	44.8%
Married	30.9%	27.8%	22.7%	41.8%
Civil partnership	2.3%	2.3%	2.5%	1.9%
Legally separated	0.6%	0.6%	0.4%	1.1%
Divorced	3.2%	4.0%	3.5%	4.9%
Widowed	0.5%	0.6%	0.4%	0.6%
Other	1.5%	2.2%	3.1%	
Prefer not to say	2.4%	2.6%	1.8%	
Not stated	2.1%	6.9%	21.0%	4.9%
Total	100.0%	100.0%	100.0%	100.0%

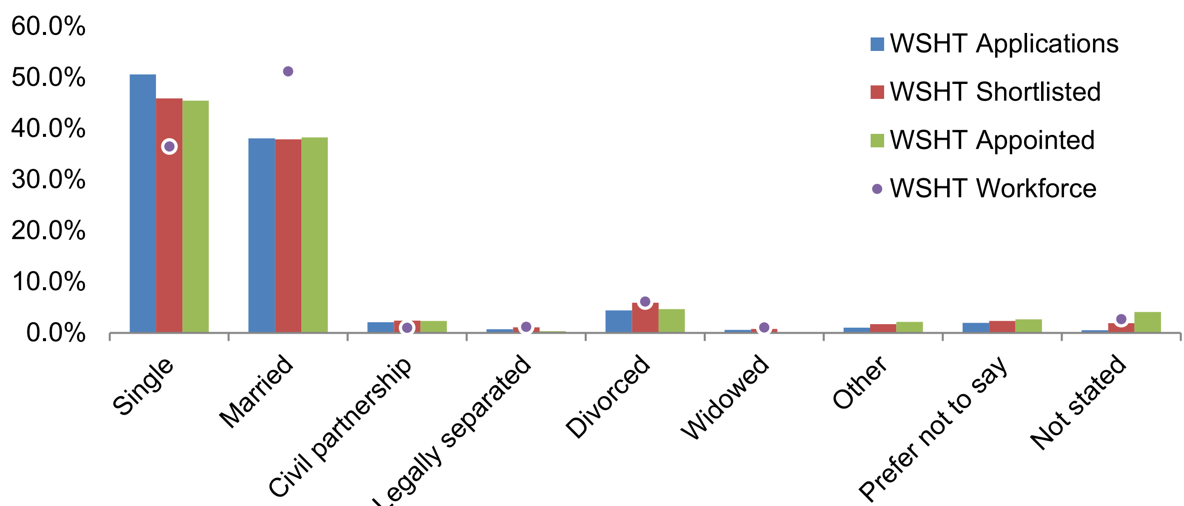


Observations

- There is a great proportion of candidates throughout all stages of recruitment in a civil partnership, particularly at the appointment stage.
- The representation of candidates in a civil partnership is consistent through the three stages of recruitment.
- Married candidates have a lower than expected representation (compared to the overall representation) in all stages of recruitment.
- Throughout the three stages of recruitment, there is a gradual decrease in representation. The representation of married candidates at appointments is about half of that of the workforce representation.

WSHT

Marital Status	Applications	Shortlisted	Appointed	Workforce
Single	50.6%	45.9%	45.4%	36.5%
Married	38.1%	37.9%	38.3%	51.2%
Civil partnership	2.1%	2.4%	2.3%	1.1%
Legally separated	0.7%	1.1%	0.4%	1.2%
Divorced	4.4%	5.9%	4.7%	6.2%
Widowed	0.6%	0.8%	0.0%	1.1%
Other	1.0%	1.7%	2.1%	
Prefer not to say	2.0%	2.3%	2.7%	
Not stated	0.5%	1.9%	4.1%	2.7%
Total	100.0%	100.0%	100.0%	100.0%



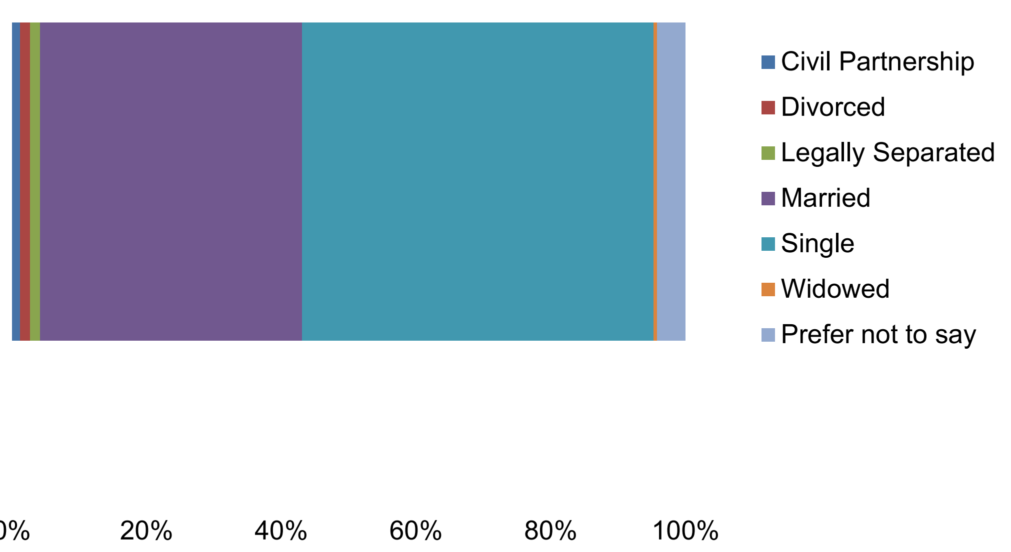
Observations

- Compared to the workforce representation, candidates in a civil partnership are represented about twice as much throughout the recruitment stages. The representation for this group is consistent throughout all stages.
- Married candidates (compared to the overall workforce representation) have a lower than expected representation. Across the three stages of recruitment, representation is broadly consistent.

Uptake of non-mandatory training or continuing professional development

BSUH

Marital Status	No. of staff attending training	% of workforce attending	Workforce Representation
Civil Partnership	4	1.2%	1.9%
Divorced	5	1.5%	4.9%
Legally Separated	5	1.5%	1.1%
Married	130	38.9%	41.8%
Single	174	52.1%	44.8%
Widowed	2	0.6%	0.6%
Prefer not to say	14	4.2%	
Unknown			4.9%
Grand Total	334	100.0%	100.0%

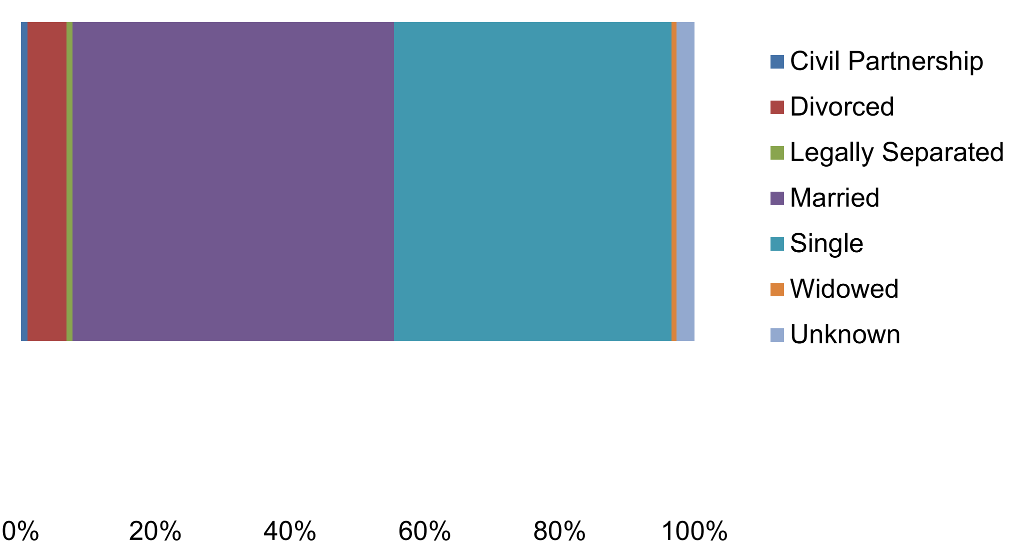


Observations

- Staff that are married or in a civil partnership have lower than expected representation in the uptake of training (compared to the overall workforce).

WSHT

Marital Status	Number of staff attending training	% of workforce attending	Workforce Representation
Civil Partnership	26	0.9%	1.1%
Divorced	160	5.8%	6.2%
Legally Separated	24	0.9%	1.2%
Married	1309	47.8%	51.2%
Single	1129	41.2%	36.5%
Widowed	19	0.7%	1.1%
Unknown	74	2.7%	2.7%
Grand Total	2741	100.0%	100.0%



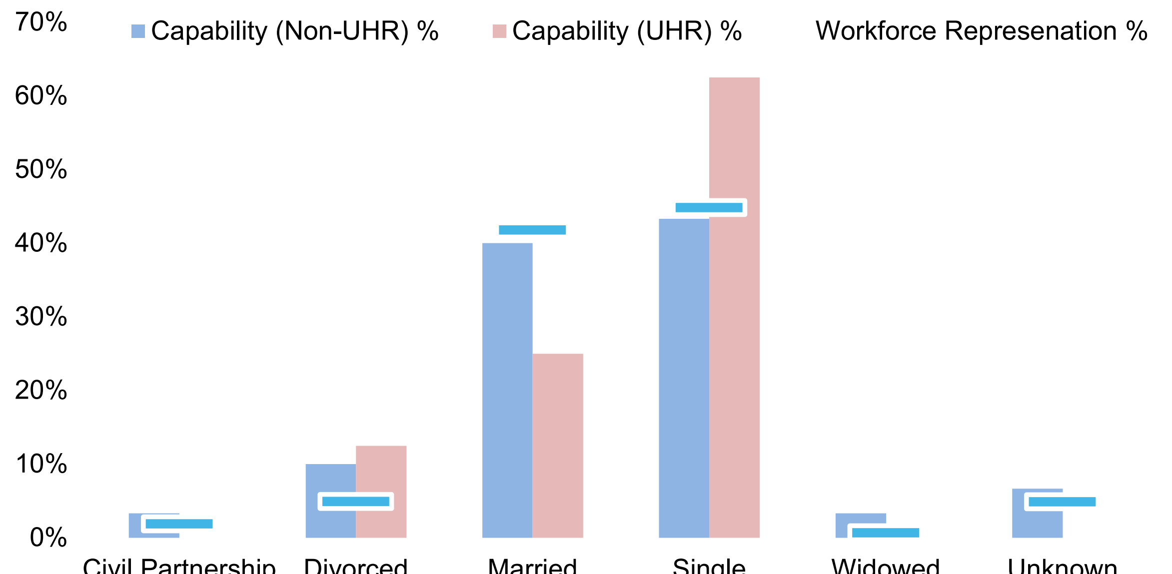
Observations

- Staff that are married or in a civil partnership have a slightly lower than expected representation in the uptake of training (compared to the overall workforce).

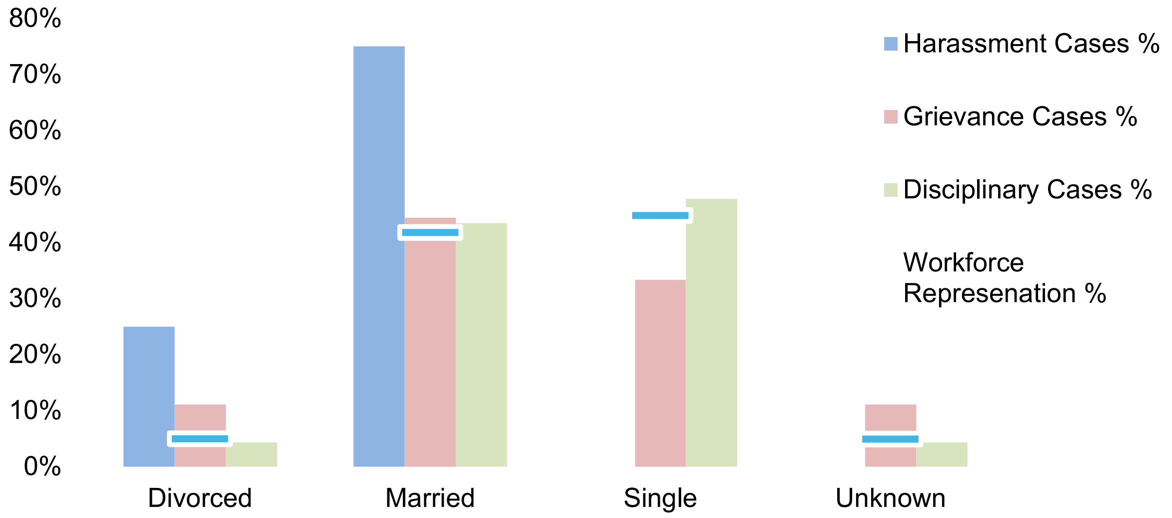
Employee relations processes broken down by marital status

BSUH

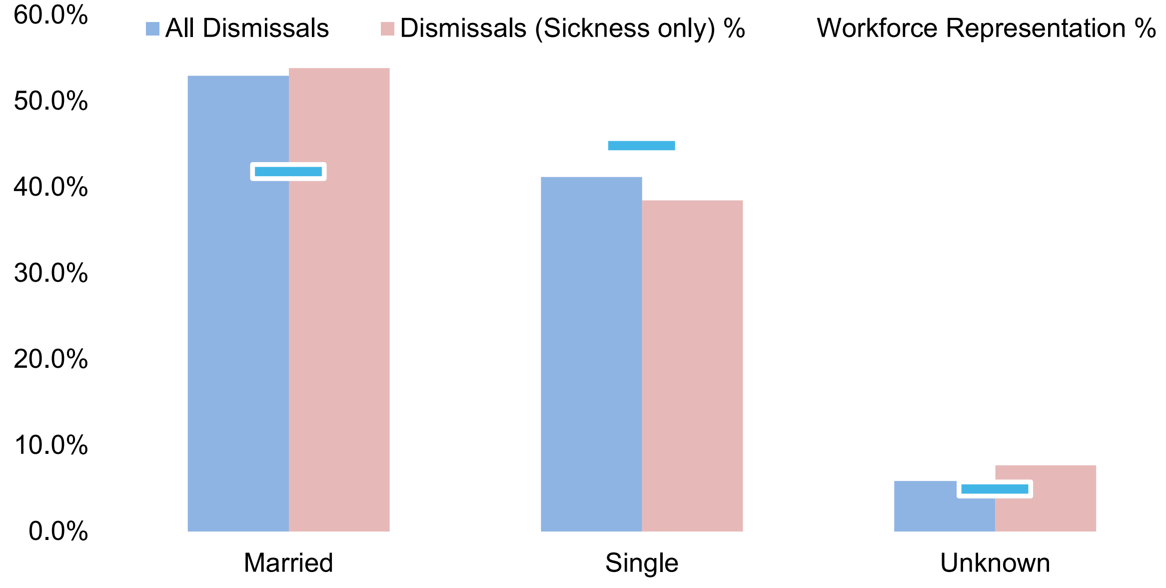
Marital Status	Capability (Non-UHR)	Capability (Non-UHR) %	Capability (UHR)	Capability (UHR) %	Workforce Representation %
Civil Partnership	1	3%	0	0%	1.9%
Divorced	3	10%	1	13%	4.9%
Married	12	40%	2	25%	41.8%
Single	13	43%	5	63%	44.8%
Widowed	1	3%	0	0%	0.6%
Unknown	2	7%	0	0%	4.9%
Total	**30**	**100%**	**8**	**100%**	



Marital Status	Harassment Cases	Harassment Cases %	Grievance Cases	Grievance Cases %	Disciplinary Cases	Disciplinary Cases %	Workforce Representation %
Divorced	1	25.0%	1	11.1%	1	4.3%	4.9%
Married	3	75.0%	4	44.4%	10	43.5%	41.8%
Single	0	0.0%	3	33.3%	11	47.8%	44.8%
Unknown	0	0.0%	1	11.1%	1	4.3%	4.9%
Total	**4**	**100.0%**	**9**	**100.0%**	**23**	**100.0%**	



Marital Status	All Dismissals	All Dismissals %	Dismissals (Sickness only)	Dismissals (Sickness only) %	Workforce Representation %
Married	9	52.9%	7	53.8%	41.8%
Single	7	41.2%	5	38.5%	44.8%
Unknown	1	5.9%	1	7.7%	4.9%
Total	**17**	**100.0%**	**13**	**100.0%**	



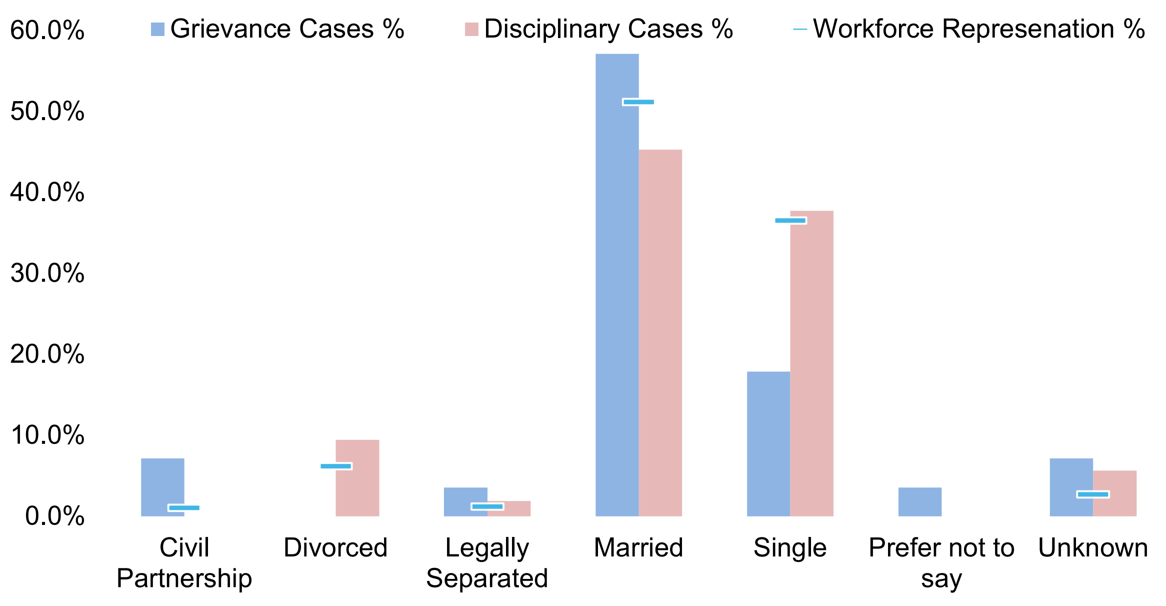
Observations

Compared to the overall workforce representation

- Within capability (non-underlying reasons), staff in a civil partnership have a higher representation, but married staff have broadly proportion representation.
- For capability (underlying health reasons), staff in a civil; partnership are not represented, and married staff have a lower representation
- Staff in a civil partnership have no representation in harassment, grievance or disciplinary processes.
- Married staff have a high representation in harassment cases, and there is a slightly higher (but broadly similar) representation in grievance and disciplinary cases.
- Staff in a civil partnership have no representation in dismissals; married staff have a high representation.

WSHT

Marital Status	Grievance Cases	Grievance Cases %	Disciplinary Cases	Disciplinary Cases %	Workforce Representation %
Civil Partnership	2	7.1%			1.1%
Divorced	1		5	9.4%	6.2%
Legally Separated	1	3.6%	1	1.9%	1.2%
Married	16	57.1%	24	45.3%	51.2%
Single	5	17.9%	20	37.7%	36.5%
Prefer not to say	1	3.6%			
Unknown	2	7.1%	3	5.7%	2.7%
Total	**28**	**96%**	**53**	**100%**	



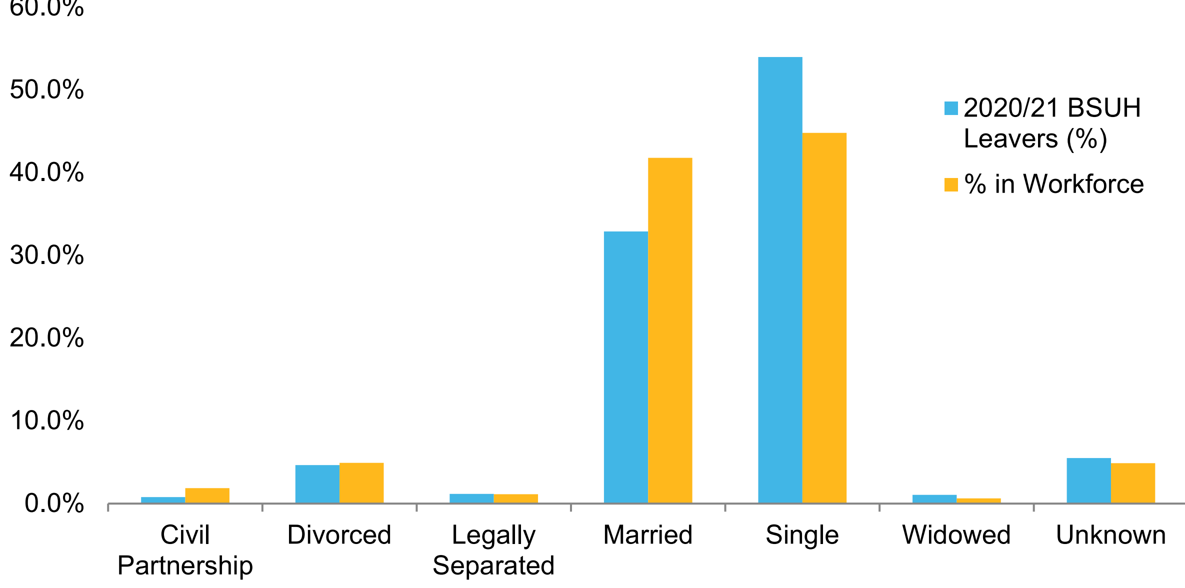
Observations

- Staff in a civil partnership or are married have a higher than expected representation in grievances. Married staff have a lower representation than the overall workforce representation in disciplinary cases, and staff in a civil partnership have no representation.

Leavers broken down by marital status

BSUH

Marital Status	2020/21 BSUH Leavers	2020/21 BSUH Leavers (%)	Number in Workforce	% in Workforce
Civil Partnership	12	0.8%	167	1.9%
Divorced	71	4.6%	437	4.9%
Legally Separated	18	1.2%	99	1.1%
Married	502	32.9%	3706	41.8%
Single	824	54.0%	3975	44.8%
Widowed	16	1.0%	57	0.6%
Unknown	84	5.5%	432	4.9%
Grand Total	**1527**	**100.0%**	**8873**	**100.0%**

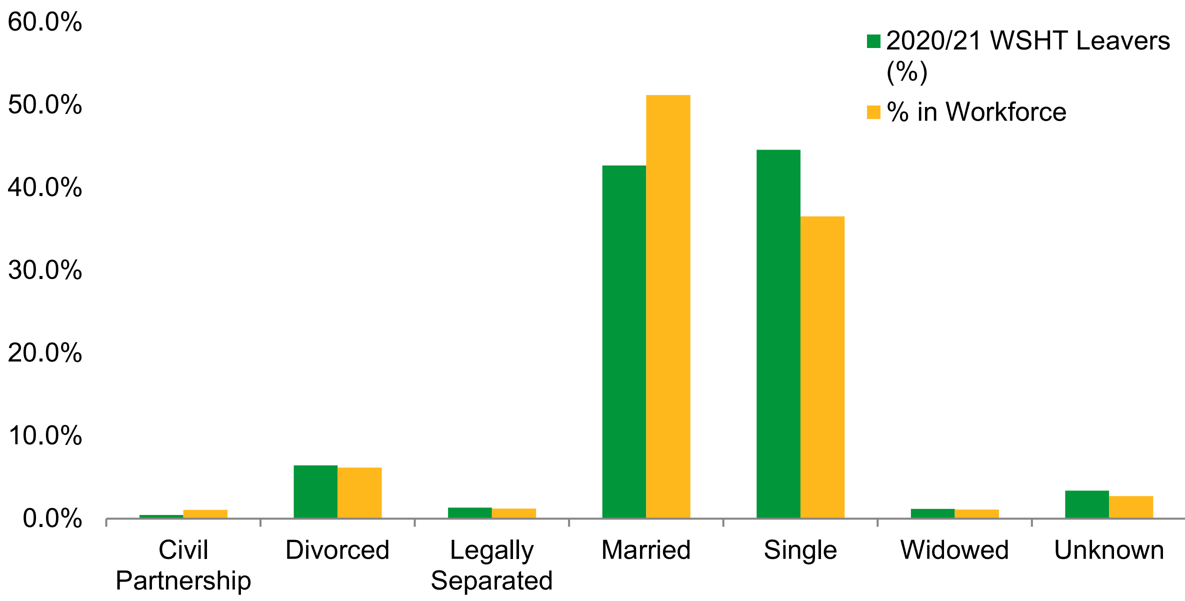


Observations

- Neither staff in a civil partnership or marriage have left the organisation at a higher rate than their representation in the overall workforce.

WSHT

Marital Status	2020/21 WSHT Leavers	2020/21 WSHT Leavers (%)	Number in Workforce	% in Workforce
Civil Partnership	3	0.4%	79	1.1%
Divorced	44	6.5%	465	6.2%
Legally Separated	9	1.3%	92	1.2%
Married	291	42.7%	3850	51.2%
Single	304	44.6%	2747	36.5%
Widowed	8	1.2%	82	1.1%
Unknown	23	3.4%	204	2.7%
Grand Total	**682**	**100.0%**	**7519**	**100.0%**



Observations

- Neither staff in a civil partnership or marriage have left the organisation at a higher rate than their representation in the overall workforce.

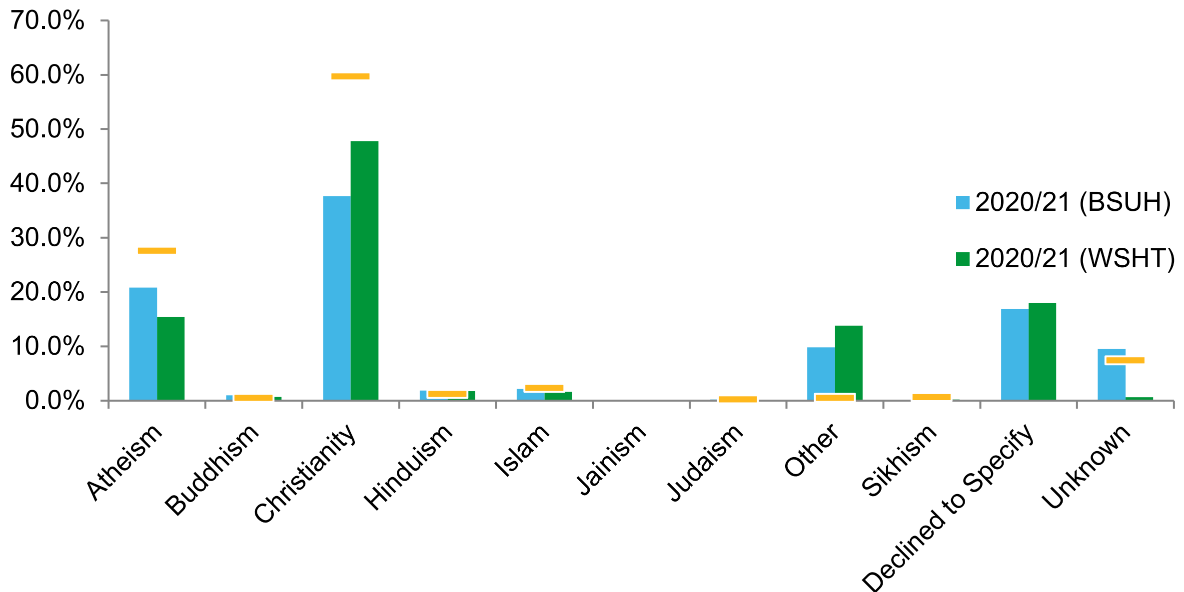
Religion or Belief

Representation of staff within the workforce broken down by religion or belief

	Atheism	Buddhism	Christianity	Hinduism	Islam	Jainism
2019/20 (BSUH)	19.3%	0.8%	37.6%	1.6%	1.9%	0.0%
2020/21 (BSUH)	20.8%	0.9%	37.6%	1.8%	2.2%	0.0%
2019/20 (WSHT)	13.8%	0.7%	48.4%	1.5%	1.6%	0.0%
2020/21 (WSHT)	15.4%	0.7%	47.8%	1.7%	1.6%	0.0%

Census 2011 (SE England)	27.6%	0.5%	59.7%	1.2%	2.3%

	Judaism	Other	Sikhism	Declined to Specify	Unknown
2019/20 (BSUH)	0.2%	9.0%	0.1%	18.0%	11.3%
2020/21 (BSUH)	0.2%	9.8%	0.1%	16.9%	9.5%
2019/20 (WSHT)	0.2%	14.1%	0.2%	18.9%	0.7%
2020/21 (WSHT)	0.2%	13.8%	0.2%	18.0%	0.6%
Census 2011 (SE England)	0.2%	0.5%	0.6%		7.4%



Observations:

BSUH Workforce:

- Compared to the 2011 Census, the Trust has a lower representation of Atheists, Christians and Sikhs, a higher representation of Buddhists, Hindus and others (religion or beliefs) and broadly equal representation for Jewish and Muslim staff.
- Compared to the previous year, most religions or beliefs increased, except for Christians and Jains, which stayed the same. The number of staff where their religion or belief is unknown has decreased.

WSHT Workforce:

- Compared to the 2011 Census, the Trust has a lower representation of Atheists, Christians and Sikhs, a higher representation of Buddhists, Hindus,

Muslims and others (religion or beliefs) and broadly equal representation for Jewish staff.

- Compared to the previous year, the overall representation of Atheists and Hindus increased, Buddhists, Muslims, Jains, Jewish and Sikh staff stayed the same and Christian and other religions or beliefs decreased.

Breakdown of religion or belief by pay banding

The items in bold show there is a great representation of that particular group compared to the representation in the overall workforce

BSUH

Pay Band	Atheism	Buddhism	Christianity	Hinduism	Islam	Jainism	Judaism	Other
Band 1	7.9%	**1.1%**	**56.2%**	**2.2%**	**9.0%**	0.0%	0.0%	9.0%
Band 2	16.5%	**0.9%**	**45.2%**	1.6%	**2.5%**	0.0%	**0.2%**	**13.5%**
Band 3	17.6%	**1.2%**	**42.5%**	1.0%	1.7%	23	0.1%	**12.2%**
Band 4	18.4%	0.6%	39.5%	0.7%	0.6%	0.0%	**0.3%**	**12.4%**
Band 5	**23.1%**	**1.0%**	**41.7%**	1.5%	0.7%	0.0%	0.1%	9.1%
Band 6	**24.0%**	0.7%	37.7%	0.8%	0.9%	0.0%	0.1%	9.1%
Band 7	**23.0%**	**1.3%**	34.9%	0.8%	0.9%	**0.1%**	0.1%	8.7%
Band 8a	**20.9%**	0.8%	32.6%	**2.7%**	1.2%	0.0%	0.0%	7.8%
Band 8b	**23.2%**	**0.9%**	31.3%	**1.8%**	1.8%	0.0%	0.0%	**10.7%**
Band 8c	**32.5%**	0.0%	27.5%	0.0%	0.0%	0.0%	0.0%	**10.0%**
Band 8d	**33.3%**	0.0%	23.8%	0.0%	0.0%	0.0%	0.0%	9.5%
Band 9	6.3%	0.0%	**56.3%**	0.0%	0.0%	0.0%	0.0%	**12.5%**
Directors	18.2%	0.0%	9.1%	0.0%	0.0%	0.0%	0.0%	0.0%
Medical & Dental - Consultant	14.3%	0.6%	26.6%	**7.2%**	**3.5%**	**0.2%**	**0.4%**	4.5%
Medical & Dental - Middle Grade	14.5%	0.0%	20.0%	**1.8%**	1.8%	**1.8%**	0.0%	1.8%
Medical & Dental - Training	**28.0%**	**1.6%**	19.0%	**4.8%**	**9.0%**	0.0%	**0.7%**	5.1%
Local Scale	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**100.0%**

Pay Band	Sikhism	Declined to Specify	Unknown
Band 1	0.0%	14.6%	0.0%
Band 2	0.1%	14.1%	5.4%
Band 3	**0.2%**	11.0%	**12.5%**
Band 4	0.0%	14.2%	**13.2%**
Band 5	0.0%	13.9%	8.9%
Band 6	0.0%	13.2%	**13.4%**
Band 7	0.0%	14.0%	**16.2%**
Band 8a	**0.4%**	15.9%	**17.8%**

Band 8b	0.0%	14.3%	**16.1%**
Band 8c	0.0%	**17.5%**	**12.5%**
Band 8d	0.0%	4.8%	**28.6%**
Band 9	0.0%	6.3%	**18.8%**
Directors	0.0%	**72.7%**	0.0%
Medical & Dental - Consultant	**0.4%**	**41.9%**	0.4%
Medical & Dental - Middle Grade	0.0%	**56.4%**	1.8%
Medical & Dental - Training	**0.7%**	**30.5%**	0.5%
Local Scale	0.0%	0.0%	0.0%

Observations

Compared to the overall representation in the workforce:

- Atheists have a higher than expected representation in bands 5-8d and medical trainees. All other bands/grades have a lower representation than expected.
- Buddhists have a fair to good representation in bands 1-8b and medical consultants and trainees. (In bands/grades 1-3, 5, 7, 8b and medics trainee have a higher than expected represented). All other bands/grades do not have any representation.
- Christians have a higher than expected representation in bands 1-3, 5 and 9, but a lower than expected representation in all other bands/grades.
- Hindus have a fair to higher than expected representation in bands 1-2, 5, 8a-b and all medical grades. There is no representation at (very) senior manager level.
- Muslims have a higher than expected representation in bands 1-2, medical consultants and trainees, a fair representation in bands/grades 3, 8b and medical middle grade. There is a lower than expected representation in bands 4-8a and no representation in (very) senior manager level.
- Jains have a higher than expected representation in band 7 and medical consultants and middle grades. There is no representation in any other grades/bands.
- Judaism has a fair to higher than expected representation in bands 2-7 and medical consultants and trainees. There is no representation in any other grades/bands.
- Other religions or beliefs have a good to higher than expected representation in the vast majority of pay bands, a lower than expected representation in 7, 8a and medical roles, and there is no representation in directors.

- Sikhs have a good to higher than expected representation in 2, n3, 8a and medical consultants and trainees. There is no representation in any other bands/grades.
- Prefer not to say – a high proportion of staff in pay bands have elected not to provide their religion or belief. Proportionally, directors and medical staff have the highest rates of declining to specify their religion or belief.
- Most unknowns (no information in the religion or belief field on Electronic Staff Records) are in pay bands 3-9.

WSHT

Pay Band	Atheism	Buddhism	Christianity	Hinduism	Islam	Jainism	Judaism	Other
Band 1	12.2%	4.9%	34.1%	4.9%	0.0%	0.0%	0.0%	9.8%
Band 2	11.6%	0.8%	48.7%	1.3%	0.6%	0.0%	0.2%	17.1%
Band 3	16.6%	0.3%	49.3%	1.3%	1.0%	0.0%	0.1%	12.6%
Band 4	18.8%	0.2%	48.0%	0.8%	0.4%	0.0%	0.0%	11.0%
Band 5	12.6%	0.5%	51.5%	0.6%	0.5%	0.0%	0.1%	19.5%
Band 6	16.8%	0.2%	51.6%	0.7%	0.6%	0.0%	0.1%	11.3%
Band 7	16.3%	0.3%	48.1%	0.7%	0.7%	0.0%	0.1%	11.3%
Band 8a	13.1%	0.0%	56.0%	1.8%	0.0%	0.6%	0.0%	7.1%
Band 8b	9.9%	0.0%	57.7%	0.0%	0.0%	0.0%	1.4%	4.2%
Band 8c	30.0%	0.0%	43.3%	0.0%	0.0%	0.0%	0.0%	6.7%
Band 8d	0.0%	0.0%	50.0%	0.0%	0.0%	0.0%	0.0%	25.0%
Band 9	28.6%	0.0%	42.9%	0.0%	0.0%	0.0%	0.0%	28.6%
Directors	4.8%	4.8%	47.6%	0.0%	0.0%	0.0%	0.0%	19.0%
Medical & Dental - Consultant	15.5%	0.8%	43.1%	7.0%	5.4%	0.0%	0.6%	6.5%
Medical & Dental - Middle Grade	25.6%	3.5%	26.3%	8.2%	12.6%	0.2%	0.2%	9.6%
Medical & Dental - Training	39.0%	0.8%	23.7%	5.1%	7.6%	0.0%	0.8%	4.2%

Pay Band	Sikhism	Declined to Specify	Unknown
Band 1	0.0%	31.7%	2.4%
Band 2	0.3%	18.3%	1.1%
Band 3	0.1%	18.3%	0.4%
Band 4	0.2%	19.6%	1.0%
Band 5	0.1%	14.1%	0.5%
Band 6	0.1%	18.4%	0.3%
Band 7	0.1%	21.8%	0.4%
Band 8a	0.0%	21.4%	0.0%
Band 8b	0.0%	25.4%	1.4%
Band 8c	0.0%	20.0%	0.0%
Band 8d	12.5%	12.5%	0.0%

Band 9	0.0%	0.0%	0.0%
Directors	0.0%	**23.8%**	0.0%
Medical & Dental - Consultant	**0.3%**	**20.0%**	**0.8%**
Medical & Dental - Middle Grade	**0.2%**	13.5%	0.0%
Medical & Dental - Training	**0.8%**	17.8%	0.0%

Observations

Compared to the overall representation in the workforce:

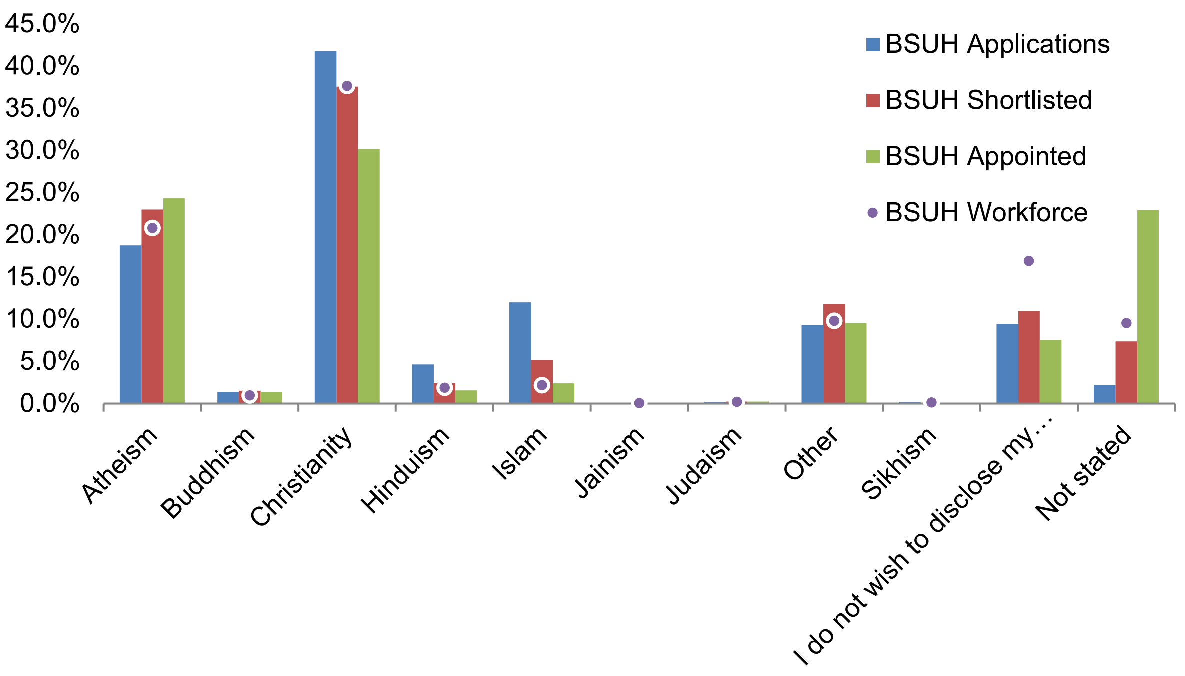
- Atheists have a higher than expected representation in bands 3-4, 6-7, 8c, 9 and all medical roles; there is a lower than expected representation in 1-2, 5, 8a-b and directors and no representation in 8d.
- Buddhists have a higher than expected representation in 1-2, directors and all medical roles). There is a fair representation 3-7 and no representation in any other bands.
- Christians have a higher than expected representation in most bands. In 1 and all medical roles, there is a lower than expected representation.
- Hindus have a higher than expected representation in 1, 8a and all medical roles, a low to fair representation in 2-7, and no representation in 8b-9 and directors.
- Muslims have a higher than expected representation in all medical roles; in 2-7, there is a low to fair representation, and there is no representation in 1, 8a-9 and directors.
- Jains have a higher than expected representation in band 8a and medical middle grades. There is no representation in any other grades/bands.
- Judaism there is higher than expected representation in band 8b and all medical roles, a fair to good representation in bands 2-7. There is no representation in any other grades/bands.
- Other religions or beliefs have higher than expected representation in 2, 5, 8d, 9 and directors; in all other bands/grades, there is a lower than expected representation (ranging from low to fair representation).
- Sikhs have a higher than expected representation in 2, 4, 8d and all medical grades. There is a lower than expected representation in 3, 5 and 7 and no representation in other bands/grades.
- Prefer not to say – the rate of staff declining to state their religion or belief is prevalent across all bands/grades. An exceptionally high proportion of staff in 1, 7-8c, directors and medical consultants, elect not to provide this information.

Breakdown of religion or belief in recruitment processes

The data compares the three stages of recruitment compared to the workforce representation within the organisation.

BSUH

Religion or Belief	Applications	Shortlisted	Appointed	Workforce
Atheism	18.8%	23.0%	24.3%	20.8%
Buddhism	1.4%	1.5%	1.3%	0.9%
Christianity	41.8%	37.5%	30.2%	37.6%
Hinduism	4.6%	2.4%	1.6%	1.8%
Islam	12.0%	5.1%	2.4%	2.2%
Jainism	0.0%	0.0%	0.0%	0.0%
Judaism	0.2%	0.2%	0.3%	0.2%
Other	9.3%	11.7%	9.5%	9.8%
Sikhism	0.2%	0.1%	0.0%	0.1%
I do not wish to disclose my religion/belief	9.4%	11.0%	7.5%	16.9%
Not stated	2.2%	7.4%	22.9%	9.5%
Total	100.0%	100.0%	100.0%	100.0%



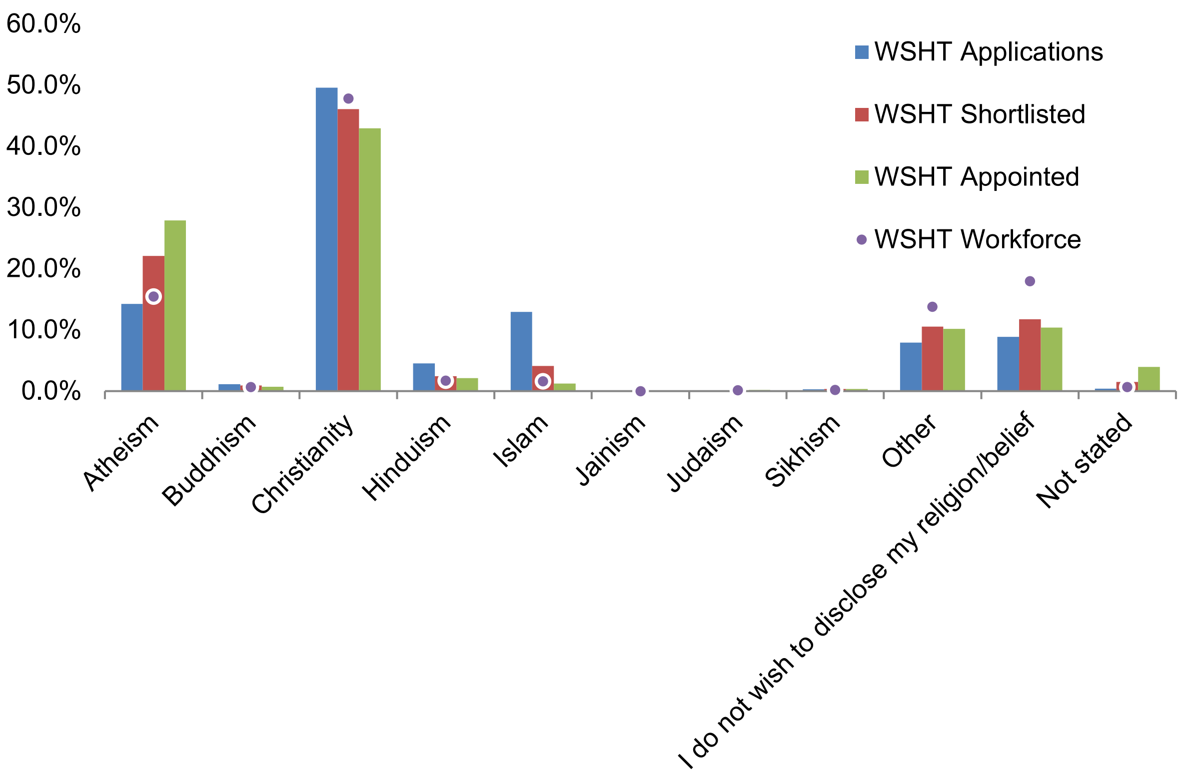
Observations

- When comparing against workforce representation, there is generally a good representation for all-known religions or belief groups.

- From the application to the shortlisting stage, the representation of Jains and Jewish candidates stayed broadly the same, whilst all other groups decreased.
- From the shortlisting to the appointment stage, representation of Atheists, Jewish and not stated. All other groups saw a decrease in representation.
- As an overview of the process, Christian, Hindu, Muslim and Sikh candidates appear to experience a possible disadvantage within the recruitment processes. In contrast, Atheist candidates appear to benefit from the processes.
- Compared to the workforce representation, fewer candidates who did not want to declare their religion or belief were appointed. A much more significant percentage where their religion or belief was 'not stated' was also appointed.

WSHT

Religion or Belief	**Applications**	**Shortlisted**	**Appointed**	**Workforce**
Atheism	14.3%	22.1%	27.9%	15.4%
Buddhism	1.1%	0.9%	0.7%	0.7%
Christianity	49.6%	46.1%	42.9%	47.8%
Hinduism	4.5%	2.4%	2.1%	1.7%
Islam	12.9%	4.1%	1.3%	1.6%
Jainism	0.1%	0.0%	0.0%	0.0%
Judaism	0.1%	0.1%	0.2%	0.2%
Sikhism	0.3%	0.4%	0.4%	0.2%
Other	7.9%	10.6%	10.2%	13.8%
I do not wish to disclose my religion/belief	8.8%	11.8%	10.4%	18.0%
Not stated	0.4%	1.5%	3.9%	0.6%
Total	100.0%	100.0%	100.0%	100.0%



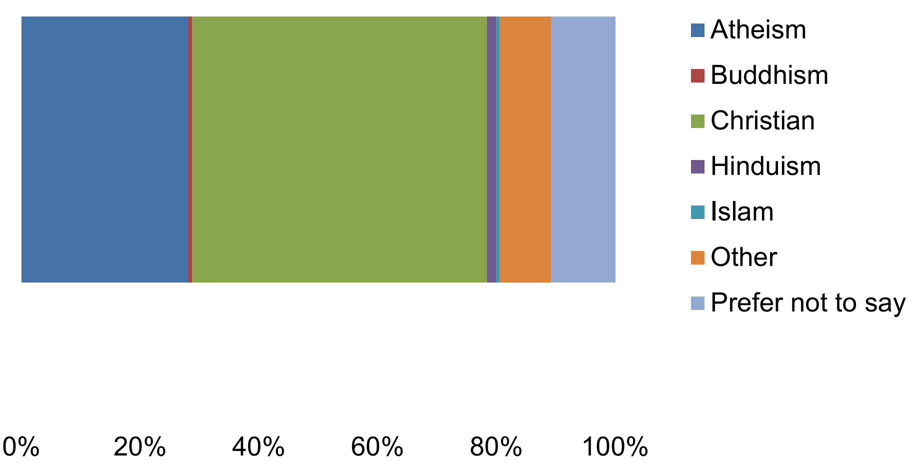
Observations

- Compared to the workforce representation, there is a good to higher than an expected representation of Atheist, Buddhist, Christian, Hindu, Muslim and Sikh candidates in the recruitment processes.
- From the application to the shortlisting stage, there was an increase in representation of Atheist, Sikh, other (religion or belief) and those who declined to declare/not stated. Jain and Jewish candidates remained broadly the same, and all other groups decreased.
- From shortlisting to the appointment stage, there were increases in representation in Atheist, Jewish, and candidates whose religion or belief was not stated. Decreases were seen in most other groups except for Sikhs which remained broadly the same.
- As an overview of the process, In contrast, Atheist, Jewish, Sikhs, other (religion or belief) and unknown status candidates appear to benefit from the processes.
- Compared to the current workforce, a small proportion of ‘prefer not to say was appointed, but a larger proportion of ‘not stated’ was appointed.

Uptake of non-mandatory training or continuing professional development

BSUH

Religion or Belief	Number of staff attending training	% of staff attending training	Workforce Representation
Atheism	94	28.1%	20.8%
Buddhism	2	0.6%	0.9%
Christian	166	49.7%	37.6%
Hinduism	5	1.5%	1.8%
Islam	2	0.6%	2.2%
Jainism			0.0%
Judaism			0.2%
Other	29	8.7%	9.8%
Sikhism			0.1%
Prefer not to say	36	10.8%	16.9%
Unknown			9.5%
Grand Total	334	100.0%	100.0%

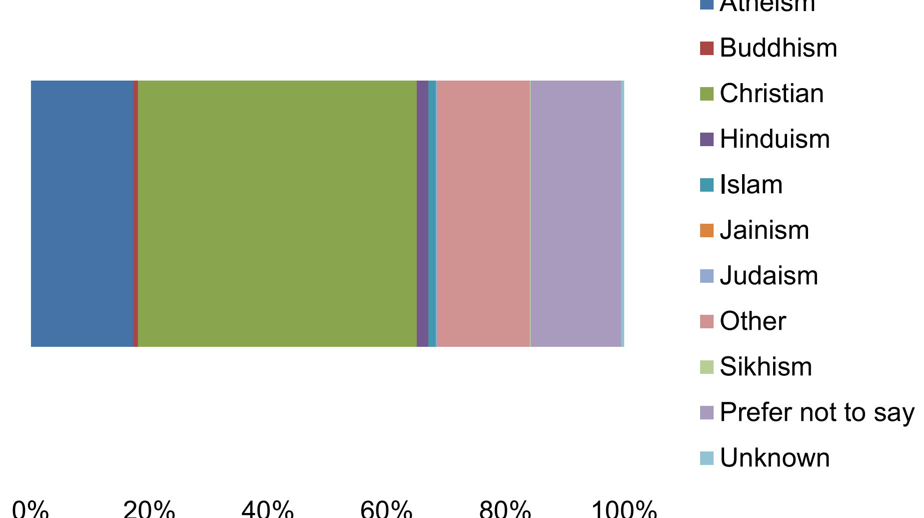


Observations

- More Atheist and Christian staff are undertaking non-mandatory/CPD training compared to the overall workforce representation.
- Compared to the overall workforce representation, there is a lower than expected representation for Buddhist, Hindu, Muslim, other (religion or belief) and those that prefer not to say.
- There were no Jain or Jewish staff that undertook non-mandatory/CPD training.

WSHT

Religion or Belief	Number of staff attending training	% of staff attending training	Workforce Representation
Atheism	474	17.3%	15.4%
Buddhism	20	0.7%	0.7%
Christian	1290	47.1%	47.8%
Hinduism	53	1.9%	1.7%
Islam	33	1.2%	1.6%
Jainism	1	0.0%	0.0%
Judaism	5	0.2%	0.2%
Other	429	15.7%	13.8%
Sikhism	4	0.1%	0.2%
Prefer not to say	419	15.3%	18.0%
Unknown	13	0.5%	0.6%
Grand Total	2741	100.0%	100.0%



Observations

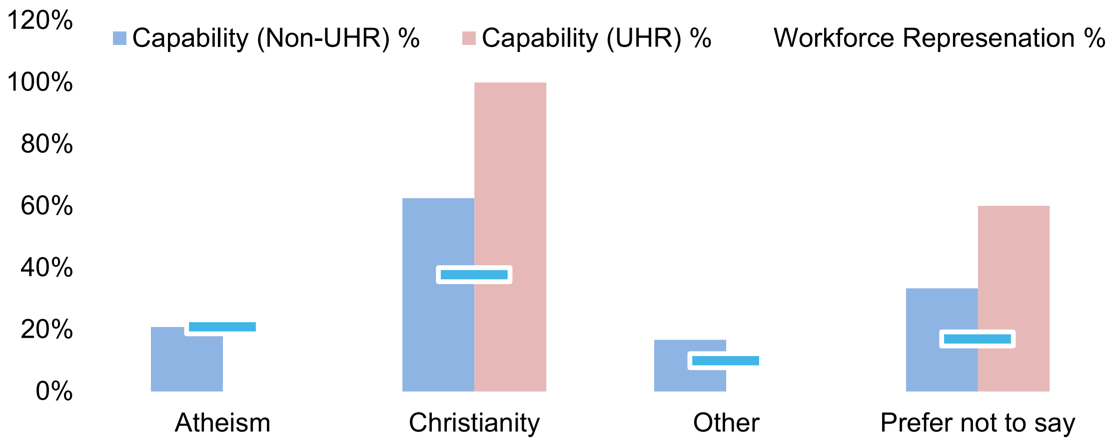
Compared to the overall workforce representation:

- A higher proportion of staff that are Atheist, Hindu, and other (religion or belief).
- Broadly similar representation in staff that are Buddhist, Christian, Jain and Jewish.
- In all other groups, there is a lower proportion of representation.

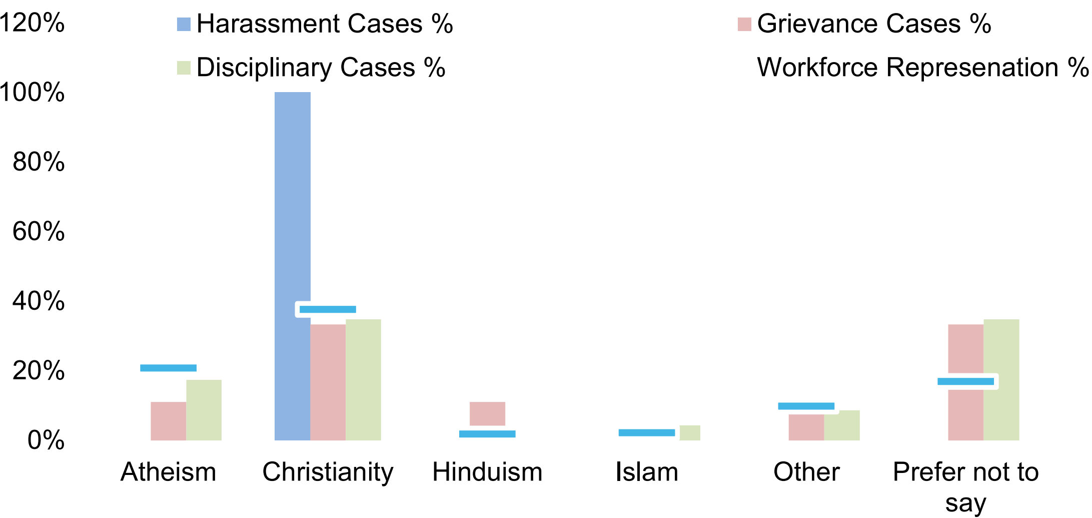
Employee relations processes broken down by religion or belief

BSUH

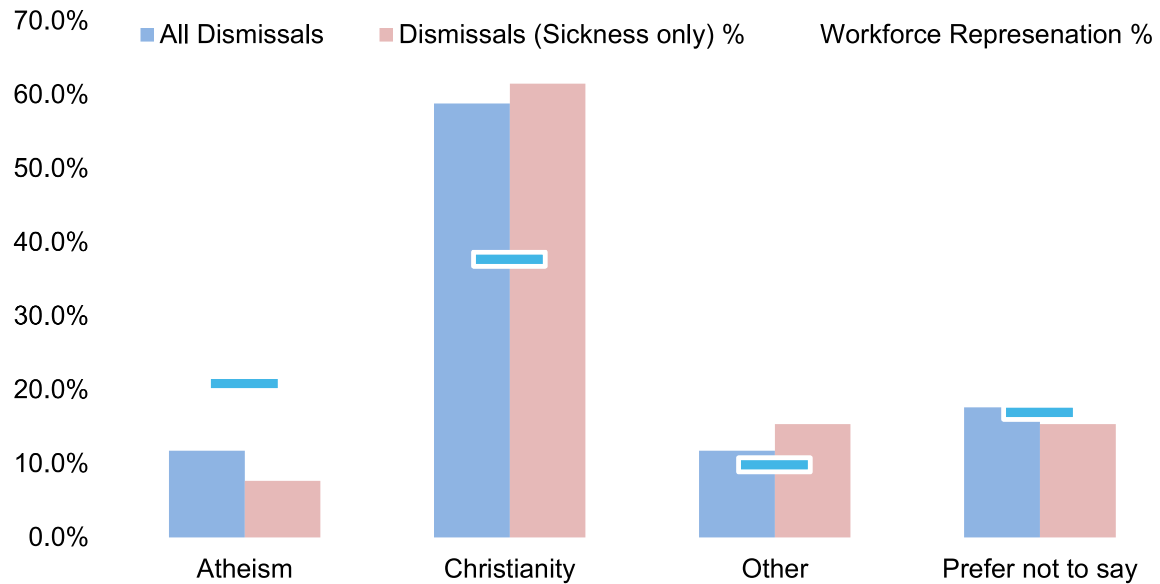
Religion or Belief	Capability (Non-UHR)	Capability (Non-UHR) %	Capability (UHR)	Capability (UHR) %	Workforce Representation %
Atheism	5	21%	0	0%	20.8%
Christianity	15	63%	5	100%	37.6%
Other	4	17%	0	0%	9.8%
Prefer not to say	8	33%	3	60%	16.9%
Total	**24**	**100%**	**5**	**100%**	



Religion or Belief	Harassment Cases	Harassment Cases %	Grievance Cases	Grievance Cases %	Disciplinary Cases	Disciplinary Cases %	Workforce Representation %
Atheism	0	0.0%	1	11.1%	4	17.4%	20.8%
Christianity	4	100.0%	3	33.3%	8	34.8%	37.6%
Hinduism	0	0.0%	1	11.1%	0	0.0%	1.8%
Islam	0	0.0%	0	0.0%	1	4.3%	2.2%
Other	0	0.0%	1	11.1%	2	8.7%	9.8%
Prefer not to say	0	0.0%	3	33.3%	8	34.8%	16.9%
Total	4	100.0%	9	100.0%	23	100.0%	



Religion or Belief	All Dismissals	All Dismissals %	Dismissals (Sickness only)	Dismissals (Sickness only) %	Workforce Representation %
Atheism	2	11.8%	1	7.7%	20.8%
Christianity	10	58.8%	8	61.5%	37.6%
Other	2	11.8%	2	15.4%	9.8%
Prefer not to say	3	17.6%	2	15.4%	16.9%
Total	**17**	**100.0%**	**13**	**100.0%**	



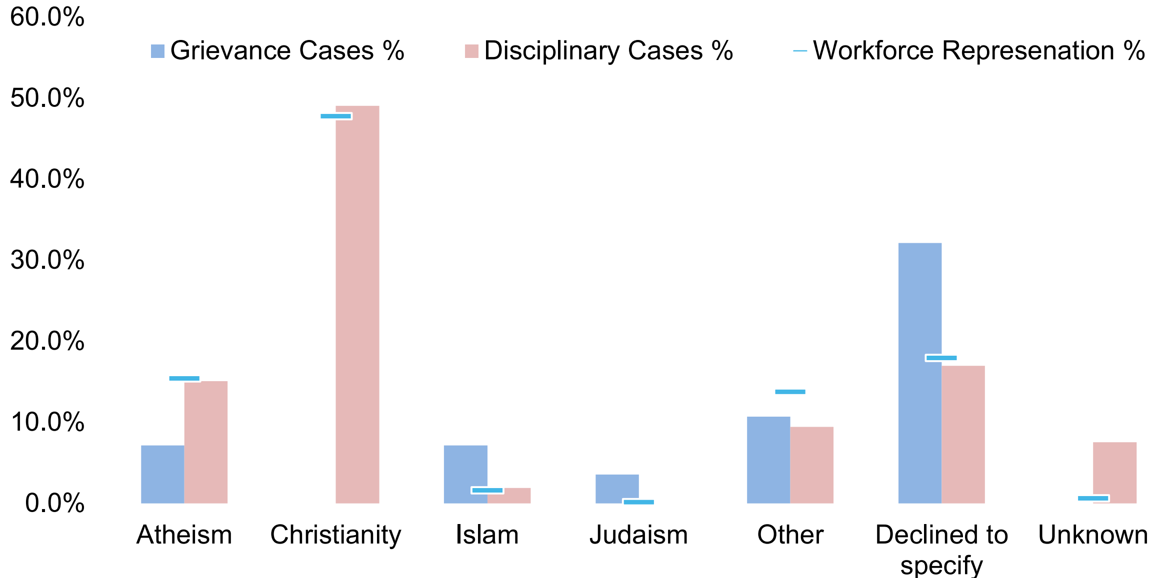
Observations

Compared to the overall workforce representation:

- There is a higher representation of Christian, other (religion or belief), and staff prefer not to say in capability (non-underlying health reasons). Atheists have a broadly equal representation in these cases.
- Christian staff are overrepresented in capability (underlying health reasons) and harassment cases.
- Hindu, other (religion or belief) and staff that prefer not to say are overrepresented in grievance procedures.
- Muslim, other (religion or belief) and staff that prefer not to say are overrepresented in disciplinary cases.
- In dismissals, Christian staff, other (religion or belief) and those that prefer not to say are overrepresented. In dismissals (sickness only), Christian and other (religion or belief) are overrepresented.

WSHT

Religion or Belief	Grievance Cases	Grievance Cases %	Disciplinary Cases	Disciplinary Cases %	Workforce Representation %
Atheism	2	7.1%	8	15.1%	15.4%
Christianity	11		26	49.1%	47.8%
Islam	2	7.1%	1	1.9%	1.6%
Judaism	1	3.6%		0.0%	0.2%
Other	3	10.7%	5	9.4%	13.8%
Declined to specify	9	32.1%	9	17.0%	18.0%
Unknown		0.0%	4	7.5%	0.6%
Total	28	61%	53	100%	



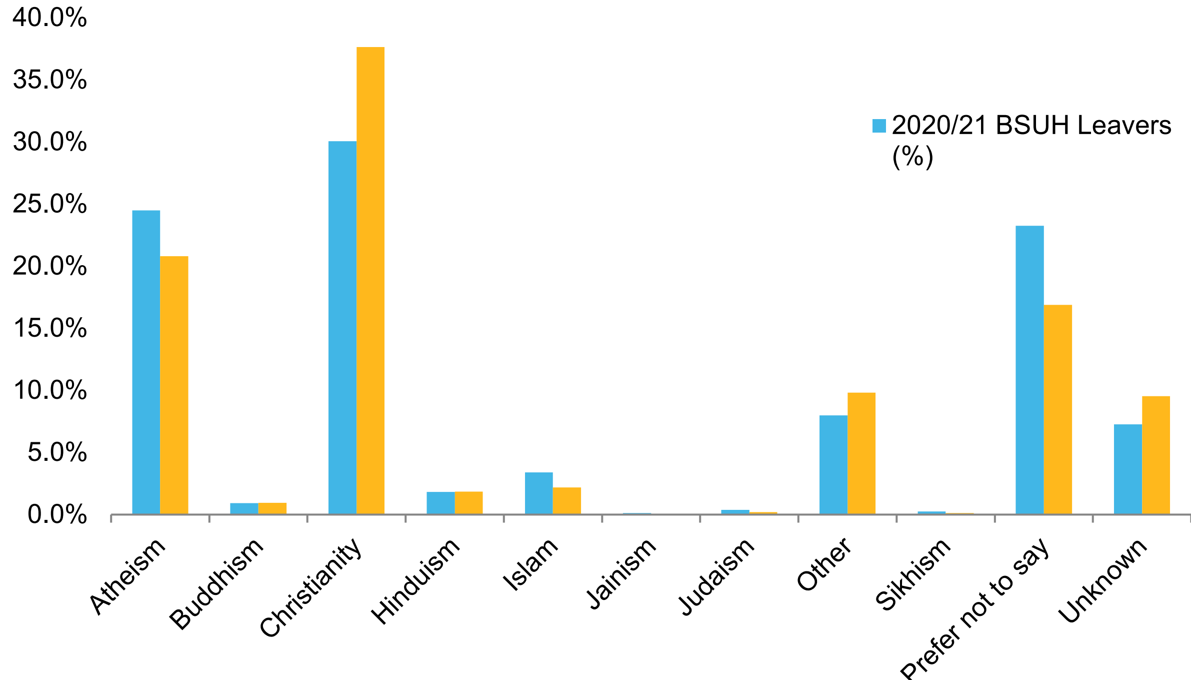
Observations

- In grievance cases, Muslim, Jewish and staff who declined to specify are overrepresented compared to the workforce representation.
- In disciplinary cases, Christians, Muslims and staff where their religion or belief is unknown are overrepresented.

Leavers broken down by religion or belief

BSUH

Religion or Belief	2020/21 BSUH Leavers	2020/21 BSUH Leavers (%)	Number in Workforce	% in Workforce
Atheism	374	24.5%	1846	20.8%
Buddhism	14	0.9%	84	0.9%
Christianity	459	30.1%	3340	37.6%
Hinduism	28	1.8%	164	1.8%
Islam	52	3.4%	193	2.2%
Jainism	2	0.1%	3	0.0%
Judaism	6	0.4%	18	0.2%
Other	122	8.0%	870	9.8%
Sikhism	4	0.3%	11	0.1%
Prefer not to say	355	23.2%	1499	16.9%
Unknown	111	7.3%	845	9.5%
Grand Total	**1527**	**100.0%**	**8873**	**100.0%**



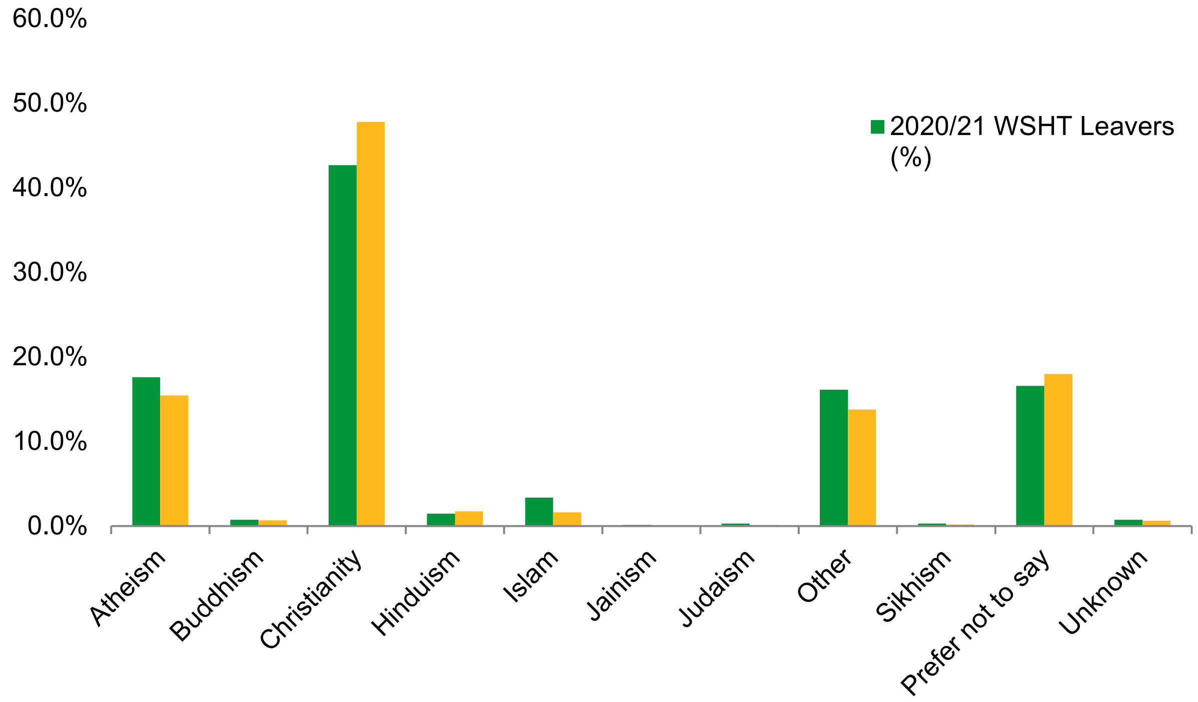
Observations

Compared to the overall workforce representation

- A higher proportion of Atheists, Muslims, Jains, Jewish, Sikhs, and staff who declined to specify their religion or belief have left the organisation.
- A broadly similar proportion of staff that are Buddhist and Hindus have left the organisation.
- A lower proportion of Christian, other (religions or beliefs) or where staff's religion or belief is unknown has left the organisation.

WSHT

Religion or Belief	2020/21 WSHT Leavers	2020/21 WSHT Leavers (%)	Number in Workforce	% in Workforce
Atheism	120	17.6%	1160	15.4%
Buddhism	5	0.7%	51	0.7%
Christianity	291	42.7%	3594	47.8%
Hinduism	10	1.5%	130	1.7%
Islam	23	3.4%	122	1.6%
Jainism	1	0.1%		0.0%
Judaism	2	0.3%	12	0.2%
Other	110	16.1%	1037	13.8%
Sikhism	2	0.3%	14	0.2%
Prefer not to say	113	16.6%	1351	18.0%
Unknown	5	0.7%	48	0.6%
Grand Total	**682**	**100.0%**	**7519**	**100.0%**



Observations

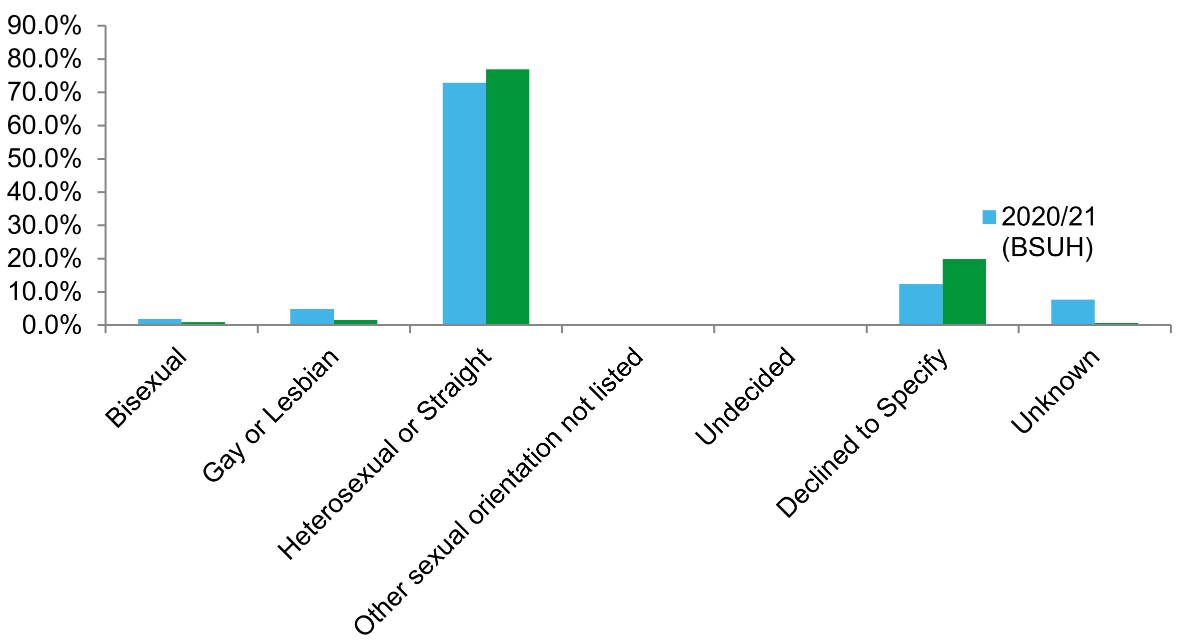
Compared to the overall workforce representation:

- A higher proportion of Atheist, Muslim, Jain, Jewish, other (religions or beliefs), Sikhs and those whose religion or belief is unknown left the organisation.
- A broadly similar proportion of Buddhist staff left the organisation.
- A lower proportion of Christians, Hindus and staff that 'prefer not to say' left the organisation.

Sexual Orientation

Representation of staff within the workforce broken down by sexual orientation

	Bisexual	Gay or Lesbian	Heterosexual or Straight	Other S/O not listed	Undecided	Declined to Specify	Unknown
2019/20 (BSUH)	1.3%	4.2%	69.1%	0.0%	0.0%	14.0%	11.4%
2020/21 (BSUH)	1.9%	5.0%	72.8%	0.2%	0.1%	12.3%	7.7%
2019/20 (WSHT)	0.9%	1.5%	75.3%	0.0%	0.0%	21.5%	0.8%
2020/21 (WSHT)	0.9%	1.6%	76.9%	0.0%	0.0%	19.9%	0.7%



Observations:

- BSUH workforce: There has been an increase in all declared sexual orientations compared to the previous year. There has also been a decrease in staff that have declined in specifying and unknown statuses.
- WSHT workforce: compared to the previous year, there has been an increase in gay or lesbian, heterosexual, declined to specify and unknown statuses. There is the same proportion of bisexuals, other sexual orientations and undecided statuses.

Breakdown of sexual orientation belief by pay banding

The items in bold show a greater representation of that particular group compared to the representation in the overall workforce

BSUH

Pay Band	Bisexual	Gay or Lesbian	Heterosexual or Straight	Other S/O not listed	Undecided	Declined to Specify	Unknown
Band 1	1.1%	0.0%	**80.9%**	0.0%	0.0%	**18.0%**	0.0%
Band 2	**2.3%**	4.8%	**77.2%**	**0.2%**	**0.2%**	10.0%	5.2%
Band 3	1.8%	**5.8%**	**74.5%**	**0.2%**	**0.1%**	7.3%	**10.3%**
Band 4	**1.9%**	4.0%	72.2%	**0.4%**	**0.1%**	10.2%	**11.1%**
Band 5	**2.6%**	4.4%	**74.9%**	0.1%	**0.1%**	10.5%	7.4%
Band 6	**2.2%**	**5.8%**	71.6%	**0.3%**	**0.1%**	9.4%	**10.6%**
Band 7	0.8%	**5.5%**	**73.5%**	**0.2%**	0.0%	8.8%	**11.2%**
Band 8a	1.6%	**6.2%**	70.9%	0.0%	0.0%	6.6%	**14.7%**
Band 8b	0.9%	**6.3%**	67.9%	0.0%	0.0%	**14.3%**	**10.7%**

Band 8c	0.0%	10.0%	70.0%	0.0%	0.0%	12.5%	7.5%
Band 8d	0.0%	4.8%	71.4%	0.0%	0.0%	0.0%	23.8%
Band 9	0.0%	18.8%	68.8%	0.0%	0.0%	6.3%	6.3%
Directors	0.0%	0.0%	45.5%	0.0%	0.0%	54.5%	0.0%
Medical & Dental - Consultant	0.6%	3.9%	60.9%	0.0%	0.0%	33.9%	0.6%
Medical & Dental - Middle Grade	1.8%	**5.5%**	41.8%	0.0%	0.0%	49.1%	1.8%
Medical & Dental - Training	1.7%	3.9%	70.9%	0.4%	0.0%	22.5%	0.5%
Local Scale	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%

Observations

Compared to the overall workforce representation:

- Bisexual staff have a higher than expected representation in bands 2 and 4-6. There is a low to fair representation in band/grades 1, 3, 7-8b and medical roles, and there is no representation in 8c-9 and directors.
- Gay or lesbian staff have a higher than expected representation in bands/grades 3, 6-8c, 9 and medical middle grades. There is a low to fair representation in bands/grades 2, 4-5, 8d and medical consultants and trainees; there is no representation in band 1 or director-level.
- Heterosexual staff have a higher than expected representation in bands 1-3, 5, 7. There is a fair to good representation in bands/grades 4, 6, 8a-9 and medical trainees; there is a low representation in directors, medical consultants, and middle grades.
- Staff with other sexual orientations have a higher than expected representation in bands/grades 2-4, 6-7 and medical trainees. There is a good level of representation in band 5; there is no representation in all other bands/grades.
- Staff that are undecided have a higher than expected representation in bands 2-6; there is no other bands/grades that have representation for this group.
- Staff that have declined to specify their sexual orientation are highly prevalent in most bands/grades, except in 8d. This status is particularly high in directors and medical roles.
- Unknown status is evident throughout the pay bands but is exceptionally high in bands 2-8d.

WSHT

Pay Band	Bisexual	Gay or Lesbian	Heterosexual or Straight	Other S/O not listed	Undecided	Declined to Specify	Unknown
Band 1	0.0%	0.0%	56.1%	0.0%	0.0%	**41.5%**	**2.4%**
Band 2	0.8%	1.5%	75.7%	0.0%	**0.1%**	**20.6%**	**1.3%**
Band 3	**1.0%**	1.3%	**83.8%**	**0.0%**	**0.1%**	13.4%	0.4%
Band 4	0.6%	1.4%	**80.4%**	0.0%	0.0%	16.5%	**1.0%**
Band 5	**1.0%**	1.0%	71.0%	**0.1%**	0.0%	**26.4%**	0.6%
Band 6	**1.1%**	**2.1%**	**78.4%**	**0.1%**	0.0%	18.0%	0.3%
Band 7	0.7%	**2.4%**	74.8%	0.0%	0.0%	**21.6%**	0.4%
Band 8a	0.6%	1.2%	**82.1%**	0.0%	0.0%	16.1%	0.0%
Band 8b	0.0%	**2.8%**	**81.7%**	0.0%	0.0%	14.1%	**1.4%**
Band 8c	0.0%	0.0%	**83.3%**	0.0%	0.0%	16.7%	0.0%
Band 8d	0.0%	0.0%	**87.5%**	0.0%	0.0%	12.5%	0.0%
Band 9	0.0%	0.0%	**85.7%**	0.0%	0.0%	14.3%	0.0%
Directors	0.0%	**4.8%**	61.9%	0.0%	0.0%	**33.3%**	0.0%
Medical & Dental - Consultant	0.3%	0.8%	**79.2%**	0.0%	0.0%	18.9%	**0.8%**
Medical & Dental - Middle Grade	**0.9%**	**3.0%**	**80.2%**	0.0%	0.0%	15.9%	0.0%
Medical & Dental - Training	**3.4%**	**3.4%**	**79.7%**	0.0%	0.0%	13.6%	0.0%

Observations

Compared to the overall workforce representation:

- Bisexual staff have a higher than expected representation in bands/grades 3, 4-6 and medical middle grade and trainees. There is a low to fair representation in band/grades 2, 4, 7-8a and medical consultants, and there is no representation in all other bands.
- Gay or lesbian staff have a higher than expected representation in bands/grades 6-7, 8b, directors and medical middle grades and trainees. There is a low to fair representation in bands/grades 2-5, 8a and medical consultants; there is no representation in other bands.
- Heterosexual staff have a higher than expected representation in bands/grades 3-4, 6, 8a-9 and all medical roles. There is a low to fair representation in bands 1-2, 5, 7 and directors.
- Staff with other sexual orientations have a higher than expected representation in bands/grades 5-6; there is no representation in all other bands/grades.

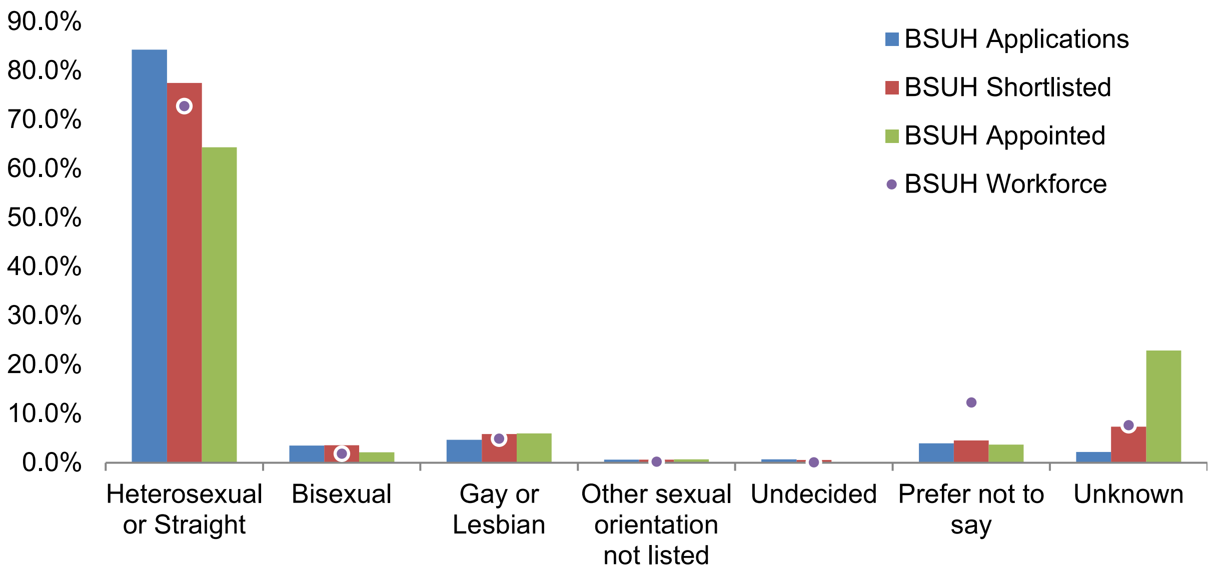
- Staff that are undecided have a higher than expected representation in bands 2-3; there is no other bands/grades that have representation for this group.
- Staff that have declined to specify their sexual orientation are highly prevalent in most bands/grades, particularly in 1-2, 5, 7 and directors.

Breakdown of sexual orientation in recruitment processes

The data compares the three stages of recruitment compared to the workforce representation within the organisation.

BSUH

Sexual Orientation	Applications	Shortlisted	Appointed	Workforce
Heterosexual or Straight	84.3%	77.5%	64.4%	72.8%
Bisexual	3.5%	3.6%	2.1%	1.9%
Gay or Lesbian	4.7%	5.9%	6.0%	5.0%
Other sexual orientation not listed	0.6%	0.6%	0.7%	0.2%
Undecided	0.7%	0.6%	0.1%	0.1%
Prefer not to say	4.0%	4.5%	3.7%	12.3%
Unknown	2.2%	7.4%	22.9%	7.7%
Grand Total	100%	100%	100%	100.0%



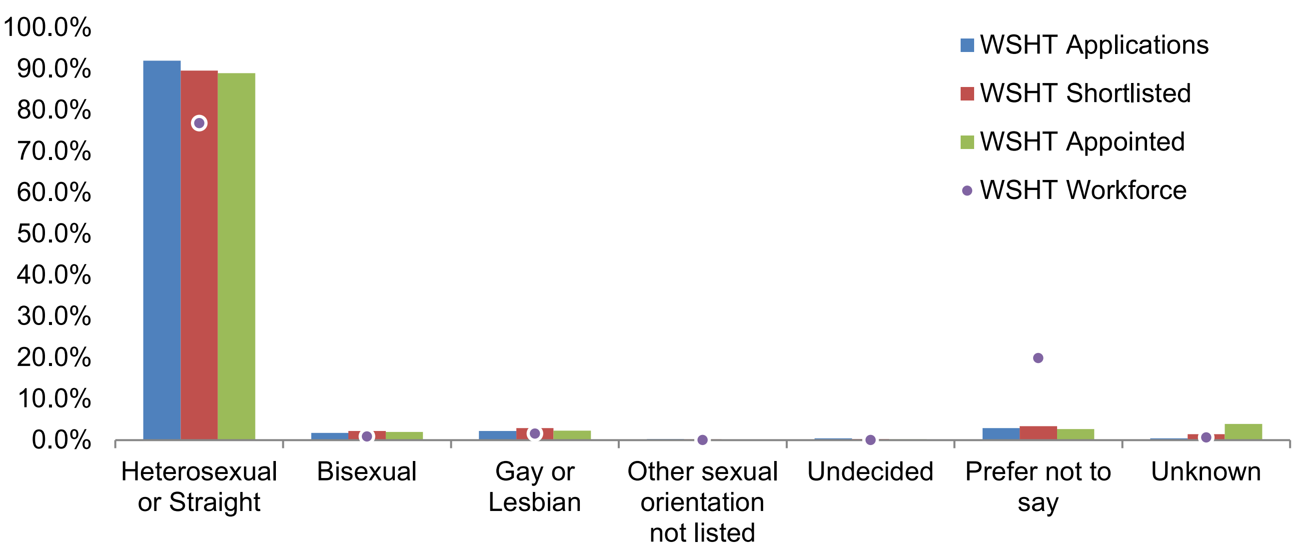
Observations

- There is a good representation for all declared sexual orientation compared to the overall workforce representation.

- From the application to the shortlisting stage, increases in representation can be seen in bisexual, gay or lesbian, candidates that prefer not to say and unknown. Broadly similar representation can be seen in other sexual orientations; a decrease in representation can be seen in heterosexuals and those identified as unidentified.
- From the shortlisting and appointment stage, increases in representation can be seen in candidates that are gay or lesbian, other sexual orientation and unknown. Decreases in representation can be seen in heterosexual, bisexual, undecided and those that prefer not to say.
- Overall it appears that gay or lesbian candidates may benefit from the recruitment processes, while heterosexual and bisexual candidates may experience a disadvantage.
- Compared to the overall workforce representation, a lower rate of candidates that preferred not to disclose their sexual orientation is entering the workforce. Still, a more significant proportion where the sexual orientation is unknown has been appointed.

WSHT

Sexual Orientation	Applications	Shortlisted	Appointed	Workforce
Heterosexual or Straight	91.9%	89.5%	88.9%	76.9%
Bisexual	1.8%	2.2%	2.0%	0.9%
Gay or Lesbian	2.2%	2.9%	2.3%	1.6%
Other sexual orientation not listed	0.3%	0.2%	0.0%	0.0%
Undecided	0.4%	0.3%	0.2%	0.0%
Prefer not to say	2.9%	3.4%	2.7%	19.9%
Unknown	0.4%	1.5%	3.9%	0.7%
Grand Total	100%	100%	100%	100.0%



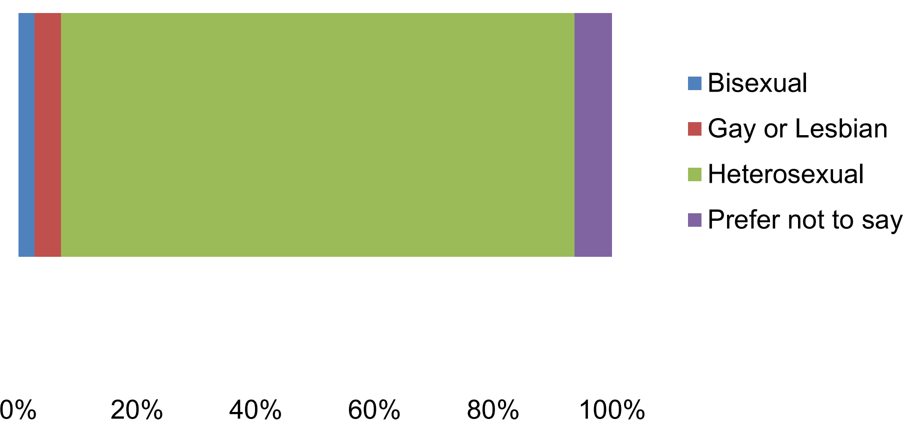
Observations

- Candidates that identify as bisexual, gay or lesbian, hetero and undecided, are well represented throughout the recruitment process.
- From application to the shortlisting stage, there is an increase in bisexual, gay or lesbian, prefer not to say and unknown representation; candidates that are heterosexual same a broadly equal representation and decreases were seen in other sexual orientation and undecided.
- The outcomes for other sexual orientation and undecided suggests that they may experience a detriment in the recruitment processes.
- Compared to the overall workforce representation, a proportionally small number of candidates who have elected not to declare their sexual orientation or where the sexual orientation is unknown will be entering the workforce.

Uptake of non-mandatory training or continuing professional development

BSUH

Sexual orientation	No. of staff attending training	% of staff attending training	% workforce representation
Bisexual	9	2.7%	1.9%
Gay or Lesbian	15	4.5%	5.0%
Heterosexual	289	86.5%	72.8%
Other sexual orientation not listed			0.2%
Prefer not to say	21	6.3%	12.3%
Undecided			0.1%
Unknown			7.7%
Grand Total	334	100.0%	100.0%

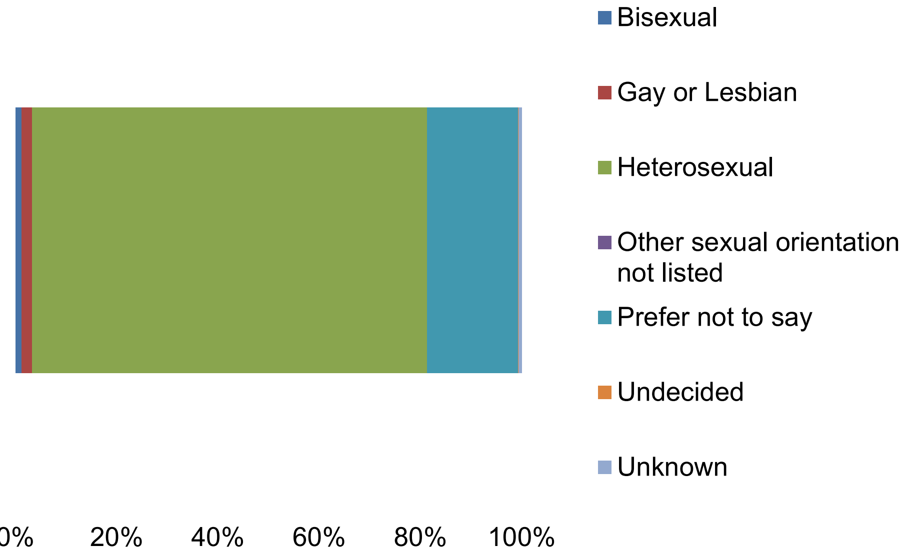


Observations

- Compared to the overall workforce representation, there is a greater than an expected representation of bisexual and heterosexual staff and a lower than an expected representation of gay or lesbian or prefer not to say.

WSHT

Sexual orientation	No. of staff attending training	% of staff attending training	% workforce representation
Bisexual	34	1.2%	0.9%
Gay or Lesbian	56	2.0%	1.6%
Heterosexual	2138	78.0%	76.9%
Other sexual orientation not listed	1	0.0%	0.0%
Prefer not to say	494	18.0%	19.9%
Undecided	1	0.0%	0.0%
Unknown	17	0.6%	0.7%
Grand Total	2741	100.0%	100.0%



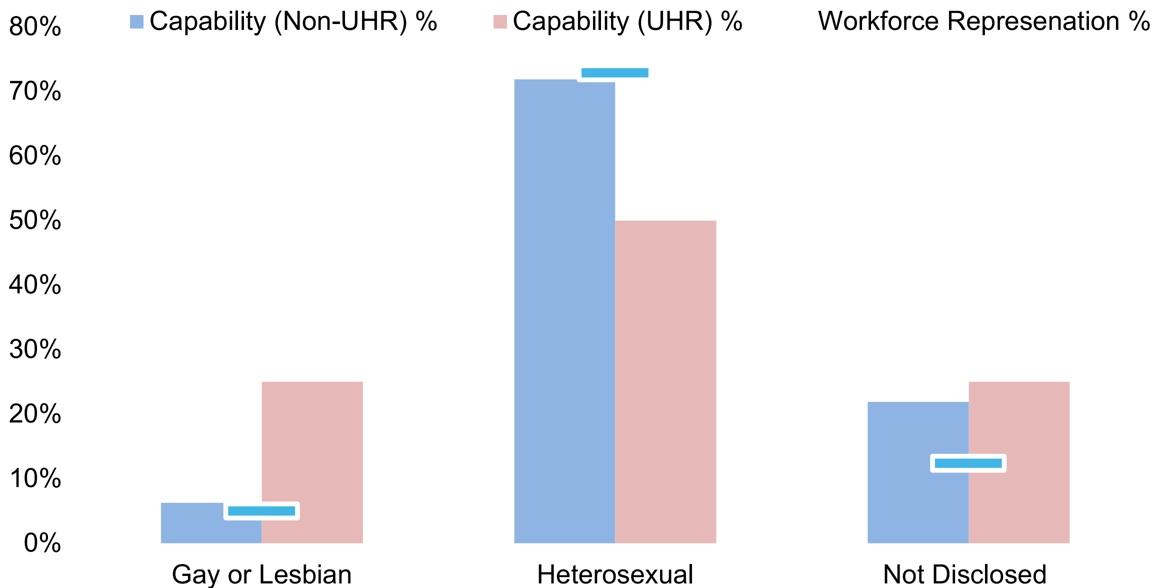
Observations

- Compared to the overall workforce representation, there is a higher than expected representation of bisexual, gay or lesbian and heterosexual staff; there was a decrease in staff representation where their sexual orientation is unknown or where they have elected not to declare.

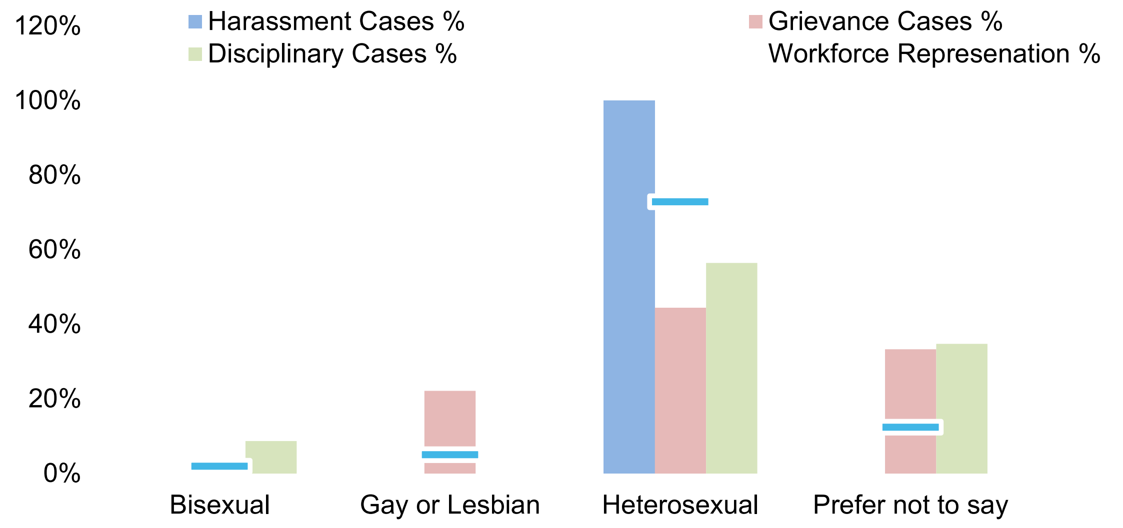
Employee relations processes broken down by sexual orientation

BSUH

Sexual Orientation	Capability (Non-UHR)	Capability (Non-UHR) %	Capability (UHR)	Capability (UHR) %	Workforce Representation %
Gay or Lesbian	2	6%	2	25%	5.0%
Heterosexual	23	72%	4	50%	72.8%
Not Disclosed	7	22%	2	25%	12.3%
Total	**32**	100%	**8**	**100%**	

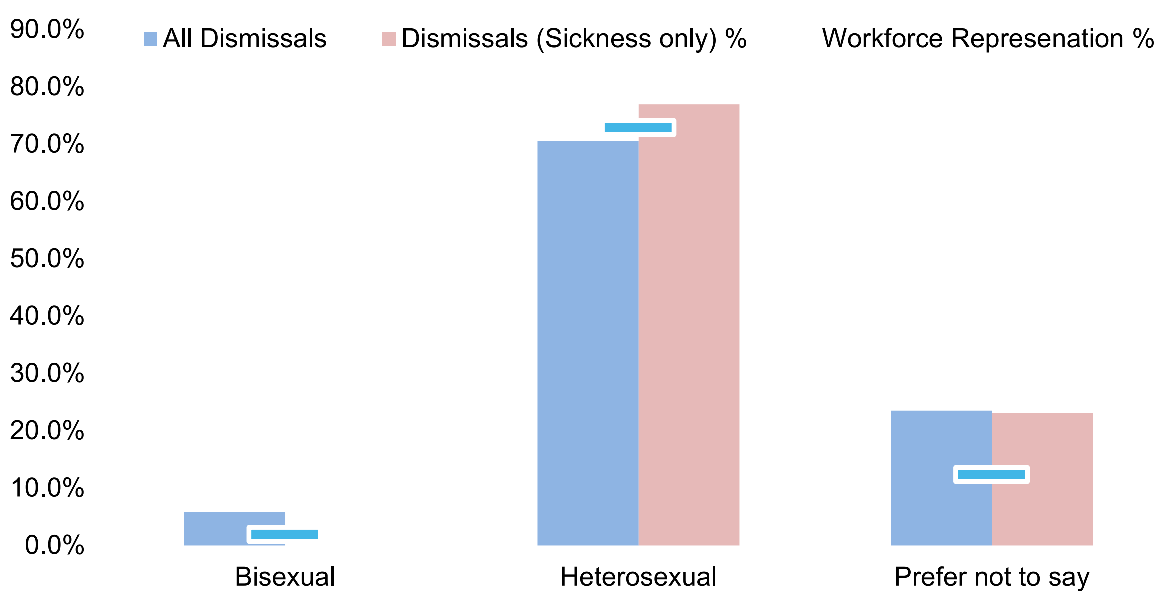


Sexual Orientation	Harassment Cases	Harassment Cases %	Grievance Cases	Grievance Cases %	Disciplinary Cases	Disciplinary Cases %	Workforce Representation %
Bisexual	0	0.0%	0	0.0%	2	8.7%	1.9%
Gay or Lesbian	0	0.0%	2	22.2%	0	0.0%	5.0%
Heterosexual	4	100.0%	4	44.4%	13	56.5%	72.8%
Prefer not to say	0	0.0%	3	33.3%	8	34.8%	12.3%
Total	**4**	100.0%	**9**	100.0%	**23**	**100.0%**	



Sexual Orientation	All Dismissals	All Dismissals %	Dismissals (Sickness only)	Dismissals (Sickness only) %	Workforce Representation %

Bisexual	1	5.9%	0	0.0%	1.9%
Heterosexual	12	70.6%	10	76.9%	72.8%
Prefer not to say	4	23.5%	3	23.1%	12.3%
Total	17	100.0%	13	100.0%	



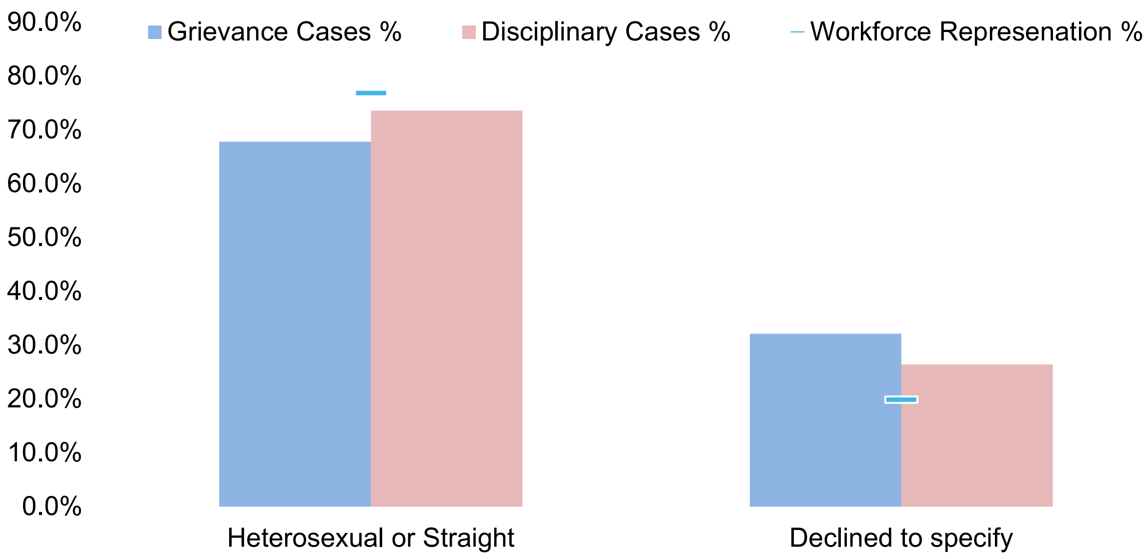
Observations

Compared to the overall workforce representation

- Capability (non-underlying health reasons), gay or lesbian staff have a higher proportional representation.
- Capability (underlying health reasons), gay or lesbian, heterosexual and staff that have not disclosed their sexual orientation have a higher proportional representation.
- In harassment cases, heterosexual staff have a higher proportional representation.
- In grievance cases, staff that are gay or lesbian and those who elected not to provide their sexual orientation have a higher proportional representation.
- In disciplinary cases, staff that are bisexual and those that elect not to declare their sexual orientation have a higher proportional representation.
- In all dismissals, staff that are bisexual and those that elect not to declare their sexual orientation have a higher proportional representation. Heterosexual staff and those that elect not to declare their sexual orientation have a higher proportional representation in dismissals for sickness.

WSHT

Sexual Orientation	Grievance Cases	Grievance Cases %	Disciplinary Cases	Disciplinary Cases %	Workforce Representation %
Heterosexual or Straight	19	67.9%	39	73.6%	76.9%
Declined to specify	9	32.1%	14	26.4%	19.9%
Total	28	100%	53	100%	



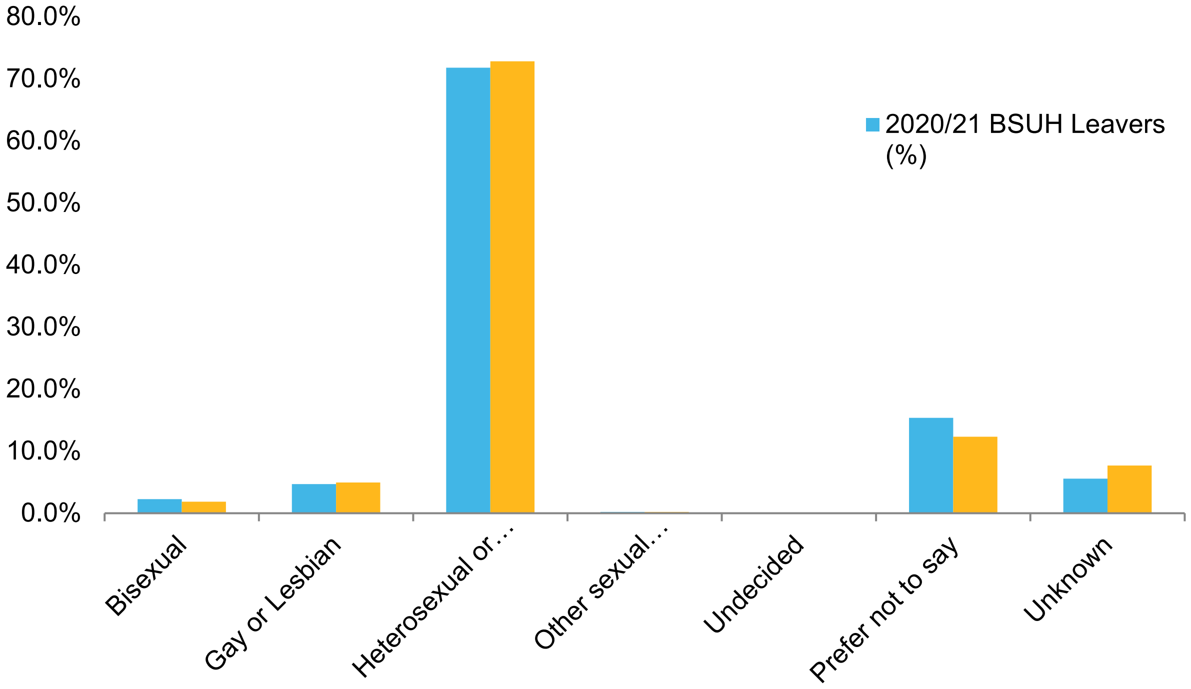
Observations

- Staff that have elected to decline to specify their sexual orientation have a higher representation in grievance and disciplinary cases than the overall workforce.

Leavers broken down by religion or belief

BSUH

Sexual Orientation	2020/21 BSUH Leavers	2020/21 BSUH Leavers (%)	Number in Workforce	% in Workforce
Bisexual	35	2.3%	167	1.9%
Gay or Lesbian	72	4.7%	440	5.0%
Heterosexual or Straight	1096	71.8%	6461	72.8%
Other sexual orientation not listed	3	0.2%	19	0.2%
Undecided	1	0.1%	9	0.1%
Prefer not to say	235	15.4%	1094	12.3%
Unknown	85	5.6%	683	7.7%
Grand Total	1527	100.0%	8873	100.0%



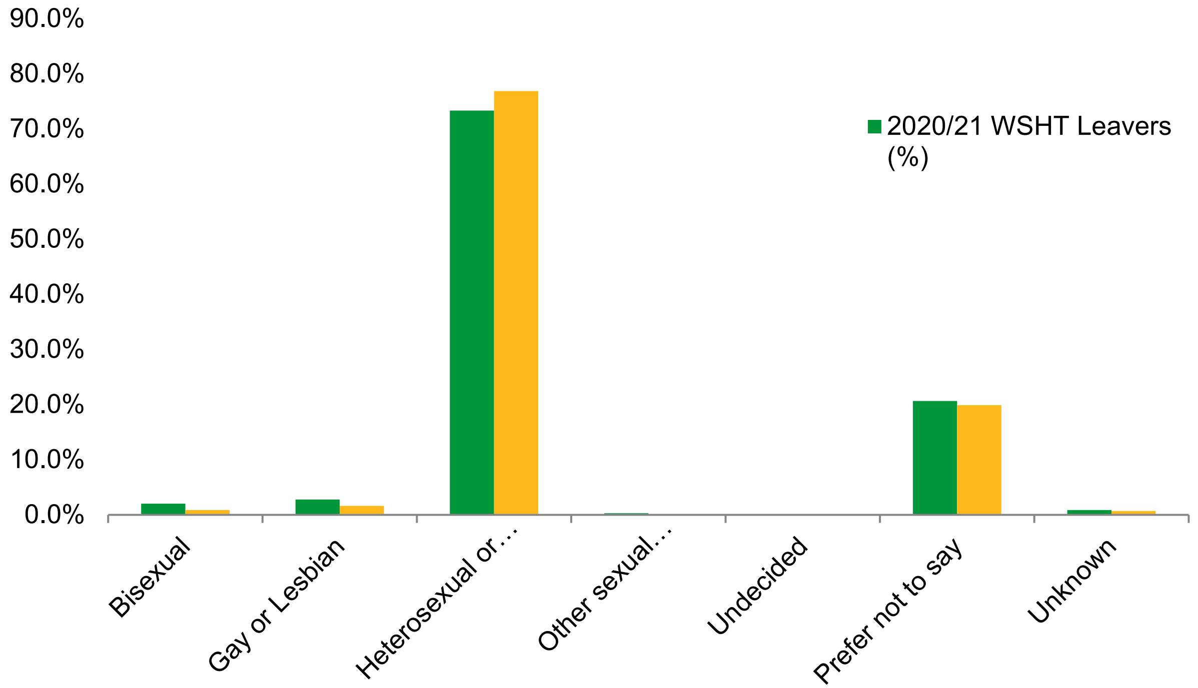
Observations

Compared to the overall workforce representation

- Staff that are bisexual or those that elected not to declare their sexual orientation have a proportionally higher representation in leavers data. All other groups representation is either in proportion or lower.
- Over 20% of leavers either chose not to declare their sexual orientation, or it was unknown.

WSHT

Sexual Orientation	2020/21 WSHT Leavers	2020/21 WSHT Leavers (%)	Number in Workforce	% in Workforce
Bisexual	14	2.1%	67	0.9%
Gay or Lesbian	19	2.8%	123	1.6%
Heterosexual or Straight	500	73.3%	5779	76.9%
Other sexual orientation not listed	2	0.3%	2	0.0%
Undecided	0	0.0%	2	0.0%
Prefer not to say	141	20.7%	1495	19.9%
Unknown	6	0.9%	51	0.7%
Grand Total	682	100.0%	7519	100.0%



Observations

Compared to the overall workforce representation

- Staff who are bisexual, gay or lesbian, and other sexual orientations prefer not to say, or unknown left the organisation at a higher proportional rate. Heterosexual and undecided left the organisation either proportionally or lower.
- Circa 20% of leavers either chose not to declare their sexual orientation, or it was unknown.

The Trust's Patients

This section reviews available data that shows information about the patients that use BSUH and WSHT's services.

During 2020/21, BSUH saw:

- 127,046 inpatients
- 605,979 outpatients

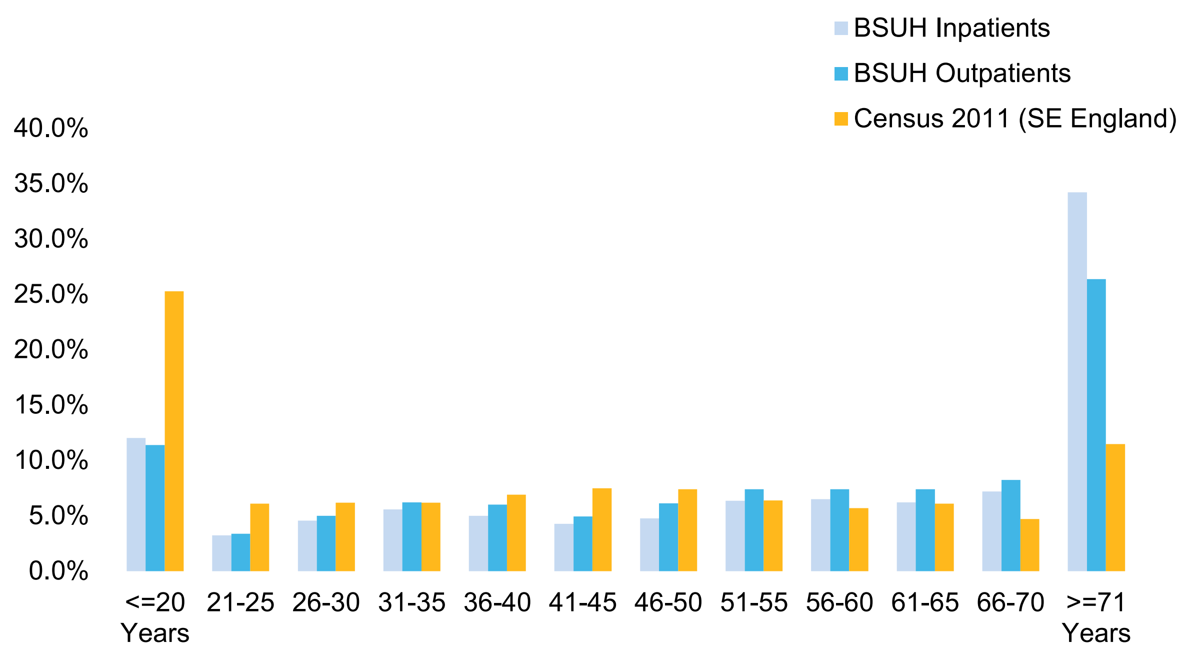
Please note that due to operational pressures during 2020/21, not all patient information was available when writing this report.

Patient Demographics

Age

BSUH:

Age Range	BSUH Inpatients	BSUH Outpatients	Census 2011 (SE England)
<=20 Years	12.0%	11.4%	25.3%
21-25	3.2%	3.4%	6.1%
26-30	4.6%	5.0%	6.2%
31-35	5.6%	6.2%	6.2%
36-40	5.0%	6.0%	6.9%
41-45	4.3%	5.0%	7.5%
46-50	4.8%	6.1%	7.4%
51-55	6.4%	7.4%	6.4%
56-60	6.5%	7.4%	5.7%
61-65	6.2%	7.4%	6.1%
66-70	7.2%	8.2%	4.7%
>=71 Years	34.2%	26.4%	11.5%
Total	100.0%	100.0%	100.0%



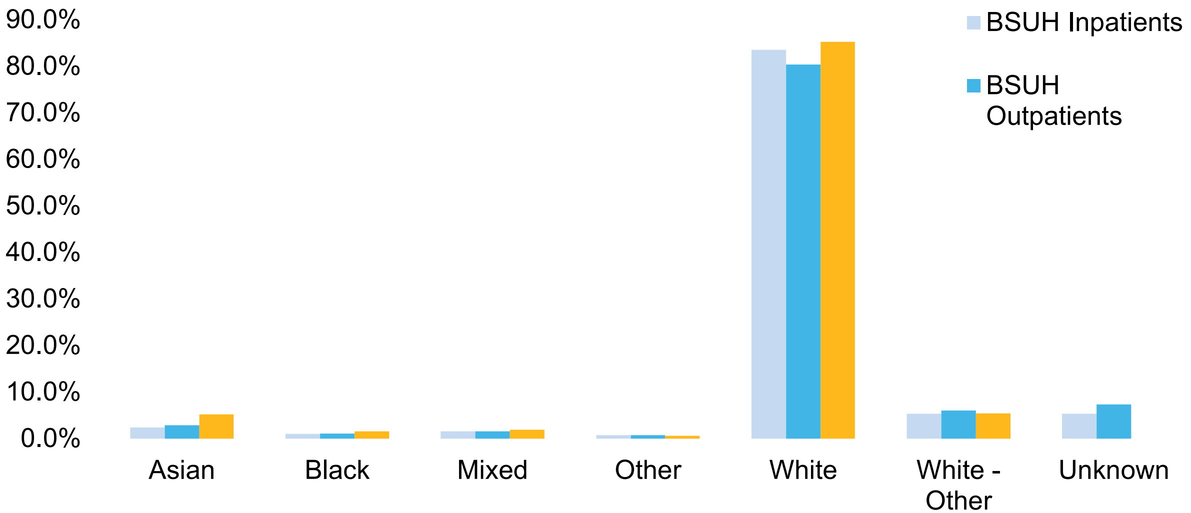
What the data tells us

Compared to the 2011 Census Data:

- There is a much lower representation of patients under 20 but a higher representation of patients 71+ using Trust services.
- Patients aged 0-50 have a lower representation in general service use.
- Patients aged 51+ generally have a higher representation in general services use.
- Patients aged 21-70 have a higher representation in outpatient services than inpatient services. Patients aged under 20 and over 71+ have a higher representation in inpatient services compared to outpatient services.

Ethnicity

Ethnicity	BSUH Inpatients	BSUH Outpatients	2011 Census
Asian	2.4%	2.9%	5.2%
Black	1.0%	1.1%	1.6%
Mixed	1.6%	1.6%	1.9%
Other	0.8%	0.8%	0.6%
White	83.5%	80.3%	85.2%
White - Other	5.4%	6.0%	5.4%
Unknown	5.4%	7.3%	
Total	100.0%	100.0%	100.0%



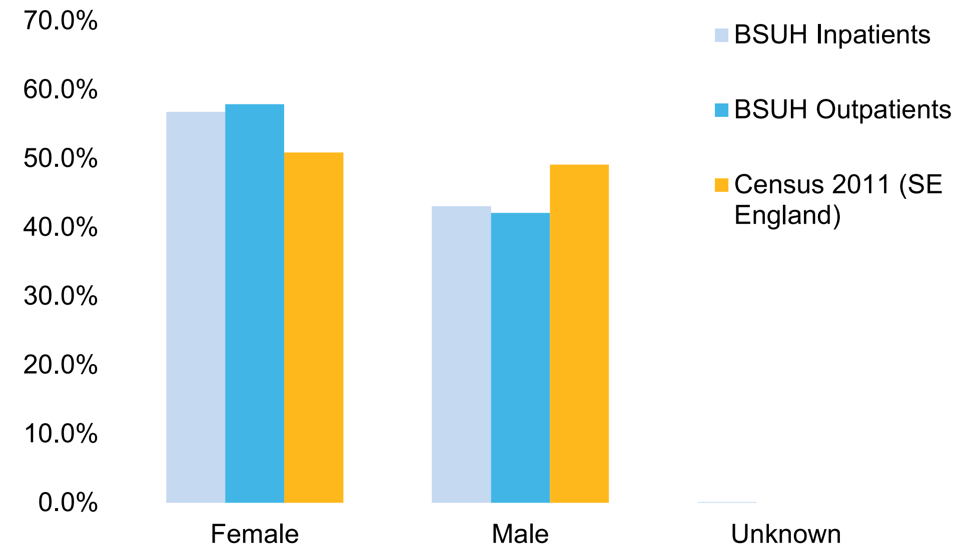
What the data tells us

Compared to the 2011 Census data:

- The majority of groups attend Trust services broadly in line with census data.
- Asian patients have a slightly lower representation in attendance in Trust services.
- Other and White-Other (inpatients) have a slightly higher representation in attendance to Trust Services.

Gender

	Female	Male	Unknown
BSUH Inpatients	56.8%	43.1%	0.1%
BSUH Outpatients	57.9%	42.1%	0.0%
Census 2011 (SE England)	50.9%	49.1%	

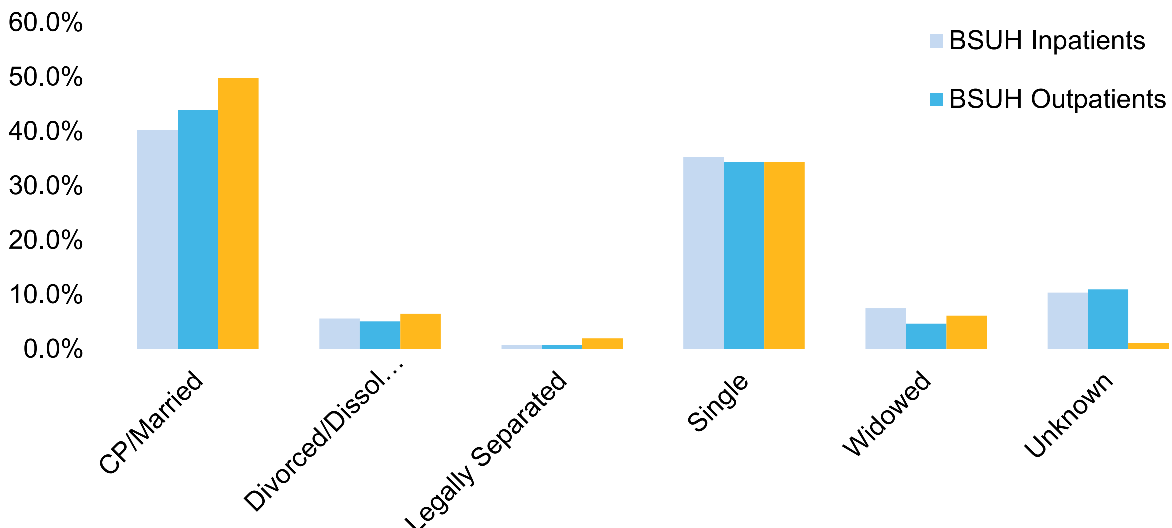


What the data tells us:

- Overall, there are more female than male patients attending Trust services.
- The breakdown of male and female patients is broadly similar in inpatient and outpatient services.
- Compared to the 2011 Census data, there is a greater representation of female patients than males using the Trust's services.

Marital Status (Marriage and Civil Partnership)

	CP/Married	Divorced/ Dissolved CP	Legally Separated	Single	Widowed	Unknown
BSUH Inpatients	40.3%	5.6%	0.8%	35.3%	7.5%	10.4%
BSUH Outpatients	44.0%	5.1%	0.8%	34.4%	4.7%	11.0%
Census 2011 (SE England)	49.8%	6.5%	2.0%	34.4%	6.2%	1.1%



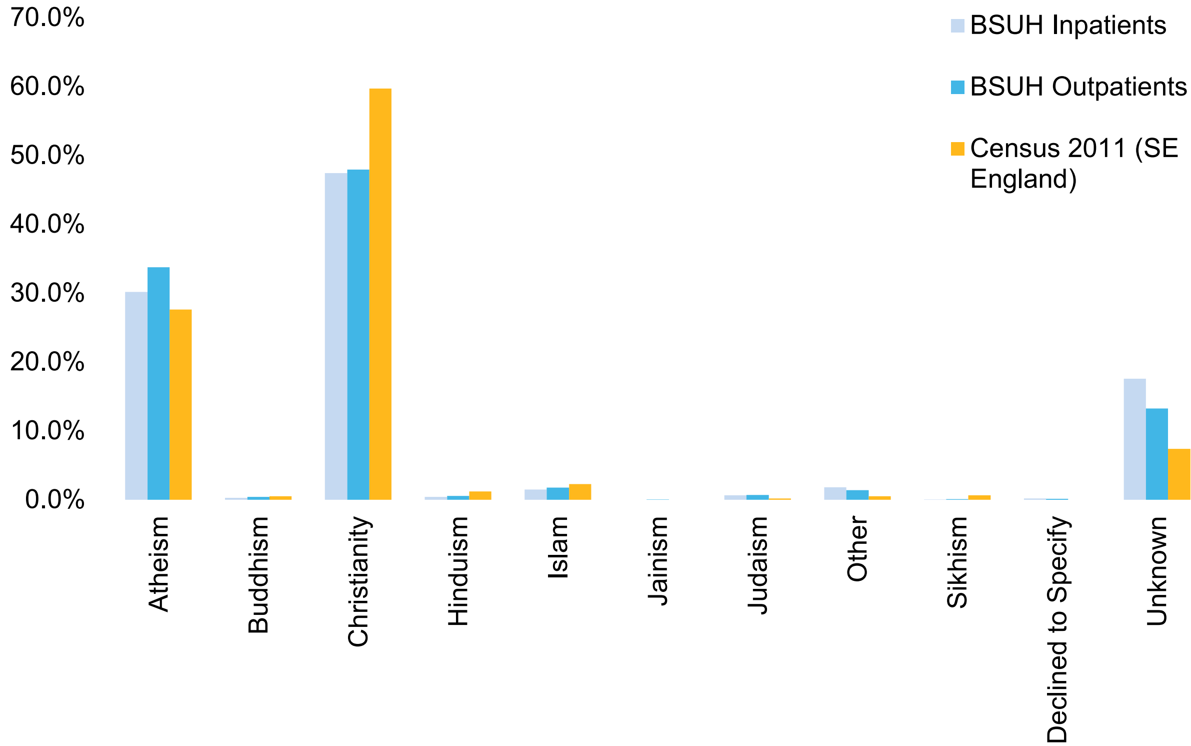
What the data tells us:

- Compared to 2011 Census data, there is a lower representation in Trust services for patients that are either married or in a civil partnership.
- There is a greater representation of patients in outpatient services compared to inpatient services.

Religion or Belief

	BSUH Inpatients	BSUH Outpatients	Census 2011 (SE England)
Atheism	30.2%	33.76%	27.6%
Buddhism	0.28%	0.43%	0.5%

Christianity	47.41%	47.94%	59.7%
Hinduism	0.44%	0.55%	1.2%
Islam	1.48%	1.79%	2.3%
Jainism		0.00%	
Judaism	0.63%	0.68%	0.2%
Other	1.81%	1.39%	0.5%
Sikhism	0.05%	0.08%	0.6%
Declined to Specify	0.17%	0.12%	
Unknown	17.56%	13.26%	7.4%



What the data tells us

Compared to the 2011 Census data:

- There is a lower representation in Trust services of patients that identify as Christian, Hindu, Muslim and Sikh.
- There is a higher representation in Trust services of patients who identify as Jewish or from another religion/belief.
- There is broadly equality representation for atheists and Buddhist patients.
- In all declared religions or beliefs, there is a higher representation in outpatient services than inpatient services.

Friends and Family Test

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided or where improvements are needed. It's a quick and anonymous way to give your views after receiving NHS care or treatment.

Patients are asked, "Overall, how was your experience of our service?" and this can be graded from very good to very poor. The tables below show how many patients highlighted a positive response.

BSUH

The Trust aims to have a positive score of more than 95%. 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.

A breakdown of responses by protected characteristic was not available at the time of authoring this report.

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%

WSHT

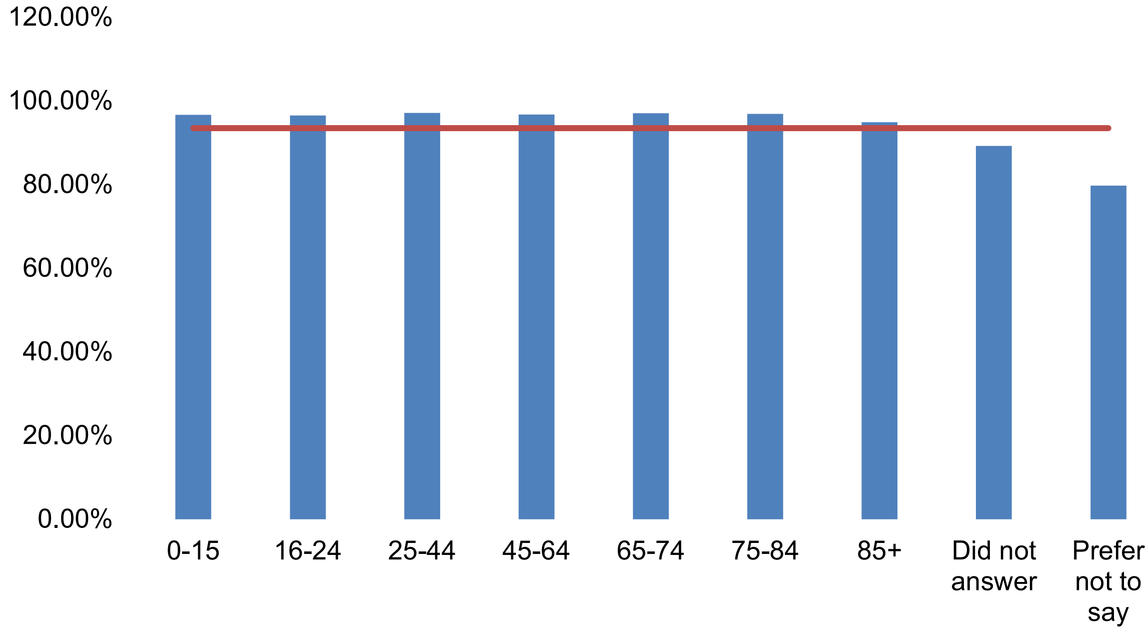
Patient Touchpoint	2020/2021 Data December 2020 to March 2021	2019/20	2018/19
Overall Trustwide	93%	95.77%	96.65%
A&E	90%	93.2%	95.2%
Maternity/Birth	96%	97.9%	97.3%
Inpatient & Day Case	97%	97.2%	97.3%
Outpatient	98%	97.3%	96.8%

Breakdown of FFT by:

Age

Age	Recommend %	Recommend	Total responses
0-15	96.68%	1194	1235
16-24	96.55%	840	870
25-44	97.15%	4129	4250

45-64	96.72%	5046	5217
65-74	97.09%	3364	3465
75-84	96.90%	3222	3325
85+	94.93%	1235	1301
Did not answer	89.25%	13393	15006
Prefer not to say	79.78%	71	89

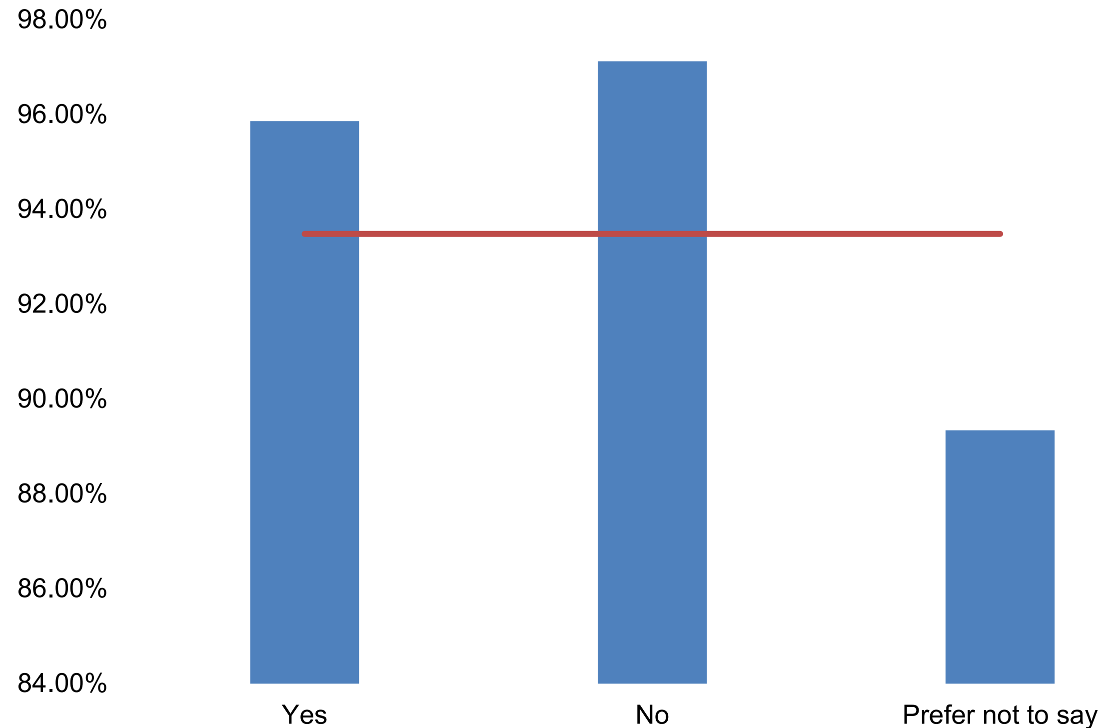


What the data tells us:

- The overall average recommend rate is 93.49% (this is shown as the red line in the about graph)
- A high proportion of patients (43.2%) have not declared their age on the FFT questionnaire.
- Patients aged 0-84 had a similar recommended rate; between 96.55-97.15% of patients would recommend the Trust’s services.
- The lowest recommended rate can be seen in patients aged 85+, where 94.93% of patients would recommend Trust services.

Disability

Disability	Recommend %	Recommend	Total Responses
Disabled	95.87%	2783	2903
Not Disabled	97.13%	15603	16064
Prefer not to say	89.34%	14108	15791

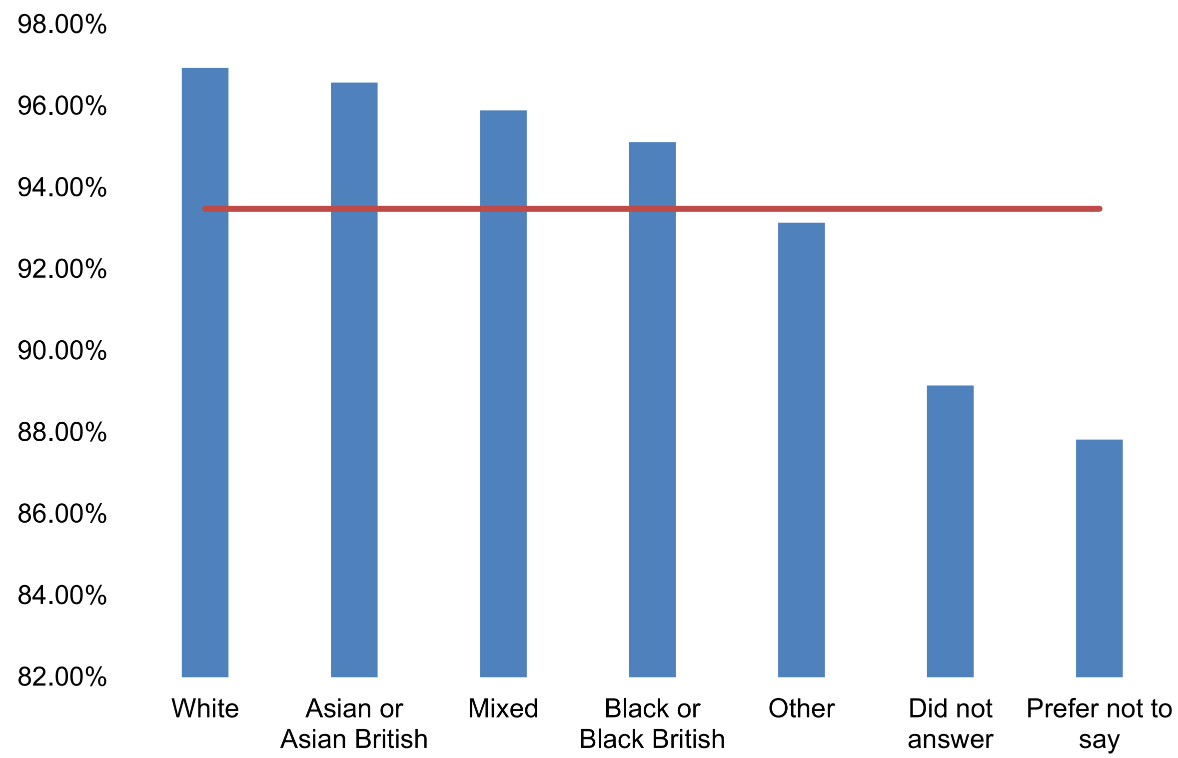


What the data tells us:

- The overall average recommend rate is 93.49% (this is shown as the red line in the above graph)
- A high proportion of patients (45.4%) selected prefer not to say in the FFT questionnaire.
- 8.4% of respondents highlighted they have a disability.
- A lower proportion of disabled patients (compared to the patients that are non-disabled) would recommend the Trust's services.

Ethnicity

Ethnicity	Recommended %	Recommended	Total responses
White	96.94%	18055	18625
Asian or Asian British	96.58%	226	234
Mixed	95.90%	374	390
Black or Black British	95.12%	117	123
Other	93.14%	163	175
Did not answer	89.16%	13393	15022
Prefer not to say	87.83%	166	189

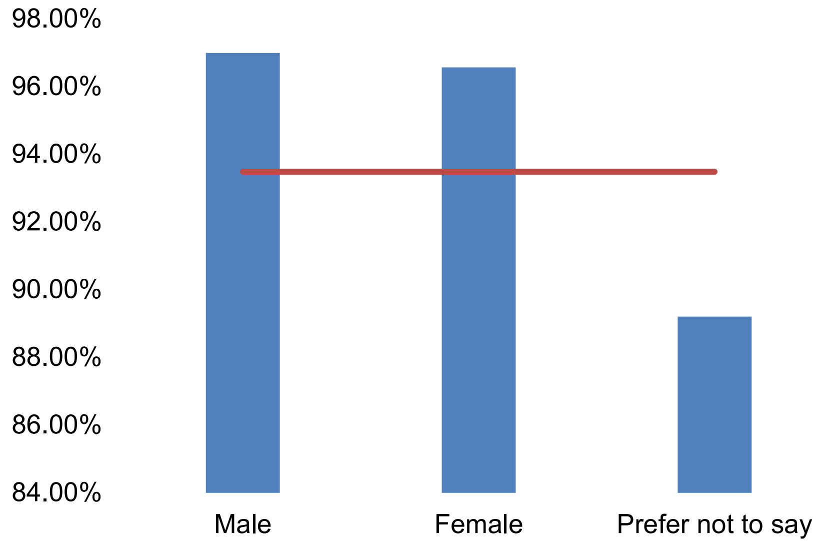


What the data tells us:

- The overall average recommend rate is 93.49% (this is shown as the red line in the above graph)
- A high proportion of patients (39.0%) have not declared their ethnicity on the FFT questionnaire.
- White, Asian, Black or mixed heritage patients had a similar recommended rate; 95.12-96.94.15% of patients would recommend the Trust's services.
- The lowest recommended rate can be seen in patients from other ethnic groups, where 93.14% of patients would recommend Trust services.

Gender

Gender	Recommend %	Recommend	Total Responses
Male	97.00%	8039	8288
Female	96.57%	11041	11433
Prefer not to say	89.21%	13414	15037

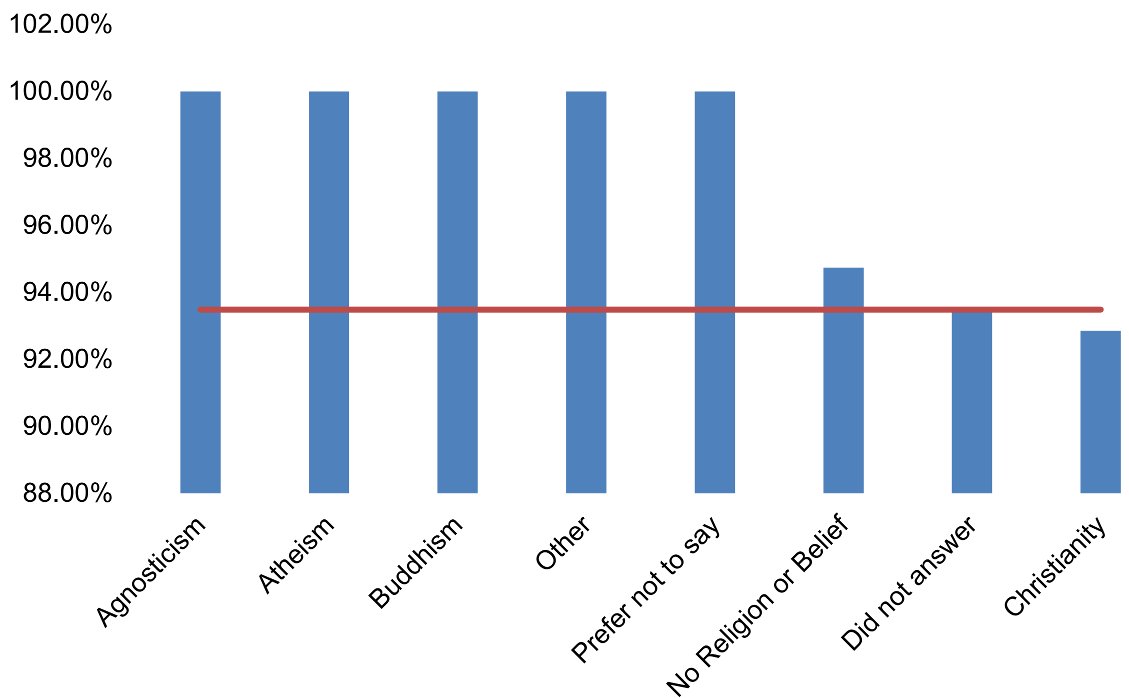


What the data tells us:

- The overall average recommend rate is 93.49% (this is shown as the red line in the above graph)
- A high proportion of patients (38.6%) have chosen the preferred not to say option on the FFT questionnaire.
- The recommended rate of female and male patients are similar.

Religion or Belief

Religion or Beliefs	Recommend %	Recommend	Total Responses
Agnosticism	100.00%	1	1
Atheism	100.00%	4	4
Buddhism	100.00%	1	1
Other	100.00%	2	2
Prefer not to say	100.00%	1	1
No Religion or Belief	94.74%	18	19
Did not answer	93.48%	32454	34716
Christianity	92.86%	13	14



What the data tells us:

- The overall average recommended rate is 93.49% (this is shown as the red line in the about graph).
- 93.3% of patients did not declare their religion or belief in the FFT questionnaire. Because of this, there is no further meaningful analysis from this data.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	14	Meeting:	Board	Meeting Date:	3 February 2022
Report Title:	Sustainability Committee Chair report to Board				
Committee Chair:			Lizzie Peers, Committee Non Executive Chair		
Author(s):			Lizzie Peers, Committee Non Executive Chair		
Report previously considered by and date:					

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

Implications for Trust Strategic Themes and any link to BAF risks		
Patient	☐	
Sustainability	✓	Assurances in relation to risks 2.1, 2.2 and 2.3
People	☐	
Quality	☐	
Systems and Partnerships	☐	

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

Communication and Consultation:

Executive Summary:

The Sustainability Committee met on the 27 January 2022 and was quorate as it was attended by two Non-Executive Directors, the Chair, the Chief Financial Officer, the Chief Executive and the Deputy Chief Executive and Managing Director West. In attendance were the Finance Director, the Director of IM&T and Director of Capital, the Director for Improvement and Delivery and the Director of Estates and Facilities.

The Committee received its planned items including the reports on the Sustainability True North, Breakthrough Objective, Strategic Initiative and Corporate Project, along with detailed updates on the Trust's financial performance, the efficiency programme, the capital programme, an IM&T update, an update on the 2022/23 financial planning framework, the sustainability risks and the Board Assurance Framework.

Key Recommendation(s):

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

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

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Sustainability Committee	**27 January 2022**	**Lizzie Peers**	✓	☐

Declarations of Interest Made

There were no declarations of interest made

Assurances received at the Committee meeting

Patient First Trust North, Breakthrough Objective and Strategic Initiative

The Committee **RECEIVED** an update on financial performance of the Trust and **NOTED** that the Trust was achieving its financial control total of breakeven for quarter 3, although there were a number of challenges and risks in relation to achieving break even at year end. It was confirmed that a detailed roadmap to year end with a update on the risks would be brought to the next meeting. The Committee was **ASSURED** through their review of the Finance Report for quarter 3 and the supporting scorecard alongside the engagement from the Trust Finance Director on the actions planned to deliver the Trust's overall year end breakeven position. The Committee was **ASSURED** through the paper and the discussions with the Chief Financial Officer and Trust Finance Director that the risks reported are fairly stated. The Committee **NOTED** the linkage between this report and the quarter 3 Efficiency Report and the quarter 3 Capital Programme Report.

The Committee **RECEIVED** updates on the delivery of the Sustainability Breakthrough Objective - Premium Spend Reduction. The Committee **NOTED** the update provided by the Trust Finance Director including the programme of schemes to support the reduction in the use of agency spend and the particular challenges faced in relation to medical spend with a deep dive requested to follow at a later meeting on this to provide further assurance. The Committee **NOTED** that given the changing environment in respect of workforce nationally and our revised operating model there would be a review of this strategy deployment.

There was an update on the Strategic Initiative - Environmental Sustainability provided by the Director of Facilities and Estates. As the Plan has now been approved and submitted, work is underway ahead of the Trust's Green Plan public launch in the week of the 7 February 2022. The Committee **NOTED** the strong engagement with our wider partners including the local authority in respect of green travel. The Committee **NOTED** the plans developed to reduce the Trust's carbon levels in line with our trajectory of net zero. The Committee was **ASSURED** with the detailed CO2 reduction tracker giving confidence over both the oversight and the delivery of the short term actions to March 2023. The Committee **NOTED** that the Green Plan is being presented to the Public Board on the 3 February.

In respect of the Corporate Project – PAS Implementation, the Committee was **ASSURED** from the feedback provided by the Director of IM&T that the lessons learnt from the BSUH PAS implementation are mitigated with the work being undertaken within this project and that there continued to be positive clinical engagement with the project and its deliverables. The Committee **NOTED** following good clinical and operational engagement the revised timing for the ED (West) element which is now planned for early March. The Committee **RECEIVED** the IM&T quarter 3 report which covered all major projects and through the presentation and discussions with the Director of IM&T was **ASSURED** over the designed mitigations for the various project risks. The Committee **NOTED** that the PAS project will be subject to a deeper dive to provide further assurance at a future Committee prior to the year-end due to its complexity and importance.

Use of Resources

The Committee **RECEIVED** the quarter 3 Efficiency Programme Report from the Director for Improvement and Delivery on the delivery of the Trust's efficiency programme and **NOTED** the risks with its delivery for the year. The Committee **NOTED** that the Trust was in a strong position for this year given that during the prior year it maintained a focus on efficiency.

The Committee was **ASSURED** over the current level of delivery of the tactical schemes and was updated on the work undertaken in respect on the delivery of the productivity schemes where the main risks in the programme are for this year. The risks and mitigations to year end full delivery of the plan were discussed in detail. The Committee **NOTED** the progress being made on the development of the 2022/23 programme noting that the work to develop that plan is slightly ahead of the level of planning from 2021/22, with the Efficiency Steering Group feeding into this process. The Committee through the presentation of the report and discussion with the Director for Improvement and Delivery was **ASSURED** over the designed mitigations for the identified risks but noted the continued impact of operational productivity on delivery of the plan. The Committee **NOTED** the work being planned to realise the benefits of the merger with a focus within the programme on recurrent productivity improvements which have already commenced in 2021/22 but this will be supported by the planned workshop with the divisions lead by the Deputy Chief Executive and Chief Financial Officer.

The Committee **RECEIVED** a quarter 3 Trust's Capital Programme Report including 3Ts. This report was submitted from the Trust's Capital Investment Group. The Committee was **ASSURED** by the Director of Capital over the Trust's monitoring processes in place to mitigate the risks of under delivery of the current year's plan. The Committee noted that there are mitigations within the programme afforded by it being over programmed, allowing alternate items to be weaved in as others move into the next year and noted the progress of a number of key businesses cases which will see schemes delivered by the year end. The Committee **NOTED** the important contribution that a number of the capital schemes delivered this year have made to the Trust's reduction in its carbon footprint as well as to patient care and experience. The Committee **NOTED** that the Trust was progressing a series of discussions in respect of the phasing of the use of the Trust's Strategic Capital with the outcomes of these conversations flowing through to Committee's scheduled reports. The Committee through the presentation of the report and discussion with the Director of Capital was **ASSURED** over the designed mitigations for the identified risks but recognised the supply chain risks our main contractors have.

The Committee **RECEIVED** the quarter 3 IM&T Programme 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. The Committee **NOTED** the positives for patients and staff as a result of the delivery of many of these projects.

The Committee **RECEIVED** a report on the development of the Trust's 2022/23 financial plan following receipt of the relevant draft revenue and contracting guidance from NHS E/I. The Committee **NOTED** the work undertaken to develop the Trust's draft 2022/23 financial plan recognising the level of uncertainty given the outstanding matters within the guidance and the need for clarity over the Trust's final allocations. The Committee **NOTED** the risks the regime change brings and that there remained uncertainty for the Trust and the ICS and therefore the BAF risks 2.1 and 2.2 remain elevated. The Committee **NOTED** that a 2022/23 Financial Plan will be presented to the Board for their approval.

ICS

The Committee **RECEIVED** an update from the Chief Financial Officer on the work of the ICS Finance Leadership Group of the ICS in January 2022. The Committee **NOTED** this work and how it linked to the prior report at the Committee in respect of the 2022/23 planning and the areas the group would focus on, including capital planning and the capital scheme prioritisation framework at an ICS level.

<u>RISK</u>

The Committee **REVIEWED** the quarter 3 Sustainability Risk Paper setting out the risks which may impact the delivery of the Sustainability True North along with the overarching risks from the respective Strategic Initiative and Corporate Project. The Committee considered this report alongside the individual discussions on risk within each of the Committee items. The Committee discussed and **AGREED** the risk paper summary noting that there are 9 risks with a current score of above 12 and 2 risks with an impact of 5 but scoring below 12 covering the areas of sustainability true north, operational pressures and productivity, capital and IM&T.

The Committee **AGREED** with the report's summary in respect of the common risk factors or emerging themes being;

a. Overall whilst the specific programmes reporting to the Committee are all managing and largely mitigating current risks, there are a number of specific challenges which could impact the delivery of the overarching True North objectives for Sustainability into 2022/23.

b. Operational pressures including Covid-19 pandemic and workforce constraints are impacting on operational costs and productivity, workforce cost driven by lack of supply and also independent sector spend. These, alongside interim financial frameworks and incomplete guidance are adding further risk to delivery of financial targets, and are potential risks to the objectives of the efficiency programme and capital projects

c. There is a collection of IM&T risks relating to pathology systems, highlighting the need to progress the upgrade of these as a single system across the pathology network. In addition, cyber security is an on-going and known risk requiring continuous oversight.

The Committee **REVIEWED** the BAF risks it has oversight for, and **AGREED**, having regard to both the BAF summary and the Committees consideration of the risks covered during the meeting, that the quarter four score for risks 2.1, 2.2 and 2.3 were fairly stated

Actions taken by the Committee within its Terms of Reference

There were no specific business cases requiring approval at this meeting.

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

There was one further item in respect of the payroll project identified to come back to the Committee over and above those items requested at the previous meeting which are already tracked to come to future meetings.

The Committee asked that as part of its cycle of business for next year that a formal quarterly report on commercial and procurement activities is provided by the Commercial Director.

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 3 February

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	15	Meeting:	Board	Meeting Date:	3 February 2022
Report Title:	Systems and Partnerships Committee Chair report to Board				
Committee Chair:			Patrick Boyle, Committee Non Executive Chair		
Author(s):			Patrick Boyle, Committee Non Executive Chair		
Report previously considered by and date:					

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

Implications for Trust Strategic Themes and any link to BAF risks		
Patient	☐	
Sustainability	☐	
People	☐	
Quality	☐	
Systems and Partnerships	✓	Assurances in relation to risks 5.1, 5.2 and 5.3

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

Communication and Consultation:

Executive Summary:

The Systems and Partnerships Committee met on the 28 October 2021 and was quorate as it was attended by four Non-Executive Directors, the Trust Chair, the Chief Executive, the Chief Delivery and Strategy Officer, the Chief Financial Officer, and the Trust's two Managing Directors. In attendance were, the Trust's Commercial Director, and the Director of Strategy and Planning and Chief Operating Officer west and the Director for Improvement and Delivery.

The Committee received its planned items including the Q3 report on the key constitution 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 review and approval of the Trust's access policy, the Trusts' Annual Emergency Planning, Preparedness and Response Annual Report, the Systems and Partnership Risk Report and the Board Assurance Framework.

Key Recommendation(s):

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

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

The Board is asked **APPROVE** the Trust's Annual Emergency Planning, Preparedness and Response report following its review by this Committee.

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Systems and Partnerships Committee	27 January 2022	Patrick Boyle	✓	☐

Declarations of Interest Made

There were no declarations of interest made

Assurances received at the Committee meeting

Constitution performance report

The Committee **RECEIVED** an update on constitutional performance for quarter three including the performance against the Trust's systems and partnership true norths and breakthrough objectives for emergency and planned care for Q3. The Committee **NOTED** the Trust's continued to focus on recovery against all of the Constitutional NHS access targets, but recognised the significant pressure on progress during quarter 3 and the impact this had on all the constitutional performance metrics which had seen a deterioration. This is in line with the National trends.

The Committee discussed the drivers of the current performance challenges especially within Urgent and Emergency care and **NOTED** the multiple different aspects to these challenges, including challenges in managing red and green pathways, the continued increasing demands on the A&E departments and the capacity within the systems to discharge patient effectively who ready for out of hospital care. The Trust has seen a significant increase in the level of these patients, those Medically Ready for Discharge within all the hospitals and the levels of these patients are at their highest levels.

The Committee **RECEIVED** an update on the implementation and effectives of the action being taken in respect of RTT and **NOTED** the Trust's focus in line with the national priority for elective recovery to be given to the treatment of the longest waiting patients, with a target to ensure no patients are waiting longer than 104 weeks for elective RTT treatment and longer than 104 days for Cancer Treatment by the end of March 2022 The Committee **NOTED** the actions taken including the use of the Independent Sector and the current Trust's current positive position in terms delivery of the trajectory for this cohort of patients and the Trust's current forecast to have no patients waiting over 104 weeks by the end of the year

The Committee **NOTED** the risks to the delivery of all constitutional targets but was **ASSURED** through the reports and the discussions with the Chief Delivery and Strategy Officer along with the two Managing Directors and the Chief Operating Officer west that the mitigation actions are well designed. The Committee also **NOTED** the complementary review of these risks undertaken by the Quality Committee in respect of those waiting including time to triage, time to treatment and harm reviews in emergency care pathways. The Committee was updated by the Chief Operating Officer west on the high level performance against some of those quality metric including time to triage and time to treatment for those attending ED and the actions taken in December which had in January had a positive impact on these performance metrics, including an expansion of support to the waiting rooms and the use of the staffing rostering systems to flex resources between departments aligned to predicted demands. Through the review of this report and the discussions held the Committee consider the respective BAF risk 5.3 to be fairly represented at 20.

The Committee **RECEIVED** updates on the Trust 3Ts hospital development Strategic Initiative. The Committee through this report **NOTED** that Stage 1 remained on track and through the discussions held

NOTED the work undertaken to refresh the 3Ts programme governance structure and workstream focus. The Committee **NOTED** the programme risks and through the updates from the Chief Delivery and Strategy Officer and Chief Financial Officer in respect of the detailed project risk register was **ASSURED** there remains clarity over their developed mitigations and the tracking of their delivery. The Committee **NOTED** the national risks which could impact 3Ts in relation to the disruption to the construction supply chain and number of workers available on site as a result of the continued covid pressures.

The Committee **RECEIVED** updates on the delivery of the respective Corporate Projects, in respect of M&A and Restoration and Recovery. The Committee **NOTED** the significant level of work undertaken within the M&A project as detailed with the report and the closure of three of the workstreams following the completion of their planned activity. The Committee **RECEIVED** the Restoration and Recovery report and NOTED the detailed discussions held on this projects progress as part of the constitutional standards report update.

ICS and Systems Collaborations

The Committee **RECEIVED** a report from the November 2021 meeting, noting that the December and January meetings did not take place to allow for the organisations to focus on the national vaccination programme work and to deal with wave 4 covid pressures. The Committee remained **ASSURED** that progress was continuing across all the Sussex Acute Collaborative Network (SACN) workstreams including those on emergency care, maternity and planned care and 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 **NOTED** that there is review underway assessing the maturity of the respective collaboratives to assist in their transition to the ICB.

The Committee **RECEIVED** an update on the work with Queen Victoria Hospital NHS Foundation Trust and **NOTED** the plan for the remobilisation of the work to develop the Full Business Case in conjunction with QVH following the outcome of the independent review being undertaken at QVH.

Emergency Planning, Preparedness and Response (EPPR)

The Committee **RECEIVED** the former Trusts' Emergency Planning, Preparedness and Response (EPPR) Annual report for 2021 as part of the Trust's statuary responsibilities under the Civil Contingencies Act. The Committee **NOTED** that the Trusts' assessed score as being substantially compliant with 44 of 46 standards being fully complaint. In respect of the remaining 2 areas which were partially complaint the Committee **NOTED** the actions planned to be taken to achieve full compliance within the next six months. The Committee was **ASSURED** by the conclusion of a review undertaken by the ICS EPPR team who agreed that the Trust's assessment was valid. Based on the report and the information provided the Committee **AGREED** to recommend the report to the Board for final approval.

Patient Access Policy

The Committee **RECEIVED** the Trust's revised patient access policy and was updated on the activity undertaken to review the previous legacy access policies along with the outcome an ICS to review of all access policies within the systems. The outcome of this work has seen the policy including all recent national updates. The revised policy has been developed with engagement from the NHS E/I Intensive Support Team, Primary Care Colleagues and Patient Groups. Feedback from NHS E/I was that the Policy is both complaint but also aligned to the spirt of the legislation. The Committee debated the link between this policy and the drive to address health inequalities noting that the policy is drafted for the current environment and future changes will look to support health equality, as the national policy and guidance within this area is clarified. The Committee **APPROVED** the revised policy.

RISK

The Committee **REVIEWED** a report on the key corporate risks and the highly scored divisional risks relevant to systems and partnerships along with the overarching risks from the respective Strategic Initiative and Corporate Projects. The Committee considered this report alongside the discussions on risk within the

respective Committee items and reports. The Committee **AGREED** based on the information received within the meeting, the risk paper summary and the respective discussions that there is 1 risk with a current score of above 12 and one risk with a potential impact of 5 but with a current score below 12 within the areas of strategy and planning, performance and information and EPPR.

The Committee **AGREED** with the report's summary in respect of the common risk factors or emerging themes being;

a. Overall whilst the specific programmes reporting to the Committee (3Ts, M&A, R&R) are all managing and largely mitigating current risks, the delivery of the constitutional targets continues to deteriorate as per the overarching True North objectives

b. Operational pressures including Covid-19 pandemic, increased system demand and delays, and workforce constraints are impacting on all operational capacity and workstreams including delivery of constitutional targets, and indirectly potential risks to the objectives of 3Ts, and Recovery and Restoration programmes

c. Specific capacity constraints in operational services (including workforce impacts) which are driving the overall increase in the elective waiting times across a wide range of services, and the resulting reliance on Independent Sector capacity to deliver the minimum National requirements for elective care

The Committee **REVIEWED** the BAF risks it has oversight for, and **AGREED**, having regard to both the BAF summary and the Committees consideration of the risks considered during the meeting, that the quarter four score for risks 5.1, 5.2 and 5.3 were fairly stated

Actions taken by the Committee within its Terms of Reference

The Committee **APPROVED** the Trust's access policy.

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

The Committee did not identify any specific matters 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 to the Board for approval the Trust's Annual Emergency Planning, Preparedness and Response report.	To Board 3 February 2022

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	15.1	Meeting:	Trust Board	Meeting Date:	03 February 2022
Report Title:	Emergency Planning, Resilience and Response Annual Report 2021/22				
Sponsoring Executive Director:			Pete Landstrom, Chief Delivery and Strategy Officer		
Author(s):			Mark Stevens – Emergency Planning and Business Continuity Manager (UHSussex West) Natasha Lentner – Head of Resilience (UHSussex East)		
Report previously considered by and date:			Trust Management Board (January 2022)		

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

Implications for Trust Strategic Themes and any link to BAF risks		
Patient	☐	
Sustainability	☐	
People	☐	
Quality	☐	
Systems and Partnerships	✓	Supports the effective operational Emergency Response plans and policies as required as part of the Trust's legal duties under the Civil Contingencies Act, and as an NHS Trust Licence requirement

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

Communication and Consultation:

The Annual Report summaries the detail of the Trust's preparedness to respond to emergencies in order to meeting the requirements of the Civil Contingencies Act (2004) and the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework. The report summarises the outcome of the externally assessed review of the Trust's preparedness as part of the Annual review and assessment process, the relevant key areas where further work is required, and has been written by the Emergency Planning and Business Continuity Manager (UHSussex West) in consultation with the Head of Resilience (UHSussex East).

Executive Summary:

The report details the work undertaken over the last year by the EPRR teams to ensure the Trust's readiness and resilience in response to any type of disruption or emergency event. This covers the following key areas;

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

During 2021/22 the continued Covid-19 pandemic continue to exert exceptional challenges and significant impact on all areas of the Trust with the EPRR teams support the response as part of the Trust and National response framework.

It was agreed by the NHS Strategic Incident Director that all communication and coordination for the response to the Covid-19 pandemic would be via the established NHS England and Improvement EPRR communication routes, and this has continued through 2021 with each NHS provider being required to operate a formal incident coordination centre 7 days a week covering set periods.

In addition to the ongoing response, the Trust has also received a Substantially Compliant rating as part of the external assurance process undertaken annually by the ICS and NHSEI, for its plans and activities (including the response to the Level 4 Pandemic Critical Incident) for 2021/22. The Trust (both East and West) is fully compliant in 44 of 46 standards, and partially compliant in 2. There are plans in place to achieve Full compliance over the course of the next 6 months.

Key Recommendation(s):

The Trust Board is asked to;

- **NOTE** the report, and specifically the assurance rating of Substantially Compliant and the actions proposed to address the remaining areas of partial compliance
- **NOTE** the continued management of merging the EPRR policies and plans, Business Continuity plans, and Risks and team as part of the ongoing merger integration work

EMERGENCY PREPARADNESS, RESILIENCE and RESPONSE ANNUAL REPORT 2021

1. INTRODUCTION

1.1 This report provides an overview of the Trust's emergency preparedness, resilience and response in order to comply with the statutory requirements of a Category 1 responder under the Civil Contingencies Act 2004 and the NHS Emergency Preparedness, Resilience and Response (EPRR) Framework.

1.2 During 2021, the Covid-19 Pandemic continued to exert exceptional challenges and massive impact on all areas of the Trust with the Emergency Preparedness, Resilience and Response Teams supporting the Trust's response to the pandemic.

1.3 It was agreed by the NHS Strategic Incident Director that all communication for the response to the Covid-19 pandemic would be via the established NHS England and Improvement EPRR communication routes and this has continued through 2021 with each NHS provider being required to operate an incident coordination centre 7 days a week covering set periods.

1.4 Since March 2020 the Emergency Preparedness, Resilience and Response Teams with the help of a limited number of 'admin staff' have managed the incident coordination centres across the Trust as well as where possible maintaining 'normal' Emergency Planning and Business Continuity work load

1.5 As well as the pandemic response, the Emergency Preparedness, Resilience and Response Teams undertook an initial scoping for the planned merger in April 2021 with a comparison of existing legacy Trust EPRR Policies and Plans in preparation for combining these when appropriate and a risk assessment was carried out of current EPRR and operational readiness risks.

1.6 Due to the fact that all NHS provider organisations are required to be compliant with the NHS England Emergency Preparedness, Resilience and Response Framework,

NHS England Business Continuity Management Framework and the NHS England Core Standards for EPRR there was not a great deal of difference between the legacy EPRR policies and Plans and all legacy plans have been reviewed to ensure

compliance with the Emergency Preparedness, Resilience and Response (EPRR) Assurance process where possible.

2 RECOMMENDATIONS

2.1 The Committee/Board are asked to **NOTE** the contents of and **RECOMMEND** this Emergency Preparedness, Resilience and Response annual report to the Board for approval.

3 CONTEXT

3.1 This report provides detail on the Trust's preparedness to respond to emergencies in order to meet the requirements of the Civil Contingencies Act (2004) and the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework.

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

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

4 MAIN REPORT

4.1 Risk

4.1. 1 Risk management is covered within the Civil Contingencies Act 2004 and is the first step in the emergency planning and business continuity process. It ensures that local responders make plans that are sound and proportionate to risks.

4.1.2 Following the merger an Emergency Preparedness, Resilience and Response Corporate Risk has been drafted on SHE listing current Emergency Planning and Business Continuity risks and is currently being further reviewed and updated by EPRR managers and the Risk Manager.

4.1.3 The Emergency Planning and Business Continuity Risks currently on Datix for are from the legacy Trusts and although still current have been reviewed and updated ready for merging where appropriate and transferring onto the new IQ Datix system as soon as this is available.

4.1.4 All Emergency Planning and Business Continuity risks are linked to the Sussex Local Resilience Forum Community Risk Register (CRR) and the Local Health Resilience Partnership (LHRP) risk register; all have been reviewed and updated on a regular basis during the year and in response to any specific events or changes.

4.2 Assurance

4.2.1 The minimum requirements which commissioners and providers of NHS funded services must meet are set out in the NHS England core standards for Emergency Preparedness, Resilience and Response. The accountable emergency officer in each organisation is responsible for ensuring these standards are met.

4.2.2 As a direct result of the legacy Emergency Preparedness, Resilience and Response teams working together, the EPRR Assurance Process for UHSussex returned a **Substantially Compliant** rating which was endorsed by the ICS EPRR Team. This recognised the UHSussex Trust EPRR Team within the ICS for the outstanding work undertaken in supporting the Assurance process to attain this rating and develop a comprehensive action plan going forward.

4.2.3 Out of the total of 46 Core Standards contained in the 2021 EPRR Assurance process, the Trust was fully compliant with 44 of the standards with the remaining 2 being partially compliant as detailed below:

4.2.4 **Shelter and Evacuation** - Pre-Merger Western Sussex Hospitals was fully compliant with a Shelter and Evacuation plan in place, however Brighton and Sussex University Hospitals was non-compliant, although the trust had developed a draft Shelter and Evacuation plan this remains as draft hence the 'partially compliant' rating.

Discussions have taken place with the Estates and Facilities and Trust Fire Safety Officers with regards to ensuring the draft Evacuation and Shelter plan and the approved Fire Strategy and fire evacuation processes, have a final review, to ensure that they are consistent with each other and the revised NHSE Evacuation and Shelter Guidance which has recently been issued.

The Legacy Shelter and Evacuation plans will then be reviewed and merged to ensure that the Trust is compliant with this core standard.

4.2.5 **Site Lockdown** - Pre-Merger Western Sussex Hospitals was fully compliant with a Lockdown Policy and Lockdown plan/action cards in place. However, Brighton and Sussex University Hospitals was non-compliant. The Lockdown Policy was reviewed and updated for UHSussex and approved by Trust Management Board on 22nd July 2021.

It is recognised that UHSussex East does not currently have a Lockdown Plan, but a Lockdown Planning Group has been instigated to progress the outstanding actions for both RSCH and PRH and the next meeting of this group is scheduled for the 27th January 2022.

4.2.6 In addition to the above two actions, the following key actions were identified as part of the Assurance process:

- **EPRR Policies and Plans** – All plans will be reviewed and updated as necessary as part of the normal processes, until all plans can be merged. Until that point legacy plans have been reviewed and remain for in place for UHSussex East and UHSussex West.

- **Command and Control – On Call Mechanism** – the Senior Management Operational Resilience Protocol has been updated for all of UHSussex. The EPRR Policy has also been updated with Senior Management On Call arrangements being added to the policy. The Senior Management On Call mechanism/protocol will continue to be reviewed and updated as part of the merger process and until then, the current tried and tested existing Mjor Incident systems remain in place for both legacy UHSussex East and West.

- **Business Continuity** – Although both UHSussex East and West are fully compliant with all Business Continuity Core standards, pre-merger, legacy Business Impact Assessment and Service Level Plan templates are different and these need to be reviewed and updated to ensure a consistent approach across all sites. This will be done as programme of work as part of the rolling review and refresh programme of BC plans.

- **Risks** – The Legacy risks will be reviewed and merged onto the New IQ Datix system as soon as this is operational. Until that point the legacy risks are maintained on each DATIX system for East and West.

4.3 Policies and Plans

4.3.1 The Trust has a mature suite of legacy policies and plans to deal with EPRR Issues and specifically Critical, Business Continuity and Major Incidents as defined by the NHS England Emergency Preparedness Resilience and Response (EPRR) Framework.

4.3.2 All legacy EPRR policies and plans have been reviewed and updated to ensure that they are current and conform to guidance and legislation detailed in, but not limited to the following:

- Civil Contingencies Act (2004)
- NHS England EPRR Framework (2015)
- NHS England Business Continuity Management Framework
- NHS England Core Standards for Emergency Preparedness Resilience and Response (EPRR)
- NHS England Operating Framework – Response to Pandemic Influenza;
- ISO 22301 – Societal Security – Business Continuity Management Systems – Requirements

4.3.3 The following Polices and plans have been reviewed and merged/updated and approved for UHSussex:

- Emergency Preparedness Resilience and Response (EPRR) Policy
- Business Continuity Management Policy
- Lockdown Policy
- Trust Business Continuity Plan
- Trust Heat Wave Plan and associated documents
- Trust Cold Weather Plan and associated documents

4.3.3 The Trust's compliance with all legal and statutory obligations has been confirmed as part of the annual external review process.

4.4 Business Continuity

4.4.1 Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity procedures continue to be embedded in the Trust with clear and comprehensive separate EPRR and Business Continuity Management policies which provide a clear division between policy and operational plans.

4.4.2 The following documents have been reviewed and updated and approved for UHSussex:

- Business Continuity Management Policy
- Corporate Level Critical Activities
- Trust Business Continuity Plan

4.4.3 As already detailed in Section 4.2 Assurance, although both UHSussex East and West are fully compliant with all Business Continuity Core standards having a suite of Department Service Level Plans, pre-merger, legacy Business Impact Assessment and Service Level Plan templates are different and these still need to be reviewed and updated to ensure a consistent approach across all sites.

4.5 Training and Exercising

4.5.1 As with all training, EPRR Training has been impacted on by the Covid-19 response and Business Continuity Incidents and the majority of training courses were cancelled, although the HazMat/CBRN Decontamination training has recommenced with several courses having been completed since Sept 2021.

4.5.2 Director on Call training and On Call Manager major incident and EPRR training has also been completed were necessary on a 1:2:1 with individuals.

5 NEXT STEPS

5.1 Key Next Steps:

- Continue to work with Lockdown Planning Group to progress the Lockdown Plan for UHSussex East sites for completion by April 2022
- Continue to work with Fire and Estates and Facilities to progress the Shelter and Evacuation Plan for UHSussex East sites for completion by April 2022
- Review EPRR Corporate Risk Assessment on SHE and ensure all risks, Hazards and Control measures are reviewed and updated.
- Ensure that the current Legacy EPRR risks on Datix are reviewed and merged/updated onto the new IQ Datix system as soon as system is available.
- Continue to review and update/merge EPRR Emergency Plans for legacy Trusts and update to UHSussex as appropriate, operational processes and clinical operating model allowing.
- Review EPRR Team structure and recruit for vacant Emergency Planning Officer post from Jan 21st for UHSussex East
- Review legacy Business Continuity Service Level plans and Business Impact Assessment templates/processes with a view to merging / aligning the process into one.

Mark Stevens Emergency Planning and Business Continuity Manager UHSussex West	Natasha Lentner Head of Resilience UHSussex East

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	16	Meeting:	Board	Meeting Date:	3 February 2022
Report Title:	Audit Committee Chair report to Board				
Committee Chair:			Jon Furmston, Non-Executive Director and Committee Chair		
Author(s):			Jon Furmston, Non-Executive Director and Committee Chair		
Report previously considered by and date:					

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

Implications for Trust Strategic Themes and any link to BAF risks		
Patient	✓	The work of Internal Audit and Counter Fraud provided assurance in respect of various elements of the Trusts' the systems of internal control relied upon in managing a number of BAF risks. The 2021/22 Internal Audit plan was aligned to the BAF and the strategic risks facing the Trust.
Sustainability	✓	
People	✓	
Quality	✓	
Systems and Partnerships	✓	

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

Communication and Consultation:

Executive Summary:

The Audit Committee met on the 13 January 2022 and was quorate as it was attended by six Non-Executive Directors. In attendance was the Chief Financial Officer, the Chief People Officer for the Internal Audit reports within the area of HR, the Deputy Chief Medical Officer for the Caldicott Guardian update, the Trust's Finance Director, the Company Secretary along with the Trust's Internal and External Auditors and Local Counter Fraud team members. For the items in respect of the LCFS and IA provision then the Trust's External and Internal Auditors and LCFS team members left the meeting.

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 3 2021/22. The Committee also received a report from the Health Safety Committee Chair, the Caldicott Guardian, the Finance Director and the Company Secretary.

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

Key Recommendation(s):

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

The Board is also asked to **NOTE** the Committee's approval of the Trust's draft accounting policies for 2021/22.

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
Audit Committee	13 January 2022	Jon Furmston	yes	no
			✓	☐

Declarations of Interest Made

There were no declarations of interest made

Assurances received at the Committee meeting

The Committee **RECEIVED** an update on Internal Audit's activity since the last Committee. The Committee **NOTED** the continued use of Internal Audit resources to both assist the Trust to make improvements as well as providing assurance over key elements of the Trust's internal control framework. The Committee was **ASSURED** by the update provided by the Chief People Office over the improvement actions being taken in respect of the Trust's recruitment process. The Committee was **ASSURED** over the Trust's systems of key financial control given the positive opinion provided by Internal Audit. The Committee **RECEIVED** the routine recommendation tracker report and was **ASSURED** over the actions taken by management given the confirmation provided by Internal Audit that such actions had been delivered. In respect of the actions in progress and the Committee was provided with confidence that those due for implementation by the next audit committee will be completed.

The Committee were **ASSURED** that countering fraud remains integral to the Trust's culture as demonstrated through the Trust's engagement with NHS counter fraud national exercises. The Committee was **ASSURED** from the LCFS that the levels of their activity remains comparable to others and received **ASSURANCE** from the Local Counter Fraud Specialists that there were no significant fraud risks that needed to be actioned urgently within the Trust. The Committee was **ASSURED** over the processes and actions taken by the Trust in respect of local and national fraud alerts.

The Committee **RECEIVED** a report from the Trusts External Auditors on their plan for the audit of the Trust's 2021/22 annual accounts and annual report and **NOTED** the early work undertaken and the work planned to understand the Trust's overall control environment given this was their first year of audit. The Committee endorsed the approach to undertake an early interim audit to reduce pressure within the final year end audit.

The Committee **RECEIVED** the Trust's draft accounting policies and **AGREED** their application in respect of the Trust's 2021/22 annual accounts. The Committee **APPROVED** the Trust's assessment with respect of preparing the accounts on a group basis with the continuation of the consolidation of Pharm@sea and the Charities.

The Committee **RECEIVED** the Losses and Special Payments registers and Tender Waiver Reports for quarter three of 2021/22. The Committee through these reports was **ASSURED** over the underlying processes applied to manage Trust resources. The Committee was also **ASSURED** through the work being undertaken within procurement that the levels of waivers will continue to reduce.

The Committee received **ASSURANCE** from the Health and Safety Committee Report from its meeting in November 2021. The report confirmed the Committee's oversight of the Trust's Health and Safety key risks and requirements, especially the Trust compliance with those in relation to RIDDOR.

The Committee **RECEIVED** a report from the Trust's Caldicott Guardian on the Trust's Quarter 3 information governance activity. The Committee was **ASSURED** by the update that the annual submission in respect of

the data security protection toolkit would be made within the required timescales. The Committee sought further information on the actions planned in respect of improving the Trust's overall levels of Information Governance training, and the mitigations of the risk impact should the training levels remain below the expected 95% level. The Committee through the receipt of the information on IG incidents was **ASSURED** that these are subject to robust investigation and that any required actions were undertaken in a timely manner. The Committee was **ASSURED** through the Trust's programme of internal management reviews that all GDPR requests are being dealt with effectively. The Committee was updated on the levels of performance when dealing with subject access requests noting the high levels of compliance with the required response times. The Caldicott Guardian provided assurance that the requests for advice were appropriate and his overview of reported incidents had not identified any significant failings. The Committee asked for further information on the Trust's processes for oversight of its information assets and the Calidcott Guardian agreed to secure that information from the IG Manager.

The Committee **RECEIVED** a report from the Trust's Company Secretary in respect of the Trust's declarations of interest policy and was **ASSURED** given the level of responses made thus far this year, and within those made so far, that there have been no areas of potential conflict identified and that the Committee had confidence that the Trust will have a complete register by the time of its Annual Report.

The Committee **RECEIVED** an update on the planned review of the Trust's Committee Effectiveness and **ENDORSED** its scope including both a desk top review of the Committee documentation and specific Executive and NED engagement events.

Actions taken by the Committee within its Terms of Reference

The Committee **APPROVED** the Trust's draft accounting policies for the 2021/22 financial statements.

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

The Committee's requested information on the Trust's processes for oversight of its information assets.

The annual report on the Trust's compliance with its Declaration of Interests Policy ahead of the production of the Trust's Annual report.

The outcome of the scheduled review of the Committee effectiveness review allowing it to be considered alongside the Committee's consideration of the Trust's year end Annual Governance Statement.

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

Item	Date
There were no matters referred to the Board for specific action, but the Board is asked to **NOTE** that the People Committee will take the lead for the oversight of the recruitment process improvement actions.	

NHS
University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	17	Meeting:	Trust Board	Meeting Date:	03/02/2022
Report Title:	Patient First, Planet First: Our Green Plan				
Sponsoring Executive Director:			Karen Geoghegan, Chief Financial Officer		
Author(s):			David McLaughlin, Facilities and Estates		
Report previously considered by and date:			Trust Board Workshop 02.12.21 Trust Board in Private 06.01.22		

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	✓	Benefits to patients will be both internal NHS e.g. ward temperature management and general e.g. less NHS traffic on the roads
Sustainability	✓	Our Green Plan will reduce our CO2 footprint and achieve associated efficiencies e.g. relative fall in utility use and £ spend
People	✓	The pre-merger survey identified that Sustainability is a high priority for our staff
Quality	✓	Our Green Plan will support the delivery of excellent outcomes whilst minimising our impact on CO2.
Systems and Partnerships	✓	Our Green Plan embraces working with our local partners, to deliver positive change for our communities.

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

Communication and Consultation:

The development of the Green Plan has been supported by a wide range of stakeholders across multi-disciplinary teams. Oversight is through the Environmental Sustainability Steering Group chaired by the Chief Financial Officer. The Green Plan has had input from and been shared for comment with the Trust Board and Trust Management Board, Governors and local partners. The Communications and Engagement Team has developed a programme of events for a launch across the Trust during February.

Executive Summary:

In October 2020, the NHS committed to deliver the world's first Net Zero Carbon health service. All Trusts are required to develop a plan to meet this ambition.

Our primary environmental target is to become Net Zero Carbon for our *direct* emissions (NHS Carbon Footprint) by 2040 and our *indirect* emissions (NHS Carbon Footprint Plus) by 2045.

Our first target milestone is a reduction in our direct carbon footprint of 57% by 2025 from a 2009/2010 baseline

The Trust's Green Plan: Patient First, Planet First was approved by the Trust Board in January 2022. The plan is available to all our staff, patients and public on the Trust website.

Key Recommendation(s):
Trust Board is asked to: a) Note Patient First, Planet First Our Green Plan, approved by the Trust Board in January 2022.

University Hospitals Sussex
NHS Foundation Trust

Patient First, Planet First:

our green plan

In partnership with

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Foreword

As executive lead for Environmental Sustainability, I am proud to introduce our Patient First Planet First Green Plan, charting how University Hospitals Sussex NHS Foundation Trust will support the NHS to become the world's first net zero health service.

The effects of climate change are very real and being felt more and more in everyone's daily lives. Around the world and including here in Sussex, weather extremes are becoming the norm; from heatwaves to flooding, the news is full of stories of the devastating impact of our climate heating beyond what is healthy for both our planet and people.

At UH Sussex, we are committed to supporting this ambition and delivering the targets set out in the For A Greener NHS national programme - our staff have told us it matters to them and it is the right thing to do for our patients and the communities we serve. This Board approved Green Plan provides a comprehensive and structured framework for the Trust to achieve this.

Delivering on this ambition will be a significant challenge and the Trust Board for UH Sussex has a key role in driving and supporting action to reduce carbon levels across the NHS and its supply chain. However, it can be difficult to know where to start with such a vital and all-encompassing task. To achieve this, we will need to think creatively, solve many problems, change our behaviours and ultimately the way we deliver care. We will use our Patient First approach to continuous improvement to focus effort on where we can make the greatest impact to improve the health of both people and our planet. To this end, our Patient First Planet First Green Plan sets out our action plan over the next 5 years and identifies opportunities for us to take forward to substantially reduce our carbon footprint.

In recent years, we have taken some significant steps on our journey towards Net Zero Carbon, many of which we are pleased to share in this document. But we know there is much more to do. We are part of a single health and care system across Sussex so we are working in partnership with accredited climate change advisors Care Without Carbon to act in step with our healthcare partners on this critical agenda.

Together we will deliver a greener NHS in Sussex that cares for our planet and enables us to secure a better, healthier life for generations to come.

Karen Geoghegan
Chief Financial Officer and executive lead for Environmental Sustainability

Introduction

Welcome to the University Hospitals Sussex Patient First, Planet First Green Plan 2021.

In October 2020, the NHS committed to deliver the world's first Net Zero Carbon health service, responding to climate change and improving health now and for future generations.

As a Trust, our core focus is patients first and foremost. And as such, we are committed to meeting the ambitious Net Zero Carbon NHS targets, and where possible, exceeding them.

Patient First is our approach to transforming hospital services for the better. It is a process of continuous improvement enabling frontline staff to identify opportunities for positive, sustainable change and the skills to make it happen. It follows that we utilise our Patient First approach to tackle the challenges of climate change, transforming our services to adapt to our changing environment.

Our Patient First, Planet First Green Plan sets out our commitments and targeted interventions aimed at ensuring that the high quality of care we are providing today is available tomorrow.

We have developed this Patient First, Planet First Green Plan based around the Care Without Carbon (CWC) framework for sustainable healthcare, developed at Sussex Community NHS Foundation Trust and since adopted by other Trusts in the region. By working in parallel with others across our ICS system and beyond, we aim to enhance our impact, share our learning with others and support our own process of continuous improvement in line with our Patient First approach to long-term transformation.

Our vision

Living within our means, providing high quality services through optimising the use of resources.

Our aims

- **Reducing environmental impact: delivering care that is Net Zero Carbon, minimising our impact on the environment and respecting natural resources.**
- **Improving wellbeing: supporting the health and wellbeing of our patients, staff and communities.**
- **Investing in the future: making best value from our financial and other resources through forward thinking, sustainable decision making.**

Our key environmental targets

- **Net Zero Carbon for our direct emissions (NHS Carbon Footprint) by 2040.**
- **Net Zero Carbon for our indirect emissions (NHS Carbon Footprint Plus) by 2045.**

Our first interim target

57% reduction in our direct carbon emissions by 2025 from a 2009/2010 baseline.

Chapter 1
Why a Green Plan is important

The Case for Sustainable Healthcare

The links between climate and health are clear. According to The Lancet, climate change is the biggest global health threat of the 21st Century – but tackling it presents the greatest opportunity to improve health that we will see in our lifetimes. We understand that tackling this supports the health of everyone; our staff, our patients and our communities.

Climate change and health

Climate change and health are inextricably linked. The International Panel on Climate Change (IPCC) Sixth Assessment Report 2021 reported that human activity is changing the Earth's climate in unprecedented ways, with some of the changes now inevitable and irreversible. Limiting global warming requires reaching at least net zero CO_2 along with strong reductions in other greenhouse gas emissions.

In Sussex we are expected to see an increase in deaths and illness related to heat, air pollution and diet, damage to essential infrastructure and disruption to supply chains and services provision - all as a result of climate change[1].

At the same time, the way we are currently delivering healthcare is in itself contributing to ill health. Within the public sector, the NHS is the largest emitter of CO_2, making up 4% of the UK's carbon footprint. And with 9.5 billion miles of all road travel in England associated with NHS business, plus huge amount of waste produced, our environmental impacts go far and wide.

Delivering better care

Health and sustainability go hand in hand. By delivering care in a more sustainable way, and supporting our staff, patients, carers and communities to live more sustainable lifestyles, we are enabling better health outcomes in our community, putting patients first and foremost.

Empowering our staff to make more sustainable, healthier choices will improve their wellbeing both at work in their personal lives.

According to the 2020 NHSEI climate change strategy, 'Delivering a Net Zero NHS', limiting climate change in line with global goals could improve the health of our populations in a wide range of areas, for example:

- **saving 5,700 lives per year from improved air quality;**
- **saving 38,000 lives per year from a more physically active population;**
- **saving over 100,000 lives per year from healthier diets;**
- **avoiding 1/3 of new asthma cases.**

[1] Adaptation to Climate Change for Health and Social Care Organisations, Sustainable Development Unit (now For a Greener NHS)

Meeting our resourcing challenges

Sustainability is shorthand for effective resource management. In the NHS we can identify three key resource challenges:

1. An environmental challenge – the NHS is the largest public sector emitter of CO_2 in the UK.
2. A wellbeing challenge – finding new ways of delivering care that reduces demand and empowers patients as well as looking after the health and wellbeing of our 1.5 million NHS and social care staff.
3. A financial challenge – with demand on our services and aging estate providing significant funding challenges.

These challenges translate into our aims, forming the backbone of the Care Without Carbon framework. This Green Plan aims to meet each of these three challenges together, identifying actions that will benefit the environment and wellbeing as well as making financial sense over the short and long term. Figure 1 demonstrates the link between these interrelated and complex challenges, through the Care Without Carbon virtuous circle.

Figure 1: Care Without Carbon creates a virtuous circle of sustainable healthcare.

The key drivers for this Green Plan

Climate emergency = health emergency: Former NHS England CEO Simon Stevens described the climate emergency as a 'health emergency' and reiterated the need for the NHS to be the change it wants to see. We firmly believe that tackling climate change ensures we are supporting the health of our staff, our patients and our community.

Delivering a Net Zero Carbon National Health Service (2020): If health services around the world were a country, they would be the fifth largest emitter of CO_2. The NHS therefore has the potential to make a significant contribution to tackling climate change in the UK. Launched in Autumn 2020, the new NHSEI climate change strategy sets out clear targets for NHS trusts to become Net Zero Carbon, and identifies specific areas of work to achieve this. More recent NHSEI communications have set a requirement for all Trusts to have a Board approved Green Plan in place by January 2022.

The NHS Standard Contract and planning guidance: The full version of the NHS Standard Contract mandates a range of targets relating to sustainability, including that all providers have a Board approved Green Plan. Planning guidance also includes a target for carbon reduction relating to outpatient appointments.

Commissioning: A Green Plan may be asked for by Commissioners as evidence of approach to Social Value.

Social Value: There is a requirement for all NHS organisations to include a 10% weighting dedicated to social value and sustainability within all tenders from 2021.

There is a strong financial business case for taking action to become more sustainable: by reducing consumption of resources such as energy, water, fuel and other materials, reusing and recycling more, NHS organisations can realise significant savings. These can then be reinvested into the frontline care, redeveloping our estate and improving working conditions.

The NHS must help to adapt to the negative impacts of climate change on health: we have been feeling the effects of climate change in the UK for some time now, with increasing temperatures, an increase in the magnitude and frequency of extreme weather events (i.e. heatwaves and flooding), as well as a deterioration in air quality. These changes in the climate impact the way in which we deliver care – from reducing access to our premises for both service users and staff, to altering the health needs of our communities.

Chapter 2
How we have developed this Green Plan

Our approach: Patient First, Planet First

University Hospitals Sussex was formed on 1st April 2021 creating a new NHS Foundation Trust for our region merging Western Sussex Hospitals (WSHT) and Brighton and Sussex University Hospitals (BSUH). A single trust provides a new certainty for patients, staff and the hospitals, paving the way for service improvements that deliver the ambitions of the NHS long Term Plan and Sussex Integrated Care System (ICS).

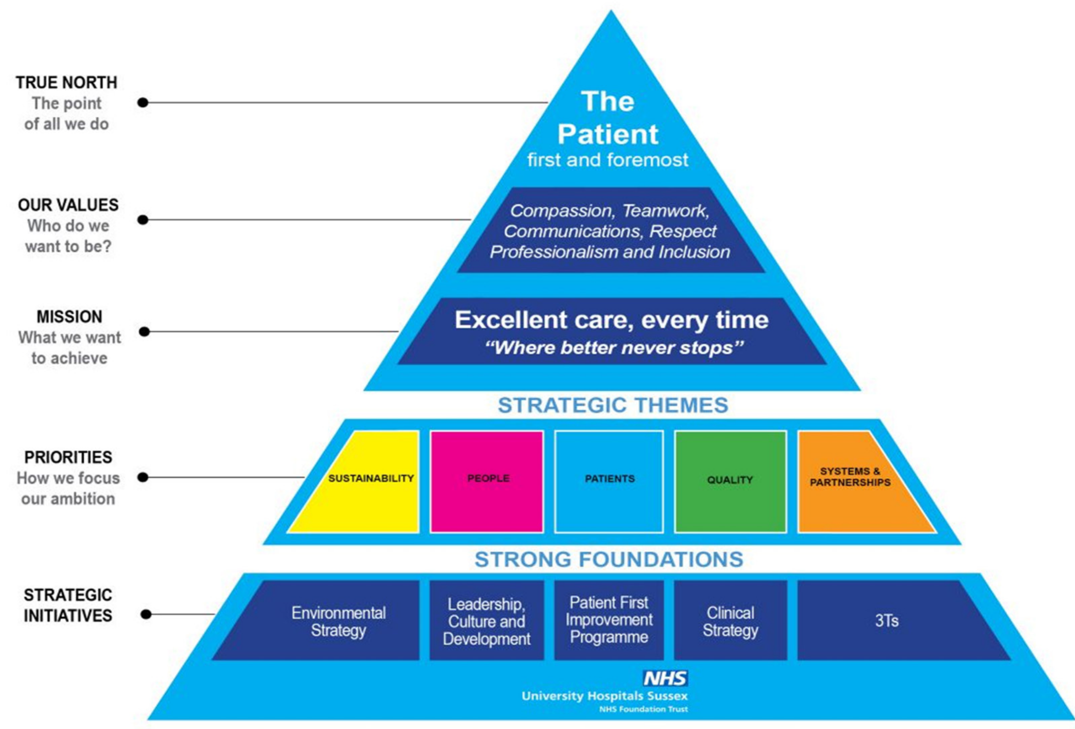


Figure 2: our Patient First Triangle.

At UHSussex, Patient First is our long-term approach to transforming hospital services for the better. It is our guiding philosophy, approach to continuous improvement and the way in which we develop and deploy our strategic priorities from board to ward and to every team and department working in our Trust.

Sustainability is one of our key Patient First strategic themes, each of which have an associated overarching ambition known as True North goals. Our sustainability True North is to live within our means providing high quality services through optimising the use of resources.

As part of delivering our True North, the Trust has committed to delivering environmental sustainability as a strategic initiative, as part of our Patient First Triangle (see Figure 2). This is one of the 5 important strategic initiatives recognised as a must do, can't fail, commitment essential in delivering the Trust's overall strategic objectives.

The climate emergency is a heath emergency and so it follows that we utilise our Patient First approach and the continuous improvement skills and tools familiar to our staff to empower and enable them to tackle the challenges of climate change, transforming our services to adapt to our changing environment: Patient First Planet First. Recognising environmental sustainability as an SI means this will be at heart of our decision making processes and help us invest for the future.

Consequently, our 20,000 staff and hundreds of hospital volunteers are key to the successful delivery of our Green Plan. Sustainability and the environment will increasingly become a key consideration in our UHSussex People Policy and Strategy and core theme of our corporate Communications and Engagement strategy.

Engaging with our staff on sustainability

We know that our staff at UHSussex see sustainability as a priority area for action.

During October 2020 we conducted a staff and community survey on the upcoming merger proposal. Under the heading of sustainability all groups highlighted "Environmental Responsibility" as a high priority.

As such, and in line with our Patient First methodology, we have engaged extensively with staff across the trust in the development of this Green Plan. This has been through a combination of 1-1 stakeholder meetings, workshops at sustainability/green groups and discussion within existing groups such as Environmental Sustainability Steering Group (ESSG).

We have had positive feedback throughout, with some specifics coming through:

- **People:** need to weave sustainability into all UHSussex core training offers as well as highlighting our credentials as a 'green employer' as part of our recruitment process.
- **Clinical:** wide range of ground breaking projects and research in progress; champions emerging across the trust; importance of partnership working, e.g. Brighton & Sussex Medical School and our community/ICS colleagues.
- **IT:** wide range of joint working opportunities identified, including integrating sustainability benefits into IT projects/change programmes.
- **Agile working:** many discussions around the positive impact of agile working on staff, patients and the environment; highlighted the need for environmental considerations to be part of the conversation on Trust strategic direction in this area.
- **Waste:** importance of at-source recycling in engaging with staff, patients and visitors; opportunity for reuse projects identified across a range of areas including clinical, IT and other items.
- **Estates:** identified need to undertake a decarbonisation of heat assessment across the entire estate to add the next level of detail to our Net Zero Roadmap; 3Ts offers clear potential for supporting the Green Plan targets, particularly in the later phases; need to consider rationalisation of the estate as a key measure for decarbonisation as part of the wider measures.
- **Travel:** existing Green Travel Plan and long running Trust-wide travel survey provides an excellent basis for work; key opportunities to support air pollution reduction locally.
- **Improvement:** importance of integrating sustainability into strategic initiatives and corporate projects.

Partnering with Care Without Carbon

We have developed this Patient First Planet First Green Plan in partnership with Care Without Carbon (CWC) and based upon their framework for sustainable healthcare, developed at Sussex Community NHS Foundation Trust.

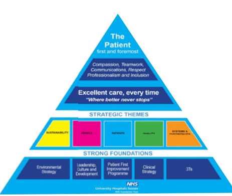
The CWC framework establishes three principles for sustainable healthcare:

> **1. Healthier lives:** Making use of every opportunity to help people to be well, to minimise preventable ill-health, health inequalities and unnecessary treatment, and to support independence and wellbeing.
> **2.Streamlined processes and pathways:** Minimising waste and duplication within the Trust and wider health system to ensure delivery of safe and effective care.
> **3.Respecting resources:** Where resources are required, prioritising use of treatments, products, technologies, processes and pathways with lower carbon, environmental and health impacts.

These principles are based on those developed by the Centre for Sustainable Healthcare, and are working to: optimise our level of activity through reducing the need for care and making our processes as efficient as possible; and reduce the carbon intensity of the care we do need to provide.

In order to deliver against our three sustainable healthcare principles and ensure we have an integrated and holistic approach to our sustainable healthcare programme, we have developed action plans under our 10 work streams based on the Care Without Carbon framework. These action plans set out our commitments in each area, a detailed set of actions and a key success measure through which we will monitor our progress. Actions are identified for the three year timeframe of this Green Plan, with targets to 2025 to reflect our Net Zero commitments. We will use our Patient First methodology for change and improvement to guide how we deliver on this Green Plan.

Our approach is set out in Figure 3.



UHSussex Patient First Strategy

"Where Better Never Stops"

Patient
Improve patient experience

Quality
Reduce harm & mortality

People
Improve staff enagegement

Sustainability
Optimise Use of Resources

Systems & Partnerships
Improve patient waiting times

UHSussex Patient First, Planet First Green Plan

framework

We achieve these aims through our sustainable healthcare principles:

Our three aims

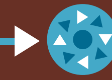
1. **Reducing the environmental impact:** Delivering care that is Net Zero Carbon, minimising our impact on the environment and respecting natural resources
2. **Improving wellbeing:** Supporting the health and wellbeing of our patients, staff and communities
3. **Investing in the future:** making best value from our financial and other resources through forward thinking, sustainable decision making

Respecting resources

Where resources are required, prioritising use of treatments, products, technologies, processes and pathways with lower carbon, environmental and health impacts.

Healthier lives

Making use of every opportunity to help people to be well, to minimise preventable ill-health, health inequalities and unnecessary treatment, and to support independence and wellbeing.



Streamlined processes & pathways

Minimising waste and duplication within the Trust and wider health system to ensure delivery of safe and effective care.

Workstreams

Travel & Transport

Clinical

Digital Transformation

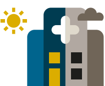
Buildings & Utilities

Food & Nutrition

Staff Engagement & Wellbeing

Partnership & Collaboration

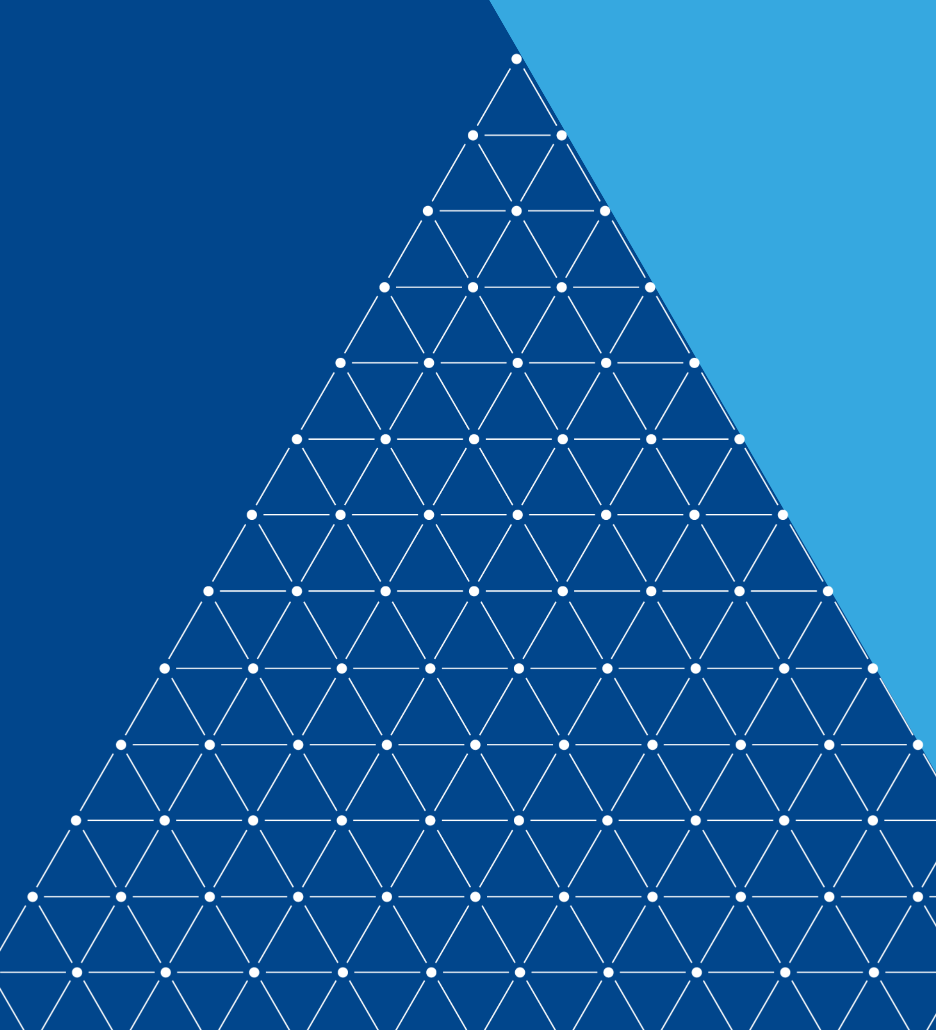
Reduce, Reuse & Recycle


Climate Adaptation

Supply Chain & Procurement

Figure 3: our Patient First, Planet First approach to sustainability

Chapter 3
What we have
achieved so far



Our environmental impact

UHSussex employs nearly 20,000 people across seven main sites in Sussex, and has an operating budget of more than £1.2 billion.

We run seven hospitals in Chichester, Worthing, Shoreham, Haywards Health and Brighton and Hove, as well as numerous community and satellite services. We deliver all district general acute services for Brighton and Hove, West and Mid Sussex and parts of East Sussex. In addition, we provide specialised and tertiary services across Sussex and parts of the South East, including neuroscience, arterial vascular surgery, neonatology, specialised paediatric, cardiac, cancer, renal, infectious diseases and HIV medicine services.

Our carbon footprint

In delivering our services we consume a significant amount of energy and water and produce a large volume of waste. Our staff travel between sites and in some cases across a substantial area to deliver services. And we purchase a wide range of equipment and services.

All of these activities generate CO_2 (carbon dioxide) emissions and can be collectively summarised as the Trust's carbon footprint (measured in tonnes CO_2e[2]. We have aligned our carbon footprint methodology with new NHSEI guidance (see Figure 4). As such, in this section we provide information relating to the following:

- **NHS Carbon Footprint, accounting for our direct emissions. This includes data for building energy, water, waste, anaesthetic gases and inhalers, and business travel and fleet.**
- **NHS Carbon Footprint Plus, accounting for the much wider, indirect impact of our Trust, but which we have influence over. This includes the impact of medicines, medical equipment, supply chain and patient travel. For the first time this year we have data for our supply chain impact, measured using P4CR methodology; this is shown in the section on Net Zero (Figure 6).**

Data reflects the carbon footprint of UHSussex using a base year of 2009/10. For dates prior to the merger (April 2021), data for the two previous trusts (BSUH and WSHFT) have been combined.

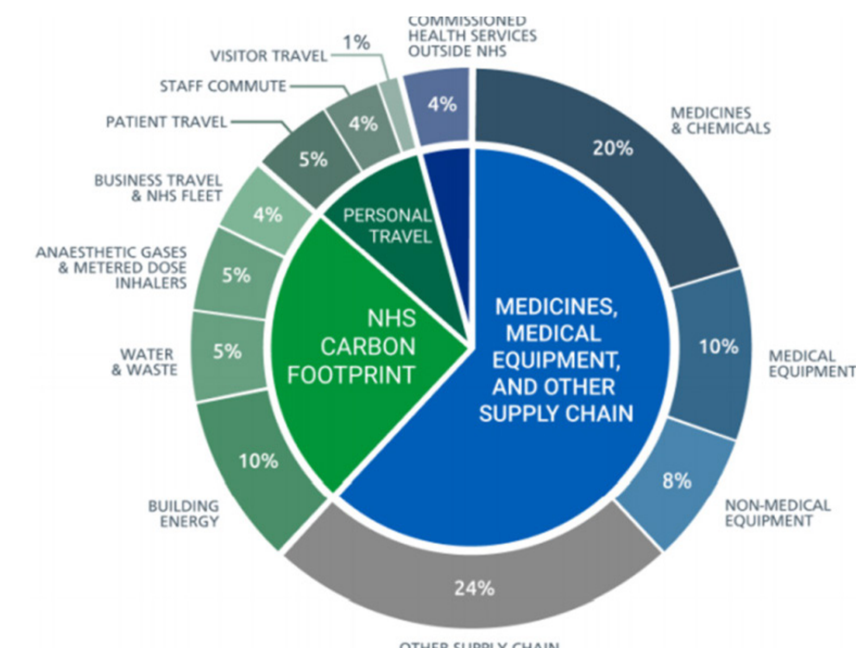


Figure 4: NHS Carbon Footprint Plus from Delivering a 'Net Zero' National Health Service (2020) illustrates the breakdown of footprint for the entire NHS. The carbon footprint associated with delivering patient care specifically at UHSussex is illustrated in Figures 5 to 6 on the following pages.

The carbon footprint associated with delivering patient care at UHSussex is illustrated in Figures 5 to 6 on the following pages.

[2] CO_2e refers to six greenhouse gases including carbon dioxide and methane. The NHS measures its carbon footprint in CO_2e in line with national and international conventions including the Greenhouse Gas Protocol. This allows for all six gases to be measured on a like for like basis, which is important as some gases have a greater warming effect than CO_2.

UHSussex NHS Carbon Footprint

Our target: net zero by 2040

Our absolute NHS Carbon Footprint is made up of our five areas of direct impact:

- Building energy (electricity and gas use)
- Water
- Waste
- Medical gases (anaesthetic gases and metered dose inhalers)
- Travel (business travel and NHS fleet)

Data reflects the carbon footprint of UHSussex using a base year of 2009/10. For dates prior to the merger (April 2021), data for the two previous trusts (BSUH and WSHFT) have been combined.

In 2009/10 our NHS Carbon Footprint was over 57,000 tonnes and has since reduced by 37% to just under 36,000 tonnes.

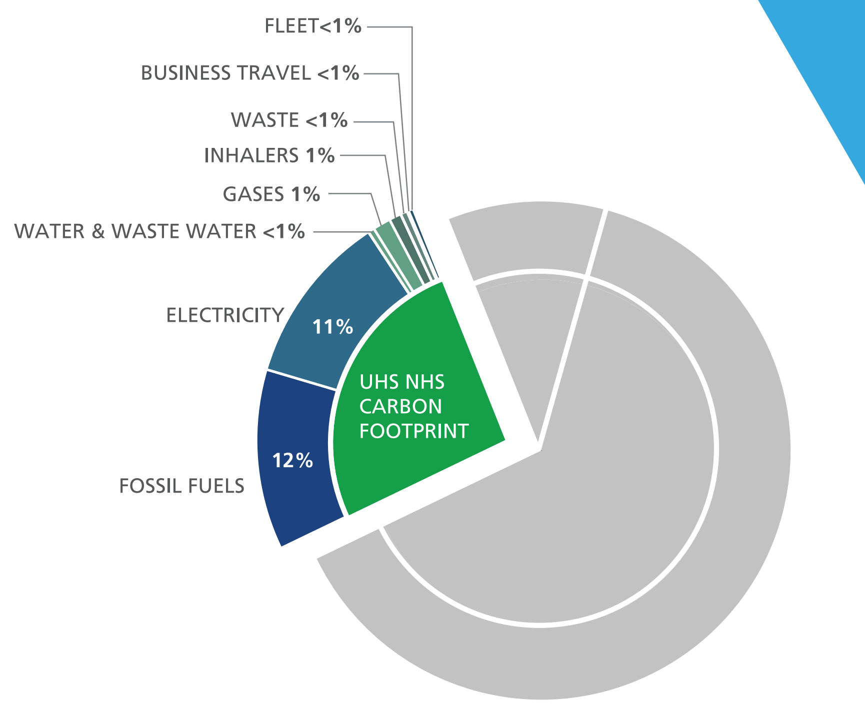


Figure 5: UHSussex NHS Carbon Footprint 2020-21 in the context of our NHS Carbon Footprint Plus (see Figure 8)

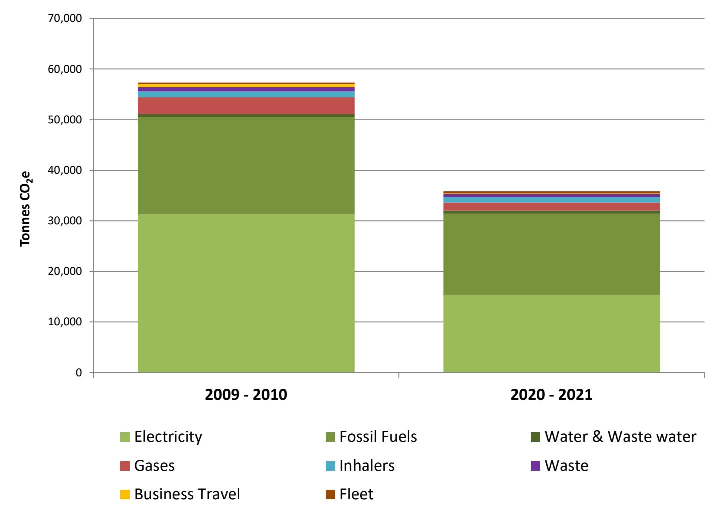


Figure 6: UHSussex NHS Carbon Footprint since base year

Top contributors to our carbon footprint

Figure 7: Breakdown of UHSussex NHS Carbon Footprint areas of impact. Our progress since our baseline (2009/2010)

Building energy

The energy used to power our buildings – primarily electricity and gas – is the main contributor to our NHS Carbon Footprint. Over the last 10 years we have made significant investment to improve energy efficiency within our estate. For example to LED lighting replacements, boiler and building management system (BMS) upgrades and building fabric improvements such as roof replacement and windows. The year on year decarbonisation of the electricity grid has also played a significant part in our emissions reductions and from April 2021 we have been purchasing 100% REGO assured renewable electricity.

Medical gases

Medical gases are a significant contributor to our carbon footprint at 6%. Over the past 3 years we have been working hard to reduce the most harmful anaesthetic gas, Desflurane, and in doing so have significantly reduced our footprint in this area. Over the last 2 years (19/20 and 20/21) our use of Desflurane has reduced to 6% of all gases, down from 25%.

Travel

Travel is another component of our footprint. In 2018/2019 our staff travelled over 1.8 million miles moving between our sites and carrying out UHSussex business. In 2018/2019 we introduced our inter-site minibus and park and ride service to enable staff to travel between Worthing, Shoreham and Chichester without their cars. This increased our direct carbon footprint but had a net benefit through reducing our indirect travel footprint.

Waste

We produced 4,525 tonnes of waste in 2020/21 including clinical waste, general waste and recycling. Waste disposal produces greenhouse gases, which have been included in our carbon footprint below. In our baseline year a large proportion of our waste was being sent to landfill, since then we have amended our waste contracts so that waste is processed at a materials recovery facility and nearby energy recovery facilities. This change provided a 27% decrease in our associated emissions.

UHSussex NHS Carbon Footprint Plus

Our target: net zero by 2045

In line with NHSEI methodology, we also illustrate here our NHS Carbon Footprint Plus (see Figure 8 below). In addition to our direct impacts, this also includes more indirect areas of impact, but which we have influence over as a Trust, specifically:

- Medicines, medical equipment and other supply chain impacts
- Personal travel
- Commissioned health services outside NHS

Medicines, medical equipment and other supply chain

The largest portion of our carbon footprint, 64%, is associated with the carbon footprint of our supply chain – the goods and services we purchase, use and dispose of.

In line with NHSEI methodology, this includes medicines, medical equipment, non-medical equipment, commissioned health services outside of the NHS and other supply chain.

Personal travel impacts

Personal travel is made up of staff commuting to work, patient and visitor travel. This area makes up approximately 10% of our carbon footprint. The reason these emissions are classified as indirect is that the Trust has no control over how staff, patients and visitors travel to and from the hospital and which modes of travel they choose.

For the purposes of illustration, we have included here estimated figures based on NHSEI information for an average NHS Trust and we will work to define a methodology for measurement over the coming years.

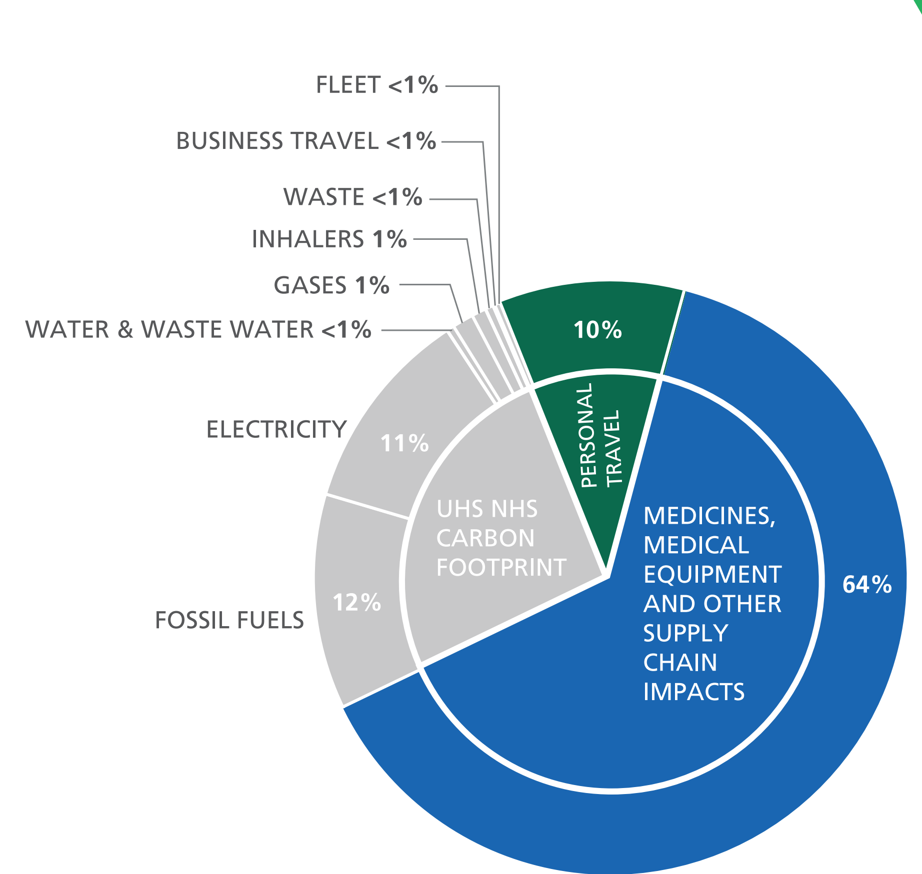
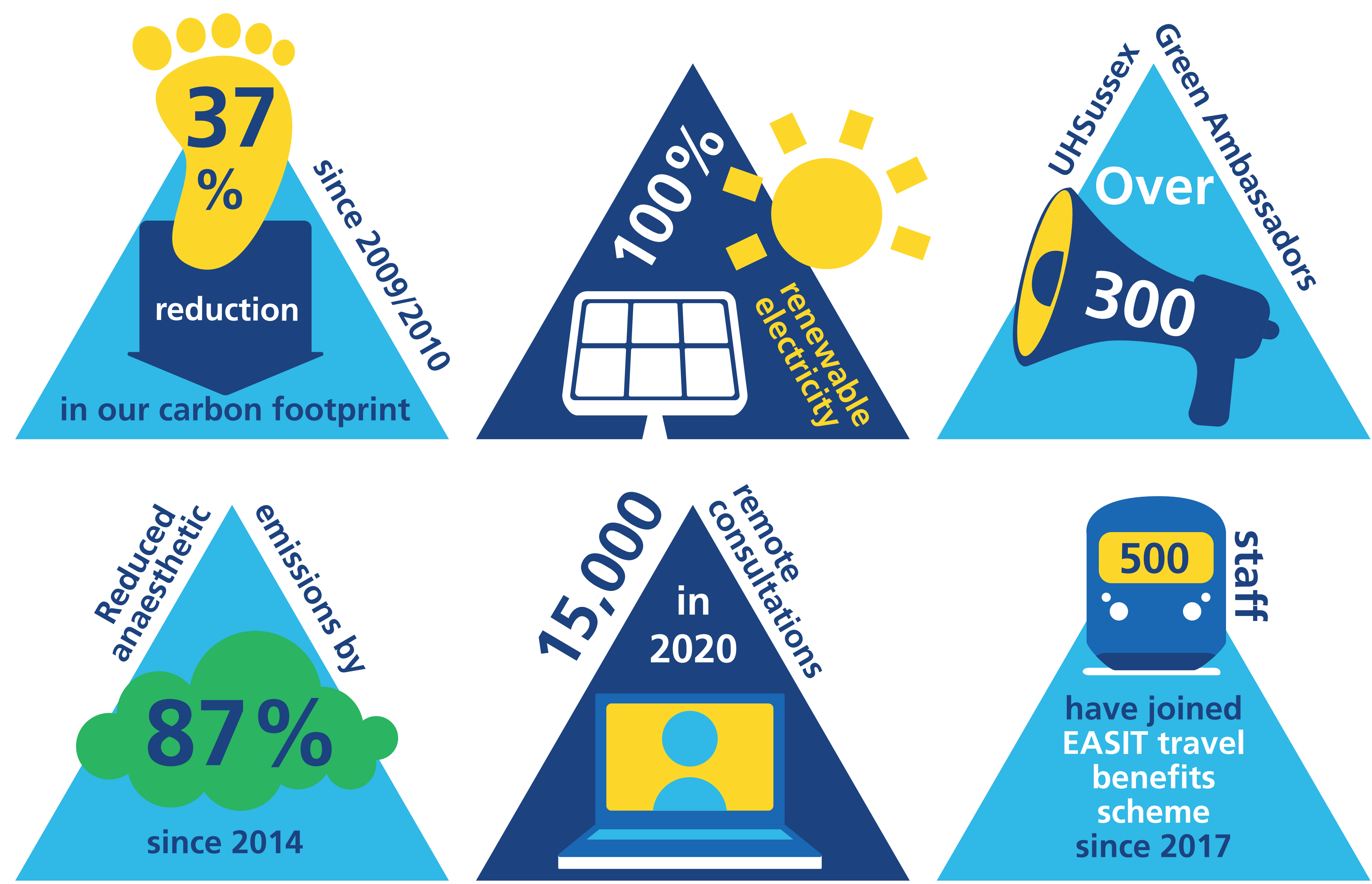


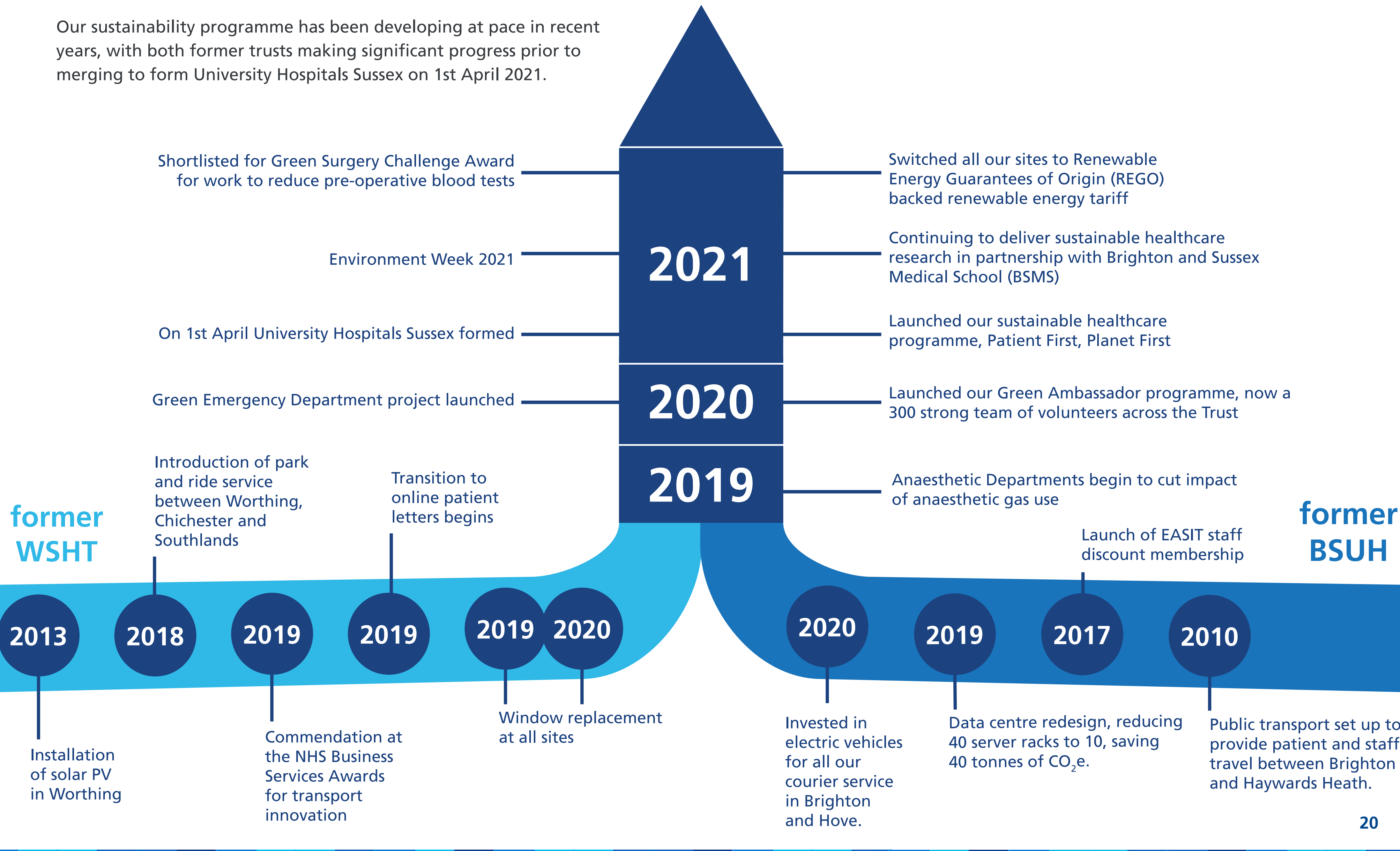
Figure 8: University Hospitals Sussex NHS Carbon Footprint Plus 2020/21

The story so far:
we are building on progress



We are on course to Net Zero

Our sustainability programme has been developing at pace in recent years, with both former trusts making significant progress prior to merging to form University Hospitals Sussex on 1st April 2021.



We have learnt a lot already

Green Ambassadors

In 2020 we set up our Green Ambassadors programme, a staff network for those that are passionate about sustainability and want to champion improvements in their teams. Our 300+ strong team of Ambassadors cover every division and dozens of different departments.

Green Ambassadors work stream lead, said: "UHSussex is full of compassionate and hardworking people who care about the health of the population and our planet. I am really looking forward to the many ideas suggested by Green Ambassadors coming to fruition – either by working individually with them on their own sustainability quality improvement projects, or feeding suggestions through to the relevant work streams."

Our ambassadors have begun forming sub workstreams within their departments aimed at reducing environmental impact from the ground up. For example Green Admin, Green Pharmacy and Green ED. Each group sets out clear objectives and aims relevant to their day to day practices and take on projects looking at paper reduction, behavioural change for utility management and awareness campaigns in wider sustainability issues.

Cutting our paper use through digitisation

We have worked hard over the last two years to cut paper use across the Trust. Key to this has been moving patient letters and clinical information to our patient portal ‘My Health and Care Record’, which ensures patients have up to date information on their care at their fingertips, while at the same time vastly reducing the amount of letters printed and posted to patients.

Since implementation some 70,000 letters have been viewed digitally avoiding postage and saving the cost of paper, envelopes and CO_2e emissions associated with postage and delivery.

An average of 77% of registered patients now view their letters electronically, over the coming months we now have a focus to move all patient letters and information from paper to digital.

Other projects across the Trust including replacing paper ordering of pathology and radiology request forms, moving to digital observation forms and the launch of Badger Babies, working with our partners trusts locally to transition maternity notes online through our new Badgernet system.

Delivering care remotely

Over the last 18 months, we have significantly increased our ability to deliver care remotely, ensuring patients are able to receive the care they need in the face of travel and movement restrictions, reducing the need to travel to appointments and supporting an improvement in efficiency of services.

Over the last 12 months, with the support from our digital and clinical teams, 15,000 appointments have been delivered remotely with associated CO_2e and £ savings from reduced travel and transport as well as a cutting the time for patients and Consultant associated with care delivery.

One specific example is within our stroke clinics. Since the first wave of the pandemic, stroke outpatient clinics at Royal Sussex were moved to telephone rather than face-to-face. Analysis showed a saving of over 35kg of CO_2e for each clinic (around 6 patients), which is the equivalent of driving from Brighton to Bristol.

Key to our work in this area has been to ensure remote consultation can be safely and effectively delivered to patients. A recent trial of remote consultation by the Ear Nose and Throat department for patients referred with recurrent tonsillitis found that doctors were happy care could be delivered effectively via telephone consultation. Patients using this service were consulted and found to be highly satisfied, with many saving time they would have had to take off work to attend an appointment, as well as financial costs of transport. In this case, the average carbon saved for each appointment was 5kg of CO_2e.

Greener Travel: bus travel between sites

With thousands of staff working at multiple sites across Sussex, driving down car journeys between our hospitals was crucial to our Green Travel work.

To start tackling this, we introduced a free bus service for patients and staff travelling for work between key hospital sites.
Our transport lead said: "We were pleased we were able to provide a service that met our green targets and benefited staff and patients. Prior to Covid, the number of people using the service was really positive. Once we get back to some sort of normal then I hope the numbers come back up and we can look to expand our greener travel options further."

In its first year of operation, this took around 2,000 car journeys off the road, saving nearly 60 tonnes of CO_2e.

Switching single-use to reusables: surgical instrument sets in A&E

Traditionally, suturing in accident and emergency departments uses single use surgical instruments, which are known to have a high carbon footprint.

In two of our hospitals alone (In two of our hospitals alone we use PRH and RSCH) we use nearly 3000 single-use suture kits every year.

We are trialling reusable surgical instruments for use in A&E, which can be sterilised on-site, and are better quality instruments, with less than 10% of the carbon footprint.

Tackling medical gases and inhalers

A study by clinicians at UHsussex found that if patients on one respiratory ward changed the inhaler they were using their collective carbon footprint could reduce by about 90% in one year - the equivalent of driving around the world three times.

One of our medicine chief registrars worked on the project alongside a Respiratory Consultant at UHSussex, and said: “Over a year we measured the volume of inhalers prescribed to 169 patients on discharge from Pyecombe respiratory ward at the Princess Royal Hospital in Hayward’s Heath.

“We found 63% were MDIs; if these were switched to DPIs, the carbon footprint of inhaler use in this group of patients could be reduced from nearly 24,000kg of CO_2e to less than 3,000kg over a year. That is about a 90% reduction, which vividly demonstrates how small changes really can make a huge difference.”

The team’s findings have been presented to a respiratory governance meeting, as well as to the national Sustainable Healthcare Academic Research Enterprise (SHARE) conference. The respiratory team has also presented their findings to other NHS trusts.

An inhaler working group is being set up and a medicine clinical fellow appointed to work on reducing MDI prescribing across UHSussex.

Capital Development and Our Estate

In 2021 we have updated our Capital Investment Business Case templates to include an environmental impact assessment. We are now looking to roll this out for all our investment decisions across other areas of the Trust.

In Brighton our new 3Ts redevelopment will provide state-of-the-art accommodation for more than 40 wards and departments. It will improve patient experience across all these services and provide a care environment that enables the best possible healthcare for all. The improvements will benefit patients, staff, visitors and healthcare students. The new facilities will make it easier to deliver care at the bedsides of patients and will help fulfil the trust's teaching role as a university hospital. The outpatient facilities will be spacious and modern with innovations that maximise patients' privacy and dignity. Overall the redevelopment will support the trust's roles as a district general hospital, specialist tertiary centre, teaching hub and major trauma centre. The development will replace aging buildings with modern ones designed to BREEAM (Building Research Establishment Environmental Assessment Method) 'Excellent' rating and stages 2 and 3 will incorporate Net Zero technology. The replacement of energy inefficient buildings dating back to the 1840s still in active use, for both clinical and non-clinical care at the Royal Sussex County Hospital site.

The 3Ts programme contributes to delivering our Green Plan:

- **Utilising modern design, insulation and building materials, which will minimise energy wastage.**
- **The retained estate will receive heating and hot water from the new efficient heating systems installed for the 3T's Hospital, this action will also reduce the carbon contribution from the retained RSCH Estate.**

- **The building has been designed and constructed to BREEAM Excellent standard following new sustainable methods of construction, this will provide a reduced carbon contribution per patient bedded when compared to the retained RSCH estate.**
- **The medical equipment within 3Ts will be new and inherently more efficient than existing that they are replacing providing a benefit from advances in technology and manufacturing techniques reducing the footprint of patient services.**

The 3Ts is a significant development and during development the carbon footprint of the Trust will increase. This will be mitigated utilising new, emerging and well established technologies in the development and across the Trust's existing estate. The development of our estates masterplan will enable the estates portfolio to be rationalised and support the exit from outlying sites with older buildings.

Patient Catering

Celebrity chef Prue Leith and Former Health Secretary Matt Hancock MP opened a new patient catering service at St Richard's Hospital in Chichester in January 2020. The event marked the conclusion of a £3 million investment to improve food and drink for patients and reduce food miles.

Every day, nearly 2,000 meals are provided for lunch and supper to inpatients at Worthing Hospital and in Chichester. Following a review of the service, the trust invested £3million in a new state of the art kitchen at St Richard's to provide cook-freeze meals for both hospitals.

A new menu was developed by the Trust's catering, dietetic, nursing and therapies teams to provide patients with more nourishing options including more plant based ones. Patients now make their selection from a choice of 27 mains and 25 snacks. Selections are made a couple of hours before each meal time on an IPad, which has reduced the paper work to zero.

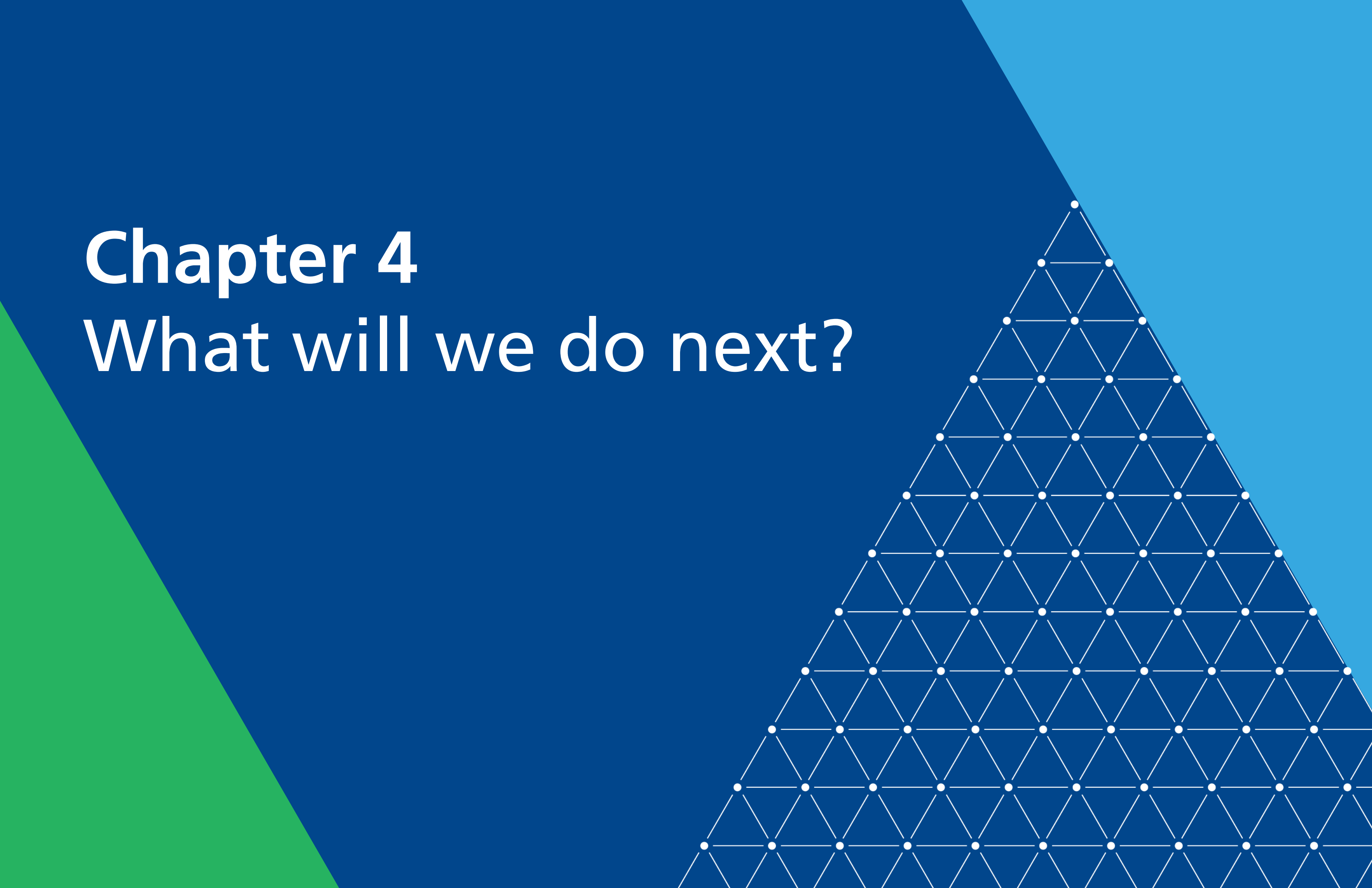
The project has not only improved the food provision for patients and staff, but also reduced food waste from 40% to 10%, reducing our carbon footprint and saving money at the same time.

Upgrading our St Richard's Laundry

Following a recent review of laundry services, a full upgrade is underway for St Richard's Laundry. This £5 million investment in new equipment is designed to deliver a local, in house laundry service to all our sites. This upgrade – due to be completed in 2022 – will provide multiple benefits:

- Minimising electricity and gas use through upgrade to new, highly efficient equipment.
- Cutting water use through technology to recycle and reuse water for initial wash of soiled items.
- Reducing our chemical and detergent usage with up to date chemical management system with both the new equipment supplier and our chemical supplier.
- Reducing or eliminating the use of plastic packaging through the use washable reusable canvas or water soluble laundry bags across the trust.

Chapter 4
What will we do next?



Achieving Net Zero

We are proud of the work we have achieved so far through our sustainability programme at UHSussex, as well as the leading work done at all sites prior to forming UHSussex in April 2021.

We are committed to matching the targets set out by NHSEI – and where we can, delivering on them sooner.

This means reaching Net Zero Carbon for our direct emissions (NHS Carbon Footprint) by 2040 and our indirect emissions (NHS Carbon Footprint Plus) by 2045 at the latest.

Our first interim target is a reduction in our carbon footprint of 57% by 2025 from a 2009/2010 baseline. This is required of all NHS organisations as part of the trajectory to Net Zero by 2040.

Our ten action plans have been developed deliver against these Net Zero targets, alongside some of our wider sustainability goals, which aren't reflected in the Net Zero target.

Figure 9 sets out our target trajectory towards Net Zero Carbon for our direct footprint (target line) against a Do Nothing scenario, which models where we would be no interventions at all. The reduction seen in the Do Nothing scenario is primarily down to the impact of the greening of grid electricity, which is projected to reach Net Zero in the 2030s.

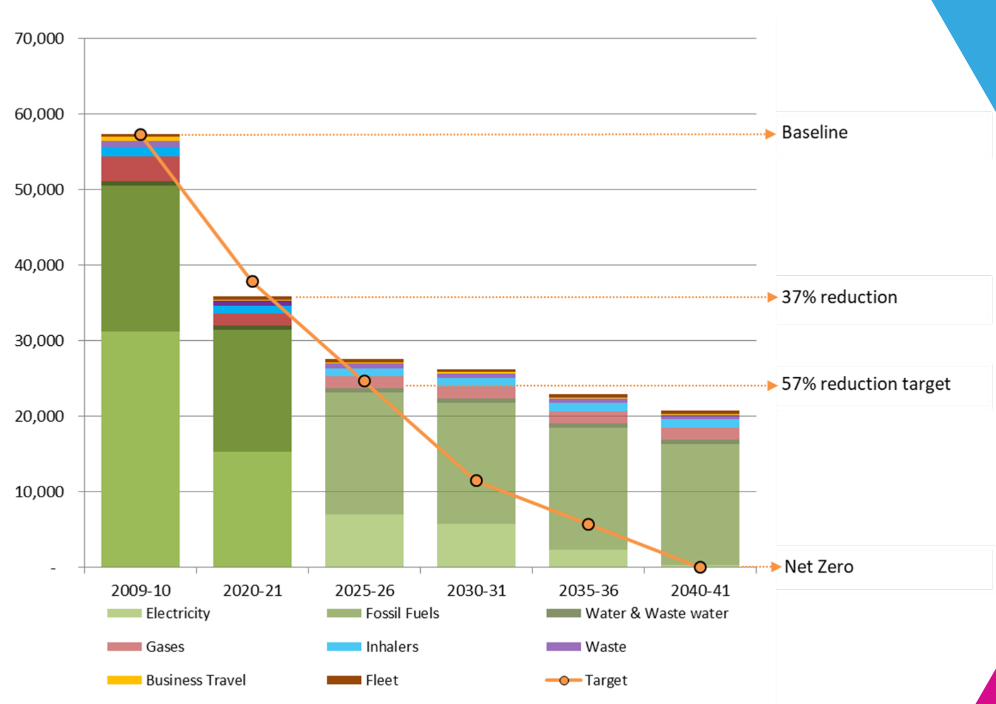


Figure 9: Our trajectory to Net Zero

Our interim target: 57% reduction by 2025

Our interim target is to deliver a 57% reduction from our 2009/10 baseline in our NHS Carbon Footprint by 2025.

We have identified below the projects and actions that will enable us to meet our 2025 target, and the work stream that will be responsible for delivering this.

These projects combined will reduce our emissions by 11,500 tonnes of CO_2e from 2020/2021. To deliver this will require us to focus on reducing consumption of resources as a priority. Where we cannot reduce then we should reuse if we are able, otherwise seek to recycle. Most importantly it will require us to rethink how we work.

A key priority between now and March 2022 will be to develop business cases and identify internal or external funding routes to deliver these projects.

Buildings and Utilities

- Worthing Heat Network & heat decarbonisation of SRH Accommodation
- Solar PV installations
- Laundry upgrade (water and utility demand reduction)
- Grid decarbonisation
- BMS & control improvements
- Building fabric improvements

Carbon reduction: 10,500 tonnes CO_2e

Reduce, Reuse, Recycle

- Improved segregation compliance
- Reduction in clinical waste generated
- Reduction in domestic waste generated
- Repair and refurbishment
- Reduction in food waste

Carbon reduction: 115 tonnes CO_2e

Clinical

- Switch MDI prescribing to DPI
- Eliminate use of desflurane
- Reduction in NOX usage and leakage

Carbon reduction: 856 tonnes CO_2e

Travel and Transport

- Reduce business travel by 10%

Carbon reduction: 14 tonnes CO_2e

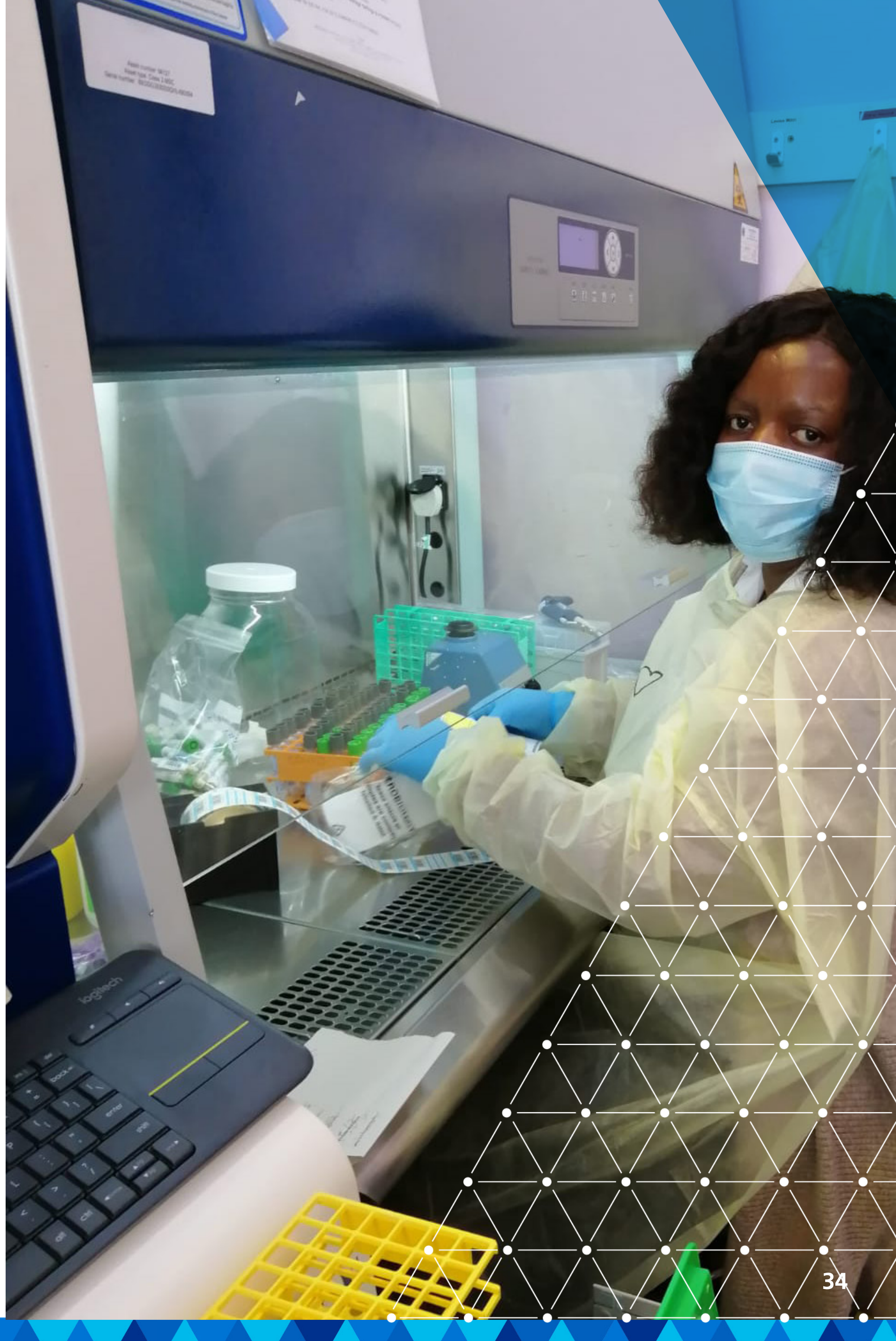
Net Zero Carbon Roadmap to 2045

As illustrated in Figure 9, there is a significant gap between our footprint under a ‘do nothing’ scenario and our Net Zero Carbon target.

Over the coming 12 months we will develop a detailed roadmap to achieve Net Zero, prioritising areas with the biggest influence. For our direct impact those areas are:

- **Fossil fuels, which make up the largest proportion of our NHS Carbon Footprint. Decarbonisation of heat across the Trust will be the key measure required to meet Net Zero for our fossil fuels.**
- **Nitrous Oxide and Inhalers. Potential of savings up 400 tonnes CO_2e**
- **Fleet vehicles. Moving to be fully electric by 2030 delivers savings of up to 300 tonnes CO_2e**

The Net Zero Carbon Roadmap will also address our indirect footprint (NHS Carbon Footprint Plus). This will build on the carbon footprint analysis of our supply chain using P4CR methodology, establishing priority carbon hotspots and actions to reduce single use items. Key to this aspect of our Roadmap will be the development of our metrics to understand the impact of staff commuting and patient travel in particular.



How we will deliver: our action plans

Our action plans are developed around ten work streams, designed to ensure we continue to have an integrated and holistic approach to our sustainable healthcare programme.

In the next section of this document, we set out our action plans for delivering against our vision, key aims – and our Net Zero Carbon targets.

These action plans set out our commitments in each area as well as a series of specific actions and the key success measures through which we will monitor our progress.

Buildings and Utilities: ensuring our workplaces are low carbon and protect local biodiversity whilst supporting wellbeing for staff, patients and visitors.

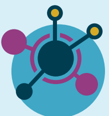
Clinical: developing and enabling lower carbon, more sustainable models of care and reducing the impacts of medicines.

Travel and Transport: ensuring the travel and transport needed between our care and our communities is low cost, low carbon and conducive to good health and wellbeing.

Reduce, Reuse Recycle: delivering against the waste hierarchy.

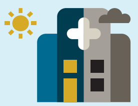
Staff Wellbeing and Engagement: empowering and engaging our people to embrace change and help us achieve net zero.

Supply Chain and Procurement: respecting our health and natural resources by creating an ethical and circular supply chain.



Digital Transformation: providing digital support and innovation to enable the decarbonisation of our clinical and non-clinical services.

Food, Catering and Nutrition: providing a sustainable catering service for our staff, patients and visitors that supports the health of our population, our environment and our supply chains.



Climate Adaption: building resilience to our changing climate and adapting our services to mitigate risk.

Collaboration and Partnership: enhancing our impact by working with others.

Holding ourselves to account: governance

Our governance structure for delivery of this Green Plan is as follows:

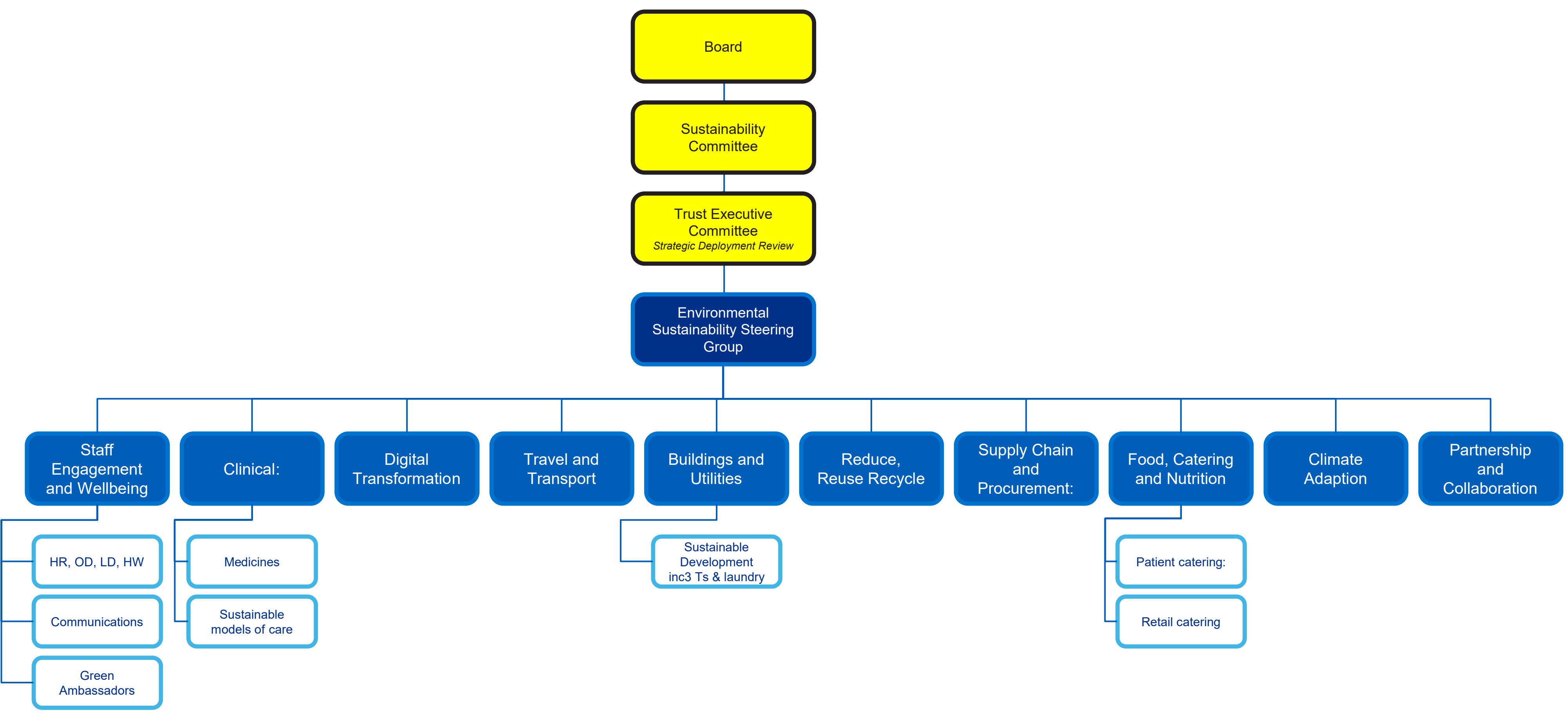


Figure 11: Governance for delivery of our Green Plan

Holding ourselves to account

Our Board lead for Environmental Sustainability and delivery of the green plan is the, Chief Financial Officer. Our Director Facilities and Estates is the Senior Responsible Officer.

Workstream leads are senior officers across the Trust with subject matter expertise who have developed the action plans within our green plan and are responsible for their delivery.
Our Energy and Sustainability Manager provides expertise and support to work stream leads.

The Trust's Programme Management Office provides expert support to ensure our green plan is on track and the Trusts Kaizen team can support local teams to use improvement techniques to structure and ensure delivery of the programme.
We have introduced a Clinical Lead for sustainability with protected time and resource to carry out this important role. This role will be supported by coordinators and dedicated project leads for medical gases, inhalers and mobility aids.

The Sustainability Committee is a sub-committee of the Board which oversees the delivery of the Environmental Sustainability strategic initiative.
Our Governors will work with the Board to ensure the trust builds sustainability into all aspects of our services. They can do this by supporting us to deliver our Green Plan and engaging with our staff and local population.

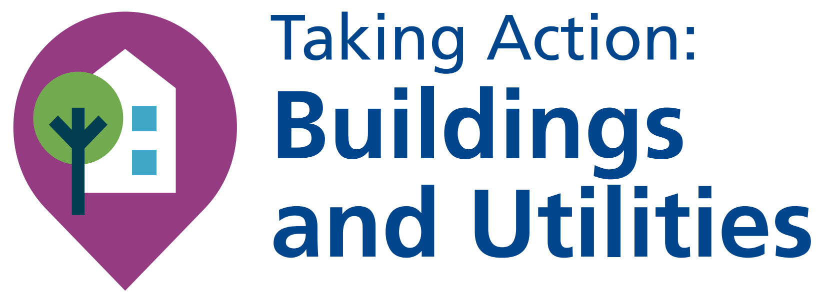
Measurement and reporting

Over the next 12 months of this programme, our Action Plans will be refined to include the development of specific metrics in line with the commitments we have made.

To ensure we are delivering against the commitments made we will:

- Provide monthly performance reports to the Environmental Sustainability Steering Group (ESSG) including updates from each of our work streams.
- Provide a formal report every quarter to the Sustainability Committee of the Board to update on delivery of the Patient First Planet First Green Plan.
- Publish a detailed Annual Sustainability Report approved by the Board, alongside the Trust Annual Report, and ensure this is publically accessible through our website alongside this strategy.
- Seek third party validation of our carbon footprint each year, publishing the results on our website and using the outputs to inform our decision making.
- Meet the national and regional reporting requirements from NHSEI and For a Greener NHS as they develop.

Chapter 5
Our detailed action plans



Taking Action:

Buildings and Utilities

Ensuring our workplaces are low carbon and protect local biodiversity whilst supporting wellbeing for staff, patients and visitors.

Key success measure to 2025: 57% reduction in all measurable buildings CO_2e.

Our approach

Our healthcare buildings are the largest contributor to our direct carbon emissions as a Trust. The impact of our utilities has fallen over the last three years, primarily due to the reduction in carbon intensity of grid electricity.

The challenge now is to drastically reduce the carbon impact of our estate by:

- reducing energy consumption;
- installing low-carbon technologies to reduce reliance on fossil fuels; and
- implementing on-site renewables.

Our commitments

- We will reduce energy and water consumption across our estate and cut our carbon emissions in line with Net Zero targets.
- We will ensure our places provide comfortable and sustainable environments for staff, patients and the local community, supporting health and wellbeing.
- We will improve our green spaces so they are more biodiverse, better able to support patient and staff wellbeing and support our low carbon care delivery ambitions.

Taking Action: **Buildings and Utilities**

UHSussex

Net Zero Carbon strategy development

- Develop a detailed Net Zero Carbon (NZC) Roadmap identifying how we will meet our Net Zero commitments in all areas of our NHS Carbon Footprint and NHS Carbon Footprint Plus. In relation to our buildings, this should focus on reducing utility demand, improving efficiency and switching to renewable technologies. The Roadmap should also include Heat Decarbonisation Plans for each site looking at short, medium and long term interventions to 2040 and a timeframe for replacement of assets. Use a strategic lens to evaluate electricity capacity on our sites, factoring in planned vehicle charging infrastructure and other projects with a significant electricity focus.
- Develop business cases for opportunities identified within our Net Zero Carbon Roadmap in readiness for funding opportunities both internally and externally.

Estates

- Ensure Net Zero Carbon principles and technologies are incorporated into all new developments, refurbishments and our capital plan aiming to upgrade and invest in infrastructure using latest and emerging technologies ensuring efficient operations and the best environment for our patients and staff. This should include meeting any required standards e.g. the NHS NZC standard upon its publication.
- Continue to deliver against our planned programme of work, in particular quick wins to support our NZC target. This includes:
  - Move all general lighting to LED by 2025.
  - Utilise our 6 Facet survey to priorities areas for upgrade and improvement works.
  - Improve the thermal efficiency of our existing estate through measures such as the refreshment of insulation and draught proofing.
  - Continue with our window replacement programme improving the building fabric of our estate.
  - Install TRVs on radiators where they are not already to improve local level control.
  - Continue our BMS optimisation and upgrade programme across the estate.
- Deliver and measure the carbon impact of our laundry upgrade project, providing a much improved service across all of our sites, and improving energy and water efficiency.
- Upgrade our estate in line with the recommendations of our Green Travel plan including cycle storage, green travel changing facilities, lockers, helmet lockers.

Taking Action: Buildings and Utilities

- Develop an estates rationalisation plan in parallel with 3Ts and the regeneration of the Barry Building site to ensure we are utilising our estate efficiently and in line with the Carter report requirements for non-clinical estate, and divest from excess estate as appropriate. This rationalising of the RSCH Estate will result in a strong carbon reduction per m2 of occupied space.
- Develop supply level management plans for gas and electricity. Including scheduled control setting reviews, maintenance and out of hours survey to ensure control measure align to occupancy and zonal requirements.
- Explore potential for increasing our on-site renewable generation this will include a review alongside planned roof upgrade works as well as new standalone installations.
- Continue to purchase 100% renewable (REGO backed) electricity and explore the opportunity for procuring RGGO gas.

3Ts

- Undertake a review of stage 2 and 3 3Ts to ensure they are in line with our long term Net Zero ambitions;
  - Integrating Net Zero Carbon technologies where possible.
  - Deliver against our commitment to the principle of reuse and recycle at source where possible.
  - Continue to pursue digitalisation in stage 2and3 with opportunities such as smart AI in addition to IOT building management systems.
  - Identify possible locations for photovoltaics renewables.

Wellbeing

- Ensure that changes to our estate produces an on-going improvement in working environment for staff and is facilitating staff to live healthier, more sustainable lives while at work. This includes ensuring provision of adequate facilities for break and rest periods, facilities for such as staff to changeing their travel plans to lower carbon options (e.g. cycling, walking etc.) and providing local rest areas and green spaces for staff and patients to enjoy.

Biodiversity

- Work with local partners to develop a Biodiversity Action Plan aiming to preserve and enhance the green spaces within our estate and beyond, ensuring they provide adequate, usable space for staff and patients. This should consider opportunities for tree planting at each of our sites, linking in with potential funding sources e.g. NHS Forests.

Communication, measurement and reporting

- Communicating consumption to staff and board educating and empowering all building users to highlight the environmental impact of our buildings and the services provided within them. Measure and report against progress against delivery of this action plan in line with Green Plan governance requirements.

Taking Action:
Buildings and Utilities

Working within the ICS

- Continue to engage and explore local opportunities with our partners for district heating systems including the ongoing proposal with Worthing and Adur Council for Worthing Heat Network.
- Through the Estates Programme Board and its constituent place based groups, work with partners across the ICS membership to develop shared objectives, target and strategy on the route towards Net Zero Carbon.
- Share utility consumption and emission data at an ICS level to develop regional benchmarks specific to healthcare buildings.
- Identify system level Places projects that could benefit from economies of scale and pooled resources.
- Ensure NZC is a fundamental component of the new Trust and ICS Estates Strategies.

Patients and wider community

- Work with our ICS partners to develop an understanding of the opportunities for offsetting and insetting projects within our local area, with a focus on projects that can directly support delivery of care within our communities.

Taking Action: **Clinical**

Developing and enabling lower carbon, more sustainable models of care and reducing the impact of medicines.

Key success measure: Clinical projects delivering positive, measurable sustainability benefits within all of our services.

Our approach

80% of our carbon footprint is driven by clinical decisions. Reaching Net Zero Carbon by 2040 will require a big shift in how we deliver care which cannot be achieved without input from clinicians, nurse and allied health professionals. Enabling clinical teams to develop and enable lower carbon, more sustainable models of care is therefore essential. We'll achieve this using Care Without Carbon's sustainable healthcare principles:

1. **Healthier lives: Making use of every opportunity to help people be well, to minimise preventable ill-health, to reduce unnecessary treatment and to support independence and wellbeing.**
2. **Streamlined processes and pathways: Minimising waste and duplication within the Trust and wider health system to ensure delivery of safe and effective care.**
3. **Respecting Resources: Where resources are required, prioritising use of treatments, products, technologies, processes and pathways with lower carbon, environmental and health impacts.**

These have been adapted from the principles developed by Centre for Sustainable Healthcare.

Our commitments

- ▲ We will support clinical projects led by clinical champions delivering positive, measurable sustainability benefits within all of our services by 2025.
- ▲ We will integrate our sustainable healthcare principles at a strategic level across the Trust and our wider ICS partners.
- ▲ We will support our clinicians, nurse and allied health professionals to deliver against these principles by making lower carbon, more sustainable choices when delivering care day-to-day.

Taking Action: Clinical

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Prioritising clinical interventions

- Undertake a carbon footprint analysis of clinical activity across the trust to understand our impact at a divisional/departmental/service level. Use this information to identify our top five areas of focus for our clinical work stream.
- Define a methodology for incorporating sustainable healthcare principles into the clinical model of care.
- Develop and deliver against action plans for our top five areas of focus using this methodology.
- Undertake an analysis of clinical sustainability interventions currently in place across the Trust and develop a programme to ensure we are sharing learning and taking a consistent approach at all sites.
- Support the delivery of this work stream by putting in place coordinator posts and providing dedicated time to individuals to deliver projects in line with workstream priorities.
- Identify appropriate governance mechanisms to support deeper integration with clinical services e.g. Clinical Fellows for sustainability with an identified governance route for delivery, ensuring there are adequate resources to deliver this workstream.

Supply chain

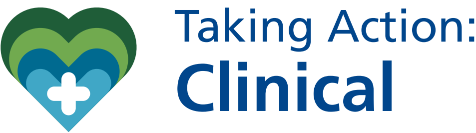
- Provide operational expertise to our colleagues in procurement to support the prioritisation and delivery of supply chain projects. Support will be focussed on areas of highest carbon impact, as identified using the Patient First data driven approach.
- Develop a circular economy hierarchy for clinical practice to enable practical decision making to be made at point of purchase of new equipment.

Tackling single use plastic and supporting reuse

- Without compromising our commitments to staff and patient safety or infection prevention and control, work with clinical colleagues to explore alternatives to single use PPE, target the use of reusables where available and appropriate and work with partners to develop more sustainable alternatives where these do not currently exist.
- Work with Infection Control to undertake a trial of reusable face masks and as appropriate, consider delivering a glove use campaign such as Great Ormond Street's 'Gloves off' campaign.
- Supported by existing and emerging evidence, continue to identify suitable opportunities to move from single-use to reusable equipment. Develop and deliver a programme to facilitate this including investing in services to facilitate reuse, such as sterile services department and laundry services.
- Collaborate with our colleagues in facilities and procurement to establish a mobility aid working group to develop a clear programme for robustly managing a returns scheme across the trust.

Medical gases

- Continue to measure and report on the carbon footprint of our medical gases each year, using this information to prioritise our work in this area and measure our progress.
- Continue our work on cutting the carbon impact of inhalers by:
  - Reducing the proportion of inhalers dispensed that are MDIs and set targets for this.



  - Developing our Inhalers Working Group to coordinate action with our community partners.
- Continue our work in the anaesthetics department to:
  - Establish a Medical Gas Working Group with the support of our colleagues in pharmacy and estates with the aim of minimising the impact and managing the use of medical gases consistently across the Trust.
  - Further reduce the use of Desflurane in surgery, aiming to eradicate use in the Trust by 2025.
  - Develop a strategy and delivery plan to improve management of Nitrous Oxide use across the Trust. This should focus on identifying and eliminating leaks and wastage, targeting overall reduction and considering opportunities for gas capture and reuse.
  - Investigate the wider environmental impacts of the anaesthetic department and when appropriate develop programmes of work which would reduce this. For example masks and equipment used and switching from IV to oral paracetamol.

Digital transformation

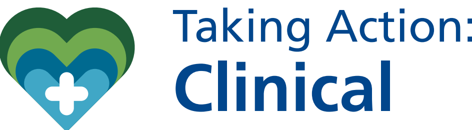
- We will work with clinical and digital transformation teams to understand the opportunities for digitisation of care in terms of carbon reduction and delivery of our sustainable healthcare principles ensuring we achieve the NHS E/I target of 25% of outpatient appointments to be conducted by digital means by 2024/5. This should include prioritisation of key areas of focus, with a programme developed to deliver against this including implementation of sustainability focussed measurement and reporting.

Communication, measurement and reporting

- Communicate achievements and measures introduced by clinical teams across the Trust and ensure roll out of successful ones across services.
- Develop and deliver targeted training to key clinical personnel with the aim of empowering and equipping all to include sustainable healthcare principles in their day to day.
- Measure and report against progress against delivery of this action plan in line with Green Plan governance requirements.

Working within the ICS

- We will work with colleagues in Brighton and Sussex Medical School who have already integrated teaching on sustainability into the curriculum for local medical students.
- Work with community colleagues to understand our highest areas of impact as a system and identify opportunities to reduce these.
- We will explore how we can best share our learning with others within our ICS and beyond and develop a programme to deliver on this. This should include a focus on clinical sustainability interventions in the community setting, considering the opportunity for joint discussion and educational events.
- Provide input and support into the development and delivery of ICS projects to reduce the impact of medical gases and pharmaceuticals across the ICS and wider region. This should include working with primary care colleagues within our ICS to understand and reduce the carbon impact of the inhalers we dispense.



Taking Action: **Clinical**

- Explore the opportunity for an ICS-wide project to share facilities for reprocessing/reuse of medical devices and metal instruments.
- Continue to support the digital transformation of clinical services at a system level, including the use of telemedicine where clinically appropriate and possible.

Patients and wider community

- Consider opportunities to educate and inform our patients on the choices they can make to improve health and wellbeing beyond their time in our care.
- Work with NHS colleagues to deliver public events for our local community to promote healthier lives – e.g. food, exercise, noise.

Taking Action: Travel and Transport

Ensuring the travel and transport needed between our care and our communities is low cost, low carbon and conducive to good health and wellbeing.

Key success measure to 2025: 57% reduction in all measurable travel CO_2e.

Our approach

In delivering care to our patients, our staff travel thousands of miles every year between our sites, with fleet vehicles delivering additional services. This all contributes to the Trust's carbon footprint, creates air pollution, and contributes to traffic congestion and impacts directly on staff and patient wellbeing.

Through our travel workstream we aim to:

- Eliminate non-essential travel.
- Minimise essential journeys.
- Ensure that all remaining travel uses the most resource-effective methods and follows the travel mode hierarchy.

Collaboration with partners across the Trust – digital and clinical in particular – as well as local partners outside of the Trust will be key to this.

Travel Mode Hierarchy

Digital communication

Walking & wheeling

Cycling

Public & shared transport

Electric vehicles & car sharing

Petrol/diesel vehicles & car sharing

Taking Action:
Travel and Transport

Our commitments

- We will work with our clinical and digital teams to minimise and decarbonise staff, patient and visitor travel associated with our delivery of care, while maximising the health benefits of travel.
- We will fully electrify our vehicle fleet to reduce air pollution locally and minimise our negative impact on health.

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Net Zero Carbon travel

- Undertake a review of our NHS Carbon Footprint data for travel to ensure we have accurate understanding of our impact in this area and embed this data into ongoing environmental and carbon reporting process allowing for monitoring impacts of actions.
- Use our travel survey and data from NHSEI to understand our more indirect travel impacts within our NHS Carbon Footprint Plus – staff commuting, patient and visitor travel.
- Use this analysis to understand the mileage reduction required to meet our 2025 carbon reduction target for travel and develop a strategy to meet this using the opportunities identified in our Green Travel Plan.

Green Travel Plan

- Deliver against actions set out in Our Umbrella Travel Plan to ensure alignment of sustainable transport measures across the Trust following the merger. This includes actions in eight different areas:
  - Demand management (parking permit eligibility and management).
  - Walking (site audits to identify opportunities).
  - Cycling (site audits, alignment and expansion of cycle provisions across sites including showers, lockers and “rest stops” for them to catch their breath before starting their work day).
  - Public transport (season tickets, linking bus routes to key public transport interchanges).
  - Car sharing (link to permit scheme, potential for allocated parking bays, emergency lift home scheme, car share scheme).
  - Electric vehicles (develop EV strategy, installation of charging points.
  - Marketing and Communications (engaging staff around green travel).
  - Monitoring (set up measurement and monitoring programme including travel survey.
- Ratify our Full Umbrella Travel Plan, with a focus on delivering against our Net Zero Carbon commitments, supporting active travel and public transport for staff, patients and visitors and cutting air pollution locally.
- Deliver against Travel Plan targets to 2029.
  - Reduce by 5% the number of staff travelling by car.
  - Increase by 5% the number of staff travelling to site by public transport.
  - Reduce by 5% the number of staff travelling alone by car to the site.
  - Increase by 3% the number of staff who car share.
  - Increase by 5% the number of staff who cycle to the site.

Taking Action:
Travel and Transport

Trust fleet and lease cars

- Extend learnings from decarbonising our courier services in the East to the whole trust.
- Maximise efficiencies in the transport of goods and services by combining deliveries where possible and, through procurement encouraging our suppliers and contractors to decarbonise their fleets.
- Extend our Green Driving Programme in developed in the East trust wide and consider expanding to provide training to trust staff travelling for work. Introduce regular reporting and monitoring of green driving for trust fleet staff using our tracking technology.
- Develop an electric vehicle strategy for our fleet and staff lease cars. This should aim to move all of our fleet vehicles to ultra-low emissions vehicles (ULEVs) or zero emissions vehicles (ZEVs) by 2030 at the latest, with a focus on new purchases and new lease arrangements in the first instance. As part of this, engage with relevant stakeholders across the trust to set a target date for all staff lease cars to move over to ULEVs or ZEVs.

Communications, measurement and reporting

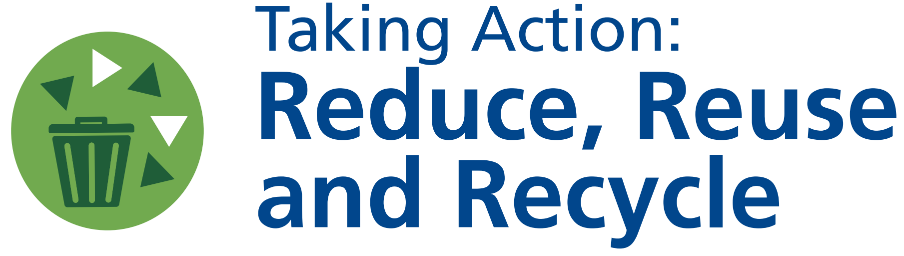
- Continue to develop our engagement programme around travel, aiming to transition Trust culture towards green travel. This should include the extension and further promotion of our Transport Bureau service, and roadshows to support staff in making sustainable transport choices for their commute.
- Continue to deliver our successful staff travel survey each year – use the results to monitor progress against the Green Travel Plan, evaluate the opportunity to extend the survey to patients.
- Measure and report against progress against delivery of this action plan in line with Green Plan governance requirements.

Working within the ICS

- Work with ICS partners to identify opportunities for joint working e.g. vehicle charging infrastructure.
- Work with public sector partners to promote and improve active and public transport to and from our sites including ongoing engagement with BHCC Sustainability Chair.
- Support roll out of ICS engagement campaign ‘Travel Smarter September ‘ focussing on air pollution.
- Continuation of ongoing Green travel stakeholder meetings, including with Chichester college, Worthing Council, Rolls Royce Chichester and Portsmouth Hospital university Trust.

Patients and wider community

- Ensure all patients and visitors have access to information on cycling and walking options and review provision for secure visitor cycle facilities.



Taking Action: Reduce, Reuse and Recycle

Delivering against the waste hierarchy: reduce, reuse, recycle.

Key success measure to 2025: Reduce our total waste year-on-year and reduce waste sent to energy recovery by 50% by 2025.

Our approach

Waste has a significant impact on the environment both in terms of its carbon footprint as well as wider impacts on the environment and biodiversity.

The waste hierarchy, reduce, reuse, recycle will be used to drive the effective management of waste at UHSussex, reducing the overall amount of waste produced and ensure that it is disposed of by the most sustainable method.

Our commitments

- We will reduce our total waste year-on-year and increase recycling, with a reduction of waste sent to energy recovery by 2025.
- We will drive up reuse including equipment and pharmaceuticals.
- We will continuously improve and deliver best practice waste management across all of our sites, improving waste segregation year on year.

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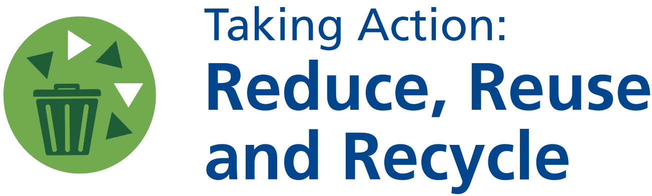
Reduce

- Work with our Food, Nutrition and Catering workstream to develop a set of objectives and targets to further reduce the environmental impact of our food and catering service, with a focus on minimising waste, and eliminating single use consumables.   This action will further compliment the significant environmental benefits achieved through the new central production unit constructed in St Richards Hospital at Chichester.



Taking Action:
Reduce, Reuse and Recycle

Reuse

- Extend our furniture repair and restore initiative to all sites and explore further options for an internal and external equipment exchange / swap shop.
- Coordinate with the Green clinical team and Product Review Group to support the switch to reusables.
- Support the clinical workstream and sterile services department to increase the use of reusable surgical instruments.
- Undertake a review of IT asset disposal to identify potential areas for improvement e.g. through reuse schemes, and to ensure disposal is zero waste to landfill.

Recycling

- Develop a programme to change our recycling model from supplier delivered to recycle at source, aiming to increase our recycling levels and the reduce amount of waste sent to energy recovery. This will include:
  - Standardising recycling provision and labelling of waste allocation bins across all of our sites.
  - Delivering an awareness raising campaign to improve segregation rates.
  - Challenging waste suppliers on best practice models and logistical set up of our sites to best accommodate this.
  - Working with Green Ambassadors to promote recycling in all areas.
- Expand the bailing and recycling of cardboard across the organisation.

Best practice waste management

- Continue with regular reviews of our waste management policy, procedures, practices and reporting, identifying opportunities for improvement to support our waste reduction targets.

Supply chain and procurement

- Work with the Supply Chain and Procurement workstream to ensure process forces consideration of the whole life footprint and waste impact of purchasing decisions and identify opportunities for reuse across the supply chain.

Communication, measurement and reporting

- Work with HR to embed our well established waste training to all members of the Trust, via mandatory training with a requirement to undertake every 12 months.
- Working with communications to develop an engagement strategy that will support our alignment with the waste hierarchy – reduce, reuse, recycle – as well asinfluence appropriate segregation.
- Further develop our reporting on waste to communicate to all stakeholders the amount, type and environmental impact of waste we generate at each of our sites.
- Measure and report progress against delivery of this action plan in line with Green Plan governance requirements.

Working within the ICS

- Identify other joint working opportunities within our ICS, for example a centralised reuse programme.

Patients and wider community

- Review the opportunity for re-use scheme such as WARP-it, in particular in areas where we have local partners.

Taking Action: **Staff Engagement and Wellbeing**

Empowering and engaging our people to embrace change and help us achieve net zero.

Key success measure to 2025: Our staff know how to actively engage with our programme and understand why it is important.

Our approach

Delivering against our sustainable healthcare ambitions will require the active participation of all staff, wherever we deliver our services. Sustainability must become our business as usual – not an add on for already pressured staff, but part of our way of life.
The staff engagement and wellbeing workstream will support this by taking the following approach:

- Explaining the links between health and climate, celebrating our successes, sharing our UHSussex green ambitions and involving others.
- Developing an engagement programme to help weave sustainability into the fabric of UHSussex culture and operations; and to support our Patient First Planet First green plan ambitions. This will involve staff through: people policy and strategy; engagement activity and corporate communications; and enabling deeper engagement through our Green Ambassadors programme.
- Raising awareness and engaging our patient and wider community with sustainable thinking and actions.

Our commitments

- We will integrate sustainability and the environment in our UHSussex People Policy and Strategy.
- We will craft a compelling narrative in support of our Patient First Planet First Green Plan, promoting sustainability both at work and at home.
- We will partner with other NHS organisations to develop the narrative on sustainable healthcare, enhance our impact and create opportunities for people to share ideas.
- We will provide focused strategic and specialist support to other workstreams to help them deliver their objectives.

Taking Action:

Staff Engagement and Wellbeing

UHSussex

HR and Wellbeing processes and practice

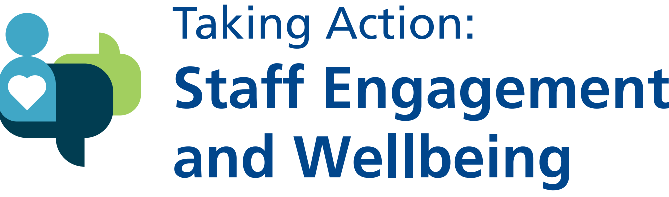
- Integrate sustainability and the environment into our UHSussex People Policy and Strategy, with a focus on areas/actions that impact our Net Zero ambitions. Key areas of focus will be remote working and the development of our employee value proposition to highlight our credentials as a green employer.
- Evaluate our wellbeing programme to ensure this is aligned with our Green Plan and vice versa. Together identify a programme of work to support delivery focussing on further enhancing staff physical and mental health by facilitating sustainable activities and green initiatives.
- Raise awareness of our credentials as a green employer integrating information on our environmental sustainability programme into our recruitment material as well as at staff induction.
- Undertake a review of our job design and performance measurement processes to understand how best to raise awareness environmental sustainability, identify how this is relevant to staff in their roles day-to-day, and where appropriate set sustainability objectives for staff.
- Introduce environmental sustainability and carbon literacy training as mandatory for all staff. This should provide staff with an understanding of our impacts and equip them with tools to support delivery of this Green Plan.

Communications and engagement

- Promote achievements of Patient First Planet First Green Plan to our stakeholders, including media, public and partners through press releases and social media, to grow the UHSussex green brand and develop a broader coalition of support for sustainability in Sussex.
- Develop a communications and engagement programme, in partnership with others, and using Patient First principles to: engage staff on sustainability; embed our sustainable healthcare principles across the organisation; and support delivery of our carbon reduction targets. This will combine insight on how best to engage staff at UHSussex on sustainability with our carbon footprint analysis to prioritise and focus our engagement initiatives to those areas that will provide the largest reductions to our carbon footprint, as well as the greatest increases to staff engagement levels, wellbeing and patient experience.
- Use our corporate communications and engagement service to promote the Green Plan to all staff, celebrate our progress to net zero, and provide focused specialist support to workstreams to help them deliver their objectives.

Green Ambassadors

- Further develop our 300 strong Green Ambassador programme, aiming to have representation across all divisions. This will include regular messaging and workshops to Green Ambassadors to develop a workforce of sustainable citizens championing and leading sustainable improvements both at work and in the community.
- Create Green Ambassador working groups, developing on the success of the established Green Pharmacy, Emergency Department and Admin groups. These groups will be set up based on targeting our areas of high impact and will be supported by our Patient First programme to develop and deliver against action plans as efficiently as possible.



Taking Action:
Staff Engagement and Wellbeing

Measurement and reporting

- Measure and report against progress against delivery of this action plan in line with Green Plan governance requirements.
- Share regular content in support of the green plan and in accordance with agreed communications and engagement objectives.

Working within the ICS

- Work with ICS colleagues to develop an engagement approach to support the Sussex Health and Care Partnership Green Plan.
- Attend meetings and establish networks to create a narrative on sustainability within the ICS.
- Measure and report against progress against delivery of this action plan in line with Green Plan governance requirements.

Patients and wider community

- Consider opportunities for embedding sustainability within existing patient and community engagement.
- Utilise our role as an ‘anchor organisation’ to promote and role model sustainable practices that also benefit public health.
- Share regular content on social media in support of sustainability and national campaigns that help reduce our carbon footprint.
- Attend events to promote the narrative around sustainable healthcare.

Taking Action: Supply Chain and Procurement

Respecting our health and natural resources by creating an ethical and circular supply chain.

Key success measure to 2025: SMART target developed and in use to understand progress against this work stream.

Our approach

60% of our emissions are associated with the goods and services we use. We need to adopt a different approach to how we use our resources and the people that produce and distribute our products – moving towards a more circular economy and aiming to minimise resource use, reuse wherever possible and switch to greener alternatives.

At a Trust level this means we need to:

- Take a joined up approach to purchasing, use and disposal of products;
- Integrate lifecycle thinking and sustainability criteria into our procurement decisions;
- Recover and regenerate products and their end of life.

Our commitments

- We will significantly reduce the carbon and environmental impact of our supply chain.
- We will work with our suppliers to improve the health and wellbeing of the people and communities supporting our supply chains.

UHSussex

Prioritising interventions

- Utilising our Patient First, Planet Frist data driven methodology, use our carbon hotspot analysis to understand the carbon impact of our supply chain and identify high impact products/suppliers/departments/services.
- Prioritise areas for action in year 1 based on this carbon hotspots analysis as well as operational expertise from our clinical colleagues and priorities identified by For a Greener NHS.

Taking Action:
Supply Chain and Procurement

- Bring together expertise from procurement, sustainability, clinical teams, infection control and SSD to develop and deliver programmes of work for each priority area. These programmes should be based on delivering against our sustainability healthcare principles, following our hierarchy of: minimising resource use, reducing wherever possible and switching to greener alternatives.
- Draw on the support of our Green Ambassadors to deliver against this work programme, including working with individual teams to make change locally.
- Keep up to date with available methodologies for measuring our supply chain carbon footprint, looking at tools that provide a more accurate representation than Procuring for Carbon Reduction (P4CR). As and when available, use these to monitor impacts of work to cut environmental impact of items purchased.

Procurement policy

- Review our procurement policies to ensure sustainability is a key factor when developing procurement strategies and making procurement decisions. This should include ensuring our products, services and suppliers are supporting our transition to Net Zero and where appropriate exceeding public sector commitments to ensuring that social value criteria are part of supplier and product selection.

Reuse

- Based on the results of our carbon hotspot analysis, seek opportunities for repair of products, takeback and packaging return schemes, remanufactured products.
- Switching to greener alternatives.
- In partnership with the Reduce, Reuse, Recycle workstream we will collaborate with our suppliers to consider the whole life footprint and impact of products we purchase.

Working within the ICS

- Use our purchasing power as a group of providers within our ICS and region to work with NHS Supply Chain and key suppliers in support of our Net Zero ambitions.
- Working with colleagues in neighbouring trust to avoid duplication of effort, sharing lessons learnt and products identified to reduce our indirect footprint.

Patients and wider community

- Work with ICS partners to develop a sustainable supplier charter for SME suppliers.

Taking Action: Digital Transformation

Providing digital support and innovation to enable the decarbonisation of our clinical and non-clinical services.

Key success measure to 2025: SMART target developed and in use to understand progress against this work stream.

Our approach

Our approach is to harness existing digital technology and systems to streamline our service delivery and supporting functions while improving the associated use of resources and reducing carbon emissions. We shall do this by:

- Using digital technology to reduce unnecessary staff and patient travel.
- Undertaking a digital transformation of clinical services e.g. telemedicine.
- Reducing paper use across the Trust.
- We shall support the delivery of the above, whilst minimising the CO_2 impact of the equipment and IT infrastructure required to deliver change.

Our commitments

- We will embrace digital transformation to deliver reductions in carbon at the same time as improving care for our community.
- We will measure and maximise the environmental benefit of our projects, such as reduced travel (patient, staff, postal and supplier), reduced resource use and improved patient experience.

UHSussex

Digitisation of care

- Work with clinical teams to understand the opportunities for digitisation of care in terms of carbon reduction and delivery of our sustainable healthcare principles ensuring we achieve the NHS E/I target of 25% of outpatient appointments to be conducted by digital means by 2024/5. This should include prioritisation of key areas of focus, with a programme developed to deliver against this including implementation of sustainability focussed measurement and reporting to measure the benefit to patients, staff and the environment.

Taking Action: Digital Transfomation

Agile working

- Ensure sustainability considerations are a key part of strategic discussions around agile working, ensuring we are able to meet our 2025 carbon targets for staff business travel.
- Continue to embed a programme of flexible working using digital consultations, MS Teams and home working to cut travel and make the best use of our estate.
- Review our own internal business operations to minimise the environmental impact. For example reducing non-essential travel for sales/account management meetings.

Digital projects

- Ensure all our digital projects incorporate our sustainable healthcare principles and include an environmental impact assessment to support the case for change.
- Develop and integrate carbon and environmental metrics into benefits analysis and realisation for digital projects, including travel focussed metrics and resource reduction.

IT equipment

- Review and update our device use policy including consideration of optimal timeframe for replacing devices from a sustainability perspective.
- Work with suppliers to ensure the equipment we use has as low as possible impact on the environment.
- Work with suppliers to reduce packaging associated with our equipment.
- Review the opportunity for reuse/reselling of IT equipment either internally or through local partnership schemes.

Communication, measurement and reporting

- Look back at positive steps already taken to highlight their contribution to reducing our environmental impacts (eg server room management).
- Measure and report against progress against delivery of this action plan in line with Green Plan governance requirements.

Working within the ICS

- Use our purchasing power as a group of providers within our ICS and region to work with NHS Supply Chain and key suppliers in support of our Net Zero ambitions.
- Continue to support the digital transformation of clinical services at a system level.

Patients and wider community

- Work with our colleagues in Communications and Equalities divisions to engage with patients and the community to measure the impact of digital transformation of care and provide support to embrace further.

Taking Action: Food and Nutrition

Providing a sustainable catering service for our staff, patients and visitors that supports the health of our population, our environment and our supply chains.

Key success measure to 2025: Reduce food waste on all sites to 10%.

Our approach

It is estimated that food and catering services in the NHS produce 1,543 ktCO_2e each year, equating to around 6% of total emissions. Healthier, locally sourced food can improve wellbeing while cutting emissions related to agriculture, transport, storage and waste across the supply chain and on NHS estate.

At UHSussex, we aim to deliver a high quality and sustainable food and catering provision across the Trust, reducing our environmental impact year on year to support our Net Zero objectives. In line with our sustainable healthcare principles, our approach to work in this area is to:

- Minimise resource use.
- Reuse wherever possible.
- Switch to greener alternatives such as plant-based foods or use of electronic ordering system.

Our commitments

- We will work with patients, staff and visitors to ensure sustainable, seasonal menus at all of our sites.
- We will work with our suppliers to improve the health and wellbeing of the people and communities supporting our supply chains.
- We will a low carbon service by electrifying our catering transport vehicles as soon as possible and cutting waste to 10%.

Taking Action:
Food and Nutrition

- The Trust signed up to the NHS Plastics Pledge in 2019 and commits to:
  - No longer purchase single-use plastic stirrers and straws, except where a person has a specific need, in line with the government consultation.
  - No longer purchase single-use plastic cutlery, plates or single-use cups made of expanded polystyrene or oxo-degradable plastics.
  - Go beyond these commitments in reducing single-use plastic food containers and other plastic cups for beverages – including covers and lids.

UHSussex

Prioritising our interventions

- Using data from our carbon hotspots analysis (see Supply Chain and Procurement action plan), measure the carbon footprint of our food, catering and nutrition offering. Use this to identify our priority areas for action and develop our programme to target those areas.

Our retail sites

- Work creatively with our staff, visitors and patients to explore different approaches to our restaurant areas that meet the needs of customers and reflect our commitment to sustainability and our role as a local anchor organisation. The Waves Restaurant in Royal Sussex County will be used as a pilot for this approach.
- Offer facilities on a pop-up basis to local businesses or to community kitchens and community food partnerships to support the development of a sustainable local food chain and reduce the carbon footprint of our retail facilities.
- Develop a sustainable catering solution for our new 3Ts hospital utilising learning and experience for the Waves restaurant pilot scheme.
- Work with retail partners to ensure local sourcing and production of healthy and sustainable menu choices, based on the learning from our carbon hotspots analysis.
- Explore the relationship between catering and “edible landscapes” and the opportunity to use our grounds to reduce food miles and food waste and improve biodiversity.
- Work with retail partners to reduce single use catering items such as cups and packaging.
- Ensure the Retail strategy includes commitments to deliver against our sustainable healthcare principles.

Our patient food offering

- Engage with staff, visitors and patients to understand their requirements and preferences including options for vegetarian, vegan and low carbon menus.
- Work with catering leads to secure local sourced contracts for patient food where possible.
- Extend our leading patient catering provision across all sites, eliminating kitchen waste and targeting an initial 10% reduction in on the floor waste.
- Work with our delivery partners to minimise waste, source more locally where possible, and reduce single use kitchen products
- Engage with patients at point of choice to highlight the benefits of a more sustainable choice for them and others.
- Implement an electronic ordering system across the Trust.

Taking Action:
Food and Nutrition

Communications, measurement and reporting

- Measure and report on the carbon footprint of our food and catering services and explore in consultation with clinical colleagues how to increase a more sustainable option, reducing reliance on high carbon foods such as beef and lamb, and improving the process for patient food waste ensuring that all our processes are sustainable.

Patients and wider community

- Build on the current promotion of healthy plant-based meals to patients whilst communicating environmental benefits.
- Through our role as an “anchor organisation” work with local food partnerships to support the development of sustainable food chains throughout our catchment area.

Taking Action: Climate Adaptation

Building resilience to our changing climate in Sussex.

Key success measure to 2025: Undertake a climate impact assessment and integrate findings into our business continuity procedures and longer term strategic health planning.

Our approach

Climate change is already having a direct impact on the health and wellbeing of our staff and the population we serve, and this is only set to increase.

We must build resilience to our changing climate in Sussex – within our estate, our services and our supply chain – to ensure we adapt those impacts, as well as working to mitigate them.

Our commitments

- We will identify and map climate change risks for our organisation, our patients and our communities.
- We will form a multidisciplinary working group aimed at delivering actions to mitigate and adapt our estate and services against these risks.
- We will work with our ICS partners to develop an action plan to address climate adaptation in Sussex, together.

UHSussex

Climate impact assessment

- Use the information from a Climate Impact Assessment to assess our estate and clinical services for specific climate risks and current responsiveness to extreme conditions. Work with clinical and estates colleagues to develop a Climate Adaptation Plan and working group to help us adapt to those changes and ensure our buildings and services are fit for the future.
- Work with finance to develop a better understanding of the cost burden of climate change to the trust in terms of health and our estate.
- Ensure climate related risks are added to the corporate risk register as required.

Taking Action:
Climate Adaptation

Adaptation

- Integrate climate change adaptation into the business continuity planning process.
- Ensure all our buildings (leased and owned) are fit for the future with appropriate adaptation measures such as solar shading, Sustainable Drainage Systems, etc, in line with the findings of the Climate Change Impact Assessment.

Communication, measurement and reporting

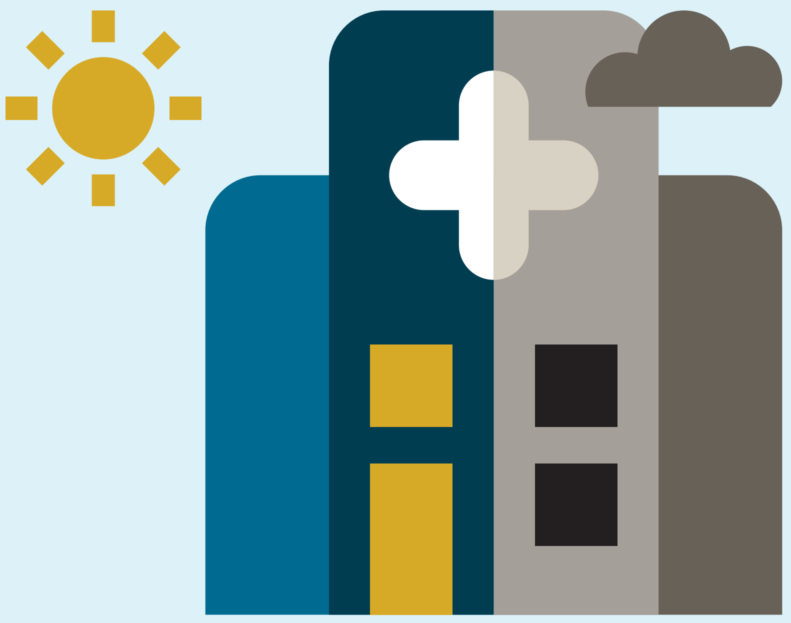
- Support delivery of our Climate Adaptation Plan by communicating to staff on what climate change adaptation is and how it relates to UHSussex.
- Work alongside our communications team to improve the access of climate adaption information for patients and staff providing tips individual adaption actions.
- Measure instances of heatwaves at the Trust and report these through the Greener NHS quarterly reporting.
- Measure and report against progress against delivery of this action plan in line with Green Plan governance requirements.

Working within the ICS

- Develop a Sussex-wide Climate Change Impact Assessment with partners in the ICS to understand the impact of climate change on our patients and services.

Patients and wider community

- Identify patient groups vulnerable to the impacts of climate change. Work with these groups to identify specific climate risks and define the actions that can be taken by the health system to support mitigation.
- Communicate with our patients and the wider community on climate change adaptation and the impacts on them including; climate related risks, changes to vector borne diseases and the action that Sussex Community and partners are taking to mitigate them.



Taking Action: Collaboration and Partnership

Enhancing our impact by working with others.

Key success measure to 2025: our sustainability aims and Net Zero Carbon commitments integrated into all key Trust strategies and decision making processes.

Our approach

Delivering sustainable healthcare within UHSussex will only be possible by integrating sustainability into day-to-day decision making across the Trust. Working with others across the Trust will provide synergy and ensure our plans are comprehensive and their implementation effective.

Working with partners at a wider level is also key. Carbon emissions across the ICS are around 70,000 tonnes CO_2e. By working together to deliver Net Zero Carbon across Sussex, we can share learning and best practice, reduce duplication, make the best use of our resources and collectively deliver against Net Zero Carbon.

Our commitments

- We will ensure our sustainable healthcare aims and principles are integrated in decision-making processes across all areas of the Trust and at all levels.
- We will work in partnership with others within our ICS and beyond to decarbonise our local health economy through collaborative projects and approaches, maximising our opportunity to learn from others and share our learning.
- We will strengthen our partnership with Brighton and Sussex Medical School to support research and people development.

UHSussex

Integrating into core business

- Undertake a review of SIs and key Trust programmes and projects to highlight initiatives already supporting this Green Plan and identify any additional areas of opportunity. This should include SIs, breakthrough objectives, efficiency programmes and other corporate projects.

Taking Action:
Collaboration and Partnership

- Ensure sustainability principles are integrated into all business cases with impacts measured as part of benefits realisation.
- Work with Kaizen programme team to integrate sustainable healthcare principles into all our improvement projects.
- Ensure the new Green Plan strategy and Net Zero Carbon commitment is recognised and supported across other Trust strategies and programmes, including: clinical services and operational teams; digital; workforce; quality and safety; improvement and delivery; finance; procurement; estates; comms and engagement; and data and intelligence.

Resourcing

- Develop a resourcing plan with allocated resource to ensure delivery against this Green Plan. This should complement the recently allocated resource for the clinical work stream.

Measurement and reporting

- Report against our NHS Carbon Footprint in line with Green Plan governance requirements, and develop our methodology for reporting against our NHS Carbon Footprint Plus.
- Measure and report against progress against delivery of this action plan in line with Green Plan governance requirements.

Working within the ICS

- We will work with colleagues in BSMS to develop a charter for sustainability and integrate sustainability into the curriculum.
- Identify the key priority areas for working together within the ICS and SE region and develop projects in support of these areas.
- Deliver and develop joint programmes with our national and international partners e.g. For a Greener NHS, Plastics in Healthcare projects.
- Review best practice from other ICSs and actively share our learning by engaging on a local and national level with case studies, examples of best practice and other content of relevance.
- Support the Sussex Health and Care Partnership to develop an ambitious ICS Green Plan that shows leadership on sustainable healthcare and Net Zero in the SE region and beyond.
- Link with Local Authority partners to collaborate on Social Responsibility and climate change initiatives.
- Through the ICS programme board, continue to develop programmes to improve buildings and infrastructure. These improvements allow UHSussex and system partners to improve efficiency through modern methods of construction and rationalisation of estates.

Patients and wider community

- Continue to hold Green travel stakeholder meetings including with
  - Local colleges and universities.
  - Neighbouring business leads (for example Rolls Royce in Chichester and the Racecourse in Brighton).
  - Local and district councils.
  - Portsmouth Hospital University Trust.

Taking Action: Collaboration and Partnership

- Work with our ICS partners to understand how we can best engage with our patients on sustainability. Together, develop an understanding of how to use our influence within our patient community to effect change and ensure we are communicating as one voice across the region.
- Ongoing work as a member of the Smart Sustainability South; chaired by Crown Central Services the group has established to benchmark ideas and develop collaborative work in support of Net Zero strategies across the region.
- Close Sustainability partnering with local councils:
  - Brighton – close liaison with the Green Sustainability group in relation to reuse and recycle, green travel including cycles and EV charging strategy, wider project ideas in relation to net zero and sharing best practice.
  - Worthing – members of the Worthing Heat Network which is an exciting opportunity for the district. The project is aiming to deliver net zero heat derived from waste water heat to multiple sites in Worthing including our Hospital.
  - Chichester – The Trust has a close relationship for Green Travel and has also been working in partnership to identify joint opportunities for net zero.

What you can do to help

Everyone's contribution is required in order to meet our goals set out in this Green Plan. Patient First approach empowers our staff to take simple improvement actions locally that collectively can make a big difference. Other mechanisms exist for everyone to contribute to projects that directly impact our Trust's environmental sustainability;

Become a Green Ambassador – we have over 300 across the Trust and already from a wide range of departments and professional backgrounds. This is a staff network supporting local initiatives requiring behavioural change or raising awareness on environmental issues within this Trust. email uhsussex.green@nhs.net

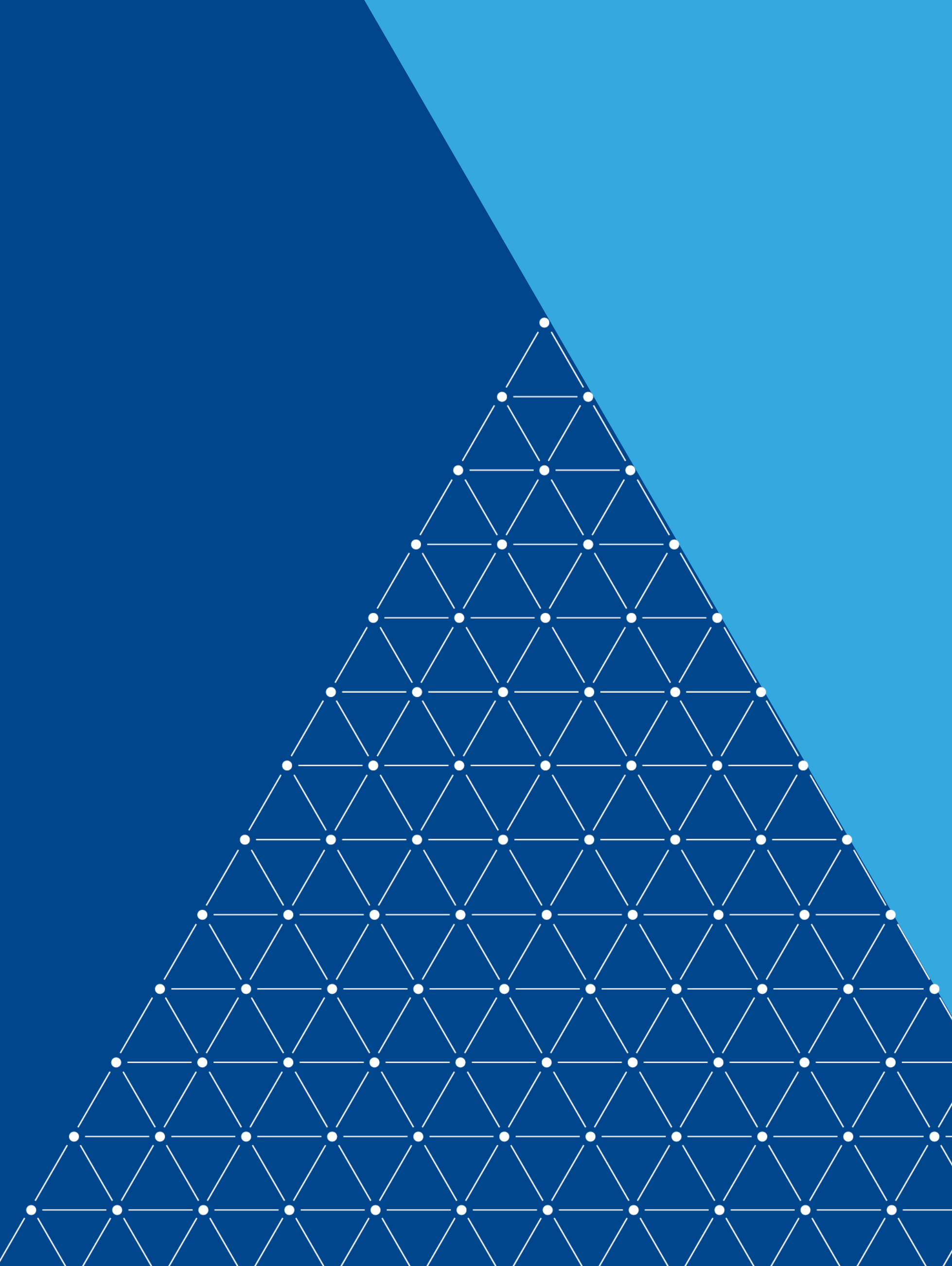
Patient First Improvement System – making a contribution to our environmental strategic initiative through structured local improvement huddles identifying small changes which can make a difference to the carbon footprint in your area of work.

We are developing a programme for Sustainability training. This will be available for everyone to develop a greater understanding of sustainability within the NHS.

Ensure Environmental impact becomes a routine part of your local decision-making and clinical or business decisions.

Project suggestions – staff are encouraged to suggest any projects that will directly impact our environmental performance. Send your suggestions and queries to uhsussex.green@nhs.net These will be picked up by our green ambassadors or our workstream leads

Appendices



Appendix 1

Our carbon footprint reporting boundary

The recent NHSEI climate change strategy 'Delivering a Net Zero National Health Service' recently set out two clear targets for the NHS:

Net Zero by 2040 for the emissions we control directly (NHS Carbon Footprint)

- **Net Zero by 2045 for the emissions we can influence (NHS Carbon Footprint Plus).**

The NHS Carbon Footprint Plus includes all three of the Green House Gas Protocol scopes, as well as the emissions from patient and visitor travel to and from NHS services and medicines used within the home (see Figure A1).

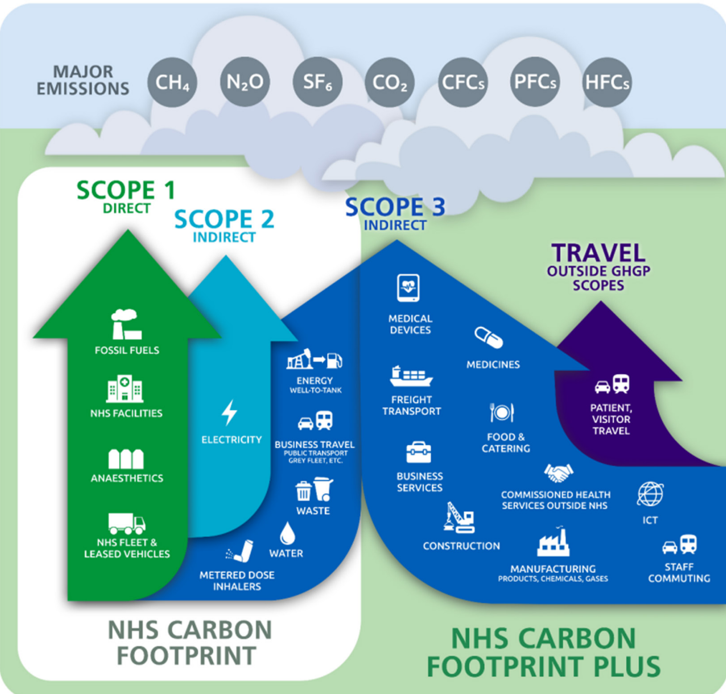


Figure 1A: Greenhouse Gas Protocol scopes in the context of the NHS

In this Green Plan, we have presented our carbon footprint to ensure we are in line with the new NHSEI requirements. As such we are reporting our:

1.NHS Carbon Footprint in full back to our baseline year 2009/10. The following data sources and assumptions have been made:

Activity	Data Source	Assumptions
Utilities	ERIC returns	The 3Ts development has been excluded from our direct emissions footprint
Waste	ERIC returns	-
Anaesthetic gases	Pharmacy DSUM report	Earliest year available 2014/15 used for baseline
Anaesthetic gases - NOX	NHSEI	Earliest year available 2018/19 used for baseline
Metered dose inhalers	Pharmacy DSUM report	Earliest year available 2014/15 used for baseline
Mileage and fleet	Finance claims and fleet fuel records	Earliest year available 2018/19 used for baseline

Our carbon footprint reporting boundary

The recent NHSEI climate change strategy 'Delivering a Net Zero National Health Service' recently set out two clear targets for the NHS:

- **Net Zero by 2040 for the emissions we control directly (NHS Carbon Footprint)**
- **Net Zero by 2045 for the emissions we can influence (NHS Carbon Footprint Plus).**

The NHS Carbon Footprint Plus includes all three of the Green House Gas Protocol scopes, as well as the emissions from patient and visitor travel to and from NHS services and medicines used within the home (see Figure A1).

2.NHS Carbon Footprint Plus using the following data:
a.Supply chain data spend data 2018/19
b.Assumption for personal travel based on the NHSEI %

In terms of reporting boundary, we report on emissions from the activities over which we have operational control. In other words, the accounting boundary is drawn around the clinical services that the Trust is commissioned to deliver and which are therefore delivered in accordance with Trust policies and procedures.

This approach aligns the Trust's carbon reporting with other national NHS reporting processes and standards, notably the annual Estates Return Information Collection (ERIC).

During Q4 2021/22 we will be creating a carbon reporting data management policy to include all emissions within our scope.

Other points to note:
All information included in our sustainability reporting corresponds to the standard public sector financial year of 1st April to 31st March.

Our emissions are reported in absolute terms (i.e. total emissions) without any degree day adjustment (correcting for weather variation).

Data is reported as UHSussex data. For years prior to the merger (April 2021), data from BSUH and WSHFT have been combined.

Appendix 2 – Activity data, emissions, targets and KPIs

a) NHS Carbon Footprint (all reported scope sources, tCO_2e) change since base year.

Carbon emissions (tCO_2e)		
Emission source	Baseline Year 2009 – 2010	2020 – 2021
Building Electricity	31,266	15,326
Building Fossil Fuels	19,218	16,101
Water and Sewerage	621	564
Waste	836	614
Anaesthetic gases	3,295	1,588
Metered Dose Inhalers	1,184	1,083
Business Travel	587	141
NHS Fleet	331	426
Total	57,338	35,842
Actual savings against baseline	-	-37%

Notes:

Where data for 2009-10 year available we have used the furthest back year available with confidence in accuracy

- Anaesthetic gases; 2014/15
- Metered does inhalers; 2014/15
- Nitrous Oxide: 2018/19
- Business miles and Fleet: 2018/19

b) UHSussex activity data for NHS Carbon Footprint since base year

Activity Data		
Emission source	Baseline Year 2009 – 2010	2020 – 2021
Purchased Electricity (kWh)	51,666,300	53,191,638
Gaseous Fossil Fuels (kWh)	92,054,140	75,138,014
Liquid Fossil Fuels (kWh)	1,276,428	1,535,874
Water (m3)	610,691	554,441
Sewerage (m3)	580,156	526,719
Waste (tonnes)	3,243	4,525
Anaesthetic Gases (litres)	1,183	386
Metered Dose Inhalers (no. units)	15,340	10,769
Business Mileage Claims (miles)	1,873,846	511,097
Fleet fuel usage (litres)	126,370	167,712

Notes:

NOX data not included in Anaesthetic gases as raw data not available. Data was provided from NHSEandI in total CO_2 for years 2018/19, 2019/20 and 2020/21

This year for the first time we have incorporated indirect carbon emissions into our carbon footprint, in line with NHSEI NHS Carbon Footprint Plus requirements. The sources of carbon emissions included within the NHS Carbon Footprint Plus are shown below in Figure A3.

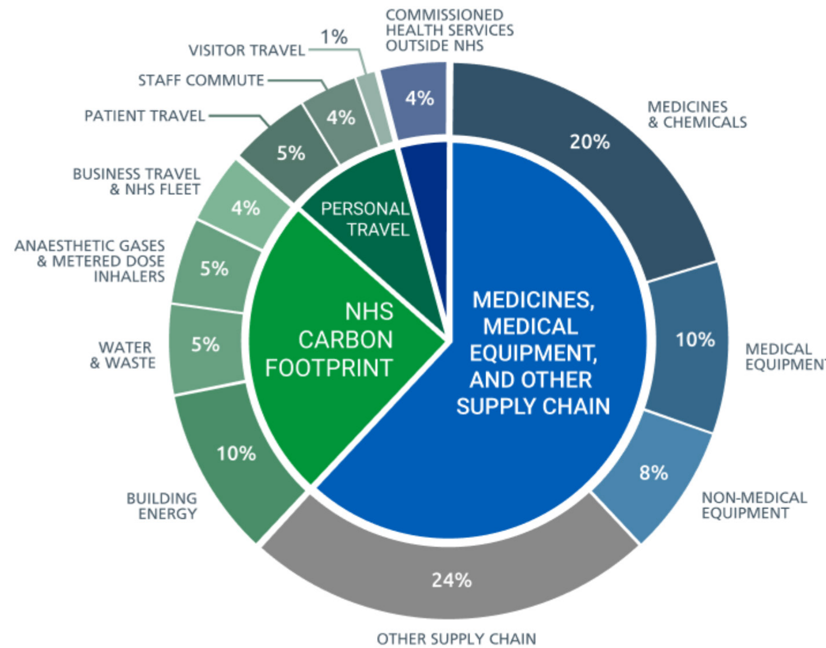


Figure A3: sources of carbon emissions by NHS Carbon Footprint Plus (from 'Delivering a Net Zero National Health Service')

Supply Chain and Commissioned Healthcare Services

For UHSussex, 'Supply Chain' covers all aspects of the NHS Carbon Footprint Plus within the 'Medicines, medical equipment and other supply chain' category.

Both Supply Chain and Commissioned Healthcare Services outside NHS were calculated using an environmentally extended input-output (EEIO) model historically used by the NHS Sustainable Development Unit (now For a Greener NHS).

Carbon factors covering the financial year 2018-2019 across 21 product and service categories were applied to the Trust's 2020-2021 financial data. These were expressed as kilograms of carbon dioxide equivalent per £ spend ($kgCO_2e/£$).

This methodology was chosen as it was the most up to date methodology available to us and has been used by For a Greener NHS. Updated tools and methodologies are required to improve reporting within this area.

Personal Travel

Data covering the Personal Travel aspect of the UHSussex NHS Carbon Footprint Plus (patient travel, staff commute, visitor travel) was not available for UHSussex.

Instead, an estimated figure has been included in order to give a clear representation of the scale of the challenge and the key areas of impact. Personal Travel emissions were estimated from 10% of our current reported carbon footprint; including all reported sections of NHS Carbon Footprint Plus (e.g. Supply Chain); and added to the total.

The 10% proportion was selected to align with NHS England estimates from the 'Delivering a Net Zero NHS' report.

We aim to more accurately report on this section as our reporting techniques in this area develop.

In partnership with

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	18	**Meeting:**	Board	**Meeting Date:**	February 2022
Report Title:	2021/22 Quarter 4 BAF				
Sponsoring Executive Director:			Chief Executive		
Author(s):			Company Secretary		
Report previously considered by and date:			BAF has been considered by each of the Trust's allocated oversight committees in January.		

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

Implications for Trust Strategic Themes and any link to BAF risks		
Patient	✓	The report covers each BAF risk
Sustainability	✓	
Our People	✓	
Quality	✓	
Systems and Partnerships	✓	

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

Communication and Consultation:

Executive Summary:

Introduction

The Trust identified 13 strategic risks at the start of 2021/22, each risk being assessed against the Trust's risk appetite when setting their target score. Following the Board meeting in November 2021 and recognising the changing environment that the Trust and the NHS more widely is operating within the original risks were reviewed and the risks relating to the quality domain resulted in a tightening of the narrative in respect of risk 4.1 to remove any possible duplication with risk 4.2. For the other patient first domains, of patient, people, sustainability and systems and partnerships the risks were considered to remain fairly described, with a minor adjustment to risk 3.3 to reflect the addition of the word sufficient in respect of the recruitment, development, training and retention of staff.

For each segment of the BAF the respective lead executive has considered their risks and proposed an opening risk score for Q4.

BAF Summary

The table below overleaf shows by risk, their current score and their target risk score. The table shows pictorially the movement in risk between the current score for Q3 and Q2 and Q2 and Q1. (⟷ No change, ↑ an increase in risk and ↓ a decrease in risk)

BAF: Strategic Objectives and Strategic Risks (Key: I = Impact L = Likelihood T = Total)	Risk Scores														
	Q1			Q2			Q3			Q4			Target		
	I	L	T	I	L	T	I	L	T	I	L	T	I	L	T
1. Patient ***(Oversight provided by the Patient Committee)***															
1.1 We are unable to deliver or demonstrate a continuous and sustained improvement in patient experience resulting in adverse reputational impact, and loss of market share.	3	4	**12**	3	4	**12** ↔	4	4	**16** ↑	4	4	**16** ↔	3	2	**6**
2. Sustainability ***(Oversight provided by the Sustainability Committee)***															
2.1 We are unable to align or invest in our workforce, finance, estate and IM&T infrastructure effectively to support operational resilience, deliver our strategic and operational plans and improve care for patients	4	4	**16**	4	4	**16** ↔	4	4	**16** ↔	4	4	**16** ↔	4	2	**8**
2.2 We cannot deliver ongoing efficiencies and flex our resources in an agile way resulting in an increasing or unmanaged deficit and inefficient, unaffordable and unsustainable services.	4	4	**16**	4	4	**16** ↔	4	4	**16** ↔	4	4	**16** ↔	4	2	**8**
2.3 We are unable to meet high standards of financial stewardship meaning we cannot sustain compliance with our statutory financial duties	4	4	**16**	4	3	**12** ↓	4	3	**12** ↔	4	3	**12** ↔	4	2	**8**
3. People ***(Oversight provided by the People Committee)***															
3.1 We are unable to develop and sustain the leadership and organisational capability and capacity to lead on-going performance improvement and build a high performing organisation	4	3	**12**	4	3	**12** ↔	4	3	**12** ↔	4	4	**16** ↑	4	2	**8**
3.2 We are unable to effect cultural change and involve and engage staff in a way that leads to continuous improvements in patient	4	3	**12**	4	3	**12** ↔	4	3	**12** ↔	4	4	**16** ↑	4	2	**8**

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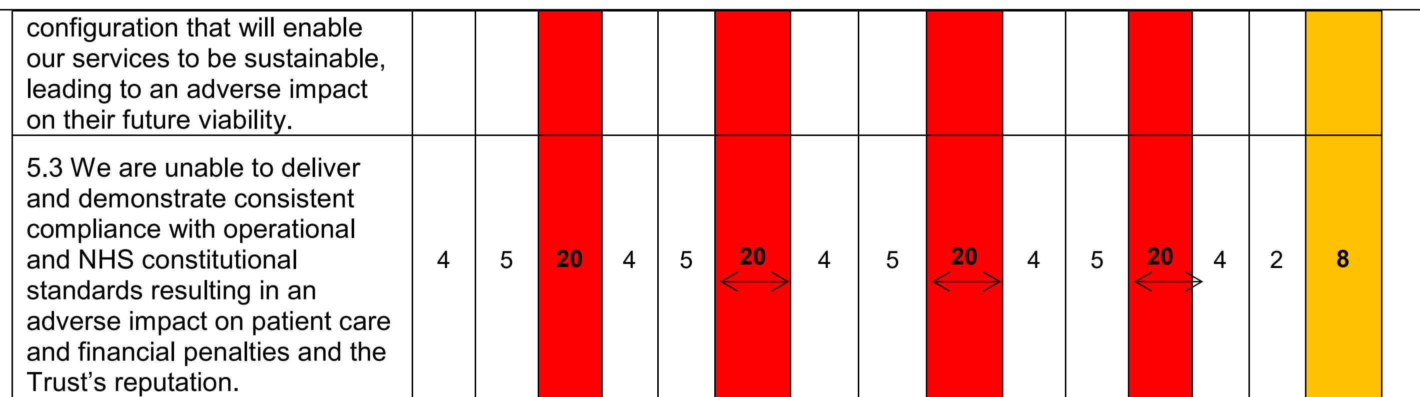
experience, patient outcomes, and staff morale and wellbeing															
3.3 We are unable to meet our workforce requirements through the effective recruitment, development, training and retention of *sufficient* staff adversely impacting on patient experience and the safety, quality and sustainability of our services	3	4	**12**	3	5	**15** ↑	4	5	**20** ↑	4	5	**20** ↔	3	2	**6**
3.4 We are unable to consistently meet the health, safety and wellbeing needs of our staff as we recover and restore services in line with CV-19 restrictions	4	4	**16**	4	4	**16** ↔	4	4	**16** ↔	4	4	**16** ↔	4	2	**8**
4. Quality ***(Oversight provided by the Quality Committee)***															
4.1 We are unable to deliver safe and harm free care to reduce non-covid mortality.	3	4	**12**	3	4	**12** ↔	4	4	**16** ↑	4	4	**16** ↔	3	2	**6**
4.2 We are unable to deliver service improvements and improve safety, care quality and outcomes for our patients or demonstrate that our services are clinically effective and demonstrate our consistent compliance with regulatory requirements or clinical standards.	3	3	**9**	3	4	**12** ↑	4	4	**16** ↑	4	4	**16** ↔	3	2	**6**
5. Systems and Partnerships ***(Oversight provided by the Systems and Partnerships Committee)***															
5.1 We are unable to develop and maintain collaborative relationships with partner organisations based on shared aims, objectives, and timescales leading to an adverse impact on our ability to operate efficiently and effectively within our health economy	4	3	**12**	4	3	**12** ↔	4	4	**16** ↑	4	4	**16** ↔	4	2	**8**
5.2 We are unable to define and deliver the strategic intentions, plans and optimal	4	4	**16**	4	4	**16** ↔	4	4	**16** ↔	4	4	**16** ↔	4	2	**8**



configuration that will enable our services to be sustainable, leading to an adverse impact on their future viability.															
5.3 We are unable to deliver and demonstrate consistent compliance with operational and NHS constitutional standards resulting in an adverse impact on patient care and financial penalties and the Trust's reputation.	4	5	**20**	4	5	**20** ↔	4	5	**20** ↔	4	5	**20** ↔	4	2	**8**

Quarter 4 summary

Following review by the Executives this has seen 6 risks increase their score for Quarter 3 / Quarter 4 (noting risk 5.1 was increased following the Committee review of that risk in October).

This sees the Trust's highest risks scoring 20 being risk 5.3 relating to the delivery of consistent compliance with the constitutional standards and risk, 3.3 relating to workforce. The BAF reflects an increase in risks scoring 16, with these risks being 1.1 regarding patient experience, 2.1 and 2.2 regarding sustainability risks 3.1, 3.2 and 3.4 relating to our people, risks 4.1 and 4.2 relating to quality and risks 5.1 and 5.2 relating to systems and partnerships.

There are 12 of the 13 risks within the BAF scoring 16 and above and there are no risks at their target score.

Respective Committee review of risks

Each of the five Board Committees with oversight for specific BAF risks met in January and their respective reviews over their allocated risks confirmed that they considered the current scores for each are fairly represented.

The Patient Committee debated the issue of health inequality and supported the development of a further strategic risk covering this area.

Key Recommendation(s):

The Board is asked to consider the Q4 risk scores in light of the changing environment the Trust is operating within and in light of the assurances provided by the respective oversight committees and those received directly at the Board agree the current scores are fairly represented.

Agenda Item:	19	Meeting:	Board	Meeting Date:	3 February 2022
Report Title:	CQC Action Plan				
Sponsoring Executive Director:			Maggie Davies – Chief Nurse		
Author(s):			Maggie Davies – Chief Nurse		
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:

In response to the latest CQC reports following the inspection of the Trust's Maternity Services across all four main sites of St Richards, Worthing, Royal Sussex County and Princess Royal and the inspection of Surgery at the Royal Sussex County the Trust developed an action plan to address the CQC observation and recommendations. This action plan incorporated the recommendations made within the CQC issued warning notice following their visit.

The attached report describes the Trust's response to the warning notice along with the internal governance structures established to oversee the embedding of these improvements along with the wider actions flowing from the CQC reports.

Key Recommendation(s):

The Board is asked to **NOTE** this update and **NOTE** the reporting of the delivery of the improvements will be made through to the Quality Committee and then to the Board.

UHSussex
CQC Action Plan

18th January 2022

UHSussex response to the CQC Warning Notice

- The CQC made an unannounced focussed inspection of Maternity Service and Surgery in the Royal Sussex County Hospital on 28th September 2021

- The CQC issued a Warning Notice which identified four areas that the Trust was required to make significant improvements in by 3rd December 2021:

  - Safe storage and administration of medicines in maternity
  - Safe, secure and contemporaneous medical records in maternity across the trust
  - Infection prevention and control in surgery at RSCH
  - Assessing and responding to risk

- The Trust provided a comprehensive response to these concerns on 6th April (response attached)

- It also identified a further two areas that required significant improvement by 29th April 2022:

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

- The Trust is addressing these concerns and will achieve the improvement required across all areas no later than 31st March 2022

- An ICS led System Oversight Meeting, includes all key stakeholders and meets monthly to track and assure delivery of UHSussex Improvement Plans

CQC Feedback to Trust's response to the Warning Notice

The Trust has received feedback from the CQC on our response to the Warning Notice submitted 3rd December 2021

The CQC has:

- Confirmed that the action plan clearly addresses the breaches in regulation and all other areas of concern identified during our inspection
- Recognises the steps the Trust is taking to ensure improvement actions are embedded within the timeframes set out in the Warning Notice
- Requested three amendments to the action plan:
  - A specific time frame allocated for each action
  - A visible review date recorded
  - A responsible/named individual recorded against the actions

The Trust has made these amendments which are reflected in the following slides

The Trust has also undertaken other improvements, which includes introduction of a new Executive role (agreed by Board 6th January 2022) to provide strengthened governance in the Trust, as well as immediate actions undertaken around a specific HR issue following original CQC visit.

UHSussex Improvement Governance

Marianne Griffiths (Chair)
Executive Team, Director Comms, Director Improvement & Delivery, PMO Lead
To oversee development and delivery of improvement plans from the five work streams (below). Report to Quality Committee and System Oversight Committee
Frequency: Monthly, to provide relevant feeds into Quality Committee and System Oversight Committee

Quality Committee

UHSussex Improvement Steering Group

System Oversight

Quality Governance

CQC Must Do / Should Do Response

Workforce & Wellbeing

Well-Led

Operational Safety Compliance

Workstream Structure and Scope

Quality Governance

- Oversee development and delivery of improvement trajectories for all elements of the Quality Governance system compliance – Incident Management, Complaints, clinical guidelines, Audit, NICE, risk management, CQC compliance (check and balance to ensure groups Surgery East and Maternity Improvement Groups are achieving trajectories),
- Develop approach to Trust wide learning and track delivery of improvement plan
- Complete integration of Quality Governance system including feed in from the Divisions
- Oversee maturity improvement of the Divisions

CQC Must Do / Should Do Response

- Comprehensive response and evidence for all Must Do, Should Do. Track improvement trajectories and report against these

Workforce & Wellbeing

- Develop improvement trajectories and track progress for STAM and appraisal compliance.
- Develop approach to workforce deployment model and roll out plan based on agreed risk based prioritisation
- Cultural improvement and engagement

Well-Led

- Oversee completion of KLOE gap analysis, improvement plans and evidence

Operational Safety Compliance

- Develop standard operating procedure and roll out plan for Safety Huddles, MSS, Environmental Safety and Drug Storage Audit
- Determine most appropriate reporting and escalation mechanism and how to integrate with BAU and Quality Governance System
- Track compliance and agree remedial actions

Key Risks

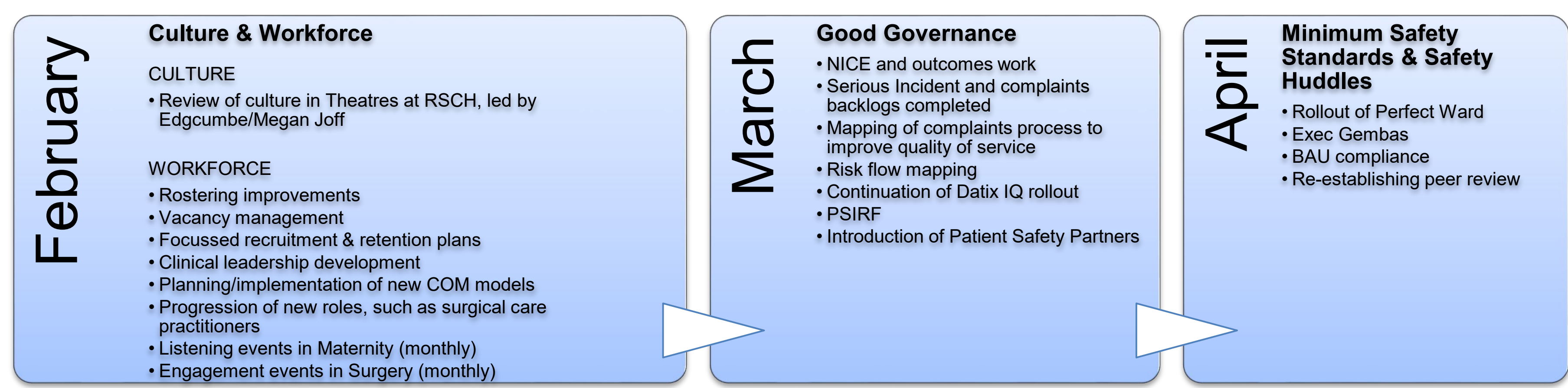
The following risks, all related to workforce, are considered the most impactful in enabling the Trust to deliver its planned improvement programmes:-

- Recruitment & Retention across all sections of the Trust's workforce
- Continued sickness absence relating to Covid (isolation or illness) reducing the effective number of deployable staff
- The impact of the mandatory vaccination programme for NHS workers, and any resulting potential loss of staff

Next Steps

Work will continue to monitor and deliver improvements in Maternity and Surgery East identified areas, according to Warning Notice requirements as well as items contained in the Final CQC Reports.

Whilst addressing specific items that were raised in the Warning Notice, the Trust is also ensuring that it takes each learning and ensures compliance across the whole Trust. Recognising that January 2022 will be primarily managing Covid surge, a series of deep dives have been scheduled for February – April on the following topics:-



These will enable the Trust to ensure that compliance actions are clearly in place, supported and working well, and embedded into business as usual activities. Where there remain any areas requiring additional support, resources will be identified to ensure support is maintained until embedding.

Other key actions in January/February include

- A refreshed focus on IT infrastructure, to ensure items such as bandwidth capacity and capability are being effectively managed and rolled out as required across UHSussex, in line with investment plans
- Detailed planning to allow the Trust to ensure all relevant local clinical guidelines are updated with electronic management solutions identified

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Agenda Item:	20	Meeting:	Trust Board in Public	Meeting Date:	February 2022
Report Title:	**Company Secretary Report**				
Committee Chair:			Glen Palethorpe, Company Secretary		
Author(s):			Glen Palethorpe, Company Secretary		
Report previously considered by and date:			The learning from deaths report has been considered and endorsed by the Quality Committee in January 2022		

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

Implications for Trust Strategic Themes and any link to BAF risks		
Patient	☐	
Sustainability	☐	
People	☐	
Quality	✓	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 3 – Appendix 1

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

The Quality Committee received and reviewed this reports at its meeting on the 25 January 2022 and the one report covers Royal Sussex County, Princess Royal, St Richards and Worthing Hospitals.

Schedule of meetings for 2022/23

As with 2021/22 the Board meetings will be held quarterly on a Thursday, and these will continue to be a week behind the supporting Committee meetings, this is to allow for the efficient flow of assurance from these Committees to the Board.

The table below shows the dates and times of these meetings which are all open to the Public, but the locations of these meetings has yet to be determined. We expect that we will be able to move back to in person meetings but we will continue to be guided by national and NHS social distancing requirements.

	May 2022	Aug 2022	Nov 2022	Feb 2023
Board of Directors	**Thurs 5 May 10.00-13.30**	**Thurs 4 Aug 10.00-13.30**	**Thurs 10 Nov 10.00-13.30**	**Thurs 2 Feb 10.00-13.30**

Council of Governors meetings

For 2022/22 there will continue to be four Council of Governors meetings held in public. These are to be held a couple of weeks after each Board meeting thus ensuring the reports to the Council reference the same data set used for the Board and as the Board papers are sent to each governor given the close proximity of the meetings then the provision of duplicate reporting can be removed.

As with the Board meetings the table below shows the dates and times of these meetings which are all open to the Public, but the locations of these meetings has yet to be determined. We expect that we will be able to move back to in person meetings but we will continue to be guided by national and NHS social distancing requirements.

	May 2022	Aug 2022	Nov 2022	Feb 2023
Council of Governors	**Thurs 19 May 14.00 – 16.00**	**Thurs 18 Aug 14.00 – 16.00**	**Thurs 25 Nov 14.00 – 16.00**	**Thurs 16 Feb 14.00 – 16.00**

Annual General Members Meeting

The Trust is provisionally targeting the Wednesday 27 July 2022 for its AGM noting this date is subject to the final year end reporting requirements that have yet to be finalised by NHS Improvement. The location for this meeting has yet to be determined.

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 Committee.

NOTE the dates of the Board and Council of Governors meetings open to the public and the proposed date for the AGM. The Board and Council meeting dates will be publicised on our web site as will the AGM date once agreed.

Agenda Item:	20	Meeting:	Board	Meeting Date:	February 2022
Report Title:	Learning from Deaths Q3 2021/22 University Hospitals Sussex NHS Foundation Trust				
Sponsoring Executive Director:			Charlotte Hopkins - Chief Medical Officer		
Author(s):			Mary Evans – Learning from Deaths Manager (Worthing and St. Richards Hospitals) Alison Young – Head of Quality Improvement Mark Renshaw - Head of Quality Improvement Tim Taylor - Medical Director for Governance and Quality assurance		
Report previously considered by and date:			Quality Committee 25 January 2022		

Purpose of the report:			
Information	✓	Assurance	✓
Review and Discussion	✓	Approval / Agreement	☐
Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	☐	Staff confidentiality	☐
Patient confidentiality	☐	Other exceptional circumstances	☐
Link to Trust Strategic Themes:			
Patient Care	✓	Sustainability	☐
Our People	☐	Quality	✓
Systems and Partnerships	☐		

Any implications for:	
Quality	Learning and quality improvement from the review of deaths
Financial	Nil
Workforce	Training requirements and time for individuals to undertake and respond to learning

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

Communication and Consultation:
A plan for communication is being developed
Executive Summary:
The purpose of the briefing is to update the board of the progress in the implementation of the structured approach for reviewing the deaths of patients to provide assurance on care and identify areas where it could have been improved.
Key Recommendation(s):
The Board is asked to NOTE the report.

Learning from Deaths Mortality Report Quarter 3 2021/22 as at 10/01/2022 for University Hospitals Sussex NHS Foundation Trust (UHSussex)

1. Purpose

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

1.2 This report is presented to the Trust Board as assurance of the efficacy of the Learning from Deaths (LfD) and Learning Disabilities Mortality Review (LeDeR) in adherence to the National Quality Board guidance on Learning from Deaths (2017).

2. Background

2.1 The National Quality Board's National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on identifying, reporting, investigating and learning from deaths in care (March 2017) set out key requirements to ensure organisations effectively respond to and learn from patient deaths.

2.2 Acute trusts in England were initially asked to set up Medical Examiner (ME) offices to focus on the certification and to provide scrutiny of all deaths that occur in their own organisation on a non-statutory basis. In February 2021, the government published "Integration and innovation: Working together to improve health and social care for all", the white paper which includes provisions for medical examiners to be put on a statutory footing. During 2021/22, the role of these offices is being extended to include all non-coronial deaths, wherever they occur. Implementation of this next phase will take place incrementally, to allow time for capacity and processes to be put in place. ME offices across UHSussex are now fully implemented and scrutinise all in hospital non coronial deaths.

3. Governance

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

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

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

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

4. Process

4.1 Structured Judgement Review (SJR) methodology is a standardised, non-rigid, case notes review methodology blending traditional, clinical judgement based, review methods with a standard format. The trained reviewers make safety and quality judgements over phases of care, make explicit written comments about care for each phase, and score care for each phase. These aspects are then applied to the overall care received. This process is structured and replicable examining both interventions and holistic care giving reviewers a rich data set of information.

4.2 SJR also allows the identification and feedback of good care in the same detail as 'problematic' care, enabling learning and spread examples of high quality care.

4.3 The process regarding SJR currently differs across the four hospital sites of University Hospitals Sussex NHS Foundation Trust (UHSussex). For the Royal Sussex County Hospital (RSCH) and Princess Royal Hospital (PRH) sites - SJRs are completed on an electronic form within PANDA (the Trust's electronic patient information system). PANDA is also used to alert the Divisional Quality and Safety Managers (DQSM) to those cases requiring an SJR. The DQSM allocates each case to a trained reviewer (multidisciplinary) to complete and share any findings for learning. All consultants can submit and review SJRs on PANDA. The 'assessment of problems in healthcare' section of the SJR records quantitative data on the nature of the problem type and whether this resulted in harm to the patient. For SRH and WGH - SJRs are completed on a word document. The outcome scores and learning themes are populated using excel spreadsheets until an electronic system is available (Datix IQ Mortality Module).

4.4 Deaths requiring review are triangulated via the Serious Incident Review Group (SIRG), Complaints, Medical Examiner office, Medico-legal Department, Learning Disabilities Team, or in response to risk adjusted mortality statistics.

4.5 Any deaths identified as potentially resulting from failures in care are recorded on the DATIX RL® incident reporting system and considered by SIRG for Serious Incident (SI) investigation.

4.6 Deaths of patients with learning disabilities (LD) are referred to the Learning Disabilities Mortality Review (LeDeR) Programme for independent care pathway review but also undergo local SJR, to ensure timely scrutiny and learning from the inpatient hospital admission, which is then shared to assist LeDeR to complete their review. LeDeR was originally introduced in 2015 in response to significant ongoing concerns about the likelihood of premature deaths of people with learning disabilities. From 1 June 2021, the name was changed to Learning from Life and Death Reviews and the processes were updated, as a result of a review of the previous process during 2019/20. There is evidence from both before and during the Covid-19 pandemic that deaths for people with disabilities and autistic people are higher than they should be and that people die earlier than ought to be the case.

5. Involving Families / Carers

5.1 All non-coronial deaths across UHSussex are reviewed by the ME office. An ME or Medical Examiner Officer (MEO) speaks with the nominated family/carers of the deceased to discuss and explain the Medical Certificate of Cause of Death (MCCD) and to ascertain any concerns regarding care. If concerns are raised either by the family or following ME scrutiny of the case, the ME refers the case for SJR.

6. Mortality Reviews

6.1 Total deaths

Table 1: Details the number of adult inpatient deaths for quarter 3 2021/22 per month, per hospital site

Table 1	SRH	WGH	RSCH	PRH
October	95	98	93	41
November	84	104	109	29
December	88	105	111	41
Total	**267**	**307**	**313**	**111**

6.2 Covid-19 related deaths

Table 2: Details the number of deaths where Covid-19 appeared on the MCCD for quarter 3, 2021/22 per month, per hospital site

Table 2	SRH	WGH	RSCH	PRH
October	11	6	4	2
November	10	7	7	6
December	6 (+ 1 PM*)	8	16	6
Total	**27** (+ 1 PM)	**21**	**27**	**14**

*PM – post mortem pending

All of the deaths where Covid-19 appeared on the MCCD, that occurred in WGH and SRH underwent ME scrutiny as per current practice and were only escalated to SJR if the criteria for referral was met. Four such cases were escalated to SJR for quarter 3 2021/22.

At RSCH and PRH 91% of the deaths in Quarter 3 were reviewed by a Medical Examiner, of these an SJR was requested in the deaths of 32 patients.

6.3 Hospital onset healthcare associated Covid-19

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

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

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

Table 3	SRH	WGH	RSCH	PRH
October	0	0	0	0
November	1 (1x cat 2)	0	0	2
December	1 (1x cat 2)	1 (1x cat 2)	1	2
Total	**2**	**1**	**1**	**4**

In accordance with national guidance, all probable or definite hospital onset healthcare associated Covid-19 infection deaths where Covid-19 appears on the MCCD, are reported and investigated as patient safety incidents. This includes; a patient safety investigation to identify learning, as well as the completion of Duty of Candour (Regulation 20).

7. Mortality reviews

7.1 Medical Examiner Office

Table 4: Details the number of deaths per hospital site, per month during quarter 3 2021/22, that underwent ME scrutiny

Table 4	SRH	WGH	RSCH	PRH
October	100	100	88	19
November	88	108	99	33
December	92	108	108	39
Total	**280**	**316**	**295**	**91**

Table 5: Details the number of deaths per hospital site, per month during quarter 3 2021/22, that were referred to the coroners

Table 5	SRH	WGH	RSCH	PRH
October	14	20	No Data	No Data
November	13	21	No Data	No Data
December	21	20	No Data	No Data
Total	**48**	**61**		

Table 6: Details the number of deaths per hospital site, per month during quarter 3 2021/22, where a conversation was held with the nominated person.

Table 6	SRH	WGH	RSCH	PRH
October	92 (92%)	80 (80%)	No Data	No Data
November	84 (95%)	87 (81%)	No Data	No Data
December	83 (90%)	88 (81%)	No Data	No Data
Total	**259 (92%)**	**255 (81%)**		

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

Graph 1

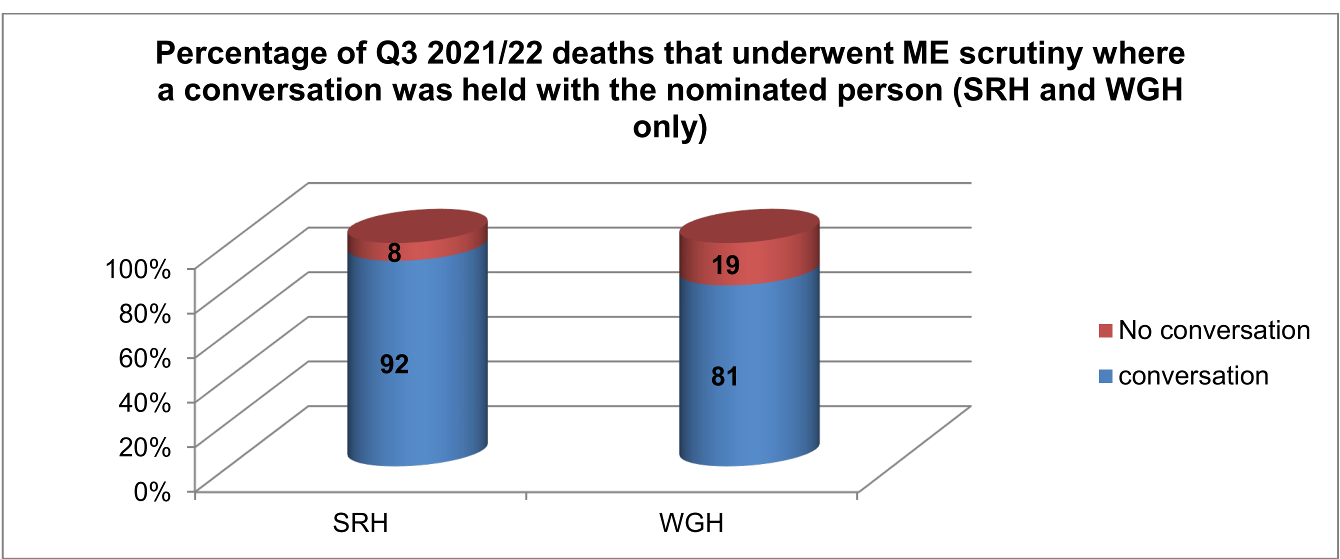


Table 7: Details the number and percentage of quarter 3, 2021/22 deaths per hospital site, per month where the nominated person raised a concern upon discussion with ME office

Table 7	SRH	WGH	RSCH	PRH
October	14 (15%)	11 (14%)	No Data	No Data
November	12 (14%)	5 (6%)	No Data	No Data
December	16 (19%)	3 (3%)	No Data	No Data
Total	**42 (16%)**	**19 (7%)**		

Graph 2: Details the percentage of quarter 3, 2021/22 deaths per hospital site where the nominated person raised a concern upon discussion with ME office

Graph 2:

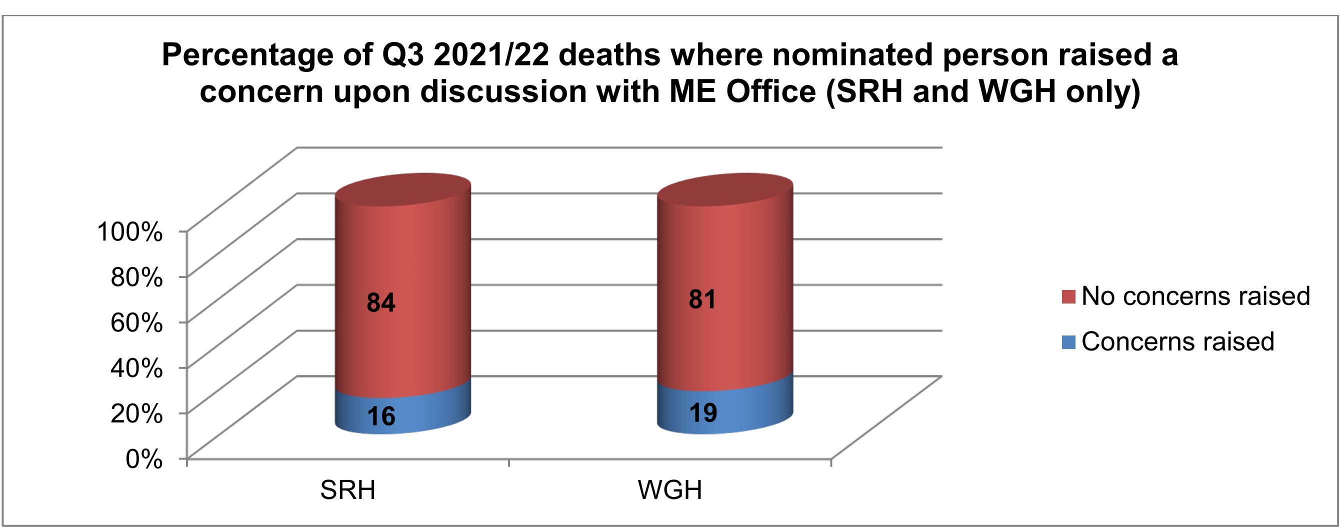


Table 8: Details the number and percentage of quarter 3, 2021/22 deaths per month, per hospital site where the nominated person provided positive feedback upon discussion with ME office

Table 8	SRH	WGH	RSCH	PRH
October	2 (2%)	11 (14%)	No Data	No Data
November	3 (4%)	5 (6%)	No Data	No Data
December	7 (8%)	9 (10%)	No Data	No Data
Total	**12 (5%)**	**25 (10%)**		

Table 9: Details the number and percentage of quarter 3, 2021/22 deaths per month, per site where learning was identified and feedback to clinicians in real time

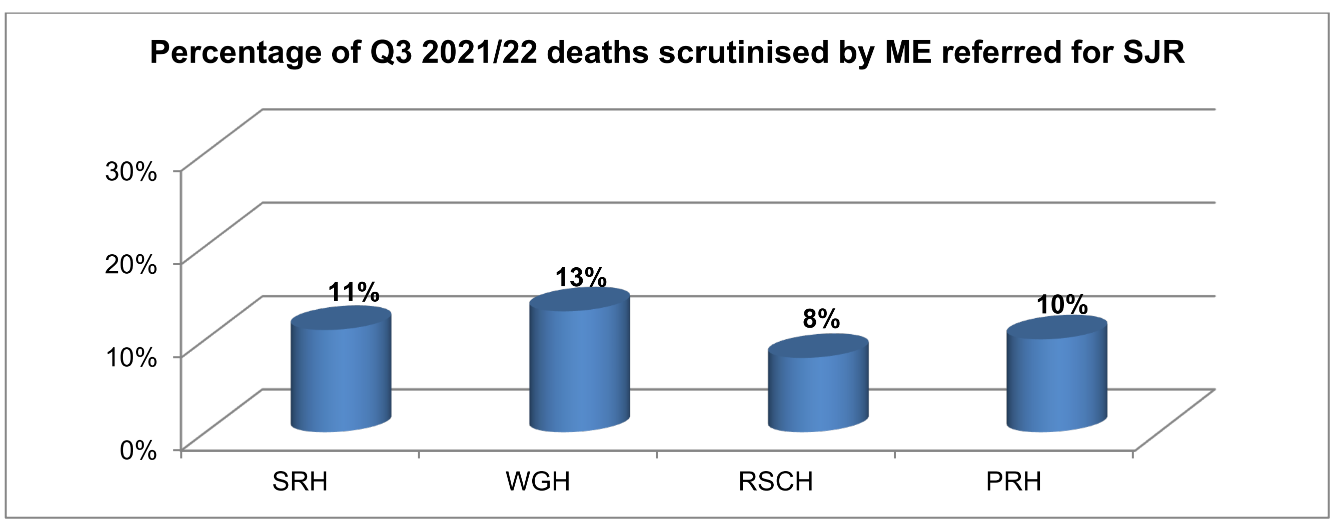
Table 9	SRH	WGH	RSCH	PRH
October	8 (8%)	12 (12%)	No Data	No Data
November	16 (18%)	7 (6%)	No Data	No Data
December	22 (24%)	3 (3%)	No Data	No Data
Total	**46 (16%)**	**22 (7%)**		

Table 10: Details the number and percentage of quarter 3, 2021/22 deaths per month, per site referred for SJR following ME scrutiny.

Table 10	SRH	WGH	RSCH	PRH
October	8 (8%)	10 (10%)	8 (9%)	2 (11%)
November	10 (11%)	17 (16%)	6 (6%)	5 (15%)
December	14 (15%)	15 (14%)	9 (8%)	2 (5%)
Total	**32 (11%)**	**42 (13%)**	**23 (8%)**	**9 (10%)**

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

Graph 3:



7.2 Structured Judgement Reviews

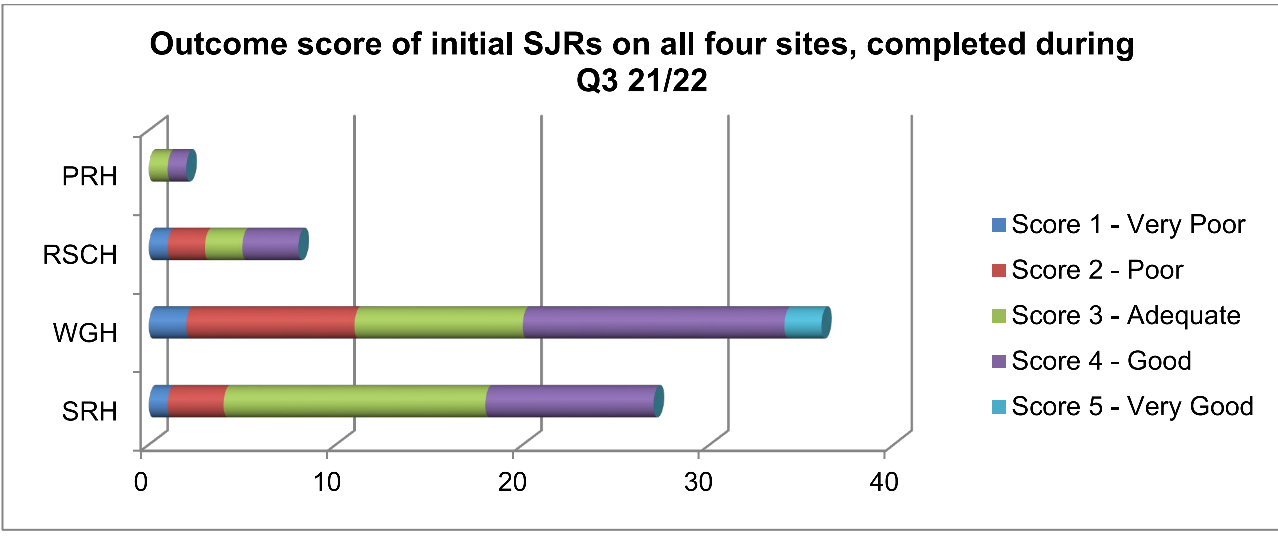
Table 11: Details the overall outcome score of initial SJR on all four sites, completed during quarter 3 2021/22

Table 11

Overall outcome score	SRH	WGH	RSCH	PRH
1 – Very poor	1	2	1	0
2 – Poor	3	9	2	0
3 – Satisfactory	14	9	2	1
4 – Good	9	14	3	1
5 – Very good	0	2	0	0
Total	**27**	**36**	**8**	**2**

Graph 4: Details the outcome scores of initial SJR on all four sites, completed during quarter 3 2021/22

Graph 4



For deaths occurring at SRH and WGH, the proportion of 'very poor' and 'poor' care being identified following SJR, as per SJR methodology, has increased. This increase is as a result of the introduction of a robust Medical Examiner system as only cases where problems in care have been identified (which may have affected the patient outcome or would provide a greater opportunity for wider learning) in addition to those where there were mandated reasons for referrals are escalated to SJR. This means that there are fewer cases for all Divisions where the overall care has been judged as 'good' or 'excellent' following SJR. For cases where 'excellent' care or feedback is identified via the ME office (through discussion with the relatives or case note scrutiny), the clinicians and teams received positive feedback from the ME office in real time. For deaths scrutinised during quarter 3 2021/22 this occurred in 37 cases (6%). Cases where there was some learning but the ME office did not feel an SJR would provide any further value were also feedback in real time to the clinical teams or the Divisional Morbidity and Mortality (M & M) leads, for them to discuss in the appropriate governance forum. This involved 68 cases (11%) of cases scrutinised by a ME for quarter 3, 2021/22).

The overall quality of care was evaluated as poor or very poor for three of the SJRs undertaken at RSCH during quarter 3, 2021/22.

7.3 Mortality reviews for people with a Learning Disability (LD) quarter 3 2021/22

Table 12: Details the number of deaths of patients with a LD during quarter 3 2021/22

Table 12	SRH	WGH	RSCH	PRH
October	0	0	0	0
November	1	1	1	0
December	0	0	0	0
Total	**1**	**1**	**1**	**0**

For SRH and WGH for quarter 3 2021/22, two 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 of both cases, within the agreed timeframe. One out of the two cases, one has completed the mortality review process having had an SJR completed and the review uploaded to either the LeDeR record and / or sent to the Sussex LeDeR programme lead. This death was not identified as being more likely than not due to problems in care.

During quarter 3, 2021/22 no completed external LeDeR reviews were shared with the Trust for patients that had died in SRH or WGH.

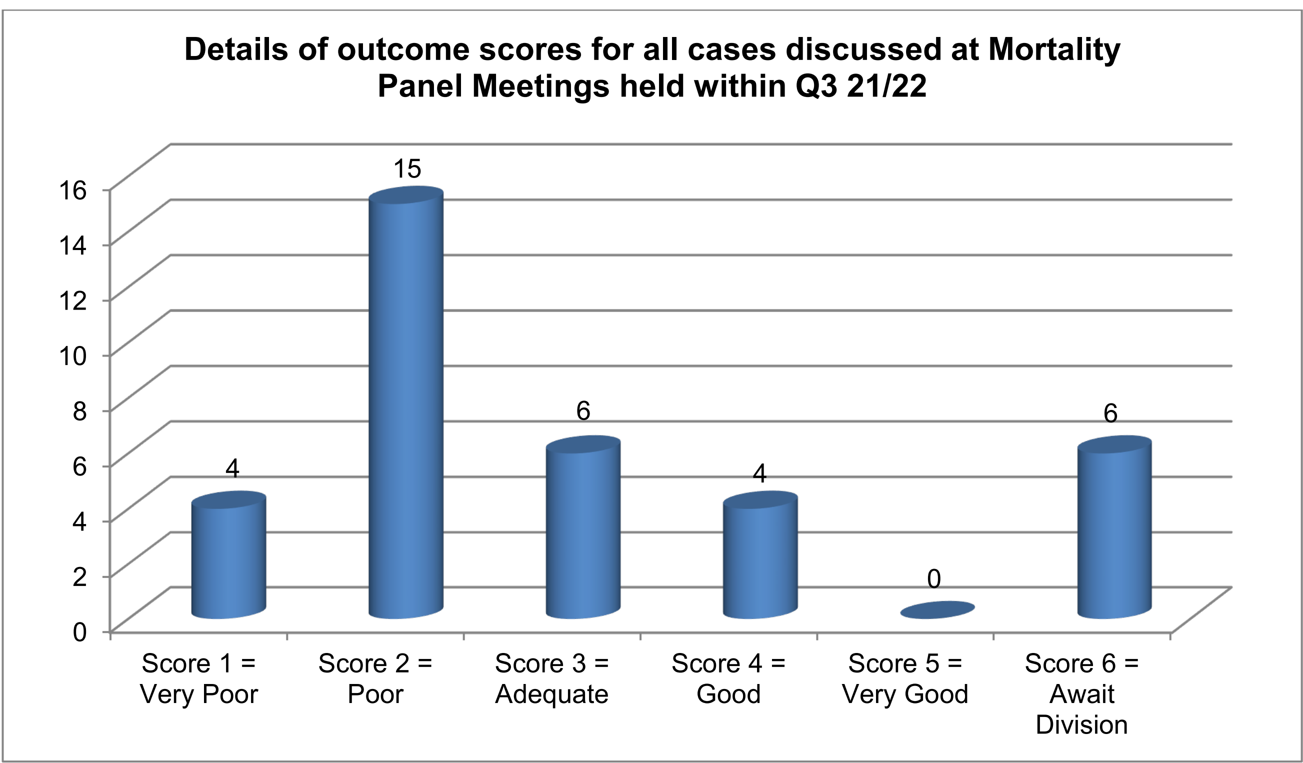
For LD deaths occurring at RSCH and PRH the processes for sharing of information with and the receiving of external feedback from completed LeDeR reviews is being established, to align with the well-established processes in place for those who die at SRH or WGH.

8. Mortality Panel Outcomes (SRH and WGH)

During quarter 3 2021/22 a total of 35 (↓) cases (of patients who died at SRH and WGH) were discussed at the weekly mortality panel meetings. These involved 9 cases from deaths that occurred in quarter 3 2020/21, 9 cases from quarter 2 2021/22 and 17 cases from quarter 1 2021/22.

Graph 5: Details final outcome scores for all cases discussed at mortality panel meetings that took place within quarter 3 2021/22.

Graph 5

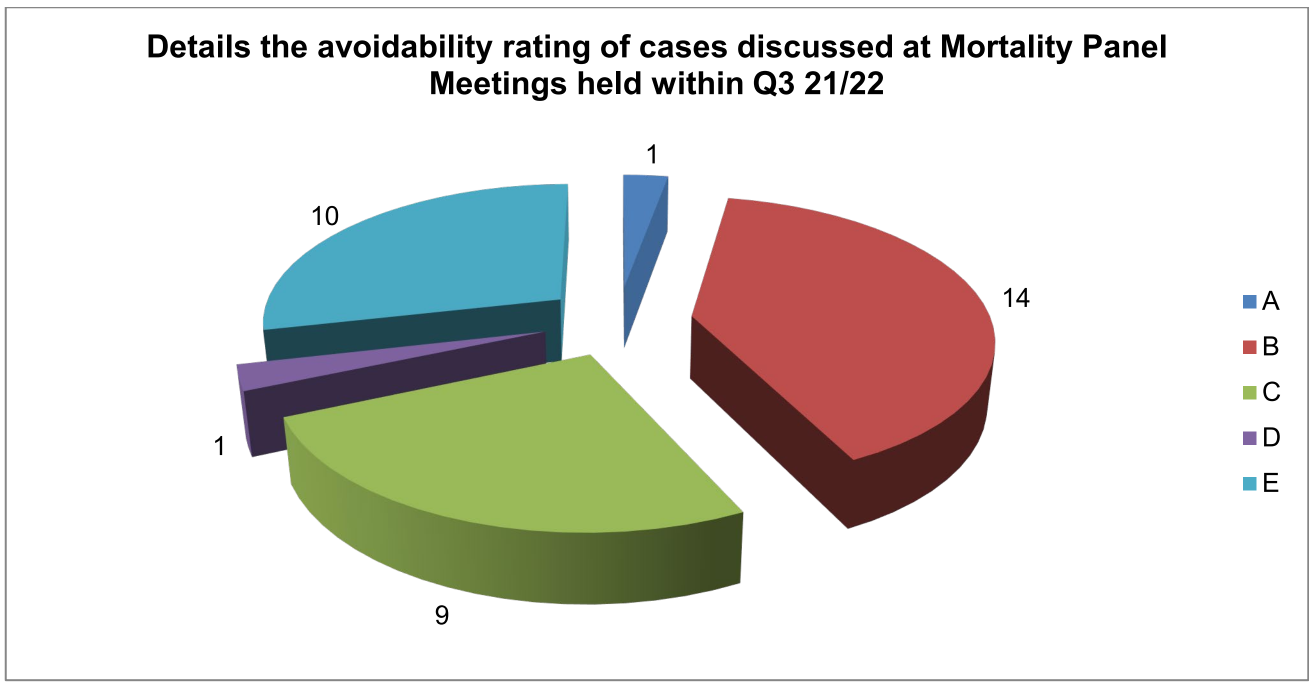


As of July 2021 an alternative avoidability rating system was adopted by the mortality panel for patients that died at SRH and WGH. This new rating system, not only gives the mortality panel wider scope when considering the effect that care issues may have had on the outcome of the patient, but it also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

A - The review group concluded that there were no issues with care Identified up to the point that the patient died
B - The review group identified care issues which they consider would have made no difference to the outcome for the patient
C - The review group identified care issues which they consider may have made a difference to the outcome for the patient
D -The review group identified care issues which they consider were likely to have made a difference to the outcome for the patient
E - Further information required

Graph 6: Details the avoidability rating of cases discussed at Mortality Panel Meetings held within quarter 3 2021/22

Graph 6:



Of the cases that were discussed at the weekly mortality panel where a final outcome score was determined *(n=25,* the review group identified one case where care issues were considered likely to have made a difference to the outcome for the patient (D). This was associated with a delay in recognising a known complication of a cardiac procedure, which led to a delay in the patient receiving timely transfer to the tertiary centre for further surgical intervention. A moderate harm RLDatix® incident report has been submitted for divisional investigation, learning and quality improvements.

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

9. Mortality Review Outcomes (RSCH and PRH)

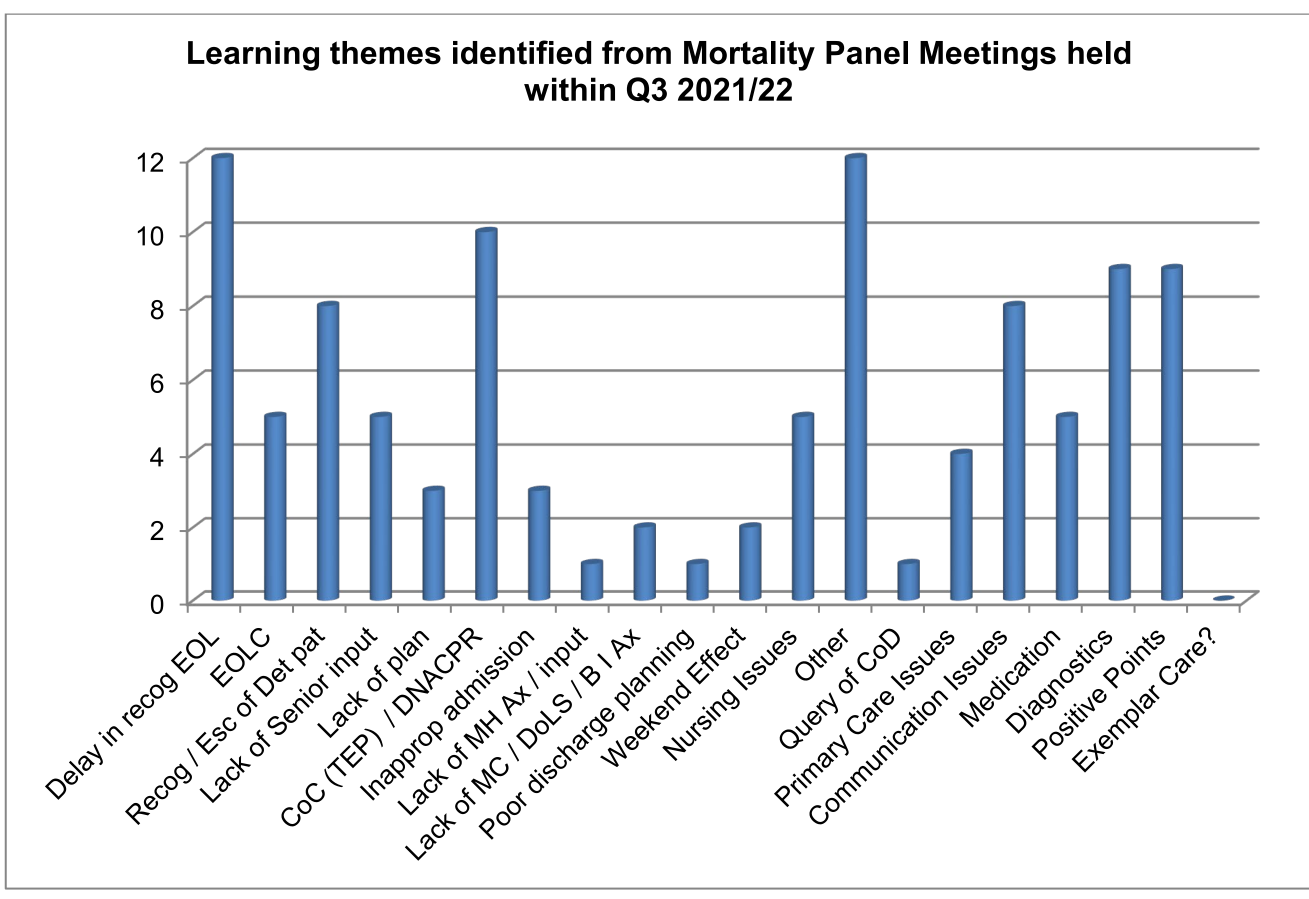
The following list highlights some of the learning from the SJR's undertaken at RSCH and PRH:

- Individualised care for a dying person - including daily clinical review and communication
- Early recognition of a patient with CO2 retention
- End of life care for vulnerable patients
- Clear documentation of neurological examinations
- Managing patients with frailty, delirium and Parkinson's disease
- Continuity of care from senior and junior medical team

10. Learning from deaths themes quarter 3 2021/22 (SRH and WGH)

Graph 7: Details learning themes identified from mortality panel meetings that took place within quarter 3 2021/22, SRH and WGH.

Graph 7



See Appendix 1 for Glossary of Terms

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

Table 13

Learning identified as "other"
EoL vs treatment conflict
Ward move
Long-term management & previous admission care re large ascetic tap
Covid related elective surgical delays
Lack of urgency re escalation for tertiary care
Reason for delayed surgery not documented
Too unstable to transfer to tertiary for cardiac surgery
Neither paced or dialysed
Delayed Cardiology ref
Previous referral to cardiology not actioned
Previous admission no treatment plan
Pathway issues for elective surgery

The top three themes identified at mortality panel meetings throughout quarter 3 2021 for WGH and SRH are;

10.1 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

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

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

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

10.3 Other

Issues identified as "other" are detailed in Table 13 above and include;

- Care pathways that require a review e.g. cardiology (in relation to tertiary centres), and elective surgery delays due to Coronavirus pandemic.
- Two cases identified care issues within the patient's previous admission that may have made a difference to the outcome of the patient on their final admission.

Table 14: Details where 'Positive points' were identified

Table 14:

Learning Identified as 'Positive Points'
Good Junior Dr discussion with family & documentation
Good communications with family & senior input
Some good documentation & Care Plans
Tissue Viability Nurse identifying signs of a fracture
Good documentation
Very good care identified by 2nd Reviewer
Very good communications with family by physician's assistant
Comprehensive consultant review
Initial care in SRH Emergency Department included timely interventions with good communications re DNACPR

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

10.4 Learning from deaths recommendations quarter 3 2021/22 (RSCH and PRH)

For RSCH and PRH, the following recommendations were made:

- The adoption of national guidance associated with individualised care for a dying person
- Completed ReSPECT forms to be included on discharge

- Consideration of unnecessary investigations
- Long trolley waits in Emergency Departments should be avoided for patients in the last phase of their lives

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

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

11.2 In the past 12 months at RSCH and PRH, 49 SJRs were requested (40 at RSCH and 9 at PRH). Currently 40 SJR requests from 2021 deaths are outstanding (82%), this includes three LeDeR reviews. At SRH and WGH 438 SJRs were requested (64 were withdrawn from the programme during business continuity associated with the coronavirus pandemic). Out of the remaining 376 cases, 80 SJR requests are outstanding (21%).

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

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

11.5 The ME offices now scrutinises every adult inpatient death across UHSussex. A further ME has started in post at SRH and WGH to support the first phase of community roll out which is to include the review of all West Sussex inpatient hospice deaths by the end of quarter 4 2021/22. Plans have also been progressed to recruit MEs from within primary care to support the next phase, which is to pilot the review of community based deaths by the end of quarter 1 2022/23.

11.5 Currently SRH and WGH use different systems for recording SJR requests and activity to those used at RSCH and PRH. Subsequently analysing joint activity and outcomes is challenging. The plan is for SRH and WGH to pilot the Datix Cloud IQ® Mortality Module as a potential first step for unifying approaches across UHSussex.

12. CONCLUSIONS

- Ongoing recruitment of both Medical Examiners and Medical Examiner Officers continues to sustain the current level of inpatient mortality reviews as well as to fully extend the Medical Examiner service to include all community deaths.

- Post-merger implementation plans towards aligning the learning from deaths processes across UHSussex continue to progress.

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

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

Colour	Status
Red	Due
Amber	Open
Green	Open on track
Blue	Closed/complete

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

All	Delay in recognising EoLC	Successful palliative care business case to extend service - consultants appointed at both sites. Nursing cover 7 days across site	TT	Completed	
		Merged UHSussex End of Life and Mortality Board (commenced June '21)	TT	Ongoing	
		Patient comfort observations on Patientrack	TT	Ongoing	
Q1 & Q2 21/22	Backlog of SJRs	Workshop to discuss benchmarking for reviewers re activity and streamlining process.	TT/ME	Completed	
		Pilot of streamlined review process (one review prior to mortality panel if reviewer considers appropriate)	TT/ME	Ongoing	
		Review job plans of reviewers – with option of half PA	TT	Ongoing	
Q1 & Q2 21/22	Align mortality review process across UHSussex	Newly appointed Medical Director for Governance and Quality assurance	TT	Completed	
		Cross site working to scope and align all elements of the mortality review process including reporting	TT/AY/ ME	Ongoing	

Appendix 1

Glossary of terms:
Delay in recog EoL - Delay in recognising patient was approaching End of Life
EOLC – Issues with the End of Life Care the patient received
Rec / Esc of det pat – Lack of recognition or escalation of the deteriorating patient
Lack of senior input – Lack of input from senior doctors
Lack of plan – Lack of treatment plan for the patient
CoC (TEP) / DNACPR – Ceilings of Care and/or Treatment Escalation Plan were not discussed or completed and/or lack of Do Not Attempt Cardio-Pulmonary Resuscitation documentation or discussion
Inapprop admission – Inappropriate admission to hospital
Lack of MH Ax / input – Lack of documented Mental Health Assessment or input from Mental Health Specialists
Lack of MC / DoLS / BI Ax – Lack of documentation regarding Mental Capacity / Deprivation of Liberties / Best Interests discussions/assessments
Poor discharge planning – Poor discharge planning
Weekend Effect – Patient care may have been compromised due insufficient clinical review at the weekend or over a Bank Holiday
Nursing Issues – Issues with nursing care identified
Any other – See separate table below
Query of CoD – There is a query over the accuracy of the Cause of Death as stated on the Medical Certificate of Cause of Death.
Primary Care Issues – Where issues with Primary Care were identified
Communication – Where poor communication between staff, teams or with the family has been identified
Medication – Where delays or errors in prescribing/administering drugs; drug errors or omissions identified.
Diagnostics – Where delays or errors in completing/reporting/actioning diagnostic tests identified.
Positive Points – Where examples of good care / processes / communication had been identified