University Hospitals Sussex
NHS Foundation Trust

Meeting of the Board of Directors

10.00 to 14:30 on Thursday 10 November 2022

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

AGENDA – MEETING IN PUBLIC

1.	10.00	**Welcome and Apologies for Absence** To note	Verbal	Alan McCarthy
		Confirmation of Quoracy To note *A meeting of the Board shall be quorate and shall not commence until it is quorate. Quoracy is defined as meaning that at least half of the Board must be present this being nine Board members. With a minimum of two Executives and two Non-Executive Directors.*	Verbal	Alan McCarthy
2.	10.00	**Declarations of Interests** To note	Verbal	All
3.	10.00	**Minutes of UHSussex Board Meeting held on 04 August 2022** To approve	Enclosure	Alan McCarthy
4.	10.05	**Matters Arising from the Minutes** NONE	Enclosure	Alan McCarthy
5.	10.05	**Report from Chief Executive** To receive and note overview of the Trust's activities	Enclosure	George Findlay
6.	10.25	**ICS** To receive and note ICS activities	Verbal	George Findlay
		INTEGRATED PERFORMANCE REPORT		
7.	10.35	**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 14* To receive assurance from Committee and recommendations from the Committee	Enclosure	Maggie Davies
8.	10.50	**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 15*	Enclosure	Maggie Davies Rob Haigh

		To receive assurance from Committee and recommendations from the Committee		
9.	11.10	**People** To receive and agree any necessary actions *At this point the Chair of the People Committee will be invited to provide their report included at item 16* To receive assurance from Committee and recommendations from the Committee	Enclosure	David Grantham
10.	11.25	**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 17* To receive assurance from Committee and recommendations from the Committee	Enclosure	Karen Geoghegan
11.	11.45	**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 18* To receive assurance from Committee and recommendations from the Committee	Enclosure	Andy Heeps
12.	12.05	**Systems Oversight Framework** To receive and agree any necessary actions	Enclosure	Darren Grayson
	12.15	***10 Minute Break***		
		<u>ASSURANCE REPORTS FROM COMMITTEES</u>		
13.	12.25	**Report from Patient Committee** To receive assurance from Committee and recommendations from the Committee - **from the meeting held on the 01 November 2022**	Enclosure	Jackie Cassell

14.	12.30	**Report from Quality Committee**
		To receive assurance from Committee and recommendations from the Committee
		- **from the meeting held on the 30 August, 27 September, and 01 November 2022 including:**
		  - Annual Organ Donation Report 2021/2022
		  - Annual Children's Safeguarding Report 2021/2022
		  - Annual Adults Safeguarding Report 2021/2022
		To approve for publication on the Trust Website
			Enclosure	Lucy Bloem

15.	12.40	**Report from People Committee** To receive assurance from Committee and recommendations from the Committee - **from the meeting held on the 02 November 2022**	Enclosure	Patrick Boyle

16.	12.45	**Report from Sustainability Committee** - **from the meeting held on the 28 July 2022** To receive assurance from Committee and recommendations from the Committee	Enclosure	Lizzie Peers
17.	12.50	**Report from Systems and Partnerships Committee** - **from the meeting held on the 28 July 2022** To receive assurance from Committee and recommendations from the Committee	Enclosure	Patrick Boyle
18.	12.55	**Report from Audit Committee** - **from the meeting held on the 18 October 2022** To receive assurance from Committee and recommendations from the Committee	Enclosure	David Curley
19.	13.00	**Report from Charitable Funds Committee** - **from the meeting held on the 11 October 2022** To receive assurance from Committee and recommendations from the Committee	Enclosure	Lizzie Peers
20.	13.10	**Board Assurance Framework and Corporate Risk Register highlight report** To approve	Enclosure	Darren Grayson / Glen Palethorpe
		QUALITY		
21.	13.15	**CQC Update** To note	Enclosure	Maggie Davies / Darren Grayson
22.	13.20	**Winter Plan** For endorsement	Presentation *(To follow)*	Andy Heeps
		WELL LED & COMPLIANCE		
23.	13.50	**Elective Recovery Self Certification** To approve	Enclosure	Andy Heeps
24.	14.00	**Strategic Priorities Refresh** To note	Presentation	Darren Grayson
25.	14.10	**Company Secretary Report** To note	Enclosure	Glen Palethorpe
		OTHER		
26.	14.15	**Any Other Business** To receive any notified business and action	Verbal	Alan McCarthy
27.	14.20	**Questions from the public** To receive and respond to questions submitted by the public at least 48 hours in advance of the meeting.	Verbal	Alan McCarthy
28.	14.30	**Date and time of next meeting:**	Verbal	Alan McCarthy

The next meeting in public of the Board of Directors is scheduled to take place at 10.00 on Thursday 02 February 2023.

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

Minutes

University Hospitals Sussex
NHS Foundation Trust

Minutes of the Board of Directors meeting held in Public at 10.00am on Thursday 04 August 2022, held in the Boardroom, Second Floor, Washington Suite, Worthing Hospital, Lyndhurst Road, Worthing, BN11 2DH and virtually via Microsoft Teams Live Broadcast.

Present:

Alan McCarthy MBE DL	Chair
Dr George Findlay	Chief Executive
Lizzie Peers	Non-Executive Director
Jackie Cassell	Non-Executive Director
Claire Keatinge	Non-Executive Director
Lucy Bloem	Non-Executive Director
David Curley	Non-Executive Director
Bindesh Shah	Non-Executive Director *(Via MS Teams)*
Sadie Mason*	Associate Non-Executive Director *(Via MS Teams)*
Dr Andy Heeps	Chief Operating Officer and Deputy CEO
Karen Geoghegan	Chief Financial Officer
Maggie Davies	Chief Nurse
David Grantham	Chief People Officer
Rob Haigh	Deputy Chief Medical Officer
Darren Grayson*	Chief Governance Officer

*Non-voting member of the Board

In Attendance:

Professor Paul Layzell	Non-Executive Director Designate
Glen Palethorpe	Company Secretary
Tanya Nicholls	Board and Committees Manager

TB/08/22/1 WELCOME AND APOLOGIES FOR ABSENCE **ACTION**

1.1 The Chairman welcomed all those present to the meeting adding that he was delighted to be able to chair the Trusts face to face Board meeting for the first time in 2 years.

1.2 Alan McCarthy welcomed the newly appointed Non-Executives attending their first Public Board meeting, David Curley, Non-Executive Director and Chair of the Audit Committee, Bindesh Shah, Non-Executive Director, Paul Layzell, Non-Executive Designate and Sadie Mason Associate Non-Executive Director.

1.3 Alan also took the opportunity to welcome George Findlay back to UHSussex as the Trusts new Chief Executive to his first Board meeting in public.

1.4 There were apologies for absence received from Charlotte Hopkins, Lillian Philip and Patrick Boyle.

TB/08/22/2 DECLARATIONS OF INTERESTS

2.1 There were no other interests declared.

TB/08/22/3 MINUTES OF THE MEETING HELD ON 05 MAY 2022

3.1 The Board received the minutes of the meeting held on 05 May 2022.

3.2 The minutes of the meeting held on 05 May 2022 were **APPROVED** as a correct record.

TB/08/22/4 MATTERS ARISING FROM THE MINUTES OF THE PREVIOUS MEETING

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

TB/08/22/5 Chief Executive Report

5.1 George Findlay introduced the Chief Executive's Report and began by acknowledging the warm welcome he had received on returning to the Trust. George added that he was delighted to be back and took the opportunity to thank Andy Heeps for stepping up as interim Chief Executive, in that time he reinvigorated the Executive Gemba visits in the workplace so that the Executive team can truly understand what it is like on the frontline for staff.

5.2 George acknowledged how extraordinarily difficult it had been for staff in recent years with the pandemic which continues to put immense pressure on our staff both in respect of urgent and emergency care demands and in respect of the backlog within our elective services. George noted that the key to meeting these challenges is our Patient First programme, that both equips and empowers colleagues with the right skills to innovate and improve care for their patients. It also provides the Trust with a strategy that enables us to focus on the areas where we can make the biggest difference to the communities and patients we serve.

5.3 The Board was advised that the Trust strives to ensure that every patient receives a good experience at UHSussex with patients receiving the best standard of care. It was noted that the Trusts average Friends and Family Test (FFT) results, which is how the Trust measures patient satisfaction, has deteriorated to 86% George advised that the Board would hear throughout the meeting the ongoing work to improve patient experience and those areas that are masked by the FFT score where excellent scores are reported.

5.4 In respect of the Quality domain the Trust aims are that no patient experiences harm whilst in hospital, George took the opportunity to thank staff for the significant reductions in harm. It was noted that mortality has been significantly affected by Covid over the last few years with crude mortality at 3.45% which places UHSussex in the middle of the peer group.

5.5 George noted that the Trust's biggest asset is its People and that evidence shows that patients receive a better quality of care when staff feel involved, empowered, and listened to. The Board were advised that recent staff survey results had disappointingly deteriorated in a number of areas however, it was noted that the Trust is working hard to say thank you, well done and celebrate staff in different and innovative ways, including the annual STAR awards which was an incredible event and recognised the real achievements of staff.

5.6 In respect of Systems and Partnerships it was noted that the priority is to work efficiently as a system to ensure timely access to care for patients. George acknowledged that the pandemic has had a significant impact on planned care and diagnostics capacity and demands in addition to emergency care demand, George extended his thanks to all UHSussex staff for their additional and continual work to reduce waiting lists and work to try and improve flow through the hospitals to support timely emergency care.

5.7 Finally, George noted that in respect of Sustainability the aspiration for the Trust was to break-even for the year but acknowledged the challenges to achieve this through the transition out of the pandemic and into living with Covid. George highlighted that the Trust had not achieved its target for Quarter 1 but that there was a clear and detailed roadmap to be on target for the end of the year.

5.8 George highlighted that there was lots more information and news regarding the Trust on the website https://www.uhsussex.nhs.uk/news/, in addition George noted that the Trust is very active on social media and encouraged the Board, staff and member of the public to follow UHSussex on all social channels.

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

TB/08/22/6 Integrated Performance Report

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

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

TB/08/22/7 Patient

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

7.2 The Board was advised that the significant majority of patients are satisfied that they have a good or better experience, however the average across all touchpoints is lower than the Trust target of 95%, and satisfaction levels are reducing. Maggie explained that this was in line with the current national average but noted that the inpatient satisfaction at St Richard's and Worthing was above the national average at 97.8% compared to 94% and Outpatient satisfaction across the Trust outperforms the current national average.

7.3 Maggie explained that there are increased numbers of concerns being raised with the Trust with an increase of 57% since Quarter 2 2021/22. Whilst numbers of open complaints have reduced overall, with Surgery open complaints cases halved since October. To achieve this and ensure quality responses, timescales for providing the response have extended resulting in reduced compliance with the local target of 65% of cases being resolved within 25 days.

7.4 The Chairman invited Claire Keatinge who had Chaired the July meeting of the Patient Committee, to update the Board on their recent meeting and the assurances received in relation to Patients.

7.5 Claire advised the Board that the Committee had discussed the 4 key areas with the Committee's True North domain including the quarter 1 Patient Experience Report including common themes for patient dissatisfaction, the Annual Patient Experience Report 2021/2022 and the Patient Experience Strategy 2022-2025 which was to be presented to the Board for endorsement later on the agenda.

7.6 Claire noted that the Committee had discussed the unacceptable level of violence and aggression experienced by staff for which there had unfortunately been increasing prevalence. The Board was advised that the Committee had received update on the Patient First Improvement Programme which was working to refresh the patient experience through this strategic initiative.

TB/08/22/8 Quality

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

8.2 Rob advised the Board that the UHSussex crude 12 month rolling mortality rate for emergency admissions was 3.38% and in month for March was 3.91%. These are within the confidence limits and below the previous month's values with a stable monthly crude mortality for Quarter 4 with a rising value in preceding quarters. The UHSussex rolling 12-month HSMR was 93.93. This was in the 'very low' range with an in-month value for March of 97.51 that lies in the 'as expected' range. The UHSussex SHMI was 108.65 Rob noted that the rising values seen over the last 18 months appear to have reached a plateau and that this remained within the expected range.

8.3 The Board was advised that in view of the significant variation in coding depth across the organisation and the potential link between the quality of coding and the SHMI; a coding and mortality working group had been established. An external audit of coding had been commissioned from Monmouth Partners. Rob explained that the audit would review a sample of 200 clinical records from each of the four acute sites. The coding audit includes urgent care and elective activity. The findings are expected in October 2022.

8.4 Maggie Davies reminded the Board that the second Quality True North for the Trust was zero harm occurring to patients in our care. Maggie explained that there had been further (positive) reduction in-month with 254 reported falls; this was the third month in row of improvement across all divisions aside from surgery at RSCH and PRH which is showing an upward trajectory over the last 3 months. In respect of Pressure Damage Maggie explained that there were increased numbers of patients with reported hospital acquired category 2 ulcers, reflecting the ongoing pressures and presenting frailty of patients.

8.5 In respect of improvement actions for harm reduction Maggie highlighted the following areas:

- Analysis of all reported patient safety incidents (site, division, service, ward) continues month on month.
- Implementing RLDATIX IQ risk and incident management and assurance system during Quarter 1 and 2 2022/2023.
- Targeted focus on the reduction of low and moderate harms (falls and pressure damage)
- 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, earlier discharge is key.

8.6 In respect of safer staffing it was noted that in response to fluctuations in staffing levels, staffing huddles are held at least twice a day to ensure that areas with challenged staffing levels are supported with unmitigated staffing shortfalls are escalated to the Director of Nursing. The Board was advised that the Safer Care Nursing Tool was currently being piloted on four wards: one on each hospital site with full roll-out in August at PRH. This will ensure timely patient care sensitive information will be available to clinical staff.

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

8.8 Lucy advised the Board that the Committee had met 3 times since the last Board meeting following a commitment of the Committee to meet a minimum of 10 times a year.

8.9 Lucy noted that at each of the meetings in May, June and July the Committee received its planned items including the reports on the respective Patient First Trust Norths, Breakthrough Objectives, Strategic Initiatives and Corporate Projects, the developing quality scorecard, the maternity scorecards including the national Ockenden report metrics, reports covering Serious Incidents and the respective learning and the duty of candour audit outcomes, and the report from the Committee's reporting group Quality Governance Steering Group. The exception was a learning from deaths report not received in July that would be substantially updated for the September meeting. In addition, the Committee received reports on a number of areas including medicines management, clinical effectiveness (including NICE) and mental health.

8.10 The Board was advised that the Trust had hosted 4 maternity Ockenden visits which had all received positive feedback, Lucy noted that the Trust was also making good progress against the Clinical Negligence Scheme for Trusts (CNST) year 4 submission which would be audited by the Trusts Internal Auditors BDO ahead of submission.

8.11 Lucy advised the Board that the Committee had also received the Annual Infection, Prevention and Control Report 2021/2022 at its meeting in July which was being presented to the Committee later on the agenda for approval ahead of publication on the Trust website.

TB/08/22/9 People

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

9.2 The Board was advised that the Trust continues to track staff engagement against patient care and outcomes which currently sits at around with the best Trusts in the Country scoring 7.4. It was noted that work is taking place in all Divisions involving staff and activities informed by the latest staff survey results and reviewed at the People Committee. Work will now transition to the new Divisions under the Clinical Operating Model and the Breakthrough Objective is being reviewed.

9.3 David provided the Board with an update in respect of the People Strategic Initiative noting that the Trust had been focussing on a number of core areas, these being Health and Wellbeing, Integrated Education, Leadership Development, Staff Engagement and Equality, Diversity and Inclusion, noting that there had been good improvements with a programme steering group in place for middle tier leaders.

9.4 It was noted that the Trust continues to grow its staffing establishment with the Trust's vacancy rate tracking just under 9% and there had been noticeable progress in respect of staff appraisal rates. David added that the team had been tracking the feedback of those that have been through the new refreshed appraisal paperwork with feedback positive.

9.5 The Chairman invited Claire Keatinge who had Chaired the July meeting of the Patient Committee, to update the Board on their recent meeting and the assurances received in relation to Patients.

9.6 Claire advised the Board that the Committee had received an update in respect of the Patient First Trust North, Breakthrough Objective Strategic Initiative and Corporate Project and noted the welcome work in respect of the staff survey results and work to address violence against staff.

9.7 It was noted that the Committee had received a divisional presentation from the Director of Midwifery, which welcomed the reintroduction of listening events for maternity staff and an update on the improvements made since the CQC inspection.

9.8 Claire advised that the Committee had also received quarterly updates from the Freedom to Speak up Guardian and the Junior Doctors Guardian of Safe Working for Worthing and St Richard's, in addition the Committee had received the 2021/2022 Annual Reports for the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES), both of which were being presented to the Board later on the agenda for approval ahead of publication on the Trust website.

9.9 Darren Grayson commented that it was important to reflect on how staff are feeling and consider this as the Trust develops its strategic approach to staff wellbeing. David commented that supporting staff wellbeing and engagement the Trust needed to better communicate some of the things that are going on, to enable them to hear about the myriad of positive developments going on across the Trust noting that the Executive team carrying out their GEMBA visits regularly allows this communication as well as offering staff a conduit to share feedback and solutions.

9.10 Alan McCarthy commented that it felt there had been a 'loss of belonging' for staff and that the Board needed to support with encouraging a sense of togetherness again. George Findlay commented that staff have been through a lot in the past two years, with the pandemic and the merger but that there was now an opportunity to reset with the new leadership, the new Clinical Operating Model launch along with the clarity the Patient First Improvement Programme will provide. George added that staff at UHSussex face a much higher level of violence and aggression than staff in other jobs and addressing that needs to be a high priority.

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

TB/08/22/10 Sustainability

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

10.2 The Board was advised that in 2022/23, the Trust is operating under a new financial framework, with some of the block funding arrangements continuing on the basis of H2 2021/22. Within funding allocations there has been an increased efficiency requirement applied, reduced funding for Covid and a significant change in income recovery for elective activity.

10.3 Karen explained that the Trust submitted a deficit plan of £12.55m on the 28 April 2022, for 2022/23; this related solely to excess inflation. It was noted that NHSE advised all ICS and Provider organisations of additional funds that were

to be made available to support excess inflation costs and other specific pressures, £1.5bn nationally. Karen advised that acceptance of the additional funding was based on an ICS plan to deliver break-even, which would require all organisations to also break-even. UHSussex received £9.3m to fund excess inflation costs and identified £3.3m additional efficiencies to allow a balanced plan to be agreed. The Trust submitted a break-even plan on the 20 June 2022.

10.4 The Board was advised that the year-to-date performance as at the end of Quarter 1 was £4.88m adverse variance to plan, the key drivers for this variance were increased operational pressures in unscheduled care linked to staff availability, flow and capacity. Cash balances were £78.9m, which was in line with the Quarter 1 plan. The capital expenditure for the year-to-date was £0.07m above plan, Karen noted that global supply chain delays are creating challenge in respect of the delivery of newly purchased medical devices , however the major works programme was ahead of schedule and the 3Ts programme was on track and at the end of Quarter 1 the efficiency programme delivered £5.4m in line with the plan.

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

10.6 Lizzie advised the Board that the Committee had received a thorough update in respect on the significant challenges faced in quarter 1 and an equally thorough financial roadmap for the rest of the year which provided assurance to the Committee.

10.7 It was noted that the Committee had asked for additional information in future reports in respect of productivity improvements that will support with achieve the Trust's financial plan with possible deep dives into Outpatients and Patient Level Costing.

10.8 Lizzie advised that the Committee had also received an update on the Green Plan and environmental sustainability activity which was positive with an increasing number of Green Ambassadors across the Trust supporting this agenda, in addition to a quarterly update in respect of the Capital Plan which covered the challenges with the supply chain. The Committee also received a quarterly update from the Commercial Director including national metrics which the Trust benchmarks positively against.

TB/08/22/11 Systems & Partnerships

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

11.2 **A&E**

Andy advised the Board that the Trust treated 63.4% of patients within 4 hours of attending all A&E departments April to June 2022, and 64.5% during Quarter 1 2022. National performance was 72.1% in June 2022 and 72.5% during Quarter 1. There was renewed pressure on Trust emergency departments in particular with increases in long length of stay patients as a result of constrained flow, exacerbated by the Omicron Covid-19 wave's re-emergence.

11.3 **RTT**

The Trust has 56.7% of patients waiting longer than the target 18 weeks at the end of June 2022 with National performance 63.5% in May 2022. The total number of patients waiting for elective treatment at the Trust was 112,029, 27 of which were waiting over 104 weeks, this was due to patient availability, or specialist complexity. Despite operational pressures the 104-week patient

numbers have continued to decrease in accordance with the Trusts aim to have no patients waiting over 104 weeks.

11.4 **Cancer**
Andy explained that 57.8% of patients who commenced cancer treatment were treated within 62 days in May whilst National performance was 61.5%. There has been an increase in over 62-day and 104-day prospective waits in June, from 389 in March 2022 to 534 for over 62-day patients, and from 95 patients in March 2022 to 120 June 2022 for over 104 week waits. Andy noted that the S&P Committee had received a Cancer Deep Dive from the Divisional Director, which provided clear trajectories for performance recovery.

11.5 **Diagnostics**
The Trust had 25.0% of patients waiting more than 6 weeks for a diagnostic against a 1% target. The Board was advised that this was an improvement of 1% relative to the March 2022 position of 26.0%. The National average for May 2022 was 26%.

11.6 Andy advised the Board that the Trust had a detailed improvement plan for the Emergency Departments (ED) which had been scrutinised by the Committee, which in addition to demand and long length of stay evidenced that delayed discharge also impacted on the Trusts 4-hour performance, as such one of the key metrics that the Trust is working towards is reducing the median time of discharge to before 12noon which analysis shows will significantly help improve ED waiting times and flow through the hospitals. Andy paid tribute to the clinical and operational teams who have been working incredibly hard.

11.7 The Chairman invited Lizzie Peers, who had chaired the Systems and Partnerships (S&P) Committee meeting in July, to update the Board on their recent meeting and the assurances received in relation to Systems and Partnerships.

11.8 Lizzie advised the Board that the Committee had noted the below national average performance for A&E but were encouraged by the 104-week performance and reassured by Cancer performance and RTT performance.

11.9 It was noted that the Committee had received a deep dive on Cancer performance and discussed the plans, the trajectories and the volume of referrals and the opportunities being pursued to address these issues.

11.10 The Committee also received updates in respect of the 3Ts Hospital Development and the pre and post occupation work currently underway, Lizzie noted that the Trust received an update on the work within the ICS.

11.11 George Findlay commented that the Trust hadn't diverted from its True North ambition in respect of delivering timely and appropriate acute care adding that it was appropriate that the Trust focus on those patients waiting 104 weeks for their care, George noted it was crucial to be focussed in the right areas. Andy concurred adding that there was focus at both the start of the pathway as well as the focus on discharge, to ensure as a Trust achieve pathway transformation can be achieved.

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

TB/08/22/12 Report from Patient Committee Chair from the meeting on 26 July 2022

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

12.2 Claire Keatinge drew the Committee's attention to the two appendices to the Chair's report, the Patient Experience Annual Report 2021/2022, and the Patient Experience Strategy both of which had been received by the Committee and were being shared with the Board for endorsement.

12.3 Maggie Davies advised the Board that the Patient Strategy builds on the Trusts Patient First philosophy with the voice of the patient at the heart of all that we do, with Trust priorities set out for the next 3 years:

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

12.4 The Board **ENDORSED** the Patient Experience Annual Report 2021/2022 and the Patient Experience Strategy for 2022-2025.

TB/08/22/13 Report from Quality Committee Chair from the meeting on 24 May, 28 June and 26 July 2022

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

13.2 Lucy Bloem, Chair of the Quality Committee, highlighted that the Committee had received the 2021/22 Infection, Prevention & Control (IPC) Annual Report from the Director of Infection Prevention and Control at its meeting in July which had been included for Board approval.

13.3 Maggie Davies Director for Infection, Prevention & Control highlighted some key areas, it was noted that March saw an increase in the number of Covid cases which had been challenging in respect of operational management and minimising the impacts on quality of the care for patients, in addition to the ongoing impact on staff.

13.4 The Board was advised that in respect of mandatory surveillance data the Trust had set new trajectories for 2021/2022, the Trust had to prioritise the pandemic response and unfortunately did not achieve these trajectories.

13.5 Finally, Maggie commended the IPC team who had worked tirelessly throughout the pandemic and were awarded as Clinical Team of the year at the annual STAR awards in May.

13.6 Rob Haigh took the opportunity to commend the IPC and Sexual Health teams for their handling of the Monkey Pox outbreak in addition to the pandemic.

13.7 The Board **APPROVED** the 2021/2022 Annual Infection, Prevention and Control Report for publication on the Trust website.

TB/08/22/14 Report from People Committee Chair from the meeting on 27 July 2022

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

14.2 Claire Keatinge drew the Committee's attention to the two appendices to the Chair's report, the Workforce Disability Equality Survey and Workforce Race Equality Survey and noted that these had been received and reviewed by the Quality Committee at its July meeting and were being recommended for Board approval.

14.3 David Grantham advised the Board that there were two minor amendments to be made in respect of Board composition to both reports and that these would be made prior to publication.

14.4 The Board received and **APPROVED**, subject to minor amendments, the Workforce Disability Equality Survey for Publication on the Trust website.

14.5 The Board received and **APPROVED**, subject to minor amendments, the Workforce Race Equality Survey for Publication on the Trust website.

TB/08/22/15 Report from Sustainability Committee Chair from the meeting on 28 July 2022

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

TB/08/22/16 Report from Systems & Partnerships Committee Chair from the meeting on 28 July 2022

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

TB/08/22/17 Report from Audit Committee Chair from the meeting on 19 July 2022

17.1 David Curley, Chair of the Audit Committee, presented the Chair's report from the meeting held on 19 July and drew out the following key points.

17.2 David advised the Board that the meeting had been his first as Committee Chair, David explained that the Committee has a cycle and that the meeting had focussed on updates provided by Local Counter Fraud Services and Internal Audit with a substantive discussion in respect of the BAF and Risk Register noting that the Committee had agreed to give both these two items more prominence by taking both items at the beginning of the meeting going forward.

17.3 The Committee had received the updated Terms of Reference and agreed to bring them back to Committee for an annual review to ensure that there have not been any substantial changes.

17.4 The Committee reviewed the Annual Report in respect of the work of the Audit Committee over 2021/22 from the Chair of the Committee during that period.

17.5 David noted that the Committee had received an internal audit report in respect of Consultant Job Planning, the Audit Committee referred the oversight of the delivery of the management actions in respect of the Internal Audit report into consultant job planning processes to the People Committee.

17.6 The Board **NOTED** the Chairs Report from the Audit Committee and **ENDORSED** the Annual Audit Committee Report for 2021/2022

TB/08/22/18 Report from Charitable Funds Committee Chair from the meeting on 12 July 2022

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

18.2 Lizzie advised the Board that the Committee had received the second version of the 2022/23 Operating Plan and budget and agreed that this provided clear information on fundraising expectations and a clear investment proposition that addressed comments on the previous draft. The Operating Plan and Budget were agreed to be recommended to the Board.

18.3 The Committee also received, considered and approved a series of funding requests supporting enhanced patient experience and mental and physical wellbeing through accelerated investment in additional equipment and facilities.

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

TB/08/22/19 Board Assurance Framework and Corporate Risk Register highlight report

19.1 Darren Grayson introduced the Quarter 1 Board Assurance Framework and Corporate Risk Report.

19.2 The Board was advised that the risks in Quarter 1 were broadly remaining the same with the exception of the way the Integrated Care Board (ICB) will function. It was noted that all the key risks had been summarised and all had been illuminated to clearly indicate both the Executive lead and NED chair.

19.3 Glen Palethorpe explained that the BAF had been reviewed by each of the Committees and was being presented to the Board for approval, it was noted that the report included a statement in respect of the highest risks from the Trusts Corporate Risk Register for the Board's information.

19.4 Darren explained that the Trust was currently going through a process of strategic prioritisation noting that as the BAF is constructed against the current strategic priorities if these change then the refreshed BAF will reflect any change, with all alignment work due to be concluded by the end of Quarter 3, or into the start of Quarter 4.

19.5 David Curley commented that being a new NED he found the BAF really helpful. The Board discussed the benefits of the BAF and the Corporate Risk Register highlight report, acknowledging that as part of the strategic filter process the Board would reassess the Trusts risk appetite for the coming year which would then flow into the BAF.

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

TB/08/22/20 CQC Update

20.1 Maggie Davies provided the Board with an update in relation to the recent CQC reinspection's, Maggie advised that the CQC had visited the Maternity teams at all four acute sites in addition to the Surgery Division at RSCH and has also undertaken an unannounced visit to the Emergency Department at RSCH.

20.2 The Board was advised that the CQC had noted good improvements in Maternity with the work underway in respect of the implementation of e-triage and the continual work on midwife recruitment.

20.3 In respect of Surgery Division at RSCH the Board was advised that the CQC had noted some areas of improvement, notably within infection, prevention and

control compliance in theatres. However, there are still a number of areas that require significant improvement. Maggie informed the Board that the Trust is submitting the additional data requested by the CQC from their reinspection.

20.4 In respect of the Emergency Department (ED) at RSCH, the inspectors noted good multidisciplinary team (MDT) working but did acknowledged the challenging physical site of the department and the challenges this presents for both patients and staff, in particular relation to Mental Health patients.

20.5 George Findlay advised the Board that both visits to Maternity and Surgery were re-visits and as a result there would be no change to the Service ratings, George noted that the current ratings unfortunately don't reflect the improvements that have been made in maternity which is somewhat disappointing for the staff in maternity. George went on to explain that the inspection within ED was a new visit from the CQC therefore this meant that the rating for the RSCH ED had changed, and that these ratings had deteriorated from the previous inspection.

20.6 The Board was advised that the Trust has developed improvement plans utilising the Trust's Patient First Improvement Programme to anchor these within the Trust's wider improvement plans, George noted that the Trust was in the process of implementing improvements prior to the CQC inspection and will continue with these having particular focus on Surgery where the CQC have continued to flag concerns of the pace of these improvements being made.

20.7 The Board **NOTED** the CQC Update.

TB/08/22/21 2021/2022 Annual Medical Appraisal and Revalidation Report

21.1 Rob Haigh presented the 2021/2022 Annual Medical Appraisal and Revalidation Report and drew out the following highlights.

21.2 The Board was advised that the purpose of the report was to provide assurance to the Board that the statutory functions of the Responsible Officer are being undertaken in accordance with the requirements of the Framework of Quality Assurance for Responsible Officers and Revalidation (2014.)

21.3 Rob explained that as at 31 March 2022, there were 1365 doctors with a prescribed connection to UHSussex. Of 1365 doctors, 1170 medical appraisal meetings had taken place. There were 195 'approved missed' appraisals, with 46 doctors unable to be allocated a trained appraiser, due to an insufficient number of appraisers. Other reasons for 'approved missed' appraisals included maternity leave, prolonged (approved) leave and sickness absence during the due appraisal window. 393 revalidation recommendations to the General Medical Council were scheduled in 2021-22 and all were carried out in a timely manner.

21.4 It was noted that there had been one non-engagement recommendation during 2021/22 and this had been upheld.

21.5 The Board was advised that the requirement to submit a 2021-22 Annual Organisational Audit (AOA) to NHS England was cancelled and is not therefore included within the report.

21.6 Alan McCarthy asked how many appraisers the Trust was short, Rob advised that appraisers are experienced medical consultants and that Trust wide UHSussex was short of approximately 15 appraisers and that this was due to a number of stepping down from this role over the last few years. Rob noted

that there was work underway to review appraiser remuneration, recruitment and retention strategies.

21.7 Andy Heeps commented whether it would be beneficial for the Trust to look at aligning medical appraisal with consultant objectives and job plans allowing a link to the Trust's patient first aims to be made. Rob commented that he felt it was essential to align medical appraisals to corporate objectives and that becoming an embedded feature of medical appraisals.

21.8 George Findlay commented that the intention of a medical appraisal was to safeguard patients in respect of a fitness to practice review and was therefore different to a performance review appraisal, adding that both processes are equally as important with medical revalidation being undertaken by peers and an annual performance review with a line manager.

21.9 The Board **APPROVED** the 2021/2022 Annual Medical Appraisal and Revalidation Report and **APPROVED** the signing of the Statement of Compliance by the Chief Executive.

TB/08/22/22 System Oversight Framework

22.1 Darren Grayson introduced the paper describing the Single Oversight Framework and drew out the following highlights.

22.2 The Board was advised that slides 1 to 3 provided an overview of how the Single Oversight Framework (SOF) is intending to ensure alignment of priorities across the NHS and with system partners with a focus on Integrated Care Boards (ICBs) and Provider Trusts throughout the framework ad an emphasis on system performance and quality of care outcomes.

22.3 Darren drew the Boards attention to slides 4 to 8 which set out the 5 themes and scope of the OSF and an additional sixth theme in respect of local strategic priorities, the Board was advised that the oversight process follows an ongoing cycle of:

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

22.4 This is cycle is managed through a monthly meeting between the Trust and ICB colleagues.

22.5 Darren explained that slides 9 to 15 of the presentation provided the Board with an overview of the segmentation process, as follows:

- To allow an overview of the level and nature of support required, to inform oversight arrangements and target support as effectively as possible
- Segmentation decisions are determined by assessing the level of support required based on a combination of objective criteria
- For UHSussex, NHSE and the ICB will discuss segmentation and the level of support the Trust requires
- Segmentation indicates the scale and nature of support needs of the Trust
    - Segment 1 – no specific needs
    - Segment 4 – mandated intensive support

22.6 It was noted that this would be manged with bi-monthly meeting between the Trust and the ICB, Darren highlighted that the process for movement between the segments for Trusts is currently still under discussion. Darren added that the Trust was looking to review the current Integrated Performance Report

(IPR) and that the Single Oversight Framework would be incorporated into the refreshed version of the IPR.

22.7 Alan McCarthy asked what the importance of the new framework was, Darren explained that it will provide confidence at a system level that the wider system is in a positive place and if required it will provide a mandated level of support, Darren noted that for UHSussex the focus remains being in a positive position for our patients.

22.8 George Findlay commented that the aspiration for the Trust is to build confidence with the ICB with UHSussex currently in Segment 2, it was noted that it is possible for the Trust to move between segments both positively and negatively so, George explained that the Trust isn't currently where it would like to be and that UHSussex is working hard to move up into Segment 1.

22.9 The Board **NOTED** the Single Oversight Framework presentation.

TB/08/22/23 Company Secretary Report

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

23.2 The Board was advised that the Annual General Meeting took place on the 27 July, the event was videoed, and it was noted that this would be loaded to the web page in due course along with the presentations from the evenings event. The annual report, including the Trust's financial statements and the Trust's quality account for the Trust can also be found on the Trust website with the following link https://www.uhsussex.nhs.uk/about/trust-board/.

23.4 It was noted that Governor elections concluded in June 2022 and these returned the following members as Governors, Maria Rees for Arun, John Todd for Adur and Pauline Constable for Worthing (noting that John and Pauline were Governors previously thus making this there second terms). Glen explained that following the retirement of Lyn Camps as Governor for Arun the Governors undertook a selection process for a new Lead Governor. The outcome of this process saw Frank Simms, public governor for Brighton and Hove, appointed as Lead Governor.

23.5 Following the successful round of interviews, the Council of Governors Nomination and Remuneration Committee approved the appointment of, David Curley, Bindesh Shah and Paul Layzell as Non-Executive Directors and Sadie Mason as an Associate Non-Executive Director.

23.6 The Board **NOTED** the Company Secretary Report for Quarter 1.

TB/08/22/24 OTHER BUSINESS

24.1 There was no other business to discuss.

TB/08/22/25 Questions from Members of the Public

25.1 The Board received one question from the public in advance of the meeting which was in respect of the current numbers of Trust patients involved in delayed transfers of care (DTOC) and any information in relation to the plans to progress in this area, including updates on the role of the Sussex Integrated Care Board in connection with planning and provision in this area.

25.2 Andy Heeps explained that the Trust no longer discusses DTOC with the focus now being on medically ready for discharge (MRDs) patients. Andy advised

that at the time of the meeting there were a total of 304 MRDs across the Trust, 73 patients in RSCH, 46 in PRH, 94 in Worthing and 91 in St Richard's. Andy advised the Board that there were plans in progress across NHS Sussex for a hospital discharge programme with a value of £4m to support with reducing MRDs to the pre-Covid baseline.

25.3 Andy explained that there had been a recent regional deep dive review of the MRD data with a particular focus on the challenges in respect of workforce and the domiciliary care market, Andy highlighted that the challenges in West Sussex are different to those experienced in Brighton and Hove.

25.4 The Board was advised that the system had been shortlisted for "Frontrunner" status, which is part of a national discharge programme, which if successful would go someway to supporting flow through the hospitals with earlier discharges.

25.5 Claire Keatinge asked if in the future the Trust would have a single dashboard showing waiting lists for Menta Health patients and those patients that require social care input to support with better planning and funding, George Findlay explained that the Trust is doing all that it can to support with earlier discharges but noted that funding for social care is very different to healthcare funding.

25.6 Andy Heeps commented that West Sussex in particular has a high proportion of patients that require Social Care who are self-funded. Andy highlighted that it is not yet known what impact the cost of living crisis will have on these patients and whether this may compound the issue further.

25.7 The Board **NOTED** the question received by the member of the public and subsequent response.

TB/08/22/26 Resolution into Board Committee

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

TB/08/22/27 The Chair formally closed the meeting

TB/08/22/28 DATE OF NEXT MEETING

28.1 It was noted that the next meeting of the Board of Directors was scheduled to take place at **10.00** on **Thursday 10 November 2022**.

Tanya Humphrys
Board & Committees Manager
04 August 2022

Signed as a correct record of the meeting

…….. Chair

…….. Date

NHS
University Hospitals Sussex
NHS Foundation Trust

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

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

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

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

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

Communication and Consultation:

n/a

Executive Summary:

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

Key Recommendation(s):

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

University Hospitals Sussex NHS Foundation Trust

To: Trust Board **Date: November 2022**

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

CHIEF EXECUTIVE BOARD REPORT

1. THANK YOU

1.1 Our staff continue to go above and beyond every day and we owe them an enormous debt of gratitude for their public service and commitment to patient care. The effects of the Covid pandemic are still being felt in our hospitals, as we address unprecedented wating times and strive to always work smarter to find new and more productive ways to keep up with demand.

1.2 Every day I am hugely impressed by the dedication, innovation, and resilience of the colleagues I meet while visiting and talking with different teams. The executive team and I ensure we are out and about regularly, to speak with staff and experience first-hand the actual environments where our patients are cared for.

1.3 In our continuous improvement approach, this is known as 'Gemba', and it is an important aspect of our Patient First philosophy that is the guiding principle behind the management of our Trust. At UHSussex, all voices count, and we are committed to listening and acting on all the feedback we receive from patients, partners and all our amazing staff.

1.4 These are testing times for the NHS and it is only by working together, listening to, and caring for each other, that we will develop the right solutions in the best interests of our patients. We know many people continue to wait too long to access our services, both for planned procedures and urgent care, and this is unacceptable to us.

1.5 Our staff, however, are working relentlessly to address these challenges that both we and the whole NHS are facing. I wish to acknowledge this and thank every one of my UHSussex colleagues for all they are doing 24 hours a day, 365 days a year, to care for more than a million people living in Sussex. They do an incredible job and the Trust Board and I are extraordinarily proud of all their efforts. Thank you.

2. WINTER

2.1 Winter preparedness has been at the top of our agenda in recent months and we're working in partnership across the Sussex integrated care system on the various challenges facing us all. This includes offering flu and Covid vaccinations to all our staff to help protect them and our patients from the seasonal respiratory illnesses that become more prevalent at this time of year.

2.2 With little let up over the summer, our hospitals this winter are already at operating either at, or very near, capacity. To ensure we can continue to admit patients from our emergency departments and provide planned care in a timely way, our focus is on where the data indicates we can make the greatest improvements to patient flow through the hospital and promote safe timely discharges.

2.3 For example, we have seen the average length of stay increase since before the pandemic and so we have launched a major improvement initiative to address this. Other key initiatives include admission avoidance, such as expanding our same day emergency care provision, and staffing and funding additional escalation beds this winter.

2.4 There are currently significant difficulties facing all aspects of the health and care system, with the main challenge for us being able to discharge patients who no longer require hospital-based care onto their next care setting or back to their home supported by carers. This is a national issue, but it is also particularly significant in Sussex.

2.5 Every day, our hospital teams work with our partners to help patients leave hospital as soon as it is safe for them to do so. We also look to families and communities to support people to leave hospital once they no longer require acute care from our specialists, as this is in all our patients' best interests.

2.6 Each week, I am meeting with fellow NHS CEOs and Council Directors across Sussex at our Winter Board to constantly review these processes and our wider winter plans to ensure we maintain improvements during these difficult months. I am looking forward to discussing our winter plans further during our November public board meeting.

3. STRATEGY REFRESH

3.1 The refresh of our Patient First strategy is another key issue that will also be discussed at our public board. Patient First is the way we run our business. It's the simple guiding principle at the heart of everything we do – the patient first and foremost.

3.2 It's a bottom-up, data-driven improvement methodology and how we strive to fulfil our mission of providing *excellent care every time*. Over the summer, we set new objectives and updated our other Patient First goals.

3.3 One of the biggest changes is the addition of a sixth strategic theme: Research and Innovation. This supports our ambition as a large university and teaching trust to provide greater opportunities for both patients and staff to participate in clinical trials and benefit from research.

3.4 Patient First is critical to help improve the care our patients receive from us. It is a proven fact that patients get better care in hospitals where staff feel able to make a difference. That is why we continue to invest in Patient First. We want to empower our people. And we want to support them in making the changes they know will improve services for patients.

4. CLINICAL LEADERSHIP

4.1 Our new Clinical Operating Model, encompassing every clinical service we provide and grouping them under a new leadership structure, is now fully operational. Eight new divisions have been created, including Cancer, Specialist Services, Women's and Children and Clinical Support Services across the whole Trust. Surgery and Critical Care, and Medicine and Urgent Care, create four divisions split by the geographical area they cover in Sussex.

4.2 The model also creates new hospital management teams to improve site planning and leadership, as well as preserve and enhance the unique identities of our individual hospitals. Our new hospital directors, and managing directors for unscheduled care and planned care, report into the board via our Chief Operating Officer, Dr Andy Heeps.

5. WELL-LED INSPECTION

5.1 At the beginning of October, we welcomed back the Care Quality Commission, this time to carry out a Well-Led inspection. This is an important assessment that all NHS trusts and foundation trusts experience as part of the health watchdog's formal processes.

5.2 We have many achievements to be proud of, but as a new organisation we also have much more to do to consistently attain the high standards we set for ourselves and that our patients rightly expect. We are under no illusions about that, and we were clear with the CQC team that we know we face real challenges and that we have plans in place to meet those challenges.

5.3 I have since received a letter from the CQC, which can be found as appendix 1 at the end of the report, confirming the initial in-person feedback we received. While we need to wait for the final report to get the full picture, it is still helpful to be able to share their immediate reaction to what they saw and heard at UHSussex.

5.4 The CQC said the teams they spoke with worked well together, that everyone recognised the importance of system working and that staff understood the part they had to play. There were of course some key areas identified for improvement. These included staff feeling able to 'speak up' and 'equality and diversity' - but the inspectors also noted that we recognised these issues ourselves and that we are taking steps to address them. We will be sharing more from the inspection process as soon as we are able to do so.

5.5 The CQC also made an unannounced inspection of the specialist Upper Gastro-Intestinal cancer surgery service at the Royal Sussex County Hospital (RSCH) in August and afterwards instructed the service should be suspended. This affects around four to six oesophago-gastric resection surgery patients a month, all of whom are now continuing their treatment with Royal Surrey County Hospital in Guildford in line with their pre-existing treatment dates. We are working with the CQC and Surrey and Sussex Cancer Alliance to agree next steps for the specialist oesophago-gastric cancer service at RSCH.

6. INVESTING IN OUR HOSPITALS

6.1 Our new hospital building in Brighton will be handed over from the contractors to us in just a few weeks' time. This is hugely exciting for us all and means we can start equipping and stocking before more than 30 wards and departments move into their new homes between now and March.

6.2 In recent weeks, new MRI scanners have been hoisted into Level 4 where the Imaging Department is located. Other equipment here includes a single-photon emission computerised tomography scanner (SPECT), as well as CT, PET and bi-planar scanners. Meanwhile, the Neurosurgery and Interventional Radiology (IR) Theatre Suite on Level 5 also has an MRI scanner installed which will be available for use during neurosurgical procedures.

6.3 Level 5 of the new building links directly with the existing Emergency Department at The Royal Sussex County Hospital (RSCH), allowing easier patient transfer to the new Neuro and IR Theatre Suite. It will also house new short-stay beds dedicated to managing demand within the ED. Plans are now underway to expand the ED into newly vacated space after 3Ts opens next year.

6.4 All the new facilities in Brighton are great news for people living right across Sussex, as RSCH is the tertiary care centre for our area. The Stage 1 building will be the new Main Entrance for RSCH, with more than one million patients, visitors and staff estimated to pass through the Welcome Space every year.

6.5 While 3Ts is the most significant development currently taking place, we also have many other programmes of work improving care and experience for our patients. For example, at **Worthing Hospital**, a new home for patients receiving chemotherapy will open in mid-November. The Amberley Unit in the North Wing of the hospital is a £6M redevelopment, providing excellent new purpose-built facilities for patients undergoing treatment for various cancers.

6.6 Surgery patients at **St Richard's** in Chichester are now being welcomed at a new Pre-op Assessment Unit ahead of their procedures. Not only is the new facility more comfortable for patients, but its design enables us to see more people in a timely manner and helping us tackle the backlog caused by the pandemic.

6.7 At **Princess Royal**, facilitating works have begun for a £14M new development to modernise and expand the Endoscopy Department at the hospital. The plans will significantly improve patient experience and help address increasing demand for the service. The department is due to open next year.

6.8 At **Southlands**, the President of the Royal College of Ophthalmology, Mr Bernie Chang, visited on 28 October to officially open The Sooffee Art Gallery that operates within the clinical environment at our eye care units at both Southlands and St Richard's hospitals. The gallery is the brainchild of consultant ophthalmologist Mr Masoud Teimory and features displays of wonderful photography for our patients to enjoy.

7. PATIENT FIRST, PLANET FIRST

7.1 A new, more efficient, and environmentally friendly Laundry Department has started operating at St Richard's, following a £7M investment. This is just one of dozens of projects and initiatives taking place across UHSussex that support our ambition to become a net-zero health provider, and the NHS's goal of being the world's first net-zero health service.

7.2 Our *Patient First Planet First* green plan was published earlier this year and continues to gather pace and reduce our use of resources and carbon emissions across our hospitals. We currently have 28 active projects taking place across ten workstreams, as well as more than 300 Green Staff Ambassadors encouraged and empowered to initiate local improvements for their team.

7.3 Recent events include replacing some beef dishes on our patient menus with new lower-carbon alternatives, as well as supporting National Recycle Week (17-23 October) with a Sussex-wide walking-aids return amnesty. In October, the team also presented the UHSussex environmental sustainability strategy at the Royal College of Nursing's Sustainability Nursing Conference.

8. STAR OF THE MONTH

8.1 All our staff are stars, but every month a broad mix of individuals and teams are nominated for special recognition after going above and beyond for patients and their families, or their colleagues. One of the highlights of my role, as well as others on the Star of the Month judging panel, is to read the many wonderful and deserving nominations our staff receive. Here, I wish to publicly congratulate all our recent winners:

8.2 Our **Finance Team** won Star of the Month in recognition of their outstanding achievements, completing the first set of annual accounts for UHSussex. The team integrated financial systems and produced a consolidated set of accounts for our new organisation working with new auditors, resulting in them receiving four nominations for Star of the Month – including from members of the board who were all hugely impressed by their achievements.

8.3 Clinical specialist and service lead for the Pelvic Health Physiotherapy Team at Worthing, **Bella D'Almeida**, won Star of the Month following a nomination from a patient. Charlotte Bainbridge was 30-weeks pregnant when she attended a physiotherapy appointment during which Bella noted some unusual symptoms. She recognised the severity of the situation and immediately took Charlotte to A&E where she was diagnosed with pre-eclampsia, and she delivered her baby in less than one hour. Thanks to Bella's swift actions, both baby and mother are doing great.

8.4 At the Royal Sussex County Hospital, a relative of a patient was so impressed with the work ethic of A&E housekeeper **Clementina Santofimio Gonzalez** that they were compelled to nominate her for Star of the Month. They commended her diligence, calmness, and how she interacted with patients and their families, as well as her colleagues in the busy environment. The judging panel agreed and Clementina was presented with her winning certificate to the applause of her colleagues.

8.5 And our most recent Star of the Month is from Princess Royal, where catering assistant **Stephen Dorman**, was nominated for staying late and ensuring a patient who changed their mind about receiving a meat ate well after the kitchen had closed for the evening. As his nomination read, the happiness expressed by the patient had no price and it was all due to the kindness of one hard-working colleague going above and beyond.

8.6 Star of the Month nominations continue and anyone wishing to put someone forward for special recognition should complete the form on our website at www.uhsussex.nhs.uk/about/star-of-the-month/. Everyone nominated receives recognition. Two runners up receive a £25 gift voucher each, while our Star of the Month is presented with a certificate in front of their colleagues, receives a £100 gift voucher and is automatically put forward to win the Employee of the Year award at our annual Patient First Star Awards.

9. INTERESTED TO FIND OUT MORE?

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

10. RECOMMENDATIONS

10.1 The Board is asked to **NOTE** the Chief Executive Report for August 2022.

Care Quality Commission
Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

By Email:

Our reference: RYR
Dr George Findlay
University Hospitals Sussex NHS Foundation Trust
Worthing Hospital
Lyndhurst Road
Worthing
West Sussex
BN11 2DH

Date: 17/10/2022

CQC Reference Number: RYR

Dear Dr Findlay

Re: CQC inspection of University Hospital Sussex NHS Foundation Trust

Following the inspection feedback meeting with yourself and your executive team, I thought it would be helpful to give you written feedback for your records.

This letter does not replace the draft report which we will send to you, but simply confirms what we fed-back on 07/10/22 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence log, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied into this letter.

An overview of our feedback:

Your new clinical operating model will give you a good foundation for moving forward.

The teams we spoke with during our inspection appeared to work well together and our interviews with them were positive.

We were pleased to hear about your improvement plans for surgery.

We noted you had a clear overarching strategy.

Everyone we spoke with talked about the importance of system working and reflected on the part they played in that. We also noted it would have been easy for you to blame the system for a lot of the pressures facing your organisation, but we didn't hear that in the narrative that was played out to us. Further, we did not hear the pandemic being blamed for the current pressures you face.

You acknowledged there was more work to do to improve the way governance and risk is managed across the organisation but we could see the new structures will help address this. There were some gaps in how risk was managed at Divisional level but again you were sighted on this as an area requiring improvement.

Equality diversity and inclusion is well behind where it should be, but again this is something you acknowledge and have a plan for how you will address this.

Trusts performance in terms of waiting time etc. is not where you want it to be and there are significant challenges for you to address. We did have some concerns that there was a mismatch between the understanding of the winter plan at divisional and corporate level, however, your winter plan and the system wide plan was only just starting to be communicated at the time of the site visit. However, the Division, as well as staff working in the trust told us how concerned they were about how they would manage patients' needs over the winter period.

As we have discussed, a large number of staff contacted us to talk to us during this inspection and we have committed to doing more analysis of the themes and trends so this is more helpful for you. We noted that staff were telling us they didn't feel safe to raise concerns and many of the staff we spoke with expressed worry about being seen talking to us. Whilst this is not a message your executive team are giving per se, staff have told us about their perceptions. We recognize the pressures that staff are working under and the workforce challenges which you and the rest of the NHS face, however, we would ask you to reflect on the level of engagement and the organisational development offer that wraps around the organisation. This is pivotal to the success of your new clinical operating model.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to Anne Eden at NHS England and NHS Improvement.

I would like to take this opportunity to thank you once again for the arrangements that you made to help support the inspection, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter please contact me through our National Customer Service Centre using the details below:

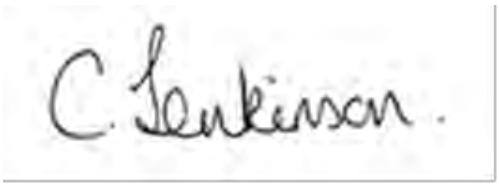
Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate

Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely



Carolyn Jenkinson

Head of Inspection

c.c. Anne Eden NHSI/E

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	7-12	**Meeting:**	Trust Board	**Meeting Date:**	10 November 2022
Report Title:	**Integrated Performance Report – Quarter 2 2022/23**				
Sponsoring Executive Directors:	George Findlay, Rob Haigh, Maggie Davies, Andy Heeps, Karen Geoghegan, David Grantham and Darren Grayson				
Author(s):	George Findlay, Rob Haigh, Maggie Davies, Andy Heeps, Karen Geoghegan, David Grantham and Darren Grayson				
Report previously considered by and date:					

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

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

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

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 2 of 2022/23

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

Key Recommendation(s):

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

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Integrated Performance Report

November 2022

Contents

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Structure of the report

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

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

System Oversight Framework

Patient First Strategy Deployment Framework

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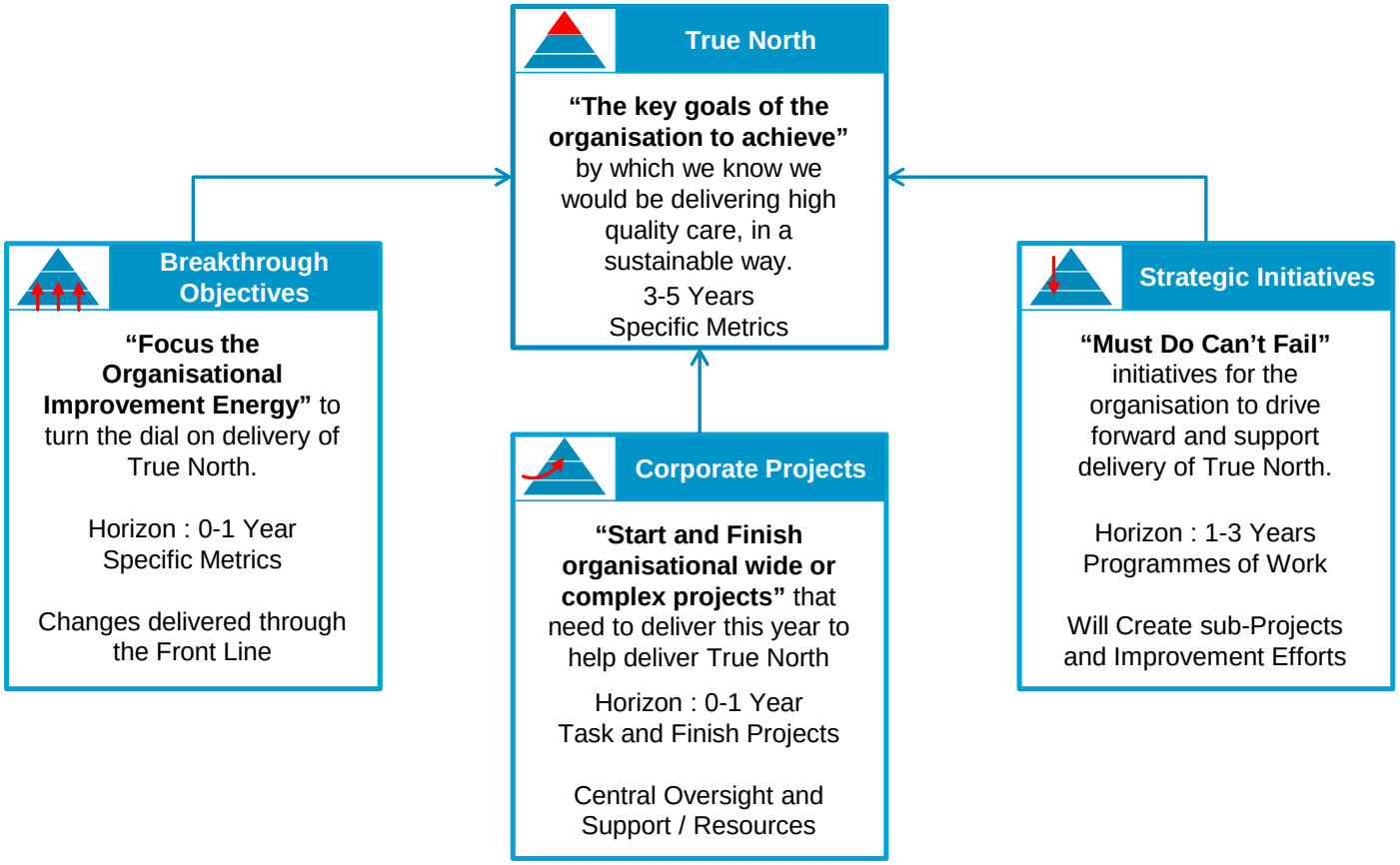

Patient First True North

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True North

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

Patient

Patient Experience:

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

Sustainability

Financial Sustainability:

To deliver the Trust's financial plan

People

Staff Engagement:

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

Quality

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

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

Systems & Partnerships

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

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

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Patient

Integrated Performance Report Section

Patient: Key performance headlines

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- Based on FFT data, the significant majority of patients are satisfied that they have a good or better experience, however the average across all touchpoints is lower than the median nationally.
- Satisfaction with EDs, which had deteriorated for all of the four main sites since the beginning on 2022, has increased steadily between July and September.
- A new survey provider for all sites has been procured and services will be encouraged to increase survey uptake. This is a continuation of existing provider for RSCH/PRH and a new provider for Worthing/ SRH. Data will be available for inpatients and outpatients for SRH and Worthing from when careflow is implemented.
- Very high numbers of concerns and complaints were received in Q2, with PALS contacts 15% higher than the previous quarter. However complaints levelled through Q2 and the number of open complaints is currently c350, a reduction on the early September peak of 413.
- Average numbers of complaints received were 108 per month, with numbers closed in 25 days averaging 28% and 37% in 40 days with performance improving through Q2.
- As such, the data for quarter 4 presents a maintained position against the true north ambition, in the context of challenging positions within the NHS and public opinion as a while, and across the trust with regard to demand, workforce and occupancy.
- Insights: Themes in negative patient feedback continue to relate to waiting (on site and for treatment), clinical treatment, communication and staff behaviours, and discharge. Communication is the priority change programme under the breakthrough objective programme.

Complaints	Currently open	New Jul 22	New Aug 22	Sep 22	Closed in 25 days: 40 days (target (65%)
	368↑	115	114	102	28%:37%↓
PALS		1011	1195	931	Total UHS Q2: 3113↑

FFT (average satisfaction for Q2 %, rates for June)	ED response rate	ED satisfaction rates						Inpatient response rates	Inpatient satisfaction		Maternity response rates	Maternity satisfaction		Outpatient satisfaction	
		W'g	SRH	RSCH	Alex	Eye	PRH	RSCH/PRH only	W/SRH	RSCH/PR	W/SRH RSCH/PR	W/SRH	RSCH/PR	W/SRH	RSCH/PR
	19%	77↑	70↑	74↑	82	90	83↑	26%	N/A	90↑	15%	87↓	93↑	N/A	94→
National average		75%							94%			94%		93%	

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

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Quality

Integrated Performance Report Section

Focus of this section

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

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

3) Safer staffing

HEDLines Indicator Dashboard: September 2022 (UHS)

Trust Performance: RYR – University Hospitals Sussex NHS Foundation Trust

Custom Indicator Set: Mortality Summary	Trust Performance			Benchmarking		
Indicator	Current	Previous	Change	Peer	National	Position
HSMR (12 mth rolling) HES Inpatients (Sep 2022)	100.05 (Aug 2021 - Jul 2022)	99.05 (Jul 2021 - Jun 2022)	1.00 ↑	-	102.89	Within expected range
HSMR (monthly) HES Inpatients (Sep 2022)	107.04 (Jul 2022)	107.89 (Jun 2022)	-0.85 ↓	-	114.00	Within expected range
HSMR - Weekday mortality (12 mth rolling) HES Inpatients (Sep 2022)	99.84 (Aug 2021 - Jul 2022)	99.83 (Jul 2021 - Jun 2022)	0.01 ↑	-	101.45	Within expected range
HSMR - Weekend mortality (12 mth rolling) HES Inpatients (Sep 2022)	100.68 (Aug 2021 - Jul 2022)	96.77 (Jul 2021 - Jun 2022)	3.91 ↑	-	107.29	Within expected range
HSMR - Without adjustment for specialist palliative care (12 mth rolling) HES Inpatients (Sep 2022)	109.59 (Aug 2021 - Jul 2022)	108.77 (Jul 2021 - Jun 2022)	0.82 ↑	-	102.70	Very high (>99.8%)
SHMI (12 mth rolling) HES Inpatients, HES-ONS Linked Mortality Datasets (Sep 2022)	112.69 (Jul 2021 - Jun 2022)	112.16 (Jun 2021 - May 2022)	0.53 ↑	-	104.11	Within expected range
SHMI (monthly) HES Inpatients, HES-ONS Linked Mortality Datasets (Sep 2022)	114.51 (Jun 2022)	120.20 (May 2022)	-5.69 ↓	-	107.54	Within expected range
Crude in-hospital mortality rate (12 mth rolling) HES Inpatients and HES-ONS Linked Mortality Datasets (Sep 2022)	1.55% (Aug 2021 - Jul 2022)	1.52% (Jul 2021 - Jun 2022)	0.03 ↑	-	1.35%	
Crude mortality rate (12 mth rolling) HES Inpatients and HES-ONS Linked Mortality Datasets (Sep 2022)	3.07% (Aug 2021 - Jul 2022)	3.16% (Jul 2021 - Jun 2022)	-0.09 ↓	-	2.71%	
Crude mortality rate (monthly) HES Inpatients and HES-ONS Linked Mortality Datasets (Sep 2022)	2.02% (Jul 2022)	2.31% (Jun 2022)	-0.29 ↓	-	1.77%	

Mortality Metrics

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The UHSx crude 12 month rolling mortality rate for emergency admissions is 3.83% and in month for July was 4.03%. Rolling 12 month rate continues to increase monthly.

The UHSx rolling 12 month HSMR is 100.05. This is within the expected range with an in month value for July of 107.04 that also lies in the expected range.
However, rolling 12 month HSMR *without adjusting for specialist palliative care* has risen into the 'very high (>99.8%)' category.

The UHSx rolling 12 month SHMI is 112.69 which remains in the expected range however continues an increasing trend, nearing the limits of triggering an outlier status.

Indicator	Current	Previous	Change
Crude in-hospital mortality rate - Emergency Admissions (12 mth rolling) HES Inpatients and HES-ONS Linked Mortality Datasets (Jul 2022)	3.83% (Aug 2021 - Jul 2022)	3.74% (Jul 2021 - Jun 2022)	0.09%
Crude in-hospital mortality rate - Emergency Admissions (monthly) HES Inpatients and HES-ONS Linked Mortality Datasets (Jul 2022)	4.03% (Jul 2022)	3.59% (Jun 2022)	0.44%

CRUDE MORTALITY

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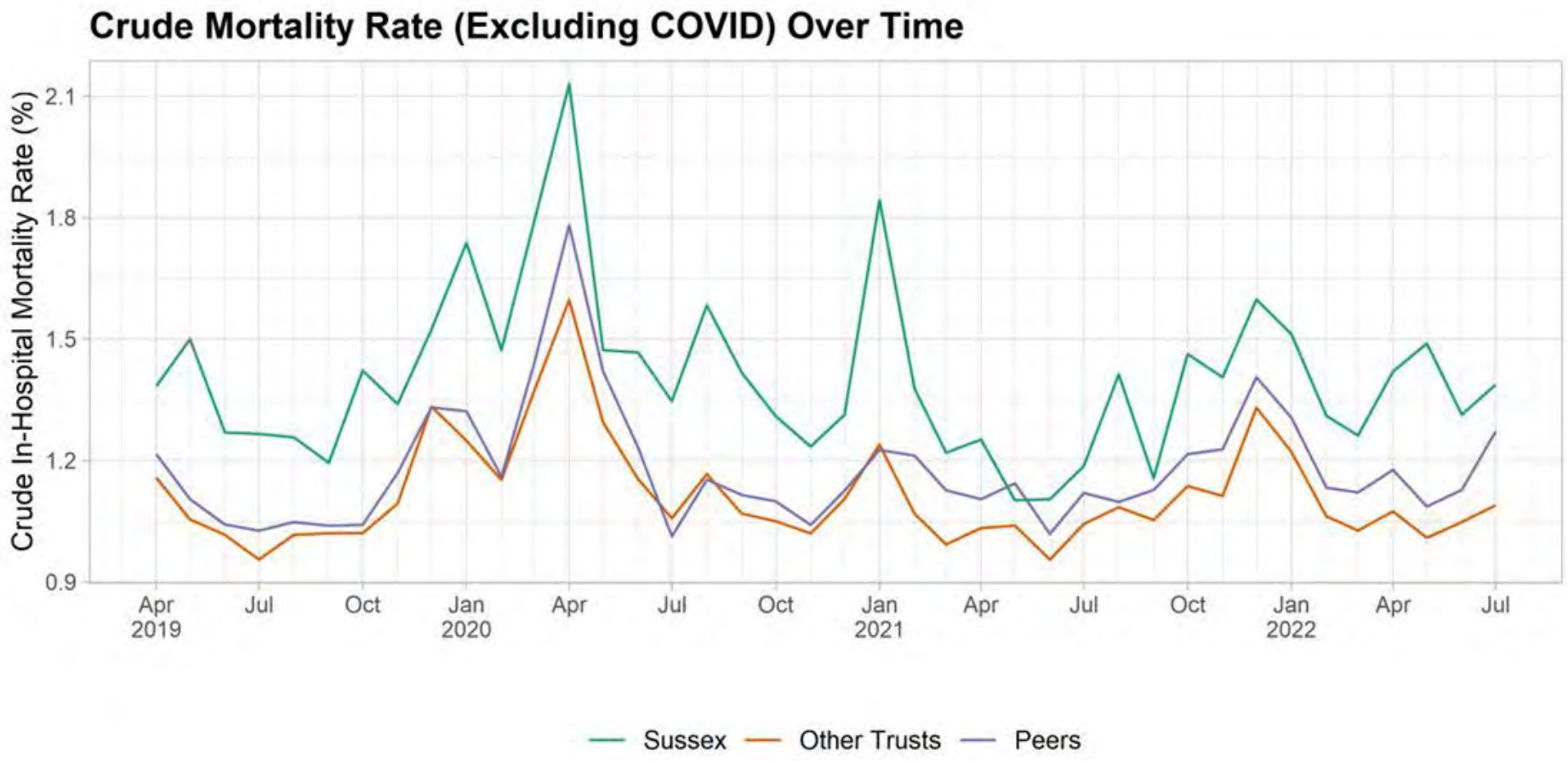

CRUDE MORTALITY

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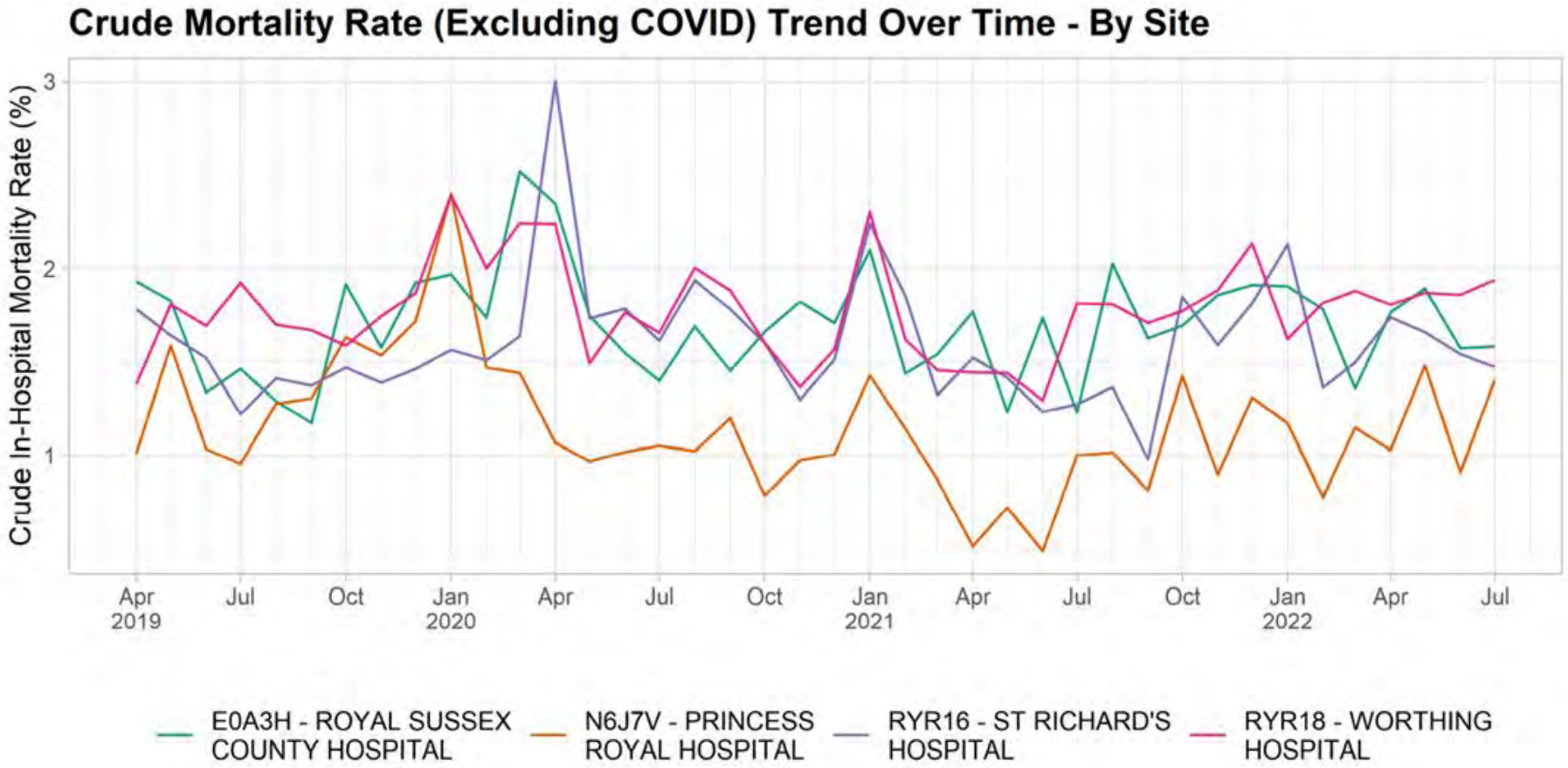

SHMI

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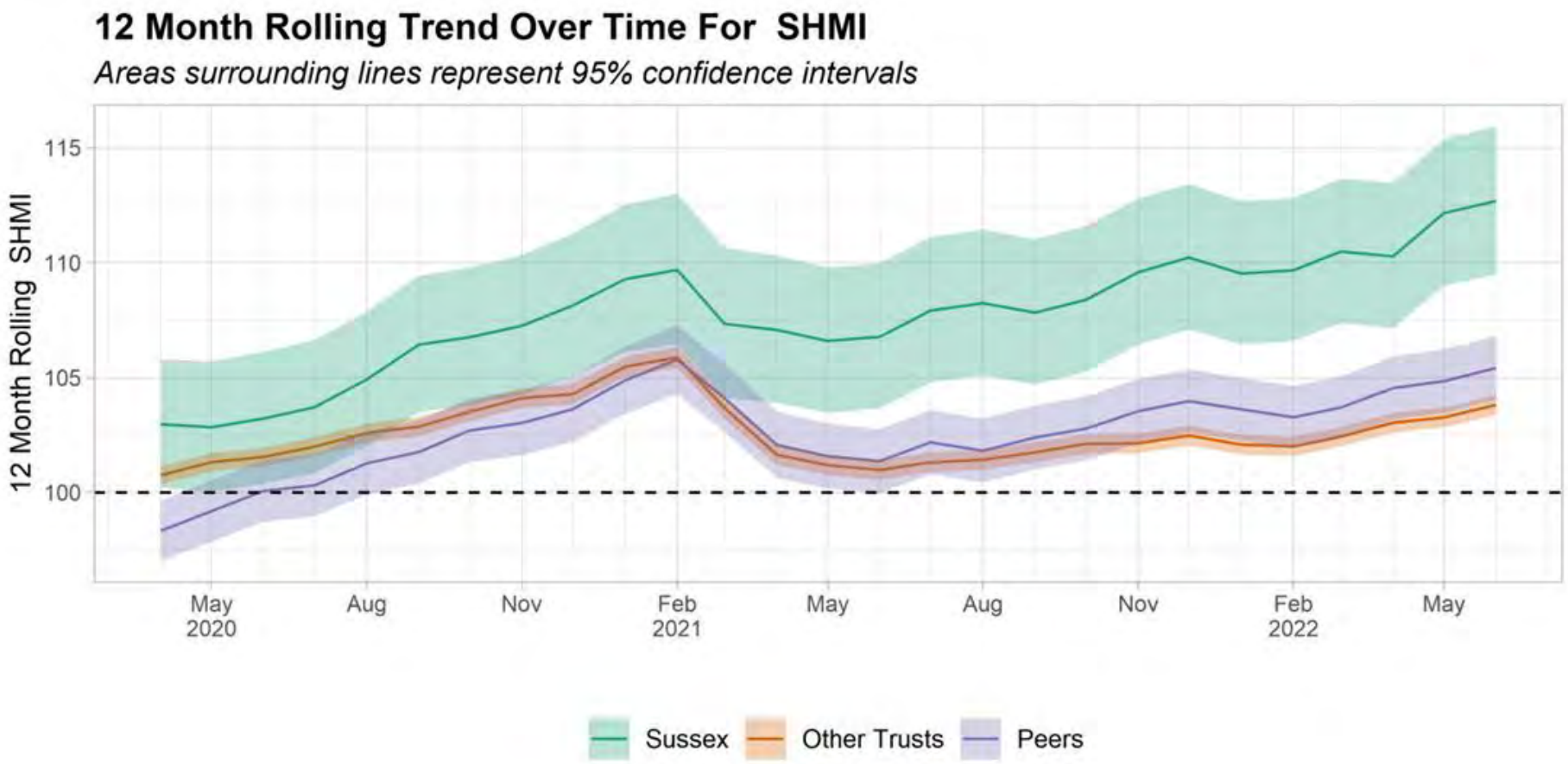

Depth of Coding

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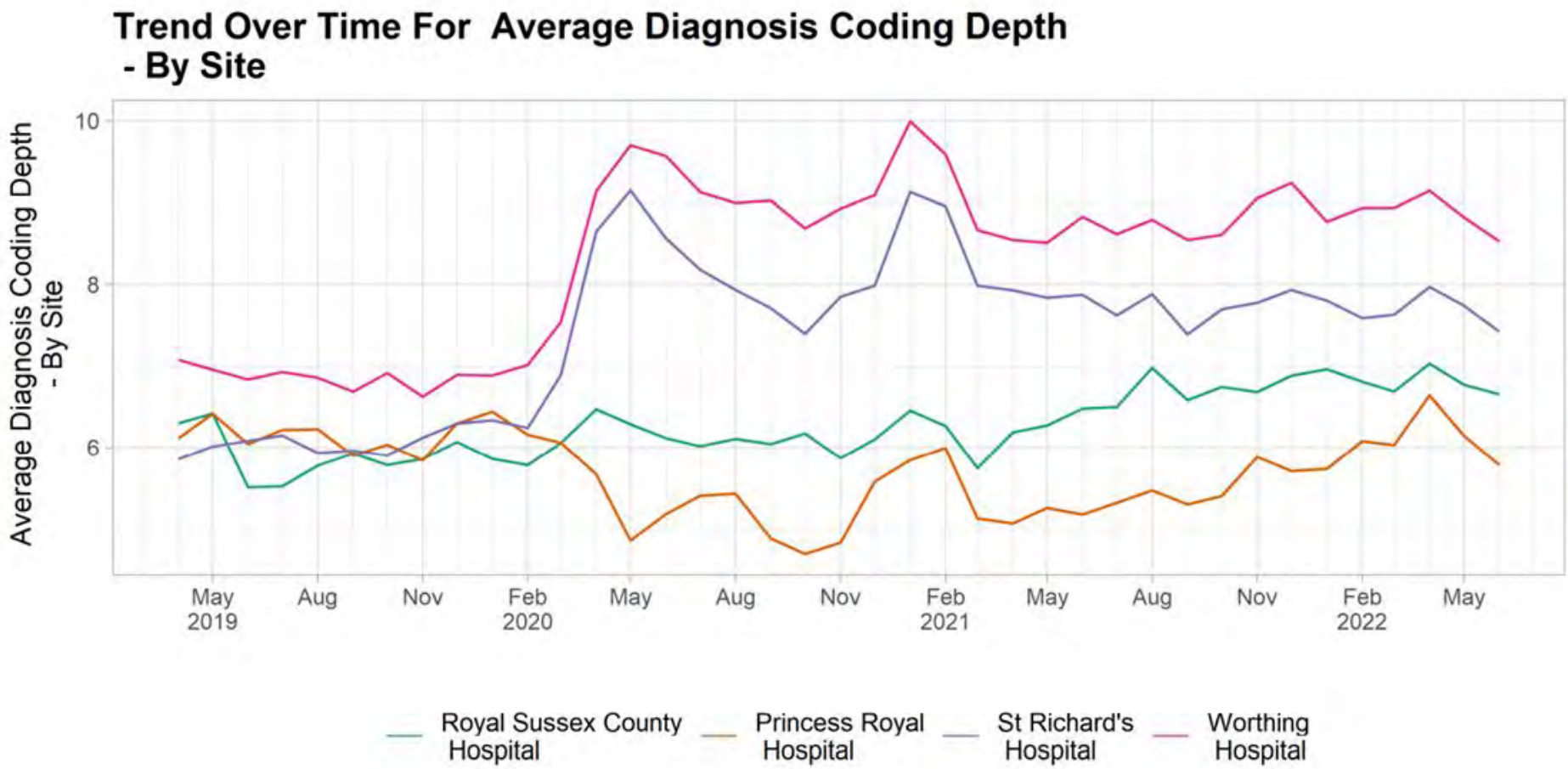

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External Review of Coding

An external audit of coding was commissioned from Monmouth Partners to review a sample of 200 clinical records from each of the four acute sites, including cohorts of deceased and non-deceased patients.

This audit found that coding 'Exceeded Standards' across all cohorts – excluding non-deceased at RSCH & PRH, which achieved only 'Standards Met' – performing relatively poorly at coding secondary diagnoses and primary procedures. There are a remaining 24 FCEs to complete with a final report pending, however these cases are not expected to materially impact the overall findings.

Recommendations from this audit include ensuring access to full medical records for coding staff, reviewing current coding policies and aligning these at Trust level and adopting a consistent approach to coding all documented comorbidities.

Patient Safety

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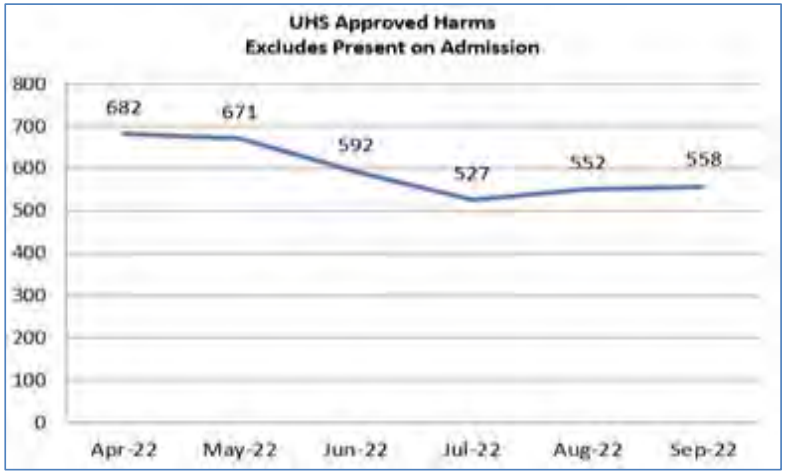
Trustwide it is expected that patients do not suffer harm whilst in our care. However, it is recognised that there are patients who suffer new harm which is acquired during their time in hospital. This has a significant impact on patients, families , carers and staff and within the wider organisation.

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

For actual harms (approved) graded as low, moderate, severe and death the numbers are detailed below. The highest percentage of reported patient safety incidents are graded as no harm (September 2022- 77%).



Site variables are due to

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

Incident Management and Learning

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

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HPA
HARMED PATIENTS ALLIANCE

- Staff feedback
- Thematic learning via governance forums and safety huddles
- Patient Story (working with patients/families)
- Harmed Patient Pathway/Standards (AvMA) working with patient/families
- Regulation 20 Duty of Candour 100% compliance Q2

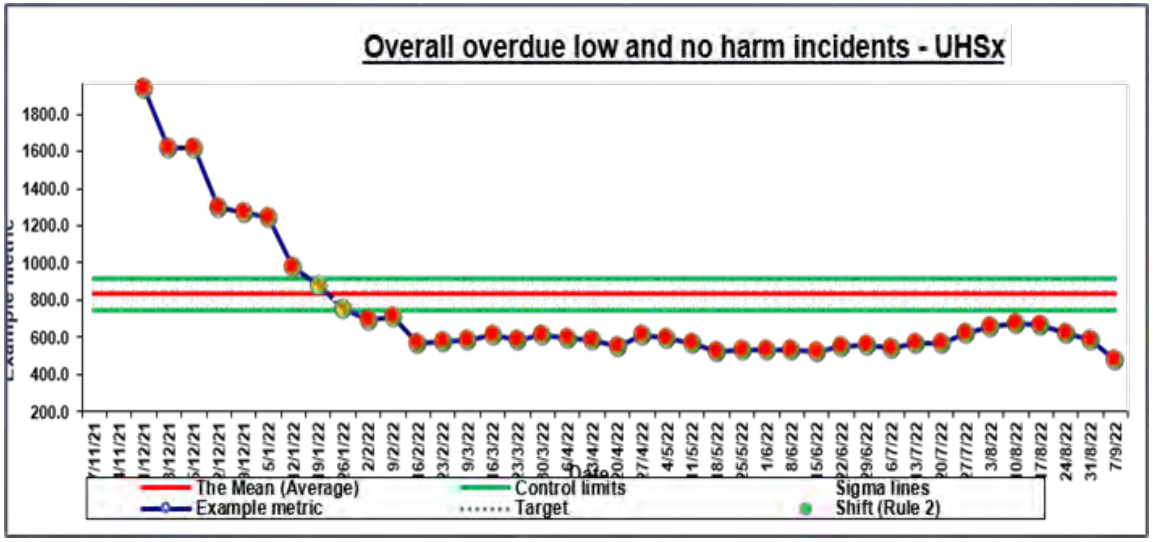

Image 1 is an overall SPC chart for all low and no harm incidents across Nov 21-September 22.
Headline report is a significant statistical change over time and continued improvement.

*DCIQ Datix incident module implementation Q3 will align with new divisional COM

Avoidable Harm– Key Metrics: Falls

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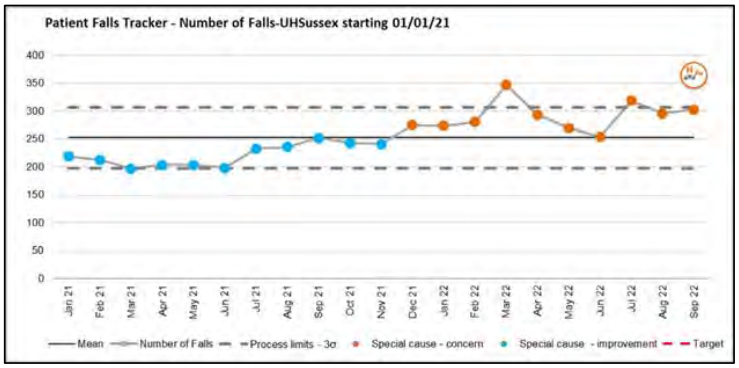

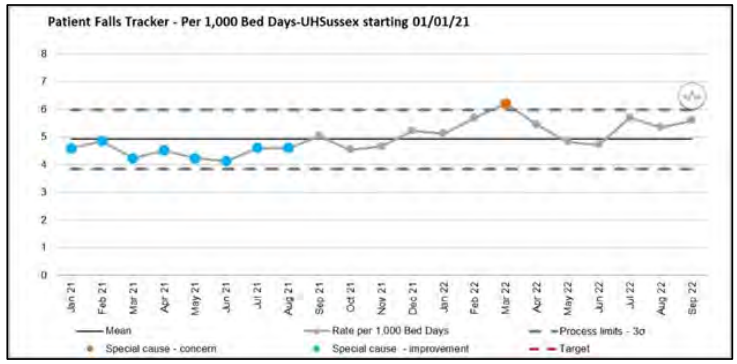

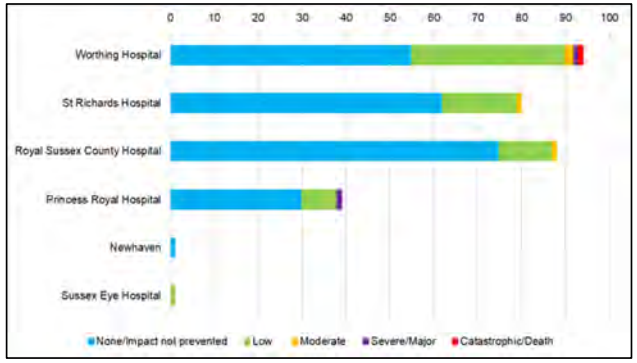

September 2022: 303 reported falls = 5.59 per 1,000 bed days; (rolling 12 month average 5.23)

Performance/ Themes:

- New baseline establishing; rate showing consistently higher number of falls compared to Q2 21
- After Action Reviews undertaken or underway for all falls graded as moderate/severe harm death; supported by harm free care nurses and patient safety team
- Admission areas across the sites continue to experience highest number of falls.
- Themes identified include staffing impacting observation and post falls care issues
- Noted theme of patient extreme fatigue due to extended hours in A/E and night time transfers
- Night moves impact the individual patient and also patients on receiving areas, in particular the Emergency Floors

Improvement Actions:

Breakthrough; refresh of A3 underway; Key workstreams include:

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

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

Post Falls and Baywatch local improvement work ongoing

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

Activities undertaken across the sites to mark national falls awareness week on 19-24 September - Theme - Maintaining Mobility and Deconditioning Prevention

Falls presentations at the HFC group highlighting silver trauma and neurological observations as key improvement areas

Avoidable Harm– Key Metrics: Pressure Ulcers

STOP THE PRESSURE.

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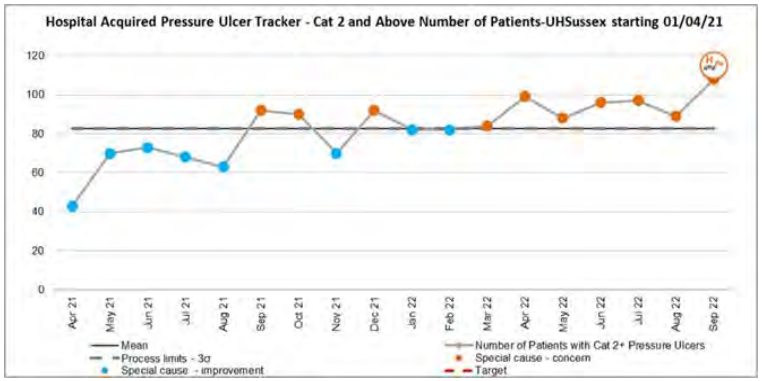

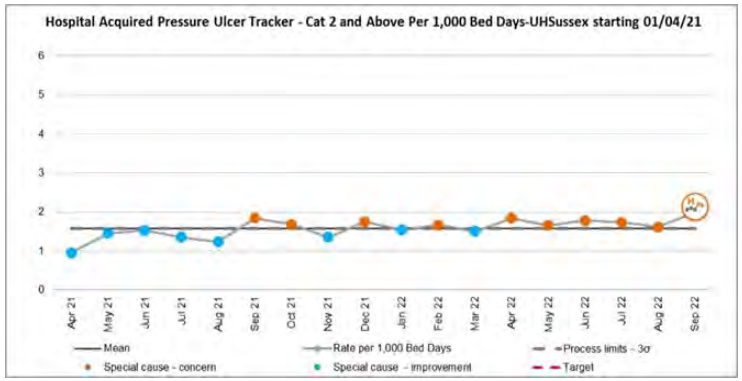

September 2022: 89 patients graded Category 2 and above pressure ulcers = 1.99 per 1000 bed days, (rolling 12 month average = 1.67);

Performance/Themes :

- New baseline establishing - whilst rate shows little recent variation, the current picture is consistently higher than Q1 and 2 2021.
- Sacral, moisture and heel DTI ulcers key themes
- High numbers of present on admission ulcers, pts spending extended time on trolleys in A/E will impact skin integrity
- Photography project at Worthing and SRH currently on hold due to IG / GDPR – impacting timely review – escalated as Trust Risk

Improvement Actions:

- Datix IQ project design phase continues
- New AAR rapid review tool in design ; capturing the ASSKING bundle elements
- Annual Static Mattress Audit planned for early October at Worthng and SRH – to be arranged for RSCH and PRH
- TV Team at Worthing and SRH have provided a two week training package on Middleton ward.
- Erringham, Ditchling, Durrington + Buckingham have had pressure ulcer prevention training focussing on implementing the aSSKINg care bundle, during their away days.
- WGH EF are now providing Heel Pro Advance Pressure Off Loading Boots in accordance with the # NOF pathway; when patients are not admitted directly onto Broadwater ward.

Improvement actions (harm reduction)

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- Analysis of all reported patient safety incidents (site, division, service, ward) continues month on month.
- Implementing RLDATIX IQ risk and incident management and assurance system Q1/2/3.
- Targeted focus on reduction of low/moderate harms (falls and pressure damage) Falls and pressure damage are noted as top 2 themes in reported harms (moderate/low).
- Post pandemic, learning identified that factors such advanced age and frailty, sex, ethnicity and weight are strong predictors of adverse outcomes, harms and mortality for older people hospitalised because of acute illness.
- Patients who are medically fit/ready for discharge but experience a delay to discharge due to the continuity of community care are at increased risk of harm.
- RTT harm reviews indicate the potential for increased low harm reporting, early identification of at risk groups and patient categorisation.

Infection Prevention and Control – COVID-19

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- Started to see increase in Covid infection
- Multiple pop ups and outbreaks across the Trust probably related to lack of testing
- Asymptomatic admission testing reintroduced
- Earlier discharge screening for community beds (to identify positives and not delay discharge)
- Screening of symptomatic patients
- Local outbreaks continue to be managed by the IPC Team
- Surge plans agreed with site teams
- Case numbers remain difficult to monitor as there is now a reliance on LF device tests which are not processed in the labs, and there is no digital results solution
- Visiting has been maintained as much possible
- The mandate for masks was reintroduced for clinical areas
- FFP3 masks recommended when caring for patients with Covid

Infection Prevention and Control – COVID-19

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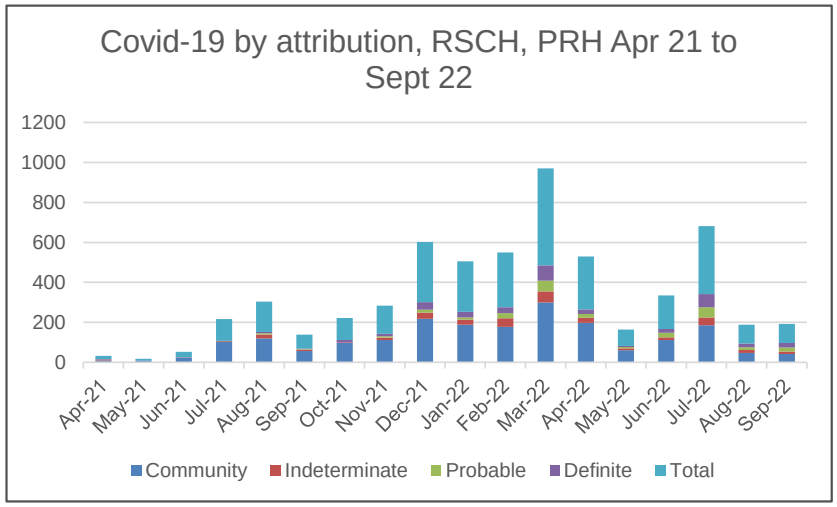
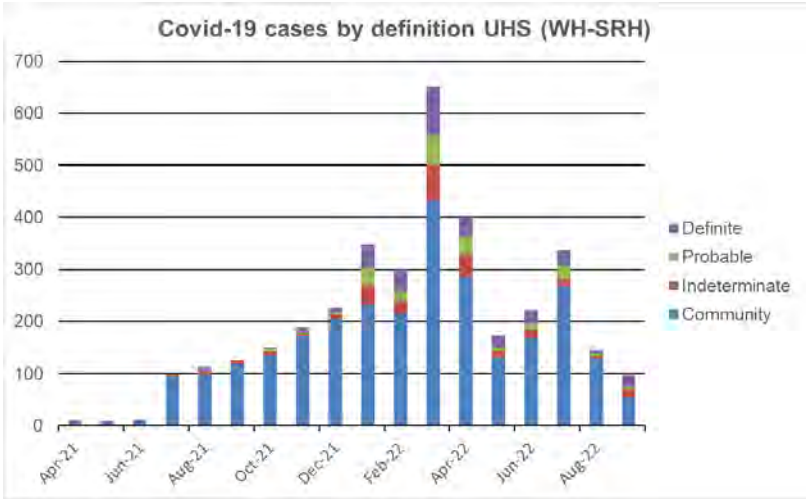
Covid -19 by attribution April 21 to September 2022





Mandatory surveillance

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

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

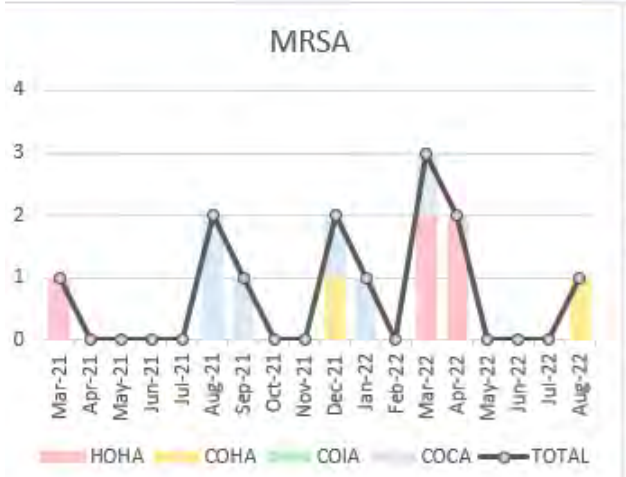
  COHA: Community Onset, Hospital Associated, acquired within 48 hours of admission to hospital, but patient had recent admission in last 28 days

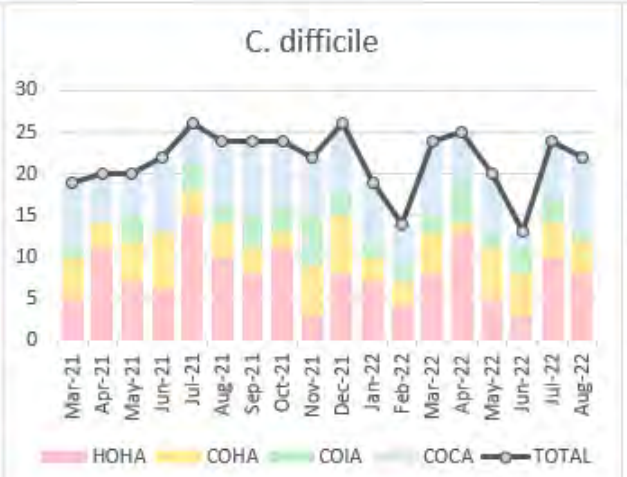
  COIA: Community Onset, Indeterminate association, acquired within 48 hours of admission to hospital, but patient had recent admission in last 84 days

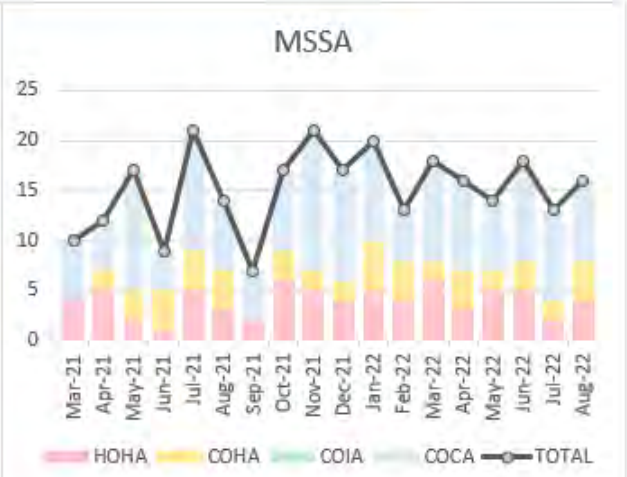
  COCA: Community Onset, Community Associated, acquired within 48 hours of admission to hospital, and no recent admission
- The chart on next slide show data up to August 2022

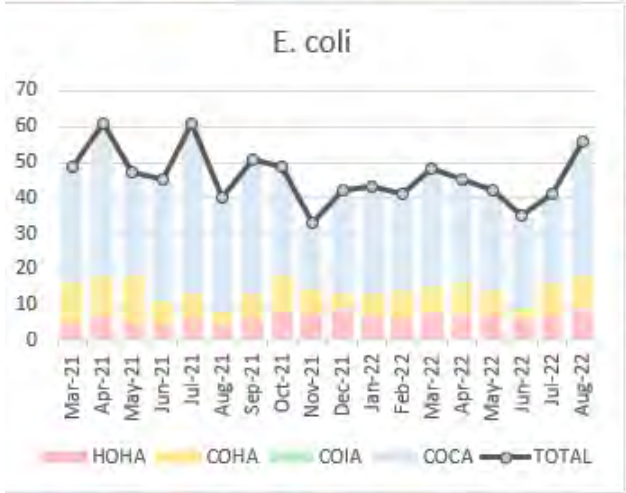
Infection Prevention and Control University Hospitals Sussex
Mandatory Surveillance dashboard | August 2022

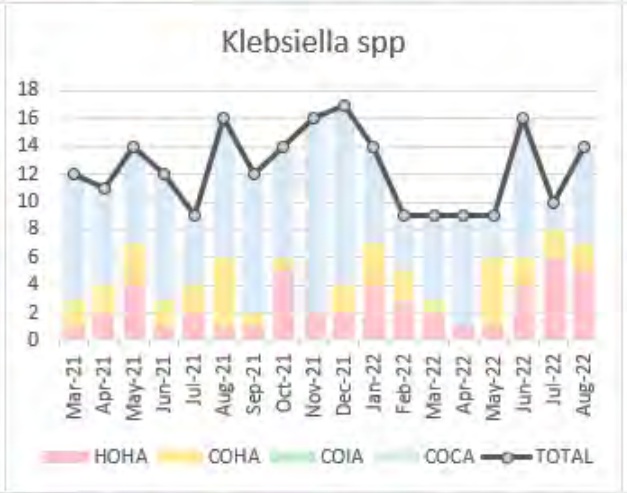
NHS University Hospitals Sussex

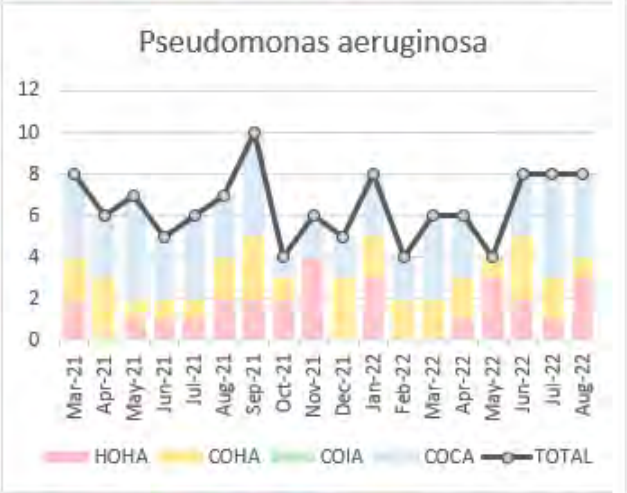












MRSA bacteraemia

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- There were 3 cases of MRSA bacteraemia in Q2. This is in addition to 2 cases (in 1 patient in Q1)
- A **COHA** MRSA Bacteraemia was identified in a patient on Pyecombe in August. The likely source was a diabetic foot ulcer. This was community onset (identified in ED). The patient was identified as MRSA positive in May 22 as an outpatient. Notes were flagged and alerted. The patient was in and out of ED and had several day case admissions. They were also admitted for 3 day to Balcombe in June, 5 nights on Pyecombe in July/Aug. The positive blood culture was taken in ED on 23rd August.
- A HOHA case was identified on Pyecombe in September. The patient was admitted in June with heart failure. They had been cared for on a variety of wards including Ardingly and Balcombe. The patient had been known MRSA positive prior to admission (since 2018). The admission screen was taken late, and only the nose was screened. They were initially negative (Ardingly). A rescreen taken 10 days later was positive and the patient was prescribed suppression therapy. They developed bacteraemia 5 days after move to Pyecombe. IV Team to review IV device access management as multiple cannulas since admission.
- A HOHA MRSA bacteraemia was identified on Albion Ward (Cardiac) at RSCH in September. The likely source was an existing soft tissue injury. The patient had been screened on admission (8/9) however results were not reported by microbiology until 29th (?due to issue with ICT track). Blood culture collected on 13/9, reported on 16/9. Started suppression on 16/9. If the result had not been reported late, he could have started suppression earlier.

Trust attributable mandatory surveillance data Q1-2 2022 against trajectory

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	Annual Trajectory		Q1	Q2	Q3	Q4	YTD
CDT	142	Trajectory	35	35	36	36	142
		Actual	33	38			71
		Variance	-2	+3			
E.coli	158	Trajectory	40	40	39	39	158
		Actual	39	52			91
		Variance	-1	+12			
Klebsiella	54	Trajectory	13	13	14	14	54
		Actual	13	26			39
		Variance	0	+13			
Pseudomonas	38	Trajectory	9	9	10	10	38
		Actual	12	11			23
		Variance	+3	+2			
MRSA	0	Actual	2	3			5
MSSA	n/a	Actual	22	18			40

Other

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Audits

- Commode cleaning 95-100% across the board
- IPC audits now going on Tendable.
- Hand hygiene 95-100%. IPC will conduct validation audits

SSI

- Commencing SSI surveillance in Cardiac at RSCH, and Orthopaedics at PRH. Existing work in place at SRH and WGH.

IPC Team

- Recruitment drive underway to address vacancies within the team. New structure and consultation agreed and near to completion.

Safer Staffing

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- In response to fluctuations in staffing levels, staffing huddles are held at least twice a day to ensure that areas with challenged staffing levels are supported. Unmitigated staffing shortfalls are escalated to the Director of Nursing.
- The overall fill rate for PRH and RSCH have improved during the quarter with a significant improvement seen on the day shifts. The CHPPD is 7.84 which is only just below the national average of 8.3 and 8.1 respectively.
- The Safer Care Nursing Tool is currently being piloted on four wards; one on each hospital site with full roll-out in August at PRH. This will ensure timely patient care sensitive information will be available to clinical staff.
- Recruitment is on going on a regular basis both domestically and internationally.

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

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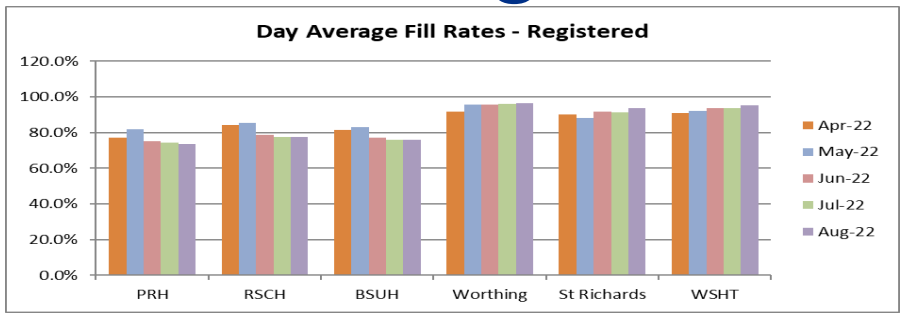

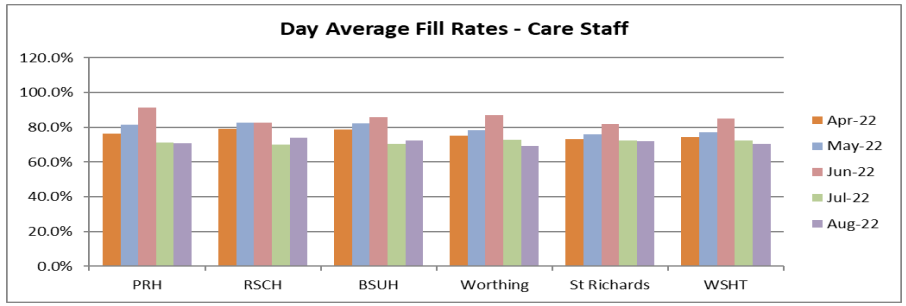

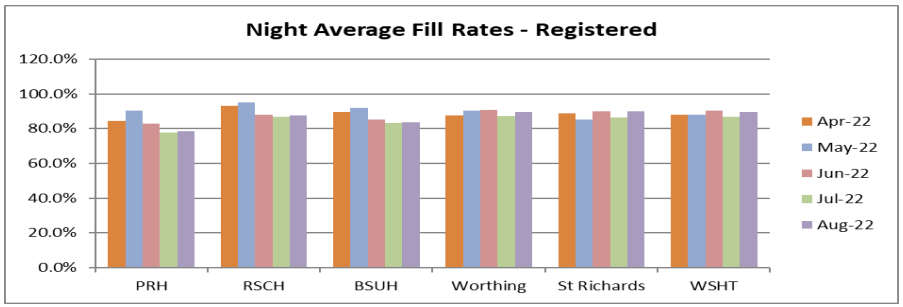

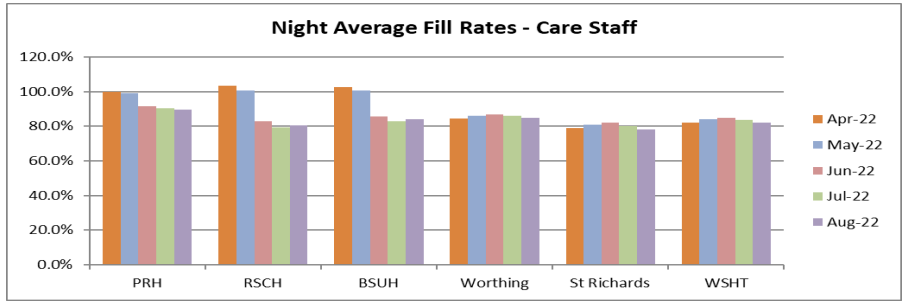

	CHPPD														
	Registered Staff					Care Staff					Overall				
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
PRH	4.03	4.45	4.23	3.92	3.79	3.58	3.86	3.60	3.30	3.29	7.61	8.31	7.83	7.22	7.08
RSCH	5.62	5.47	5.54	5.46	5.22	3.43	3.28	3.20	3.22	3.11	9.05	8.75	8.75	8.68	8.33
BSUH	**5.42**	**5.45**	**5.42**	**5.25**	**5.03**	**3.43**	**3.41**	**3.28**	**3.23**	**3.14**	**8.85**	**8.86**	**8.70**	**8.48**	**8.17**
Worthing	4.15	4.31	4.33	4.20	4.24	2.83	2.94	2.88	2.73	2.68	6.98	7.25	7.21	6.93	6.92
St Richards	4.10	4.12	4.35	4.38	4.35	2.36	2.52	2.33	2.38	2.32	6.46	6.64	6.68	6.76	6.67
WSHT	**4.13**	**4.22**	**4.34**	**4.28**	**4.29**	**2.61**	**2.75**	**2.63**	**2.58**	**2.52**	**6.74**	**6.97**	**6.97**	**6.86**	**6.81**
UHSussex	**4.77**	**4.84**	**4.89**	**4.77**	**4.67**	**3.02**	**3.08**	**2.96**	**2.90**	**2.84**	**7.80**	**7.92**	**7.84**	**7.68**	**7.51**

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People

Integrated Performance Report Section

Focus of this section

University Hospitals Sussex NHS Foundation Trust

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

People True North

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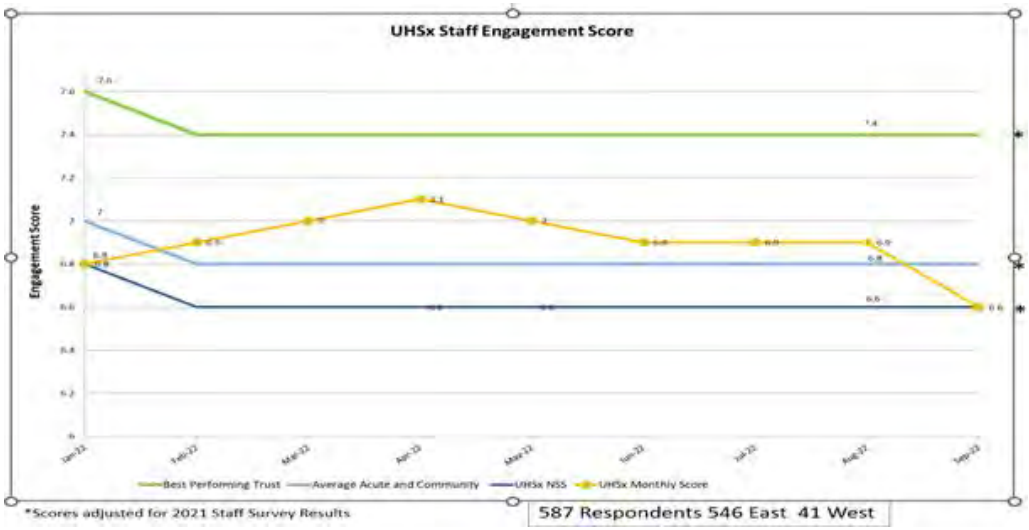
True North goal: Top acute trust for staff engagement. Target: to be within the top quartile of acute trusts for the staff engagement score (National Staff Survey). Current performance 6.6 (latest engagement measure from pulse survey):



- September saw a fall in engagement to 6.6
- Still have issues capturing data across the Trust
- 2022 staff survey now underway

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

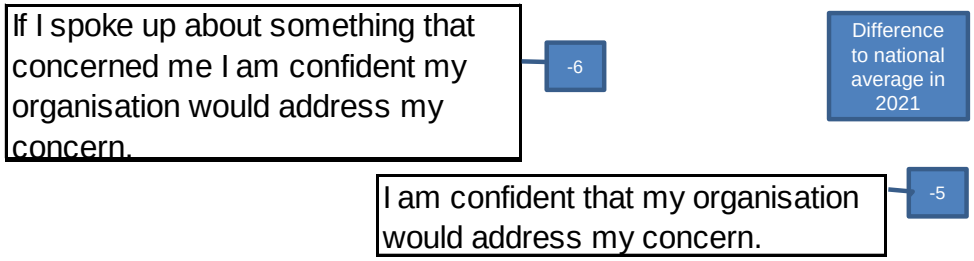
People Breakthrough Objective

University Hospitals Sussex NHS Foundation Trust

- New objective: staff voice that counts
- Divisions engaged
- New FTSU guardian recruited
- Pulse survey updated to capture performance
- Project charter agreed

New breakthrough chosen as '*staff voice that counts*' because:

- Is a contributor to staff satisfaction and more focussed than '*recommendation as a place to work*'
- Is not specifically covered by the current Strategic Initiative on leadership culture and OD
- Is capable of some rapid intervention and improvement
- Is complementary to safety initiatives, PFIS improvement work and strengthening teamwork
- Also supports other areas for improvement such as bullying and harassment and anti racism as encourages issues to be raised
- Will contribute to improved sense of wellbeing and stress reduction too
- Has featured in feedback from CQC and others as well as at listening events
- Other areas of low score are covered by other work/initiatives, or are less within Trust control or longer timescales
- Measurable through staff survey (giving a benchmark) – aim to at least match other Trusts in 2023:



People Strategic Initiative

University Hospitals Sussex NHS Foundation Trust

November 2022 Summary Position:

- The SI has been refreshed 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 and (c) Equality Diversity and Inclusion.

- An updated Project Charter has been developed and delivery plans for each workstreams reviewed. A single steering group has been created supported by feeder groups on
  - Health and wellbeing (inc sub group on violence and aggression)
  - Leadership development
  - Equality Diversity and Inclusion

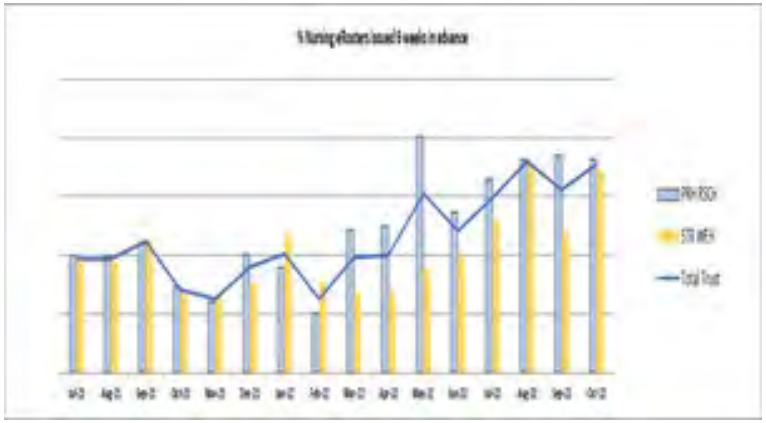
- Work on Integrated Education continues outside the SI from September.

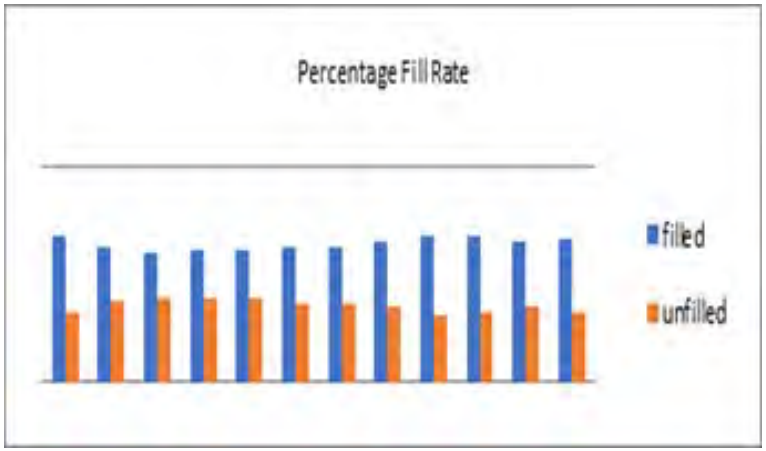
People Corporate Project: Electronic Workforce Deployment (EWD)

Replacing multiple electronic workforce systems and reducing reliance on non-automated processes to ensure effective deployment of the substantive and bank workforce to ensure quality and safety and improve operational workforce reporting.

Current programme on-track to conclude by 31 March 2023. In October 93% of non-medical staff are now on a roster. Nursing rosters issued 6 weeks in advance improved to 71% (improved performance at SR and WH). Filled shift rates improved. Benefits realisation work commenced and safer care tool roll-out.

Options appraisal for medical EWD project completed and will be a new corporate project.





People scorecard

University Hospitals Sussex NHS Foundation Trust

- 16,148 WTE posts*
- 14,801 WTE in post
- 1,346 vacancy (8.34%)
- RN vacancy 7.01%
- HCA vacancy 18.65%

- Sickness 5.27% (4.08% in month)
- Turnover 9.47%

- Appraisal (non-medical) 80.47%
- Consultant 89.04%

- STAM 87.56%

- Latest staff engagement score 6.60%
- Recommendation 59.57%

*Winter plan will see the establishment increase to substantiate additional bed capacity is use. This will see the vacancy rate increase

People Committee Scorecard - UHSx														September 2022	
	Key Performance Indicator	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Trend
	True North - Engagement	6.6	6.7	6.9	6.8	6.8	6.9	7.0	7.1	7.0	6.9	6.9	6.9	6.6	
	Breakthrough - Place to work (included in some of the surveys)	59.27%	62.63%	65.13%	59.02%	62.02%	62.26%	66.67%	67.70%	64.93%	63.06%	62.22%	63.92%	59.57%	
	Survey Responses	586	415	461	384	509	487	394	377	467	396	434	518	587	
Workforce Capacity	FTE - Budgeted	15,984.96	16,017.54	16,021.05	16,053.74	16,059.52	16,040.39	16,024.63	16,018.18	16,024.57	16,096.71	16,107.15	16,125.53	16,148.14	
	FTE - Substantive contracted	14,613.69	14,658.54	14,645.01	14,683.37	14,736.02	14,728.95	14,781.80	14,953.18	14,599.22	14,652.26	14,572.76	15,185.38	14,801.57	
	FTE - Substantive contracted variance from Budget	1,371.27	1,359.00	1,376.04	1,370.37	1,323.50	1,311.44	1,242.83	1,065.00	1,425.35	1,444.45	1,534.39	940.15	1,346.57	
	Vacancy Factor (Substantive contracted FTE)	8.58%	8.48%	8.59%	8.54%	8.24%	8.18%	7.76%	6.65%	8.89%	8.97%	9.53%	5.83%	8.34%	
	Vacancy Factor HCA Band 2 (Substantive contracted FTE)	10.13%	12.85%	14.03%	13.59%	14.96%	15.66%	14.66%	16.29%	17.15%	19.34%	20.65%	18.55%	18.65%	
	Vacancy Factor Nurse Band 5 (Substantive contracted FTE)	18.29%	16.52%	15.18%	13.47%	12.17%	11.59%	10.37%	8.24%	9.91%	6.84%	8.08%	5.27%	7.01%	
	Spend - Bank as a % of total staffing	5.43%	7.02%	7.60%	8.78%	10.20%	8.43%	5.52%	8.38%	7.76%	8.83%	8.69%	9.10%	8.70%	
	Spend - Agency as a % of total staffing	2.86%	3.10%	3.28%	3.18%	3.10%	3.14%	3.42%	3.77%	5.17%	5.43%	5.63%	5.27%	4.79%	
	Substantive Headcount	16,508	16,521	16,618	16,586	16,628	16,649	16,682	16,651	16,600	16,571	16,524	16,694	16,646	
Workforce Efficiency	Absence - Sickness (12 month)	3.92%	4.01%	4.05%	4.10%	4.12%	4.21%	4.33%	4.48%	5.07%	5.17%	5.21%	5.27%		
	Absence - Sickness in month	4.13%	4.98%	4.66%	4.70%	4.72%	5.16%	4.83%	4.62%	4.39%	4.09%	5.33%	4.08%		
	Absence - Maternity in month	2.13%	2.07%	1.99%	2.00%	2.00%	1.95%	1.89%	1.86%	1.70%	1.80%	1.90%	1.86%		
	Absence - Special, Study & Other Leave in month	8.08%	8.44%	8.36%	8.59%	9.09%	8.85%	9.37%	8.58%	8.32%	8.49%	8.43%	7.75%		
	Absence - Total in month	14.35%	15.49%	15.01%	15.29%	15.80%	15.96%	16.09%	15.06%	14.40%	14.38%	15.66%	13.69%		
	Sickness - Short Term (< 28 days)	1.97%	2.54%	2.42%	2.24%	2.48%	2.51%	2.54%	2.33%	2.01%	1.92%	2.99%	1.94%		
	Sickness - Long Term (>= 28 days)	2.17%	2.44%	2.24%	2.46%	2.24%	2.66%	2.29%	2.29%	2.38%	2.17%	2.34%	2.14%		
	Sickness - Stress in month	0.96%	1.07%	1.03%	0.91%	0.87%	1.05%	0.85%	0.93%	0.98%	0.81%	0.89%	0.76%		
	Sickness - Gastro Intestinal in month	0.34%	0.34%	0.32%	0.33%	0.27%	0.40%	0.33%	0.37%	0.33%	0.37%	0.33%	0.32%		
	Sickness - Other Musculoskeletal in month	0.38%	0.44%	0.41%	0.44%	0.37%	0.52%	0.40%	0.36%	0.43%	0.37%	0.42%	0.42%		
	Sickness - Cough, Cold & Flu in month	0.35%	0.76%	0.70%	0.72%	0.46%	0.48%	0.48%	0.46%	0.38%	0.31%	0.31%	0.26%		
	Sickness - Back in month	0.27%	0.22%	0.20%	0.16%	0.13%	0.21%	0.17%	0.16%	0.22%	0.19%	0.23%	0.20%		
	Episodes - New sickness episodes in month	2,541	3,442	3,133	2,932	2,630	2,604	3,058	2,668	2,734	2,609	3,236	2,573		
	Episodes - On-going sickness episodes in month	676	793	682	801	867	841	766	873	696	641	828	663		
	Episodes - Total sickness episodes in month	3,217	4,235	3,815	3,733	3,497	3,445	3,824	3,541	3,430	3,250	4,064	3,236		
	Maternity - Number of staff on maternity leave	413	412	392	396	401	392	370	374	337	362	372	378		
	Turnover - Trust (12 month)	9.06%	8.96%	8.83%	8.87%	9.01%	9.00%	9.05%	9.17%	9.33%	9.39%	9.31%	9.28%	9.47%	
	Turnover - Medical & Dental (12 month)	14.17%	14.17%	13.82%	13.81%	13.45%	13.65%	13.73%	12.81%	12.23%	12.75%	11.84%	11.04%	10.46%	
	Turnover - Nursing & Midwifery (12 month)	7.59%	7.23%	6.68%	6.50%	6.38%	6.27%	6.00%	6.19%	6.26%	6.13%	6.02%	6.13%	6.33%	
	Turnover - Scientific, Therapeutic & Technical (12 Month)	8.40%	8.72%	8.83%	8.84%	9.16%	9.60%	9.39%	9.56%	9.68%	9.69%	9.28%	9.39%	8.92%	
	Turnover - Admin, Clerical & Estates (12 months)	9.22%	9.26%	9.64%	9.84%	10.32%	10.25%	10.60%	11.01%	11.32%	11.57%	11.74%	11.82%	12.52%	
	Turnover - Support Staffing (12 months)	10.09%	9.94%	9.61%	9.86%	9.98%	9.88%	10.23%	10.12%	10.48%	10.55%	10.66%	10.41%	10.58%	
	Stability %	88.38%	88.09%	87.86%	87.14%	87.1%	86.7%	86.5%	85.8%	85.5%	85.5%	85.4%	85.4%	85.4%	
Training and Development	% of appraisals up to date All Staff (AfC Staff and Consultants Only	73.34%	70.75%	71.13%	71.01%	70.56%	71.27%	68.51%	68.93%	73.28%	77.33%	80.56%	80.03%	80.99%	
	% of appraisals up to date Medical Staff (Consultants Only)	27.07%	25.93%	26.06%	28.14%	27.45%	26.72%	28.28%	36.34%	87.53%	82.47%	90.33%	90.00%	89.04%	
	% of appraisals up to date AfC Staff (excl Medical staff)	77.26%	74.58%	75.03%	74.72%	74.28%	75.13%	72.01%	71.06%	72.34%	76.99%	79.92%	79.38%	80.47%	
	STAM Weighted Average	82.74%	82.62%	82.29%	82.64%	84.29%	85.39%	86.19%	85.35%	86.84%	88.07%	88.71%	88.33%	87.56%	
	% In Date - Fire	80.31%	79.77%	79.46%	79.99%	82.51%	83.42%	84.90%	84.58%	85.73%	86.58%	86.41%	85.73%	84.48%	
	% In Date - Infection Control (Role Specific)	79.67%	79.63%	79.33%	79.94%	82.43%	83.64%	84.83%	84.67%	85.55%	88.13%	87.74%	87.50%	86.56%	
	% In Date - Back Training (Role Specific)	75.19%	75.91%	76.17%	76.88%	78.53%	79.60%	81.28%	83.88%	85.60%	87.10%	88.43%	88.71%	88.07%	
	% In Date - Child Protection (Role Specific)	86.03%	86.07%	85.18%	85.46%	86.72%	87.84%	88.65%	83.19%	86.71%	88.39%	90.81%	90.27%	89.44%	
	% In Date - Information Governance	78.06%	76.87%	77.48%	78.12%	80.12%	81.45%	82.60%	82.45%	84.79%	85.69%	85.29%	84.59%	83.65%	
	% In Date - Adult Protection	88.44%	88.74%	88.27%	88.40%	89.54%	90.50%	90.91%	85.82%	88.74%	90.38%	92.35%	91.83%	91.08%	
	% in Date - Equality & Diversity	88.80%	88.53%	88.06%	88.48%	89.87%	91.03%	91.70%	91.92%	92.42%	93.16%	93.60%	92.65%	92.46%	
	% in Date - Health & Safety	93.87%	93.86%	93.52%	93.51%	93.34%	93.68%	93.21%	93.40%	93.31%	93.78%	93.79%	92.59%	92.47%	
	% in Date - Resus	70.01%	69.89%	68.56%	68.13%	71.05%	73.28%	73.25%	74.60%	74.62%	75.01%	75.63%	77.52%	75.97%	
Capacity	Starters	287	286	229	139	209	201	190	189	202	157	140	692	210	
	Leavers	151	184	107	127	135	127	156	145	120	124	136	388	166	
COVID*	Absence	157	169	170	308	456	329	424	0	0	151	186	96	0	
	Vaccination % First Dose	89.65%	89.65%	89.65%	89.65%	89.65%	89.65%	89.65%	89.65%	89.65%	89.65%	89.65%	89.65%	89.65%	
	Vaccination % Second Dose	86.23%	86.23%	86.23%	86.23%	86.23%	86.23%	86.23%	86.23%	86.23%	86.23%	86.23%	86.23%	86.23%	
	Clinically Extremely Vulnerable	12	12	11	7	10	10	11	0	0	0	0	0	0	

People scorecard - Commentary

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Current Performance	Response / Actions Planned
Turnover • The September UHSussex Turnover rate (external leavers) stood at 9.47%. The rate has seen a steady increase since February 22 when it stood at 9.00%. • For RSCH/PRH the Turnover rate in September stood at 9.51% and remains substantially lower than the figure of 10.48% seen in September 21. • For WH/SR the Turnover rate for September stood at 9.44%. Turnover rates here have been increasing, and the current rate is substantially higher than the rate of 7.4% seen in September 21.	• Nursing and Midwifery Steering Group established. • NHSE Nursing & Midwifery Retention Self Assessment Tool to be completed to benchmark current position and 5 high impact changes to be interpreted for UHSussex and implemented to improve retention of registered and unregistered nurses and midwives. • Promoting exit questionnaire and interviews to further analyse reasons for leaving (Medicine WTG/SRH). • Listening events being held in a number of Divisions: CCS (Pharmacy, Pathology, Physiotherapy), Junior Doctors (Medicine RSCH/PRH) and Womens & Children. • Theatre Staff Engagement plans at all sites include development of values and behaviours blueprint and leadership development and coaching for managers, and making environmental improvements. • Focus on quality appraisals and staff development (eg: role enrichment from HCA led clinics, apprenticeships and mental health training for HCAs).
Sickness Absence • In August the UHSussex one month Sickness Absence rate was 4.08% and the 12 month rate 5.27%. • The August in month Sickness Absence rate for RSCH/PRH was 4.55% which is down from the rate of 4.85% at the same point last year (September 21). The average rate over the previous 12 month period is 5.39%. The 12 month Sickness Absence rate is 5.94%, and remains much higher than the rate of 4.62% seen in September 2021. The current in month absence split is 2.01% Short Term and 2.53% Long Term (28 days or more). • The WH/SR in month Sickness Absence rate for August was 3.52%, an increase on the figure of 3.26% seen in September 21. The average rate over the previous 12 month period is 3.76%. The 12 month Sickness Absence rate is 4.48%, and again is substantially higher than this time last year (3.06%). The current in month absence split is 1.85% Short Term and 1.66% Long Term (28 days or more).	• The ER Team have continued with the project team of 2 ER Advisors to focus on the management of long term sickness. This is providing dedicated focus on LTS cases and proactive support to managers, ad hoc training and support in hotspot areas. • In the first 6 months of 2022/23 there have been 12 dismissals for sickness. • Facilities and Estates remains the Division with the highest absence and training sessions are planned with supervisors in the Division. Alongside this, HRBP working with ER Advisors to undertake review of existing A3 Sickness Action Plan to identify current contributors and improvement actions. • The health and well being team continues to ensure that psychological support is available to all staff and for specific teams as required whilst ensuring there are resources available for staff and managers to access.

People scorecard - Commentary

University Hospitals Sussex NHS Foundation Trust

Current Performance	Response / Actions planned
Appraisal • The September UHSussex (non medical) Appraisal rate stood at 80.47%. The rate has continued to rise since February 22 (72.01%) and sits above the rate of 76.26% in September 21. The Appraisal rate in RSCH/PRH stood at 76.78% versus 72.43% in September 21, whereas in WH/SR the Appraisal Rate is 84.6% against 82.73% this time last year.	• As at September 2022, the non-medical appraisal rate was 80.5%, an increase on 79.4% in August 2022. This is the highest level of compliance in the last 12 months, although less than the 90% target. • Currently only Facilities & Estates (Trust wide) is achieving target (at 91.7%). • The poorest performing Divisions are Chief Executive (49.0%), Chief Nurse (55.6%), Chief People Officer (63.1%) and Chief Financial Officer (63.7%) • 1,250 staff have now completed the Development Appraisal appraisee feedback survey. Highlights: • 90% agreed they had had the opportunity to discuss all the topics they wanted to • 89% agreed they felt safe to talk about personal issues • 87% agreed their appraisal was a positive experience overall • 85% agreed the feedback they received was useful • Poor performance within Corporate Divisions has been flagged to the respective Executive Director. • Appraisal Trajectory Tool has been launched by the HRBPs to assist Divisions with increasing compliance and meeting new stretch targets of 95% or 100% • Compliance continues to be reviewed and monitored at Divisional SMT and through the SDR process.
STAM • The UHSussex STAM compliance rate stood at 87.56% for September, up from 82.74% this time last year. If compliance rates are split between East and West then they show RSCH/PRH at 88.1% (up from 83.34% in September21), and WH/SR at 86.91% (up from 82.04% this time last year).	• All staff continue to be encouraged to complete outstanding STAM requirements as part of the One UH Sussex programme • All STAM subjects have increased compliance across most modules and only one still red across the Trust - Resuscitation although a plan to drive up is in place through providing more in-situ training rather than general groups • Focus is currently on our worst performing areas to drive up compliance particularly with online training at SRH/WGH and f2f at RSCH/PRH • Reporting stepped up and targeted communications will continue and a need to focus on link with appraisal work as compliance should be assessed at point of appraisal. • PRH/RSCH sites are just below 90% compliance overall but compliant in in 3/9 modules, 5/9 modules are in the 80%-89% range and 1/9 is below 80% (No change on last month) • WGH/SRH sites have now achieved above 90% compliance in 3/9 modules, 5/9 modules are in the 80%-89% range and 1/9 is below 80% (Slight decrease in performance against last month). • F&E remain well above Trust target at 96%.
Vacancy • The September UHSussex Vacancy Rate stood at 8.34%, slightly down from 8.58% in September last year. If vacancy rates are split between RSCH/PRH and WH/SR, then it shows RSCH/PRH at 7.98% against 7.56% in September 21, and WH/SR at 8.75% against a rate of 9.79% this time last year.	• Funding bid for a further 50 Staff Nurses has been made to NHSE who, if successful, will be due to land Feb/March 2023. • Resourcing team and matron for nursing workforce are focused on HCA recruitment, oversight being provided via the new N&M Workforce Steering Group, A3 in progress. • Target to recruit an average of 65 HCAs each month to catch up on current gaps • Challenges regarding candidate pool, head of resourcing meeting with princes trust and DWP to establish alternative candidate channels. • Open days planned for HCAs and plans to focus on 3Ts vacancies using new building as a marketing opportunity • High level action plan regarding resourcing improvement being developed.

People risks and forward look

University Hospitals Sussex NHS Foundation Trust

- Q1 & Q2 and as we enter Q3 the burden of managing the ongoing demands of the recovery from the pandemic, increased workforce pressures and the general issues in the wider economy (inflation etc) remain tough for staff. The principle people risks (as discussed at the People Committee) remain around:
  - Maintaining sufficient staffing for the levels of activity / demand being experienced
  - Staff absence / availability
  - Health and wellbeing of staff
  - Staff stretch and the impact of that on their and patients' experiences
- There is increased risk of industrial action following the decision of a number of health service TUs to ballot on this. The Trust is engaged in planning for such eventuality.
- The Trust's Winter Plan will see a number of posts currently covered on a temporary basis consolidated, with some impact on the vacancy position while substantive recruitment takes place but hopefully mitigating the level of staff stretch.
- Qs 3&4 of 2022-23 provides opportunity re-invigorate the re-focussed programmes of work following the review of Trust True Norths, including People. As reported in the SDR the BO, SI and CP continue to progress with more detailed plans. Key areas to strengthen are the Trusts support for wider culture change, building on and around its Patient First Improvement System and improving staff feedback.

University Hospitals Sussex
NHS Foundation Trust

Sustainability

Integrated Performance Report Section

Sustainability True North – Financial Plan

University Hospitals Sussex NHS Foundation Trust

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

- The financial target for 2022/23 is breakeven; consistent with statutory requirements.
- The financial plan is based on the relevant financial framework, tariff requirement and impact of local application of funding allocations.
- The efficiency requirement for 2022/23 is £47.7m (3.7% of turnover).
- At the end of quarter 2, the reported year-to-date deficit is £14.9m, which is £8m above plan.
- The cash balance of £63.8m is £21.9m less than plan at the end of month 6, this is not a cash flow risk, and is in part due to improving our performance against the Better Payments Practice Code.
- Capital expenditure is £1m above plan. Within this, expenditure for 3T's is on track, with expenditure on digital schemes ahead of trajectory. Forecast outturn remains on plan.
- Year to date , efficiency performance remains on plan, tactical schemes linked to drug schemes and procurement continue to deliver ahead of expectation.

Sustainability Key Metrics

University Hospitals Sussex
NHS Foundation Trust

			R
I&E £k	**YTD Plan**	**YTD Actual**	**Variance**
Income	(670,700)	(670,063)	(637)
Operating Costs	667,523	675,257	(7,734)
Finance Costs	10,766	10,165	601
Performance Adjustments	(645)	(419)	(226)
Overall performance	6,944	14,940	(7,996)

The year-to-date deficit of £14.94m is a £8.00m adverse variance to plan due to increased costs of insourcing and outsourcing, to deliver activity, and operational pressures linked to staff availability, flow and capacity.

			A
Cash £k	**YTD Plan**	**YTD Actual**	**Variance**
	85,670	63,818	(21,852)

Cash is £21.85m less than the plan submitted to NHSE/I due to making higher than planned payments in order to maintain the Trust's Better Payments Practice Code (BPPC) performance and the year-to-date deficit against plan.

Work is on-going to review and improve the invoice approval process in order to improve the BPPC performance.

			G
Capital £k	**YTD Plan**	**YTD Actual**	**Variance**
3T's Phase 1	(21,589)	(21,471)	(118)
Operational Schemes:			
Medical Devices / Digital	(2,879)	(4,472)	1,593
Service Developments	(12,757)	(12,654)	(103)
Estates	(7,144)	(6,771)	(373)
Charitable	(115)	(113)	(2)
Overall performance	(44,484)	(45,481)	997

The year-to-date expenditure is ahead of trajectory primarily due to shorter delivery timescales for digital equipment.
Estates infrastructure schemes have started slightly later than planned. The forecast out turn remains on plan.

			G
Efficiency £k	**YTD Plan**	**YTD Actual**	**Variance**
	15,200	15,243	43

As at month 6 the efficiency programme is performing £43k ahead of plan.

Non NHS income is less than plan, however this is offset by over performance on cost reduction and productivity schemes which includes recognition of delivered productivity improvements for the year-to-date.

Sustainability – Risks

University Hospitals Sussex NHS Foundation Trust

- **Elective Performance** - Risk that the Trust is unable to deliver required reductions in 78 week waits and recover to 100% of 19/20 activity levels.
  - Reliance on insourcing and outsourcing to the Independent Sector which has a significant financial impact.

- **Urgent Care** - There continues to be significant impacts on patient flow and hospital capacity.
  - This could crystalize as a risk to delivery of elective activity.
  - The cost to support urgent care demand either through bed escalation capacity and additional resources in our emergency departments.
  - Increased levels of temporary staffing with premium cost.

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

- **Inflation -** Risk that the Trust does not have the ability to mitigate the pressures from the significant utilities above inflation price increases. Current rates of inflation in H1 are between 7-10% and expenditure is expected to increase further in H2 based on RPI projections.

Sustainability - Actions & Recommendations

University Hospitals Sussex NHS Foundation Trust

There are no actions required of the Board.

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

- The year-to-date performance as at the end of Quarter 2 is a £8m adverse variance to plan.
- The efficiency programme is £15.24m year-to-date, which is on plan.
- The current forecast for year end is to breakeven. Given the current deficit position at the end of Q2, this is a high risk.
- Mitigating actions have been identified for the risks, with Executive level oversight.
- Detailed financial performance information has been shared with Sustainability Committee; who continue to provide oversight on behalf of the Board.

NHS
University Hospitals Sussex
NHS Foundation Trust

Systems & Partnerships

Integrated Performance Report Section

Systems & Partnerships Summary Q2

University Hospitals Sussex NHS Foundation Trust

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

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

- The overall Trust performance against these measures at the end of Quarter 2 2022/23 has deteriorated for emergency care, with significantly increased pressure on operational services as a result of ongoing Covid impacts, and wider system challenges against these targets.

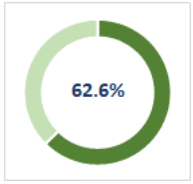
- Despite these operational pressures, there has been continued progress in the delivery of the plans to address long waiting RTT and Cancer patients.

Performance Summary September-22 , Q2

University Hospitals Sussex NHS Foundation Trust

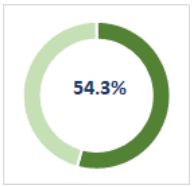
True North and NHS Constitutional Targets

A&E



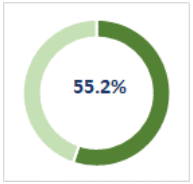
- The Trust treated 62.6% of patients within 4 hours of attending all A&E departments July to September 2022, and 63.5% 2September 2022. National performance was 71.0% Sep-22 and 71.1% Q2.
- There was renewed pressure on Trust emergency departments in particular with increases in long length of stay patients as a result of constrained flow, exacerbated by the Omicron Covid-19 wave's re-emergence.

RTT



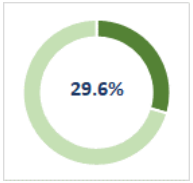
- The Trust has 54.3% of patients waiting longer than the target 18 weeks at the end of Sep-22. National performance was 60.8% Aug-22 (latest available national performance)
- The total number of patients waiting for elective treatment at the Trust is 118,754, 26 of which were waiting over 104 weeks, due to patient availability, or specialist complexity. Although non elective operational pressures have increased the Trust has remained committed to eliminating long waits for patients on an RTT pathway.

CANCER



- 55.2% of patients who commenced cancer treatment were treated within 62 days in August. National performance was 61.9%.
- There has been an increase in over 62 and 104 day prospective waits in Q2, from 534 at the end of Q1 to 714 at the end of Q2 for over 62 day patients, and from 120 patients at the end of Q1 to 161 at the end of Q2 for over 104 week waits.

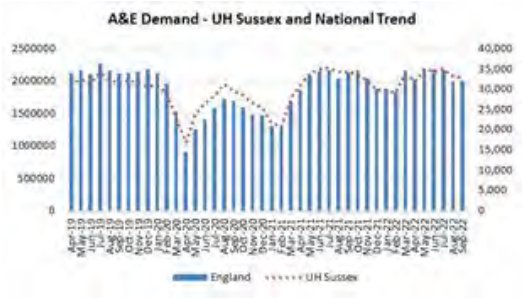
DIAGNOSTICS

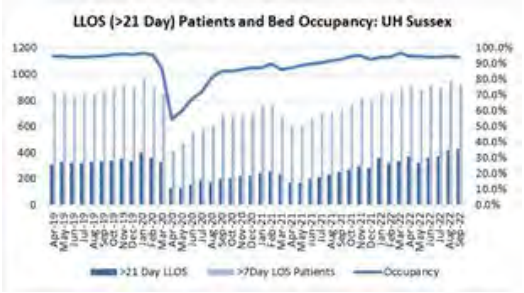


- The Trust had 29.6% of patients waiting more than 6 weeks at the end of September for a diagnostic against a 1% target. This is deterioration of 4.6% relative to the end of Q1 position of 25.0%
- The National average for Aug-22 was 30.5% (latest available national performance)

A&E Performance Summary Q2

University Hospitals Sussex
NHS Foundation Trust





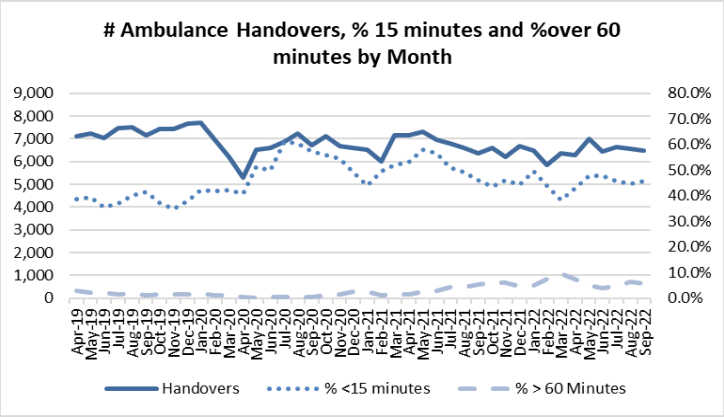
- The Trust treated 62.6% of patients within 4 hours of attending all A&E departments July to September 2022, and 63.5% September 2022. National performance was 71.0% Sep-22 and 71.1% Q2.
- To ensure patient safety, the time to triage, treatment and mean waiting times are key areas of focus for the Emergency Department teams. These have been continued to be challenging in Quarter 2 2022.

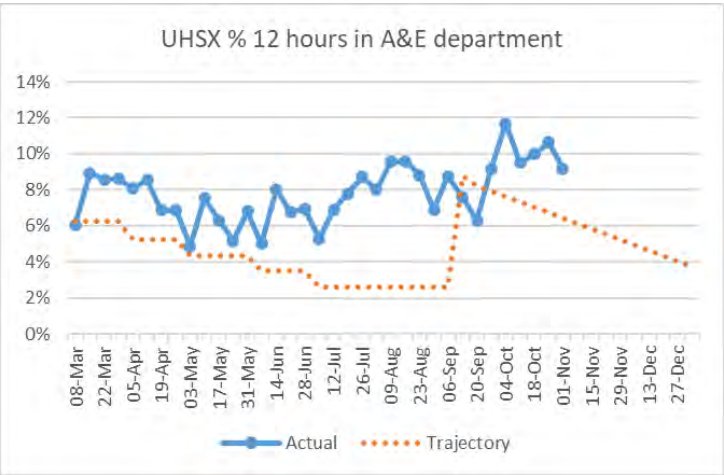
UHSussex	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Time to Triage:	22.9	23.6	21.7	18.9	18.6	22.6	29.1	25.3	21.3	22.2	23.7	21.3	23.2
Time to Treatment:	115.8	109.8	106.6	102.5	99.2	114.8	143.0	130.4	128.1	134.1	142.2	137.5	131.7
Mean Waiting Time:	261.7	271.4	273.0	275.0	280.7	296.3	332.9	319.8	306.4	316.6	332.4	347.3	343.8

- There are high levels of emergency demand (not back to pre pandemic levels) but flow is made more complex and delayed by the ‘red/green’ pathway split within ED and the hospitals and this is made more challenging each time there is another wave of covid. The main driver for long wait times is the inability to create flow out of the Emergency Departments and admit patients in a timely manner.
- The Trust is working with system partners whilst simultaneously looking at internal processes to balance the discharge profile against the A&E demand. This includes working on morning discharges as well as working to increase weekend discharges with the aim to decompress Monday/Tuesday pressures.
- There have been material increases in the numbers of patients in the Trust’s acute beds who are Long length of stay patients over 21 days, 21% increase from the end of Q1. A corporate project looking at Length of Stay and how we will work to reduce this has been launched. There are three workstreams in this project to ensure that all aspects of LoS are covered
- The key metrics describe overall Trust performance but there has been material variation by site, although in September-22 all of the Emergency Departments have been challenged. Each site is developing plans for use of super surge capacity to ensure boarding and plus 1 is done safely and in a robust way.

Ambulance Handovers and A&E 12 Hours

University Hospitals Sussex NHS Foundation Trust

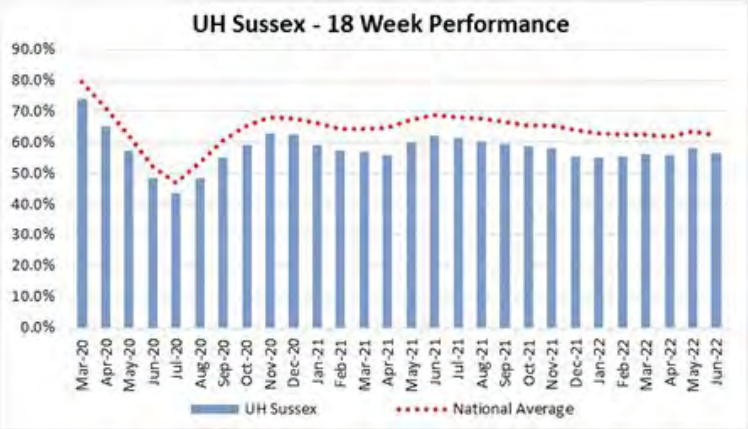


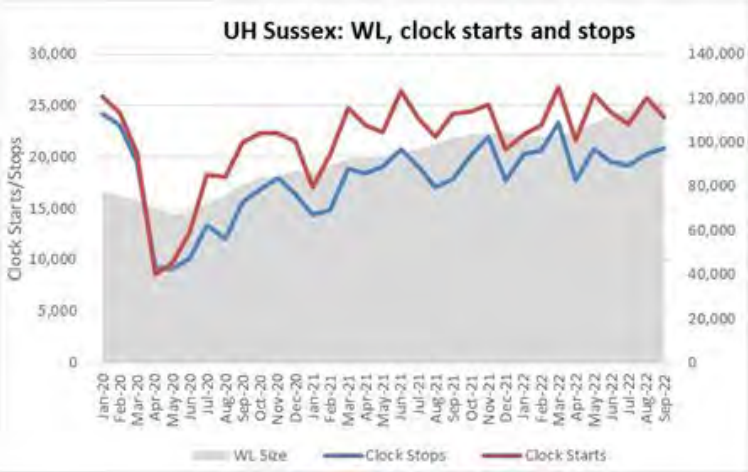


- Over 60 minute handovers in September reduced to 367 (5.7%) compared to 409 (6.2%) Aug-22 and compared to 75 (1.1%) in September-19. 218 of the 60 minute plus handovers were at the Royal Sussex County Site and 89 at SRH
- The Trust saw a marginal improvement to 45.6% of handovers within 15 minutes September-22 , compared to 44.7% Aug-22, and to September-19 (41.4%). This is variable by site, with 25.5% at RSCH, 27.8% PRH, 60.7% SRH, and 61.0% Worthing
- Patients 12 hours in A&E department decreased in September-22 compared to August-22 (7.9% compared to 8.7% August) of attendances. However, this has increased as a proportion of attendances in October (10.2%). Performance is most challenged at RSCH with 15.7% on average of RSCH attendances in department more than 12 hours in September-22 compared to 18.6% August-22 and 17.4% October 2022
- Patient safety is a concern for both long ambulance handovers and patients remaining in the department for over 12 hrs. Flow through EDs of admitted patients is a driver of both of these metrics: patients stay longer in the department whilst waiting for a bed and this leads to congestion in the EDs and delays offloads of ambulances.
- Both of these metrics require the flow through the EDs to be increased and for this be maintained through the day.
- The project work on LoS, the safe use of super surge capacity is underway as well as work with system partners to ensure discharge processes are as efficient as possible: these schemes of will create capacity on the wards allowing better flow through the ED reducing 12 hr stays and reducing ambulance handover delays

RTT Performance Summary Q2

University Hospitals Sussex NHS Foundation Trust



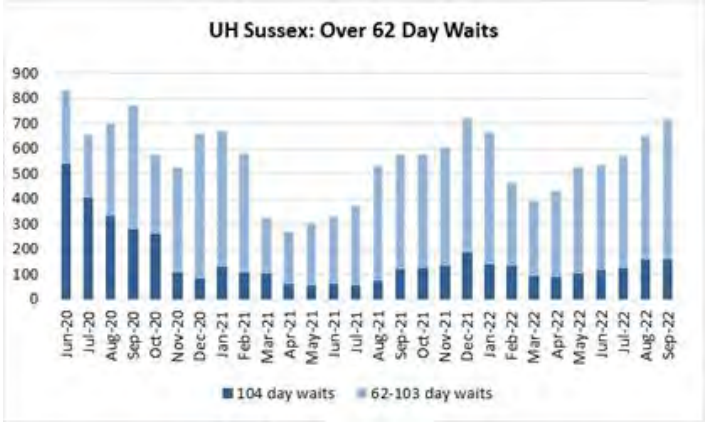


- The Trust has 54.3% of patients waiting longer than the maximum 18 week target at the end of Sep-22. National performance was 60.8% (Aug-22.)
- There were 8372 52 week breaches end of Q2 compared to 7392 at the end of Q1.
- Progress has been maintained in treating the longest waiting patients, and at the end of Sep-22 there were 26 patients waiting over 104 weeks (compared to 286 December-21), all of which are classified as patient choice, clinical reasons or due to the specialist nature of the pathway.
- The Risk cohort for patients whose 78 week breach date is before the 1st April has reduced by 5,165 (Circa 44%) in the last 10 weeks. Despite this reduction the numbers of patients currently waiting over 78 weeks has remained static at circa 1100.
- The Trust has plans to the manage the majority of the 78 week wait cohort by the end of the financial year however further plans are still required for a residual risk cohort of circa 750 patients. The plans focus on productivity improvements, internal additional capacity, mutual aid across Sussex and the use of the independent sector.
- There were 23,841 clock starts in Sep-22. The Trust commenced 20,820 definitive treatments Sep-22, 7% less than Sep-19. The waiting list grew by 989 patients in June to 118,754. The waiting list has grown by 6% since the end Jun-22. This is mirroring the national trend for increasing patients on the waiting list, and illustrates supply is not keeping pace with increased demand.

Cancer Performance Summary Q2

University Hospitals Sussex NHS Foundation Trust

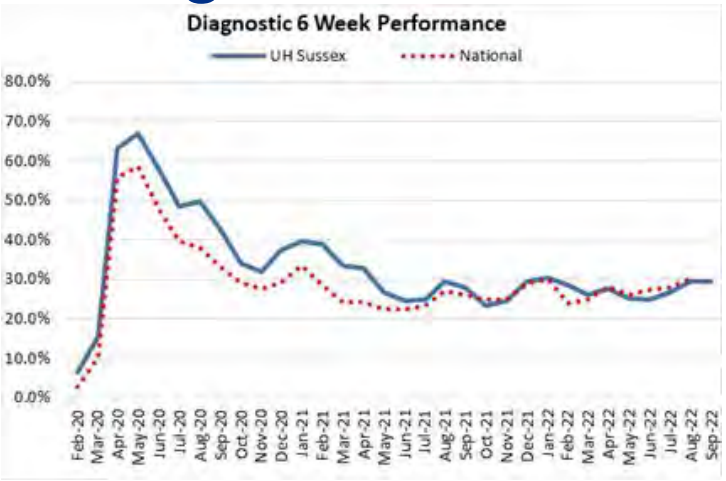
	2022/23			
	May-22	Jun-22	Jul-22	Aug-22
2ww	81.45%	70.29%	62.06%	62.55%
2ww Breast	82.83%	40.39%	13.67%	21.17%
31 day surg	70.00%	80.56%	75.00%	86.11%
31 day drug	100.00%	99.03%	98.78%	96.59%
31 Day - First	91.87%	92.72%	90.41%	90.56%
31 Day - Radiotherapy	89.50%	85.96%	83.93%	68.52%
62 Day - GP Refs	59.34%	52.62%	57.83%	55.19%
62 Day - Screening	78.89%	74.70%	52.13%	72.73%
62 Day - Upgrade	70.37%	67.59%	60.95%	61.32%
28 Day FDS	69.47%	68.15%	69.37%	66.79%

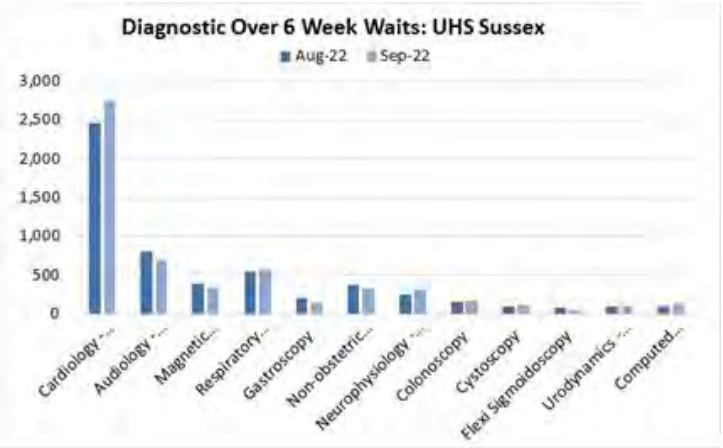


- Cancer 62 day cancer treatment targets were not met in Aug-22 with 55.2% starting treatment in under 62 days. National performance was 61.9%.
- There has been an increase in over 62 and 104 day prospective waits in Q2, from 534 at the end of Q1 to 714 at the end of Q2 for over 62 day patients, and from 120 patients at the end of Q1 to 161 at the end of Q2 for over 104 week waits.
- The Trust performance has deteriorated against the new 28 Day Faster Diagnosis Standard in Quarter 2, with performance at 66.8% Aug-22 due to capacity constraints particularly in the skin anatomical site. National performance was 69.5% Aug-22
- The key driver for this has been the significant increases in cancer referrals over the last quarter, with volumes +20% above 2019 levels UHSussex West, and +28% UHSussex East.
- In agreement with system colleagues a revised trajectory has been developed with the ambition to deliver the requirement of recovering 62 day prospective waits (to Feb-20 levels) and 75% for Faster Diagnosis Standards, by Jan-23.
- Improvements have been observed in October with a reduction in the numbers of patients waiting longer than 62 or 104 days for treatment and the revised trajectory has been met.

Diagnostic Performance Summary Q2

University Hospitals Sussex NHS Foundation Trust





- UHSussex diagnostic performance against the 6 week target deteriorated to 29.6% of patients waiting longer than 6 weeks for a diagnostic at the end of Q2 compared to 25.0% at the end of Q1. National performance was 30.5% (Aug-22)
- Performance was most challenged in the West with 34.8% of patients waiting longer than 6 weeks for a diagnostic at the end of Q2, a 2% increase from the end of Q1. This continued under-performance as a result of workforce constraints in key specialist diagnostic areas, and the impact of having to utilise areas such as Endoscopy and Cardiac Physiology to support inpatient surge capacity.
- Imaging, ECGs (Echocardiograms), and Neurophysiology have been most impacted by workforce constraints. High emergency pressures have also resulted in significantly higher demand for imaging services in particular.
- Plans are in place to increase service capacity at Worthing for Echocardioghraphy/
- Positively, clinical areas have been able to restart and increase diagnostic activity. In addition plans are continuing to expand capacity with Independent Sector and community diagnostic centres to support clearance of the backlogs.
- Some areas such as MRI, and gastroscopy have seen significant reductions in 6 week backlog since Mar-22

Summary and Forward Look 22/23

University Hospitals Sussex NHS Foundation Trust

- Performance in Q2 has been significantly challenged, but there has been good progress with mitiogation plans that are designed to address the continued pressures.
- Within Emergency care, work has continued with Sussex ICS partners to focus on both alternatives to A&E attendance, and the Trust has ‘gone live’ with additional UTC capacity which will enable increased clinical capacity in the departments to treat patients attending. The Trust is also conducting a pilot in Worthing A&E for booking patients into the UTC.
- The Trust is focussing efforts with partners to target MRD patients, and LOS for patients not on a complex pathway.
- The elective and cancer recovery plans are well developed and continue into Q2 22/23. Executive weekly scrutiny and system support have meant the Trust are on a strong footing to continue to reduce long waiting patients in 22/23. This enable the potential risks within them to be closely managed and early identification of mitigations to ensure that as many long waiting patients are treated as possible.
- The key risk remains the operational pressures relating to urgent elective and emergency demand and the impact of Covid-19 on the capacity and workforce across all areas of delivery.

University Hospitals Sussex
NHS Foundation Trust

System Oversight Framework

Integrated Performance Report Section

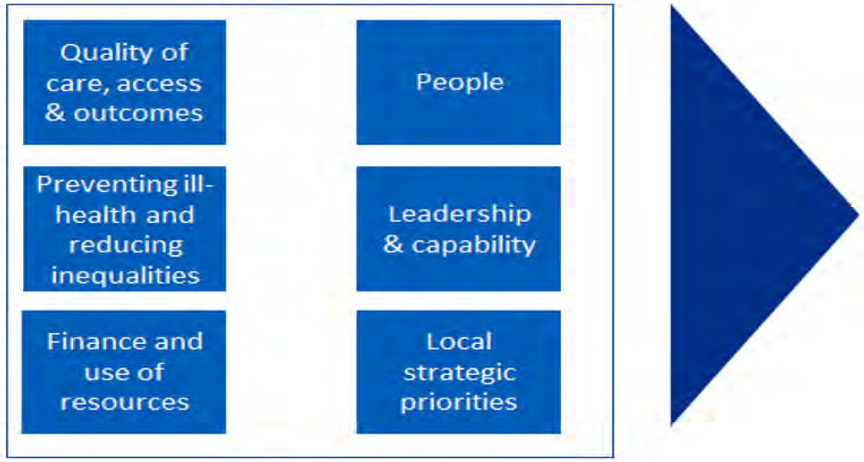
Systems Oversight Framework

University Hospitals Sussex NHS Foundation Trust

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

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

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



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

Systems Oversight Framework

University Hospitals Sussex NHS Foundation Trust

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

The oversight process follows an ongoing cycle of:

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

System Oversight Framework Q2 Position

University Hospitals Sussex NHS Foundation Trust

Trust's current rating

The Trust's position within the System Oversight Framework for Quarter 2 is Segment 3. The Trust's position for Quarter 3 has yet to be determined but it is likely the Trust will remain in Segment 3.

Implications of this segmentation

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

Actions being taken to move from segment 3

The move to segment 2 will be contingent on the Trust delivering its operational plan along with the agreed improvements following the recent CQC inspections

System Oversight Framework – Actions and Recommendations

University Hospitals Sussex NHS Foundation Trust

There are no actions required of the Board

The Board is asked to **NOTE** the Trust's segmentation rating of 3 for Quarter 2

The Board is asked to **NOTE** that the Trust's move to segment 2 will be contingent on delivery of the its operational plan along with any improvements required following the recent CQC inspections

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	13	**Meeting:**	Board	**Meeting Date:**	November 2022
Report Title:	Patient Committee Chair report to Board				
Committee Chair:		Jackie Cassell, Committee Chair			
Author(s):		Jackie Cassell, Committee Chair			
Report previously considered by and date:					
Purpose of the report:					
Information		☐	Assurance	✓	
Review and Discussion		☐	Approval / Agreement	☐	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		☐	Staff confidentiality	☐	
Patient confidentiality		☐	Other exceptional circumstances	☐	
Implications for Trust Strategic Themes and any link to BAF risks					
Patient	✓	Assurances in relation to risk 1.1			
Sustainability	☐				
People	☐				
Quality	☐				
Systems and Partnerships	☐				
Link to CQC Domains:					
Safe		☐	Effective	☐	
Caring		✓	Responsive	✓	
Well-led		✓	Use of Resources	☐	
Communication and Consultation:					

Executive Summary:

The Patient Committee met on the 1 November and was quorate as it was attended by four Non-Executive Directors, one Associate Non-Executive, the Chief Nurse, the Chief Medical Officer and the Chief People Officer. In attendance were the Director of Patient Experience, the Deputy Director of Engagement and Involvement and the Director for Improvement and Delivery, Assistant Director Patient Experience and Associate Director of Infection Prevention and Control.

The Committee received its planned items including the reports on the respective Patient First True North, Breakthrough, Corporate Project and Strategic Initiative, the quarter 2 patient experience report, the patient experience strategy and the 2021/22 patient experience annual report. The Committee also considered both the Corporate Risks with a potential patient impact and the BAF risk for which it has assigned oversight.

The Committee noted the delivery made in quarter 2 against the Trust's 2022/23 priorities for improving patient experience and was assured these are aligned to those areas within the developed Patient Experience Strategy. The Committee noted the resourcing challenges impacting on the capture of some elements of Friends and Family Test (FFT) data, but that these are scheduled to be resolved for December 2022.

The Committee noted the results from the National Adult Inpatient Survey report for 2021 relating to survey of patients who were discharged from hospitals in November 2021. The Trust's response rate was 38%, with the national average response rate being 39% supporting the usefulness of this feedback. The Committee reflected how the areas identified with the greatest improvement opportunity were aligned to the areas within the Patient Experience Strategy and correlated to the Trust's revised Patient Breakthrough Objective.

The Committee noted the detailed Committee oversight arrangements for each True North, Breakthrough Objective, Strategic Initiative and Corporate Project and the developments being made to the Strategy Deployment Process with the inclusion of a Hospital Strategy Development Review and the progress with the capacity building work within the Programme Management team.

The Committee discussed the Patient First Improvement methodology planned developments to support divisional engagement along with the enhanced linkage with the patient experience team to ensure the voice of the patient is central to the improvement project developments.

The Committee endorsed the Trust's Patient Breakthrough Objective Project Charter and the updated Project Charter for the Patient Strategic Initiative.

The Committee reviewed the Trust's key risks with the potential to impact on patient experience and noted those with the highest current score and their alignment to the Patient Strategic Risk which is maintained its score at 16.

The Committee also asked for an update to be provided on the work being undertaken to harness the value of the Trust's patient first methodology in respect of health inequality improvement actions.

Key Recommendation(s):

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

The Board is asked to **NOTE** both Committee's review and endorsement of the One UHSussex Corporate Project closure and absorption of the remaining actions to the Trust business as usual processes or through developed other corporate projects.

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

University Hospitals Sussex NHS Foundation Trust

COMMITTEE HIGHLIGHTS REPORT TO BOARD

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

Declarations of Interest Made

There were no declarations of interest made

Assurances received at the Committee meeting

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

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

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

2022/23 Quarter 2 Patient Experience Report

The Committee **RECEIVED** the quarter 2 report on the patient experience feedback and the actions taken as a result of this feedback. The Committee **NOTED** that the Trust report is providing data aligned to the clinical operating model as well as for friends and family results by area, A&E, Outpatients, Inpatients and Maternity. The Committee **NOTED** that the analysis undertaken in respect of the themes from these sources of feedback, reflecting that waiting specifically on site for treatment, communication and discharge all are areas for action within the patient experience strategy. The Committee also **NOTED** that the Friends and Family Test (FFT) satisfaction results for each of the four Emergency Departments had increased this month. The Committee **NOTED** that there had been data collection issues in respect of FFT feedback data for Worthing and St Richards inpatient and outpatient activity. The Committee was informed that this data should be collected from December 2022 with the building of a data capture interface. The Committee discussed the Trust's processes for hearing from our patients and communities outside the FFT feedback that will enhance Trust processes. The Committee **NOTED** the breadth of opportunities for the Trust to secure feedback which include peer reviews and within the improvement projects where the voice of the customer is sought.

The Committee was updated on the identified good practice reflected in the plaudits received which is shared widely so others can replicate these actions. The Committee **NOTED** the update from the Director of Experience, Engagement and Involvement and was **ASSURED** that the Trust remains committed to listening to all feedback and acting where improvements are required. The Committee **NOTED** the delivery in quarter 2 against the Trust's 2022/23 priorities for improving patient experience and was **ASSURED** these are aligned to those areas within the developed Patient Experience Strategy.

2021 National Inpatient Survey

The Committee **RECEIVED** the Adult Inpatient Survey report for 2021 relating to a national survey of patients who were discharged from hospitals in November 2021. The response rate from our patients was 38%, with the national average response rate being 39%. The report provided the meeting with information on the areas where the Trust performed well along with those areas where it performed relatively poorly to the national average. The Committee noted the areas with the greatest improvement opportunity were waiting times for admission, discharge including the information provided to those leaving, help with eating and noise at night. The Committee was **ASSURED** by the update from the Director of Experience, Engagement and Involvement that the areas raised are being addressed through specific actions, noting that communication of the survey findings is to be discussed with the Hospital Directors of Nursing to secure their support and engagement with the identified improvements.

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

The Committee **RECEIVED** the update on the delivery of the Trust's Breakthrough objective for 'Patient', this being the area where improvement action has the potential to have the largest positive impact on the True North. The Committee was updated on the data analysis undertaken to determine the key priorities for improving the experience of those patients waiting. The data analysis in respect of the areas for improvement correlated with the Trust's patient experience strategy and the Trust's priority refresh. The Committee **ENDORSED** the Breakthrough Objective project charter to improve communication with patients about their care. The Committee was updated by the Director of Patient Experience and Engagement on how this developing project plan is progressing and **NOTED** the immediate actions being undertaken, including the creation of a discharge placement staff to facilitate early discharge discussions with patients to aid their return and understanding of the steps in that process.

Strategic Initiative – Patient First Improvement Project

The Committee **RECEIVED** the update on the delivery of the Strategic Initiative where oversight is provided by this Committee, this being the Patient First Improvement Programme, from the Director of Improvement and Delivery. The update reminded the Committee of the Strategy Refresh which had been reported to Board and provided information on the respective Committee oversight arrangements for each True North, Breakthrough Objective, Strategic Initiative and Corporate Project. The Committee **NOTED** the developments being made to the Strategy Deployment Process with the inclusion of a Hospital Strategy Development Review along with established fortnightly patient first maturity huddles to support improving the focus is brought to the Trust's PFIS maturity levels following the implementation of the revised clinical operating model. The Committee **NOTED** the update from the Director of Improvement and Delivery on the Programme Management Office (PMO) capacity building actions. The Committee **NOTED** from the update that the PMO team has engaged with Patient Experience team to ensure that the voice of the patient (customer) is central to the developing improvement projects.

The Committee **ENDORSED** the revised Patient Strategic Initiative project charter on the Patient Frist Improvement Programme.

Corporate Project – One UHSussex

The Committee **RECEIVED** an update from the Director of Improvement and Delivery on the Committee's assigned Corporate Project, entitled the One UHSussex Programme, which was developed to support the launch of the revised clinical operating model. The Committee **NOTED** the actions delivered and **ENDORSED** the closure of this Corporate Project with the absorption of the remaining actions into the Trust's business as usual processes or through developed other corporate projects.

ICS and System Collaborations

The Committee **RECEIVED** an update from the Chief Medical Officer on the establishment of a forum for Chief Medical Officers / Chief Nursing Officers and Public Health which the Trust is actively engaged with. The Director of Experience, Engagement and Involvement also informed the Committee on the work that is being undertaken with the ICB to co-ordinate engagement with our population.

Reporting Groups

The Committee **RECEIVED** a report from the Chair of the Patent Experience and Engagement Group meeting, the Director of Experience, Engagement and Involvement in respect of the meetings that took place in July and September. The report provided an update on the activity of the group at these meetings with the Committee **NOTING** the alignment of this Group's work with the Patient Experience Strategy improvement

projects. The Committee **NOTED** that the Group referred no specific items for support to the Quality Governance Steering Group or the Committee itself.

The Committee **NOTED** that the Quality Governance Steering Group (QGSG) provides a formal detailed report to the Quality Committee but has a dual reporting line to this Committee. The Committee **RECEIVED** a verbal update from the Chief Medical Officer as chair of QGSG that confirmed there were no items referred to this Committee.

Risk and BAF

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

Across both of the patient and quality domains there are 26 risks for quarter 2, that have been raised that have the potential to have an impact on quality and or patient experience, which have been identified with a post-mitigation score of 12 or above. Of these risks there is one risk identified with a current risk score of 20, and four scoring 16 and six risk scoring 15. There has been a reduction in the number of risks scoring 20 in this quarter. The highest scoring risks relate are: -

- Risk 53 - Emergency Department capacity to meet demands leading to patients waiting in crowded areas leading to long waits.
- Risks 724, 93, 82, 49, 906 - Workforce pressures and staff vacancies impacting on the ability to meet patient experience expectations especially within escalation areas.
- Risks 1107, 908, 90 – availability of equipment.
- Risk 228, increased cancellations due to limited resources leading to long waits
- Risk 1051, relating to the Trust's ability to meet patient dignity with high levels of occupancy.

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

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

The Committee **AGREED** with the proposal that the new Research and Innovation Patient First domain will be overseen by this Committee in the short term.

Actions taken by the Committee within its Terms of Reference

The Committee **ENDORSED** the Trust's Patient Breakthrough Objective Project Charter and the Project Charter for the Patient Strategic Initiative.

The Committee **AGREED** to recommend the quarter 3 score for BAF risk 1.1 to the Board.

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

The Committee asked for an update on opportunities for patient engagement within the Trust's patient communications.

The Committee also asked for an update to be provided on the work being undertaken to harness the value of the Trust's patient first methodology in respect of health inequality improvement actions.

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

Item	Referred to
The Committee following a detailed discussion agreed to **RECOMMEND** to the Board that risk 1.1 within the BAF for which it has oversight are fairly represented.	Board Nov 2022

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	14	**Meeting:**	Board	**Meeting Date:**	November 2022
Report Title:	Quality Committee Chair report to Board				
Committee Chair:		Lucy Bloem, Committee Non Executive Chair			
Author(s):		Lucy Bloem, Committee Non Executive Chair			
Report previously considered by and date:					
Purpose of the report:					
Information		✓	Assurance	✓	
Review and Discussion		☐	Approval / Agreement	☐	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		☐	Staff confidentiality	☐	
Patient confidentiality		☐	Other exceptional circumstances	☐	
Implications for Trust Strategic Themes and any link to BAF risks					
Patient	✓	Links to risk 1.1			
Sustainability	☐				
People	☐				
Quality	✓	Assurances in relation to risk 4.1 and 4.2			
Systems and Partnerships	☐				
Link to CQC Domains:					
Safe		✓	Effective	✓	
Caring		✓	Responsive	✓	
Well-led		✓	Use of Resources	☐	
Communication and Consultation:					

Executive Summary:

The Quality Committee meets monthly and therefore this report covers three meetings in August, September and October 2022. The Meetings on 30 August, 27 September and 1 November (this being the October meeting) were quorate, attended by at least two Non-Executive Directors and two executives. In attendance at the meetings were the Trust's Medical Director, Deputy Chief Nurse, the Director of Patient Safety and Learning along with Director of Midwifery for the August and September meetings and the Associate Director of Infection Prevention and Control being present for the November meeting.

At each of the meetings in August, September and November the Committee received its planned items including the reports on the respective Patient First Trust Norths, Breakthrough Objectives, Strategic Initiatives and Corporate Projects, the developing quality scorecard, the perinatal quality surveillance dashboards including the national Ockenden report metrics, reports covering SIs and the respective learning and the duty of candour audit outcomes, and the report from the Committee's reporting group: Quality Governance Steering Group. In addition, the Committee received reports over the three meetings on a number of areas including organ donation, resuscitation, learning from deaths, safeguarding, infection prevention and control, mental health strategy development, the Trust's clinical harm reviews processes and the Trust's processes for undertaking Quality Impact Assessments for developed improvement projects. The Committee also considered both the Corporate Risks with a potential quality impact at each of its meetings and the Board Assurance Framework (BAF) risks for which it has assigned oversight at its meeting on 1 November.

The Committee in considering the **quality dashboard** noted the continuing improvement in the data completeness and the narrative. The Committee received an update on the risks to **Clinical Outcomes and Effectiveness** due to the capacity and restructure and the action plan that is in place.

In respect of the **perinatal quality surveillance (pqs)** dashboards the Committee noted the enhanced oversight these have brought to the Committee. Within the pqs dashboards the Committee noted that the data supports the low-risk maternity pathway at PRH. In October the **MBRRACE** (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries) **Perinatal Mortality Surveillance Report** Jan-Dec 2020 was received showing The Trust's overall perinatal mortality rate was between 5-15% lower than the group average. **Midwife Workforce Report** was received, and the Committee noted that progress had been made with SRH/WG is fully staffed but RSCH/PRH still having high vacancy rates. A review of **Medical obstetrician staffing** showed challenges in staffing at all levels and specific recruitment and rota challenges and this was referred to the People Committee. The Committee also noted the planned update to the format scheduled for early 2023 which will further enhance these as trend and statistical analysis will be shown.

The Committee on receiving the updates in respect of the Trust's required year four **Clinical Negligence Scheme for Trusts (CNST) self certification** noted the positive assurance provided by the Trust's Internal Auditors over the Trust's processes for its completion. The Committee recognised that work is underway to secure full compliance and within two of the required standards there is a risk that full compliance may not be achieved and escalated to the Board. The Committee noted the developed action plans for these standards and that these will be subject to further internal audit review

The **external mortality coding review** was commissioned in response to concerns regarding raised hospital mortality measures to provide the Committee with assurance over the accuracy of the Trust's clinical coding processes. The Committee noted that there had been changes made during covid which brought challenge into the coding process to secure a greater depth to the coding, but these have now been adjusted back to on site coding processes which facilitates higher levels of engagement between the coders and the clinicians.

The Committee on reviewing the **Quarter 2 learning from deaths report** noted that there needed to be a strengthened link to the Serious Incident Review Group in respect of the reported outcomes from the reviews undertaken through the medical examiner and structured judgement review processes. The Committee also asked that the report to Board be adjusted to make clear that there is a differentiated approach across the various sites which will be standardised over the next quarter for the oversight and review of deaths across the Trust's four sites.

From the report covering the Trust's processes for assessing **clinical harms** the Committee was assured over the process governance and noted that this is reviewed with the ICB. However further work is needed to strengthen links to the Trust's Serious Incident Review Group to enable learning to be cascaded across the Trust as well as coverage of the reviews in some areas. The Committee noted that based on the outcomes of previous reviews in respect of patients waiting in ED these have been paused with a focus being provided on dealing with the causes of these waits.

In the **Q1 Serious Incident** report the Committee noted 1 Never Event and a theme relating to venous thromboembolism (VTE) for which a thematic review will be completed in January.

The Committee supported the Trust's development of the **Mental Health Strategy** with system partners and agreed this supported the Trust's ambition to improve the quality of services for this cohort of patients.

The Committee considered the Trust's **annual children and adults safeguarding reports** and following their presentation to the Committee by the safeguarding team endorsed their onward reporting to the Board for their information. Of note was the significant increase in mental health related cases and detainments- this is reflected in the risk report overseen by the Committee.

The Committee considered the Trust's **annual organ donation** report agreed that it matched the information provided by the specialist team and therefore should be presented to the Board for their information.

The Committee discussed and reviewed the action plans that have been developed for Maternity, Surgery RSCH and ED RSCH resulting from **CQC** inspections noting how the plans have been developed and that one, Surgery will become a corporate project.

The Committee received a report on the Trust's **quality impact assessment** processes, recognising the level of oversight provided by the quality impact assessment panel led by the Chief Medical Officer or Chief Nurse. The Committee noted there were no improvement schemes being progresses with a high-quality risk and evidence was shared that schemes had been rejected or revised to reduce risk.

The Committee endorsed the Trust's **Quality Breakthrough Objective Charter**, **Strategic Initiative Charter** and the **two Corporate Project Charters**.

The Committee reviewed the **Trust's key risks** with the potential to impact on quality and noted there had been an increase in risks scoring 20, seeing eight scoring 20 at quarter 2. The Committee had a discussion on the **BAF** and the respective risks it has assigned oversight, this being risks 4.1 and 4.2. The Committee reflected on the information received during the meetings in respect these risks along with the update provided post the review by the Audit Committee and agreed these risks were fairly stated noting these risks would remain under active review given the operational and workforce pressures facing the Trust.

Key Recommendation(s):

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

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

The Committee received the Adult Safeguarding and Child Safeguarding 2021/22 Annual Reports and **RECOMMENDED** these to the Board (Attached as an appendix to this main report).

The Committee received the Trust's Annual Organ Donation Report for 2021/22 and **RECOMMENDED** this to the Board. (Attached as an appendix to this main report).

The Committee **RECOMMEND** the report to the Quarter 2 learning from deaths report to the Board subject to the final report reflecting the recognition of a differentiated approach across the various sites which will be standardised over the next quarter including these processes linking to the Serious Incident Review Group oversight for learning. (This updated report is included within the co sec report to the Board)

NHS
University Hospitals Sussex
NHS Foundation Trust

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Dates	Chair	Quorate	
			yes	no
Quality Committee	**30 August 2022, 27 September 2022 and 1 November 2022**	**Lucy Bloem**	✓	☐

Declarations of Interest Made

There were no declarations of interest made

Assurances received at the Committee meeting

Quality Dashboard

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

At each meeting the Medical Director took the Committee through the Quality scorecard narrative in respect of the dashboard segments covering the domains of mortality, clinical outcomes and effectiveness, patient safety and patient experience. Between August and October reports, there was improvement in the data flows into the quality scorecard and gaps in data continue to reduce. The Committee **NOTED** that with the development of the dashboard will take a step change forward from early 2023 with the use of Power BI tool.

The Committee at each meeting discussed the key elements within Patient Experience relating to complaints remaining high, predominantly due to long waits as well as the continued caseload pressure on the complaints team. The Committee **NOTED** the transition to a new Friends and Family Test provider had impacted the data flow to the quality scorecard from the SRH and WH hospital sites.

The Committee at each meeting discussed the key elements relating to Patient Safety trends in incident learning as well as the Trust's performance in associated processes around incidents including the timeliness of incident investigation and adherence to duty of candour. The Committee **NOTED** the supporting reports in respect of incident investigation and the reports in respect of the reduction in harms breakthrough objective.

The Committee **NOTED** within the scorecard reported progress around Clinical Outcomes and Effectiveness with measures of compliance with NICE guidance the range of national clinical audits, local clinical audits, National Confidential Enquiries and Stroke audits (SSNAP) as well as the arrangements within the team. The Committee **NOTED** that all clinical effectiveness support processes are under significant resource and capacity pressures due to a period of restructure coinciding with considerable vacancies. The Committee **ENDORSED** that the impact on these assurance processes is reflected as a risk on the Corporate Risk Register.

The Committee NOTED the scorecard listed Mortality measures and the supporting reports it receives in respect of mortality performance, the external review and assurance in respect of the Trust's coding.

Maternity

At each meeting the Committee **RECEIVED** reports in respect of the Trust's Perinatal Quality Surveillance Reports & Dashboards for all four of its maternity units, which included the Ockenden data sets within the current dashboards. The Committee considered each of the dashboards across each of the domains of; learning from any deaths or incidents where the medical Director cross referred to the information within the

incident and learning from deaths reports; training which had seen an improved position in respect of staff undertaking their training; and the voice of the patient where the Committee was reminded that information in respect of the Trust's friends and family rates and resultant actions are reported to the Patient Committee. The Committee **NOTED** the information within the reports and the associated dashboards.

Through receipt of reports the Committee was **ASSURED** that the Maternity Directorate continue to report neonatal deaths and engages with the Healthcare Safety Investigation Branch (HSIB) as required The Committee **NOTED** that Trust wide deaths and harm are generally lower than national rates and averages using the MBRRACE national benchmarking which allow for high and lower risk pathways. The Committee was **ASSURED** of the continued embedding of learning within integrated safety and quality processes within the Women and Children's division and were pleased to hear of the high level of engagement with the daily safety huddles across all four sites and weekly listening events continue.

The Committee **NOTED** the medical staffing challenges, particularly at RSCH and PRH due to vacancies and sickness and the improvements being made in respect of levels of training, and the challenges the lower levels of training within the anaesthetists staff cohort provides a challenge for the Trust's confirmation with the CNST year four safety standards.

The Committee **NOTED** that across the Trust there is an extensive programme of digital works planned for 2022/23. The Committee at its September meeting received an update on the Maternity Digital Strategy and **ENDORSED** that Maternity will utilise the Trust's main Digital Strategy rather than develop a separate Strategy.

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

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

Reducing Harm

The Director of Patient Safety and Learning provided an update on the True North in relation to harms and in **RECEIVING** these reports reflected on the processes for the management of incidents and through the updates at each meeting was **ASSURED** over the Trust's continuing focus on learning through the information provided and the Trust's processes to support families through the investigation process.

The Committee was updated on the Trust's mobilisation for the revised patient safety incident response framework, to ensure the Trust is delivering this from April 2023. At each of the meetings, the Committee **RECEIVED** through the updates from the Director of Patient Safety and Learning on the associated breakthrough objective aligned to the True North on Harm. The Committee was updated on the data analysis undertaken to determine the key priorities for reducing the level of harm whilst maintaining a strong reporting culture. The Committee **NOTED** this update and recognised that further information on the outcome of these actions would routinely flow through the updates provided to the Committee. The Committee was **ASSURED** over the operation of the patient safety group, which including external partner ensures the Trust's processes is transparent

Clinical Harms

The Committee **RECEIVED** a report from the Medical Director on the Trust's harm review processes in its November meeting. The Chief Medical Officer also provided an update in respect of harm reviews linked to patients waiting in ED, the Committee reflected on the review that was undertaken and overseen by the Chief Medical Officer reviewing those wasting over 12 hours. The review considered cases during a of 6 months period and concluded there was no causal links of the waits on the patients' outcomes. As a result of that review focused on the RSCH ED and with the agreement of the ICB individual harm reviews for those waiting over 12 hours in ED has been paused with the Trust focusing on addressing the drivers of the waits. The Committee also **NOTED** that the cases subject to the harm reviews had been triangulated with reported incidents and again no issues were identified as being causes by any wait. The Committee noted that based

on the outcomes of previous reviews in respect of patients waiting in ED these have been paused with a focus being provided on dealing with the causes of these waits.

In respect of the review of the longest waits for patients to receive their planned care and the ICB has confirmed that Trust's sampling methodology and reviews process is satisfactory. The Committee **NOTED** that the harm reviews are to be extended form looking purely at physical harm to include an assessment of psychological harm. A tool for this assessment is being developed with the ICS. The Committee **NOTED** that whilst no significant harms were identified the report did provide evidence of changes being made as a result of the work which are reducing waits for future patients.

The Committee was **ASSURED** over the processes followed and their alignment to the national guidance and the process governance, but that further work is needed to strengthen their links to the Trust's Serious Incident Review Group to enable learning to be cascaded across the Trust

Mortality

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

The Committee **RECEIVED** at its November meeting the preliminary report in respect of the external mortality coding review. The Committee noted the **ASSURANCE** this report provides along with the update provided by the Medical Director provided over the Trust's clinical coding processes. The Committee **NOTED** the information this review provided in respect of the changes made during covid which brought challenge into the coding process, and whilst the accuracy of coding remained, the depth of coding from discharge summaries only is less. The Committee **NOTED** the coding processes have now been adjusted back to on site coding processes which will facilitate higher levels of engagement between the coders and the clinicians to support with the depth of coding. The Committee **NOTED** the lag in national reporting and therefore endorsed the Trust's decision to review the depth of coding monthly to provided confidence that actions being taken are being sustained. The Committee reflected that the final report on coding would be reported back to the Committee along with fuller detail in respect of the PRH outlying data.

The Committee **NOTED** that the new Breakthrough Objective around the Deteriorating Patient which is being mobilised from September 2022 provides particular focus on the work to ensure improvements are made in this area.

The Committee **RECEIVED** the Learning From Deaths reports from Quarter 2 for 2022/23 as well as the 2021/22 annual report, noting the prior year annual report information has been received at Board previously. The quarterly report showed similar themes to the coding review identified matters. While there was considerable variation between sites and examples of poor care, there had been good governance in the process of reporting and for learning. The Committee was **ASSURED** over the process applied and the drive for the identification of learning and its cascading across the Trust through the Trust's medical examiner reviews leading then to Structured Judgement Reviews as required. The Committee **NOTED** the addition to the report of the learning action tracker which gives confidence that the focus is maintained on learning, noting that cross site learning meetings are being undertaken. The Committee **NOTED** that there is some difference in the depth of information across the four sites and the combined oversight to be provided by a single learning from deaths manager will bring a consistent process to secure a depth to the reviews and information to

support the comparability of the outcomes from the reviews of deaths. The Committee asked that a review of deaths of any patients with Learning Disabilities at RSCH and PRH is undertaken for the previous 12 months. The Committee noted that the Quality Governance Corporate project will look at the resources and processes being applied to bring consistency and link to SIRG to ensure that these processes are aligned and linked together.

Quality Priority Project Charters

The Committee **RECEIVED** the developed project charters for the Quality Breakthrough Objectives (harms reductions), Corporate Projects (General Surgery and Quality Governance Effectiveness) and the revised charter for the Strategic Initiatives (clinical strategy). The Committee **ENDORSED** these charters and their alignment to the Trust's strategic priorities refresh for 2022/23 – 2023/24.

The Committee **NOTED** the actions taken in respect of the Surgery Corporate Project form the development of the charter and was encouraged with the pace in commencing this improvement project and the level of engagement across the service with this project.

Clinical Negligence Scheme For Trusts (CNST) Maternity Incentive Scheme

In each of the meetings the Committee **NOTED** progress against CNST year 4 is underway for submission of evidence prior to January 2023. The Committee **NOTED** that the Trust's internal auditors, BDO, had been engaged to review the process of evidence capture prior to submission and had provided an initial positive conclusion on the Trust's processes and they have confirmed the Trust's identified risk. The Director of Maternity and Deputy Chief Nurse confirmed that there would be clear touch point dates throughout 2022 to substantiate the evidence ahead of the revised submission deadline of February 2023.

Two safety standards have been assessed by the Trust as requiring further work to achieve compliance by the year end, BDO have confirmed that there are no other areas of concern. The Committee **NOTED** the actions in train to meet the safety standards and the oversight process established to allow the final declaration to be made. The Committee recognised that there remains a risk to full compliance and that oversight will be maintained.

VTE

The Committee **RECEIVED** an update from the Director of Patient Safety and Learning in respect of the work into the VTE patient risks, this is being undertaken as a thematic review with a multi-disciplinary approach being undertaken to offer the best opportunity for the identification of learning across the Trust. The Chief Medical Officer reflected the benefit of taking a wider review that specific individual incident reviews and confirmed this is in line with the Patient Safety Incident Response Framework and will enhance the depth to the action and learning plan.

Mental Health

The Committee **RECEIVED** at its meeting in November an update on the developing Mental Health Strategy. The Medical Director provided the Committee with the work undertaken with system partners to develop this Strategy. The Committee **NOTED** the linkage of this work to the Trust's ambition for this cohort of patients and how the Strategy was aligned to the Patient First Domains where improvements will be realised through the developing implementation plan for this Strategy. The Committee **ENDORSED** the strategy and asked that in respect of oversight of this strategy then work should be considered to add a subset of metrics into the Quality Dashboard. The Committee **NOTED** this document is to be shared with the partners lead through the planned meeting with SPFT.

Quality Impact Assessments

The Committee **RECEIVED** the report in respect of the Quality Impact Assessment process applied for the schemes within the Trust's efficiency programme. The Committee **NOTED** that there were no high risk assessments referred to the Committee recognising the robust screening of quality risks being applied as the schemes are developed. The Committee **NOTED** the work of the QIA panel and was **ASSURED** through the panel's membership which include the senior clinical leadership including the Chief Nurse or Chief Medical Officer or their deputies and **ENDORSED** the panel's recommendation to progress with the 140 projects as they all have a lower level of quality risk, noting that any change in these scheme risks these would be reported to the Committee directly.

Safeguarding

At the meeting in August the Committee **RECEIVED** the annual reports for safeguarding and in receiving these the Committee acknowledged the considerable work undertaken to present joint annual reports for Adults and Children's Safeguarding activity for the year 2021-2022.

The Committee **NOTED** that the Trust the Integrated Safeguarding Strategy Committee, meets quarterly and gains assurance that all safeguarding commitments and responsibilities for both adults and children are met. It oversees the work of the Safeguarding Adults Operational Group and Safeguarding Children Operational Group. It further seeks assurance that there are suitable processes in place to ensure that safeguarding arrangements are reviewed and updated on a regular basis through the Work Plans and those actions are completed within agreed timescales and reviewed on a regular basis. The Committee was **ASSURED** that these meetings were taking place.

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

The Committee **RECEIVED** and **NOTED** the Children's Safeguarding Annual Report that drew out the details of how the Trust responds to the statutory requirements, national guidance and events and outlines the safeguarding achievements from 2021 – 2022 and demonstrates the priorities for 2022 – 2023.

The Committee **NOTED** that there was increasing complexity and demand within the health and care system, particularly for young people requiring specialist mental health placements. There had been 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 had created significant challenges for children, young people, families and staff involved. The number of children detained under the Mental Health Act had doubled over the year. The Committee **NOTED** the serious incidents and complaints that relate to children and young people with mental health issues including eating disorders. The safeguarding team have met with families and worked with the complaints team.

The Committee was **ASSURED** that the Trust participates in child death reviews led by the acute child death leads for Worthing and St Richards hospitals and supported by the child death administrator, in accordance with statutory guidance. There were sadly 33 deaths of which 12 were neonatal and 22 children, during the year 2021-2022. The full oversight of child deaths was provided by the Sussex Child Death Overview Panel (CDOP).

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

Infection Prevention and Control (IPC)

The Committee **RECEIVED** the quarter 1 2022/23 IPC report from the Director of Infection Prevention and Control at its meeting in September. There was particular focus on the flu vaccination programme coinciding with covid-19 vaccinations given the anticipated significance of these areas to the Trust's winter pressures.

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

Care Quality Commission

The Committee **RECEIVED** updates from the Chief Nurse on the responses to the re-inspection of maternity services across the Trust and surgery at RSCH as well as the new inspection of the Emergency Departments in April 2022. The Committee **NOTED** the improvement plans and updates on the actions

In relation to the ED improvement plan, the Committee acknowledged the Trust wide challenges around patient flow that become most apparent on pressure building within the emergency department. The Committee questioned the patient boarding policy and the risks associated with patient flow and bed availability. The Committee **NOTED** that further mitigating actions are required to ease this pressure point noting that information in respect to this improvement project was presented to the Board.

In the meeting in November the Committee **RECEIVED** a further update on the working relationships with the CQC and **NOTED** that the reports from the recent inspections including well led is still awaited. The Committee asked that for future updates that a tracking report be provided showing the delivery of the actions and where the direct oversight for their delivery would occur, citing that the surgery corporate project would be expected to cover those from the RSCH Surgery inspection.

Committee Reporting groups

At each meeting in August, September and November the Committee **RECEIVED** an update from the Chief Medical Officer on work of the Quality Governance Steering Group (QGSG) at its preceding meetings detailed within the formal report provided to the Committee. The Chief Medical Officer confirmed that the agenda of the QGSG continued to be aligned to the work of this Committee and the key quality risks. The Committee were asked to **NOTE** that a review of divisional risks 12> had been undertaken. The consideration of risks linked to staffing challenges in the clinical effectiveness team was noted.

At the November meeting, the Committee noted the work taken to improve the timeliness of complaints responses, referencing this is covered in Patient Committee. The Committee **RECEIVED** information from the Chief Medical Officer on the work undertaken at each Division in respect to the Clinical Outcomes and Effectives and **NOTED** that a monthly meeting frequency would be maintained for Clinical Effectiveness and Outcomes to provide oversight of the actions being taken to address the risks added in respect of Clinical Effectiveness which were discussed at the prior meetings.

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

Risk and BAF oversight

The Committee **RECEIVED** and discussed the Corporate Risk Register report at each meeting which provided information in respect of those corporate risks with a potential quality impact. Within the November meeting

the Committee considered the risks recorded in October 2022 across the quality domain the Committee which have been identified with a post-mitigation score of 12 or above. The Committee gave greater consideration of the eight of these identified risks which had a current risk score of 20, noting there has been a slight increase from the prior reporting period, but recognising the transfer to the new datix system has allowed all risks to be reviewed and their scores updated on transfer. These highly scored risks are summarised below as:

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

The Committee recognised the interlinkages of the quality risks with those within the People and Patient domains.

The Committee had a discussion on the BAF and the respective risks it has assigned oversight, this being risks 4.1 and 4.2. The Committee reflected on the information received during the meeting in respect these risks along with the update provided post the review by the Audit Committee. The Committee **AGREED** given both the direct review of the BAF and the supporting corporate risk report that the current score for BAF risks 4.1 and 4.2 were fairly stated as well as being supported by the information received within the meeting. The Committee noted these risks would remain under active review given the operational and workforce pressures facing the Trust.

Actions taken by the Committee within its Terms of Reference

The Committee **AGREED** to recommend the quarter 2 score for BAF risks 4.1 and 4.2 to the Board

The Committee received the Adult Safeguarding and Child Safeguarding 2021/22 Annual Reports and **RECOMMENDED** these to the Board.

The Committee received the Trust's Annual Organ Donation Report for 2021/22 and **RECOMMENDED** this to the Board.

The Committee **ENDORSED** the Trust's Quality Breakthrough Objective Charter, Strategic Initiative Charter and the two Corporate Project Charters.

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

The Committee sought information in respect of the Trust's Stroke Sentinel National Audit Programme performance and the actions being undertaken to improve the performance at St Richards and Worthing.

The Committee referred to QGSG that they should continue to provide oversight of the 12 – 16 divisional scored risks.

The Committee reflected that it has within its cycle of business it will receive a report in relation to end of life care and this update will be provided to a meeting in January.

Items referred to the Board or another Committee for decision or action	
Item	**Referred to**
The Committee following a detailed discussion agreed to **RECOMMEND** to the Board that risks 4.1 and risk 4.2 within the BAF for which it has oversight are fairly represented.	Board Nov 2022
The Committee received the Adult Safeguarding and Child Safeguarding 2021/22 Annual Reports and **RECOMMENDED** these to the Board.	Board Nov 2022
The Committee received the Trust's Annual Organ Donation Report for 2021/22 and **RECOMMENDED** this to the Board.	Board Nov 2022
The Committee **RECOMMEND** the report to the Quarter 2 learning from deaths report to the Board subject to the final report reflecting the recognition of a differentiated approach across the various sites which will be standardised over the next quarter including these processes linking to the Serious Incident Review Group oversight for learning.	Board Nov 2022

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Agenda Item:	10.	**Meeting:**	Quality Committee	**Meeting Date:**	30 August 2022
Report Title:	Actual and Potential Deceased Organ Donation 1 April 2021 - 31 March 2022				
Sponsoring Executive Director:	Dr Rob Haigh, Chief Medical Director				
Author(s):	Alex Harrison, Clinical Lead for Organ Donation (RSCH PRH)				
Report previously considered by and date:	QGSG 25 July 2022				

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

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

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

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

Communication and Consultation:

Executive Summary:

This report provides an update on the Annual Organ Donation report for 2021/22, the Trust achievements, priorities, consent rates and external reporting updates.

Key Recommendation(s):

For the Committee to note the data within the report.

Actual and Potential Deceased Organ Donation 1 April 2021 - 31 March 2022

NHS Blood and Transplant

University Hospitals Sussex NHS Foundation Trust

Taking Organ Transplantation to 2020

In 2021/22, from 43 consented donors the Trust facilitated 34 actual solid organ donors resulting in 83 patients receiving a life-saving or life-changing transplant. Data obtained from the UK Transplant Registry.

In addition to the 34 proceeding donors there were 9 consented donors that did not proceed.

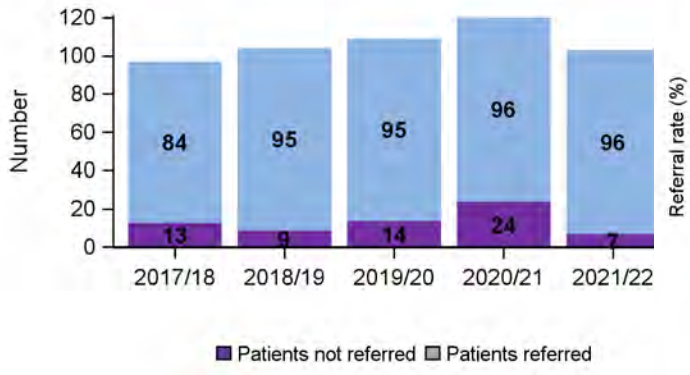
Best quality of care in organ donation

We acknowledge that the data presented in this section includes the period most significantly impacted by COVID-19 and appreciate that the COVID-19 pandemic affected Trusts/Boards differently across the UK.

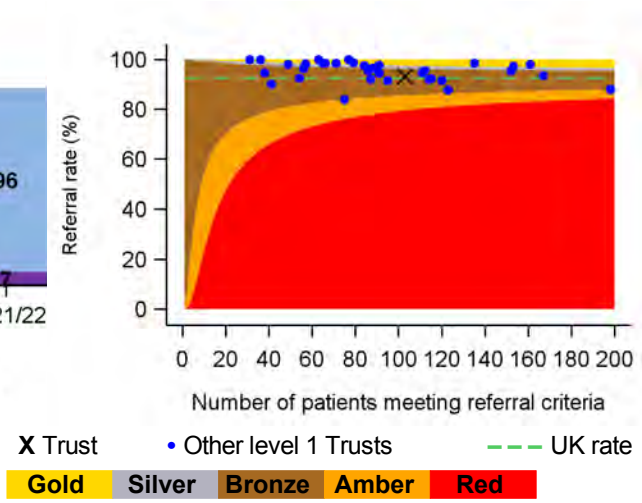
Referral of potential deceased organ donors

Goal: Every patient who meets the referral criteria should be identified and referred to NHS Blood and Transplant's Organ Donation Service

Aim: There should be no purple on the chart



Aim: The Trust (marked with a cross) should fall within Bronze, Silver, or Gold

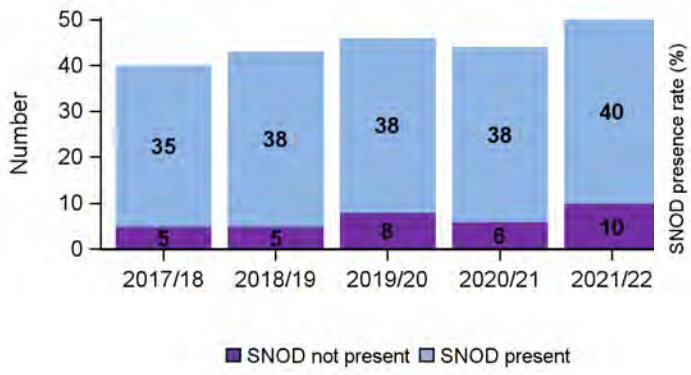


The Trust referred 96 potential organ donors during 2021/22. There were 7 occasions where potential organ donors were not referred.

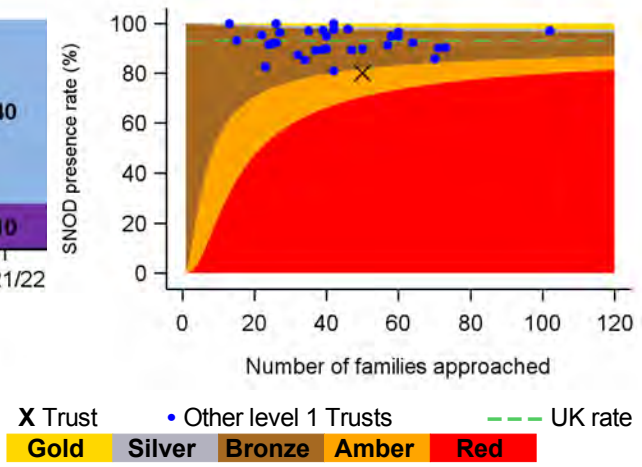
Presence of Specialist Nurse for Organ Donation

Goal: A Specialist Nurse for Organ Donation (SNOD) should be present during every organ donation discussion with families

Aim: There should be no purple on the chart



Aim: The Trust (marked with a cross) should fall within Bronze, Silver, or Gold



A SNOD was present for 40 organ donation discussions with families during 2021/22. There were 10 occasions where a SNOD was not present.

Why it matters

- If suitable patients are not referred, the patient's decision to be an organ donor is not honoured or the family does not get the chance to support organ donation.
- The consent rate in the UK is much higher when a SNOD is present.
- The number of patients receiving a life-saving or life-changing solid organ transplant in the UK is increasing but patients are still dying while waiting.

Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	South East Coast*	UK
1 April 2021 - 31 March 2022		
Deceased donors	90	1,397
Transplants from deceased donors	179	3,410
Deaths on the transplant list	19	422
As at 31 March 2022		
Active transplant list	317	6,269
Number of NHS ODR opt-in registrations (% registered)**	2,197,695 (47%)	27,751,289 (43%)

*Regions have been defined as per former Strategic Health Authorities
** % registered based on population of 4.63 million, based on ONS 2011 census data

Further information

Further information on potential donors after brain death (DBD) and potential donors after circulatory death (DCD) at the Trust are shown below, including a UK comparison. Data obtained from the Potential Donor Audit (PDA).

Key numbers, rates and comparison with UK data, 1 April 2021 - 31 March 2022

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	33	1919	74	5198	103	6767
Referred to Organ Donation Service	33	1894	67	4700	96	6258
Referral rate %	G *100%*	*99%*	B *91%*	*90%*	B *93%*	*92%*
Neurological death tested	25	1530				
Testing rate %	B *76%*	*80%*				
Eligible donors[2]	22	1373	49	2972	71	4345
Family approached	21	1239	29	1445	50	2684
Family approached and SNOD present	19	1188	21	1306	40	2494
% of approaches where SNOD present	B *90%*	*96%*	A *72%*	*90%*	A *80%*	*93%*
Consent ascertained	17	861	24	902	41	1763
Consent rate %	B *81%*	*69%*	S *83%*	*62%*	S *82%*	*66%*
- Expressed opt in	12	522	19	550	31	1072
- Expressed opt in %	*100%*	*95%*	*91%*	*90%*	*94%*	*92%*
- Deemed Consent	4	260	5	267	9	527
- Deemed Consent %	*67%*	*63%*	*71%*	*56%*	*69%*	*59%*
- Other*	1	78	0	83	1	161
- Other %*	*100%*	*66%*	*0%*	*47%*	*50%*	*55%*
Actual donors (PDA data)	15	787	19	602	34	1389
% of consented donors that became actual donors	*88%*	*91%*	*79%*	*67%*	*83%*	*79%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

* Includes patients where nation specific deemed criteria are not met and the patient has not expressed a donation decision in accordance with relevant legislation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

Gold | Silver | Bronze | Amber | Red

For further information, including definitions, see the latest Potential Donor Audit report at www.odt.nhs.uk/statistics-and-reports/potential-donor-audit/

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Organ Donation

QUALITY COMMITTEE AUGUST 2022

ALEX HARRISON – CLINICAL LEAD FOR ORGAN DONATION (UHSx EAST)

Organ Donation

- Regulated by NHSBT / HTA / CQC
- Externally funded by NHSBT
- Monitored by NHSBT – the Potential Donor Audit

- Legacy committees across the Trust continue, but now with an overarching Steering Group for the whole Trust
- Standing Agenda:
  - PDA and Trust Report
  - Stretch Goals
  - Budget
  - Matters arising from legacy ODC meetings

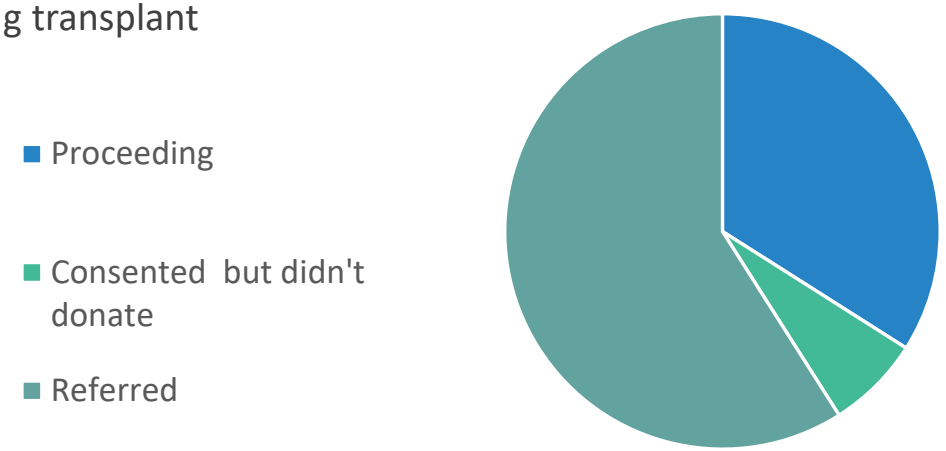
Committee changes

- Created one effective committee for oversight of organ donation at the Trust – unifying the two sides of the trust, sharing good practice, and developing cohesive policies
- New lay chairs at both sides of the trust
- New appointment of deputy CLOD (UHSx East)
- Appointment of the only two trainee representatives in organ donation (TRODs) in the South East Region
- Supporting Research in Organ Donation
  - SIGNET trial (RSCH only)

External Report - NHSBT 2021/22

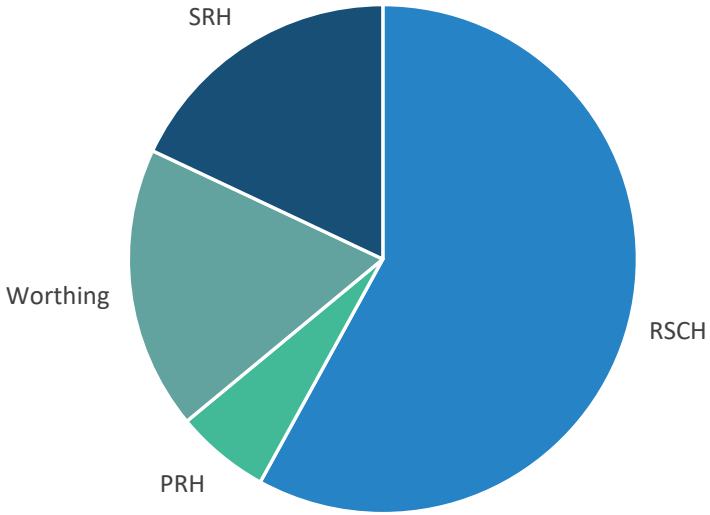
From 41 consented donors, University Hospitals Sussex NHS Foundation Trust facilitated:

- 34 actual solid organ donors
- resulting in 83 patients receiving a life-changing transplant

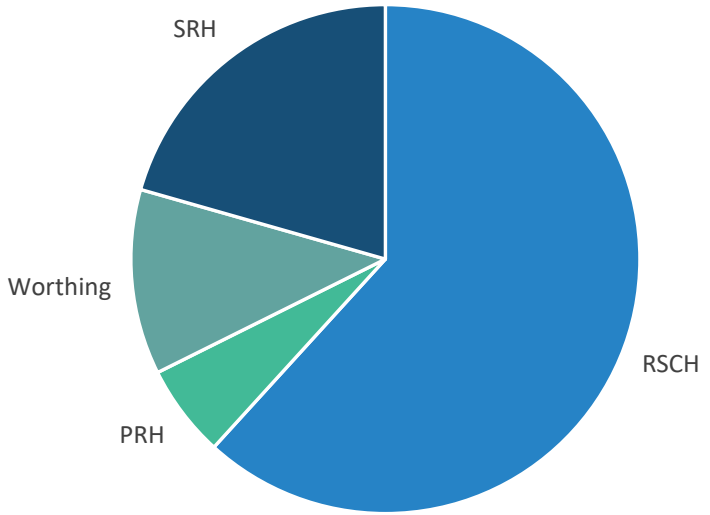


Site-specific workload

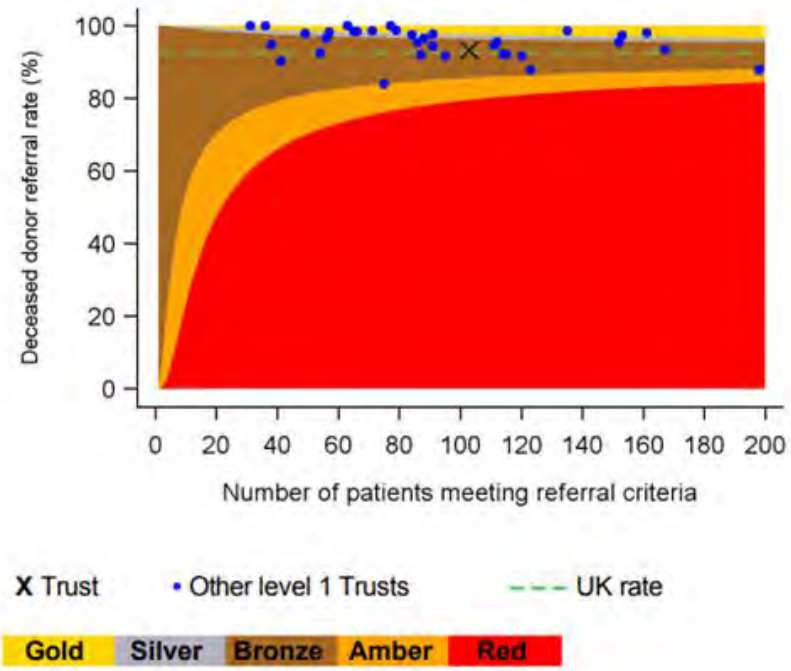
Referrals to SNOD



Proceeding donors

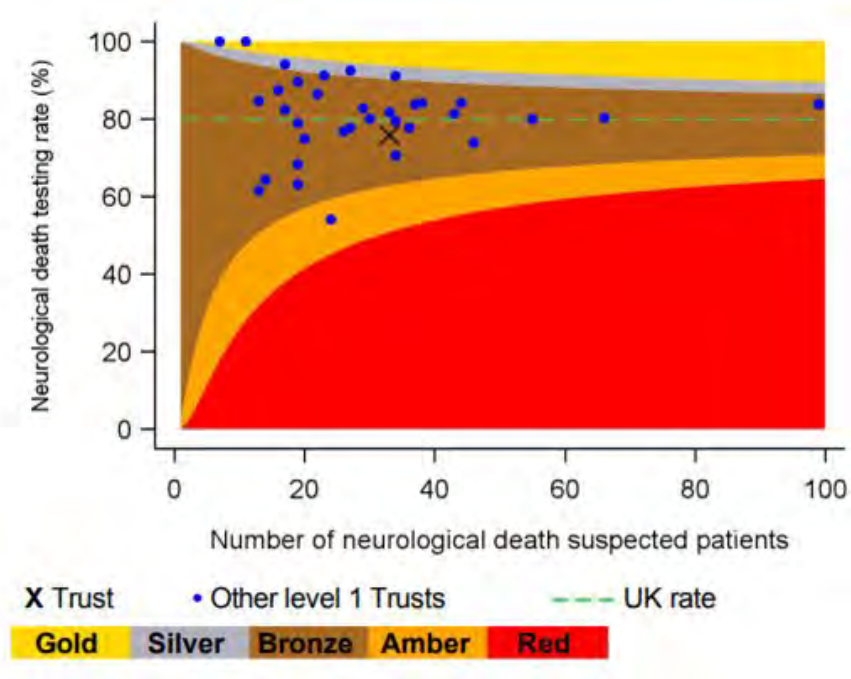


Referral of potential deceased organ donors

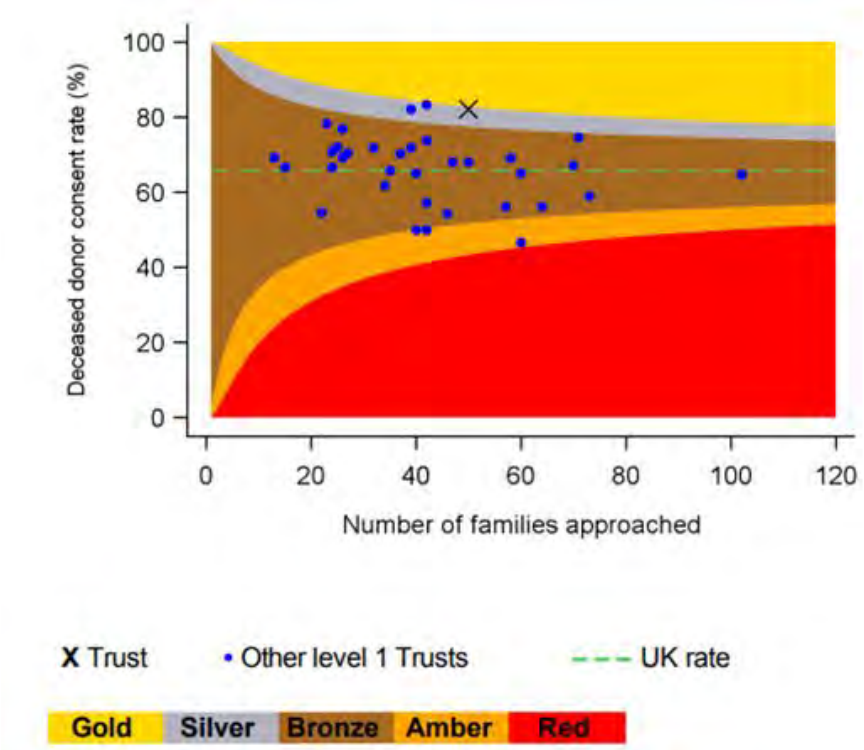


- DBD 100% / DCD 91%

Neurological death testing

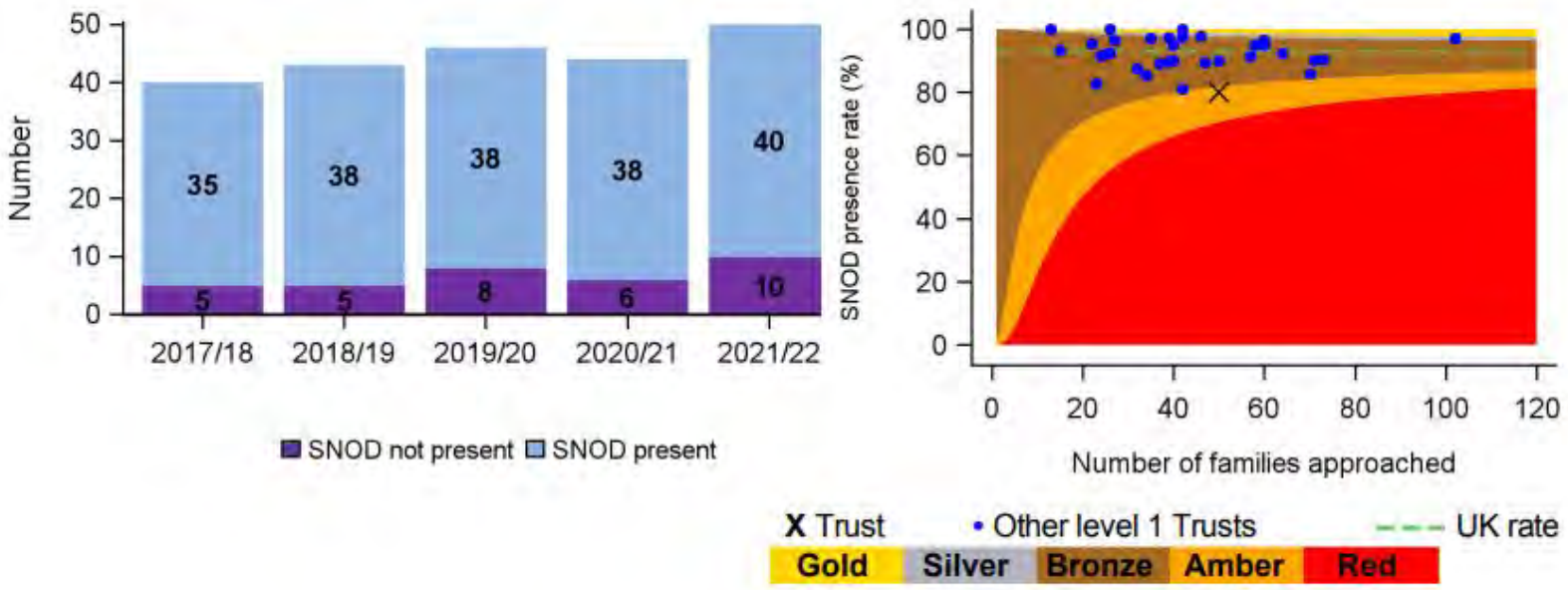


Consent rates



- DBD 81% / DCD 83%

SNOD presence at organ donation discussions



Summary

- Good or excellent outcomes for our audited deceased donation activity
- Changes to oversight structure with Trust merger
- New committee members
- South East regional ‘Stretch Goal’ of 100% SNOD presence during every organ donation discussion with families
- Need parity between sites around priority access to theatres for donation cases
- Need parity between sites regarding celebration of donation, especially public artwork in 3Ts

University Hospitals Sussex
NHS Foundation Trust

Safeguarding Children & Looked after Children Annual Report 2021-2022

Prepared by;

Catherine Coppard (Lead & Named Nurse Safeguarding Children Worthing and Chichester Hospitals)

Debi Fillery (Nurse Consultant & Named Nurse Safeguarding Children Brighton & Haywards Heath Hospitals)

Contents

1. Introduction and Executive Summary

The Safeguarding Annual Report provides details of how University Hospitals Sussex NHS Foundation Trust (UHSFT) has responded to its statutory responsibilities, national and local guidance, safeguarding partnership work and improvement work for 2021/22.

This is the first joint children's safeguarding annual report for University Hospitals Sussex NHS foundation trust (UHSFT) since the organisation was formed in April 2021. The safeguarding teams are working together to develop safeguarding within the newly formed trust however as this is a gradual process, for this year's annual review sections will be presented in the report as UHSFT- Brighton & Haywards Heath; (Royal Sussex County Hospital, Royal Alexandra Hospital and Princess Royal Hospital) and UHSFT- Worthing & Chichester (Worthing & Southlands and St Richard's Hospital). Some of the data sets are arranged slightly differently.

This report outlines the structures and processes for safeguarding children and looked after children and how these relate to wider safeguarding children arrangements within the trust. The report also reviews children's safeguarding and looked after children activity and outlines relevant safeguarding children guidance, policy and priorities for the forthcoming year at USHFT.

Safeguarding children at the trust adheres to the standard that the 'welfare of children is paramount' and in accordance with the principles as defined in the Children Act 2004;

- 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)

As required by Section 11 of The Children Act 2004, UHSFT strives to fulfil 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 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
- A culture of learning and promoting best practice

The pandemic has impacted on children and their families in different ways depending on their age and circumstances, with no one universal experience (NSPCC 2022). The mental health and wellbeing of some groups of children have been disproportionately affected children while for some children spending time with their family away from pressures of school brought greater happiness. Children including those identified as most vulnerable spent less time in school. Children and families had less contact with health and other professionals and although levels of child protection referrals dropped the level of complexity and harm resulted in the same number of children entering the Child protection system remaining fairly unchanged.

The pandemic has caused hidden harms and placed many families under heightened pressure, impacting on their relationships, finances, and physical and mental health and wellbeing. This can create increased insecurity and impact on a child's wellbeing and increase the risk of abuse or neglect (Romanou and Belton 2020) Levels of reported parental anxiety increased and still remain higher than pre- pandemic levels. (ONS, 2021C) The need for effective early help and intervention to support children and families has increased.

Child abuse is usually hidden from view. However, limited data indicates that some forms of abuse increased during the pandemic. Serious incident notifications (following a child death or serious harm) increased nationally by 19% during 20-21 (DfE 2021a). The NSPCC (2022) report children exposed to domestic abuse and exploitation and sexual abuse increased. Parental substance misuse (drugs or alcohol) and concerns on the impact on children has also increased.

The pandemic highlighted and exacerbated, health inequalities faced by some children and young people, in particular those people living in deprived areas. It has also had a significant impact on the mental health of children and young people, and has led to an increased demand on services, particularly eating disorder services.

There has been an increase in complexity and seriousness of safeguarding and domestic abuse cases and services are experiencing a significant surge in safeguarding activity. This increase has created extra pressures and demands on services for children and the wider system. This increase in demand and challenges as outlined in this report has created additional pressures in safeguarding children, as outlined in the following.

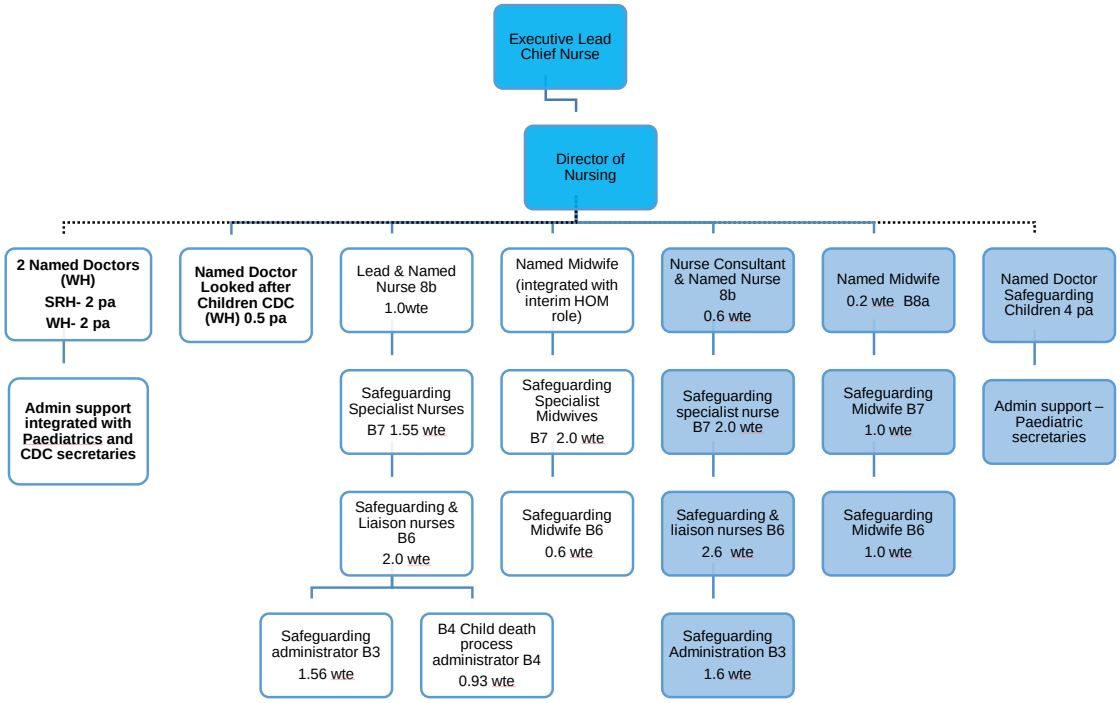
1.1 Key Messages for the Board

Key Priorities for the forthcoming year for Safeguarding Children at University Hospitals Sussex NHS Foundation Trust;

1. Develop a domestic abuse strategy and identify funding to resource and support the delivery of the strategy across all sites
2. Update the Safeguarding Children and Looked after Children policy
3. Develop an integrated safeguarding training strategy
4. Work towards integrating safeguarding structures, systems and processes, across the trust, ensuring, place based safeguarding is also strengthened.
5. Liberty Protection Safeguards and strengthening MCA
6. Developing a sustainable solution for information sharing and paediatric liaison with the healthy child programme.
7. Strengthen safeguarding arrangements for children and young people admitted to hospitals with mental health issues
8. Strengthen the safeguarding Champions role
9. Strengthen arrangements for looked after children across the trust
10. Increase inclusivity to reflect the diversity of Sussex children and promote ‘trauma Informed care’.
11. Strengthen Transitional safeguarding across the trust

2. Governance & Accountability Arrangements

2.1 University Hospitals Sussex Children's Safeguarding Team

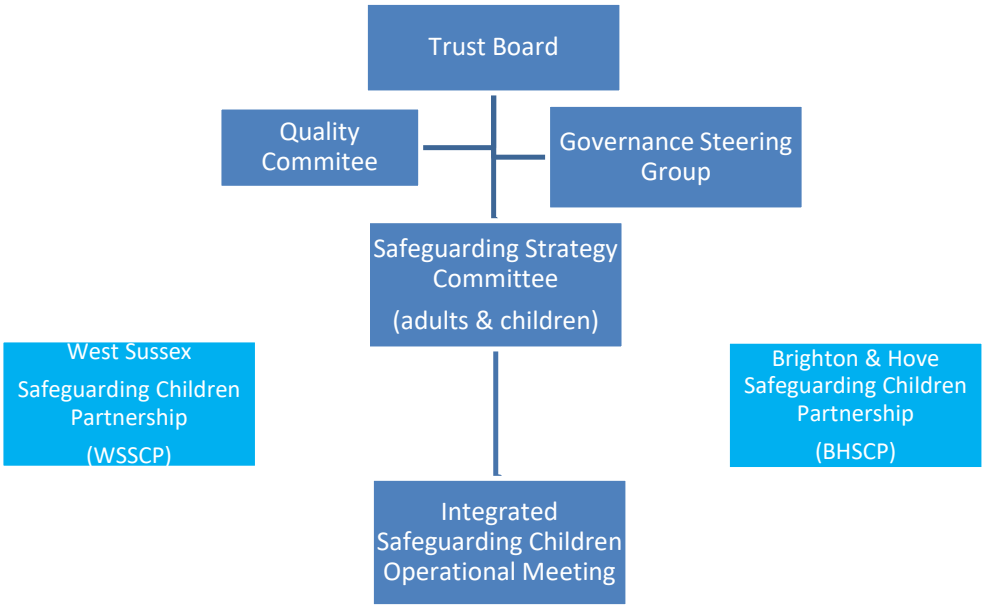


The safeguarding teams are responsible for ensuring structures, systems and processes are in place so that safeguarding activities are effectively coordinated in the hospitals making appropriate use of available resources.

Worthing & Southlands Hospital & Chichester Hospitals Safeguarding team are responsible in supporting safeguarding activities for both district general hospitals local geographical area providing the following services; paediatrics, maternity, emergency services, urgent treatment centres, outpatient, outreach services, sexual health services (including at Crawley) and adult services. Worthing site also has a child development centre which provides health assessments for looked after children in West Sussex.

Brighton & Haywards Heath Hospitals Safeguarding team are responsible in supporting hospital services for the Princess Royal- Haywards Heath, Royal Sussex County Hospital and Royal Alexandra Children's Hospital and Eye Hospital in the local geographical area providing the following services; paediatrics, maternity, emergency services, urgent treatment centres, outpatient, outreach services, sexual health services and adult services. Tertiary services for children are provided for patients across the South east in most of these services.

2.2 Governance Arrangements



The safeguarding teams are currently structured within the women & children divisions and contribute to their divisional governance board meetings in addition to the following; Patient safety group, Serious incident review group, Mental health Strategy and Quality Group and Children and Young People's Mental Health Improvement Board.

Information, learning and updates are shared through safeguarding newsletters, staffnet, training and supervision and learning events and safeguarding theme of the week events held in Emergency department, focusing on specific areas of improvement.

2.3 Local Safeguarding Children Partnerships

Both safeguarding teams contribute to their local hospitals geographical area safeguarding children partnerships & the subgroups as outlined in table below;

Worthing and Chichester Hospitals contribute to;		Brighton & Haywards Heath Hospitals contribute to;
West Sussex Safeguarding Children Partnership (WSSCP) Board		Brighton & Hove Safeguarding Children Partnership (BHSCP) and West Sussex Safeguarding Children Partnership (WSSCP) Board.
Quality Assurance		Monitoring and evaluation
Learning & Development		Learning & Development
Child exploitation		Child exploitation
Child safeguarding Liaison group		Child safeguarding Liaison group x 2
Child Health safeguarding forum		Child Health safeguarding forum x 2
Case Review Group		Case Review Group

Partnership Priorities include;

- Partnership Engagement and Accountability
- Violence and Exploitation
- Reducing neglect
- Mental Health and Emotional Health/Wellbeing

The Partnership bi-annual section 11 audit is due in 2022.

The previous section 11 development issues for all sites related to care for 'looked after children', domestic abuse support, monitoring and improving the update of safeguarding training. These development issues and outstanding actions have been escalated with the board and continue to be progressed.

3 Review of the Year

3.1 Evaluation of Progress against Priorities

Worthing and Chichester Hospitals; review of progress of priorities set in 2021	
Priority	Progress
1. Develop the Domestic abuse strategy to include leadership, training, specialist support and coordination for the trust	Ongoing discussions and some money provided by NHSE to support training. Domestic abuse strategy requires agreement.
2. Develop Integrated working for the safeguarding children teams across the trust	The teams are working together on policies and in developing a governance framework.
3. Develop the safeguarding champion role to support best practice in the clinical areas	Ongoing- staff have been identified for ED, paediatrics and Sexual health services.
4. Emergency department to share Royal college of Emergency medicine standards (RCEM) safeguarding children audits for each site	A full review of RCEM has been undertaken and is being reviewed at divisional level.
5. Develop a protocol for the management of substance misuse in pregnancy	Protocol development underway.
6. Improve Integrated working to support safeguarding children within the hospitals (ED, UTC)	Work streams; • **Attendance to safeguarding meetings;** CAMHS liaison attend on the Worthing site and discussions are ongoing regarding attendance to Chichester meeting. • **Information sharing;** is a dynamic process and challenges remain due to different health record systems. Communication between CAMHS liaison and hospital safeguarding

	team has improved following expansion of liaison service. Continue to working with UTC to ensure information and concerns are shared • **Training**; integrating shared learning and training opportunities between teams and agencies needs to be a facilitate
7. Transitional safeguarding; develop pathways alongside adult safeguarding team, to support vulnerable young people transitioning to adult services.	A children's and adult's safeguarding specialist nurse have been identified and are working together to identify opportunities for improvement and bridging the gap.
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	Await the new/ updated incident reporting system to support improved monitoring and reporting of these risks for children and young people.
9. Liberty Protection Safeguards continue to work towards implementation	Working towards a standard approach to ensure compliance with mental capacity assessments for 16-17 year olds and embed into practice. Awaiting further information on training and medical assessment standards from NHSE.

Brighton and Haywards Heath Hospitals; review of progress of priorities set in 2021	
Priority	Progress
1. Development of an integrated Safeguarding strategy	The draft business plan was agreed and the recruitment process began. Some of the new team members were in place by April and the rest are due by June 2022. The Nurse Consultant for safeguarding is retiring and a new structure has been agreed to strengthen the 'child voice' across the Trust. Interviews took place in August 2022 with successful appointment made.
2. To continue to plan and respond to safeguarding issues raised by the Covid-19 pandemic	The safeguarding team continued to work on site for the whole of the pandemic. The safeguarding team participated in safeguarding network meetings to co-ordinate care during the pandemic & worked with the Partnership on all aspects as usual. The safeguarding team adapted the training provision to be all e learning as face to face sessions were not possible. Supervision continued face to face on the wards and via telephone and online 'team' meetings.

	Individual video recordings were shared on specific topics
3. To participate in the Liberty Protection Safeguards initiative	The named Nurse participated in the steering groups for LPS (which has been delayed until 2023). The updates were presented via the committee. A standard approach will need to be addressed in 2022/23
4. To participate in Partnership and monitoring arrangements eg: section 11 review.	The section 11 review and action plan formulated. The Named Nurse had correspondence with the partnership Board who were assured by the actions taken. The Named Nurse attended the B&H Partnership Board and subgroups and helped with the pan Sussex safeguarding audits and reviews.
5. The Named Nurse role for looked after children needs to be clarified & strengthened	The Named Nurse currently attends the looked after children monthly meetings & has attended specific training in relation to this vulnerable group. The top 10 tips for best practice to support looked after children shared with staff. Joint working across the new Trust will be strengthened
6. To continue to have Directorate assurance & evidence that 'safeguarding children' is discussed and that staff are aware of their role and responsibilities.	The issues for the Division have been identified in newsletters & via the operation group and the safeguarding committee. Assurance needs to be demonstrated during 2022/23.
7. To update any safeguarding policies which become out of date in 2021/2.	The Named Nurse has commented on various joint trust policies.
8. 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.	The training for 2021/22 included learning for SCR and practice panels. The newsletter provides information to staff Supervision provides opportunities to discuss national and local learning.
9. To complete the audit programme.	The audit plan has achieved most of the planned audits and is an ongoing process.
10. Continue & complete the work itemised in the Safeguarding Children & Young People Committee action plan.	The committee action plan is a rolling process.
11. To ensure the maternity action plan is addressed and the named midwife role is embedded.	The maternity action plan was addressed however the issue of increasing Named Midwife hours to support safeguarding remains outstanding and requires a solution.
12. To ensure the domestic abuse action plan is addressed & that the	The domestic abuse action plan is being supported within the Trust.

Independent Domestic violence advisor is supported.	However, the new HIDVA provider has not been able to recruit to the post so this has been escalated to the commissioners. Changes to the Job description were agreed and recruitment started in July 2022, successful appointment made in August 2022.

3.2 National Context

The following figures provide a snapshot of the latest child protection activity in England:

- At the more acute end of the children's social care system, there were 50,010 children on a child protection plan at 31 March 2021 (Department for Education, 2021). This is the equivalent to around 1 in every 250 children in England Children on a child protection plan have been assessed as suffering or being likely to suffer serious harm.
- Children in need much larger cohort of children in need - 388,490 children were considered in need at 31 March (DfE 2021). This includes 80,850 looked-after children (Department for Education, 2021).
- It is estimated 1 in 10 children were considered in need in the previous six years (Department for Education, 2019).
- There were 536 serious incident notifications in the year ending 31 March 2021, relating to the death or serious harm to a child where abuse or neglect is known or suspected (Department for Education, 2021e). A significant proportion - over 60% in 2020 were previously known to children's services.

The COVID-19 pandemic has had an enormous impact on the mental health of children and young people, and has led to an increased demand on services, particularly eating disorder services.

Children living in poverty and from deprived areas are more likely to be overweight or obese; less likely to attain the expected level of attainment across educational key stages; more likely to admitted to hospital for self-harm; more likely to become pregnant as a teenager; and more likely to grow up in a household where someone smokes.

3.3 Local Context

3.3.1 West Sussex

West Sussex estimated population is 859,000 an increase of 8.6% over the last 10 years and is projected to increase further. There are 191,300 children and young people aged 0-19 years in West Sussex, overall, 22% of the population are aged 0-19 years, compared with England (24%). As of the 30th June 2022 there were; 867 Looked after children, 632 children subject to a Child Protection plan and 1678 children with a Child in Need Plan.

Overall people enjoy a good quality of life, however there is considerable inequality in West Sussex and differences between areas and different groups within the population. Arun and Crawley neighbourhoods now rank amongst the poorest 10% of all areas in England, and risk of greater health inequalities.

In West Sussex, almost 17,000 children live in poverty. Children in poverty are more likely to come from single parent/carer families, be disabled or live in a household with an adult who is

disabled. It is also important to recognise that, on average, children who are in care or are care leavers have significantly poorer health and educational outcomes than their peers. Emotional and mental health are intrinsically linked to physical wellbeing and longer term outcomes. Children who are happier and more emotionally resilient tend to have better physical health. (jsna.westsussex.gov.uk)

The safeguarding children team at Worthing and Chichester hospitals were nominated twice in the year for UHSFT star awards and highly commended.

3.3.2 Brighton & Hove

Brighton and Hove population is estimated to be 295,300 in 2020 and the population is expected to rise by 8.1% by 2030 compared to 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.

Between 11% and 15% of the population aged over 16 are estimated to be lesbian, gay or bisexual. 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.

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.

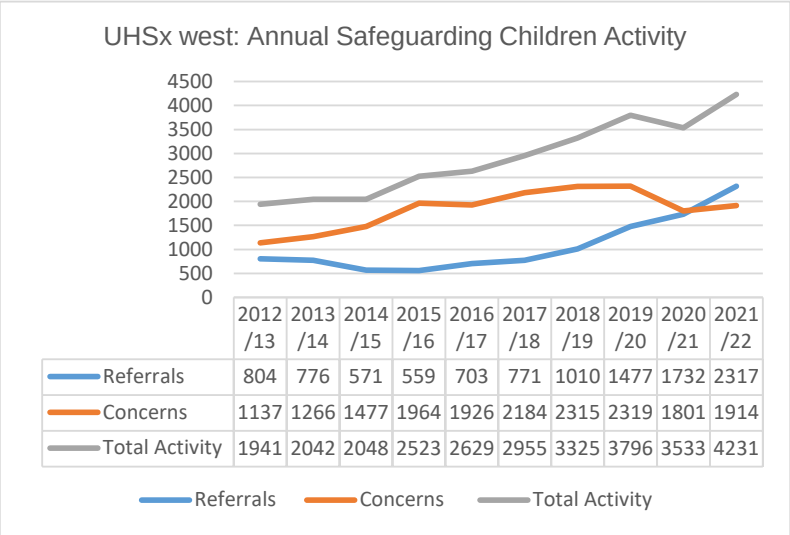
In February 2022 there were 269 children subject to a child protection plan (53.5% per 10,000 which is significantly higher than the national average of 41.4% per 10,000)

Quarter	Sept 2012	June 2013	June 2014	June 2015	June 2016	June 2017	June 2018	June 2019	Feb 2020	Feb 2021	Feb 2022
Total children with a CP Plan in B&H	340	300	328	385	381	380	370	326	331	288	**269**
B&H per 10,000	N/A	59.9	59.9	57.1	74.7	74.2	72.1	63.5	64.5	57.3	**53.5**
National average per 10,000	N/A	37.8	37.9	42.1	42.9	43.1	43.3	43.7	43.7	42.8	**41.4**
Statistical neighbour				44.4	42.1	45.3	49.8	40.4	40.4	45.6	**43.5**
League table (n=152)	8th	15th	24th	33rd	25th	10th	17th	25th	24th	25th	**40th**

The trust safeguarding children teams have had another extremely challenging year safeguarding children and vulnerable families and in supporting the trust to meet its statutory obligations. The team have continued to evolve and work as effectively as possible within the constraints of the service.

3.4 Worthing and Chichester Hospitals- Safeguarding Children Activity 2021-2022

Table 1 Children's Safeguarding Activity Summary 2012-2022



	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Referrals	804	776	571	559	703	771	1010	1477	1732	2317
Concerns	1137	1266	1477	1964	1926	2184	2315	2319	1801	1914
Total Activity	1941	2042	2048	2523	2629	2955	3325	3796	3533	4231

Safeguarding activity has increased by over 218 % at Worthing and Chichester hospitals over, the past 10 years. It also shows for the first time the threshold for referral to children's social care referral rates have surpassed concern rates, which highlights the increase level of harm which meets the threshold for referral to children's social care. The annual referral rates have increased by over 30% over the year, compared to the previous year and reflects the complexity and level of concerns being seen. It is important to note the data excludes concerns and referrals completed by mental health liaison services and urgent treatment centres, due to these services using alternative referral processes and the hospital safeguarding teams do not have sight of this information.

Information sharing is a dynamic process and an essential requirement to safeguarding children. All safeguarding concerns and referral's generated by trust staff require as a minimum; review, liaison, information sharing and uploading to a child's electronic records. The safeguarding team also undertake a significant proportion of information to the; GP, Healthy Child Programme (health visitors or school nurses) Looked after children's services, Social worker for children in Sussex and beyond. The increase in safeguarding activity and related information sharing has placed significant demand on the safeguarding team and trust.

The team are currently in discussion with partner agencies to review the current information sharing criteria and process and consider more sustainable solutions. Any changes to the current processes will need to be risk assessed by all agencies involved and agreed by the Local Safeguarding Children Partnerships (LCSP).

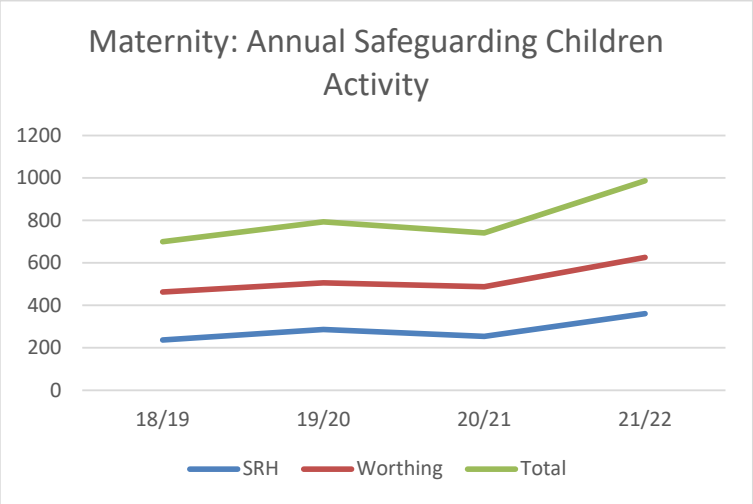
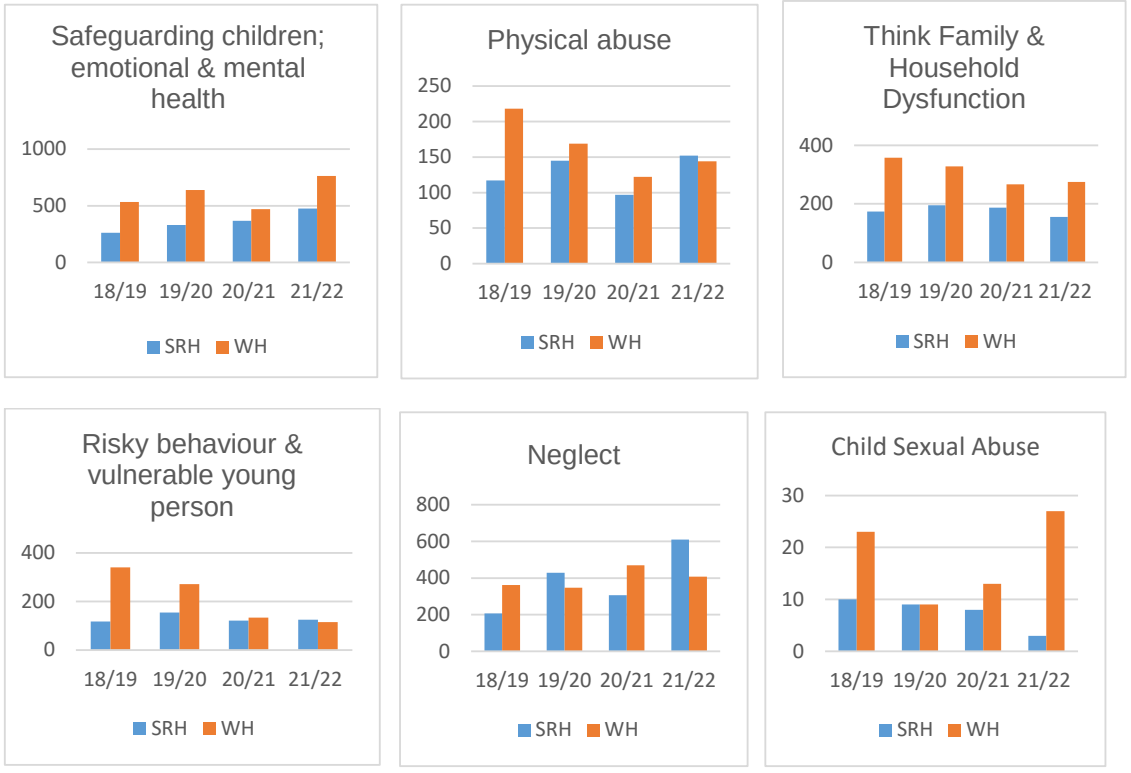


Table 2 Maternity: Annual safeguarding Children Activity

Activity has increased for maternity safeguarding team; new Perinatal Mental Health Midwife role commenced February 2022 to lead on supporting improvement in outcomes for women experiencing poor mental health during and immediately after their pregnancy and to liaise between maternity services and the wider multi-disciplinary professional network and deliver specialised antenatal classes alongside the Perinatal Health Visitor. These classes will specifically target women experiencing anxiety/stress/depression with the aim of reducing the impact of negative emotions and promoting a healthy bond with unborn.

Table 3 Annual Safeguarding Activity by Principle Concern 2021-2022 (excludes maternity data)

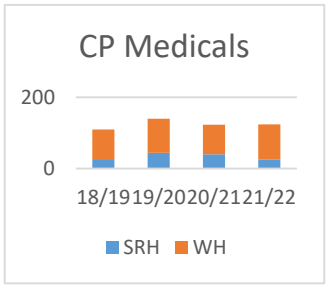


The were 15 disclosures of FGM in over 18 year olds for the year

3.4.1 Child Protection Medical Service

Table 4 Child Protection Medicals 2021-2022

Site/ Monthly total	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Totals
Worthing Acute	1	2	2	0	2	1	3	0	1	1	1	1	**15**
Worthing Community	2	6	6	9	8	7	4	5	5	9	13	10	**84**
Worthing	3	8	8	9	10	8	7	5	6	10	14	11	**99**
Chichester	2	3	2	2	3	0	1	3	3	3	1	1	**24**

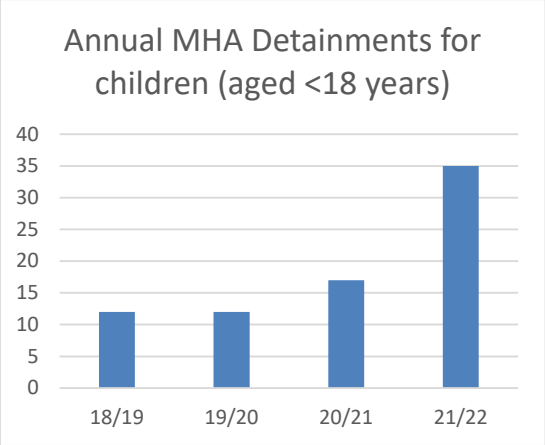


There were in total 122 child protection medicals across Worthing and Chichester hospitals this compares to 123 the previous year. Worthing child development centre provide a child protection service during normal working hours and Worthing acute paediatrics provide this service out of hours or if the child has been admitted to hospital. Due to the limited resource in the Chichester child development centre, acute paediatrics in Chichester hospital continues to support the child protection medical service within the Chichester area and the impact of this risk remains on the risk register and continues to be reviewed.

There is no clinical photography service to support the delivery of child protection medicals, which has been identified as a risk and remains on the risk register. Guidelines to support medical staff in undertaking child protection medicals was updated this year in accordance with best practice and statutory guidance.

3.4.2 Mental Health Act Detainments

Table 5 Worthing and Chichester Hospitals Mental Health Act Detainments



The number of children detained under the Mental Health Act has doubled over the year. Between 2021-2022 there were 35 children aged between 12-17 years detained to the children's wards either under either a section 5 (2), section 2 or section 3.

There were 23 children detained under a section 136 and brought to ED by Police.

New statutory guidance to protect patients who are "detained under the Mental Health Act 1983 for assessment and treatment of their mental disorder" applies from March 2022 and is relevant for general hospital adult and children's wards. www.mental-health-units-use-of-force-act-2018. gov.uk .

The safeguarding team are working to support the trust with compliance.

3.4.3 Children's Safeguarding Reviews

Worthing and Chichester Hospitals contributed information to the following learning and practice reviews as requested by the WSSCP Children's Safeguarding Practice Review Group.

Date	Type of review & reason	Actions Provided by Safeguarding team
April 2021	Operation Swallowtail- review serious violence incidence	Minimal involvement. Information shared for scoping report
May 2021	Rapid Review (R-A):	Scoping report & Chronology
	Rapid Review (EL): unexplained fractures	Scoping report & Chronology
	SPR Hazel & Lily– historic neglect and bereavement	Scoping report & Chronology & agency reflective report, provided as requested, later in year
	Rapid Review (RS)	Scoping report
June 2021	Rapid Review (CON) mental health	Scoping report & Chronology
	SPR Comorant- transition to adult services themed multi-agency review	Scoping report, Chronology & agency report provided
Sept 2021	Rapid Review (OB) mental health	Scoping report & Chronology
	SPR Hazel & Lily– historic neglect and bereavement	agency report provided
January 2022	Rapid Review (ASS)- neglect	Scoping report & Chronology
March 2022	Rapid Review EF-D	Scoping report and Chronology and confirmation to proceed to full review practice review

The names Hazel & Lily are not attributed to the actual individual children but names generated as part of the process.

Identified Themes West Sussex
• **Lack of quality assessments**: Greater use of professional network and better use of history required • **Under-use/poor use of pre-birth assessments**: Improvement in quality, timeliness and sharing of open & closed pre-birth assessments needed • **Safeguarding response to late presentation**: Identifying right support as linked to maternal behaviours in pregnancy and knowing that safeguarding doesn't start at birth • **Lack of parental histories:** Need for increased curiosity and engagement with parents to understand influences on their attitudes/behaviours • **Use of professional network to raise/lower concerns**: Timely escalation when required and information sharing for accurate understanding presenting needs • **Professionals use of interpreters and experience of working with under-represented communities**: Importance of understanding cultural needs and behaviours to provide support for sustained change (cultural competency) • **Recognition of young carers**: Provision of safeguarding response to young people impacted by complex parental needs • **Early consideration of Non-Accidental Injuries/Perplexing Presentations/**FII: Use of key protocols and professional network to enable early discussion • **Use of Multi-Agency and Multi-Discipline meetings**: Need to understand

role/responsibilities of partners, ownership of actions and purpose of meeting • **Understanding long term impact of neglect and trauma**: Recognition of how this may present in behaviours and the need for supporting carers of trauma affected children • **Working with older & transition aged children**: In particular, those impacted by exploitation, understanding development, rights and participation and collaboration with relevant services • **Professional curiosity**: Professional approach to reduce over-reliance on self-reporting through understanding history and unknown adults within the family home/carers • **Management oversight and secondary trauma**: Provision of support and challenge through supervision and recognition of impact of being exposed to traumatic accounts and experiences of children

Promoting a whole family approach and the need to “Think Family” continues to be a feature within findings from reviews, not only in situations of parental mental ill health but in a variety of complex family and other caring situations.

The outcome of the cases are still awaiting final publication.

3.4.4 Serious Incidents Risks and Complaints

Worthing & Chichester Hospitals; Risks and Serious Incidents relating to children’s safeguarding

Management of children and young people requiring specialist inpatient mental health or eating disorder care Risk 1307
Increasing episodes of children and young people having prolonged inpatient stay on a general children’s ward awaiting mental health or local authority placement continues along with episodes of escalating harmful behaviour, deteriorating mental health and emotional wellbeing and absconding and assaults to staff on ward. This can also negatively impact other children and families and staff well-being on the ward. Multi-agency collaborative network meetings, including on occasions parents and child, are held regularly for each individual young person in order to formulate care plan and plan for ongoing care. Increasing incidents of young people being admitted and requiring restraint and associated risks; deprivation of liberty and delay in their receiving specialist therapeutic support. Improvement is being led by provider collaborative and trust mental health committee.
Absence of Clinical Photography Service for Child protection medicals Risk 1486
Worthing and Chichester Hospitals do not have a clinical photography service to support child protection medicals. Business case being developed by Clinical photography services in Brighton. Medical staff currently have to provide this service in accordance with guidance.
Impact of community paediatrics problems on acute paediatrics Risk 1149/1434
Acute paediatrics at Chichester are undertaking work which historically was provided by Chichester child development centre which includes child protection medicals. Discussions are in progress with commissioners.
Absence of specialist domestic abuse support Risk 1428
No identified domestic abuse support on Worthing and Chichester hospitals and overall domestic abuse strategy. Domestic abuse strategy to be developed for the new organisation and business case to support specialist support within the trust being considered
Safeguarding Training Compliance Risk 2042
Compliance remains below 90%. Issues are multifactorial. Workforce report is not able to accommodate change in levels required for staff who rotate to areas where level 3 are

required from level 2 areas. Systems is unable to accommodate a blended learning approach.

Table 6 Worthing and Chichester Hospitals; Safeguarding Incident (SI) relating to children

Safeguarding Incident (SI) relating to children			
Q1	Q2	Q3	Q4
0	0	3	2

Four of the serious incidents have related to children and young people with mental health problems and some with eating disorders.

There were 3 complaints which included; one formal complaint from a family following a disagreement with a referral and two informal complaints from parents whose baby had been referred due to an unexplained mark. The safeguarding team met with the families and worked with the complaints team. The team are also working with partners to improve the communication and experience of the pathway for babies and children referred with unexplained marks or bruises.

3.4.5 Allegations against staff referrals

Table 7 Worthing and Chichester Hospitals; referrals to Local Allegations Designated Officer (LADO)

Allegations against staff and referrals to Local Allegations Designated Officer (LADO)			
Q1	**Q2**	**Q3**	**Q4**
4	**3**	**2**	**3**

3.4.6 Child Death Reviews

In partnership with the child death review nurses based with Sussex commissioners, child death reviews are led by the acute child death leads for Worthing and Chichester hospitals and supported by the child death administrator, in accordance with statutory guidance.

There were sadly 33 deaths of which 12 were neonatal and 22 children, during the year 2021-2022. Child deaths, which occur in the community within West Sussex and brought to our hospitals, are also included and supported by this team. There were safeguarding concerns raised for 19 of these reviews for neonates and children and the hospital safeguarding team were involved in 10 of the reviews. The full overview for child deaths is provided by West Sussex Child death overview panel (CDOP).

Child death www.ncmd./2021/child-suicide-report

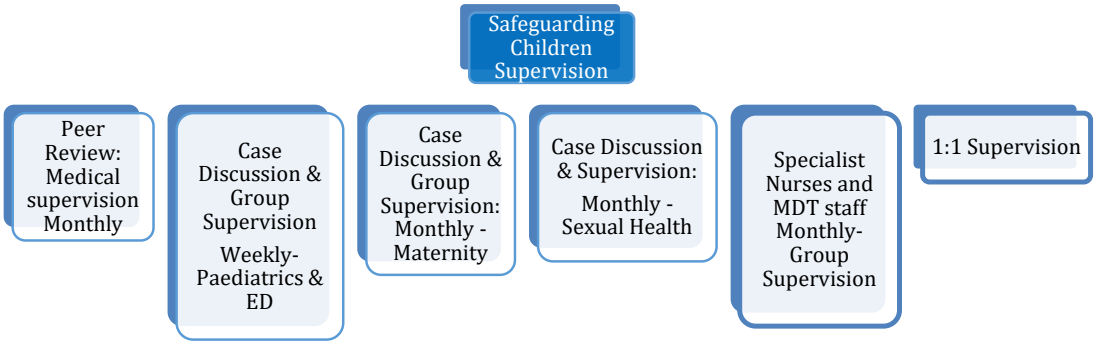
3.4.7 Training and Supervision

Table 8 Worthing and Chichester Hospitals; Child Protection Training by Level Required June 2022

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	2613	1932	73.9%	0	0	-	2606	1932	74.1%
Level 2	4033	3457	85.7%	697	559	80.2%	3343	2898	86.7%
Level 3	969	819	84.5%	207	161	77.8%	762	658	86.4%
Total	7615	6208	81.5%	904	720	79.6%	6711	5488	81.8%

There has been a reduction in safeguarding children training compliance over the year and an integrated Training strategy is to be developed to support improvement in training compliance across the trust.

Table 9 Supervision Opportunities



Staff have access to informal and formal supervision either through the various group case discussions, peer review or monthly supervision offered to specialist services. The safeguarding team also provide individual supervision and are responsive to need. Safeguarding teams have supervision provided regularly and named professionals receive supervision via the designate professionals.

3.4.8 Looked after children and Adoption

The integrated child development site at Worthing provides initial health assessments (IHA) and a small number of review health assessments (RHA) assessments. The Worthing Child Development Centre (CDC) provide 2 slots for medicals per week and provide medical adoption summaries for the whole of West Sussex.

Following the Somerset Judgement, there has been a recent change in process for the adoption medical requests. All Adoption Medical summaries are now completed by a Medical Advisor and as the medical advisors for West Sussex are based at Worthing CDC, it is expected that there will be increased workload placed on Worthing CDC, therefore resources will need to be reviewed.

Table 10 Looked after children activity- Completed Health Assessments

	Completed Health assessments		Medical Adoption Summaries	Was Not Brought /Did Not Attend	Cancelled appointments	Unfilled appointments
	Initial Health Assessment (IHA)	Review health assessment				
Worthing CDC	75	17	37	3	15	3

Looked after children make up 0.5% of the West Sussex population of children under the age of 18 years. There are 50/10000 (0.5%) of the population are looked after children in west Sussex. Representation of Looked After Children accessing Worthing or St Richard's Hospitals with safeguarding concerns (excluding maternity) was 5.6% (n194). This is an over representation of looked after children.

It is widely documented that Looked After Children have poorer health outcomes than their peers and that they are a particularly vulnerable group of children that we have responsibility to ensure that they have equal opportunity to access our health services. We have incorporated good practice guidance into our local trust Safeguarding Children's policy as it is acknowledged the inequities in access to health services in this group of children. i.e. re: informing social worker and designated nurse when a child moves out of area if on waiting list or transfer of care to their new local services as necessary for a chronic health condition for example. We recognise that Looked After Children should be considered for expedition on waiting lists if they have moved from out of area so that they can be offered an equitable service to their peers.

Table 11 Annual Safeguarding Activity; for Looked after Children by Principle Concern for 2021-2022

Principle Concern	Site/ No. of concerns and referrals		Percentage of total number of Looked After Children presenting with safeguarding concerns
Child mental health and emotional health	WGH 56	SRH 35	46%
Physical abuse	WGH 10	SRH 3	6.7%
Child sexual abuse	WGH 2	SRH 0	1%
Household dysfunction/ adult issues	WGH 6	SRH 4	5.1%
Neglect	WGH 14	SRH 18	16.5%
Contextual safeguarding	WGH 25	SRH 21	23.7%

Worthing generally has higher numbers of presentation of Looked After Children with a safeguarding need. It is interesting to note that in comparison to all children with safeguarding needs that have contact with the Trust that Looked After Children's distribution between the categories are much higher in mental health, risky behaviour and neglect, which reflects the distribution in the general population who have much higher presentation in mental health, neglect and think family categories. It is worth noting that risky behaviour can be related to sexual health and that the category chosen is dependent on the practitioner inputting the data particularly when concerns/ referrals are applicable across a range of categories.

We have embedded training around the vulnerabilities of Looked After Children as per the Looked After Children: roles and competencies of health care staff (RCPCH 2020) which has also informed the updating of our Children's safeguarding policy this year.

We have had a challenging year with regards to complex mental health presentations throughout the year and in part these have been in relation to children and young people on the edge of care or who are already Looked After. Our Trust has worked well in partnership with Designated Nurses for Children and Young People in Care, the Looked After Children's Health Team, CAMHS, Children's Social care and Education. Some children and young people have remained on our Paediatric wards for many months either waiting for Tier 4 CAMHS beds or awaiting an appropriate placement that is therapeutic and able to manage risks within the community – this is an identified area for improvement in the wider context.

The Children's Safeguarding team/ Named Doctor for Looked After Children attend West Sussex Children Looked After Health Operational Group and Looked After Children NHS Professionals Group meetings to enable wider networking of local issues and challenges that professionals face and to remain up to date with new developments within Looked After Children's Services and legislation.

A member of the Children's Safeguarding team has a specialist interest and expertise in working with Looked After Children and supports the IHA appointments for those young people aged over 13 years, this is in part due to the identification of improvements through audit suggested for specific areas of health promotion such as sexual health, substance misuse and mental health.

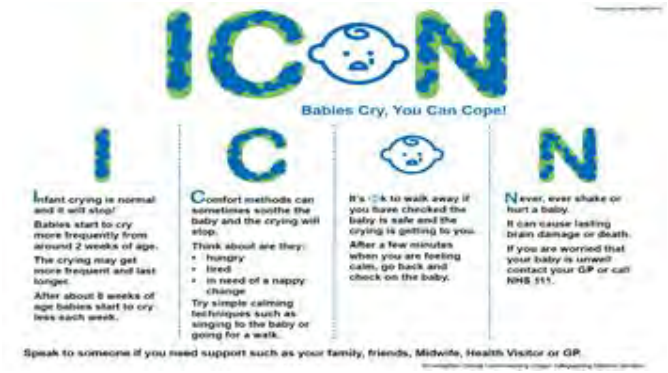
Nice guidance (NG205) baseline assessment undertaken for Looked after Children and young people. Areas for improvement include developing a system to collate feedback from Looked after Children to inform health service provision and develop trauma informed care.

3.4.9 Audit

A joint audit of information sharing with the healthy child programme (HCP) was undertaken over a June/July 2021. Results indicated appropriate information sharing in accordance with the West Sussex information sharing agreement following A&E attendance. The majority of information shared was for information only. Requests for Healthy Child Programme (HCP) to make contact with the family related were made due;

- the family needed support
- Home safety advice
- Child did not have a registered GP.

The children's safeguarding team contributed to a WSSCP child exploitation multi-agency audit during June 2021. Our single agency findings from this audit highlighted the following; need to strengthen processes around documenting consent for information sharing, evidencing the voice of the child during consultations, exploring with practitioners how they ask about education, health care plans and developmental needs for vulnerable children. This will be included in training and updated guidelines.



There is good evidence that the ICON public health message continues to be shared by practitioners at key points with parents, in particular the male care giver, along the course of the unborn baby's life and new-born period up to 6 months of age.

3.5 Brighton and Haywards Heath Hospitals Safeguarding Children Activity 2021-2022

The following charts highlight an escalation in the numbers of children under 18 attending children's emergency department and the need for some of those children to be referred to children's social care.

Children's A&E attendances during 2021

Chart 1

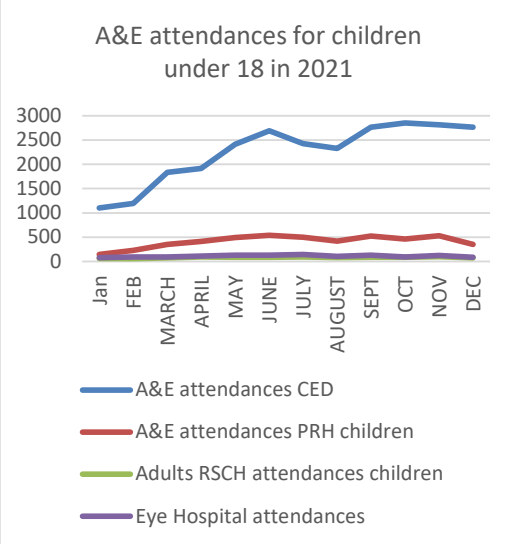


Chart 2

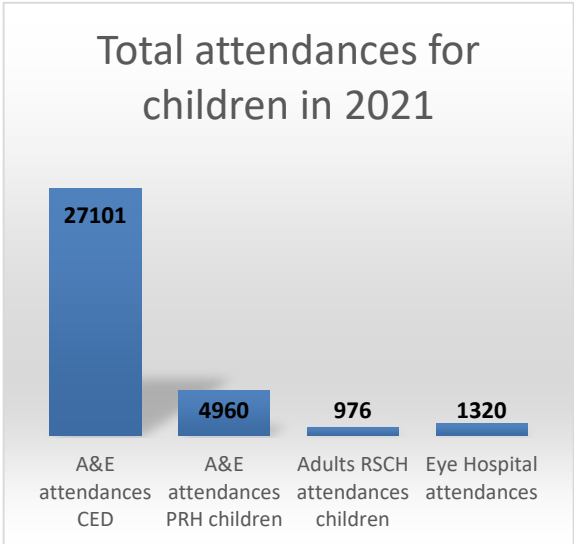
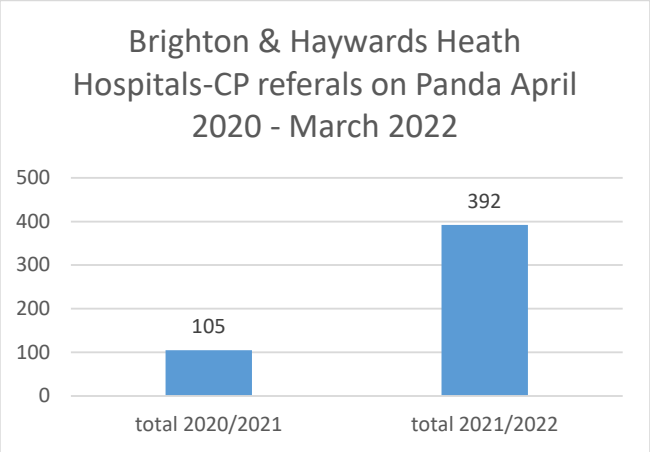


Chart 3:



Some referrals to the Local authority are undertaken electronically using PANDA (Paediatric Acuity and Nurse Dependency Assessment) and illustrates a dramatic increase from 2020/21, however this may be due to staff becoming more adept at using the system which was introduced in 2020. Staff can also use the Local authority online referral system and a paper version. The PANDA safeguarding children section where specific read only action plans can be stored is being used for highly complex cases only but this will be developed throughout 2022/23.

Referrals to the Local Authority due to concerns about abusive situations including the possible effect on children of adult issues eg Domestic violence, mental health or substance issues. This excludes referrals provided by the mental health liaison teams who are employed by SPFT.

Chart 4.

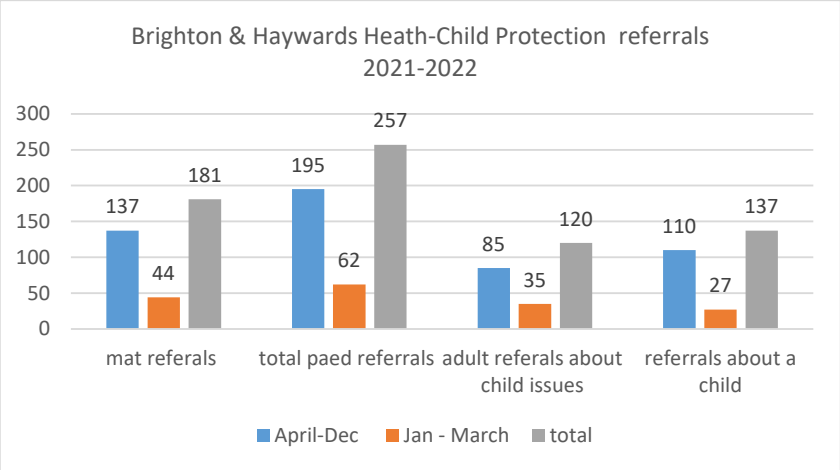


Chart 5

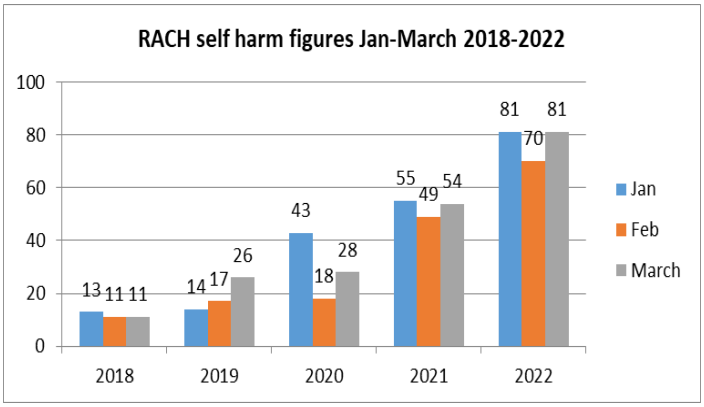
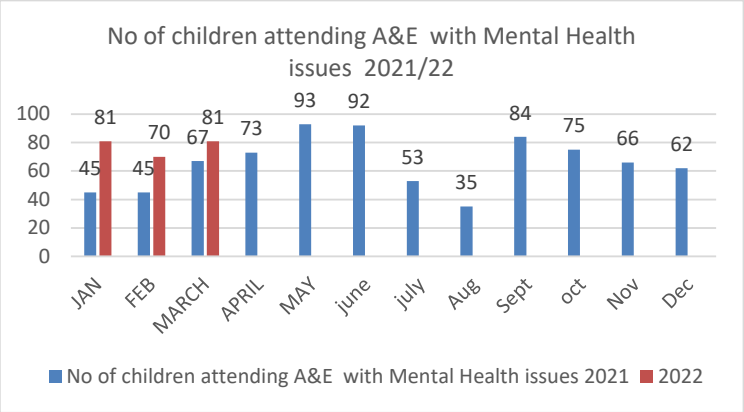


Chart 6



There has been a year on year increase in the numbers of young people attending RACH with self-harming behaviour. As highlighted in charts 5 and 6. This reflects the national numbers and those seen in other parts of the Trust

Chart 7

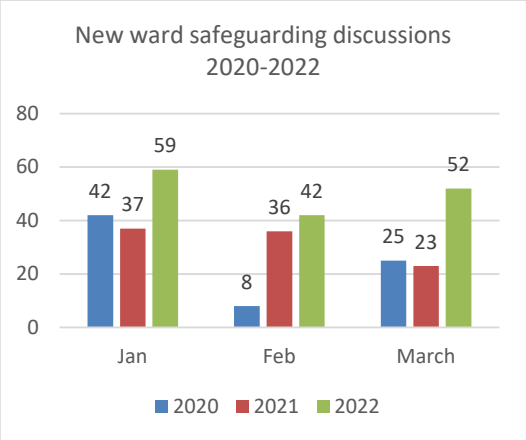
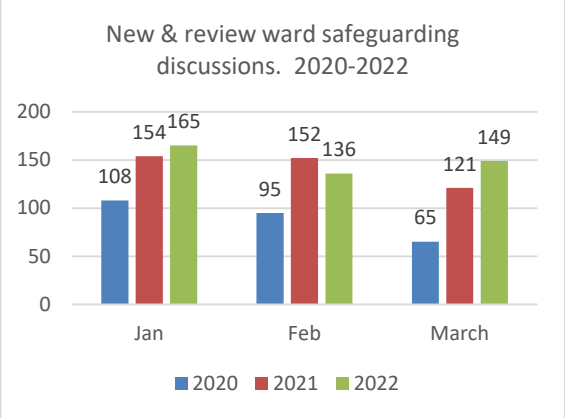
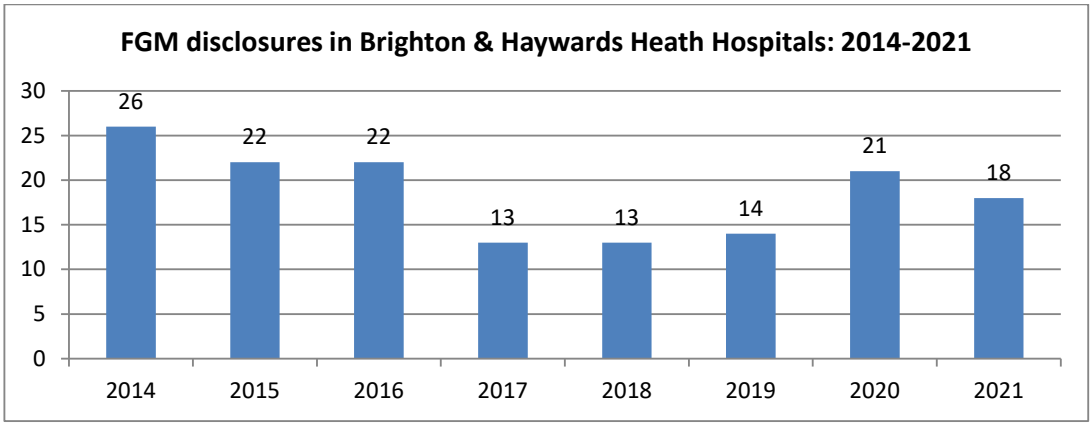


Chart 8



The safeguarding team undertake a daily ward round to support families and staff who have safeguarding issues and the following charts indicate a rise in those discussions. Chart 8 indicates combined discussions on the ward round of those new admissions and the longer stay patients.

Chart 9



The number of women disclosing FGM remains small as there were 17 disclosures of FGM made by women all of whom were over 18 yrs of age. All were reported as per standards.

Domestic abuse
The Domestic Abuse Act 2021, came into force on 29 April 2021, aiming to strengthen measures to protect victims of domestic abuse and address the behaviour of perpetrators.

Victims of domestic abuse can include members of staff who should feel confident to seek help from the safeguarding team, their managers, occupational health and the HELP service.

Commissioned Domestic abuse support - a Hospital Independent Domestic Violence Advisor (HIDVA) is provided for the Brighton Hospitals Sites, however, after 16 years, in April 2021 the service provision changed from RISE to Victim Support service.

Unfortunately, the recruitment to the HIDVA post has not been successful. Support has been given by the duty line however the visibility and prompt face to face support for people affected by domestic abuse has not been possible and this has affected referrals. This is disappointing given the national information which suggests domestic abuse rose during the pandemic.
The commissioners are aware of the problem and have made moves to improve the job offer and it is hope this will encourage someone to apply in 2022/23.

Some domestic abuse training is included in safeguarding training and there continues to be a 'top 10 tips' leaflet about domestic abuse to help staff and a poster indicating how Covid-19 can impact on domestic abuse.

The use of a blue teardrop (replacing the red triangle) to flag victims of domestic abuse who have been discussed at MARAC was introduced in 2019/20 and continues to be a successful alert.

Domestic abuse Support is also offered as part of the child and adult safeguarding team roles.

3.5.1 Child Protection Medicals

Chart 10

	2016/17	2017/18	2018/19	2019/20	2020/21	**2021/22**
CP medicals	109	112	112	111	71	**48**

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.

3.5.2 Children's Safeguarding Practice Reviews or learning reviews.
Brighton and Hove (B&H) have had 2 Children's Safeguarding Practice Reviews called Delta and Epsilon and 2 requests for information related to other possible reviews.

1. Delta started in 2019 and publication has had to be delayed due to parallel investigations by the Police with court hearings.
2. Epsilon has also been delayed with Panel meetings and practitioner events being postponed due to parallel criminal and family court processes taking place
3. 2 further chronologies and scoping reports have been undertaken for rapid reviews but no reviews have been required.

Themes of learning across Sussex & national reviews have been discussed at the various Safeguarding partnership sub-groups and incorporated into training including:

1. recognition and response to neglect
2. Considering Black, Asian and diverse cultures within assessments and across systems
3. Safeguarding Children affected by family drug and alcohol use.
4. The myth of invisible men
5. The new FII guidance
6. Professional curiosity
7. ICON and abusive head trauma.
8. Criminal exploitation
9. Looked after children

The NSPCC website has 48 published & 13 up to June 2022.

See various reminders and newsletter items during 2021/22 including the following themes; back to basics- make every contact count, child to parent violence poster, domestic abuse joint targeted area inspection (JTAI)

3.5.3 Serious incidents, complaints, allegations against staff and risk

Chart 11

2021/2	April 21	May 21	June 21	July 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	total
SI	0	0	0	0	0	0	0	0	0	0	0	0	0
Complaint	0	0	0	0	0	0	0	0	1	0	0	0	1
Allegation against staff	0	0	0	0	0	0	0	0	1	1	0	0	2

Serious incident, although there was no reportable serious incident this year it would be useful to review the trigger list in 2022/23 for such events in relation to safeguarding children to ensure consistency.

The complaint related to an IT issue not being able to record the pronoun ‘they’. This was relayed back to the department.

The allegations against staff were investigated with HR department and the local Authority and support given to the member of staff. No further action was required.

3.5.4 Child Death Reviews

The co-ordination of child death is currently the responsibility of individual departments (Neonates, maternity & paediatrics) and in partnership with the Child Death Review nurses based with the Sussex Commissioners. The full overview for cases is provided by the Sussex Child death overview panel (CDOP).

3.5.5 Training and Supervision

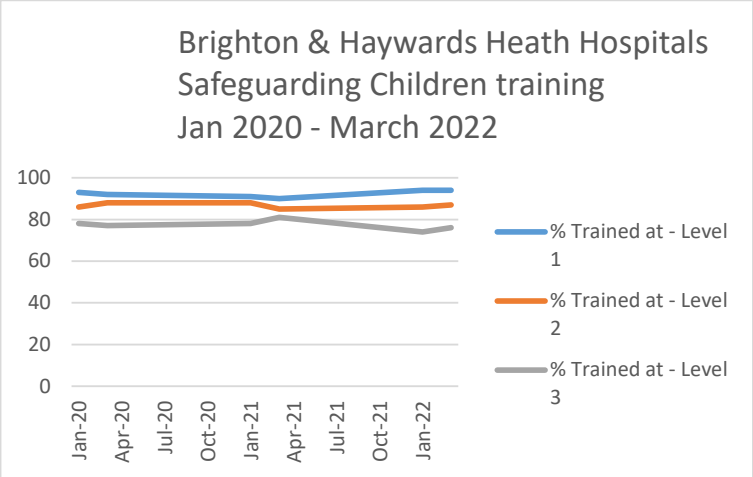
There continues to be on-going commitment to safeguarding training ensuring all staff receives the required levels of safeguarding training under guidance of the Intercollegiate Document for Safeguarding Children (RCPCH 2019)

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

Chart 12



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. Some face to face training is now planned for 2022/23.

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.

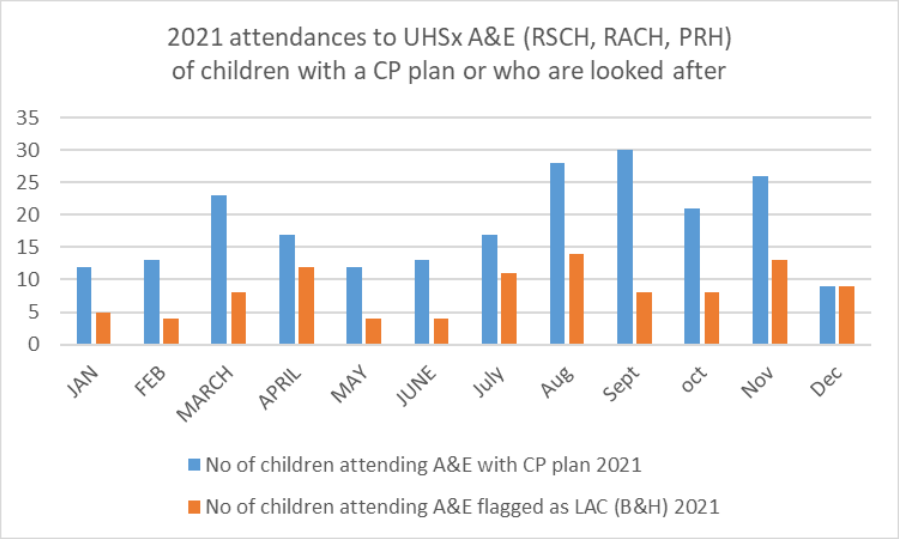
3.5.6 Looked after Children

Brighton and Haywards Heath Hospitals do not provide a commissioned health assessment service for looked after children.

All children are treated as individuals but also respectful of the statutory recommendations in the 'Promoting the health and wellbeing of looked after children' report (2015 DfE DOH) to address health inequalities.

Training has been updated to include aspects of health inequalities and adverse childhood events (ACE). The team have also welcomed the input of 2 young people who have experience of being 'looked after' to visit the RACH and discuss their experiences in order to help inform future practice. The maternity team have planned a learning event in July 2022 with the same young people and the 'looked after' Designated nurses.

Brighton and Haywards Heath Hospitals have permission to flag all Brighton & Hove young people who are 'looked after' on Hospital IT systems; Symphony & Careflow to add a further layer of information sharing to inform clinician decision making. East and West Sussex have not given the information necessary to flag the young people from those areas.



3.5.7 Inspection and Audit

1. No specific safeguarding CQC/JTAI inspections were conducted in B&H during 2021/22 but preparations are ongoing.
2. The action plan from the CQC visit in 2019 has been completed and various audits have taken place to ensure the learning/changes are embedded. The issues raised were about maternity documentation, the use of tools for assessment and CP-IS documentation at night in Children's Emergency Department (CED).
3. A safeguarding update to contribute to the B&H Safeguarding Partnership annual report was given.
4. The safeguarding team have been involved with two Partnership audits (relating to issues relating to culture and ethnicity and neglect.)
5. Maternity have undertaken 2 audits on Badgernet about documentation.
6. Adherence to getting CP-IS information has also been reviewed and as a result a request for admin support to CED over the weekend has been introduced.
7. An audit of gaining and documenting consent for CP medicals was undertaken and shared at the yearly safeguarding governance/audit meeting.
8. A snapshot pilot audit of staff understanding of ICON (prevention of abusive head trauma) showed that staff were aware and could talk to parents/carers about the subject. This will be repeated in 2022/23.
9. Co-ordination of audits across the trust sites is a priority for 2022/23

4. Conclusions and Priorities for 2022-23

This report provides evidence of safeguarding activity between April 2021 and March 2022 and evidences a significant increase in activity, the challenges but also the improvements. Safeguarding and protecting children from abuse is complex and challenging work which requires a careful mix in skills between caring and control combined with the application of professional curiosity and an understanding of diversity and bias, when making a judgement whether a child or young person is experiencing harm (DfE 2022)

It is acknowledged that it has been a challenging year and due to the significant emotional demands experienced, staff are reminded and have access to support ensure their health and wellbeing remains of the highest priority. Staff have had access to health and wellbeing support from the trust but also have access to psychological support within the women and children division. This, along with regular supervision, peer support and working within a supportive collaborative cohesive team, has been beneficial.

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)

4.1 Priorities for 2022-2023

Key Priorities for Safeguarding Children at University Hospitals Sussex NHS Foundation Trust

1. Develop a domestic abuse strategy and identify funding to resource and support the delivery of the strategy across all sites
2. Update the Safeguarding Children and Looked after Children policy
3. Develop an integrated safeguarding training strategy
4. Work towards integrating safeguarding structures, systems and processes, across the trust, ensuring, place based safeguarding is also strengthened.
5. Liberty Protection Safeguards and strengthening MCA
6. Developing a sustainable solution for information sharing and paediatric liaison with the healthy child programme.
7. Strengthen safeguarding arrangements for children and young people admitted to hospitals with mental health issues
8. Strengthen the safeguarding Champions role
9. Strengthen arrangements for looked after children across the trust
10. Increase inclusivity to reflect the diversity of Sussex children and promote ‘trauma Informed care’.
11. Strengthen Transitional safeguarding across the trust

5. Glossary of Terms

BHSCP	Brighton & Hove Safeguarding Children Partnership
CDC	Child Development Centre
CED	Children's Emergency Department
CIN	Child in Need Plan
CPP	Child Protection Plan
CP-IS	Child Protection Information Sharing System
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
ICS/ ICBB	Integrated Care System / Integrated Care Board
IHA	Initial Health Assessment for looked after children
IPC	Innovations in Primary Care
JTAI	Joint Targeted Area Inspection
LCSPR	Local Child Safeguarding Practice Review
LSCP	Local Safeguarding Children's Partnership
MCA	Mental Capacity Act
MHA	Mental Health Act
NHSE/I	National Health Service England and NHS improvement
NICE	National institute of clinical effectiveness
PANDA	Paediatric Acuity and Nurse Dependency Assessment
RACH	Royal Alexandra Children's Hospital
UHSFT	University Hospitals Sussex NHS Foundation Trust
UTC	Urgent Treatment Centre

WSSCP	West Sussex Safeguarding Children Partnership

University Hospitals Sussex
NHS Foundation Trust

Safeguarding Adults Annual Report 2021-2022

Contents

1.Introduction

The Safeguarding Adults Annual report reflects the arrangements to safeguard and promote the welfare of adults at risk within University Hospitals Sussex NHS Foundation Trust (UHSussex) for the period of April 2021 to March 2022. In doing so, the Trust discharges part of its responsibility for Board-level assurance, scrutiny and challenge of safeguarding practice within the Trust, in line with the statutory requirements of the Mental Capacity Act 2005 and the Care Act 2014.In addition to the requirements of the Care Act 2014, the Trust, as a registered provider with the Care Quality Commission (CQC), must have regard for the Regulations as established under the Health and Social Care Act (2008). In relation to Safeguarding, including but not limited to, Regulation 13 and Regulation 17, relating to protecting service users from abuse and good governance, respectively.

This report highlights the work undertaken by the University Hospitals Sussex NHS Foundation Trust Adults Safeguarding teams in respect to its commitment and responsibilities in maintaining the safety and protection of vulnerable safeguarding adults at risk of abuse and neglect. Every person should live a life that is free from harm and abuse and this is a fundamental human right of every person and an essential requirement for health and well-being.

The responsibility to safeguard adults at risk and to promote their welfare is more comprehensive than protection. In order to minimise the risk of abuse staff members need to recognise their individual responsibility to safeguard and promote the welfare of adults who are vulnerable as well as the commitment of Trust management to support them in this. This includes ensuring staff have access to appropriate training, advice, support and supervision in relation to the Care Act (2014), the Mental Capacity Act (2005, 2019), and the Counter-Terrorism and Security Act (2015).

2. Background

The purpose of this report is to inform the Trust Safeguarding Strategy Committee and Executive Board of the safeguarding arrangements currently in place to ensure UHSussex meets its statutory responsibilities to safeguard and promote the welfare of adults with care and support needs. It provides a detailed review on key aspects of safeguarding activity and partnership working with agencies across Sussex. The Trust's Safeguarding Adults Service has the following overarching aims. To:

- Ensure the Trust has safeguarding arrangements in place as defined by the Care Act (2014) by providing visible and professional safeguarding leadership for all aspects of safeguarding adults to ensure that day to day advice, support and expertise is

available to all staff in the Trust. This includes the responsibility of the implementation, maintenance, and development of effective and efficient systems for the detection, prevention, surveillance, investigation and control of harm and abuse.

- Facilitate safeguarding adults training sessions across the hospital to ensure that learning, skills sets and knowledge of staff is provided as per statutory and mandatory training requirements. This includes all matter of communication across the hospitals to ensure that the local needs and risks to adults are understood and dealt with to a degree by the frontline staff using lessons learnt from national and local case reviews, best practice and research.
- Ensure that 'making safeguarding personal' is central to the way the UHSussex staff respond to people with care and support needs who may be in vulnerable circumstances and at risk of abuse or neglect by others. In these cases that we work together with local services to identify those at risk and take steps to protect them.
- Work in partnership with key internal and external stakeholders to deliver a comprehensive, cohesive, safe, and effective safeguarding service for the hospital. This includes engagement with at risk patients, relatives, and advocates gaining feedback in order to ensure services and service improvements are patient centred and enhancing equality and parity of esteem.
- Ensure the Trust is compliant with its duties towards people under the statutory legislation including the Mental Capacity Act (MCA) 2005 and Mental Health Act (1983&2007).

3. CURRENT POSITION

3.1 External Assurance

3.1.1. Sussex Safeguarding Adults Policy and Procedures

The Policy sets out the approach taken to adult safeguarding across Sussex. The Procedures explain how agencies and individuals should work together to put the Sussex Safeguarding Adults Policy into practice. They have been updated in accordance with the Care Act 2014 and the Care and Support Statutory Guidance, and should be read in conjunction with these. The update has taken into account lessons learnt from Safeguarding Adults Reviews, audits and practice.

These Procedures represent the standards for good practice in adult safeguarding in Sussex and have been endorsed by Brighton & Hove, East Sussex and West Sussex Safeguarding Adults Boards.

3.1.2. The West Sussex Safeguarding Adults Board (WSSAB).

The West Sussex Safeguarding Adults Board was established in 2011**.** The board Has a core membership of statutory partners from: West Sussex County Council (WSCC), NHS West Sussex Clinical Commissioning Group (CCG) and Sussex Police. University Hospitals Sussex is also one of the member of WSSAB. The purpose of a Safeguarding Adults Board (SAB) is to safeguard adults with care and support needs by ensuring that:

- Local safeguarding arrangements are in place as defined by the Care Act 2014 & statutory guidance;
- Safeguarding practice is person-centred & outcome-focused;
- Safeguarding practice is continuously improving & enhancing the quality of life of adults in its area.
- Agencies give timely & proportionate responses when abuse or neglect have occurred; & by
- Agencies are working collaboratively to prevent abuse & neglect where possible.

SABs have three core duties, to fulfil statutory requirements:

- Have a Strategic plan,
- Produce an Annual Report,
- Carry out Safeguarding Adult Reviews. Information is available on their website.

The Trust has been involved in the planning and development of the partnership arrangements for services for Adults in West Sussex. The Trust is represented on the Board by Trust senior safeguarding adults lead and is an integral decision maker in the development and progression of the local safeguarding agendas. The Trust representative plays a key role in informing the multi-agency board on the development of safeguarding initiatives specifically related to health. The Trust is also represented on a number of WSSAB sub-groups, including the Quality & Performance Subgroup (Q&P) and Learning & Policy Subgroup (L&P).

3.1.3 Brighton and Hove Safeguarding Adults Board

The Brighton and Hove Safeguarding Adults Board (BHSAB) is a multi-agency statutory partnership that provides leadership and strategic oversight of adult safeguarding work across Brighton and Hove. There is a strong focus on working together to protect adults with care and support needs from abuse and neglect. The purpose, core duties and statutory partners are as discussed above for the WSSAB.

UHSussex are partners of the BHSAB and are represented by the Lead Nurse Safeguarding Adults. The BHSAB have developed a strong working relationship with UHSussex to

promote policies, procedures, protocols and guidance that has been developed in continuing to raise knowledge and awareness of adult safeguarding practice. UHSussex shares information with the BHSAB to contribute to the development of the BHSAB Annual Report – the full published report is available on the BHSAB website. The report has been shared with the Trust Safeguarding Committee.

The Lead Nurse Safeguarding Adults also represents UHSussex on the BHSAB Quality Assurance subgroup and has recently been appointed vice-chair of the BHSAB Learning and Development subgroup.

3.2 Internal Assurance

3.2.1. The Safeguarding Strategy Committee

The Integrated Safeguarding Strategy Committee meets quarterly and seeks assurance that all safeguarding commitments and responsibilities for both adults and children are met. It oversees the work of the Safeguarding Adults Operational Group and Safeguarding Children Operational Group. It further seeks assurance that there are suitable processes in place to ensure that safeguarding arrangements are reviewed and updated on a regular basis through the Work Plans and those actions are completed within agreed timescales and reviewed on a regular basis.

3.2.2. Safeguarding Adults Operational Group

The Safeguarding Adults Operational group is a subgroup of the Trust Integrated Safeguarding Committee and is chaired by the Trust Safeguarding Adults Leads. The group meets quarterly and takes relevant action in regard to any operational safeguarding adult issues, MCA and DoLS, Dementia, Learning Disability, Domestic Abuse and sexual violence, PREVENT and Modern Slavery. The group maintains an overview of the progress of the Safeguarding Adult Work Plan. The Terms of Reference have been developed, reviewed and membership identified.

3.2.3. 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 adult professionals within the NHS across Sussex. Meetings take place on a monthly basis and although chaired by one of the CCG Designated Safeguarding Adults Nurses, they 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. NHS Professionals forums have also been implemented in relation to Prevent and LPS.

UHSussex is represented at these meetings by the Trust Senior Lead for Safeguarding Adults and the Lead Nurse Safeguarding Adults.

3.2.4 Safeguarding Adults Teams

The Safeguarding Adults teams within UHSussex work collaboratively to ensure consistent good practice and leadership around safeguarding adults and the implementation of Mental Capacity Act principles in clinical practice. Internal assurance arrangements are integrated across the Trust and both Safeguarding Leads actively participate in external SAB activity, providing assurance to both the SAB and CCG regarding safeguarding adults throughout UHSussex.

Due to the geographical spread of hospital sites within UHSussex, day to day operational safeguarding adults provision is maintained across the historic site based teams.

3.2.5. Worthing / Southlands / St. Richards Hospitals

The team consists of x1 WTE band 8b Senior Lead for Safeguarding, 0.8 WTE band 7 specialist nurse and 0.9 WTE band 7 Mental Capacity Lead. Further support is provided by band 7 safeguarding nurse via temporary staffing two days per week. The team is supported by 0.6 WTE band 3 administrator.

The Safeguarding Specialist Nurse is responsible as part of a team for supporting the staff across the organisation to implement good practice around Safeguarding Adults. This includes delivering training, responding to queries from staff and gathering information around safeguarding concerns that are raised. They work closely with the Mental Capacity Lead to embed the Mental Capacity Act into practice across the organisation.

3.2.6. Royal Sussex County Hospital / Sussex Eye Hospital / Newhaven / Princess Royal Hospital

The team consists of 1 WTE Band 8a Lead Nurse Safeguarding Adults and 1WTE band 7 Named Nurse Safeguarding Adults. They are supported by a 0. 67 band 4 Safeguarding Adults Team Administrator.

Both the Lead Nurse and Named Nurse are responsible for providing support and guidance to staff to ensure good safeguarding practice and embedding the principles of the Mental Capacity Act in clinical practice. This includes developing and delivering training, responding to queries from staff; and providing direct support in clinical practice when responding to safeguarding concerns as well as in regard to mental capacity assessments, best interest meetings and the application of Deprivation of Liberty Safeguards.

The two safeguarding adults lead nurses continue to shape collaborative working practices across clinical services to provide consistent and robust standards of safeguarding. They

ensure that recommendations from regulatory and professional safeguarding standards are implemented. The leads for safeguarding adults work in partnership with the Lead & Named Nurses Safeguarding Children and are supported by the Senior Leadership Team who understand the need to foster a culture of safeguarding and the challenges faced. They report directly to the Director of Nursing.

The safeguarding adult's leads play a key role in ensuring quality safeguarding for adults at risk. In collaboration with other members of their teams, they support all activities necessary to ensure the organisation meets its responsibilities for safeguarding adults at risk. The leads are strategic in nature but with an operational focus, who work closely with professionals and partner organisations to deliver a comprehensive safeguarding function. They play a key role in promoting excellent professional practice within the organisation, providing advice, support, supervision, and expertise for fellow professionals and ensure safeguarding training and supervision is in place from board to floor.

3.2.7. Disclosure and Barring Service (DBS)

Disclosure and Barring Service (DBS) regulations are in place for the Trust. All new employees and volunteers are checked as part of the employment/volunteer process. Safer recruitment processes are followed, and the safeguarding team work closely with Human Resources when concerns are raised**.**

3.2.8. Quality Schedule

The Safeguarding Adults Leads produce a quarterly exceptional report to be submitted to the CCG to ensure that the Trust is compliant with its statutory safeguarding requirement. The report looks at progress of the Trust agreed key performance indicators with the CCG.

4. Safeguarding Activity

4.1. Worthing / Southlands / St. Richards Hospitals

Safeguarding incidents in the Trust are monitored by the safeguarding team daily. Alerts for safeguarding incidents are generated via Datix and email. All safeguarding referrals to the social services are completed through an integrated form from the Trust intranet. The adults safeguarding team involves in providing safeguarding expertise when required. The incidents and referrals are analysed to detect trends and themes and to improve safeguarding within the Trust.

4.2 Royal Sussex County Hospital / Sussex Eye Hospital / Newhaven / Princess Royal Hospital

In accordance with Sussex policy and procedures, safeguarding adults concerns are raised directly to East Sussex, Brighton and Hove or West Sussex Adult Social Care via their respective on-line referral processes. Hyperlinks to each are available on the safeguarding adults' team intranet site. The safeguarding team provide advice and guidance to staff raising concerns and support the development of safeguarding plans to protect the adult at risk of, or experiencing, harm or abuse as appropriate. Making Safeguarding Personal is central to safeguarding practice.

5. LEARNING, DEVELOPMENT AND TRAINING

University Hospital Sussex NHS Trust has aligned its staff statutory training requirements to the Skills for Health Core Skills Training Framework (Skills for Health 2018). Included in this is the need for completion of safeguarding training for adults and children which is underpinned by an Intercollegiate Document Guidance for Safeguarding Adults NHS England 2018. Each level of training requires that staff need to complete a minimum number of hours training over a three-year period and that these training hours can be met by undertaking a variety of different training interventions. The Trust complies fully with these documents.

The team continues to face challenges due to the Covid pandemic. All face-to-face training was cancelled across the Trust which was the method by which the safeguarding team delivered most of its training. The team had to adapt in order to continue delivering training to our staff.

5.1. Worthing / Southlands / St. Richards Hospital

The adults safeguarding team worked with the workforce team to develop and then deliver 'virtual' face to face Level 3 adults safeguarding training and delivered via TEAMS. A training video was also recorded and uploaded to CORTEX to provide E-learning for safeguarding adults level 2 and MCA training.

In collaboration with safeguarding children a booklet was developed to provided safeguarding knowledge that will meet competence requirements for both safeguarding adults and children and PREVENT.

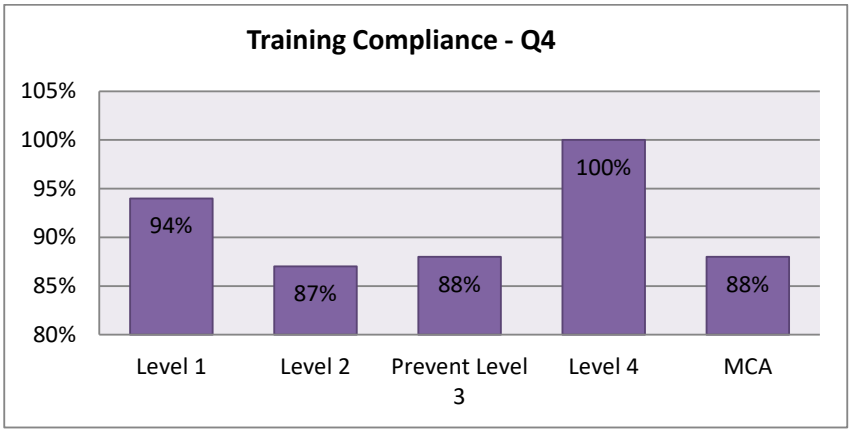
Figure1: Last two quarters of safeguarding adults training compliance.

Safeguarding Training Level	Staff Trained Q3	Staff Trained Q4
Level 1	97.84%	98.10%
Level 2	86.61%	88.68%
Level 3	80.00%	80.20%
Level 4	100%	100%

5.2. Royal Sussex County Hospital / Sussex Eye Hospital / Newhaven / Princess Royal Hospital

The safeguarding adult's team worked with the IRIS team to develop e-learning modules for safeguarding adults Level 1 and Level 2 and are accessible to staff via IRIS. The level 2 e-learning contains Mental Capacity Act and DoLS information but in addition they have developed a stand-alone MCA and DoLS e-learning module. Prevent basic awareness is provided via the safeguarding adults training but the more detailed Level 3 Prevent training requirement is provided by accessing the Home Office approved level 3 Preventing Radicalisation e-learning via IRIS.

Figure2: Training compliance-Q4



6. AUDIT

In line with the Brighton and Hove, and West Sussex SAB objectives for 2021/22 UHSussex completed the safeguarding self-assessment tool developed by the SAB. In conjunction with partner agencies, both safeguarding leads took part in the SAB challenge event, which provides a framework for peer scrutiny and oversight of each self-assessment led by the SAB Chair. As a result, UHSussex rated themselves Amber overall with actions in relation to integrating policies and establishing governance arrangements following the merger. UHSussex also identified areas that need to improve in relation to sharing learning from SAB activity. The SAB challenge event has helped shape the safeguarding priorities for UHSussex moving forward in 2022 – 23, refer to page 26 of this report.

7. SAFEGUARDING ADULT REVIEWS / DOMESTIC HOMICIDE REVIEWS

7.1. Worthing / Southlands / St. Richards Hospital

The Safeguarding Adults Team received 3 Summary of Involvement (SOI) and Information Management Review (IMR) requests regarding Domestic Homicide Reviews (DHR) during 2021/2022. No requests were received for Safeguarding Adults Reviews.

The Safeguarding Adults Team represented the Trust on all three panels and was able to provide updates to the panel/chair about improvements that have already been made within UHSussex within the IMR summaries. The Safeguarding Adults Team has implemented a greater emphasis on Domestic Violence and Domestic Abuse within the training provided for staff during this period, this incorporates updates from the new Domestic Abuse Act (2021); awareness of the dangers of stalking and harassment has been raised during a Trustwide “Theme of the Week”; a “Theme of the Week” about Domestic Violence and appropriate reporting has also been undertaken alongside the development of a luggage label, which acts as an aide memoire for practitioners when encountering patients who are victims of this crime; When the team receives copies of adult safeguarding concerns regarding Domestic Violence we encourage practitioners to adopt a “Think Family” approach. The Domestic Abuse Act (2021) defines that children are no longer to be deemed as witnesses to Domestic Abuse but as victims in their own right, this requires appropriate reporting to children’s social care and the police.

The panels acknowledged that the lack of hospital IDVA was a potential area of improvement. The Trust Senior Leads for Safeguarding acknowledged that, although

improvements have been made, there is a need to develop a Domestic Violence Strategy within UHSussex. This would need to include a hospital IDVA/navigator, alert flagging system for adults on patient administrative system, body mapping, clinical photography and guidelines for preserving evidence.

The final versions of all three reports are currently being written by the independent chairs. These then need to be approved by the Home Office before they are published. On publication these reports will be received by the Trust's Safeguarding Committee. These will be made available, alongside the Executive Summaries, to all staff via links on our intranet pages.

7.2. Royal Sussex County Hospital / Sussex Eye Hospital / Newhaven / Princess Royal Hospital

The Safeguarding Adults Team provided information to support statutory Domestic Homicide Reviews and Safeguarding Adults Review as requested by both East Sussex and Brighton and Hove. In addition to these, the Lead Nurse participated in a multi-agency review panel in line with the Sussex Adult Death Protocol.

In addition to identifying learning and making recommendations, it is important that statutory reviews recognise and share good practice. The Lead Nurse Safeguarding Adults was a panel member for East Sussex SAR KK, following the death of a gentleman with both Learning Disability and mental health care needs. The information provided by the Lead Nurse identified good collaborative working and support for the ward whilst in UHSussex by the LD Liaison Nurse Team, and timely referral for an IMCA to support best interest decision making and subsequent discharge planning as part of end-of-life care.

The Lead Nurse also contributed to two SARs taking place within Brighton and Hove who are awaiting publication of the final reports. Initial recommendations include ensuring agencies have up to date policies in relation to Mental Capacity Act (this has now been implemented); and also, improvements to discharge planning and communication between hospital and community services when there are ongoing specific care plans for example in relation to dietetics and management of nutrition for people with a learning disability.

Brighton and Hove SAB published a learning briefing for SAR James which highlights the complexities of supporting adults with acquired brain injury as well as substance misuse; and the need for specialist support for practitioners in health and adult social care to fully understand the impact on executive functioning when undertaking mental capacity assessments to support decision making.

8. POLICIES AND PROCEDURES

The Safeguarding Adults Policy has been completely updated and re-written. The MCA and DoLS Policies have been updated, but as the Government LPS Code of Practice has not been published these will not be re-reviewed until the latest guidance is provided.

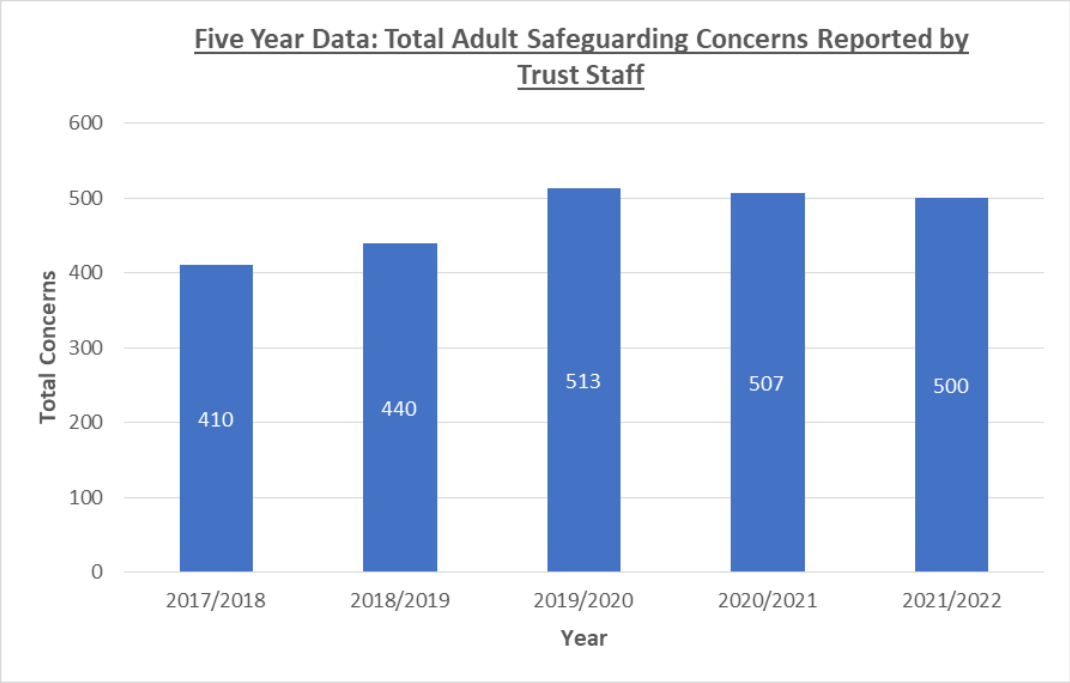
9. SAFEGUARDING ADULTS ENQUIRIES / REFERRALS AND INCIDENTS

9.1. Worthing / Southlands / St. Richards Hospital

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 Worthing and St Richards under the Mental Health Act.

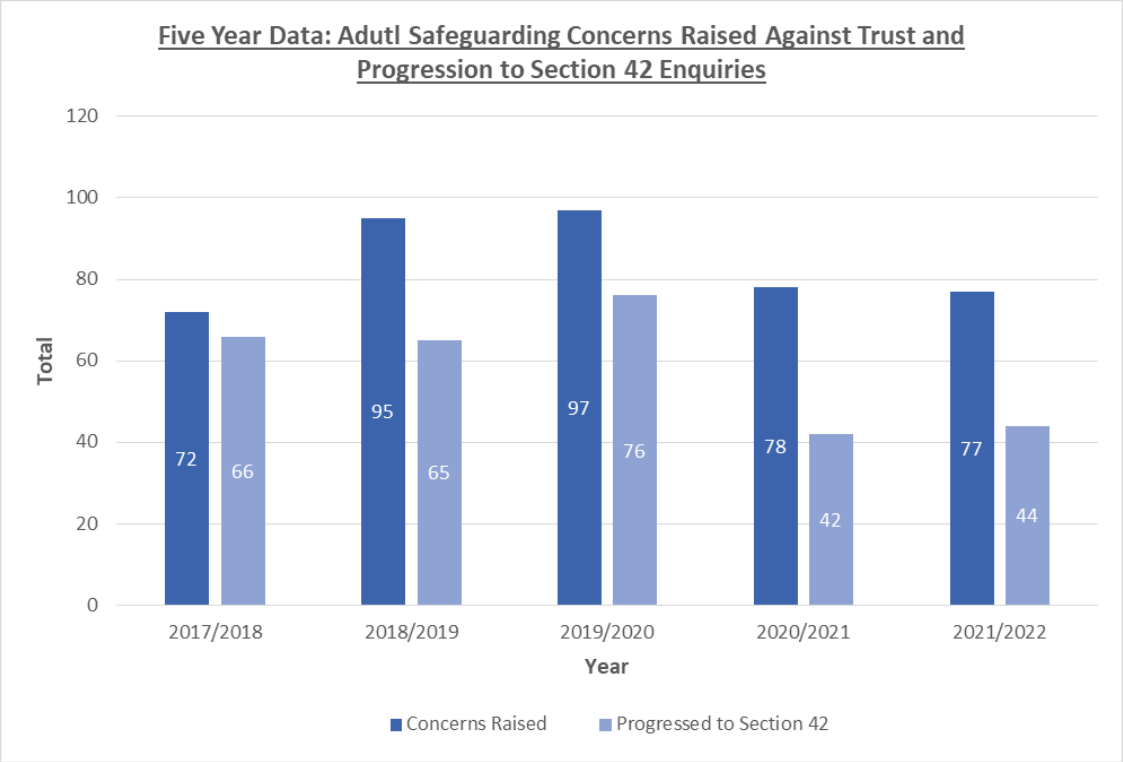
There were 500 Safeguarding Adults referrals made by Trust staff during the reporting period. The referral rates to the Local Authority have remains similar compared to the previous period 2020/21 when 507 referrals were made.

Figure 2 details are for St Richards and Worthing hospital 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 and concerns raised about Trust care. Under the Care Act, the Trust is required to respond to such requests for information to inform safeguarding enquiries. **Figure:3**



During this period (**figure 4 below**) the Trust received 77 Cause for Concern referrals, but only 44 that lead to section 42 enquires. This figure is consistent to 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. Where safeguarding and Cause for Concern investigations have taken place, the outcomes have been shared with staff members via ward / department meetings to review and instigate processes/clinical practice to prevent similar incidents from occurring.

Figure 4



The 44 cases that resulted in section 42 enquires fell within neglect and sexual categories of types of abuse. 59% of neglect cases were linked to discharge and 41% were not related to discharge. This is decreases of 35% compared to the last year when 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 thread most commonly being communication. There is evidence that the new processes the Trust has put to improve discharge has had a positive outcome.

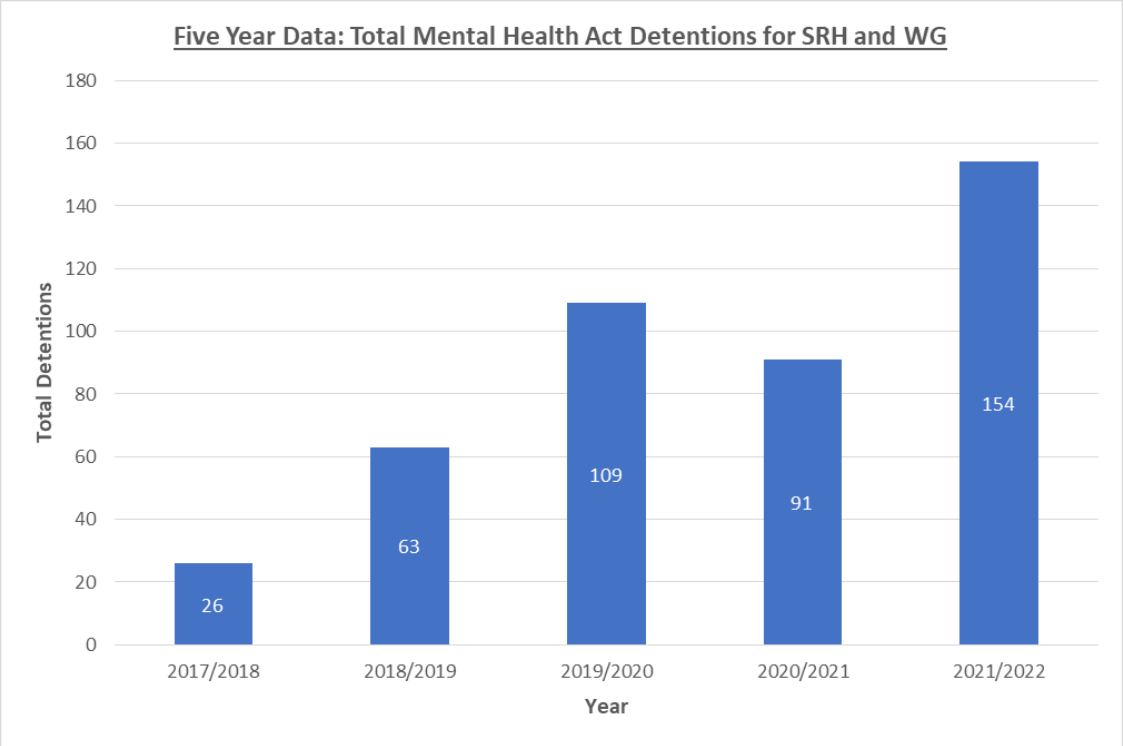
There were two cases of sexual abuse concern raised in the year. One concern was sexual patient on patient incidents and other concern was allegation towards a staff member. All

such cases are thoroughly investigated with full involvement of the police. No further action has been taken in any of the cases.

9.2. The Mental Health Act (1983) Activities

The Trust has a contract with Sussex Partnership 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 Worthing and St Richard hospitals.



The adults safeguarding lead for Worthing, St Richards and Southlands has been working with SPFT to review our policies around MHA and training in order to improve our staff knowledge around MHA. This is also including making sure these vulnerable patients group their rights are protected and supported to exercise them.

9.3. Royal Sussex County Hospital / Sussex Eye Hospital / Newhaven / Princess Royal Hospital

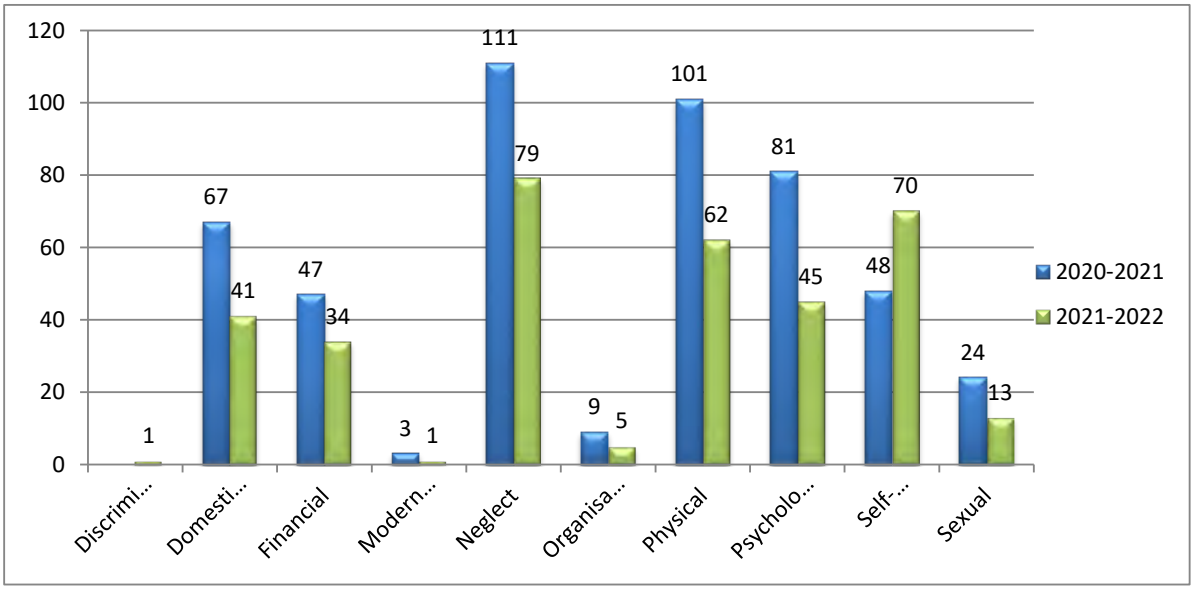
The Care Act 2014 identifies ten key categories of harm and abuse:

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

Safeguarding Concerns Raised by Staff

The data below shows the number of safeguarding concerns under each category, raised by staff for 2021/22; in comparison to the previous 2020/21.

Fig 5: Safeguarding concerns



The data shows a significant decrease in the majority of abuse and neglect categories reported during 2021-22, in particular concerns in relation to neglect, physical abuse, psychological abuse domestic violence and sexual abuse. The recording structure allows for multiple categories to be recorded in relation to one safeguarding concern e.g. a safeguarding concern reported for domestic abuse may also be recorded as physical, sexual and psychological abuse depending on the information provided by the patient and by the person raising the concern.

Fig. 6 below shows the number of concerns raised by staff and recorded by the Safeguarding Adults Team specifically in in relation to the overarching category of Domestic abuse / domestic violence for 2020 / 21 and 2021 / 22.

Fig.6 – Domestic abuse

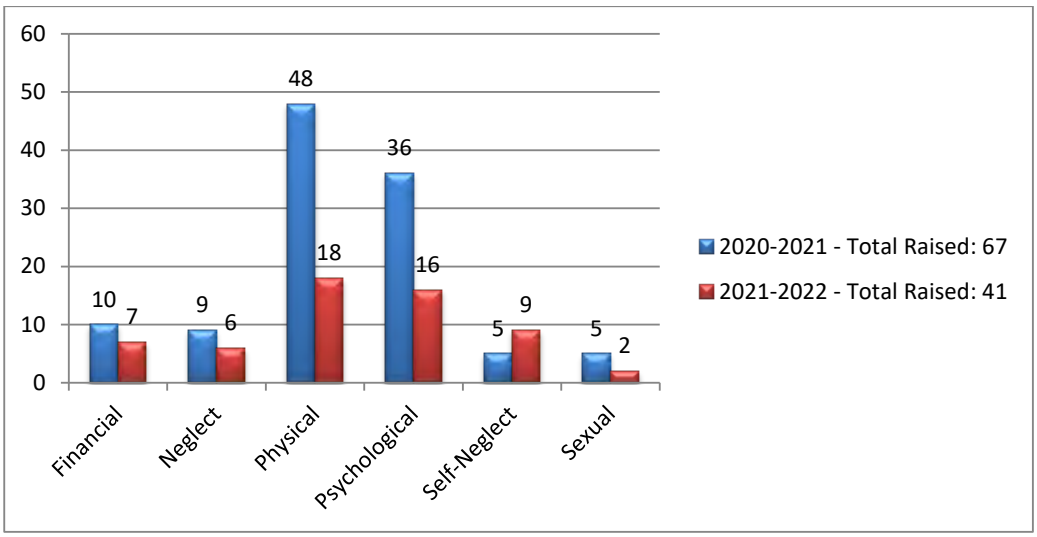


Fig. 7 – Safeguarding concerns raised, excluding Domestic Abuse

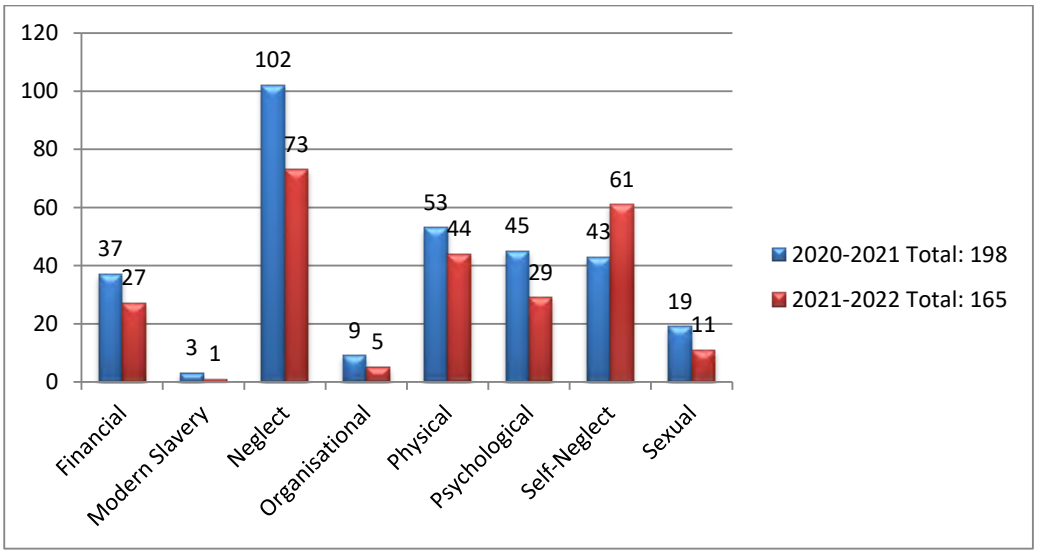


Fig 7 shows the comparative data for safeguarding concerns raised in 2020 / 21 and 2021 / 22 **excluding** data relating to domestic abuse. Whilst there is still a decrease in many categories, the data shows that the more significant decrease in 2021 / 22 is in relation to the overarching area of domestic abuse. The difference may, in part, be explained by the impact of lockdown during 2020/21 and the increased risk of harm this placed on those experiencing domestic abuse, who were in many cases, living in isolation with the

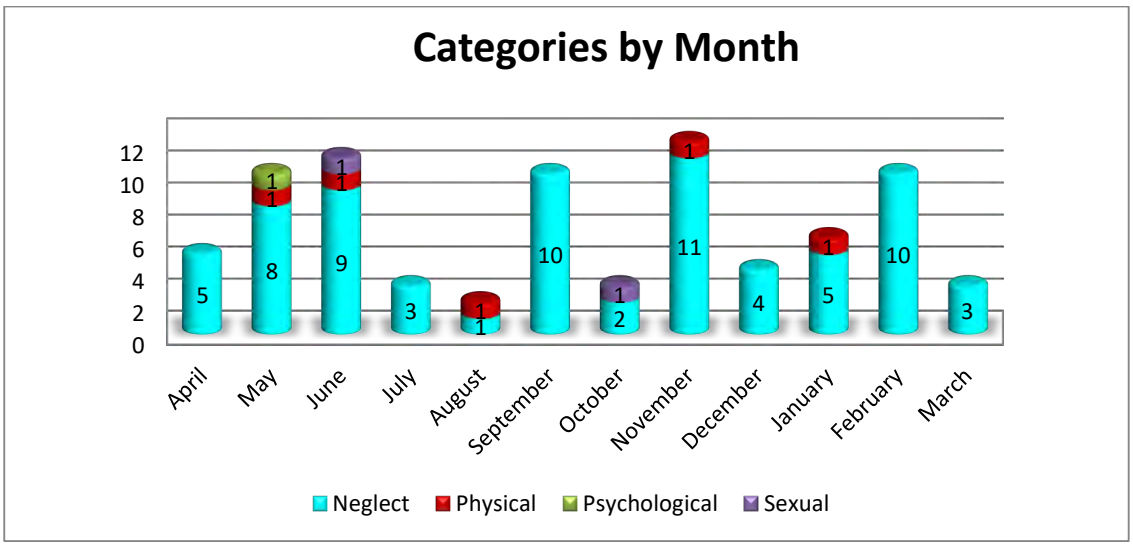
perpetrators of domestic abuse. Fig.6 shows that the multiple categories relate to 67 individual safeguarding referrals i.e. for 67 individual people. This is almost double that raised in the previous year (2019 – 20) pre-COVID and lockdown, when 36 safeguarding concerns had been raised for domestic abuse.

The data also shows a significant increase in the number of safeguarding concerns raised by staff in relation to self-neglect. This had previously been an area of focus during safeguarding training. It also reflects some of the longer-term impacts of COVID, where people have not accessed care and support; have remained at home with an increase in alcohol /substance misuse and the potential impact of changes in their financial circumstances.

Section 42 Enquiries Received

In line with Section 42 – 48 of the Care Act, if Adult Social Care assess that a safeguarding concern reported to them meets the threshold for investigation, they will submit a 'Causing Others to Undertake Further Enquiry' to the appropriate agency. The table below **(figure8)** shows the number of 'causing others' received by the Safeguarding Adults Team each month from April 2021 to March 22; and the category of harm or abuse alleged to have taken place. The aim of the enquiry is to understand the circumstances leading to concerns regarding the care provided and identify any learning outcomes to improve patient care where appropriate.

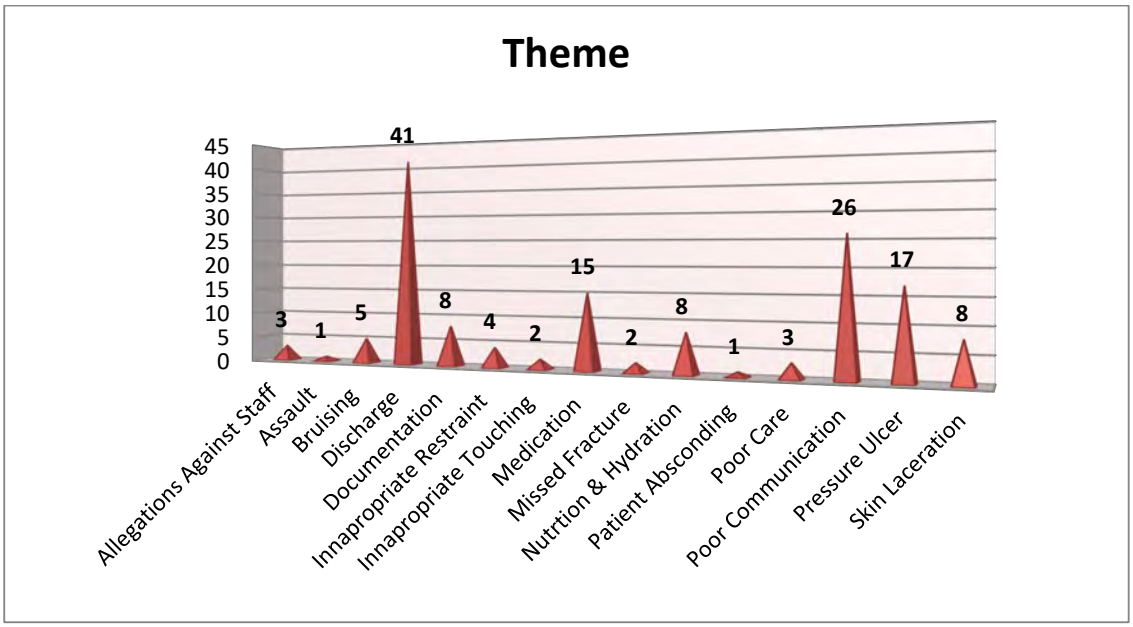
Figure 8.



In addition to the categories of harm and abuse, the Safeguarding Adults Team monitor and identify more specific themes in relation to the concerns raised against UHSussex. One

category may relate to multiple themes; for example an allegation of Neglect may relate to the themes of discharge which may include poor communication, incorrect medication on discharge etc. The table below **(figure9)** provides an overview of the underlying themes raised and, as in previous years, continues to highlight discharge as an area of concern.

Figure 9



10. MENTAL CAPACITY ACT (MCA) AND DEPRIVATION OF LIBERTY (DOLs)

10.1. Mental Capacity Act Activity

The Mental Capacity Act Lead continues to deliver training on understanding and assessing mental capacity and best interest decision making and the Deprivation of Liberty Safeguards (DoLS), to a variety of wards, specialist departments and disciplines. This training supports all staff groups to increase their knowledge and to feel more confident in lawful application of the Mental Capacity Act (2005).

Additionally, a Consent and Capacity Workshop was delivered to final year Medical Doctor's from Brighton University and to First Year Doctors on their induction training to the Trust. It is hoped that these will become recurring annual slots to deliver high quality, practical support to the participants before they begin their ward placements.

Numerous bespoke sessions in different departments and disciplines have been delivered and these have been well received.

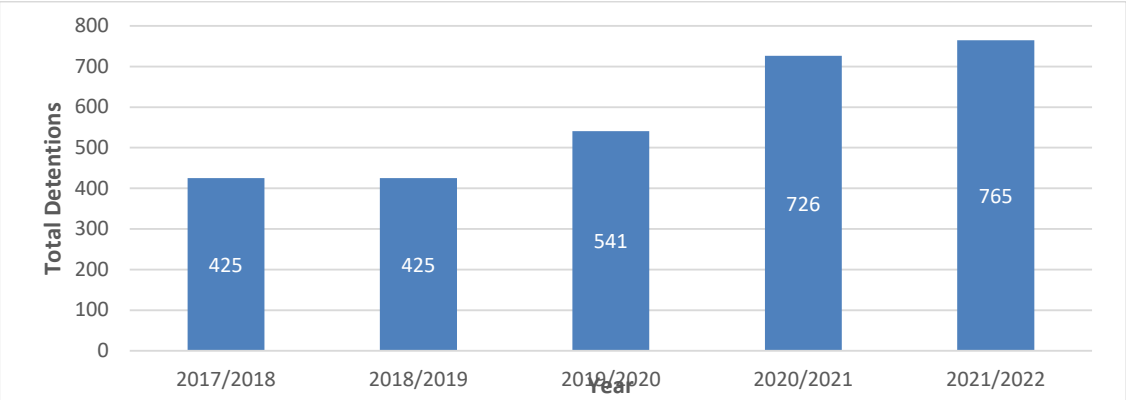
Highly complex situations continue to require a more individualised approach and there remains a constant, and sometimes significant, stream of cases bought to the Mental Capacity Act Leads attention. These cases often cross over in to safeguarding work and involve close collaboration with the Local Authority, Community Health Services, and other service providers. Advice and support in these cases is provided directly to practitioners to navigate them through the process, ensure that patients' rights are upheld, the legal framework is followed and that patients at risk are protected.

A key objective remains to review the current training needs analysis from the legacy Western Sussex Hospitals NHS Foundation Trust with that of legacy Brighton and Sussex University Hospitals NHS Foundation Trust to ensure continuity of training, particularly in regard to mandated standalone Mental Capacity Act training, across all staff groups for the now formed University Hospitals Sussex NHS Foundation Trust.

10.2. Worthing / Southlands / St. Richards Hospital

As seen in **figure 10** below, there has been consistent and steady increase of 80 percent in the number of Deprivation of Liberty Safeguards (DoLS) authorisation requests across both Worthing and St Richards sites combined in the last five-year period.

Figure 10: Total Deprivations of Liberty Safeguards Authorisation Requests for Past Five Years: Worthing and St Richards Hospitals.



In 2021/22 there was a five percent increase in the number of DoLS applications compared to 2020/21.

Each application made has to be reviewed within the Adult safeguarding Team for lawful compliance, returned for amendment as required and logged for reporting to the Integrated Care Boards, Safeguarding Adults Boards and Care Quality Commission.

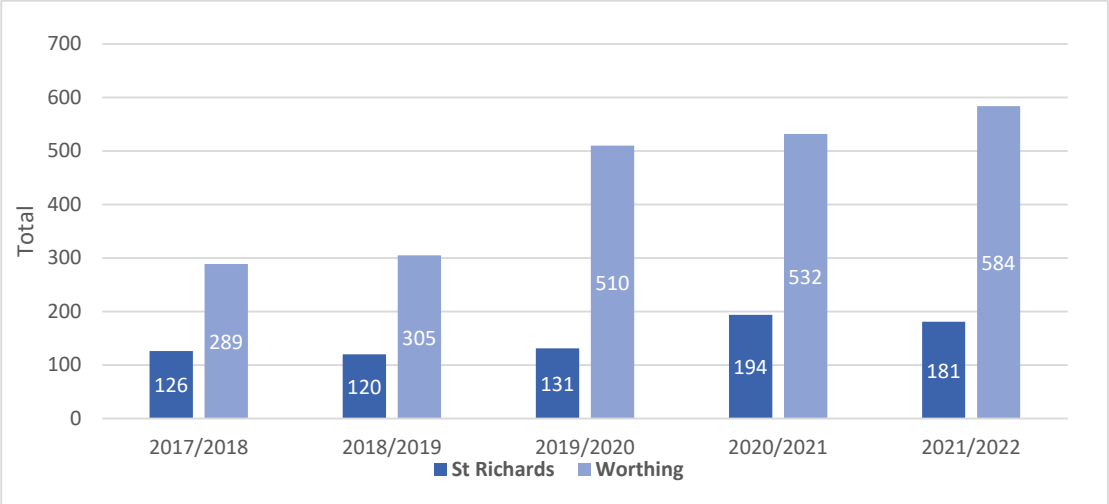
There was only 1 patient fully assessed by the West Sussex County Council DoLS team in 2021/22 to give the legal authorisation to the deprivation. This is due to the ongoing significant numbers of DoLS authorisation requests being received by the DoLS team following the Cheshire West court case in which the 'Acid Test' for determining if a deprivation of liberty is occurring was laid down. The DoLS team are aware of the failure to assess our patients and continue to review their processes, with certain cases being able to be highlighted but acute hospitals continue to not be considered a priority area.

The low rate of assessments by the DoLS Team continues to be raised at the NHS Safeguarding Professionals meeting as an area of risk and is also on the Trust's Risk Register.

A process of review remains implemented for wards for when the lawful urgent authorisation that the Trust is able to grant itself runs out, although this does not mitigate the risk to the Trust, it does ensure that the appropriate checks are in place to ensure the criteria and need to deprive the person of their liberty remains, is the least restrictive option and is in the patients best interests.

We continue to see a large discrepancy in DoLS numbers between the St Richards and Worthing Sites as shown in **figure 11**. Initial data gathering has indicated significant differences in the presenting cognitive states for patients between the sites and further investigation to understand this is required involving those responsible for clerking patients for admission. Early 2022 the MCA Lead produced a clear guide and assessment tool for inclusion into the clerking proforma to support practitioners in identifying when a DoLS application is required. Any impact from this will be seen in the annual reporting for 2022/2023.

Figure 11: Total Deprivations of Liberty Safeguards Authorisation Requests by Individual Site for Past Five Years.



10.3. Royal Sussex County Hospital / Sussex Eye Hospital / Newhaven / Princess Royal Hospital

The Lead Nurse and Named Nurse for safeguarding adults work collaboratively with clinical colleagues to support the consistent application of MCA principles in practice. This includes supporting assessment of mental capacity and best interest decision making for those patients who may have fluctuating capacity and/or complex care needs. As well as supporting clinical staff, the team often work closely with family members or friends to support them to understand and navigate the legal complexities relating to MCA and DoLS; ensuring the patient remains central to decision making.

Documentation relating to mental capacity assessments however is not always consistent in terms of demonstrating the reasoning – or 'evidence' - behind assessment decisions. The Lead Nurse has developed a template document which can be used to support documentation of decision specific mental capacity assessments in line with legislation and best practice.

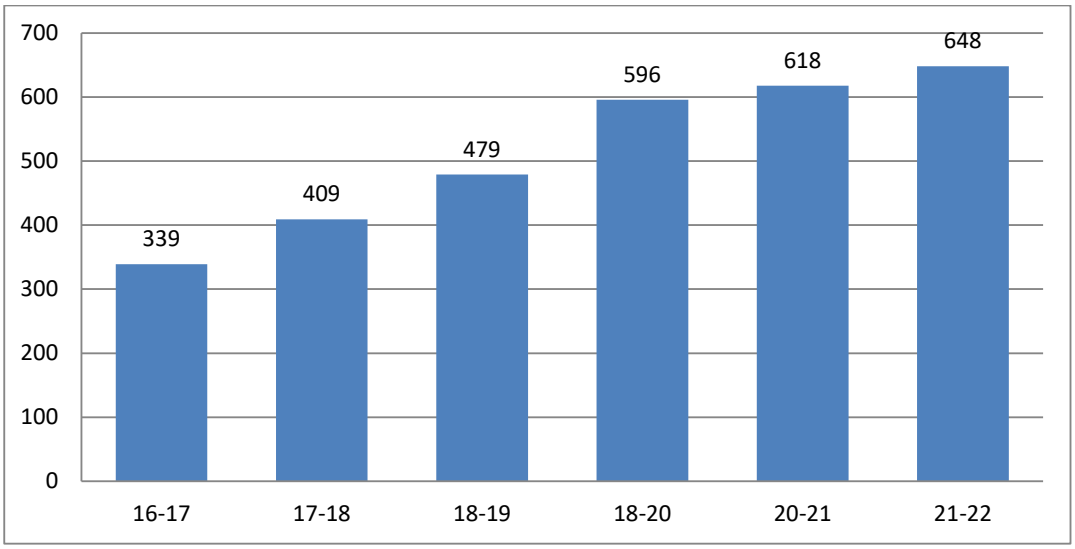
Training regarding MCA and DoLS is via e-learning but the team have continued to provide bespoke departmental sessions on request e.g. Occupational Therapy and Physiotherapy teams as well as ward updates.

As part of the learning action plan relating to a Duty of Candour / SI report, the Lead Nurse worked collaboratively with the Dementia Specialist Lead Nurse to develop a one day training combining supporting patients with dementia / application of MCA and DoLS /

Safeguarding Adults which is now included as part of the nursing Preceptorship programme for newly qualified and internationally educated nurses.

Royal Sussex County Hospital / Sussex Eye Hospital / Newhaven / Princess Royal Hospital

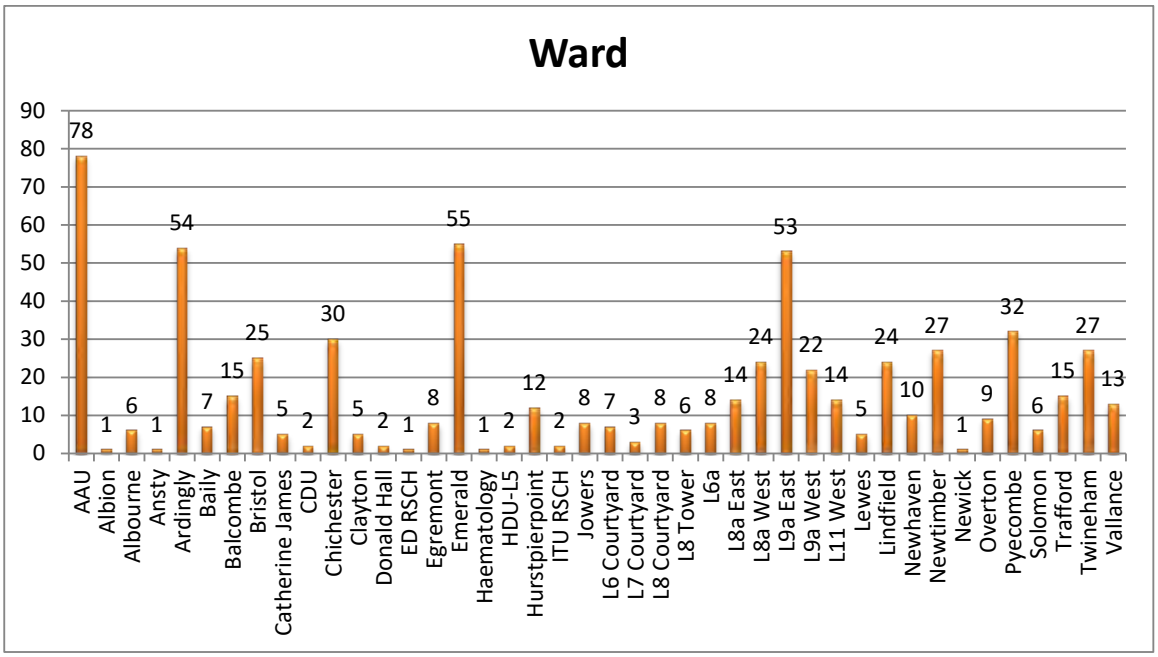
Figure 12: DoLS Applications



The Safeguarding Adults Team continues to see a steady increase in DoLS Urgent authorisations / Standard applications. Similar to the pressures on the West Sussex DoLS teams already discussed, Brighton and Hove also experience significant demand for authorisations from hospitals and care homes in their region. UHSussex can apply for an extension to the Urgent authorisation, providing a 14-day (total) authorisation. It is not unusual for this to still be insufficient time for the DoLS teams to complete the necessary assessments required for a standard authorisation to be granted. The safeguarding team continue to provide advice to ward staff regarding any ongoing restrictions or restraint that may be necessary to ensure the safety and treatment of the patient.

The table below shows the number of DoLS applications received by clinical area.

Figure 13.



10.3. The Future of DoLS

The Mental Capacity (Amendment) Bill was passed in law in May 2019. It replaces the Deprivation of Liberty Safeguards (DoLS) process with a scheme, come to be known as, Liberty Protection Safeguards (LPS). Implementation had been originally due in October 2020, but due to subsequent delays this is now, tentatively, forecast for October 2023.

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 to meet the requirements. The draft revised Code of Practice for both the Mental Capacity Act and Liberty Protection Safeguards was provided in May 2022, and the consultation on this closed in July. Whilst this has given some further clarity regarding the expectations being placed upon the responsible bodies, there remains substantial areas to clarify. It is anticipated that the final revised code will address these, particularly in relation to the acute sector who received little mentioned in the initial draft version. In the interim, all providers remain urged to continue to improve upon staff knowledge and application of the Mental Capacity Act and Deprivation of Liberty Safeguards.

A running audit is in place for St Richards and Worthing Hospitals that is providing data as to the likely numbers of patients who will require the responsible body to undertake the full LPS process upon to evidence resource requirements for implementation.

12. PREVENT

The Counterterrorism and Security Act 2015 introduced the Prevent Duty which requires health bodies, local authorities, schools, colleges, higher education institutions, prisons and probation and the police to consider the need to safeguard people from being drawn into terrorism.

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.

The aim of *Prevent* is to stop people from becoming terrorists (often referred to as being radicalised) or supporting terrorism. It operates in the pre-criminal space before any criminal activity has taken place.

The safeguarding leads for both adults and children work collaboratively to raise awareness of Prevent through safeguarding training, in line with the NHS England Prevent Training and Competencies Framework (DHSC 2021). The Director of Nursing acts as the Trust Prevent Lead, providing oversight to ensure the Trust has the necessary processes in place to support reporting and information sharing relating to Prevent concerns in line with regional and NHS England reporting requirements.

UHSussex are a partner agency on the Brighton and Hove Prevent Board. The Board meets quarterly and is attended by the Lead Nurse Safeguarding Adults. Partners on the Prevent Board work collaboratively to share information that may inform the understanding of risks in the area and support the development of the Counter Terrorism Local Profile.

Channel is a multi-agency panel consisting of professionals from partner agencies and those who are in contact with the particular individual referred via Prevent. Having a Channel panel is a statutory duty placed on local authorities and there is a 'Duty to Co-operate' on all partners. The Channel panel will include a chair from the local authority and a Prevent

police representative. 'Health' is represented by the CCG and in particular the Mental Health Trust. UHSussex does not regularly attend Channel unless asked to do so in relation to a specific case.

13. ORGANISATIONAL RISKS

There are currently three risks on the corporate register:

1021- Following Security Operational Group it has been highlighted that clinical staff are having to perform physical restraint of patient to keep patients and staff safe in various situations, such as, Theatre Recovery when patients come round after operation and dealing with delirious patients and when enforcing DOLS.

899 - The Mental Capacity Act 2005 provides a statutory framework for acting and making decisions on behalf of people who lack the mental capacity to do so for themselves. The Deprivation of Liberty Safeguards were added to the Act; these enable people, for their own safety and in their best interests, to be accommodated under care and treatment plan which may have the effect of depriving them of their liberty. Following the Supreme Court judgement in March 2014, DoLS apply to an increasing number of patients. The impact of this judgement is that the DoLS team in the local authority are unable to assess all the DoLS authorisation requests. This means that we may refer a person and place them under an urgent DoLS for 7 days. However, the local authority appears to struggle to assess the patient within the 7 days period for standard authorisation due to a sheer number of applications received. The consequence is that as the person has not been formally assessed, they do not have a right of appeal against being unlawfully detained.

It is possible that a patient or their family could complain against a possible unlawful detention, despite the fact that by applying for a DoLS we are adhering to the requirements of the law.

The Trust can request an urgent assessment if the patient is very agitated and the DoLS team will aim to assess the patient. In addition, the DoLS team also telephone the ward soon after receiving the application to undertake a "telephone triage" of the cases, but the focus of the DoLS team work tends to be concentrated in Nursing and Care Homes.

1428 - Absence of an Independent Domestic Abuse Advisor (IDVA) at Worthing, St Richard's and Southlands Hospitals. The Trust currently has no IDVA who could offer advice and support to victims of domestic abuse and advice, support and training to Trust staff.

1 in 4 women and 1 in 6 men will experience domestic abuse (DA). A high proportion of victims have been found to access services via the NHS.

Domestic abuse is reported to cost the NHS £1.2 billion per annum. A proportion of this cost will relate to treatment for physical injuries, mental health issues and NHS staff absenteeism (where NHS staff are experiencing DA). This illustrates the potential opportunity for staff to recognise and respond to and report incidents of DA.

The role of an IDVA would be to promote awareness of domestic abuse, protect and support individuals and improve the Trust's performance in managing DA appropriately, and ensuring that those experiencing DA receive the care and support they need.

Having an IDVA would improve patient experience; support the Trust in achieving compliance with NICE guidance and statutory safeguarding responsibilities, including achieving the recommendations from two Domestic Homicide Reviews. Currently we have no such service within the Trust.

14. OBJECTIVES AND PRIORITIES FOR 2022/2023

- Development of integrated safeguarding work plan.
- Support Trust on adoption and establishment of the Liberty Protection Safeguards (LPS) systems in the Trust and strengthening MCA.
- Continue working towards integrating safeguarding team in term of training, policies and process across the Trust.
- Continue to work towards improving safeguarding adults mandatory training compliance rates especially PREVENT training.
- Continue attendance at the Safeguarding Adults Boards and multi-agency partnership meetings to enable the Trust to meet statutory responsibilities and engage with wider partnerships and services.
- Working together with Safeguarding children team to develop Domestic abuse strategy.
- Working with Safeguarding Children to Strengthen Transitional safeguarding across the Trust.
- Strengthen safeguarding arrangements for adults admitted to hospitals with mental health issue.

15. CONCLUSION

The UHSussex Safeguarding Adults Team work closely with partner agencies to provide leadership and support for safeguarding practice across the Trust. This is the statutory requirements for NHS organisations to discharge their safeguarding children and adults obligations which are enshrined in law and supported by legislation. Safeguarding forms an integral part of the wider responsibilities of the Trust which meets the requirements of the Care Act 2014 for adults with care and support needs.

The Safeguarding Adults agenda is ever growing. UHSussex works in collaboration with other statutory and voluntary sectors partner organisations across East Sussex, Brighton and Hove, and West Sussex; to work in partnership to safeguard the population of which it serves. This partnership working is essential to protect the community and improve safeguarding in developing fields of practice such as Violence Against Women and Girls, Prevent; Support for Asylum Seekers; Slavery and Exploitation; and Transitional Safeguarding. As a result, safeguarding activities across the Trust over the last five years has increased exponentially. In addition, the Trust has identified learning within investigation of datix incidents, concerns raised, S42 enquiries undertaken and in participation with SARS and DHRs. During the pandemic nationally there is evidence of increased domestic abuse and increase in child abuse. In contrast to the growth in safeguarding both nationally and locally, there has been limited investment in the safeguarding Adults Team. Resources are limited and therefore our ability to work proactively as a leading community partner will be compromised without further investment.

In addition to the safeguarding agenda, the forthcoming LPS agenda with additional accountability for NHS Trusts is currently under National consultation. The impact of this change in legislation on the organisation will be fully reviewed and brought to a future Safeguarding Committee.

The Safeguarding Adults team commit to continue providing leadership support, advice and guidance to staff across UHSussex, ensuring that the Trust provides the highest level of care to all its patients and supporting their families. UHSussex continues to strive to ensure that the most vulnerable patients who are less able to protect themselves from harm, neglect or abuse are protected from abuse and neglect. To support this we aim to have a workforce that recognises safeguarding is ‘Everyone’s Business’.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	15	**Meeting:**	Board	**Meeting Date:**	November 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 2 November 2022 and was quorate as it was attended by three Non-Executive Directors, the Chairman and one Associate Non-Executive Director as well as the Chief People Officer, the Chief Operating Officer and Chief Executive. In attendance were the Director of Integrated Education, the Director of Workforce Planning and Deployment, Director of Medical Education, the Associate Director for Leadership, OD and Engagement, the Deputy Chief Nurse and senior members of the HR and Wellbeing team. The Guardian of Safe Working and Medical Director joined the meeting for their respective element of meeting.

The Committee received its planned items including the reports on the respective Patient First Trust North, Breakthrough Objective, Strategic Initiative and Corporate Project, Staff Survey for 2022; the GMC staff survey report; a presentation in respect of surgery showing the corporate project oversight for people improvements; updates on health and wellbeing, leadership, culture and development, EDI, Violence Prevention and Reduction; the Medical Workforce Systems review; workforce scorecard (KPIs), an update on the activity of the Freedom to Speak up Guardian as well as a report from the Guardian of Safe Working. The Committee also considered both the Corporate Risks with a potential people impact and the Board Assurance Framework (BAF) risks for which it has assigned oversight.

The Committee through the review of the Surgery Corporate Project project charter and update was assured that it incorporates the expected people dimension, noting that the Committee will obtain its assurance over the delivery of the project through the oversight provided by the Quality Committee oversight and reporting to the Board.

The Committee in receiving the reports from the Guardian of Safe Working noted the differential oversight at Royal Sussex County and Princess Royal with their reduction in administrative support to that provided at

both Worthing and St Richards. The Committee agreed there was an urgent need to progress the filling of the Guardian position covering Royal Sussex County and Princess Royal to ensure that exception reporting is acted on to support the Junior Doctors in having confidence their voice is heard. The Committee was assured by the update from the Guardian of Safeworking that the exceptions for Worthing and St Richards are reviewed and acted upon in a timely way and that there is a strong process for encouraging reporting to enable the staff to be remunerated where excess hours have been worked

The Committee through the receipt of the report in respect of the 2022 General Medical Council Survey Report by the Director of Medical Education noted the high-level response rate achieved. The Committee noted the actions taken where improvements opportunities were identified and that the oversight processes for the actions and their engagement with the Divisions and where operation matters are identified this includes the support from the respective Chiefs of Service. The Committee was assured by the update that all significant concerns were reviewed, and detailed responses were provided to Health Education England in respect of action taken or being taken to address the concerns raised

The Committee received a report from the Associate Director of Leadership, OD and Engagement on the Trust's developing Health and Wellbeing plan, noting the plan's alignment to the improvement areas flagged within the prior year staff survey and other feedback the Committee reviewed and endorsed the immediate (within one year) priorities and agreed to recommend these to the Board (included as an appendix to their report)

The Committee considered the developed People Breakthrough Objective project charter in respect of Staff Voice that counts, increasing the percentage of staff who are confident that the organisation would address concerns if raised. The Committee endorsed the charter and was assured from the updates from both the Chief Operating Officer and the Chief Executive that this breakthrough objective is built into the divisional strategy deployment review meetings which will support the achievement of this breakthrough objective in a more visible and structured manner to the delivery of the previous breakthrough objective

The Committee reviewed the developed workforce dashboard and welcomed the enhanced commentary provided within the report against each of the scorecard domains. The Committee noted the continuing operational demand pressure on staff and the impact this is having on the Trust's levels of compliance with its targets for staff training and appraisals as well as the wider people strategic risks of recruitment and retention. The Committee endorsed the activities being taken in respect of staff retention and was pleased to note that the level of turnover continues to remain below the NHS average and the Trust's own internal target.

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

Key Recommendation(s):

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

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

University Hospitals Sussex
NHS Foundation Trust

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
People Committee	**2 November 2022**	**Patrick Boyle**	✓	☐

Declarations of Interest Made

There were no declarations of interest made

Assurances received at the Committee meeting

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

True North

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

The Committee **RECEIVED** a report on the 2022 Staff Survey where the Chief People Officer provided an update on the 2022 Staff Survey, confirming the survey questions remain as last year aligned to the people promise and the two themes of staff engagement and morale. The Committee was informed that staff participation with the survey is lower than at this time last year and behind that of other Trust's using this survey provider. The Committee **NOTED** that a range of medium is being used to allow staff to participate, from paper forms to access to PCs and reminders of the importance of staff participation has been made through local team meetings and through wider staff communications. The Chief People Officer also provided an update on the progress against the 2021 actions. The Committee **NOTED** the linkage between the prior year feedback to the Trust's revised people breakthrough objective in respect of supporting staff to speak up.

The Committee **RECEIVED** a report on the actions it has taken as a result of identified learning from employee relations feedback. The Committee **NOTED** the learning identified seeing a need to enhance awareness training for staff at all levels in respect of how to better recognise and deal with poor behaviours. The Committee also noted the work being undertaken to better equip staff and managers to manage staff sickness in a clear but compassionate manner. The Committee **NOTED** the development of performance measures to allow the HR department to track the timeliness of their support to deal with matters raised.

The Committee **RECEIVED** the 2022 General Medical Council Survey Report. The Director of Medical Education informed the Committee that the results collated by the GMC remained under the Trust's former organisations of WSHFT and BSUH, noting this did aid with the comparison of this survey results with those from the previous year. The Committee **NOTED** the high level response rate achieved by the Trust as its completion is actively encouraged by the Trust. The Committee **NOTED** the results, those indicating a positive experience and those where improvement opportunities were identified. The Committee also noted that the survey allows for trainees to flag any wider concerns they have and that a small number of trainees had flagged capacity concerns, long waits, the reduction in staff on specific shifts. The Committee was **ASSURED** by the update from the Director that all such concerns were reviewed, and responses were provided to Health Education England in respect of action taken or being taken to address the concerns raised. The Committee **NOTED** the Director's review of the survey performance from this survey year to the prior year and was informed of the actions being undertaken and how these become embedded within the divisional oversight processes. The Committee **NOTED** the oversight processes for the actions and their engagement with the Divisions and where operation matters are identified this includes the support from the respective Chiefs of Service. The Director of Medical Education informed the Committee of the Trainer survey and **NOTED** that the response rate to this survey is lower that the Trainee survey both nationally and locally.

The Committee **RECEIVED** an update on how the Surgical Division Corporate Project Charter incorporates the people dimension as the project will consider how the service is structured and delivered, this will work with the staff. There is a dimension within the project to review leadership and culture which aligns to prior

staff feedback. The Committee **NOTED** this project is to be overseen by the Quality Committee and from the update was **ASSURED** that the project will adequately incorporates the people dimension.

Breakthrough Objective

The Committee was updated by the Chief People Officer on how this breakthrough objective was developed and the project charter. The Committee **NOTED** the developing project plan to deliver this objective and its linkage to the wider people initiatives. The Committee **ENDORSED** the Breakthrough Objective project charter in respect of Staff Voice that counts, increasing the percentage of staff who are confident that the organisation would address concerns if raised. The Committee was **ASSURED** from the updates from the Chief Operating Officer and the Chief Executive that this breakthrough objective is built into the divisional strategy deployment review meetings through the Trust patient first methodology will make a difference to the prior year's noting the divisional oversight through the clinical operating model will empower the local leadership to address concerns.

Strategic Initiative

The Committee **RECEIVED** an update on Strategic Initiative in respect of Leadership, Culture, and Development from the Associate Director for Leadership, OD and Engagement. The Committee **NOTED** the activity being undertaken across the Trust's three leadership development programmes, noting that for three of these programmes these are in the planning stage and will commence in the latter part of 2022/23. The Committee **NOTED** from the update by the Chief People Officer that there are other programmes available to staff for their development alongside these three areas.

Corporate Project

The Committee **RECEIVED** the project charter for the established people corporate project relating to medical workforce systems and **NOTED** the work undertaken to develop this charter and the determination of the projects expected benefits. The Committee **ENDORSED** the project charter.

Committee Activity

Health and Wellbeing Plan

The Committee **RECEIVED** a report from the Associate Director of Leadership, OD and Engagement on the Trust's developing Health and Wellbeing plan. The Committee **NOTED** the plan's alignment to the improvement areas flagged within the prior year staff survey. The Committee **ENDORSED** the immediate (within one year) priorities along with the wider three-year plan focus and **RECOMMENDED** these to Board (see appendix 1)

Cost of Living Support

The Committee **RECEIVED** an update on the options being considered by the Trust to support with cost-of-living pressures, recognising that support may be best placed to come for others and the Trust's role would be to signpost staff to these expert partners. The Committee **DISCUSSED** the update and agreed that a further discussion be held at Board.

Violence Prevention and Reduction

The Committee **RECEIVED** an update from the Associate Director for Leadership, OD and Engagement on the Violence Prevention and Reduction workstream. The Committee noted the work of the workstream that was established in the Summer of 2022. A Diagnostic analysis has been undertaken supported with input from the Trust's Security Operational Group, reported incidents of violence and aggression on Datix. The Committee **NOTED** the developing work against the national violence prevention and reduction standard and

that the work within this area is linked to one of the priority areas for the ICS People Committee supporting the NHS People Plan

Staff vaccinations

The Committee **NOTED** the update on the Staff vaccination programme in respect of Flu and Covid.

People Scorecard

The Committee **NOTED** the developed workforce dashboard and welcomed the enhanced commentary provided within the report against each of the scorecard domains. Through the update provided by the Chief People Officer the Committee **NOTED** the Trust's performance across the core metrics of recruitment, retention, appraisals, training, and engagement. The Committee **NOTED** the detailed commentary continued to be provided as requested previously and that this will aid the reporting to the Board within the integrated performance report. The Committee **NOTED** the continuing operational demand pressure on staff and the impact this is having on the Trust's levels of compliance with its targets for staff training and appraisals as well as the wider people strategic risks of recruitment and retention. The Committee **RECEIVED** a detailed update on the Trust's staff retention activities from the Chief People Officer. The Committee **NOTED** the level of turnover remains below the NHS average and the Trust's own internal target. The Committee discussed the analysis provided in respect of leavers and the actions being taken across each division.

Freedom to Speak Up

The Committee **NOTED** the report prepared by the Chief People Officer in respect of the Trust's Freedom to Speak up Guardian activities.

Guardian of Safeworking

The Committee **RECEIVED** the reports in respect of the Guardian of Safeworking activity across the first two quarters of 2022/23 for all four principal sites of the Trust. The Committee **NOTED** the formal process available to the Junior doctors to raise exceptions and that the level of these exception reports remains comparable to the prior periods in 2021/22. The Committee was **ASSURED** by the update from the Guardian of Safeworking that all exceptions are reviewed and acted upon in a timely way and that there is a strong process for encouraging reporting to enable the staff to be remunerated where excess hours have been worked. The Committee **NOTED** the high attendance levels at and the work of the junior doctor forum. The Committee **NOTED** that differential oversight at RSCH and PRH with their reduction in administrative support and **NOTED** the update provided by the Chief People Officer in respect to the actions taken to reinstate the provision of this administration support as the recruitment of a further Guardian is progressed. The Committee **AGREED** there was an urgent need to progress the filling of the Guardian position covering RSCH and PRH to ensure that exception reporting is acted on to support the Junior Doctors in having confidence their voice is heard. The Committee **NOTED** that the recruitment of the Guardian is underway by the Chief Medical Officer supported by the Chief People Officer.

Integrated Education

The Committee **RECEIVED** a report from the Director of Integrated Education on the national initiatives relating to education, training and professional development activities and how the Trust is engaging with these to support staff and how these initiatives will encourage future recruitment. The Committee also **NOTED** within the report how the work within this area aligns to the other reports taken at the meeting in relation to retention. The Committee **NOTED** the activity of the integrated training team and the achievements of this team across the breadth of the Trust's workforce.

Risk

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

Across each of the people domain the Committee's attention was drawn to risks that have been raised that have the potential to impact on our people domain which for quarter 2 have been identified with a post-mitigation score of 12 or above. Those scoring 15 and above are summarised below:

- HCA vacancies (Chief Nursing Officer) (current score 20)
- ENT / OMFS staffing - following 2 resignations (ENT) (current score 20)
- Staff retention (conversion of FTCs into ongoing roles) (Surgery East) (current score 16)
- Health and wellbeing – (current score 16)
- Staff stretch and patient experience – (current score 16)
- High levels of consultant vacancies at RSCH and PRH (current score 16)
- Staff retention (current score 16)
- Payroll staffing resilience (current score of 15)

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

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

Actions taken by the Committee within its Terms of Reference

The Committee **AGREED** to recommend the quarter 3 score for BAF risks 3.1 to 3.4 to the Board.

The Committee **ENDORSED** the People Breakthrough Objective Charter and the relevant Corporate Project Charter.

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

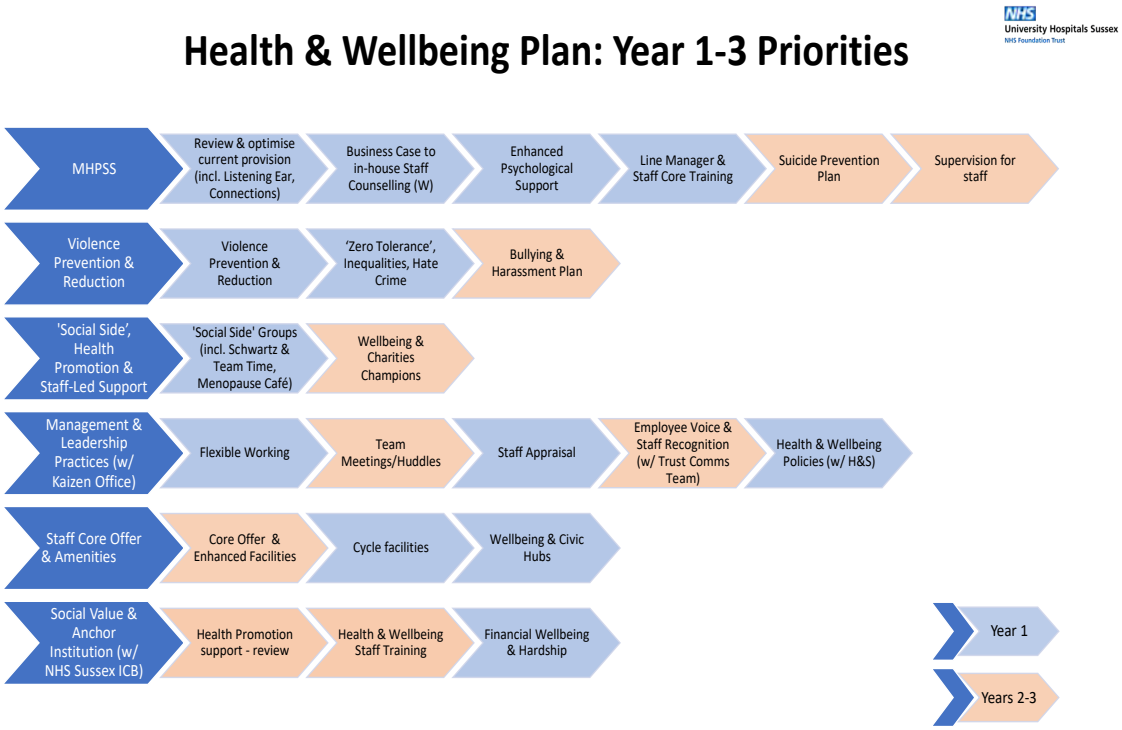
The Committee asked that within the report on employee relations that information is provided to show the level of those raised which are supported and dealt with locally in a timely manner to allow information to flow regarding supporting staff to raise concerns with confidence that action is taken.

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

Item	Referred to
The Committee recommended to the Board that after careful consideration of the continued pressures facing staff that the risk scores for BAF risks 3.1 to 3.4 are fairly stated for quarter 3.	Board November 2022
The Committee endorsed the Health and Well Being Plan year one priorities and is recommending these to the Board (see appendix 1)	Board November 2022

University Hospitals Sussex
NHS Foundation Trust

Appendix 1 Health and Wellbeing year one priorities



University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	16	**Meeting:**	Board	**Meeting Date:**	November 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 3 November 2022 and was quorate as it was attended by two Non-Executive Directors, the Chair, the Chief Financial Officer, the Chief People Officer, the Chief Operating Officer, the Chief Medical Officer, Chief Executive and the Chief Governance Officer. In attendance were the Finance Director, the Director of Capital, the Director of Estates and Facilities, the Commercial Director and the Director for Improvement and Delivery.

The Committee received its planned items including the reports on the Sustainability True North, Breakthrough Objective, Strategic Initiative (environmental sustainability) and Corporate Project (PAS), along with a comprehensive report on the Trust's Financial Performance with a forecast road map for 2022/23, the Efficiency Programme, the Capital Programme, an IM&T update, an update on the Commercial team activities including procurement, an ICS finance update, a payroll hub update, a patient level information costing paper, a risk paper and the Board Assurance Framework. The Committee considered an investment decision in respect of replacement of endoscopy scopes.

The Committee had a extended discussion on the Trust's current highly challenged financial position and forecast year end outturn. The Committee recognised the significant risk within the forecast actions and based on this the Committee agreed to refer this to the Board for a fuller discussion. The Committee agreed that after the Board discussion, the relevant BAF risk may need be increased to reflect the increase in risk.

The Committee noted the successful delivery of the first half year's capital programme and how the breath of schemes delivered benefits our patients and our staff across all hospital sites. However, the Committee noted the delivery risks in respect of the volume of strategic capital projects in the second half of the year and the reduced flexibility to defer capital from one year to another within the current system capital regime.

The Committee noted the successful delivery of the first half year's efficiency. Whilst schemes had been identified which equate to the full value of the programme there was a degree of risk with some of the schemes coupled with the programme's required step up delivery in the second half of the year in an increasingly pressurised operational environment. The Committee would be provided at a subsequent meeting with a refreshed assessment of these risks.

The Committee endorsed the project charters for the new Sustainability Breakthrough Objective (Productivity) and the new Corporate Project (Estates Strategy and Master planning) noting their alignment to the Trust's strategic priorities refresh for 2022/23 – 2023/24.

In the reports provided by the Director of IM&T on Pas go live and a range of major IT programmes, the Committee noted the risks relating to IT and was assured by the Director of IM&T that these are being managed with strong support by the Clinical Chief Information Officers. Additional oversight over cyber risk is provided through the Audit Committee.

The Committee received an update in relation to the mobilisation of the SHC Payroll Hub, in partnership with NHS Shared Business Services (SBS) and was assured over the transfer by the update provided by the Finance Director noting the flexibility exhibited by SBS when dealing with operational challenges and the enhanced management information received.

The Committee noted the particular processes challenges within payroll during the months of August and September and that a detailed review had been undertaken. Recommendations were presented to the Audit Committee and shared with affected parties. Progress on the recommendations was discussed. These process challenges led to an increase in the score for BAF risk 2.3, with an expectation that this score will reduce once assurance over the actions undertaken is received within the next few months.

The Committee approved an investment decision in relation to the endoscopy scope replacement following the outcome of a robust procurement process.

The Committee reviewed the quarter 2 Sustainability Risk Paper and agreed the 14 risks detailed (a reduction of 4 from the prior quarter) with a current score of 12 were reflective of the Trust and consistent with the papers discussed in the meeting. The Committee noted the reduction in risks scoring 12 or above was due to the closure of risks attributed to the delivery of the 2021/22 financial plan, including the capital plan as discussed at the last meeting but that new risks attributable to 2022/23 financial plan had been added. In reviewing this report and the other reports presented to the Committee the Committee agreed that the BAF risks it has oversight of were fairly stated, noting that following the Board review of the financial forecast roadmap these may increase further.

Key Recommendation(s):

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

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

University Hospitals Sussex NHS Foundation Trust

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Sustainability Committee	**3 November 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, Strategic Initiative and Corporate Projects

Financial position and year end forecast

The Committee **RECEIVED** an update from the Chief Financial Officer and Finance Director on the financial performance of the Trust at Quarter 2 and **NOTED** that the Trust is adverse to its plan. The Committee **NOTED** the internal and external drivers of this position, including the delivery of elective recovery through a higher level of use of outsourcing and insourcing; urgent care demands requiring a continuation of the use of escalation beds being supported by agency staff, increasing numbers of RMNs above our plan and inflationary pressures.

The Committee **NOTED** the actions being taken and those that underpin the mid case and best case forecasts in the financial roadmap to year end. The Committee **NOTED** the assumptions within the forecast options and with a number of actions having been taken including the issue of control totals for each Division, the funding of the winter plan through delegated budgets, the establishment of regular oversight meetings with the divisions and a focus on opportunities to increase internal productivity. The Committee was **ASSURED** from the update from Finance Director over the control total approach given the high level of engagement from each divisional senior leadership teams.

The Committee considered the heightened degree of risk within the roadmap delivery, the challenge of mobilising the Trust's arrangements for productivity improvement quickly and the continued operational pressures from emergency activity and winter and **AGREED** this financial risk needed further board discussion and supported an increase to the Trust BAF risks score from 12 to of 16 for the relevant sustainability strategic risk.

Productivity Breakthrough Objective

The Committee discussed the developed productivity breakthrough objective project charter. The Committee **RECEIVED** an update from the Managing Director for Planned Care and Cancer on the mobilisation work undertaken. The Committee **ENDORSED** the Charter recognising its alignment to the Trust's agreed refreshed priorities but noted the risks to mobilisation at pace in the current operational environment and as the project is only just being launched. It was agreed that an update on worst/mid/best case on delivery by year end would be provided.

Strategic Initiative - Environmental Sustainability

There was an update on the Strategic Initiative - Environmental Sustainability provided by the Director of Facilities and Estates. The Committee **NOTED** that the Trust's delivery remains on track across the 28 identified schemes developed to achieve the 57% carbon reduction to 2025, noting three have completed their delivery already. The Committee **NOTED** continuing success of the Trust in securing external sources of funds

to progress the schemes at an increased pace. Through the update from the Director of Facilities and Estates the Committee was **ASSURED** over the processes in place for the project SRO transfer noting the depth of expertise in the team created around the SRO and the strong Executive leadership provided by the CFO.

Corporate Project – PAS

The Committee was **ASSURED** from the feedback provided by the Director of IM&T over the actions taken in respect of the identified project issues which delayed the PAS go live date. The Committee **NOTED** that the project continues to be well supported by strong levels of clinical and operational engagement. The Committee discussed the risks, actions and plans developed for implementation during the go live transition period. From the update provided by the Chief Operating Officer the Committee was **ASSURED** over the robustness of the checkpoints within the transfer/go live plan and that there is a formal set of go live criteria the design of which has been subject to external assurance and will support an effective system go live.

Corporate Project - Estates Strategy and Master Planning

The Director of Capital presented the developed corporate project charter and **NOTED** how the development of this master plan will support other Trust's processes including capital prioritisation and business case development. The Director of Capital updated the Committee on the project milestones and timescales and the interrelationship with this and internally with the Trust's Clinical Strategy and externally with the ICS estates strategy development. The Committee **ENDORSED** this charter and its alignment to the Trust's strategic priorities.

Efficiency Programme

The Committee **RECEIVED** the quarter 2 Efficiency Programme Report from the Director for Improvement and Delivery. Through the update provided by the Director the Committee **NOTED** that the Trust has an identified plan matching the full efficiency programme but noted there remained a number of individual schemes where work is needed to fully develop these and so present a risk for the year end position. The Committee **NOTED** that for the first half of the year the Trust had delivered fully its plan for that period and **NOTED** that within the next report a refreshed analysis of the level of risk within the second half year scheme delivery will be provided. The Committee was **ASSURED** over processes for delivery as the efficiency programme and noted it is fully aligned to interlinked project charters especially those for length of stay and productivity.

The Director for Improvement and Delivery advised that there has been strong engagement with the divisional leaders recognising that increased support has been provided to those newly recruited to these leadership positions within the Clinical Operating Model.

The Committee **NOTED** the QIA processes applied to each of the schemes recognising that there are no schemes with high quality risks and the outcome of the QIA panel has been reported the Quality Committee.

Capital Plan

The Committee **RECEIVED** the Q2 update against the Trust's 2022/23 capital plan and the Director of Capital informed the Committee on the Trust's capital prioritisation process. The Committee **NOTED** that the level of over programming within the capital programme has reduced with the management of this undertaken through the Trust's business case approval processes through the Capital Investment Group and Business Case Scrutiny Panel. The Committee **NOTED** that Trust strong position in that at the end of month 6 the capital expenditure was just ahead of the plan but recognised that there remains a significant level of strategic

schemes to be delivered across the second half of the year. The Committee **NOTED** the breadth of schemes supported by the Capital Programme and **NOTED** the patient and staff benefits these schemes bring.

The Committee were **ASSURED** by the update from the Director of Capital over the work delivered and the controls in place to mitigate the risks within the programme but requested for assurances at the next SDR over the delivery of the remaining strategic capital spend by year end.

IM&T Programme update

The Committee **RECEIVED** the quarter 2 IM&T Programme Report on the wide-ranging Trust's IM&T programme of work. The Committee **NOTED** the main IM&T work being undertaken over the last quarter and those scheduled for the remaining part of the year focusing on infrastructure and platform replacement alongside data showing the performance of the IT department itself. The Committee were advised that there had been a particular focus on addressing cyber attack risks recognising that a detailed assurance report in this area had been provided to the Audit Committee. The Committee **NOTED** the risks referenced in the report and was **ASSURED** by the Director of IM&T that these are being managed with strong support by the Clinical Chief Information Officers.

Commercial Team

The Chief Financial Officer on behalf of the Commercial Director provided an update on the activities of the commercial directorate. The Committee **NOTED** the Q2 activities around the payroll hub development, the retail strategy for 3Ts and the other Trust sites, and work with the Sussex Pathway Network. The Commercial Director also provided the Committee with an update on the activity of Trust's procurement function realising the benefits in respect of contract alignment and enhanced contract oversight. The Committee was **ASSURED** through the recruitment to the team of the team's ability to continue to enhance the support provided into the organisation's compliance with the Trust's catalogue management. The Committee **NOTED** that the Trust's procurement function benchmarks well with National benchmarking metrics.

Investment decisions

The Committee considered an investment decision in relation to the endoscopy scope replacement and **APPROVED** their purchase following the outcome of a robust procurement process.

Deep Dive Assurance

SHC Payroll hub

The Committee **NOTED** an update in relation to the mobilisation of the SHC Payroll Hub, in partnership with NHS Shared Business Services (SBS). The committee was **ASSURED** of the change through the update provided by the Finance Director that there had a positive start to these arrangements with the transfer of Trust to these arrangements. The Committee **NOTED** the enhanced management information developed providing contemporaneous information in respect of the hub service provision. The Committee **NOTED** that whilst the project is early in its delivery the hub has reacted flexibly to operational challenges presented during the transfer. There remain risks in respect of staff transferring to the hub, but these risks are currently being managed with support provided by other SBS service centres coupled with active recruitment to establish the workforce ahead of transfer of the remaining payroll transfers later in 2022/23.

The Committee **NOTED** the processes challenges within payroll during the months of August and September and the actions taken in response to the issues identified and **NOTED** these had been reflected within the increase to BAF risk 2.3 with an expectation that these will reduce once assurance over the actions have been undertaken which is expected over the next few months.

Patient Level Costing

The Committee **RECEIVED** a report in respect of the results of the 2020/21 National Cost Collection and the 2021/22 submission. The Committee **NOTED** the results from the 2020/21 collection programme recognising these related to the two former Trust's, showing the relative costs for each Trust were below 100 national benchmark and that the 2021/22 submission will be the first for UHSussex. The Committee **NOTED** that the Trust made its required submission within the required timescales with no issues identified by the national team in respect of the submission.

The Committee also received the requested update on the Trust's Patient Level Information Costing System (PLICS) Programme, **NOTING** the significant work undertaken given the national changes to the costing reporting requirements to develop the Trust's reporting tools. The Committee **NOTED** the teams are exploring how these reports integrate into the Trust's developing Power BI dashboards. The Committee **NOTED** that the PLICS outcome data will flow into the Trust's reporting for the next financial year.

ICS

The Committee **RECEIVED** an update from the Chief Financial Officer on the developing guidance for any financial forecast changes which places a number of criteria on providers and the ICB when considering any change in their forecast outturn . The Committee **NOTED** that the understanding of the developing guidance would be considered alongside the forecast roadmap referred to Board.

The Committee also **RECEIVED** an update from the Chief Financial Officer on the work of the ICS Finance Leadership Group during quarter 2. The Committee **NOTED** the update from the Chief Finance Officer on the meeting of Sussex Health and Care CFOs at which the Q2 position of the Sussex system was discussed. The System financial position and efficiency plan position were reported including the Trust's contribution to those balances. The Committee **NOTED** that the groups priorities was to quantify the system financial risks for Q3 and Q4, and the process for enhanced scrutiny of recovery plans for those organisations with a deficit along with a review of the capital forecast for H2 along the development of a framework for the prioritisation of capital schemes across the ICS for years 2 and 3.

The Committee **NOTED** the system risks, these being a system at Q2 being adverse to its plan, the slippage within the capital programme although most of this is due to technical phasing of the capital plan by NHSE and that the Elective Services Recovery Plan Fund claw back mechanism will not be implemented at a system level but the ICB have yet to confirm if there will be any resource adjustments for under or over performance. The Committee **NOTED** this uncertainty continues to align to the elevated scores for the BAF risks 2.1 and 2.2.

Risk

The Committee **REVIEWED** the quarter 2 Sustainability Risk Paper on the programme risks which may impact the delivery of the Sustainability True North along with the overarching risks from the respective Strategic Initiative and Corporate Project. The Committee considered this report alongside the respective discussions on risk within the respective Committee items. The Committee **AGREED** the risk paper summary and through the respective discussions that there are 14 risks (a reduction of 4 from the prior quarter) with a current score of 12 or above noting two risks are scored at 15. The reduction in risks scoring 12 or above is as discussed at the prior meeting due to the closure of risks linked to 3Ts stage one noting that those for the 2021/22 financial and the capital plan have reduced but are being replaced by new risks attributable to 2022/23 Plan. The Committee noted that the level of risk is likely to increase with the receipt and review of the 2022/23 year end road map.

The Committee **REVIEWED** the BAF risks it has oversight for, and **AGREED**, having regard to both the BAF summary and the Committees consideration of the risks considered during the meeting, that the quarter four score for risks 2.1 and 2.3 were fairly stated with 2.2 to be subject to board review.

Actions taken by the Committee within its Terms of Reference
The Committee **AGREED** to recommend the quarter 3 score for BAF risks 2.1 to 2.3 to the Board, noting that risk 2.2 will be subject to further review at the Board. The Committee **ENDORSED** the developed project charters for the new Sustainability Breakthrough Objective (Productivity) and Corporate Project (Estates Strategy and Master planning) and their alignment to the Trust's strategic priorities refresh for 2022/23 – 2023/24.
Items to come back to Committee (Items the Committee keeping an eye on outside its routine business cycle)
The Committee noted that information in respect of productivity improvements will flow through the Breakthrough Objective, and requested an update on delivery risks relating to the strategic capital spend to year end, a refreshed risk assessment of delivery risk of the second half of the year efficiency programme. It was agreed further deep dives linked possibly to medical pay, or productivity would be identified going forward.
Items referred to the Board or another Committee for decision or action

Item	Referred to
The Committee recommended to the Board for review the financial year end road map and the associated BAF risk scoree.	To Board November 2022

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	17	**Meeting:**	Board	**Meeting Date:**	November 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 3 November 2022 and was quorate as it was attended by three Non-Executive Directors, the Trust Chair, the Chief Executive, the Chief Operating Officer, the Chief Financial Officer, and the Chief Governance Officer. In attendance was the Director of Strategy and Planning, the Managing Director for Planned Care and Cancer, the Director of Improvement and Efficiency and the Divisional Director of Operations for Cancer for the more detailed agenda item on cancer.

The Committee received its planned items including the Q2 report on the Trust's performance against the key constitutional standards, reports on the respective the Systems and Partnerships Strategic Initiative, the 3Ts development, along with updates on the Trust's work within the ICS, Systems and Partnerships key risks and the Board Assurance Framework.

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

The Chief Operating Officer presented the Trust's draft winter plan for 2022/23 that had been developed following discussions with Divisional teams, Hospital Directors and Divisional leaders. The Committee noted the details of the draft plan, focussed on the key objectives: to safely avoid admissions; safely create more capacity and reduce length of stay; maintain operational grip and control while participating in the Sussex system winter plan development and implementation. The Committee was updated by the Chief Financial

Officer on the financial modelling undertaken in support of the developed plan. The Committee in noting the risks within the plan, recommended the Winter Plan to the Board for discussion.

The Committee recognised the significant benefit that 3Ts will bring to patients and staff and through the reports received, were assured on the oversight and governance process surrounding the move to the mobilisation phase of the Stage 1 project. The Committee also noted that formal approval has been received to progress with the development of the full business case of phases 2 and 3. At the meeting the Committee was updated on the work of the 3Ts Clinical and Operational Readiness workstream reporting to the Steering Group, which is overseeing the move and the plans being developed covering the preoccupation phase to ensure there are robust, benchmarked and quality assurance plans for non-clinical and clinical team moves.

The Committee received an update from the Chief Operating Officer and Managing Director for Planned Care and Cancer on the Trust's engagement with the Super September national initiative which saw the Trust develop a suite of initiatives to deliver change during that month for patients on the non-admitted pathways. The Committee noted the positive impact these initiatives had resulted in and took assurance from the fact that the Trust had been cited as an exemplar for the outcome of our initiatives.

The Committee reviewed the quarter 2 Systems and Partnership Risk Paper and noted the risks detailed with a current score of 12 were reflective of the Trust. The Committee noted the reduction in risks scoring 12 or above given the successful progress with the 3Ts stage one programme. In reviewing this report and the other reports presented to the Committee, the Committee agreed that the BAF risks it has oversight of were fairly stated but recognised that the Board review and discussion of the winter plan may change some of these risk scores. The Committee recognised that work is progressing well which should see risk 5.1 reduce during the latter quarter of the year.

Key Recommendation(s):

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

The Board is asked to **NOTE** the outcome of the Committees review of BAF risks 5.1, 5.2 and 5.3 that the Committee's view is that these risks are fairly represented noting the Committee recognised that the Board review and discussion of the winter plan may change some of these risk scores. The Committee also recognised that work is progressing well which should see risk 5.1 reduce during the latter quarter of the year.

The Board is asked to **NOTE** that the Committee refereed the Winter Plan to the Board for a fuller discussion.

University Hospitals Sussex
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COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Systems and Partnerships Committee	**3 November**	**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 two including the performance against the Trust's systems and partnership true norths and breakthrough objectives for emergency and planned care for the same quarter.

The Committee **NOTED** the Trust has continued to focus on recovery against Constitutional NHS access targets. However, there continues to be significant pressure for urgent and emergency care. Elective recovery has progressed well with improvements observed in the constitutional standards and reductions in those patients waiting the longest for completion of their clinical pathway.

The Committee **NOTED** that as during quarter 1 in this quarter Emergency demand remains high and performance has remained challenged across all main A&E sites even further as a result. All parts of the Sussex ICS are continuing to experience significant pressures and there have been very high numbers of Medically Ready for Discharge patients within all the Trust's hospitals and across the wider system.

The Committee **NOTED** Trust's focus for elective recovery switched to the treatment of those patients waiting the longest for treatment, with a target to ensure no patients are waiting longer than 104 weeks for elective RTT treatment, or 104 days for Cancer treatment, and to eliminate patients waiting over 78 weeks by March 2023. The Chief Operating Officer confirmed that progress continues to be made on the delivery of the requirements of the 2022/23 planning guidance although further improvement needs to be made on the internal delivery of activity to meet the 2019/20 baseline activity. Milestones have been set to have a maximum 85 week wait buy the end of Q3 and the delivery of a maximum of 78 weeks wait by the end of 22/23. The Managing Director for Planned Care and Cancer informed the Committee that within the remaining cohort of patients waiting 78 weeks there is an increasing level of treatment complexity which is bringing increased risk to achieve the set milestones.

The Committee **NOTED** that the actions discussed by the Cancer Service at the last meeting were delivering as the Trust was achieving its trajectory within this area.

The Committee **NOTED** that the Trust's diagnostic performance is under significant pressure from the emergency operational demands.

The Committee welcomed the benchmarking information for the southeast included in the report which offered context to the Trust's performance.

The Committee **NOTED** the interlinkage between the activity reports received at this Committee the reports at the People Committee on workforce pressures and the reports at the Sustainability Committee in respect of productivity challenges and based on this agreed in the Systems and Partnership strategic risks were correctly reflecting these noting that risk 5.3 remains at a score of 20.

Breakthrough Objective

The Committee **NOTED** the refreshed Systems and Partnerships Breakthrough Objective in respect of the median hour of discharge and how the project goals, critical success factors support the Trust's drive to improve patient flow across the hospitals. The Committee **RECEIVED** an update from the Managing Director for Planned Care and Cancer on the mobilisation work undertaken recognising will aid the project to be progressed within the identified priority wards.

3Ts Strategic Initiative

The Committee **RECEIVED** updates on the Trust 3Ts hospital development Strategic Initiative from the Director of Improvement and Delivery. The Committee **NOTED** that the 3Ts Strategic Initiative continues to focus on the operational readiness phase for phase 1. The Committee **NOTED** the work of the Clinical and Operational Readiness workstream which has a focus on the development of the service models and associated business cases supporting the changes. Training plans to support the move of the staff moving into stage 1 have been developed and commenced. The Committee was **ASSURED** over the oversight of the move recognising the increase in the frequency of the Steering Group meetings.

The Committee recognised the significant benefit that 3Ts will bring to patients and through the reports received were assured over the oversight and governance process surrounding the move to the mobilisation phase of the Stage 1 project. The Committee **NOTED** that that formal approval has been received to progress with the development of the full business case of phases 2 and 3. Through the report the Committee was updated on the work of the 3Ts Clinical and Operational Readiness workstream reporting to the Steering Group which is overseeing the move and the plans being developed covering the preoccupation phase to ensure there are robust, benchmarked and quality assurance plans for non-clinical and clinical team moves.

The Committee also **NOTED** that the Trust is developing a Decommissioning and 100 day post handover plan to ensure the expected benefits from the move are realised and any problems identified early and addressed quickly.

The Committee **NOTED** that formal approval has been received to progress with the development of the full business case of phases 2 and 3.

The Committee noted the programme risk register and through the report and associated discussion was **ASSURED** over the alignment of the risk mitigations, the tracking of their delivery and that these are subject to regular review by their assigned risk owners. The Committee **NOTED** that an emerging issue as the work on the deployment into 3Ts is progressing through the development of detailed occupation plans which is likely to see a new risk on workforce capacity being added.

Systems and Partnerships Priority Refresh Project Charters

The Committee **RECEIVED** the developed project charters for the Systems and Partnerships Breakthrough Objective (Median Hour of Discharge) and Corporate Projects (Reducing Length of Stay, Community Diagnostic Centres and Patient Access Transformation). The Committee **NOTED** the update from the Chief Operating Officer, Medical Director for Planned Care and Cancer and the Director of Strategy and Planning on the drivers for these projects and the work undertaken to plan for these projects and the expected project benefits. The Committee **NOTED** the Patient Access Transformation project is phased to commence towards the end of 2022/23 and once launched then it will flow to this Committee at the start of 2023/24. The Committee **ENDORSED** these charters and their alignment to the Trust's strategic priorities refresh for 2022/23 – 2023/24.

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Winter Plan

The Chief Operating Officer presented the Trust's draft winter plan for 2022/23 that had been developed following discussions with Divisional teams, Hospital Directors and Divisional leaders. The Committee **NOTED** the details of the draft plan, focussed on the key objectives: to safely avoid admissions; safely create more capacity and reduce length of stay; maintain operational grip and control while participating in the Sussex system winter plan development and implementation. The Committee was update by Chief Financial Officer on the financial modelling undertaken in support of the developed plan

The Committee in noting the risks within the plan **RECOMMENDED** the Winter Plan to the Board for a fuller discussion.

Super September Programme

The Committee **RECEIVED** an update from the Chief Operating Officer and Managing Director for Planned Care and Cancer on the Trust's engagement with the Super September national initiative which saw the Trust develop a suite of initiatives to deliver change during that month for patients on the non-admitted pathways. The Committee **NOTED** the positive impact these initiatives had resulted in and took **ASSURACE** from the fact that the Trust had been cited as an exemplar for the outcome of our initiatives.

The Committee **NOTED** the Trust's engagement with this programme is one of the criteria expected of Trust's who are in tier 1 or 2 for elective care which is where the Trust is.

ICS and Systems Collaborations

The Committee **NOTED** the Trust's engagement with the ICS on the development of the Sussex Health and Care Strategy. The Director of Strategy informed the Committee that the development of the strategy is centred around 4 key principles: population and place first, evidence and data, co-production, and the NHS Plan. The Committee **NOTED** the process established and being applied for the development of this Strategy. The Committee agreed that key to the success of the Strategy will be the underpinning delivery plan which will be developed through the place based partnerships, as this will be how the Trust and partners will make a difference for Sussex patients, Sussex communities along with the specific actions the Trust will take in respect of how we engage and deliver our services.

Risk and BAF

The Committee **RECEIVED** and discussed the quarter 2 System and Partnership Risk Paper on the programme risks which may impact the delivery of the Systems and Partnership True Norths along with the overarching risks from the respective Strategic Initiative and Corporate Project. The Committee **NOTED** that a number of the risks included are due to be reviewed as the outcomes of the Strategic Filter concludes in the forthcoming months.

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

The Committee **AGREED** the risk paper summary correlated with the discussions had on the prior papers

The report identified 13 risks with a current score of 12 or above, noting four of these scored over 15, these cover the following areas

a. The development of a clinical strategy post-merger
b. The risk of a worldwide outbreak of a novel strain of influenza or COVID-19 or other respiratory virus
c. The ability to respond to a mass casualty event given current operational pressures
d. The risk of cyber attack
e. End-of-life digital systems in use

f. The risk of not having the operational capacity to occupy and transition to the 3Ts building as planned
g. A risk the 3Ts building will not meet stakeholder expectations resulting in reputational impact
h. A risk that 3Ts recurrent costs exceed those previously modelled and incorporated into the medium-term financial plan
i. A risk that there is not the capacity to recruit the workforce approved in 3Ts business cases.

The Committee reflected on the linkage of these risks those considered at Quality, People and Sustainability Committees.

The Committee **REVIEWED** the BAF risks it has oversight for, and **AGREED**, having regard to both the BAF summary and the Committee's consideration of the reports and the more detailed risk paper during the meeting, that the quarter three scores for risks 5.1, 5.2 and 5.3 were fairly stated but recognised that the Board review and discussion of the winter plan may change some of these risk scores. The Committee recognised that work is progressing well which should see risk 5.1 reduce during the latter quarter of the year.

Actions taken by the Committee within its Terms of Reference

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

The Committee **ENDORSED** the developed project charters for the Systems and Partnerships Breakthrough Objective (Median Hour of Discharge) and Corporate Projects (Reducing Length of Stay, Community Diagnostic Centres and Patient Access Transformation) and their alignment to the Trust's strategic priorities refresh for 2022/23 – 2023/24.

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

The Committee asked that during future performance reporting that in respect of discharges could an overlay be placed on the impact of the Length of Stay improvement expectation.

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

Item	Referred to
The Committee recommended to the Board that the risks within the BAF for which it has oversight are fairly represented.	To Board November 2022
The Committee having regard to the risks within the draft Winter Plan recommended the plan for a discussion at Board	To Board November 2022

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Agenda Item:	18	**Meeting:**	Board	**Meeting Date:**	November 2022
Report Title:	Audit Committee Chair report to Board				
Committee Chair:	David Curley, Non-Executive Director and Committee Chair				
Author(s):	David Curley, Non-Executive Director and Committee Chair				
Report previously considered by and date:					

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

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

Implications for Trust Strategic Themes and any link to BAF risks		
Patient	✓	The work of Internal Audit and Counter Fraud provided assurance in respect of various elements of the Trusts' the systems of internal control relied upon in managing a number of BAF risks. The Internal Audit plan is aligned to the BAF, therefore their assurance is linked to the strategic risks facing the Trust.
Sustainability	✓	
People	✓	
Quality	✓	
Systems and Partnerships	✓	

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

Communication and Consultation:

Executive Summary:

The Audit Committee met on the 18 October 2022 and was quorate as it was attended by four Non-Executive Directors. In attendance was the Chief Financial Officer, the Chief Governance Officer, the Trust's Deputy Director of Finance, the Trust's Commercial Director, and the Company Secretary along with the Trust's Internal and External Auditors and Local Counter Fraud team members. A The Trust's Director of IM&T attended to present a report on the Trust's cyber security arrangements.

The Committee received its planned items with the focus being on receiving the reports in relation to work undertaken by Internal Audit and Counter Fraud during Quarter 2 of 2022/23. The Committee also received its scheduled reports in relation to tender waivers, losses and special payments and the report from the interim Health and Safety Committee chair on the activity of that Committee. The Committee received the Trust BAF and a report on the process enhancements to the reporting of compliance against the Trust's risk management policy.

The Committee asked for enhancements to be made to the reporting in respect of the BAF and H&S Chair's report to allow the Committee to understand the processes for the oversight of assurances and actions where risks increase in the quarter. The Committee endorsed the Chair of the Quality Committee's action to have the quality risks within the BAF adjusted to reflect the quality governance corporate project work.

Through the reports the Committee was assured that 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 where functioning adequately and where improvement actions had been identified then appropriate improvement actions were being taken. The Committee welcomed the Finance Director's suggestions for enhancing the processes for oversight of the delivery of agreed management actions resulting from internal audit reviews.

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.

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COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Audit Committee	**18 October 2022**	**David Curley**	✓	☐

Declarations of Interest Made

There were no declarations of interest made

Assurances received at the Committee meeting

Risk Register and BAF reports

The Committee **RECEIVED** the latest risk report providing information on the Trust risks scoring over 15, and of these the Committee noted that there were six risks scoring 20. The report showed the mapping of these risks to the relevant patient first domains and thus which Committee would provide the oversight of these risks and their actions. The Committee **RECEIVED** information on the progress with the Trust risk register alignment programme and **NOTED** this project would provide enhanced reporting over the Corporate and Operational compliance with the Trust Risk Management Policy.

The Committee **RECEIVED** the Quarter 3 BAF, noting that this information is to be subject to review by each of the Board Committee's in their meetings next week. The Committee Chair reflected that the current report could benefit from a review to determine if its structure could be adjusted to provide an 'at a glance' summary of changes and how any elevated risks map to the planned actions. The Committee was informed by the Quality Committee chair, via email, that given the developing Quality Corporate Project then risks 4.1 and 4.2 should be adjusted to reflect the developing processes mapped to their ability to provide to extended assurance over these risks. The Committee **NOTED** that the change in risk 2.3 would be subject to review at the Sustainability Committee at the start of November and therefore did not need further referral.

The Committee **ENDORSED** having these items earlier on the meeting agenda was beneficial and that having a high level executive summary showing changes and associated actions would assist the Committee focus its attention and cross reference to sources of assurance available to the Trust to determine if seeking further 3rd party assurance from Internal Audit may be beneficial.

Internal Audit activity

The Committee **RECEIVED** the Internal Audit progress report incorporating the management action plans for the work undertaken since the last meeting against the 2022/23 internal audit plan. The Committee **NOTED** the plan had been developed to continue to use the Internal Audit resources to assist the Trust to make improvements. The original plan contained a degree of flexible resource to deal with changing or emerging matters.

The Committee considered the Internal Audit report in respect of Theatre Utilisation noting the overall positive opinion provided. Through this report the Committee was **ASSURED** over the systems of internal control within this area, noting that actions had been developed for each area of identified improvement. The Committee **NOTED** that the outcomes of these improvement actions in respect of productivity and that these will be reported within the corporate project overseen by the Sustainability Committee.

The Committee **RECEIVED** the findings from the Internal Audit assessment of the Trust's processes for making its required year 4 CNST submission. The Committee **AGREED** that this area would be referred to the Quality Committee, noting that the Quality Committee chair had indicated that this area is scheduled for review at its meeting. The Committee **NOTED** that Internal Audit intend to review this area again in late October to assess the continued levels of evidence secured.

The Chief Financial Officer presented to the Committee the Trust's self-assessment against the nationally set Financial Sustainability Arrangement framework. The Committee **NOTED** the Trust's self assessment demonstrated an overall strong position and where improvements could be made that robust actions have been developed. The Committee **NOTED** that the scheduled internal audit to confirm the Trust's self assessed position has commenced and will report to the next Audit Committee meeting. Internal Audit reflected that the process applied by the Trust in undertaking the self-assessment was robust and an exemplar from their client base.

The Committee **RECEIVED** the Internal Audit follow up review which provided information in respect of actions completed. This gave **ASSURANCE** over the delivery of agreed actions and in respect of those not yet completed that the revised timescales were reasonable. The Audit Committee reflected on those outstanding recommendations, whilst there was a reduced number from those at the prior meeting, there remained a need for management to provide updates in order for the Committee to assess the risk to those systems whilst agreed improvements have yet to be implemented. The Committee **ENDORSED** the recommend enhanced system of oversight to be established by the Finance Director which will see formal sign off for any revised dates extending beyond a quarter and any where updates are not being provided.

The Committee **RECEIVED** information in the respect of an update of matters Board's should consider in respect of EDI and **NOTED** the value of this sector update findings whist not explicit for this Trust will allow the Trust to improve ahead of the scheduled Internal Audit review of this area which the Committee had agreed at its last meeting should be retained within the 2022/23 Internal Audit activity plan. The Committee **AGREED** to provide this information to the Chief People Officer to allow him to consider this as the Trust's EDI strategy and plan is developed.

Local Counter Fraud

The Committee **RECEIVED** the Local Counter Fraud progress report for Quarter 2, 2022/22. This report provided information in respect of their proactive work undertaken, fraud awareness raising work with our staff and the work in response to any reported concerns. The update from the Trust LCFS also included benchmarking information of single tender waivers and provided a report on the work undertaken in respect of testing the Trust's systems dealing with requested mandate changes. The LCFS benchmarking report corroborated the report provided by the Commercial Director on the work to manage the use of waivers, and the proactive exercise showed the Trust's controls to be robustly applied.

The Committee was **ASSURED** by the updates provided by the Local Counter Fraud Specialists on their work during the quarter that there were no significant fraud risks which Trust needed to be actioned urgently within the Trust.

External Audit

The Committee **RECEIVED** a report from the external auditors on their work planning for the 2022/23 audit.

The Chief Financial Officer and Deputy Director of Finance provided information on the lessons learnt from the 2021/22 annual report and accounts process. The Committee was **ASSURED** that the Trust's strong processes would continue and that through this process opportunities for improvements would be taken to further enhance the 2022/23 audit.

Losses and Special Payment Report and Tender Waiver Report

The Committee **RECEIVED** the Trust's Losses and Special Payments registers. The Trust's Deputy Director of Finance provided information on those cases in Quarter 2 alongside the overall position for the preceding year, noting that the levels of these cases in quarter 2 were lower than those for that period last year. The

Committee discussed the processes for learning from these instances whilst not large in number each offer an opportunity to learn. The Commercial Director updated the Committee on the continuing work by the procurement teams with the divisions which supports the continued reduction in the number of waivers required, noting for Quarter 2 the numbers were within the trajectory for a reduction to be achieved for the year 2022/23. The Committee, through these reports, was **ASSURED** over the underlying processes applied to manage Trust resources.

Following from a previous losses report, an update from the Trust's Associate Chief Pharmacist for RSCH and PRH, was provided on the investigation undertaken into the loss of drugs due to a fridge failure. The report informed the Committee of the outcome of the investigation, including the contributory factors and associated improvement actions. The Committee discussed the improvement actions including the revision to the SOP, staff training on the processes to be followed should a temperature alert occur along with the developing supportive staff prompt (action) cards. The Committee **NOTED** that the learning from this incident had been considered in the design of the systems for operation within the 3Ts building. The Committee was also informed that the findings of this review had been through the respective oversight groups allowing the learning to applied at the other sites of St Richards, Worthing and Southlands.

Cyber Security Update

The Committee received **ASSURANCE** from the Director of IM&T though his report on the Trust's cyber security activities. The Director of IM&T referred to the change within the environment the Trust and the NHS operates. The Committee NOTED the close working relationship between the Trust and the NHS Cyber Security Operation Centre to learn and adapt to the evolving risks in this area.

Audit Committee Reporting Group – Health and Safety

The Committee received **ASSURANCE** from the Health and Safety Committee Chair's report from its meeting in August 2022. The Committee noted that work continues to schedule the Health and Safety Committee meetings to have the full quarters data available to the Committee and thus enhance the assurance this report provides to the Audit Committee. The report from the Committee Chair confirmed the Trust has effective oversight of the Trust's H&S key risks and requirements, especially the Trust's compliance with those in relation to RIDDOR.

The report also provided the Committee on the active management of the Health and Safety risk assessments. The Committee asked that the report provide more detail on where the oversight of elevated risks occur to enable the Committee to assess if it needs to secure further assurance.

Actions taken by the Committee within its Terms of Reference

The Committee in receiving its schedule report on the BAF and the report from the H&S Committee Chair asked that these documents be reviewed to draw out more clearly the risk mitigation assurances and action oversight arrangements.

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

There were no items considered at this meeting requiring specific reports to come back to the next meeting as all items where action was requested are scheduled for the next meeting.

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

Item	Referred to
The Committee requested that the EDI Considerations Report to be shared with the Chief People Officer to be considered as part of a future EDI Board Workshop.	Chief People Officer

The Committee requested that the CNST – Maternity Incentive Scheme advisory report to be shared with the Quality Committee to provide additional scrutiny and oversight. The Committee referred	Quality Committee

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Agenda Item:	19	**Meeting:**	Trust Board in Public	**Meeting Date:**	November 2022
Report Title:	Charitable Funds Committee Chair report				
Committee Chair:	Lizzie Peers, Non-Executive Director				
Author(s):	Lizzie Peers, Non-Executive Director				
Report previously considered by and date:					

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

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

Implications for Trust Strategic Themes and any link to BAF risks		
Patient	✓	The Charities' activities underpin the Trust's strategic themes.
Sustainability	✓	
People	✓	
Quality	✓	
Systems and Partnerships	✓	

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

Communication and Consultation:

Executive Summary:

The Charitable Funds Committee met on the 11 October 2022 and was quorate as it was attended by four Non-Executive Directors, one associate Non-Executive Director, the Chief Financial Officer and Chief Governance Officer. In attendance was the Interim Charity Director for both BSUH and Love Your Hospital (LYH) Charities and other members of the Trust's finance and Charity's teams.

The Committee received the operational and financial reports for month 5, the developing spending plan and a series of funding requests supporting enhanced patient experience and mental and physical wellbeing through accelerated investment in additional equipment and facilities.

Key Recommendation(s):

The Board is asked to **NOTE** the activity of the Committee and the assurances received over the stewardship of the funds.

The Board is also asked to **NOTE** the decisions taken by the Committee within its delegated authority that included support for funding proposals that exceeded the Committee's delegated authority.

The Board is asked to **NOTE** that the audited accounts and annual reports for both LYH and BSUH Charities will be presented to the Trustees for signing prior to submission to the Charities Commission.

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COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Charitable Funds Committee	**11 October 2022**	**Lizzie Peers**	✓	☐

Declarations of Interest Made

There were no declarations of interest made.

Assurances received at the Committee meeting

BSUH and LYH Charities Financial and Operational Reports – Month 5

The Committee was **ASSURED** there had been no identified regulatory or compliance issues with the operation of both Charities.

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

The Committee was **ASSURED** that both Charities were operating within their respective objectives through the receipt of the respective performance reports from the Interim Charity Director for both Charities. The operations update included the performance scorecard that provided a progress update for both BSUH and LYH Charities along with a review of the Charities' risk register and mitigations.

The Committee **NOTED** the market impact in respect of the invested funds in the context of the decision to have a low risk and ethical portfolio which was taken by the Trustees as they selected the investment managers. The Committee **AGREED** to secure a further update from the investment manager on future forecasts for the market and requested the finance team provide information on actions that could be taken to minimise investment risk and secure maximum interest for monies held in bank accounts whilst safeguarding those funds.

The Committee **NOTED** that the Charity is developing its 2023 – 2025 strategic plan which will support the developing spending plan and be aligned to the Trust's strategy.

The Committee **NOTED** the developed Fundraising on the Trust estates and Ethics Policies for LYH which mirror those developed for BSUH Charity allowing both Charities to operate on a consistent basis.

Spending Plans

The Chief Governance Officer introduced the high level spending plan. The Committee **NOTED** that for each headline item specific bids will be developed and presented to Committee to enable the Committee to advise the Trustee's on the appropriate use of the donated funds. The Committee requested that the plan explicitly map the planned spend areas to patient first domains thus allowing the Committee to consider the balance of the use of the funds across the domains and demonstrate strategic alignment between the charity and the Trust. The Committee also asked that the high-level spending plan be presented to the Trust Management Committee after broader engagement with the divisions and that it needed to ensure support was spread across all hospital sites.

The Committee **NOTED** the links between the Charity, the Capital Investment Group and the development of the Capital Plan which enable the Charity and Divisions to both be aware of potential opportunities for the use of charitable funds in support of advancing the patient benefit.

The Committee **ENDORSED** the developing spending plan and confirmed that this supports the Charities' ambition to use donated funds for the benefit of our patients.

The Committee **AGREED** that communication and impact reporting be developed to provide confidence to our communities that donations made are being used effectively and to assure the trustees that the funds have achieved the expected outcomes.

Charity Bids

The Committee recognised that given the developed spending plan there would now be an increase in the volume of bids and so there may be a need to supplement the current meetings with specific focused meetings to consider the bids for use of charitable funds. The Committee **ENDORSED** the work being recommended by the Executives to enhance the quality of the bid requests, as had been discussed at prior Committee meetings. This would include securing greater and earlier Executive and Director engagement in the development of the bids, clear statements of the measurable outcome benefits and explicit confirmation of compliance with all the required internal governance processes.

The Committee considered a number of bids and assessed these against the expected public/patient benefits. It **APPROVED** bids for the provision of mental health first aid for our staff utilising monies from NHS Charities together and the provision of a further OCT Scanner, recognising that the provision of this extra machine allows for less movement of patients between different areas of the Trust. It also brings additional capacity into the Trust which will bring benefit as patients will be able to access a scanner earlier in their care pathway.

Charity Annual Reports and Accounts 2021/22

The Committee **RECEIVED** and reviewed the Charity Annual Reports and Accounts 2021/2022 for both BSUH Charity and Love Your Hospital along with the relevant draft unqualified External Audit Opinions, reports and the draft letters of representations. It agreed to recommend these to the Trustees for approval, noting there had been no significant changes to the draft accounts submitted to audit for each Charity. The Committee provided their thanks to the work of the auditors, charity and finance teams in securing such positive audit outcomes.

Actions taken by the Committee within its Terms of Reference

The Committee **RECEIVED** the 2021/22 annual report, accounts and unqualified external audit opinions for each of the BSUH and LYH Charities. The Committee **AGREED** these as well as the letters of representation should be progressed for signing and publication.

The Committee **APPROVED** the following funding bids

- OCT scanner
- Provision of mental health staff first aid courses

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

The Committee **AGREED** to secure a further update from the investment manager on the future forecast for the market and requested the finance team provide information on actions that could be taken to minimise investment risk and secure maximum interest for monies held in bank accounts whilst safeguarding those funds.

The Committee **AGREED** to review the Charities' risk appetite in line with the market forecast update from the investment manager for both Charities and the bank interest paper.

The Committee **AGREED** to consider the establishment of specific meetings focusing on the consideration of the bids being made for Charitable Funds.

Items referred to the Board or another Committee for decision or action	
Item	
The Board is also asked to **NOTE** ▪ the work of the Charity and the support provided by our donors to enhance patient experiences as well as staff wellbeing; ▪ the decisions taken in respect of approvals for the use of funds; ▪ the assurances received in respect of the stewardship of the donated funds; and ▪ the referral of the accounts and annual reports for both LYH and BSUH Charities to the Trustees for signing.	

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Agenda Item:	20	**Meeting:**	Board	**Meeting Date:**	November 2022
Report Title:	2022/23 Quarter 3 BAF and Corporate Risk Report				
Sponsoring Executive Director:	Chief Governance Officer				
Author(s):	Company Secretary				
Report previously considered by and date:	The Trust's BAF and Corporate Risks have been considered by each of the Trust's allocated oversight committees in their meeting preceding the Board.				

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

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

Implications for Trust Strategic Themes and any link to BAF risks		
Patient	✓	The report covers each BAF risk
Sustainability	✓	
Our People	✓	
Quality	✓	
Systems and Partnerships	✓	

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

Communication and Consultation:

[3]

Executive Summary:

Introduction

The Trust has continued with the 13 strategic risks identified in 2021/22. These risks will be reassessed following the Trust's strategic priority refresh that has just occurred and is being reported to the Board in November 2022.

Each risk has been assessed against the Trust's risk appetite when setting their target score, and each segment of the BAF continues to have a lead executive and lead oversight committee.

For each segment of the BAF the respective lead executive has considered their risks along with the supporting highly scored and corporate risks when determining the quarter 3 score.

The quarter 3 BAF elements have been considered by the respective Board Committees at their meetings in early November 2022.

BAF Summary

The table below overleaf shows by risk, their current score and their target risk score. The table shows pictorially the movement in risk between the current score for Q3 and Q2, Q1 and Q4 from the prior year. (⟷ No change, ↑ an increase in risk and ↓ a decrease in risk)

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BAF: Strategic Objectives and Strategic Risks (Key: I = Impact L = Likelihood T = Total)	Risk Scores														
	2021/22 Q4			2022/23 Q1			2022/23 Q2			2022/23 Q3			Target		
	I	L	T	I	L	T	I	L	T	I	L	T	I	L	T
1. Patient *(Oversight provided by the Patient Committee)*															
1.1 We are unable to deliver or demonstrate a continuous and sustained improvement in patient experience resulting in adverse reputational impact and poor patient outcomes	4	4	16 ↔	4	4	16 ↔	4	4	16 ↔	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	3	12 ↔	4	3	12 ↔	4	3	12 ↔	4	4	16 ↑	4	2	8
3. People *(Oversight provided by the People Committee)*															
3.1 We are unable to develop and sustain the leadership and organisational capability and capacity to lead on-going performance improvement and build a high performing organisation	4	4	16 ↑	4	4	16 ↔	4	4	16 ↔	4	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	4	4	16 ↑	4	4	16 ↔	4	4	16 ↔	4	4	16 ↔	4	2	8

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improvements in patient experience, patient outcomes, and staff morale and wellbeing															
3.3 We are unable to meet our workforce requirements through the effective recruitment, development, training and retention of *sufficient* staff adversely impacting on patient experience and the safety, quality and sustainability of our services	4	5	20 ↔	4	5	20 ↔	4	5	20 ↔	4	5	20 ↔	3	2	6
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.	4	4	16 ↔	4	4	16 ↔	4	4	16 ↔	4	4	16 ↔	3	2	6
4.2 We are unable to deliver service improvements and improve safety, care quality and outcomes for our patients or demonstrate that our services are clinically effective and demonstrate our consistent compliance with regulatory requirements or clinical standards.	4	4	16 ↔	4	4	16 ↔	4	4	16 ↔	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	4	16 ↔	4	4	16 ↔	4	3	12 ↓	4	3	12 ↔	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

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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 3 summary

Following review at the end of quarter 3 the Executives this have agreed that the all risks continue to exceed their target score, risk 2.3 has increased at the start of this quarter as it recognises that whilst the new payroll arrangements have commenced service resilience/staffing capacity is challenged following the onboarding of UHSussex (RSCH/PRH) payroll and the operational issues across the August/September pay period. A detailed action plan has been delivered and many actions have been completed with assurance over the delivery of these planned to be reported later this quarter which then will see the risk score reassessed with an expected reduction in the score closer to its target score.

For quarter 3, the scores for 12 of 13 strategic risks reflect these as being significant.

The BAF reflects that the Trust's highest risks scoring 20 are risk 5.3 relating to the delivery of consistent compliance with the constitutional standards and risk, 3.3 relating to workforce. The BAF reflects the sustained level of risks scoring 16 from 2022/23.

The Sustainability and Systems and Partnerships Committees in the review of the strategic risks they have allocated oversight of recognised that the Board review of the Winter Plan and the Financial Forecast may see increases to a number of these risks.

The BAF is to be adjusted during quarter 3 to reflect the refreshed Trust strategic priorities which have been expanded to include a new priority in relation to Research and Innovation.

The Key Strategic Risks

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 (BAF risk 3.3)

Cause

Failure to recruit new staff in an increasingly competitive labour market, inability to retain staff through creating a positive inclusive environment. Weaknesses in people processes, leadership and support

processes. Impact of cost of living crisis and national pay awards below rate of inflation. National staffing shortages in nursing and some medical specialties such as care of the elderly, stroke medicine and ENT.

Effect

Staff cannot be recruited and/or retained, vacancy and turnover rates increase impacting on the Trust's ability to maintain service levels.

Oversight of this risk is via the People Committee but the risk links to the other patient first domains.

We are unable to deliver and demonstrate consistent compliance with NHS constitutional standards resulting in an adverse impact on patient care and financial penalties and the Trust's reputation. (BAF risk 5.3)

Cause

Peaks in emergency demand place pressure on EDs resulting in compromised patient care including corridor care at the RSCH. High levels of Medically Ready for Discharge patients impact on patient flow through the hospitals. Demand for elective care exceeds the Trust's available capacity

Effect

Potential poor experience and/or clinical outcomes for long waiting patients and a rise in complaints and a fall in patient satisfaction. Failure to meet NHS Constitutional standards.

Oversight of this risk is via principally by the Systems and Partnerships Committee but has strong links to the Sustainability Committees and links to the other patient first domains.

Our ability to deliver our strategy is compromised by the relative immaturity of some systems and processes and of some leadership teams (all risks).

Cause

The Trust is in the early stages of its development with the Clinical and Corporate Operating models still being embedded after implementation in 2021/22. There have been a significant number of new appointments to both the senior leadership teams within the corporate and clinical operating model along with new Board (Executive and NED) appointments.

Effect

Some business processes such as, business intelligence and quality governance are not as efficient or effective as required compromising the Trust's ability to identify issues early and develop effective management interventions.

Oversight of this risk is via the Board supported by each Committee as this risk underpins the BAF risks.

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Supporting Key Risks

Each Committee at their meetings in prior to the Board November considered the respective key risks with the potential to impact on the Committee's relevant patient first domain. These included consideration of the risks in relation to the domain's True North, Breakthrough Objective, Strategic Initiative and Corporate Project along with a consideration of the highly scored risks within datix (noting that the highly scored risks within Datix are included within a separate report).

There are also a number of organisational (enduring risks) in overseen by the Health and Safety Committee which include Fire, Estates, EPRR, along with specific specifics such as radiology protection, waste management which are reported directly to the Audit Committee. The majority of these Health and Safety risks have a current score close to or at their target scores, with any significantly elevated included within Datix.

Each Committee at their meetings reviewed these key risks and the supporting information provided from the Datix IQ system.

Below is a table of the Key Risks, from each of the Patient First Thematic Board Committees to the Board. The key risks are mapped to their identified themes and to the BAF risks by patient first domain.

BAF	Corporate Themes	Key Risks
Patient		
1.1 We are unable to deliver or demonstrate a continuous and sustained improvement in patient experience resulting in adverse reputational impact and poor patient outcomes	Management of young people requiring inpatient care for mental health problems Failure to meet access targets and impact on patient experience A&E RSCH Cohort area is a poorly designed place in which to look after patients which has the potential to impact on patient experience	Levels of nursing vacancies and an inability to provide consistent nursing & medical cover for escalation/outliers if bed capacity full. Management of young people requiring inpatient care for mental health problems A&E RSCH Cohort Area Availability of equipment and supplies.
Sustainability		
2.1 We are unable to align or invest in our workforce, finance, estate and IM&T infrastructure effectively to support operational resilience, deliver our strategic and operational plans and improve care for patients 2.2 We cannot deliver ongoing efficiencies and flex our resources in an agile way	Operational pressures including Covid-19 pandemic and workforce constraints are impacting on operational costs and productivity. These, alongside organisational capacity and a new financial framework are adding further risk to delivery of financial targets, a required step-up in elective capacity and	Capital Developments Cyber Security Payroll resilience Financial Plan Deliverability

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resulting in an increasing or unmanaged deficit and inefficient, unaffordable and unsustainable services. 2.3 We are unable to meet high standards of financial stewardship meaning we cannot sustain compliance with our statutory financial duties	delivery of a challenging efficiency programme. The new financial framework for capital funding and allocations significantly reduces flexibility within the capital programme. This, alongside the high number of complex projects to be delivered presents a significant capacity challenge within the capital projects team to deliver the programme There is continues to be level of risk for cybersecurity. This is an on-going and known risk requiring continuous oversight.	
People		
3.1 We are unable to develop and sustain the leadership and organisational capability and capacity to lead on-going performance improvement and build a high performing organisation 3.2 We are unable to effect cultural change and involve and engage staff in a way that leads to continuous improvements in patient experience, patient outcomes, and staff morale and wellbeing 3.3 We are unable to meet our workforce requirements through the effective recruitment, development, training and retention of *sufficient* staff adversely impacting on patient experience and the safety, quality and sustainability of our services 3.4 We are unable to consistently meet the health, safety and wellbeing needs of our staff as	The stretch on staffing and their morale and wellbeing. These pressures are not unique to UHSussex but nevertheless pose a significant risk to delivery. Operational pressures including Covid-19 pandemic and workforce constraints are impacting on people, patient safety and trust operational costs and productivity. The general pressure on staffing of being able to sustain the levels of workforce needed, particularly at times of stretch (escalation beds, extra RTT activity etc)	Risk of insufficient medical staff Insufficient numbers of registered nurses and health care nurses Vaccination (flu and Covid) Health and wellbeing Staff stretch and patient experience Emerging risk in relation to the possibility of industrial action

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we recover and restore services in line with CV-19 restrictions		
Quality		
4.1 We are unable to deliver safe and harm free care to reduce non-covid mortality. 4.2 We are unable to deliver service improvements and improve safety, care quality and outcomes for our patients or demonstrate that our services are clinically effective and demonstrate our consistent compliance with regulatory requirements or clinical standards	Operational pressures including acute system pressures, escalation wards and staffing, referral to treatment delay and workforce constraints are all impacting on the delivery of the quality and safety of patient care. Patient profile, frailty, mental health, delays to specialist placement (in particular child and adolescent mental health), long waits for pre-hospital assessment (ambulance transfers) reduced care in community and social care placement and primary care capacity.	Levels nursing cover due to high levels of nursing vacancies and an inability to provide consistent nursing & medical cover for escalation/outliers if bed capacity full. Management of young people requiring inpatient care for mental health problems A&E RSCH Cohort Area is a poorly designed Increase in RTT waiting times
Systems and Partnerships		
5.1 We are unable to develop and maintain collaborative relationships with partner organisations based on shared aims, objectives, and timescales leading to an adverse impact on our ability to operate efficiently and effectively within our health economy 5.2 We are unable to define and deliver the strategic intentions, plans and optimal configuration that will enable our services to be sustainable, leading to an adverse impact on their future viability. 5.3 We are unable to deliver and demonstrate consistent compliance with operational and NHS constitutional standards resulting in an adverse impact on patient care and financial penalties and the Trust's reputation.	Operational pressures including 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 new corporate projects eg reducing length of stay and transforming patient access. Specific capacity constraints in operational services (including workforce impacts) which are driving the overall increase in the elective waiting times across a wide range of services, and the resulting reliance on Independent Sector capacity to deliver the plan to have no patient waiting more than 78 weeks for treatment	Failure to meet access targets and impact on patient experience Capacity constraints leading to Increase in waiting times Occupational capacity Winter Plan

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Conclusion

The Board is asked to note the oversight provided by the respective Board Committees and that each Committee on review of the BAF and underpinning highly scored and corporate risks have considered these risk as reasonably scored. The Board is also asked to note that the Sustainability and Systems and Partnerships Committees in the review of the strategic risks they have allocated oversight of recognised that the Board review of the Winter Plan and the Financial Forecast may see increases to a number of these risks.

Key Recommendation(s):

The Board is asked to AGREE the BAF risk scores for quarter 3, noting that these may change following the review of the Winter Plan and the Financial Forecast during quarter 3 itself.

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Agenda Item:	21	**Meeting:**	Board	**Meeting Date:**	10 November 2022
Report Title:	**CQC Update**				
Committee Chair:			Maggie Davies, Chief Nurse		
Author(s):			Maggie Davies, Chief Nurse		
Report previously considered by and date:			The detailed reports have been reported to Board		
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:					

Report

This report provides the Board with an update as to the recent CQC activity at the Trust

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

Following the inspection, we have received the Upper GI report which we are going through factual accuracy process before returning 3/11/22

To support the embedding and sustainability of CQC required improvements, ‘must dos’ and ‘should dos’, trackers for each Division have been developed and reviewed (Surgery RSCH, ED RSCH & Maternity Services across all 4 sites). There is an ICB & NHSE meeting being arranged to review our actions utilising these developed action trackers

The Trust is awaiting both the neurosurgery report and well led report from the most recent inspections.

Key Recommendation(s):

The Board is recommended to **NOTE** the update

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Agenda Item:	22	**Meeting:**	Trust Board	**Meeting Date:**	10 November 2022
Report Title:	Winter Capacity Plan 2022/23				
Sponsoring Executive Director:	Dr Andy Heeps, Chief Operating Officer				
Author(s):	Siobhan Murray, Managing Director, Unscheduled Care				
Report previously considered by and date:	Systems and Partnerships Committee, 1 November 2022				

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

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

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

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

Communication and Consultation:

Executive Team, Hospital Directors, Hospital Directors of Nursing, Divisional leadership teams, Trust directors.

Executive Summary:

This paper sets out the Trust's winter capacity plan for 2018/19; this has been developed by the Clinical Divisions and informed by meetings of the Trust Operational Management Group and other groups which has included Hospital Directors and Hospital Directors of Nursing, Divisional Directors of Operations and Nursing as well as Chiefs. The plan is focussed on delivery of the following key objectives:

(i) Safely avoid admissions – five overarching schemes
(ii) Safely create more capacity – nine overarching schemes
(iii) Safely reduce length of stay – two overarching schemes
(iv) Maintain operational grip and control

The total cost of the winter capacity plan is £1.2m (best case) to £3.4m (worst case). Substantiating the unfunded beds currently in use requires investment of £4m for H2 and £8.1m FYE. In addition to the unfunded beds, "Fit to Sit" in the ED at RSCH and the 7.8 WTE additional clinical fellows for RSCH & PRH requires investment of £0.7m for H2 and £1.4m FYE which is still to be agreed.

The Trust received £6m of non-recurrent funding from ICB to support additional bed capacity. A 50% conversion in current premium rate deployment to substantive would represent a FYE run-rate saving of £1m. There is an ongoing risk that further recruitment will not reduce premium spend but increase fill rate.

Key Recommendation(s):

Trust Board are invited to note the Winter Capacity Plan and note that ongoing oversight will be provided by the Operational Management Group

University Hospitals Sussex
NHS Foundation Trust

1. Introduction

This paper provides an oversight of the Trust's winter capacity plan for 2022/23, outlining progress against each of the schemes and highlighting any risks to delivery.

2. Background

The overarching aim of the winter capacity plan is to ensure there is sufficient capacity to manage demand, maintain patient safety and patient flow throughout the winter period. The key principles for the winter capacity plan, which will be measured and reported on through the winter period, were set out as follows:

(a) 19/20 phasing (adjusted for March as this was impacted by covid)
(b) 22/23 actuals to June forecast forward
(c) 2% growth assumption (in line with regional modelling)
(d) 95% occupancy
(e) Includes average 8am A&E admissions awaiting beds
(f) Calculated per day
(g) Aggregated to min-max and upper quartile range per month

For winter 2022/23 these are to be achieved through the delivery of the following key objectives:

(h) Safely avoid admissions
(i) Safely increase capacity
(j) Safely reduce length of stay
(k) Maintain operational grip and control

Costs described are indicative and a financial summary is included at section 7.

3. Safely avoid admissions

Scheme description	Details	RAG rating	Cost above run rate per month	Risks
Seven day services through emergency floors at all sites	We will plan for seven day services to be delivered on the emergency and acute medical floors at St Richard's, Worthing and Royal Sussex County Hospitals		£115,395pcm	Failure to recruit or failure to take up additional bank shifts
Same Day Emergency Care at St Richard's	We will establish a multi-speciality Same Day Emergency Care unit at St Richard's Hospital in the Kaizen Space (16 spaces) – which can be used to decant patients awaiting admission every morning		tbc	
EACU at Royal Sussex County Hospital will be open from 8.00am until 12.00am daily	1 RN, 1 HCA		£30,793pcm	
Participation in NHS Sussex Virtual Ward programme	Admission avoidance for frailty, cardiology and respiratory pathways		-	Managed externally by SCFT
Ensuring as many staff and patients as possible have their flu jab	-		-	-

4. Safely increase capacity

Scheme description	Details	RAG rating	Cost above run rate per month	Risks
RSCH – additional 23 beds in 3Ts	Dependent upon 3Ts move		-	-
RSCH – reprovide 10 beds on Lewes ward for Medicine division – reduction of outliers	1 consultant, 1 junior doctor per day		£17,500pcm	Failure to recruit staff
RSCH – AAU re-providing a 3 bedded – net gain of 2 beds/4 chairs	Small amount of capital work		tbc (capital costs)	-
Worthing – reopening of Eastbrook (24 beds)	Nursing establishment, consultant, 2 junior doctors		£1.2M capital £114,484pcm	Use to be confirmed
SRH – Chilgrove – break ringfence; urgent and non elective T&O into Aldwick	Staffing changes to be confirmed – January only		tbc	Reduction in elective capacity to deliver 78 week target
RSCH – establish unfunded beds from M7	12 beds on 9AE 5 beds on 8AW 9 beds on CY8		£170,180pcm	Risk that further recruitment will not reduce premium spend but increase fill rate.
PRH – establish unfunded beds from M7	ED additional area		£36,540pcm	
Worthing – establish unfunded beds from M7	Beacon Buckingham Brooklands Ditchling		£245,000pcm	
SRH – establish unfunded beds from M7	Ashing Birdham Fishbourne Apuldram		£227,500pcm	

There are a small number of further capital costs being developed for Princess Royal Hospital which will be reviewed by the Operational Management Group.

5. Safely reduce length of stay

Scheme description	Details	RAG rating	Cost above run rate per month	Risks
Long length of stay ward rounds	Hospital directors of nursing will lead a twice weekly review of 14+ and 21+ LOS patients on their hospital site to focus the work of discharge teams to facilitate earlier discharge		-	Lack of capacity on social care and community trust pathways to facilitate onward discharge
Reducing number of moves for inpatients	We will monitor number of ward moves and each site will develop a plan for reducing the number of ward moves experienced by inpatients, implemented by the site team		-	COVID surges resulting in patient moves required to cohort exposed and sick patients

6. Maintain operational grip and control

Scheme description	Details	RAG rating	Cost above run rate per month	Risks
Senior nurse of the day at weekends	Senior clinical decision making		-	Rota changes for senior nurses, changes to on call rota

7. Financial summary

The winter plan costs suggest a range of additional expenditure to current run-rate of:

- Best case £1.2m
- Mid-Case £1.9m
- Worst case £3.4m

This does not include quotations for additional capital works as they are still at scoping stage.

Substantiating the unfunded beds currently in use requires investment of £4m for H2 and £8.1m FYE. In addition to the unfunded beds, Fit to Sit in the ED at RSCH and the 7.8 WTE additional clinical fellows for RSCH & PRH requires investment of £0.7m for H2 and £1.4m FYE which is still to be agreed.

The Trust received £6m of non-recurrent funding from ICB to support additional bed capacity. A 50% conversion in current premium rate deployment to substantive would represent a FYE run-rate saving of £1m. There is an ongoing risk that further recruitment will not reduce premium spend but increase fill rate.

There is no separate winter funding source this year, so costs will be agreed and factored into the financial recovery plan. Management of cost will be through the Chief Finance Officer, Chief Operating Officer and Managing Directors.

8. Summary

The Trust has made good progress in implementing the winter capacity plan with the majority of schemes designed to safely avoid admissions, increase medical bed capacity and maintain operational grip progressing as planned.

The key risks to delivery are for the schemes designed to safely increase capacity. The risks to delivery of these schemes are as a result of the potential that further recruitment will not reduce premium spend but increase fill rate.

The plan will be monitored at the Operational Management Group.

Siobhan Murray
November 2022

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	23	**Meeting:**	Trust Board	**Meeting Date:**	10th November 2022
Report Title:	Elective Recovery Self Certification				
Sponsoring Executive Director:	Andy Heeps, Deputy CEO/COO				
Author(s):	Ben Stevens, Managing Director				
Report previously considered by and date:	N/A				

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

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

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

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

Communication and Consultation:

Executive Summary:

All trusts delivering elective activity were assessed and allocated a tier from 1 to 3 based on the waiting list position in terms of long waiting patients. Tier 1 trusts are those deemed to require the most intervention whilst tier 3 trusts are those deemed to require the least input to deliver the ask of no 78 or over week waits by the end of March 2023. Due to the current position in terms of the long waiting backlog size University Hospitals Sussex was placed in Tier 2. This means that regional oversight and support was recommended.

On the 25th October NHS England issued a letter to all Trust CEO's and Chairs detailing expectations on next steps for elective care for Tier one and Tier two providers. The letter details the steps that Trusts should be taking to support delivery of the reduction in long waiting patents. As part of the priorities that have been set out each provider is being asked to undertake a board self-certification process for elective recovery, to be signed off by Trust Chairs and CEO's by 11th November 2022.

Organisations unable to complete the self-certification process will be required to discuss gaps and mitigations with the regional team.

The self-certification process asks the Chair and the CEO to confirm that the board meets 12 key elements associated with elective recovery.

Following a self-assessment undertaken the current position is that 10 of the 12 key elements have been met but that there are further actions to be taken in respect of the remaining 2.

On this basis the Trust is unable to complete the self-certification by the 11th November and therefore there is the requirement to discuss mitigation and actions with the regional team. Proposed actions would deliver the requirements of the final two elements in December and therefore enable completion of the self-certification.
Key Recommendation(s):
• Agree that self-certification cannot be completed within the deadline • Final items to for self-certification to be completed and submitted post the receipt of the final two documents in December.

University Hospitals Sussex
NHS Foundation Trust

Report to:	Trust Board
Meeting Date:	10th November 2022
Report From:	Andy Heeps, Deputy CEO/Chief Operating Officer
Author:	Ben Stevens, Managing Director
Title:	Elective Recovery Self Certification

Purpose

1. The purpose of this report is to detail the outcome of a self-assessment undertaken in response to the requirement from NHSE to undertake a Board self-certification process for the Trust elective recovery.

Executive Summary

2. All trusts delivering elective activity were assessed and allocated a tier from 1 to 3 based on the waiting list position in terms of long waiting patients. Tier 1 trusts are those deemed to require the most intervention whilst tier 3 trusts are those deemed to require the least input to deliver the ask of no 78 or over week waits by the end of March 2023. Due to the current position in terms of long waiting backlog size University Hospitals Sussex was placed in Tier 2. This means that regional oversight and support was recommended.

3. It should be noted that University Hospitals Sussex was placed in tier 2 for elective RTT only and not for cancer delivery.

4. On the 25th October NHS England issued a letter to all Trust CEO's and Chairs detailing expectations on next steps for elective care for Tier one and Tier two providers. The letter details the steps that Trusts should be taking to support delivery of the reduction in long waiting patents. As part of the priorities that have been set out each provider is being asked to undertake a board self-certification process for elective recovery, to be signed off by Trust Chairs and CEO's by 11th November 2022.

5. Organisations unable to complete the self-certification process will be required to discuss gaps and mitigations with the regional team.

6. The self-certification process asks the Chair and the CEO to confirm that the board meets 12 key elements associated with elective recovery.

7. Following a self-assessment undertaken the current position is that 10 of the 12 key elements have been met but that there are further actions to be taken in respect of the remaining 2.

8. On this basis the Trust is unable to complete the self-certification by the 11th November and therefore there is the requirement to discuss mitigation and actions with the regional team.

9. Proposed actions would deliver the requirements of the final two elements in December and therefore enable completion of the self-certification.

RTT and Cancer Delivery

10. University Hospitals Sussex has made significant progress in reducing the number of patients waiting over 104 weeks for treatments. In September 2022 there were 26 patients waiting longer that 104 weeks for treatment, a reduction from 286 patients waiting at the end of December 2021. The 26 over 104 week waiting patients were a combination of patient choice, clinical reason for delay or complex pathways.

11. Whilst the Covid pandemic has impacted the size and shape of the waiting list the current position is, in part, as a result of previous commissioning decisions not to commission activity levels that would deliver an 18 week compliant position.

12. There is ongoing work in progress to deliver a reduction in the number of patients waiting more than 62 days on a cancer pathway by the end of January. Due to a combination of the current waiting list position and the plans to deliver improvement there was sufficient assurance provided to prevent UHSx being placed in a tier for cancer recovery delivery.

Self-Certification Requirements

13. The Chair and CEO are asked to confirm that the Board:

    a) Has a lead Executive Director(s) with specific responsibility for elective and cancer services performance and recovery.

    b) That the Board and its relevant committees (F&P, Safety and Quality etc) receive regular reports on elective, diagnostic and cancer performance, progress against plans and performance relative to other organisations both locally and nationally.

    c) Has an agreed plan to deliver the required 78ww and 62 day trajectories for elective and cancer recovery, and understands the risks to delivery, and is clear on what support is required from other organisations.

    d) Has received a report on the current structure and performance of Lower GI, Skin and Prostate cancer pathways (including the proportion of colonoscopies carried out on patients who are FIT negative or without a FIT; the proportion of urgent skin referrals for whom a face to face appointment is avoided by use of dermoscopic quality images; and a capacity/demand analysis for MRI and biopsy requirements on the prostate pathway), and agreed actions required to implement the changes outlined in this letter.

    e) Is pursuing the opportunities, and monitoring the impacts, presented by Outpatient transformation and how this could accelerate their improvement, alongside GIRFT and other productivity, performance and benchmarking data and opportunities.

    f) Have received a report on Super September and have reviewed the impact of this initiative for their Organisation.

    g) Have received reports on validation, its impact and has a validation plan in line with expectations in this letter.

h) Have challenged and received assurance from the lead Executive Director, and other Board colleagues, on the extent to which clinical prioritisation (of both surgical and diagnostic waiting lists) can help deliver their elective and cancer objectives. This should include receiving a review of turnaround times for urgent suspected cancer diagnostics and agreeing any actions required to meet the backstop maximum of 10 days from referral to report.

i) Discuss theatre productivity at every trust board; we suggest with the support of a non-executive director to act as a sponsor.

j) Routinely review Model Health System theatre productivity data, as well as other key information such as day-case rates across trusts.

k) Confirm your SROs for theatre productivity.

l) Ensure that your diagnostic services reach at least the minimum optimal utilisation standards set by NHS England.

14. Following receipt of the letter on the 25 October 2022 a self-assessment has been undertaken against each of the 12 components listed above. The output of the self-assessment is detailed in table 1 below:

Table 1:

Elective Recovery Self Certification

The Chair and CEO are asked to confirm that the Board:

Task	Accountable Exec	Lead	Statement of Compliance/Gap analysis	Evidence	Able to Self Certify	Next Steps/Mitigations
Has a lead Executive Director(s) with specific responsibility for elective and cancer services performance and recovery.	Andy Heeps	Andy Heeps	Andy Heeps, COO/Deputy CEO has executive responsibility for elective and cancer services performance and recovery.	Executive Portfolio	Yes	N/A
That the Board and its relevant committees (F&P, Safety and Quality etc) receive regular reports on elective, diagnostic and cancer performance, progress against plans and performance relative to other organisations both locally and nationally.	Andy Heeps	Ben Stevens Siobhan Murray	Performance reports received by S&P TN and BO updates received by S&P Integrated performance report to Board The BaF has a specific section relating to performance and is updated quarterly	S&P Minutes Board meeting minutes/papers BaF	Yes	N/A
Has an agreed plan to deliver the required 78ww and 62 day trajectories for elective and cancer recovery, and understands the risks to delivery, and is clear on what support is required from other organisations	Andy Heeps	Ben Stevens	Revised trajectory and delivery plan retains a residual gap to 78 week delivery. Revised 62 day trajectory and delivery plan aims to deliver the requirement by the end of Jan	Trajectories Delivery Plans	Yes	
Has received a report on the current structure and performance of Lower GI, Skin and Prostate cancer pathways (including the proportion of colonoscopies carried out on patients who are FIT negative or without a FIT; the proportion of urgent skin referrals for whom a face to face appointment is avoided by use of dermoscopic quality images; and a capacity/demand analysis for MRI and biopsy requirements on the prostate pathway), and agreed actions required to implement the changes outlined in this letter.	Andy Heeps	Siobhan Murray Dominic Clarke	A report of this granular level has not been to board or any of the board sub committees to date	Reporting to board required	No	Detailed report covering all components is required for the December board and S&P committee
Is pursuing the opportunities, and monitoring the impacts, presented by Outpatient transformation and how this could accelerate their improvement, alongside GIRFT and other productivity, performance and benchmarking data and opportunities.	Andy Heeps	Ben Stevens	Outpatient transformation is a programme of work at UHSx including: PIFU pathway expansion Virtual appointment models Advice and Refer pathways FiT test less than 10 - Alternate pathways	Performance metrics for PIFU, A&G and Virtual appointment	Yes	Review reporting to the board
Have received a report on Super September and have reviewed the impact of this initiative for their Organisation.	Andy Heeps	Ben Stevens	Super September work has been undertaken with initial reporting through TMC and OMG. To be reported through S&P on 3rd November	Minutes and reports	Yes	To be covered at S&P on 3rd November and a summary to December Trust Board
Have received reports on validation, its impact and has a validation plan in line with expectations in this letter.	Andy Heeps	Ben Stevens	See point 6 as validation is a component part of the super September work and reporting	Minutes and reports	Yes	To be covered at S&P on 3rd November and a summary to December Trust Board
Have challenged and received assurance from the lead Executive Director, and other Board colleagues, on the extent to which clinical prioritisation (of both surgical and diagnostic waiting lists) can help deliver their elective and cancer objectives. This should include receiving a review of turnaround times for urgent suspected cancer diagnostics and agreeing any actions required to meet the backstop maximum of 10 days from referral to report.	Andy Heeps	Siobhan Murray Dominic Clarke	A report of this granular level has not been to board or any of the board sub committees to date	Reporting to board required	No	Detailed report covering all components is required for the December board and S&P committee
Discuss theatre productivity at every trust board; we suggest with the support of a non-executive director to act as a sponsor.	Karen Geoghegan	Ben Stevens	Theatre productivity is now a component of the sustainability breakthrough and has been reported, reviewed and discussed at sustainability committee.	Sustainability committee minutes and papers	Yes	N/A
Routinely review Model Health System theatre productivity data, as well as other key information such as day-case rates across trusts.	Andy Heeps	Ben Stevens	Included in the productivity Breakthrough reporting to sustainability committee.	Sustainability committee minutes and papers	Yes	Ensure model hospital data is included in all reports
Confirm your SROs for theatre productivity.	Andy Heeps	Ben Stevens	Theatre productivity is now a component of the sustainability breakthrough. The SRO is Ben Stevens. Operationally the SRO is Hardev Gill A clinical champion/s is required	Project Charter	Yes	Clinical SRO/Champion to be identified
Ensure that your diagnostic services reach at least the minimum optimal utilisation standards set by NHS England.	Andy Heeps	Siobhan Murray	There is the requirement to hit 120% activity relative to 19/20 including CDC's. Trust delivery YTD is 110% of 19/20 baseline. September is 125%	System and Trust performance	Yes	Further reporting to be included in performance reporting.

15. As detailed previously the self-assessment has identified that 10 of the 12 elements can be confirmed for certification. The 2 elements that are not confirmed are:

    The board:

    - Has received a report on the current structure and performance of Lower GI, Skin and Prostate cancer pathways (including the proportion of colonoscopies carried out on patients who are FIT negative or without a FIT; the proportion of urgent skin referrals for whom a face to face appointment is avoided by use of dermoscopic quality images; and a capacity/demand analysis for MRI and biopsy requirements on the prostate pathway), and agreed actions required to implement the changes outlined in this letter.

    - Have challenged and received assurance from the lead Executive Director, and other Board colleagues, on the extent to which clinical prioritisation (of both surgical and diagnostic waiting lists) can help deliver their elective and cancer objectives. This should include receiving a review of turnaround times for urgent suspected cancer diagnostics and agreeing any actions required to meet the backstop maximum of 10 days from referral to report.

16. It should be noted that the first point refers to cancer pathways and whilst University Hospitals Sussex was placed in Tier 2 for elective RTT care the organisation was not placed in tier for cancer service provision. However, for completeness the element relating to cancer will also be fulfilled.

17. Therefore, the proposal is to send the reports, that will fulfil the two elements above, to the systems and partnerships committee on 1 December with a summary update to board members if required.

Risks Assessment

18. Whilst good progress is being made on the recovery of RTT and cancer waiting times the programmes remain vulnerable to some risk. These potential risks have been considered at a high level and are summarised below with potential mitigationss:

	Risk	Mitigation
1.	The impact of increased urgent and emergency care demand (above forecast in the winter plan) on the ability to continue elective services.	• Ringfenced elective capacity including SOTC. • The development and utilisation of community diagnostic centres for elective diagnostics. • Implementation of the winter plan. • Access to alternative capacity such as the independent sector and mutual aid within the system.
2.	Further Covid Waves	• Ringfenced elective capacity • Access to alternative capacity such as the independent sector and mutual aid within the system.
3.	Potential industrial action	• Expectation that urgent and cancer work would not be affected. • Trust industrial action response plan.

Conclusion and Recommendations

19. The Board is asked to approve:

a. The self-assessment in Table 1 above
b. The declaration that self-certification will not be completed on 11th November and regional colleagues will be informed accordingly. This is on the basis of the two unmet elements that need to be resolved.
c. That reports covering the two unmet elements will be considered by the Systems and Partnerships members on 1 December
d. That the self-certification be completed and submitted following receipt of the two reports agreed by Systems and Partnership members.

To: NHS Trust and Foundation Trust chief executives and chairs

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

25 October 2022

Dear colleague,

Next steps on elective care for Tier One and Tier Two providers

On 18 October, NHS England wrote to the NHS outlining further plans to boost capacity and resilience for services over the coming challenging winter period. This letter now sets out immediate next steps for tier one and tier two of the elective recovery programme to ensure that our phase two objectives around 78 week waiters and 62 day cancer waits are met.

The NHS has delivered a massive reduction in patients waiting two years and is also now steadily reducing the number of people waiting more than 18 months and 62 days respectively. Activity levels compared to pre-pandemic are increasing but we can still do more. There is no one silver bullet, but through a combination of getting the basics right and data-led management and innovation, particularly on outpatient and diagnostic activity, we firmly believe that we can continue to make genuine progress.

We realise that there are a lot of asks on providers and that each of you will know best your local circumstances and what works well. However, through each wave of Covid over the past two years, hospitals have got better and better at protecting elective and cancer care. There are significant learnings from individual organisations across the country that can make a huge difference if adopted collectively. That is why we are now asking all colleagues to step up efforts on all of the measures outlined below. With this in mind, we ask that you complete the Board self certification, (see appendix A) to allow us to support you where you are having the greatest challenges. The fundamentals that we have, collectively, proven to work are:

Excellence in the Fundamentals of Waiting List Management
Ensuring operational management and oversight of routine elective and cancer waiting lists aligns with best practice as outlined/directed within the national programme and current Cancer Waiting Times guidance. All patients past 62 days for cancer and 78

weeks for wider elective care should be reviewed and the actions required to progress them to the next step in their pathway prioritised.

Validation

The validation and review of patients on a non-admitted waiting list is important for the appropriate use of outpatient capacity and to provide clean visible waiting lists to ensure timely and orderly access to care. There are three phases to validating waiting lists that providers are required to undertake routinely – technical, administration and clinical and, following on from guidance sent out on 16 August available here, we expect providers to meet this timeline:

a) By 23rd December 2022
   Any patient waiting over 52 weeks on an RTT pathway (at 31 March 2023) who has not been validated* in the previous 12 weeks should be contacted

b) By 24th February 2023
   Any patient waiting over 26 weeks on an RTT pathway (at 31 March 2023) who has not been validated* in the previous 12 weeks should be contacted

c) By 28th April 2023
   Any patient waiting over 12 weeks on an RTT pathway (at 20 April 2023) who has not been validated* in the previous 12 weeks should be contacted

Appropriate surgical and diagnostic prioritisation

We know that 85% of patients waiting longer than 62 days from their referral for urgent suspected cancer are waiting for a diagnostic test. For cancer in particular, the significant demand for additional diagnostic capacity means that Trusts need to adhere to the maximum timeframes for diagnostic tests within each tumour-specific Best Practice Timed Pathway, but should at all times have a maximum backstop timeframe of 10 days from referral to report. Trusts should undertake a comprehensive review of current turnaround times and what further prioritisation of cancer over more routine diagnostics would be required to meet this backstop requirement.

Trusts should ensure that existing community diagnostic centres (CDCs) capacity is fully utilised by ringfencing it for new, additional, backlog reducing activity, and working with their wider ICS partners to use a single PTLs across the system. Trusts should work across their systems to accelerate local approval of business cases CDCs, additional acute imaging and endoscopy capacity; and expedite delivery of those investments once approved, and should continue to explore partnerships with the independent sector to draw on or build additional diagnostic capacity.

Surgical prioritisation should continue to follow the guidance set out in the letter of 25 July, providing ringfenced elective capacity for cancer patients (particularly P3 and P4 urology and breast patients) and 78ww patients. Performance against the 31 day standard from decision to treat to treatment should be used to assess whether the first of these objectives is being met.

Cancer pathway re-design for Lower GI, Skin and Prostate

There are three pathways making up two-thirds of the patients waiting >62 days and where increases over the past year have been the largest: Lower GI, Skin and Urology. Service Development Funding was made available to your local Cancer Alliance to support implementation of these changes and additional non-recurrent revenue funding has also been made available nationally.

Lower GI: Full Implementation of FIT in the 2ww pathway

As set out in the joint guidance on FIT issued by the British Society of Gastroenterology and Association of Coloproctology of Great Britain and Ireland (ACPGBI), and reinforced in this letter, most patients with suspected colorectal cancer symptoms but a FIT of fHb <10 µg Hb/g, a normal full blood count, and no ongoing clinical concerns should not be referred on a LGI urgent cancer pathway. Where referred, teams should not automatically offer endoscopic investigation but consider alternative, non two week wait, pathways as set out in the letter.

Full implementation of teledermatology in the suspected skin cancer pathway

All Trusts should work with their ICS to implement teledermatology and digital referral platforms to optimise suspected skin cancer pathways and reduce unnecessary hospital attendances to tackle the backlog and meet increasing demand. NHS England's guidance on the implementation of teledermatology pathways is endorsed by the British Association of Dermatologists and supports a Best Practice Timed Pathway for skin cancer which has been published this week.

Implementation will require provision for dermoscopic images to be taken for Urgent Suspected Cancer Skin cancers. This could be delivered by primary care, a separately contracted service delivered by primary care, in a community image taking hub setting, or by medical illustration departments in secondary care. Capacity must be in place for daily dermatologist triage of images, as either additional activity or as part of existing job plans. Following triage, the consultant or a member of their team should communicate with the patient (via telephone, video or face-to-face consultation) and be booked directly for surgery and receive appropriate preoperative advice and counselling if required.

Full implementation of the Best Practice Timed Pathway for prostate cancer
All provider Trusts should implement the national 28-day Best Practice Timed Pathway for prostate cancer, centred on the use of multiparametric MRI (mpMRI) before biopsy. Using pre-biopsy mpMRI means patients can be triaged towards a biopsy so at least 25% can avoid it, over 90% of significant cancers can be diagnosed on imaging and fewer insignificant cancers are diagnosed. Use of local anaesthetic transperineal biopsy where clinically indicated provides increased accuracy and reduced risk of infection, without the resource intensity of procedures done under general anaesthetic.

Implementation will require all patients to be booked in for both mpMRI and biopsy at the point of triage, with triage taking place no later than 3 days from the date the referral is received. Ring-fenced mpMRI slots should be in place – weekly demand analysis from radiology requesting systems should be used to inform the level at which this is set, with frequency of mpMRI slots sufficient to support delivery of timely biopsy. Maximum use of local anaesthetic transperineal prostate biopsy should also be ensured, with general anaesthetic biopsy used only where clinically indicated or for patient preference. Pre-biopsy mpMRI and biopsy procedures should take place no later than 9 days from the date the referral is received.

Outpatient transformation
Outpatients make up around 80% of the total waiting list and it is crucial that, over the winter period, providers continue to keep a strong operational focus on providing these services. Providers are asked to continue their work to deliver a 25% reduction in outpatient follow up appointments by March 2023.

a) As part of this, trusts are asked to continue the expansion of patient initiated follow up (PIFU) to all major outpatient specialties, especially increasing the volume of PIFU activity in specialties where it is now well established.
b) Continue to deliver at least 16 specialist advice requests per 100 first outpatient appointments. Providers are asked to focus efforts on pre-referral advice models.
c) Further initiatives to support outpatient follow-up (OPFU) reduction should also include improved and standardised discharge procedures and more effective administrative processes – including focusing on reducing DNAs in outpatient settings
d) In order to enable a personalised approach for outpatients and where it is clinically appropriate to do so, outpatient appointments should continue to be delivered via video and telephone, at a rate of 25% of all outpatient appointments. Remote consultation guidance and implementation materials can be found on NHS Futures here.

Surgical and theatre productivity

It is essential that we make best use of available surgical capacity, to drive productivity improvements and protect elective activity through winter. As such we expect providers to:

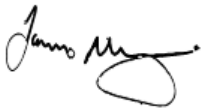
a) Review the senior responsible officer(s) (SROs) and oversight arrangements in relation to theatre productivity and strengthen these if necessary. Ideally, it should consist of a senior manager working ‘shoulder-to-shoulder’ with a senior clinician – to succeed we need both groups working together.
b) Drive up theatre utilisation to 85%, underpinned by the cases per list standards set out within the GIRFT high volume low complexity (HVLC) programme.
c) Make elective surgery daycase by default, delivering daycase rates across all surgery of 85%, and helping to free up valuable inpatient beds for complex work.
d) Maximise Right procedure right place, taking simple surgical procedures out of theatre into procedure rooms, eg hand surgery, cyctoscopy, hysteroscopy
e) Adopt best practice pre & peri-operative medicine pathways to reduce issues of under booking of lists, on the day cancellations, and pro-longed length of stay, as well as providing better care for patients.
f) Optimise the booking & scheduling processes, ensuring that patients are ready for surgery prior to being offered a surgery date, with an embedded data driven, clinically led approach.
g) Not performing those interventions identified as ‘must not do’ on EBI lists 1 and 2 and following the stated process for those List 1 and 2 interventions that should only be performed after applying the specific criteria.

Board Self-certification

As part of the above priorities, we are asking each provider to undertake a Board self certification process and have it signed off by Trust Chairs and CEOs by November 11, 2022. If you are unable to complete the self certification process then please could you discuss next steps with your Regional team. The details of this self certification can be found at Appendix A.

Thank you for all of your continued hard work in addressing what are two critical priorities for the NHS over the winter period. Please share this letter with your Board, key clinical and operational teams and relevant committees, and do email england.electiveopsanddelivery@nhs.net should you have any questions.

Yours sincerely,



Sir James Mackey
National Director of Elective Recovery
NHS England

Dame Cally Palmer
National Cancer Director
NHS England

Elective Recovery Self certification **Appendix A**

The Chair and CEO are asked to confirm that the Board:

a) Has a lead Executive Director(s) with specific responsibility for elective and cancer services performance and recovery.

b) That the Board and its relevant committees (F&P, Safety and Quality etc) receive regular reports on elective, diagnostic and cancer performance, progress against plans and performance relative to other organisations both locally and nationally.

c) Has an agreed plan to deliver the required 78ww and 62 day trajectories for elective and cancer recovery, and understands the risks to delivery, and is clear on what support is required from other organisations.

d) Has received a report on the current structure and performance of Lower GI, Skin and Prostate cancer pathways (including the proportion of colonoscopies carried out on patients who are FIT negative or without a FIT; the proportion of urgent skin referrals for whom a face to face appointment is avoided by use of dermoscopic quality images; and a capacity/demand analysis for MRI and biopsy requirements on the prostate pathway), and agreed actions required to implement the changes outlined in this letter.

e) Is pursuing the opportunities, and monitoring the impacts, presented by Outpatient transformation and how this could accelerate their improvement, alongside GIRFT and other productivity, performance and benchmarking data and opportunities.

f) Have received a report on Super September and have reviewed the impact of this initiative for their Organisation.

g) Have received reports on validation, its impact and has a validation plan in line with expectations in this letter.

h) Have challenged and received assurance from the lead Executive Director, and other Board colleagues, on the extent to which clinical prioritisation (of both surgical and diagnostic waiting lists) can help deliver their elective and cancer objectives. This should include receiving a review of turnaround times for urgent suspected cancer diagnostics and agreeing any actions required to meet the backstop maximum of 10 days from referral to report.

i) Discuss theatre productivity at every trust board; we suggest with the support of a non-executive director to act as a sponsor.

j) Routinely review Model Health System theatre productivity data, as well as other key information such as day-case rates across trusts.

k) Confirm your SROs for theatre productivity.

l) Ensure that your diagnostic services reach at least the minimum optimal utilisation standards set by NHS England.

Signed by CEO Date:

Signed by Chair Date:

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	24	**Meeting:**	Trust Board	**Meeting Date:**	10 November 2022
Report Title:	**Strategic Priorities Refresh**				
Sponsoring Executive Directors:	Darren Grayson, Chief Governance Officer				
Author(s):	Oliver Phillips, Director of Strategy and Planning				
Report previously considered by and date:					

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

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

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

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

Communication and Consultation:

Executive Summary:

The Trust updates its Patient First Strategy on a regular basis. As part of this, the Patient First strategy deployment process focusses on the achievement of long term organisational unifying objectives (our True North).

A suite of measures and projects are refreshed annually as part of the Trust's planning cycle; however over recent years this has been severely disrupted by the COVID-19 Pandemic - 2022/23 is therefore an opportunity to review and reset these objectives fully for the first time as a new organisation.

A detailed strategy refresh process has taken place during June and July 2022, with extensive involvement of the Executive Team, to review the Strategic A3s for each of the True North Domains. This process has resulted in an updated set of strategic aims covering

- ❑ Our True North Goals and Targets
- ❑ Breakthrough Objectives
- ❑ Strategic Initiatives
- ❑ Corporate Projects

Details of which can be found in the accompanying report.

Key Recommendation(s):

The Board is asked to **NOTE** the refresh of the Trust's Strategic Priorities.

NHS
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Strategic Priorities Refresh

Trust Board

10th November 2022

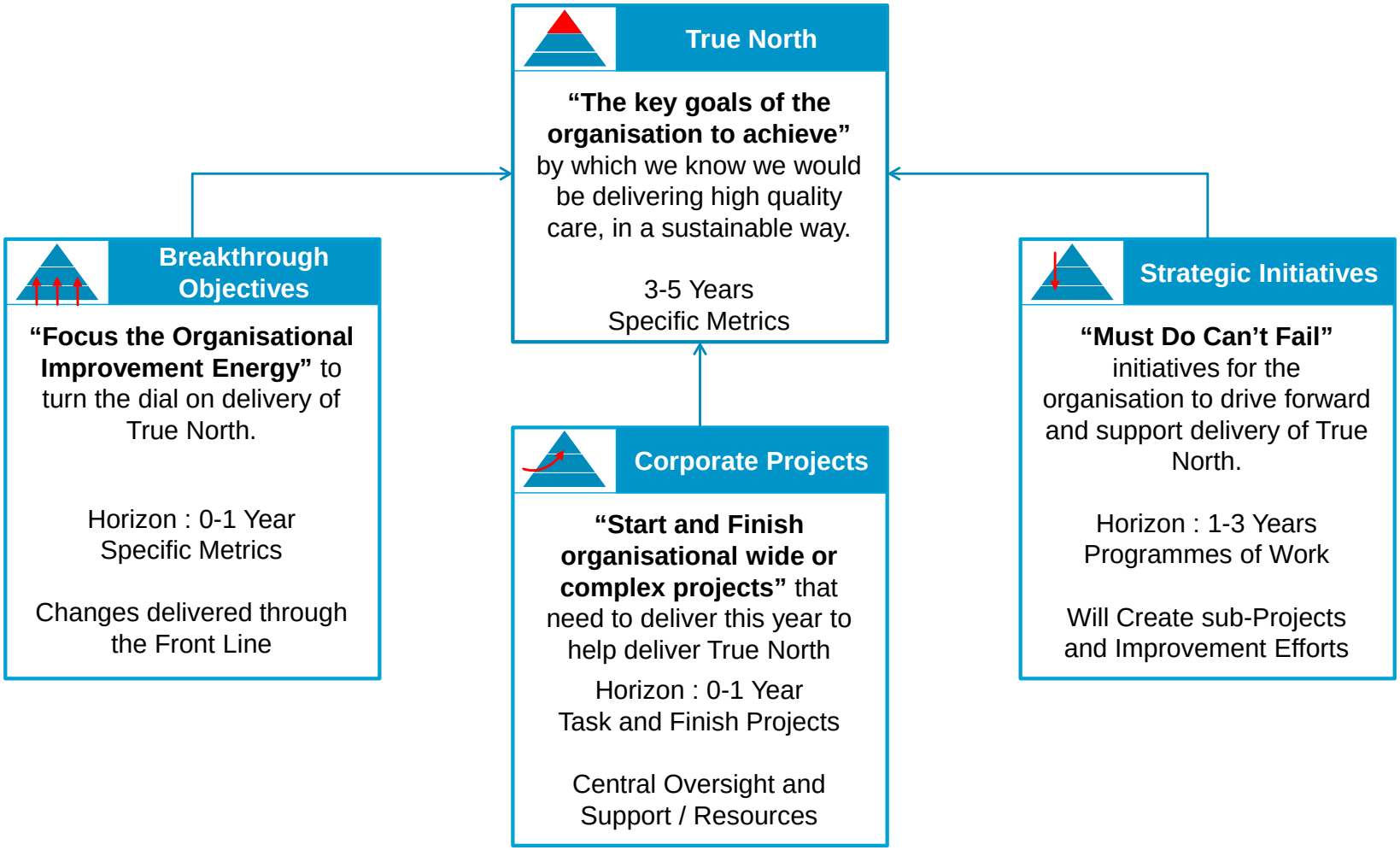
Introduction

University Hospitals Sussex NHS Foundation Trust

- The Trust updates its Patient First Strategy on a regular basis. As part of this, the Patient First strategy deployment process focusses on the achievement of long term organisational unifying objectives (our True North).
- A suite of measures and projects are refreshed annually as part of the Trust's planning cycle; however over recent years this has been severely disrupted by the COVID-19 Pandemic - 2022/23 is therefore an opportunity to review and reset these objectives fully for the first time as a new organisation.
- A detailed strategy refresh process has taken place during June and July 2022, with extensive involvement of the Executive Team, to review the Strategic A3s for each of the True North Domains. This process has resulted in an updated set of strategic aims covering
    - ❑ Our True North Goals and Targets
    - ❑ Breakthrough Objectives
    - ❑ Strategic Initiatives
    - ❑ Corporate Projects
- A definition of each of these elements is provided in the next slide

University Hospitals Sussex NHS Foundation Trust

Key elements of our Strategy Review



Our refreshed True North & Breakthrough Objectives

University Hospitals Sussex NHS Foundation Trust

	Strategic Vision	Strategic Goal	Current Target	Breakthrough Objective
Patient	Providing outstanding, compassionate care for our patients and their families, every time	To ensure that all our patients have a positive experience of the care they receive	To be in the top quartile nationally for patients rating their experience as good or very good for all touchpoints	Improve communication with patients about their care. Measured by: reduced number of concerns and complaints regarding communication or staff attitude (via FFT/Complaints).
Sustainability	Living within our means and providing high quality, accessible services to patients and staff through optimising the use of our resources	For the Trust to consistently live within the resources made available to us	For the Trust to achieve break even	To deliver the activity plan of 4.6% increase on elective activity above 2019/20 levels through productivity (and supported by key contributors such as theatres, medical workforce and coding)
People	To be the employer of choice and have the most highly engaged staff within the NHS, passionate about delivering the best care	To be top acute trust for staff engagement within three years	To be in the top quartile of Trusts for staff engagement, reaching top half of Trusts within 12 months	'Staff voice that counts' - Increase the percentage of staff are confident that the organisation would address their concerns if raised
Quality	Excellent outcomes ensuring no patient comes to harm and no patient dies who should not have	**Harm:** Zero preventable harms occurring to our patients when in our care **Mortality:** To achieve the lowest possible mortality within our peer group as measured by SHMI	**Harm:** Reduction of 5% in preventable harms. Balancing Metric: No statistically significant decrease in reporting of harms beyond the targeted 5% **Mortality:** SHMI equal to or less than 100 for the trust and individual hospital sites - PRH, RSCH, WH, SRH.	**Harm:** To reduce falls harms whilst in the care of UHSussex by 30% **Mortality:** Improvement in the management of deteriorating patients (as measured by the CQUIN measure)
Systems & Partnerships	Delivering timely, appropriate access to high quality planned, cancer and emergency acute care as UHSussex and as part of the wider integrated care system	To achieve the constitutional standards for planned, cancer, and emergency care	**Emergency care:** No patients to exceed a 12 hour wait in our emergency departments **Planned care:** By March 2023, no patient is waiting more than 78 weeks for treatment. **Cancer:** to achieve the 62 day standard	**Emergency Care:** median hour of discharge will be 10.00 – 10.59am *NB no separate Breakthrough for Cancer and Planned Care as the True North provides the focus for improvement in these areas*
Research & Innovation	All patients and staff have the opportunity, and equality of access to high-quality R+I which is relevant to them.	To be in the top 10% of Acute Trusts nationally for total numbers of patients contributing to portfolio research	Within 3 years to be in the top 20 Acute Trusts nationally for patients recruited into portfolio studies	To recruit additional patients in the next twelve months, with a targeted plan implemented as a result of the R&I Strategy

Strategic Initiatives

University Hospitals Sussex NHS Foundation Trust

- At the outset of the process, the Executive Team agreed that there would be no significant change to the Strategic Initiatives currently in place
- Each of the Strategic Initiatives has been reviewed, and the project charters updated
- The Trust's Strategic Initiatives are as follows and will continue to report through to the Committee identified below

Strategic Theme	Strategic initiative
Patient	Patient First Improvement Programme
Sustainability	Environmental Strategy
People	Leadership, Culture, and Development
Systems & Partnerships	3Ts
Quality	Clinical Strategy

University Hospitals Sussex
NHS Foundation Trust

Corporate Projects

- An Executive Team workshop was held in August 2022 to determine what Corporate Projects the organisation should support
- A long list of potential corporate projects was drawn up from a range of sources, including those emerging from the A3 process, National Drivers, and emerging themes from the Corporate and Divisional Teams
- The Trust's Strategic Filter was then used to determine both the level of priority and the complexity of the project in order to determine the top corporate projects for the year
- Current Corporate Projects were also reviewed by the Executive Team to determine whether these had met the agreed exit criteria and could be safely managed as business as usual.
- As a result of this two Corporate Projects remain from previous years
  - Electronic Workforce Deployment – with a shift if focus to the Trust's Medical Workforce Systems
  - PAS implementation – to be retained in the short term until PAS go live
- The remaining prior Corporate Projects have been formally closed down and reported to the relevant committee
- Following the prioritisation process, project charters have been developed for all of the new Corporate Projects
- The Corporate Projects will report through to the Committees as set out in the table below

New Corporate Projects

University Hospitals Sussex NHS Foundation Trust

Proposal	Title	Description	Board Committee
Corporate Project	PAS Implementation	Continuation of current Corporate Project until PAS implementation	Sustainability
	Electronic Workforce Deployment	Implementation of UHSussex-wide E-Rostering System with a focus Medical Workforce Systems	People
	Community Diagnostic Centres	Establish a Community Diagnostic Centre at Southlands, plus spokes in Bognor and Falmer to increase diagnostic capacity, transform pathways, and improve patient experience	Systems and Partnerships
	Quality Governance	As part of the One UHSussex programme, ensure that our approach to Quality Governance is comprehensive and robust	Quality
	Improving General Surgery	Enhanced Support of General Surgery	Quality
	Reducing Length of Stay	UHSussex trust-wide improvement programme for Urgent and Emergency Care in order to support performance and flow focusing on reducing length of stay	Systems and Partnerships
	Patient Access Transformation	UHSussex trust-wide programme of work to review Patient Access and Pathways to support performance and flow	Systems and Partnerships
	Estates Master Planning	Programme to consider any possible estates changes in a holistic way across UHSussex, taking into account any impact on dependent services	Sustainability

Previous Corporate Projects

University Hospitals Sussex NHS Foundation Trust

- All previous Corporate Projects have either been continued, or have been formally closed down and reported to the relevant committee

Proposal	Title	Outcome
Corporate Project	PAS Implementation	To continue as a Corporate Project until implementation complete
	Electronic Workforce Deployment	To continue as a Corporate Project with a focus on Medical Workforce Systems
	Restoration and Recovery	Project closed. Focus on increasing elective activity now covered by the True North for Systems and Partnerships
	Outpatient Transformation	Project closed. Improvement in outpatient transformation to be covered through the Patient Access Transformation Programme
	CQC Preparation	Project completed following CQC well led inspection with elements taken forward by One UHS Sussex programme. One UHSussex Programme reported as closed to the Patient Committee
	Merger and Acquisition	Merger project stood down following move to new Clinical Operating Model with elements taken forward by One UHSussex Programme. One UHSussex Programme reported as closed to the Patient Committee

Next Steps

University Hospitals Sussex NHS Foundation Trust

- Patient Charters for the new and updated Corporate Projects and Strategic Initiatives are currently being presented to the relevant Committees
- Reporting on the updated True North, Breakthrough Objectives, Corporate Projects, and Strategic Initiatives will commence with the November round of Committee meetings and Trust Strategy Deployment Review meeting
- The new metrics and projects will also be introduced at the November SDR meetings with the operational Divisions, having gone through the Catchball review process in September and October
- An assessment of the key risks associated with the new True North, Breakthrough Objectives and Corporate Projects will need to be considered by the Committees, to ensure that this is fed through to the Trust's Board Assurance Framework

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	25	**Meeting:**	Board	**Meeting Date:**	10 November 2022
Report Title:	**Company Secretary Report**				
Committee Chair:			Glen Palethorpe, Company Secretary		
Author(s):			Glen Palethorpe, Company Secretary		
Report previously considered by and date:					

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

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

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

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

Communication and Consultation:

Executive Summary:

This report provides the Council of Governors with an update, including matters for which the Trust has complied with NHS I or other regulatory requirements.

Learning from Deaths reports 2021/22 quarters 1 and 2 – Appendix 1 and 2

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

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

2023/34 Board and Council of Governors meetings

The Trust has commenced its construction of its Board and Council of Governors meeting schedule for 2023/24. The Trust intends to maintain its meeting rhythm of quarterly meetings that will be open to the public to observe either in person at Trust HQ in Worthing or through MS Teams. The dates of these meetings are listed overleaf:-

Board

Meeting	May-23	Aug-23	Nov-23	Feb-24
Board of Directors (Trust HQ in Worthing Hospital)	Thurs 04 May 10.00-14:00	Thurs 03 Aug 10.00-14.00	Thurs 09 Nov 10.00-14.00	Thurs 08 Feb 10.00-14.00

Council of Governors

Meeting	May-23	Aug-23	Nov-23	Feb-24
Council of Governors (Trust HQ in Worthing Hospital)	Thurs 18 May 14.00-17:00	Thurs 17 Aug 14.00-17:00	Thurs 23 Nov 14.00-17:00	Thurs 29 Feb 14.00-17:00

Non-Executive Directors

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

Lead Governor

Lindy Tomsett replaces Frank Sims as lead governor from 20 October 2022, noting that Frank remains the public governor for Brighton and Hove.

Key Recommendation(s):

The Board is recommended to

- **NOTE** the Trust's learning from deaths reports for quarter 1 and 2 of 2022/23 and note the learning identified from the structured judgement review process, recognising the detail of this work is subject to scrutiny and oversight at the Quality Committee.
- **NOTE** that the scheduled dates for the Board and Council of Governors meeting which are open to the public
- **NOTE** the extension to the term of office for Lizzie Peers to 10 May 2024
- **NOTE** the Trust's lead governor is Lindy Tomsett