University Hospitals Sussex
NHS Foundation Trust

Meeting of the Board of Directors

10.00 to 13:30 on Thursday 04 May 2023

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 02 February 2023** 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.	10.20	**ICS** To receive and note ICS activities	Verbal	George Findlay
		INTEGRATED PERFORMANCE REPORT		
7.	10.25	**Patient** To receive and agree any necessary actions	Enclosure	Leanne Mclean
8.	10.30	**Research and Innovation** To receive and agree any necessary actions	Enclosure	Katie Urch Rob Haigh
	10.35	*After this section the Chair of the Patient Committee will be invited to provide their report included at item 15* To receive assurance from Committee and recommendations from the Committee		
9.	10.45	**Quality** To receive and agree any necessary actions	Enclosure	Leanne Mclean Katie Urch Rob Haigh

	10.55	*After this section the Chair of the Quality Committee will be invited to provide their reports included at item 15* To receive assurance from Committee and recommendations from the Committee		
10.	11.05	**People** To receive and agree any necessary actions	Enclosure	David Grantham
	11.10	*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		
11.	11.20	**Sustainability** To receive and agree any necessary actions	Enclosure	Karen Geoghegan
	11.25	*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		
12.	11.35	**Systems and Partnerships** To receive and agree any necessary actions	Enclosure	Andy Heeps
	11.40	*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		
13.	11.50	**Systems Oversight Framework** To receive and agree any necessary actions	Enclosure	Darren Grayson
	11.55	***5 Minute Break***		
		ASSURANCE REPORTS FROM COMMITTEES		
14.	-	**Report from Patient Committee *including Research and Innovation*** To receive assurance from Committee and recommendations from the Committee - **from the meeting held on the 25 April 2023**	Enclosure	Claire Keatinge
15.	12.00	**Report from Quality Committee** To receive assurance from Committee and recommendations from the Committee - **from the meeting held on the 28 February, 28 March and 25 April 2023** To approve	Enclosure	Lucy Bloem
16.	12.10	**Report from People Committee** To receive assurance from Committee and recommendations from the Committee - **from the meeting held on the 26 April 2023 including:**	Enclosure	Patrick Boyle

		- ***Staff Survey Results 2022-23*** To approve for publication on the Trust Website		
17.	-	**Report from Sustainability Committee** - **from the meeting held on the 27 April 2023** To receive assurance from Committee and recommendations from the Committee	Enclosure	Lizzie Peers
18.	-	**Report from Systems and Partnerships Committee** - **from the meeting held on the 27 April 2023** To receive assurance from Committee and recommendations from the Committee	Enclosure	Bindesh Shah
19.	12.20	**Report from Audit Committee** - **from the meeting held on the 20 April 2023 including:** - ***Annual Provider Licence Self-Certification*** To receive assurance from Committee and recommendations from the Committee	Enclosure	David Curley
20.	12.30	**Report from Charitable Funds Committee** - **from the meeting held on the 18 April 2023** To receive assurance from Committee and recommendations from the Committee	Enclosure	Lizzie Peers
21.	12.40	**Board Assurance Framework and Corporate Risk Register highlight report** To approve	Enclosure	Darren Grayson Glen Palethorpe
21.1	12.50	**Risk Management Strategy** To approve	Enclosure	Darren Grayson Glen Palethorpe
21.2	13.00	**Strategic Risks 2023/2024** To approve	Enclosure	Darren Grayson Glen Palethorpe
		WELL LED & COMPLIANCE		
22.	13.10	**Company Secretary Report** To note	Enclosure	Glen Palethorpe
		OTHER		
23.	13.15	**Any Other Business** To receive any notified business and action	Verbal	Alan McCarthy
24.	13.20	**Questions from the public** To receive and respond to questions submitted by the public at least 48 hours in advance of the meeting.	Verbal	Alan McCarthy
25.	13.30	**Date and time of next meeting:** The next meeting in public of the Board of Directors is scheduled to take place at 10.00 on Thursday 03 August 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*	Verbal	Alan McCarthy

Minutes

University Hospitals Sussex
NHS Foundation Trust

Minutes of the Board of Directors meeting held in Public at 10.00am on Thursday 02 February 2023, 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
Patrick Boyle	Non-Executive Director
Jackie Cassell	Non-Executive Director
Claire Keatinge	Non-Executive Director
Lucy Bloem	Non-Executive Director
Professor Paul Layzell	Non-Executive Director
Lizzie Peers	Non-Executive Director
David Curley	Non-Executive Director
Bindesh Shah	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	Chief Medical Officer
Darren Grayson*	Chief Governance Officer

*Non-voting member of the Board

In Attendance:

Glen Palethorpe	Company Secretary
Tanya Nicholls	Board and Committees Manager

TB/11/22/1 WELCOME AND APOLOGIES FOR ABSENCE **ACTION**

1.1 The Chairman welcomed all those present to the meeting.

1.2 There were apologies for absence received from Lillian Philip and Sadie Mason.

TB/11/22/2 DECLARATIONS OF INTERESTS

2.1 There were no other interests declared.

TB/11/22/3 MINUTES OF THE MEETING HELD ON 10 NOVEMBER 2022

3.1 The Board received the minutes of the meeting held on 10 November 2022.

3.2 The minutes of the meeting held on 10 November 2022 were **APPROVED** as a correct record.

TB/11/22/4 MATTERS ARISING FROM THE MINUTES OF THE PREVIOUS MEETING

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

TB/11/22/5 Chief Executive Report

5.1 George Findlay began by acknowledging the incredibly challenging December and January experienced by the Trust and expressed his gratitude and thanks to staff for their continued hard work and dedication during very difficult circumstances as a result of early onset pressures for both Covid and Flu. George went on to explain to the Board that for the first time a Sussex wide Critical Incident was declared, which enabled other hospitals and system partners to come together to manage operational pressures in a different collaborative way with a system approach.

5.2 The Board was advised that industrial action had been agreed by a number of unions that was affecting UHSussex staff, it was noted that the first 2 days of RCN strikes were well managed. George highlighted that the Trust was not in conflict with its staff the industrial action was between the unions and Government and had been dealt with professionally and calmly and in a way that had continued to keep both staff and patients safe.

5.3 George noted that he had the pleasure, along with the Chairman and Chief People Officer to attend the long service awards at the Metropole in Brighton to celebrate our staff, George commented that the event had recognised 95 colleagues with their combined service totalling 2.5k years!

5.4 It was noted that the Trust had been working with NHS Sussex and partner organisations over the past two years on a comprehensive review of Stroke Services in Coastal West Sussex, following on from this collaborative review George explained that the Trust had developed a proposal to create an Acute Stroke Centre (ASC) for the coastal area of West Sussex and locate it at St Richard's Hospital in Chichester. George advised the Board that there was currently a public consultation underway and directed any colleagues of members of the public that would like any further information to the NHS Sussex website at www.sussex.ics.nhs.uk.

5.6 Finally, George highlighted that the Trust was pleased to announce the naming of the new Louisa Martindale building at the Royal Sussex County Hospital in November which is expected to open in the Spring with an estimated footfall of more than 1 million patients and visitors every year.

5.7 Alan McCarthy took the opportunity to extend his thanks and that of the Board to the Staff and the Executive team for all their hard work over what has been an incredibly challenging quarter.

5.8 Lizzie Peers asked in respect of the system wide critical incident, had it changed the way the Trust works, and will it have some long-standing benefits, George commented that he felt that it had changed the way the Trust works and engagement with the ICS is developing and evolving over time. As such it had been agreed that a system priority was to eliminate corridor care which saw the Community Trust open additional beds, which was a tangible example of positive system working.

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

TB/11/22/6 ICS

6.1 George Findlay provided the Board with a brief update on the Trusts work with the ICS highlighting that the NHS Sussex Strategy had been agreed through the ICS partnership, which was focussed around Starting Well, Living Well and Aging well with additional emphasis on community with collaborative and holistic care of patients within the Community. George noted that the strategy doesn't explicitly mention acute hospitals within it, however it was important

that UHSussex consider its role and how it would support with the delivery of services in the Community to meet the system strategy.

6.2 It was noted that the ICS was now beginning to develop a plan of how the strategy will be delivered across the system, which would be supported by the CEOs within the system leading the 8 priority streams of work each with ICS leadership and support.

6.3 The Board thanked George and **NOTED** the update on the ICS.

TB/11/22/7 Integrated Performance Report

7.1 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.

7.2 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/11/22/8 Patient

8.1 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).

8.2 The Board was advised that 28,950 patients provided a survey response in Q3 of whom 86% (c24,900) patients left a positive review. Maggie explained that based on (FFT) data, the significant majority of patients, 86% in Q3, are satisfied that they have a good or very good experience of their care with UHSussex. Positive ratings were maintained in most EDs but with Worthing declining slightly as a quarterly average and a considerable decline in positivity rating for RACH, this is attributed with the considerable pressure seen in the department in respect of Strep A.

8.3 Maggie explained that themes within the negative patient feedback continue to relate to waiting both on site and for treatment, clinical treatment, communication and staff behaviours and discharge. It was noted that these are the drivers behind the improvement goals within patient experience strategy 2022-25. Staff attitude and communication is now the priority change programme under the patient breakthrough objective and the other drivers are addressed within other aspects of the Trust strategy.

TB/11/22/9 Research and Innovation

9.1 Rob Haigh provided the Board with an update in respect of the new Research and Innovation (R&I) Patient First domain and drew out the following key headlines.

9.2 The Board was advised that the R&I breakthrough objective was a 10% increase in total recruitment across all specialities to NIHR Portfolio studies. It was noted that the breakthrough objective was on track and that the governance for this project had been established. Rob explained that the targeted development of specialities where there are significant opportunities to contribute to high quality research relevant to our services and patients was underway.

9.3 It was noted that in respect of the wider strategic development of the R&I domain there were a number of initiatives underway including the start of the Clinical Nurse Fellows programme which is due to launch during February 2023, new webpages and live communication is in place, a regional research delivery network hosting bid has been submitted by the Trust and R&I has been included on the BAF with initial key risks identified and mitigating actions being developed.

9.4 The Chairman invited Jackie Cassell, Chair of the Patient Committee which includes the oversight of both the Patient and R&I, to update the Board on their recent meeting and the assurances received in relation to patients and research and innovation.

9.5 Jackie advised the Board that the Committee had a productive meeting and noted that it was positive to see the new system is delivering thematic information enabling the Trust to look at the content of the FFTs. It was noted that the strategy for the Patient First Improvement Programme (PFIS) was progressing well with significant amounts of work underway.

9.6 In respect of the new R&I domain, it was noted that the Committee had reviewed the updated Terms of Reference for the Patient Committee as well as receiving the first strategy for R&I with significant multi professional involvement which was incredibly positive.

9.7 Claire Keatinge commented that it was really positive to see the number of patients that recognise and comment positively on Trust services. Claire also welcomed the new R&I focus noting that it was enormously important for staff and patients alike.

9.8 Patrick Boyle asked in respect of complaints handling if the Trust continues to have targets for the handling of formal complaints and the response times, Maggie confirmed that the Trust did have a quality metric that, however the Trust continued to encourage teams to contact families raising a concern within 3 days of receiving the complaint which helped in most instances to resolve the issue speedily and efficiently.

TB/11/22/10 Quality

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

10.2 Rob advised the Board that the UHSussex crude 12-month rolling mortality rate for non-elective admissions was 3.38% and in the month for December was 4.31%. It was noted that the monthly crude mortality had increased substantially, with the rolling 12-month rate continuing to increase monthly.

10.3 The UHSussex rolling 12-month HSMR is 99.7 Rob noted that this is within the expected range, however an in-month value for October of 114.37 had increased and was considered ‘high (>95%)’. The rolling 12-month HSMR, without adjusting for specialist palliative care had remained in the ‘very high (>99.8%)’ category.

10.4 In respect of the UHSussex rolling 12-month SHMI is 111.35 which remains in the expected range however there continues to be an increasing trend, nearing the limits of triggering an outlier status. Rob explained that this follows the national trend and is almost certainly a consequence of untreated disease within the population. Rob noted that out of hospital SHMI is particularly high at PRH and advised that there ongoing work being undertaken by the Trusts data providers HED.

10.5 Maggie Davies reminded the Board that the second Quality True North for the Trust was zero harm occurring to patients in our care and highlighted that the Trust was moving towards a new standardised system for capturing this information which would further support staff with learning from harm.

10.6 The Board was advised that as had already been mentioned earlier in the meeting, the Trust had experienced significant pressure during the quarter which had impacted on flow and capacity, this was largely due to high cases of Covid, seasonal flu and Norovirus, this also impacted on staff sickness which negatively impacted on the number of falls. It was noted that falls were above trajectory, however Maggie explained that there was renewed effort in respect of falls reductions work with bay-watch continuing to help support the drive for reduction in patients falling. It was noted that the Trust had seen an increase in the number of patents admitted from the Community with pressure damage.

10.7 Maggie advised that the Trust had seen a decrease in the fill rate for both Registered Nurses (RNs) and unregistered staff however there was a slight increase in the care hours per patient per day, both of which are monitored closely by the new local hospital director leadership teams. It was noted that the Trust had implemented 'Safer Care' software across the Trust which was ensuring that staff are redeployed depending on patient acuity and dependency.

10.8 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.

10.9 Lucy advised the Board that the Committee had met 3 times since the last Board meeting and during those meetings had received the quality scorecard through which it had been tracking the performance of the Trust in respect of neck of femur outcomes, the Committee has asked that the management carry out an audit of the Trust data compared to the National data base and report back with any associated action plan.

10.10 The Committee noted the findings of the external mortality coding review into the Trust's clinical coding processes. They supported the hypothesis that shallower coding had missed circumstances that would have impacted the mortality data. The external review assured the accuracy of coding at Worthing and SRH and outlined recommendations to secure a greater depth to the coding across the Trust's other sites.

10.11 Lucy advised that she had attended the maternity voices listening event which allowed the team to look at the previous quarter, the Board was advised that there had been really excellent feedback on the care UHSussex is providing for its patients. The Committee noted the significant programme of work in respect of the CNST submission, as Chair of the Committee Lucy assured the Board that she had personally reviewed the evidence as part of the process.

10.12 Claire Keatinge commented that avoidable harms must be difficult to assess and ascertaining whether pressure damage has occurred in the Community or in hospital must be challenging. Maggie concurred with Claire's statement adding that it is very distressing to patients and their families when harm occurs noting that the Trust does all that it can to avoid those harms.

TB/11/22/11 People

11.1 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.

11.2 The Board was advised that the level of recorded staff engagement was slightly down this was attributed to the increased operational pressures over the quarter coupled with the ongoing industrial action, although David was clear to note that the industrial action was between the unions and the Government, not between the Trust and staff. It was noted that the training platform IRIS had now been implemented across the Trust and it is hoped that this will enable the Trust to improve its response rate in respect of staff engagement.

11.3 David advised the Board that since the slides had been written unfortunately the newly appointed Freedom to Speak Up (FTSU) candidate had withdrawn their candidacy so an alternate solution was being sought. It was noted that the Trust had held its first Leadership, Culture and Organisational Development (LCD) day which had been very successful with a total of 70 leaders attending the away day.

11.4 David highlighted the key statistics noting a reduction in the in-month staff sickness rates and increase in consultant appraisals and a reduction in the number of HCA vacant posts. In addition, the Board as advised that Winter plan saw the establishment increase by 100 to substantiate roles associated with additional bed capacity in use, this had impacted on the vacancy figure with currently 7.75% RN vacancy.

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

11.6 Patrick advised the Board that the Committee had reflected on the workforce challenges and looked in depth at the Trust vacancy and retention levels, it was noted that the Trust had done well in respect of international recruitment for nursing posts. Patrick highlighted that staff sickness had increased over the last 12 months and the Committee had discussed this at length and was expecting to receive a deep dive to the next Committee meeting in respect of the mitigations in place and the additional training being provided to managers in relation to managing staff sickness.

11.7 The Board was advised that the Committee had received a deep dive from the Cancer Division, which was very positive and insightful, Patrick noted that the Committee was hoping to have regular divisional deep dives. The Committee noted its disappointment at the withdrawal of the FTSU candidate and the vacancy for the junior doctors Guardian of Safe Working but noted the ongoing work to fill these vacancies.

11.8 Bindesh Shah asked how the cost-of-living pressures were manifesting themselves. David advised that in respect of the number of staff leaving the Trust was fairly low and remained stable and positively was lower than the number of new staff joining the Trust. It was noted that the Trust was seeing a little churn in the lower banded roles of the Trust, David explained that there was ongoing work to support staff with up skilling where there was a wish for it.

TB/11/22/12 Sustainability

12.1 Karen Geoghegan presented the Sustainability section of the IPR advising the Board that the update centred around the Trust's True North objective to break-even.

12.2 The Board was reminded that the financial target for 2022/23 is breakeven. It was noted that as at the end of Q3, the Trust reported a year-to-date deficit of £18.9m; which is £13.9m adverse to plan.

12.3 Karen explained that achievement of the financial target was challenging, particularly in the context of urgent and emergency care pressures, elective activity requirements and excess inflation costs. It was noted that mitigating actions had been deployed to improve the deficit position but that it was now unlikely that that the financial target would be achieved in full for the 2022/23 financial year.

12.4 The Board was advised that the Trust is reviewing the current year-end trajectory, in partnership with ICB colleagues and it is likely that in Month 10 there will be a change in the forecast year-end position.

12.5 Karen highlighted that the cash balance of £74.2m was £8.7m less than plan at the end of Month 9, it was noted that work continued on making timely payments to improve the Trusts performance against the Better Payments Practice Code. Capital expenditure is £9m variance below plan, within this, expenditure for 3T's is on track, the underspends relate to service developments and forecast outturn remains on plan.

12.6 The Board was advised that year-to-date the efficiency performance is £2.8m below plan with operational pressures having impacted on the productivity of a number of the schemes delivery. The forecast outturn for the efficiency programme is expected to be a £6m deficit by year end.

12.7 Karen explained to the Board that the two key drivers for the Trust's deficit position were elective activity, with the Trust spending £20m more than had been expected on both insourcing and outsourcing, and additional escalation beds to support with the increased operational pressures has a significant cost associated with it.

12.8 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.

12.9 Lizzie advised the Board that the Committee had discussed at length the Trust's current financial position and focussed on understanding the causes, risks and mitigations taken so far. In addition, it was noted that the Committee had spent time discussing the best use of the workforce to ensure maximum productivity. Lizzie noted that the Committee had received full transparency, with detailed papers in respect of the assumptions, risks and mitigations.

12.10 The Board was advised that the Committee had received an update on the new breakthrough objective of Improving Clinical Productivity and noted the rich data that was available to the Trust that would support the work being undertaken in this area.

12.11 Finally, Lizzie noted that the Trust had also received updates in respect of Capital and IM&T highlighting that the Committee received an update on the PAS implementation that had taken place before Christmas.

12.12 Claire Keatinge commented on the clear and transparent reporting of the finances and asked what the impact would be of the Trust being in a deficit position. Karen explained that it was yet to be formally confirmed, however Trusts reporting a deficit would have to abide by a national set protocol but there would be as a minimum a requirement for a recovery plan, in addition to much closer scrutiny at both an organisational and system level along with anticipated limitations to the system Capital programme.

12.13 Claire went on to ask another question in respect of whether this was a general trend cross NHS Trusts. Karen confirmed that there were number of Trusts that were reporting deficit and had changed their year-end-forecast at Month 9.

TB/11/22/13 Systems & Partnerships

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

13.2 **A&E**
Andy advised the Board that the Trust treated 59.4% of patients within 4 hours of attending all A&E departments October to December, and 56.2% December 2022. National performance was 65% during September 2022. There was renewed pressure on the Trust Emergency Departments (ED) 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, with additional pressures associated with Industrial Action also having an impact.

13.3 Andy explained that during the quarter, following the system wide critical incident, the Trust had focussed on ambulance handovers with improvements in less than 60-minute handovers during December with an increase from 6.3% during November to 11.8% in December. The Trust saw a deterioration to 31.3% of less than 15-minute ambulance handovers during December this was from 40.9% in November.

13.4 **RTT**
The Trust had 49.8% of patients waiting longer than the target 18 weeks at the end of December 2022. National performance was 60.1% during November 2022. The total number of patients waiting for elective treatment at the Trust is 125,576, 15 of which were waiting over 104 weeks, due to patient availability for planned treatment, or through the specialist complexity of their treatment. Although non-elective operational pressures had increased the Trust had remained committed to eliminating long waits for patients on an RTT pathway.

13.5 **Cancer**
It was noted that 54.7% of patients who commenced cancer treatment were treated within 62 days in November. National performance was 61.0%. The Board was advised that there had been a reduction in over 62-day and 104-day prospective waits in the period up to November 2022. For over 62-day patients this was a reduction from 543 during August 2022 to 378 during November 2022, and for patients waiting over 104-days this was a reduction from 127 patients during August 2022 to 98 during November 2022. The Board was advised that this had increased in December to 462 over 62-day patients, and 100 for patients waiting over 104-days.

13.6 **Diagnostics**
The Trust had 37.6% of patients waiting more than 6 weeks at the end of December for a diagnostic test against a 1% target. The Board was advised that this was a deterioration of 10.3% relative to the November 2022 position of 27.3%. The National average for November 2022 was 26.9%.

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

13.8 Bindesh advised the Board that the Committee had been assured that the Trust understands the underlying causes for the current performance in both A&E and RTT, these being a combination of productivity, operational pressures, and industrial action. It was noted that the Committee had discussed that the system working had helped during the busiest periods during November and December and discussed the benefits of this becoming a sustained way of working in order to improve discharges in addition to reducing the length of stay for patients.

13.9 It was noted that the Committee had discussed the significant benefits that the opening of the Louisa Martindale Building will bring and what an excellent achievement it was of all involved, Bindesh extended congratulations to the teams and that the Committee had been assured by all the mitigations in place ahead of the planned move into the building over the coming months.

13.10 Lizzie Peers asked in respect of the operational planning for 2023/2024 will that take place collectively across the system, Andy advised that the development of the 2023/24 plan would done in accordance to the NHSE guidelines and that the Trust would need to be clear about what was realistic and achievable within the workforce and financial resources that the Trust currently has, but that it would require system level conversations in order for the system plan to meet collectively the asks of the national planning framework

13.11 George Findlay advised that UHSussex would be held accountable as the targets sit within the acute sector but as this is a system plan it would be crucial that the challenge is managed as a system, with responsibility shared across the areas that may impact negatively on the Trust achieving the system plan.

TB/11/22/14 System Oversight Framework

14.1 Darren Grayson presented the Systems Oversight Framework (SOF) section of the Integrated Performance Report and began by reminding the Board that the Trust had received the oversight framework which allowed for the ICB to take a view on the performance of all Trusts.

14.2 Darren advised the Board that the Trust remains in segment level 3 and is expected to remain at this level during Q4. Darren reminded the Board that segment level 3 allows the Trust with access to additional support which the Trust is utilising and using the opportunity as a virtue.

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

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

TB/11/22/15 Report from Patient Committee Chair from the meeting on 24 January 2023

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

TB/11/22/16 Report from Quality Committee Chair from the meeting on 20 December 2022 and 24 January 2023

16.1 The Board received and **APPROVED** the Mental Health Strategy for publication on the Trust website.

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

TB/11/22/17 Report from People Committee Chair from the meeting on 25 January 2023

17.1 The Board received the Gender Pay Gap Report, David Grantham advised that the People Committee had discussed the report at length but highlighted that the gap in pay was primarily driven by the Consultant Clinical Excellence awards.

17.2 David explained that although there were no award panels running currently when they are re-implemented that the Trust would continue, as it has in previous years, to actively communicate and encourage all consultants to partake and thus seek to address historic gender pay disparities .

17.3 The Board **APPROVED** the Gender Pay Gap Report for publication on the Trust website.

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

TB/11/22/18 Report from Sustainability Committee Chair from the meeting on 26 January 2023

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

TB/11/22/19 Report from Systems & Partnerships Committee Chair from the meeting on 26 January 2023

19.1 The Board received and **APPROVED** the Emergency Preparedness, Response and Resilience Annual Report for publication on the Trust website.

19.2 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/11/22/20 Report from Audit Committee Chair from the meeting on 17 January 2023

20.1 David Curley, Chair of the Audit Committee, presented the Chair's report from the meeting held on 17 January and drew out the following key points.

20.2 David advised the Board that there were no recommendations from the Committee for the Board to action from this meeting. David noted that the Committee had received positive assurance from the Trust's internal auditors BDO on the Trust's key Financial Systems.

20.3 In addition, David explained that the Committee had discussed at length the work and updates made in respect of the Board Assurance Framework (BAF), noting that the Committee would continue to closely scrutinise the BAF with a view to dedicating 40 – 50% of future meetings to this work.

20.4 David advised the Board that the Committee had also discussed the need for greater integration with the other Board Committees when considering the work of the Auditors and additional Executive attendance to provide a broader spectrum of input to key risks and actions being taken.

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

TB/11/22/21 Report from Charitable Funds Committee Chair from the meeting on

21.1 Lizzie Peers, Chair of the Charitable Funds Committee, presented the Chairs report from the meeting held on 10 January and drew out the following key points.

21.2 Lizzie advised the Board that the Committee had received the Charity Strategy 2023-25 and the Operational Budget and Plan, it was noted that the strategy introduced outcome metrics for spending to ensure that all spend is aligned to the Trust's Patient First True Norths.

21.3 It was noted that the Committee had received operational reports for both LYH and BSUH Charities for the period October to December 2022 which confirmed the Charities processes for the stewardship of donated funds were being applied robustly.

21.4 Lizzie advised the Board that the Committee had received a number of bids which it was recommending to the Corporate Trustees for approval, all of which had been assessed these against the expected public/patient benefits and recognised the enhancements made to the quality of bid paperwork.

21.5 Finally, Lizzie advised the Board of the sad passing of Sam Craycraft, who was the Events and Community Fundraiser and a valued member of the Charity team, who had recently passed away following a brief illness. The Board took the opportunity to share their condolences with Sam's family.

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

TB/11/22/22 Board Assurance Framework and Corporate Risk Register highlight report

22.1 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 Research and Innovation had been added to the BAF for the quarter with 3 new strategic risks which would be overseen by the Patient Committee. The BAF now contains some 16 risks being scrutinised by the five committees and the audit committee.

22.2 It was noted that risk 5.1 had seen a reduction in its target score given the continued maturity of the processes for system working. The Board was advised of the expected reduction in risk 2.3 following the delivery of the actions following the review into the issues that led to the non-payment of some staff, meaning this would be expected to reduce further to its target score as the divisions deliver their plans.

22.3 The Board noted the increase in Quality risk 4.2 reflecting the inter linkage of this risk and those relating to workforce and performance impacting on the Trust's ability to deliver its improvements in clinical quality at the pace it desires.

22.4 Glen highlighted that the Board would see a change in the BAF structure over the next quarter as it moves to having a 12-month target score in conjunction

with an overall risk appetite driven goal score, which it is anticipated will provided added clarity on the impact of actions over the shorter 12 month and longer timeframes. Glen advised that this change was going to be made following feedback from the Trust's internal auditors where this had been implemented in other Trusts and had been successful. It was noted that the change had been endorsed by all Board Committees.

22.5 Alan McCarthy noted that the BAF reflected the high level of risk that the Trust was currently managing.

22.6 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/11/22/23 CQC Update

23.1 Maggie Davies presented the CQC Action Plan Compliance Report in respect of the 3 previous inspections in Surgery, Maternity and the Emergency Department (ED) and highlighted the following key areas.

23.2 The Board was advised that the action plan had been both reviewed and scrutinised by the Quality Committee at its meeting in January, Maggie explained that the report summarised the 'Must do' and 'Should do' actions from the published CQC inspection reports in conjunction with the current divisional compliance status.

23.3 Maggie advised the Board that CQC action delivery workstream was monitored and managed through the Quality Committee. The Quality Committee had requested that the report being presented provided the Committee with a clear indication of where the Trust is improving against the actions, with clear distinction between those actions on track and those completed in the next report. Maggie highlighted that there was clear improvement in a number of areas with many now of 'green' status and many other areas partially complete.

23.4 Darren Grayson highlighted that in relation to the RSCH ED actions, there were many that had due dates still to be confirmed and went on to ask if this related to the Capital Plan for the department. Rob Haigh explained that all of the 'Must Do' actions that remain amber in the main do relate to the capital build and as such the due date is yet to be confirmed.

23.5 Alan McCarthy asked if there were any interim solutions where the 'must do' actions within the ED action plan have an extended lead time. Darren explained that there would be a further iteration to the report that would make it clearer where mitigations are in place if it has not been possible to complete and close down the action.

23.6 The board **NOTED** the update on the CQC Action Plan.

TB/11/22/24 Clinical Negligence Scheme for Trusts (CNST) Year 4

24.1 Maggie Davies presented to the Board an update in respect of the Trust's CNST submission for Year 4 and reminded the Board that The Trust completed a comprehensive review of the planned declaration at its January Board meeting and approved its submission to the ICB and then NHS Resolution (NHSR).

24.2 As per NHSR guidance, Maggie explained that the update being provided to the Board was to formally confirm ICB support and approval of the declaration

as presented in January. It was noted that support and sign off was confirmed during a meeting held with the CEO of the ICB on 24 January 2023. This meeting referenced a review of Trust papers and acknowledged the evidence catalogue, in addition to the Internal Audit review that had been conducted in support of the year 4 declaration.

24.4 The Board was advised that the ICB would within their review provide the Trust with confirmation of this support via formal correspondence and the inclusion of ICB signatures on the NHSR declaration template.

24.5 During the ICB meeting delivery of all standards, with the exception of Safety Action One was noted. The ICB supported the Trusts position including support for a request of NHSR to consider the minimal impact of an administrative error and given no impact to the safety of patients, a request to release the full CNST rebate.

24.6 Maggie advised the Board that following approval by the ICB, the Trust had submitted its declaration to ensure submission of paperwork was completed by midday Thursday 2 February and had received confirmation of receipt from NHSR.

24.7 The Board **NOTED** the Year 4 CNST update.

TB/11/22/25 Company Secretary Report

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

25.2 The Board was advised that the Trust is required to receive reports on learning from deaths. The Board was reminded that the detail of these reports had been scrutinised by the Quality Committee, with the report for quarter 3 considered at the meeting on the 24 January 2023. It was noted that at that meeting the Committee was updated on the progress being made to standardise the processes across all four sites with plans to increase the level of scrutiny for the outcomes of Structed Judgement Review's (SJRs) and medical examiner office reviews.

25.3 Glen explained that the reports 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.

25.4 The Board was reminded that it had, when acting as Corporate Trustees for both Love Your Hospital and BSUH Charities, approved the annual reports for both Charities, these have been submitted to the Charity Commission and placed on the Trust's website at http://www.uhsussex.nhs.uk/charity/about/

25.5 It was noted that both annual reports detail the generous support given by our communities and highlight some of the amazing individual and group fundraising activities undertaken along with key highlights on how those donations have made a difference to our patients and staff.

25.6 The Board **NOTED** the Company Secretary Report for Quarter 3.

TB/11/22/26 OTHER BUSINESS

26.1 There was no other business to discuss.

TB/11/22/27 Questions from Members of the Public

27.1 The Board received two questions from the public the first which was in relation to government monies in respect of supporting delayed transfers of care and who in Sussex was taking responsibility for meeting the criteria to achieve a share of the second (60%) tranche of funding. Andy Heeps began by explaining that the term Delayed Transfers of Care is no longer used, and the Trust refers to Medically Ready for Discharge (MRDs). Andy went on to explain that the Trust was seeing a positive reduction in the number of MRDs at SRH, RSCH and PRH with an overall assessment of the impact of the use of the extra monies made available would be made by the ICB.

27.2 Andy went on to explain, in respect of the second tranche of government funding, that the Chief Delivery Officer of the ICB, Claudia Griffiths, works closely with the Chief Executive's of the Trust's and Local Authorities within West Sussex and Brighton & Hove to ensure that the criteria for the use of the funds and what constitutes a medically ready for discharge patient was adhered to.

27.3 George Findlay advised that the ICS had also been awarded Front Runner Status which would further support with some additional resource in relation to reducing MRDs.

27.4 The second question was in relation to the new 3Ts building situated in Eastern Road, Kemptown and was from a member of the local neighbourhood who highlighted concerns in respect of the main staircases which are lit continuously during the hours of darkness and the light pollution caused by these. Karen Geoghegan explained that the building will use the designed lighting controls which will automatically turns lights off after a set period, but that these will be in operation after the Trust has completed it process of commissioning the building and noted that at present security patrols being undertaken regularly which require the lights to be on the stairwells. The Board was advised that as the building becomes busier with more activity the lights will transfer to a timer enabled function. Karen advised that the new Louisa Martindale building would be busy but that the Trust had done a lot of work to ensure that it is a sustainable building, despite this it was likely that there would be periods in the hours of darkness and that these would activate the lights within segments of the stairwells.

TB/11/22/28 Resolution into Board Committee

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

TB/11/22/29 The Chair formally closed the meeting

TB/11/22/30 DATE OF NEXT MEETING

30.1 It was noted that the next meeting of the Board of Directors was scheduled to take place at **10.00** on **Thursday 05 May 2023**.

Tanya Nicholls
Board & Committees Manager
02 February 2023

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:**	May 2023
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: May 2023**

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

CHIEF EXECUTIVE BOARD REPORT

1. THANK YOU

1.1 The months of February, March, and April this year continued to prove extremely challenging for our staff and services, and I want to publicly acknowledge what a phenomenal job my colleagues have been doing in very difficult circumstances. Continued industrial action, winter pressures and ongoing impacts of the pandemic have all meant this last quarter has been even more challenging than was previously expected.

1.2 Our teams have repeatedly gone above and beyond to put our patients first and ensure we continued to provide safe emergency and urgent care for those who needed us most, no matter the extraordinary pressures or staffing constraints we experienced. Countless colleagues have worked additional shifts, longer hours, provided support outside their normal roles or cancelled leave to support one another and our patients. Thank you to all our staff for their hard work, commitment, and resilience in the face of such adversity.

1.3 Regrettably, the impact on our patients has been greater during more recent periods of industrial action as it has been necessary for us to postpone thousands of appointments and elective procedures to prioritise patient safety and life-preserving care. Such decisions are never taken lightly, and I want to apologise to everyone who has been affected in this way and thank them for their patience as we do all we can to reschedule them as swiftly as we can.

1.4 Despite these testing times and the relentless demands upon our staff, there are also many positive developments and achievements that it is important we take time to celebrate and share. As such, I am delighted to highlight a selection of these below that have occurred since our last Public Board meeting at the beginning of February. Well done to all colleagues involved.

2. ACHIEVEMENTS, AWARDS AND RECOGNITION

2.1 More colleagues and teams from across the Trust have graduated from our Patient First Improvement System (PFIS) training programme, delivered by our in-house Kaizen continuous improvement team. PFIS trains and empowers frontline colleagues to identify opportunities for positive, sustainable change and teaches them the skills and support they need to make improvements happen. Congratulations to the following team's for joining our UHSussex-wide army or problem-solvers: Ophthalmology at Southlands; Discharge Lounge teams and discharge co-ordinators trust-wide; Booking Department in Worthing; Referral Hub teams; Vascular Ward team, Brighton; Royal Alex Children's Hospital level 9 medical ward team; and the Clinical Site Management teams at all our hospitals.

2.2 Our cancer teams at St Richard's and Worthing were presented with the Myeloma UK Clinical Service Excellence Programme (CSEP) Award in recognition of their outstanding care and dedication to patients with myeloma, an incurable blood cancer which claims the lives of 3,000

people in the UK each year. Staff were praised for their efforts to improve patients' quality of life and eagerness to truly listen to their needs.

2.3 The Sussex Orthopaedic Treatment Centre at Princess Royal has been named as one of eight elective surgical hubs in the country to receive national accreditation for the highest standards in clinical, operational practice, and care for patients. Additionally, two of the centre's orthopaedic surgeons, Mr Stephen Bendall and Mr Joel Vernois, were amongst those receiving the Roger A. Mann Award, presented for the first time to recipients outside of the USA, after a clinical paper they supported was presented at the American Foot & Ankle Society (AOFAS) conference.

2.4 Colleagues at Royal Sussex County Hospital are helping to deliver a key NHS target to end new Hepatitis C infections. All patients over 16 who attend A&E in Brighton are now being screened for Hepatitis C when having routine blood tests taken - unless they choose to opt out. The screening is in addition to routine HIV testing which was introduced last year. Earlier detection improves treatment options and reduces onward transmission.

2.5 Clinicians from UHSussex helped ensure the annual Brighton Marathon ran safely again this year, by volunteering their clinical expertise as part of the medical support for the event. This year, for the first time, they helped saved a runner's life by applying an innovative cold-water immersion method to treat severe heatstroke brought on by over-exertion. The runner was treated and monitored for four hours, after which they could go straight home, avoiding admission to hospital.

2.6 Professor Yvonne Gilleece, a UHSussex consultant in HIV Medicine and Sexual Health, was elected Chair of the British HIV Association (BHIVA), becoming the first candidate outside London to hold the prestigious position. Yvonne also helped promote HIV Testing week in February with a special appearance on ITV's Good Morning Britain programme.

2.7 The radiology team at Royal Sussex County Hospital achieved a quicker and more efficient CT scanning service, despite a 40% increase in the number of scans requested each week. Putting continuous improvement into practice, the team worked with doctors, porters, healthcare assistants and IT specialists to identify key areas where CT scan delays occurred and introduced counter-measures to improve the service.

2.8 The colorectal cancer service is assessing more than 200 patients each week, in new faster diagnosis clinics across UHSussex, helping to address the growing demand for the service which now receives 1,100 urgent referrals a month following a 25% increase since 2019. Nationally, because of such high demand, only around 40% of patients with suspected lower gastrointestinal tract cancers are being diagnosed within the standard time frame – but by introducing an innovative faster diagnosis model, our teams are reaching more than 60% in some of the clinics.

2.9 Patients at the Princess Royal requiring urgent gynaecological assessments can now be seen in a new Gynaecology Assessment Unit (GAU) that streamlines them directly from the hospital's Emergency Department (ED), or from GP referrals or Urgent Treatment Centres. The unit provides a rapid assessment and diagnostic service, which not only significantly reduces the time these patients spend in ED, but also enables other patients to be seen more quickly in the department.

3. £48 MILLION INVESTMENT TO IMPROVE EMERGENCY DEPARTMENT IN BRIGHTON

3.1 Plans have been agreed to invest £48 million at the Royal Sussex County Hospital (RSCH), to deliver a radical improvement to the Emergency Department (ED) and the way in which the local NHS supports people needing urgent care. With more space, more resuscitation beds, and a new three-storey Urgent Treatment Centre (UTC), the ambition is to completely transform the current ED, which is ageing and cramped, and increasingly not fit for purpose.

3.2 The new 'emergency floor' will be more than twice the size of the current A&E. It will cover the existing ED area, additional space freed up by other services moving into the new Louisa Martindale Building and it will include a new-build UTC. Improving urgent and emergency care is a key area of work for NHS partners across Sussex. The investment for the improvement work is supported by NHS Sussex and national funding. The phased building programme is scheduled for completion by 2028.

4. LOUISA MARTINDALE BUILDING OPENING SOON

4.1 Our new £500 million Louisa Martindale Building at the Royal Sussex County Hospital in Brighton is now just weeks away from welcoming patients. Recently, we have revised our opening plans slightly to provide a bit more time to commission the building management system.

4.2 This is a hugely complex process – for example, LMB has 14,000 items of medical equipment within it and the building management system must not only support all of the individual systems across the 11 floors, but also ensure they all work together - and so we are taking a little more time to make sure everything is ready.

4.3 When staff begin to move into the LMB it will be the new home for a diverse range of outpatient, inpatient and specialist services. It will be a fantastic new environment for patients and staff alike. We are currently commissioning the LMB's new theatres and major medical equipment and will carry out a full clinical clean of the 11-storey building as part of the commissioning process. These works will make the building ready to welcome the 100,000 patients a year.

4.4 To find out more about this incredible new asset that will benefit patients from across all of Sussex, please visit www.uhsussex.nhs.uk/LMB.

5. STROKE IMPROVEMENT PROGRAMME

5.1 Thank you to everyone who participated in the 12-week "Improving in-hospital stroke service" public consultation than ended on 21 April. More than a thousand people responded to a public consultation and many more had opportunities to find out more and ask questions about our proposal to develop a new Acute Stroke Centre at St Richard's Hospital in Chichester.

5.2 For the past two years, we have been working with NHS Sussex and partner organisation on a comprehensive review of our stroke service for people living in Adur, Arun, Chichester, Worthing and south of Horsham. The public consultation sought to involve and seek the views of people living locally on our preferred option and proposed service change.

5.3 We are confident our proposal would bring many benefits, including improved access to specialist stroke services 24 hours a day, seven days a week; a reduction in disabilities and death caused by strokes; and shorter hospital stays for people who have a stroke.

5.4 To make the changes, and realise these benefits, it would mean Worthing Hospital would no longer be a receiving centre for stroke admissions and more stroke patients would be seen at the proposed Acute Stroke Centre at St Richard's and the Comprehensive Stroke Centre at Royal Sussex County Hospital in Brighton.

5.5 An independent organisation is currently collating all the consultation feedback that NHS Sussex and UHSussex will respond to in a new Decision-Making Document later in the summer. The timeframe for the next steps in the stroke improvement programme is subject to the feedback received. Further information is available on the NHS Sussex website at www.sussex.ics.nhs.uk.

6. NEW CHARITY *"My University Hospitals Sussex"*

6.1 Our former charities Love Your Hospital and BSUH Charity have officially merged under a new name: *My University Hospitals Sussex*. But the charity's mission remains the same – to raise funds to support UHSussex patients, families, and staff above and beyond what is possible through core government funding alone. The funds the charity will raise for treatment, care and research will all make a real and tangible difference to patients and staff alike. Please visit www.muyuhsussex.org to find out more and pledge your support.

7. SUPPORTING OUR PEOPLE

7.1 Our staff are our most precious resource, and we have a broad programme to provide support for them, as well as thank, acknowledge, and recognise everything they do for our patients, each other, and the Trust. Below are some recent examples of the many actions we take to show our appreciation and care of our colleagues.

7.2 Nearly 600 colleagues have attended our Long Service Awards so far this year. Held away from the hospitals, the events are an opportunity to thank staff who are marking significant milestones, such as 20, 30, 40 and even more years of service to the NHS. Attendees enjoyed a cream tea with colleagues at six different events. It was calculated that the combined years of service totalled an incredible 13,677 years!

7.3 In February, March and April we provided complimentary tea bags, coffee and squash to all staff areas as a small gesture of thanks and contributions towards the cost-of-living crisis. Additionally, our Crisis Support Fund panel that was set up in January. It meets every week and has so far allocated £12,757 to 56 members of staff who sought financial assistance.

7.4 In February and March, we offered 20-minute massages to front line staff working in our main hospitals. More than 400 colleagues enjoyed the stress-busting treatment in staff lounges and selected departments.

7.5 Wellbeing Hubs for staff were launched in January at RSCH and in April at Princess Royal. Located in communal staff lounges, new wellbeing assistants are on hand to provide advice and support. Staff are invited to pop along for refreshments, decompression art activities, wellbeing signposting, and massage chairs.

7.6 In April, we introduced new Conflict Resolution Training for all staff as part of their mandatory training three-year requirements. The measure was in direct response to findings from the NHS

staff survey results which show too many colleagues continue to experience violence, aggression, or abuse while at work. The training is part of a much broader Reducing Violence and Aggression strategy being developed across the Trust.

7.7 In March, we officially signed up to the Menopause Workplace pledge. Menopause guidance and cafes have been established for over a year to help address a range of menopause issues. To date, a community of more than 150 members of staff has developed to share information and offer peer support.

7.8 As part of our Patient First breakthrough objective to support and encourage 'speaking up', we have introduced more guidance and materials to help colleagues raise concerns. This included a new web page, suite of resources and leader toolkits published in March.

8. INTERESTED TO FIND OUT MORE?

8.1 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.

9. RECOMMENDATIONS

10.1 The Board is asked to **NOTE** the Chief Executive Report for May 2023.

NHS
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Agenda Item:	7-13	**Meeting:**	Trust Board	**Meeting Date:**	04 May 2023
Report Title:	**Integrated Performance Report – Quarter 4 2022/23**				
Sponsoring Executive Director:	George Findlay, Katie Urch, Rob Haigh, Maggie Davies, Andy Heeps, Karen Geoghegan, David Grantham and Darren Grayson				
Author(s):	George Findlay, Katie Urch, 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	☐

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	✓	Link to Trust Annual Plan	✓

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

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

Regulatory / Statutory reporting requirement

Regulatory

Communication and Consultation:

Executive Summary:

Attached is the Trust's integrated performance report for quarter 4 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

May 2023

Contents

University Hospitals Sussex NHS Foundation Trust

Structure of the report

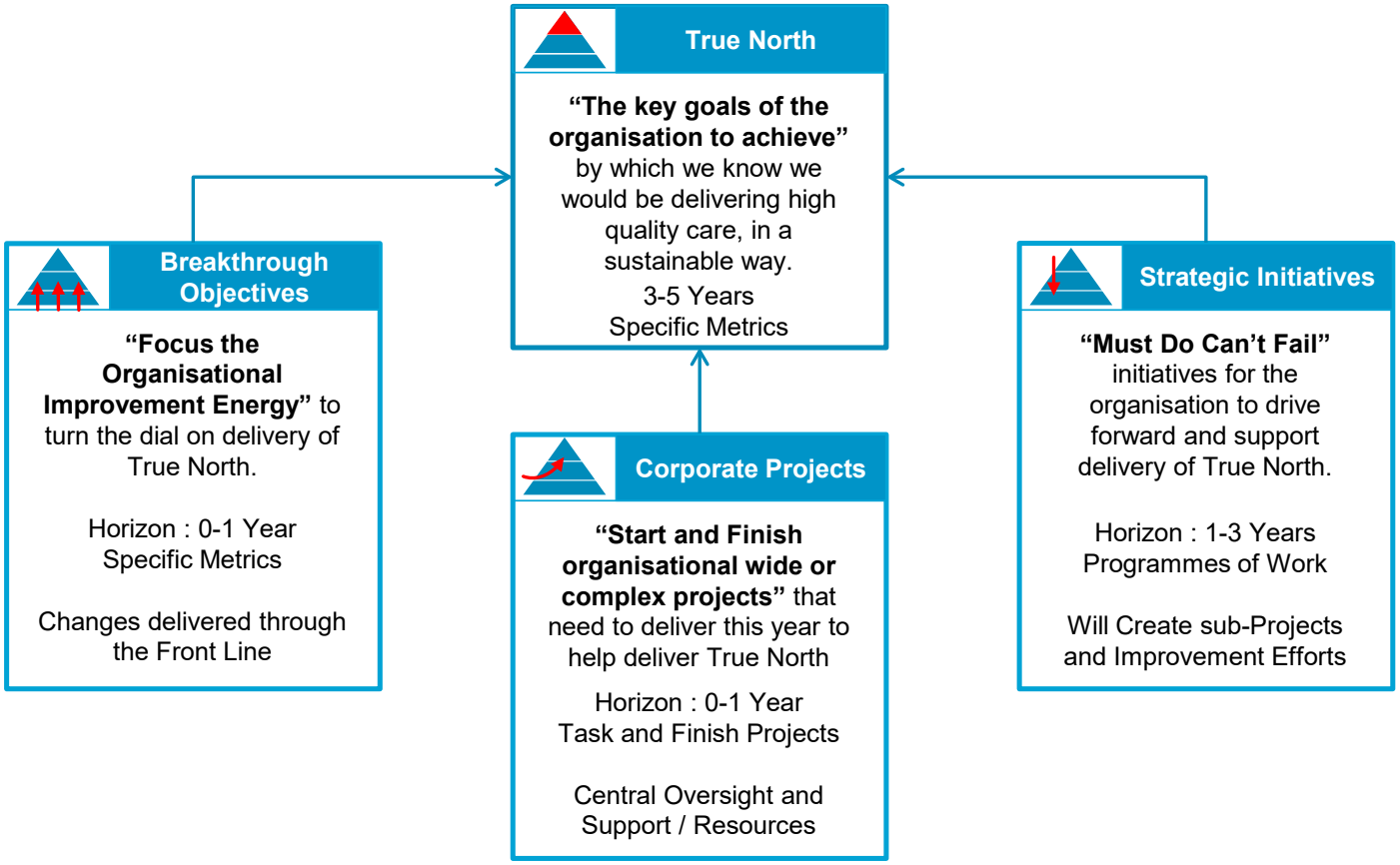
Patient First Strategy Deployment Framework
Patient First True Norths
Patient First Performance Updates

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

System Oversight Framework

Patient First Strategy Deployment Framework

University Hospitals Sussex NHS Foundation Trust



Patient First True North

University Hospitals Sussex
NHS Foundation Trust

True North

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

Patient

Patient Experience:

To be in the top quartile nationally for patients rating their experience as good or very good for all touchpoints

Sustainability

Financial Sustainability:

For the Trust to achieve break even

People

Staff Engagement:

To be in the top quartile of Trusts for staff engagement, reaching top half of Trusts within 12 months

Quality

Mortality:
SHMI equal to or less than 100 for the trust and individual hospital sites

Harm:
Reduction of 5% in preventable harms

Systems & Partnerships

Planned Care:
By March 2023, no patient is waiting more than 78 weeks for treatment.

Cancer:
To achieve the 62 day standard

Emergency Care:
No patients to exceed a 12 hour wait in our emergency departments

Research and Innovation

Research:

Within 3 years to be in the top 20 Acute Trusts nationally for patients recruited into portfolio studies

University Hospitals Sussex
NHS Foundation Trust

Patient

Integrated Performance Report Section

Patient Experience

University Hospitals Sussex NHS Foundation Trust

- Based on available FFT data, the significant majority of patients (91% in Q4) are satisfied that they have a good or better experience. This is a considerable increase on Q3 (average 86%), with positivity levels influence by improvement in ED ratings commencing in January which was also seen in the national data for which the latest data is for January 23 (national positivity ratings increased from 73% in EDs in December 2022 to 83% in January 23%). It is believed this was influenced by the profile of, and public support for, industrial action.

- For UHS, 37,125 patients provided a review in Q4 with an average response rate of 24%.
- The improved positivity ratings are in contrast to the number of complaints received which increased through Q4

- 275 complaints were received in Q4 with the overall number of complaints open maintained on Q3 despite an upward trajectory in the numbers of complaints received in Q4. The overall pattern for PALS contacts is upwards over the last year and increase in enquiries relating to appointments was seen in line with the new PAS and letter production system.

- Themes in negative patient feedback continue to relate to waiting (on site and for treatment), clinical treatment, communication and staff behaviours and discharge – these are the drivers behind the patient experience strategy 2022-25.

- Specific patient engagement work has commenced on key developments for the trust, including ED redevelopment at RSCH and for stage 2 of the 3Ts programme.
- The national maternity survey due spring 23.

- **Risks: to patient experience**: patient satisfaction in EDs at WGH/ RACH; waiting time.

- **Risks For patient experience teams**: complaints/ divisional team capacity versus demand and high caseloads; different systems in use on different sites;

Complaints	Currently open	New January 23	February 23	New March 23	Closed in 25 days
	352➔	98	111	112	20%↓
PALS		996	857	1123	Total UHS Q4: 2966↑

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

FFT (average positive ratings for Q4)	ED positivty rates						Divisional positivity rates								Maternity			
	W'g	SRH	RSCH	Alex	Eye	PRH	Med RSCH/PRH	Sur RSCH/PRH	Med WGH/SRH	Sur WGH/SRH	Spec	W&C	Cancer	CSS	WGH	SRH	RSCH	PRH
	84↑	83↑	85↑	86↑	92↑	91↑	96	94	94	94	95	95	94	96	98↑	95↑	99↑	95➔
National average	75.5% (Average 2022)						93% inpatients 94% outpatients (Jan 23)								95%			

University Hospitals Sussex
NHS Foundation Trust

Research and Innovation

Integrated Performance Report Section

Research and Innovation
Key performance headlines

University Hospitals Sussex NHS Foundation Trust

Breakthrough Objective	Research and Innovation	Executive Sponsor: Prof Katie Urch Senior Responsible Officer: Prof Martin Llewelyn / Vivienne Colleran Metric and Target: 10% increase in total recruitment across all specialities to NIHR Portfolio studies.	On Track	Reporting Period: March 23

Baseline Target Last 12 Enrolment Months plus 10%						
Year	Qtr	Month	Participants enrolled (Edge)	Studies enrolling participants in month	YTD Target	Cumulative % towards target
2021-22	Q3,4		1912	192	X	X
2022-23	Q3	OCT	299	177	350	85.43%
2022-23	Q3	NOV	707	173	700	101.00%
2022-23	Q3	DEC	1070	159	1050	101.90%
2022-23	Q4	JAN	1523	169	1400	108.79%
2022-23	Q4	FEB	1980	189	1750	113.14%
2022-23	Q4	MAR	2507	199	2100	119.38%
2023-24	Q1	APR			2450	
2023-24	Q1	MAY			2800	
2023-24	Q1	JUN			3150	
2023-24	Q2	JUL			3500	
2023-24	Q2	AUG			3850	
2023-24	Q2	SEP			4200	
Oct 2022-Sept 2023	Summary		2507	x̄ 178	2100	119.38%

Breakthrough objective

- Over target recruitment
- Largely driven by reproductive health recruiting well to GBS3 study
- Targeted development of specialities where there are significant opportunities to contribute to high quality research relevant to our services and patients e.g. respiratory medicine
- Detailed follow up discussions to plan for growth in research activity with:
  - Respiratory, Neurosurgery, Endocrine, Gastro, Renal, Obstetrics, Paediatrics
- Research growth discussions with highly research active specialties including: Cancer, Cardiology, Infectious disease, HIV & GUM

Wider strategic development

- RISSG developing a new UHSussex 5 year Research and Innovation Strategy and balanced score card - presentations to TMC and Patient Committee April
- New Associate Clinical Director for Research appointed – Dr Luke Hodgson
- Communications plan in place to promote research internally and externally
  - New @UHSx_research account
  - Research groups profiling underway for webpages
- Brighton and Sussex Health Research Partnership Board met and agreed to the development of a collaborative Clinical Academic Training Office (CATO) proposal
- Call for second round of Clinical Fellows and Chief Nurse Fellows in progress
- New patient research engagement survey planned – 6 monthly snap shot survey
- NIHR vaccine innovation pipeline scoping submitted

University Hospitals Sussex
NHS Foundation Trust

Quality

Integrated Performance Report Section

Focus of this section

University Hospitals Sussex NHS Foundation Trust

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

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

3) Safer staffing

4) Infection Prevention and Control

HEDLines Indicator Dashboard: March 2023 (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	Module Link
HSMR (12 mth rolling) HES Inpatients (Mar 2023)	99.13 (Feb 2022 - Jan 2023)	99.20 (Jan 2022 - Dec 2022)	-0.07 ↓	-	101.16	Within expected range	
HSMR (monthly) HES Inpatients (Mar 2023)	93.77 (Jan 2023)	105.84 (Dec 2022)	-12.07 ↓	-	99.52	Within expected range	
HSMR - Weekday mortality (12 mth rolling) HES Inpatients (Mar 2023)	98.08 (Feb 2022 - Jan 2023)	98.65 (Jan 2022 - Dec 2022)	-0.57 ↓	-	99.84	Within expected range	
HSMR - Weekend mortality (12 mth rolling) HES Inpatients (Mar 2023)	102.26 (Feb 2022 - Jan 2023)	100.84 (Jan 2022 - Dec 2022)	1.42 ↑	-	105.29	Within expected range	
HSMR - Without adjustment for specialist palliative care (12 mth rolling) HES Inpatients (Mar 2023)	107.14 (Feb 2022 - Jan 2023)	107.47 (Jan 2022 - Dec 2022)	-0.33 ↓	-	101.07	Very high (>99.8%)	
SHMI (12 mth rolling) HES Inpatients, HES-ONS Linked Mortality Datasets (Mar 2023)	111.59 (Jan 2022 - Dec 2022)	110.38 (Dec 2021 - Nov 2022)	1.21 ↑	-	103.36	Within expected range	
SHMI (monthly) HES Inpatients, HES-ONS Linked Mortality Datasets (Mar 2023)	122.59 (Dec 2022)	100.15 (Nov 2022)	22.44 ↑	-	118.14	Within expected range	
Crude in-hospital mortality rate (12 mth rolling) HES Inpatients and HES-ONS Linked Mortality Datasets (Mar 2023)	1.62% (Feb 2022 - Jan 2023)	1.60% (Jan 2022 - Dec 2022)	0.02 ↑	-	1.33%		
Crude mortality rate (12 mth rolling) HES Inpatients and HES-ONS Linked Mortality Datasets (Mar 2023)	3.22% (Feb 2022 - Jan 2023)	3.32% (Jan 2022 - Dec 2022)	-0.10 ↓	-	2.73%		
Crude mortality rate (monthly) HES Inpatients and HES-ONS Linked Mortality Datasets (Mar 2023)	2.47% (Jan 2023)	3.28% (Dec 2022)	-0.81 ↓	-	1.99%		

Mortality Metrics

University Hospitals Sussex
NHS Foundation Trust

The UHSussex crude 12 month rolling mortality rate for non-elective admissions is 3.26% and in month for March was 2.71%. Both Monthly and 12 month rolling crude mortality have been decreasing since December.

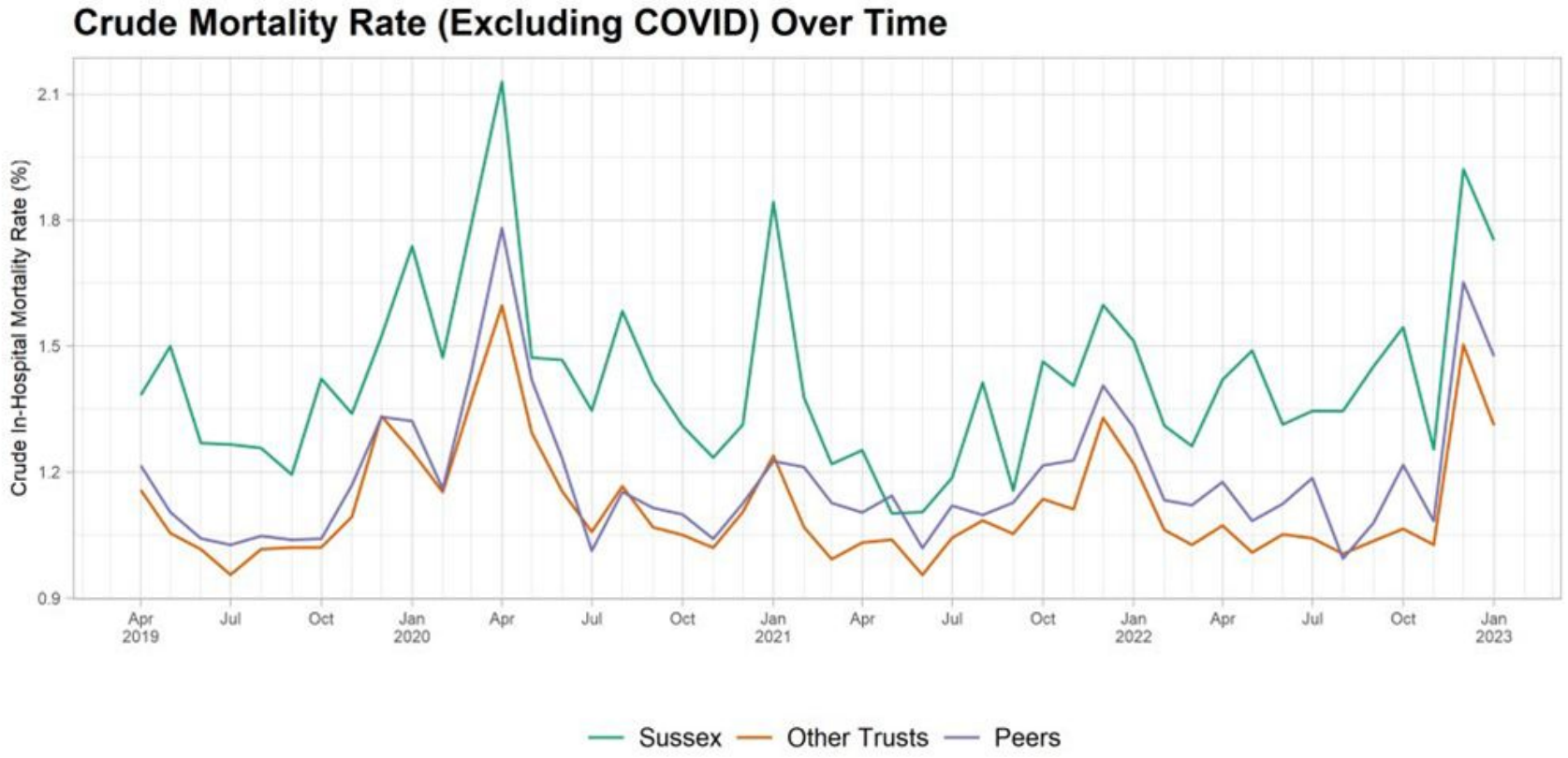
The UHSussex rolling 12 month HSMR is 99.1. This is within the expected range and decreasing. Rolling 12 month HSMR *without adjusting for specialist palliative care* has remained in the 'very high (>99.8%)' category.

The UHSussex rolling 12 month SHMI is 111.6 which remains in the expected range.

Indicator	Current (Apr 2022 - Mar 2023)	Previous (Mar 2022 - Feb 2023)	Change
Crude in-hospital mortality rate - Non-Elective Admissions (12 mth rolling)	3.26%	3.30%	0.04%
Crude in-hospital mortality rate - Non-Elective Admissions (monthly)	2.71%	3.04%	0.33%

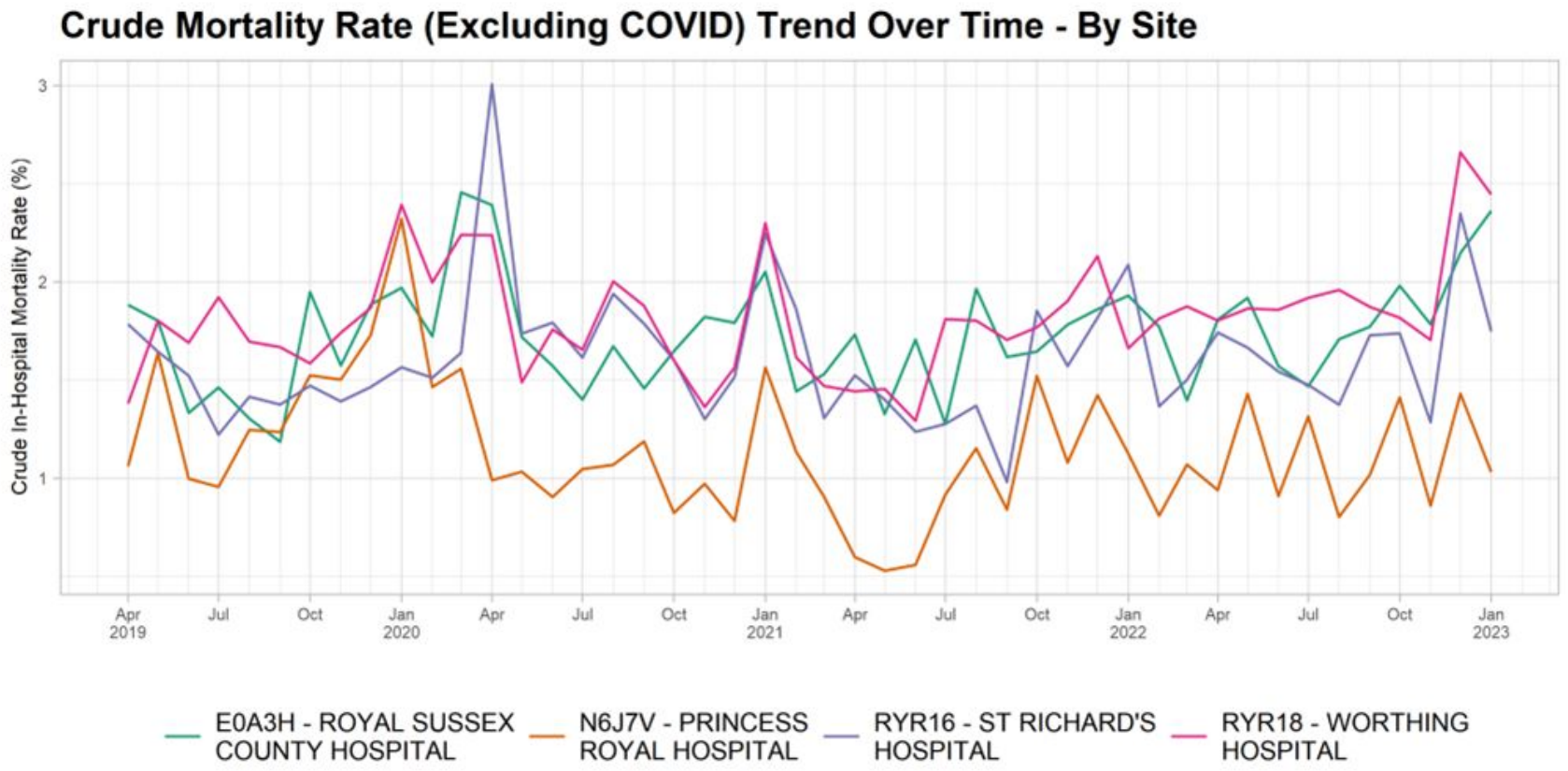
CRUDE MORTALITY

University Hospitals Sussex
NHS Foundation Trust



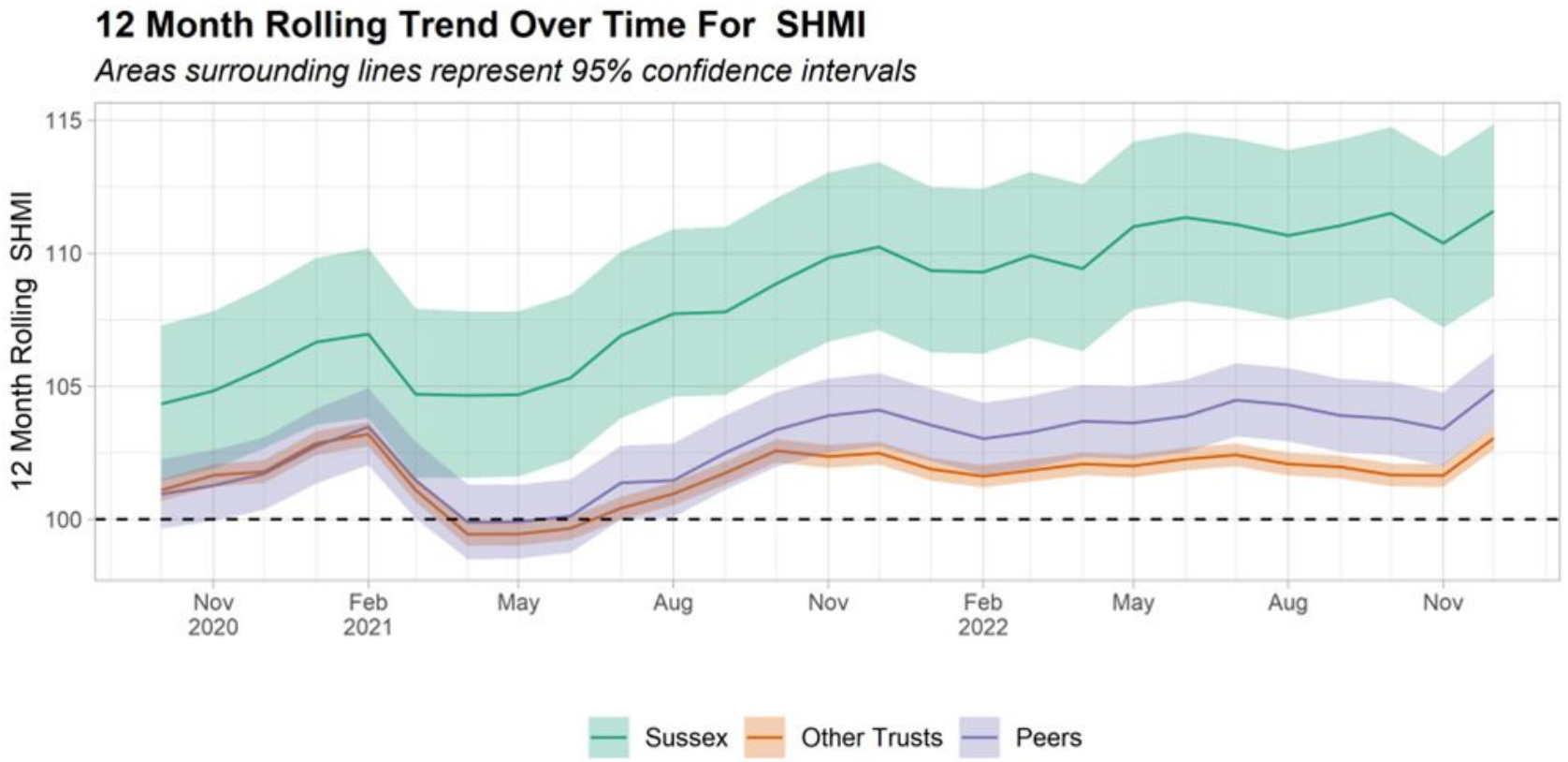
CRUDE MORTALITY

University Hospitals Sussex
NHS Foundation Trust



SHMI

University Hospitals Sussex
NHS Foundation Trust



Depth of Coding

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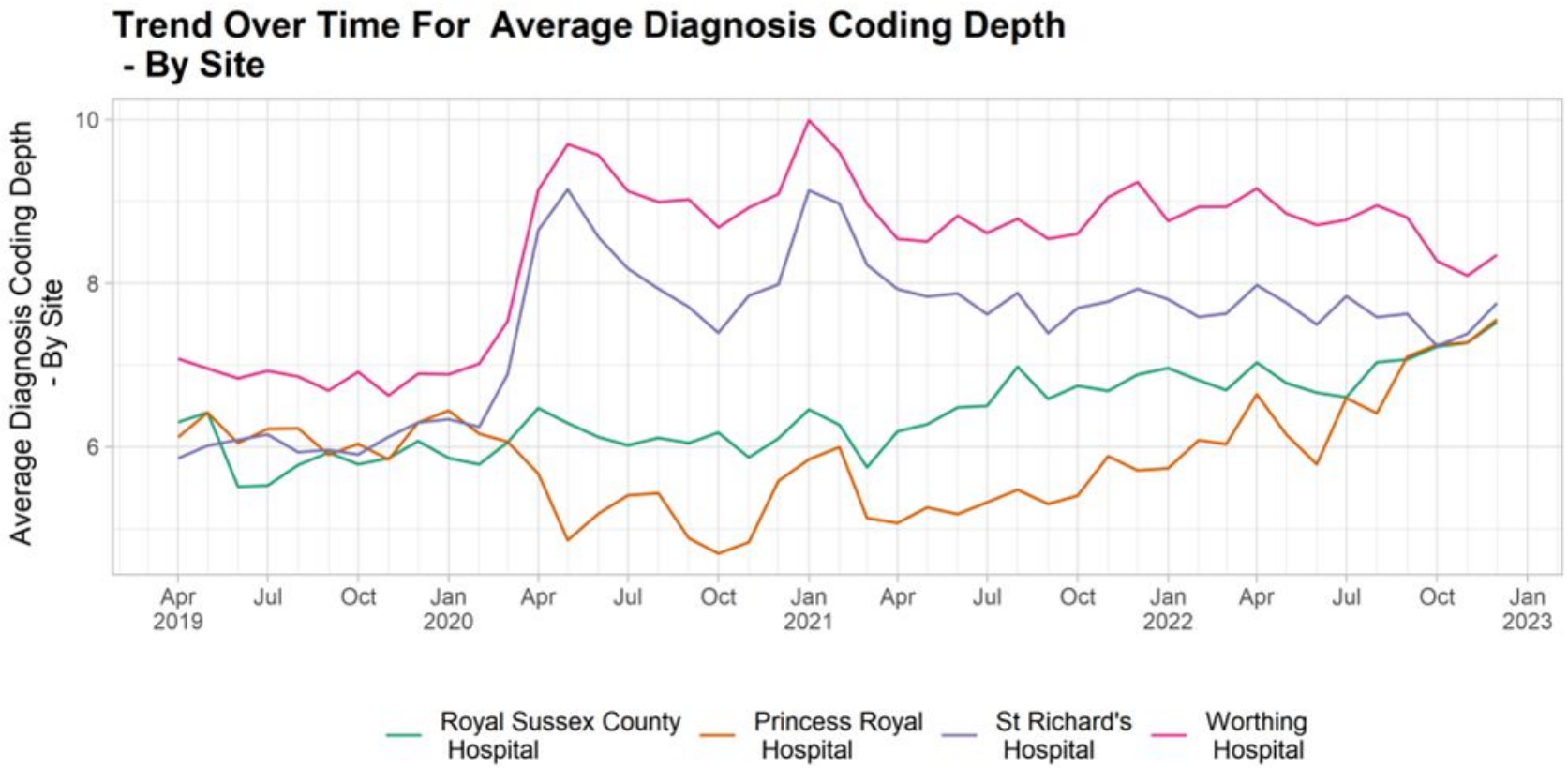


Mortality Summary

University Hospitals Sussex NHS Foundation Trust

After a spike in December, 12 Month rolling crude mortality continues to fall Trust wide and at all sites, rolling crude mortality is particularly low at Princess Royal Hospital at 2.40%. SHMI continues to be high across the Trust. This is mainly driven by a very high SHMI at Royal Sussex County Hospital (124.9), whilst SHMI at Princess Royal Hospital which had been an issue previously has now fallen every month since May 2022 and now sits at a similar level to Sr Richards Hospital and Worthing Hospital.

Out-of-Hospital (OOH) SHMI at Princess Royal Hospital remains an outlier. However, the re-categorisation of Same Day Emergency Care activity since April 2020 has been (externally) investigated and now validated as a significant contributary factor in the increased OOH SHMI. The previous reduction coding depth at Princess Royal Hospital during the pandemic (a consequence of remote working), is no longer a factor – now being similar on all 4 acute sites.

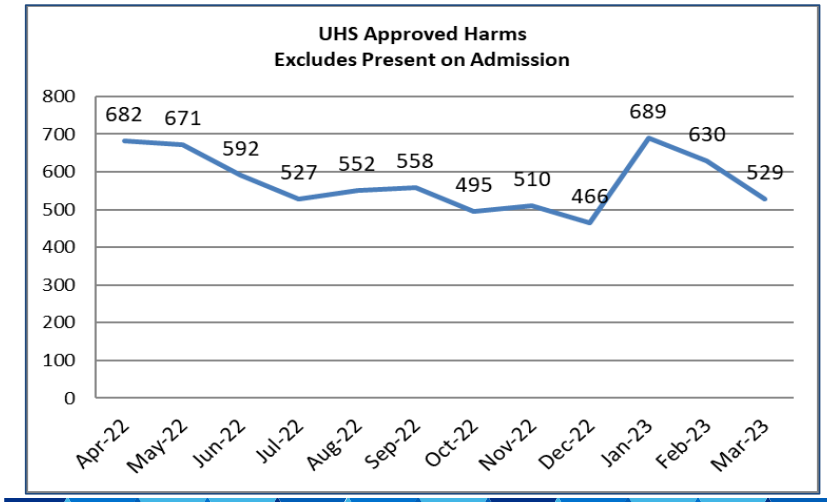
Patient Safety

University Hospitals Sussex
NHS Foundation Trust

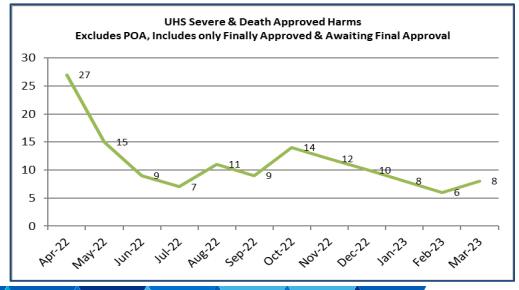
Trustwide it is expected that patients do not suffer harm whilst in our care. However, it is recognised that there are patients who suffer new harm which is acquired during their time in hospital. This has a significant impact on patients, families , carers and staff and within the wider organisation.

The **Quality True North** for harm at UHSussex is '*Zero harm occurring to our patients when in our care',* with a target to reduce the number of **all harms** categorised as 'low, moderate, severe harm and death' by 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 (March 2023- 69%).



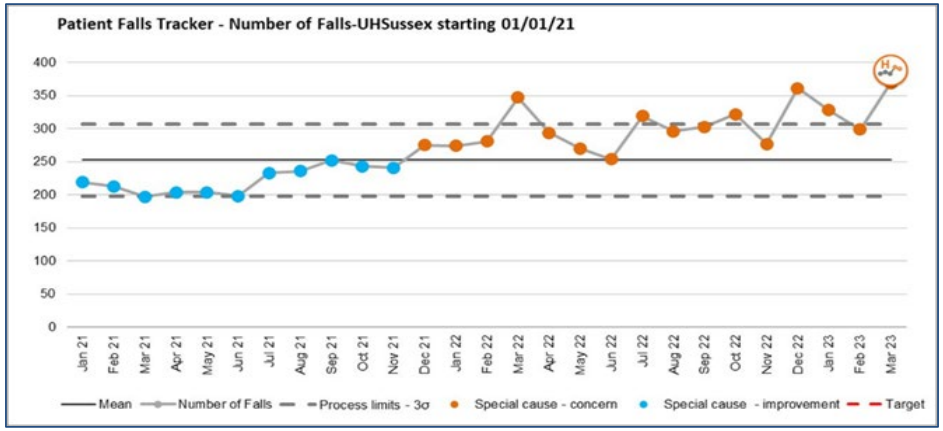
- *Actual harm (low/moderate Severe) reduced by 160 since the peak in January 2023*
- *Falls/Pressure Damage /Medication/Staffing/IPC most commonly reported no/low harm*
- *BCI/ Sussex-Wide Critical Incident. High numbers of Flu A/B Covid and Norovirus outbreak result in high patient acuity and staff sickness. Bay closures and staffing reduce efficacy of Baywatch/cohort nursing: this has resulted in an increase **moderate/severe** harm in Jan/Feb (but still < October 2022)*

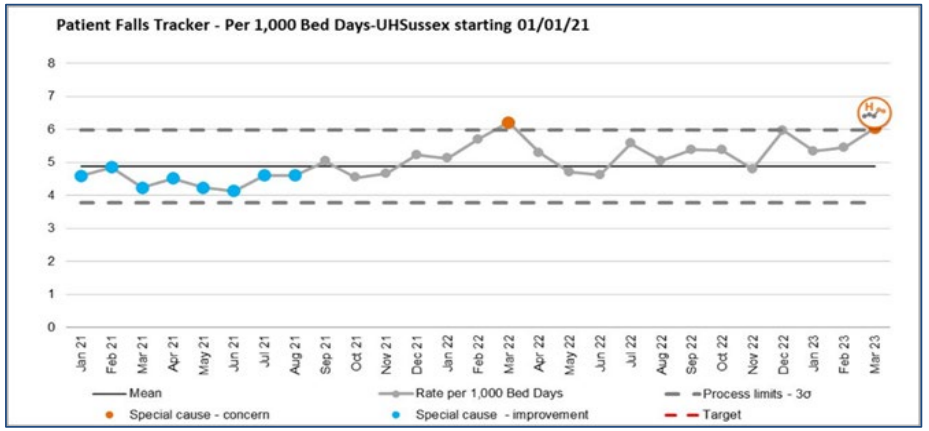


35% reduction in severe harm/death since April 22 (Reduction Covid Nosocomial death)

Avoidable Harm – Key Metrics: Falls

University Hospitals Sussex NHS Foundation Trust





March 2023: 369 falls = 6.04 per 1,000 bed days; (5.30 rolling 12 month average)

Performance/ Themes:

- The increased bed occupancy (escalation, boarding, super-surge) and extended length of stay has reflected another challenging month.
- WH-SRH continues on the upward trend, with Emergency Floors at both sites remaining the top reporters.
- Watch wards: Birdham and Beacon – Harm Free Care nurse continues to monitor.
- RSCH-PRH remain in trend with last 6 months. Balcombe and Newhaven seen higher numbers this month. Harm Free Care nurse to review these areas.
- AAR's have highlighted recurring themes relating to patients diagnosed with acute confusion, continence and staffing levels continue to impact on ability to *Baywatch.* The number of unwitnessed falls is increasing in month.
- Recording of falls risk assessments & lying & standing blood pressure require improvement.

Improvement Actions:

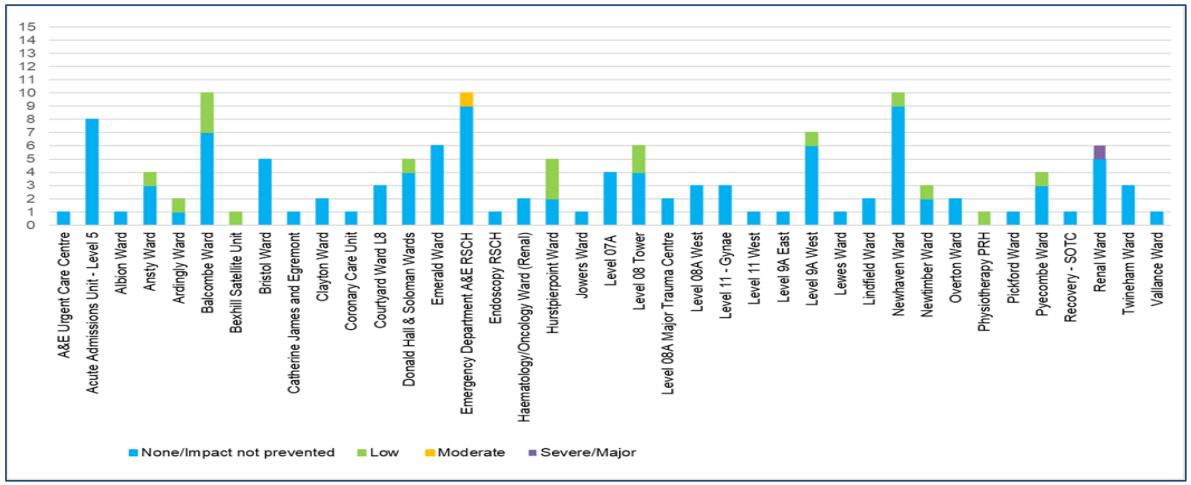
- **Update on Breakthrough Wards**
- SRH-WH - Ashling, Boxgrove, Ford & Lavant continue to work on their A3s to identify their areas for QI; Buckingham, Eartham, Erringham and Emergency Floor WH also making progress with A3's.
- Emergency Floor WH have formed a falls team – working on a patient information leaflet which will be distributed in April.
- RSCH-PRH - Clayton – low number of falls reported. Ward has reduced down to 10 beds with fewer medical outliers; Ardingly – Falls now as a watch metric, still seeing low numbers; Newtimber – Reduced number of falls; Lindfield – low falls numbers; Vallance – only 1 fall in month.
- **Harm-free Care Nurse to continue with:**
  - Promotion of patient education for falls prevention through distribution of information leaflets.
  - Face- to-face training of overseas nurses, HCA inductions, and ward based teaching to promote improvement with assessments.
  - Continence product selection guides to be instigated in clinical areas.
  - HoN to undertake review of medical wards at WGH and SRH in relation to increase in falls.

Harm-Free Care March 2023

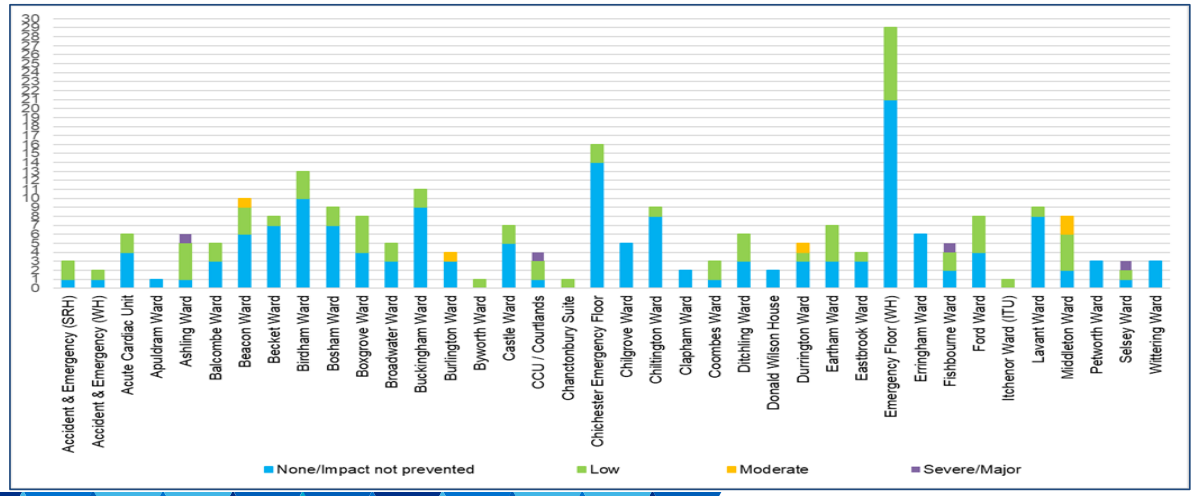
Avoidable Harm – Key Metrics: Falls

University Hospitals Sussex NHS Foundation Trust

RSCH-PRH Locations & Harm



WH-SRH Locations & Harm

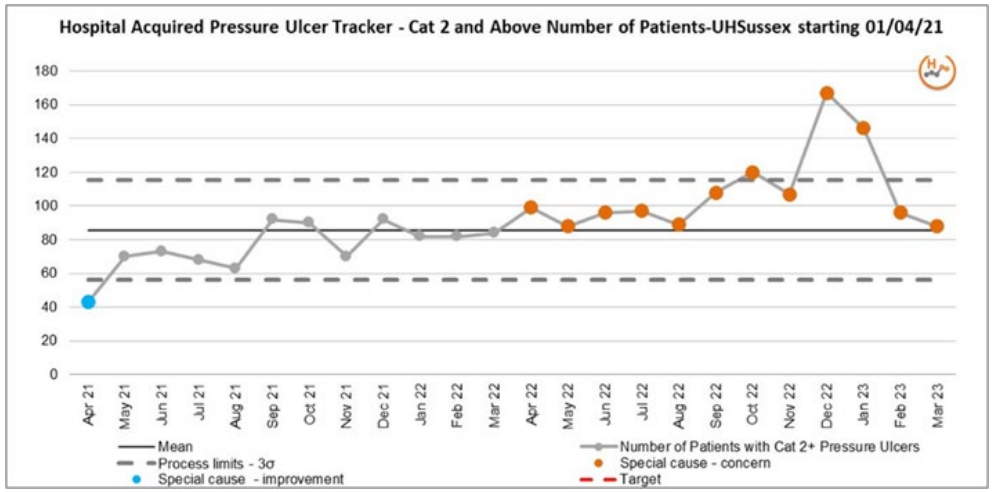


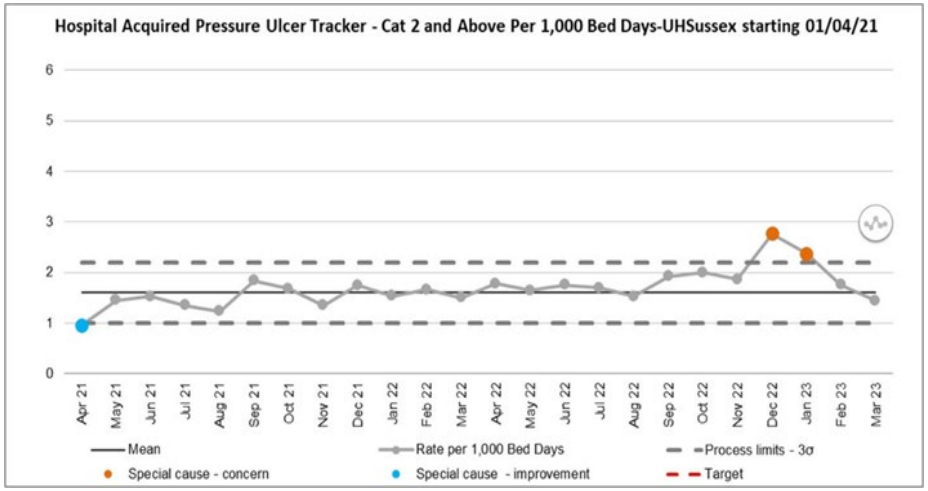
Harm-Free Care March 2023

Avoidable Harm –
Key Metrics: Pressure Ulcers

STOP THE PRESSURE.

University Hospitals Sussex
NHS Foundation Trust





March 2023: 88 patients graded Category 2 and above pressure ulcers = 1.44 per 1000 bed days, (1.87 rolling 12 month average)

Performance/Themes :

- A positive reduction in Category 2 hospital acquired pressure ulcers particularly at WH-SRH sites.
- Hospital Acquired Deep Tissue Injury (DTI) s to heels at WH-SRH remain a theme this month.
- The iPad project for wards to accurately record wound with photos; enabling the TVN team triage assessment, is currently undergoing IT/IG legal checking process.
- Moderate harms themes identified in relation to toe and heel related pressure damage at WH-SRH.

Improvement Actions:

- Moisture Associated Skin Dermatitis awareness week. This included education with staff at the time of patient assessment and educational displays.
- Awareness of pressure ulcers to heels and heel offloading equipment training provided to wards, and posters provided with heel offloading algorithms to mitigate risk. More training planned to continue next month at WH & SRH.
- Repose boot trial continues at SRH, further education provided.
- The iPad training is being provided to all band 6 nurses on the Emergency Floor SRH.
- The manual handling team will provide extra training in the use of slide sheets when moving patients to reduce the risk of friction injury.

Harm-Free Care March 2023

Improvement actions (harm reduction)

University Hospitals Sussex NHS Foundation Trust

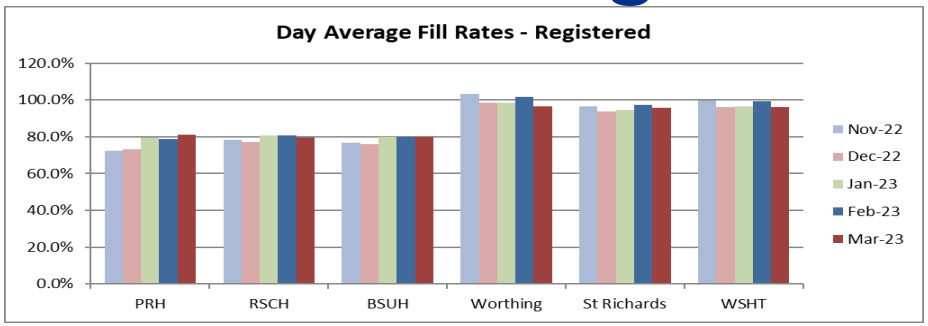
- Analysis of all reported patient safety incidents (site, division, service, ward) continues month on month.
- Implementing RLDATIX IQ risk and incident management and assurance system Q1 2023.
- Targeted focus on reduction of low/moderate harms (falls and pressure damage) Falls and pressure damage are noted as top 2 themes in reported harms (moderate/low).
- This quarter has seen unprecedented pressures nationally with flow and capacity, and industrial action, resulting in BCI/ Sussex-Wide Critical Incident. High numbers of Flu A/B Covid and Norovirus outbreak resulted in high patient acuity and staff sickness. Bay closures and staffing reduce efficacity of Baywatch/cohort nursing.
- 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.
- In line with the new Patient Safety Incident Response Framework, thematic reviews have commenced in Q3 2022/23. These reviews were initiated due to themes or ‘cluster’ incidents being identified via SI’s, trends identified via Datix reporting of incidents or concerns being raised by staff. The review provide a greater opportunity for detailed analysis and shared learning/improvement Trustwide.

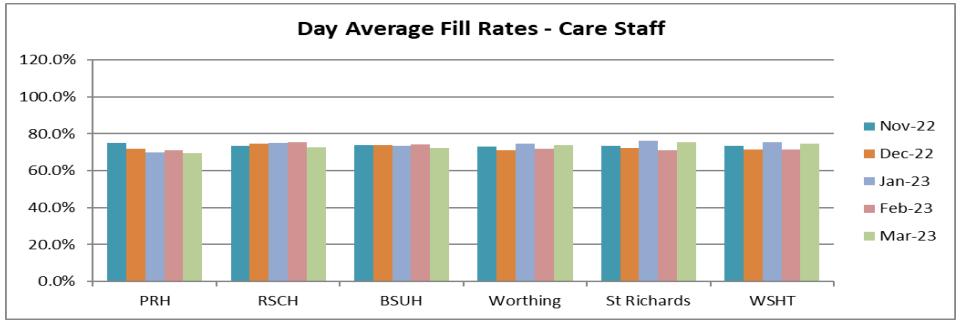
Safer Staffing

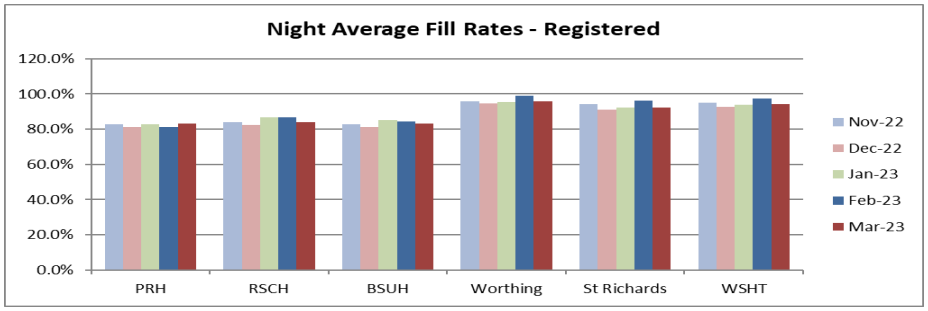
University Hospitals Sussex
NHS Foundation Trust

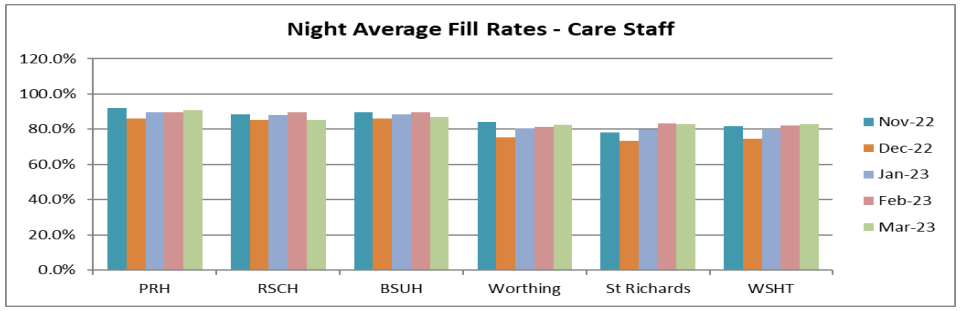
- In response to fluctuations in staffing levels, staffing huddles are held at least twice a day to ensure that areas with challenged staffing levels are supported. Unmitigated staffing shortfalls are escalated to the Director of Nursing.
- There has been a slight increase in the overall fill rate for both Registered Nurses and Unregistered staff during the last quarter in comparison to the third quarter of 2022/23, however, the Care Hours Per Patient Day (CHPPD) remained between 7.42 and 7.58 similar to the previous quarter. This remains below the peer median score of 8.1 (Model Hospital data, January 2023).
- "Safe Care" has been fully implemented at the Royal Sussex County and Princess Royal Hospital sites. It has been rolled out to 50% of the eligible areas at Worthing Hospital, and eventually at St Richard's Hospital. It is a tool providing live visibility of staffing levels and by matching with patient demand, can highlight areas which are short on workload-based care hours. 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.
- The Trust have successfully recruited circa 167 Health Care Assistants (HCA) since January 2023 via HCA Assessment days which were being held rotationally in four of our hospital sites.
- During the nurses' industrial action, there was a concerted effort to ensure that safe staffing levels were maintained in our clinical areas.

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









	CHPPD														
	Registered Nurses					Care Staff					Overall				
	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
PRH	3.72	3.67	4.18	4.41	4.06	3.41	3.27	3.60	3.71	3.35	7.13	6.94	7.78	8.12	7.41
RSCH	4.91	4.76	4.80	4.77	5.27	3.24	3.11	3.10	3.14	3.39	8.15	7.87	7.89	7.91	8.66
BSUH	**4.80**	**4.68**	**4.92**	**4.92**	**5.13**	**3.23**	**3.12**	**3.21**	**3.24**	**3.33**	**8.03**	**7.80**	**8.13**	**8.17**	**8.46**
Worthing	4.38	4.70	4.11	4.36	4.12	2.64	2.80	2.51	2.59	2.67	7.02	7.50	6.62	6.95	6.79
St Richards	4.39	4.58	4.41	4.66	3.93	2.24	2.32	2.26	2.29	2.28	6.63	6.90	6.67	6.95	6.20
WSHT	**4.38**	**4.64**	**4.26**	**4.51**	**4.02**	**2.45**	**2.56**	**2.39**	**2.44**	**2.47**	**6.83**	**7.20**	**6.64**	**6.95**	**6.49**
UHSussex	**4.60**	**4.66**	**4.60**	**4.73**	**4.61**	**2.86**	**2.87**	**2.82**	**2.86**	**2.92**	**7.46**	**7.53**	**7.42**	**7.58**	**7.53**

Infection Prevention and Control

University Hospitals Sussex NHS Foundation Trust

Mandatory surveillance

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

- The following category definitions are used:

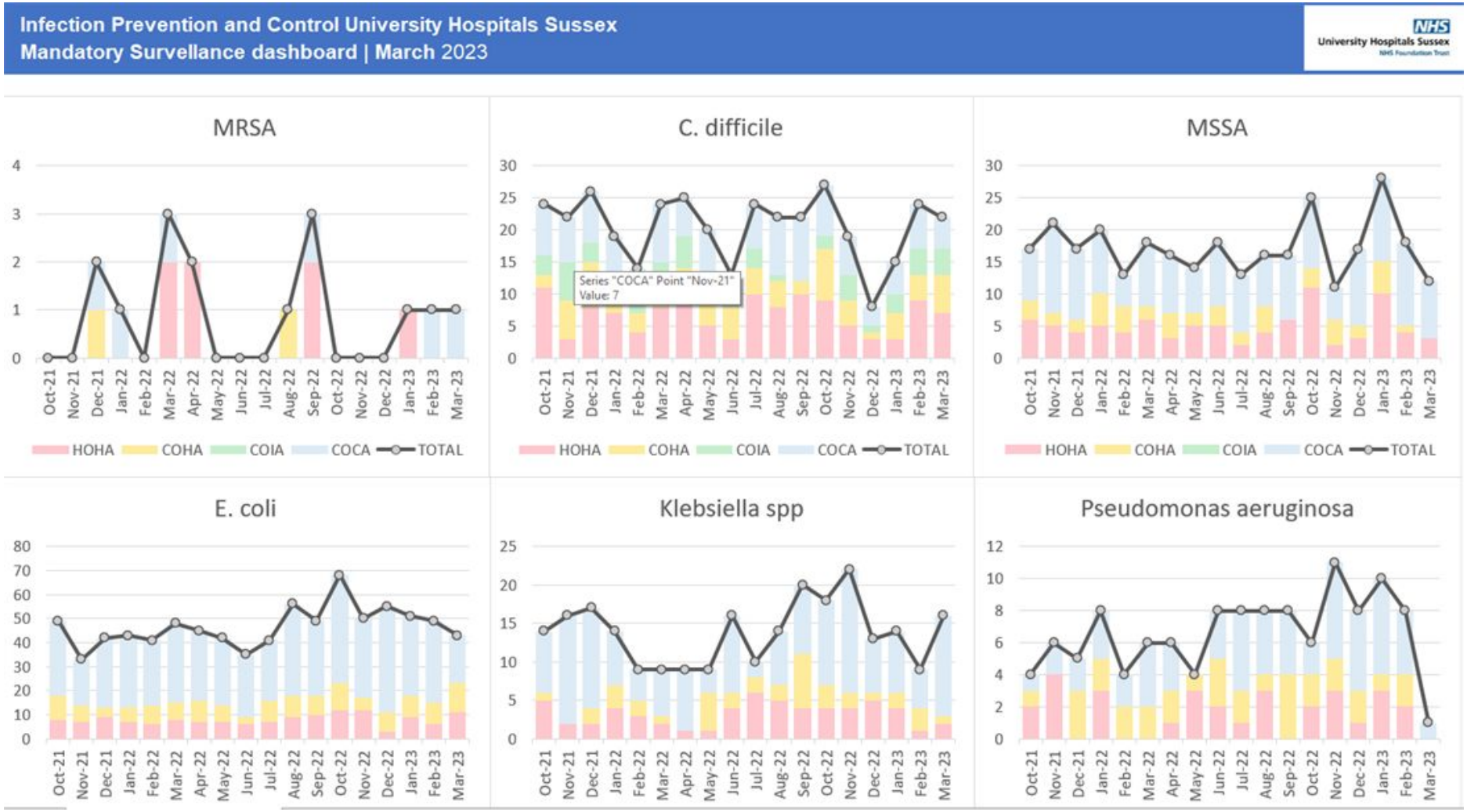
  HOHA: Hospital onset Hospital Associated, acquired after more than 48 hours in hospital

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

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

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

The charts on next slide show data up to end of March 2023

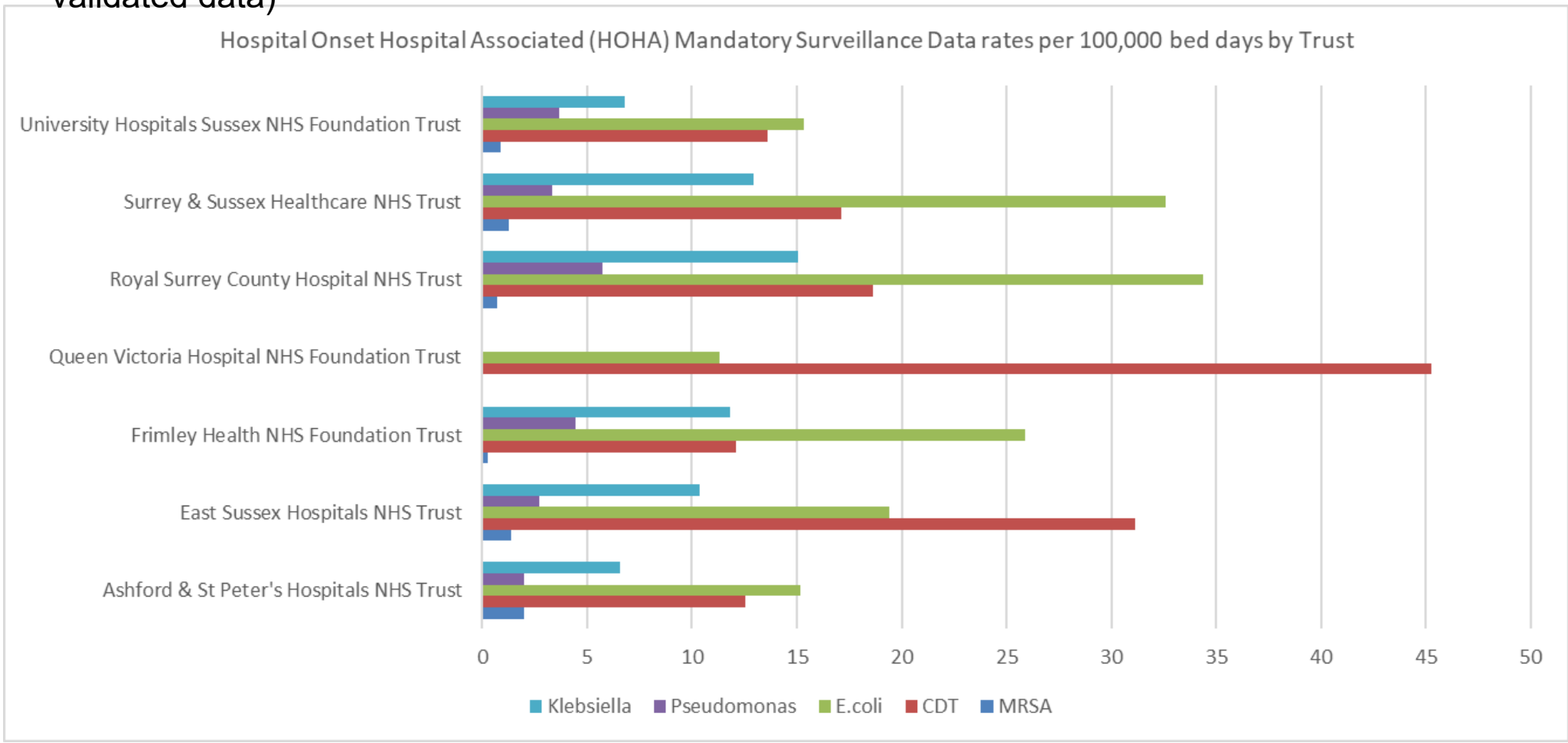

Infection Prevention and Control University Hospitals Sussex
Mandatory Surveillance dashboard | March 2023
NHS
University Hospitals Sussex
MRSA
C. difficile
MSSA
E. coli
Klebsiella spp
Pseudomonas aeruginosa
Series "COCA" Point "Nov-21"
Value: 7
HOHA
COHA
COIA
COCA
TOTAL
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23

Trust attributable mandatory surveillance data 2022-23 against trajectory

Actual v Trajectory 2022/23

Key Organisms	Annual Trajectory		Q1	Q2	Q3	Q4	YTD
CDT	142	Trajectory	35	35	36	36	142
		Actual	33	38	30	33	134
		Variance	-2	3	-6	-3	-8
E.Coli	158	Trajectory	40	40	39	39	158
		Actual	39	52	51	56	198
		Variance	-1	12	12	17	40
Klebsiella	54	Trajectory	13	13	14	14	54
		Actual	13	26	19	13	71
		Variance	0	13	5	-1	17
Pseudomonas	38	Trajectory	9	9	10	10	38
		Actual	12	11	12	8	43
		Variance	-3	-2	-2	2	-5
MRSA	0	Trajectory	0	0	0	0	0
		Actual	2	3	0	1	6
		Variance	2	3	0	1	6
MSSA	n/a	Actual	22	18	25	23	88

Benchmark Mandatory Surveillance Data to End Feb 2023 (latest validated data)



Infection Prevention and Control

University Hospitals Sussex NHS Foundation Trust

Key Points

- Met CDT trajectory with minus 8 cases. (Last year the trust was 29 over)
- Benchmarked data shows that despite not meeting other trajectories, UHSx performs well when compared with other organisations.
- Covid continues to cause outbreaks, but with less severity.
- Testing and isolation guidance has been amended in line with NHSE instructions.
- The mask mandate for clinical areas was lifted in April 23

Infection Prevention and Control

University Hospitals Sussex NHS Foundation Trust

Other updates

Audits

- IPC hand hygiene audits now on Tendable with training being rolled out.
- Hand hygiene 95%.

SSI

- Commenced SSI surveillance in Cardiac at Royal Sussex County, and Orthopaedics at Princess Royal.
- New surveillance nurse for Surgery East has commenced post
- Existing SSI surveillance in place at St Richards and Worthing. Work in progress to look at reported rates.

3Ts

- Louisa Martindale Building nearing completion with significant IPC input for snagging
- IPC involved in designs for stage 2 and also ED reconfiguration.

IPC Team

- Team almost fully appointed
- In process of appointing to the data analysis/epidemiology post

University Hospitals Sussex
NHS Foundation Trust

People

Integrated Performance Report Section

Focus of this section

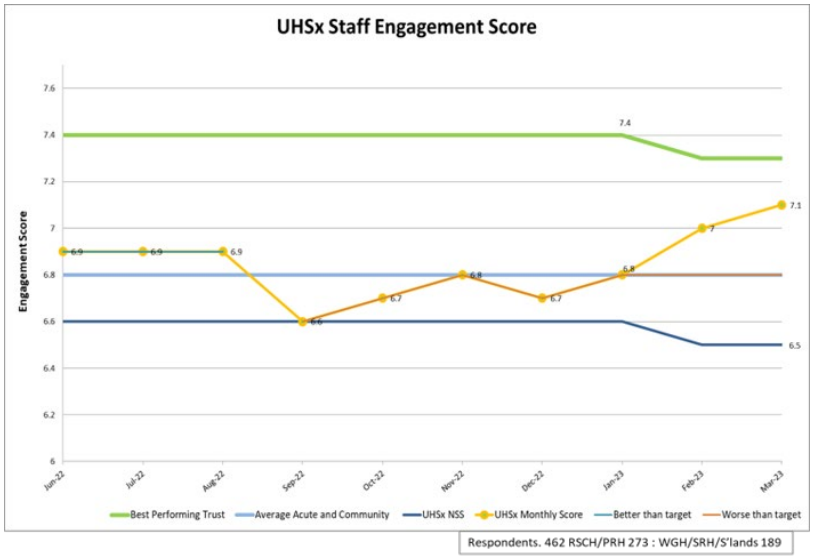
University Hospitals Sussex NHS Foundation Trust

- 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

University Hospitals Sussex NHS Foundation Trust

True North goal: Top acute trust for staff engagement. 2023-24 target: to be within the top half of acute trusts for the staff engagement score (National Staff Survey). Current performance 7.1 (latest engagement measure from pulse survey):



Pulse Survey Data
Pulse engagement score in month = 7.1/10
Above target of 6.8 (2022 national staff survey average)
Improvement in monthly score for three consecutive months
Sample size increased and expectation that over 1000 staff will complete the survey from May onwards allowing data to be stratified by Divisions

2022 Staff Survey Results
Published 9th March
Shared widely across the organisation including CEO All Staff Briefings for 3 weeks, Trust messages and development of dedicated intranet pages
Divisional results and top "10 areas for improvement" shared with senior Divisional leadership teams before publication of results
Bespoke Power BI Tool has been developed enabling Divisions to breakdown data to cost centre level

Corporate Actions
In addition to BO and LCD programmes; merging engagement workstreams include Internal Communications, Values and Behaviours/Civility and a refresh of Ambassadors/Engagement Champions

Divisional Actions
Divisions developing a specific plan in response to results. Progress of role out of results and plan shown below. Plan to be completed by end of April

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.

Speaking up & Equality Diversity & Inclusion

University Hospitals Sussex NHS Foundation Trust

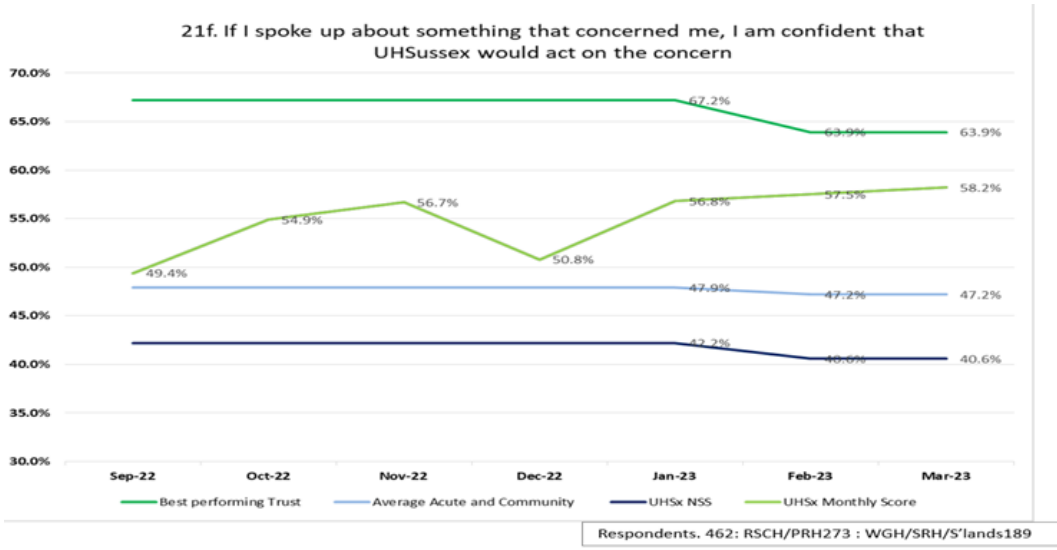
2022 National Staff Survey Results
40.6% of staff (compared to 42.2% in 2021) “Felt confident that if they spoke up about something that concerned them that the organisation would address their concern”. Below national average of 47.2% compared to 48% (2021)

Pulse Survey
58.2% responded positively in month (highest score to date)
Above target compared to 2022 national staff survey average
Improvement in monthly score for the last three consecutive months
Sample size has increased and the expectation is that over 1000 staff in May will complete pulse survey

Corporate Actions
All original actions implemented (Pathway documents, toolkits etc)
New corporate workstreams under development to support cross Divisional themes including “Tool kit” coaching sessions

Divisions Actions
Focus groups held in March as planned
Summary action plans to be developed by end of April

Breakthrough objective measure 58.2%:



Leadership, Culture and Organisational Development

University Hospitals Sussex NHS Foundation Trust

Overall/Governance
•LCD metrics – recommendations to be considered by People Committee 24/4/23 (Trust and Div level)
•LCD Risk Register and Project-level KPIs – workshop scheduled 4/5/23
•LCD Programme Board subgroups – membership, meetings etc. being reviewed now Business Manager in post

Leadership
•Phase 1 of COM Divisional Triumvirate/Corporate Director/Exec. Programme plenary day held on 13/03/23
•Scoping meeting held 01/03/23 with Salisbury Apprenticeships Procurement Lead on bespoke UHSussex management/leadership apprenticeships.
•Coaching survey completed and 150 staff members have expressed interest in being trained – details passed to NHS Sussex
•Workshop held on 30/03/23 to commence project transitioning appraisal/PDP reporting to Iris

Equalities & Inclusion
•Workstream-level Project Plan/milestones completed
•'Lived experiences' training video filming completed 24/03/23 – expect to introduce at Corporate Induction from May 2023
• EDI Internal Audit (Maturity Assessment) commenced with agreed TOR (BDO)

VPR
•Conflict Resolution Training (Level 1) for all staff now included in Trust's STAM policy. To be included in STAM compliance reporting from May 2023
•First draft of Staff Support SOP (staff wellbeing following incident) in development
•VPR assessment completed with national NHSE VPR team – confirms Trust self-assessment (ie. partial compliance)

Key stats – people scorecard (Mar)

University Hospitals Sussex NHS Foundation Trust

- 16,578 WTE posts*↑
- 15,066 WTE in post→
- 1,511 vacancy (9.12%)↓
- RN vacancy 11.07%↑*
- HCA vacancy 16.06%↓

- Sickness in month 6.73% (1115 WTE)↑ (last 12 months 5.92%↑)
- Turnover 9.98%↓

- Appraisal (non-medical) 78.05%↓
- Consultant 92.24%↑

- STAM 88.65%↓

- Latest staff engagement score 7.10%↑
- Recommendation 58.23%↑

*step change in nurse establishment in Jan 2023 establishing posts associated with escalation beds

People Committee Scorecard - UHSx

March 2023

	Key Performance Indicator	Target	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Trend
	True North - Engagement		7.0	7.1	7.0	6.9	6.9	6.9	6.6	6.7	6.8	6.7	6.7	7.0	7.1	
	Breakthrough - If I spoke up about something that concerned me		-	-	-	-	-	-	52.28%	52.62%	55.42%	53.50%	55.58%	57.54%	58.23%	
	Survey Responses		394	377	467	396	434	518	587	401	406	329	484	676	462	
Workforce Capacity	FTE - Budgeted		16,024.63	16,016.18	16,022.57	16,096.71	16,107.15	16,125.53	16,147.73	16,126.70	16,341.93	16,445.99	16,431.47	16,644.93	16,578.18	
	FTE - Substantive contracted		14,776.18	14,944.10	14,596.73	14,646.29	14,572.66	15,184.48	14,798.50	14,897.44	14,870.39	14,863.15	14,922.24	14,983.46	15,066.30	
	FTE - Substantive contracted variance from Budget		1,248.45	1,072.08	1,425.84	1,450.42	1,534.49	941.05	1,349.23	1,229.26	1,471.54	1,582.84	1,509.23	1,661.47	1,511.88	
	Vacancy Factor (Substantive contracted FTE)		7.79%	6.69%	8.90%	9.01%	9.53%	5.84%	8.36%	7.62%	9.00%	9.62%	9.18%	9.98%	9.12%	
	Vacancy Factor HCA Band 2 (Substantive contracted FTE)		14.66%	16.29%	17.15%	19.34%	20.65%	18.55%	18.65%	18.36%	20.91%	20.37%	18.67%	17.86%	16.06%	
	Vacancy Factor Nurse Band 5 (Substantive contracted FTE)		10.37%	8.24%	9.91%	6.84%	8.08%	5.27%	7.01%	6.86%	7.16%	7.75%	10.29%	11.64%	11.07%	
	Spend - Bank as a % of total staffing		9.24%	8.29%	7.43%	8.80%	8.63%	9.03%	8.68%	8.89%	8.72%	9.05%	8.63%	8.64%	10.74%	
	Spend - Agency as a % of total staffing		4.73%	4.03%	5.09%	5.65%	5.86%	5.32%	4.48%	5.32%	5.45%	4.76%	6.26%	5.66%	5.96%	
	Substantive Headcount		16,682	16,651	16,600	16,571	16,524	16,694	16,646	16,761	16,812	16,748	16,864	16,961	17,012	
Workforce Efficiency	Absence - Sickness (12 month)		4.33%	4.48%	4.55%	4.57%	4.67%	4.64%	4.64%	4.67%	5.46%	5.32%	5.35%	5.92%		
	Absence - Sickness in month		4.83%	4.62%	4.39%	4.10%	5.33%	4.08%	4.16%	5.29%	5.12%	5.31%	5.42%	6.73%		
	Absence - Maternity in month		1.89%	1.86%	1.70%	1.80%	1.90%	1.86%	1.95%	2.08%	2.15%	2.14%	3.74%	4.16%		
	Absence - Special, Study & Other Leave in month		9.38%	8.58%	8.32%	8.49%	8.43%	7.75%	8.27%	8.23%	8.44%	8.17%	10.44%	10.59%		
	Absence - Total in month		16.10%	15.07%	14.41%	14.39%	15.67%	13.69%	14.38%	15.60%	15.72%	15.63%	19.59%	21.48%		
	Sickness - Short Term (< 28 days)		2.54%	2.34%	2.01%	1.92%	2.99%	1.94%	2.04%	3.04%	2.83%	3.43%	2.56%	3.36%		
	Sickness - Long Term (>= 28 days)		2.29%	2.29%	2.38%	2.17%	2.34%	2.14%	2.12%	2.25%	2.29%	1.88%	2.85%	3.37%		
	Sickness - Stress in month		0.85%	0.93%	0.98%	0.81%	0.89%	0.76%	0.81%	0.87%	0.98%	0.74%	1.00%	1.43%		
	Sickness - Gastro Intestinal in month		0.33%	0.37%	0.33%	0.37%	0.33%	0.32%	0.32%	0.31%	0.32%	0.36%	0.30%	0.40%		
	Sickness - Other Musculoskeletal in month		0.40%	0.36%	0.43%	0.37%	0.42%	0.42%	0.41%	0.40%	0.40%	0.31%	0.43%	0.67%		
	Sickness - Cough, Cold & Flu in month		0.48%	0.46%	0.38%	0.31%	0.31%	0.26%	0.38%	0.75%	0.69%	1.34%	0.93%	0.74%		
	Sickness - Back in month		0.17%	0.16%	0.22%	0.19%	0.23%	0.20%	0.19%	0.22%	0.23%	0.16%	0.21%	0.32%		
	Episodes - New sickness episodes in month		3,058	2,668	2,734	2,609	3,236	2,573	2,721	3,878	3,595	4,695	3,186	3,307		
	Episodes - On-going sickness episodes in month		766	873	696	641	828	663	655	825	764	767	997	981		
	Episodes - Total sickness episodes in month		3,824	3,541	3,430	3,250	4,064	3,236	3,376	4,703	4,359	5,462	4,183	4,288		
	Maternity - Number of staff on maternity leave		370	374	337	362	372	378	375	406	418	424	710	798		
	Turnover - Trust (12 month)		9.34%	9.41%	9.52%	9.54%	9.40%	9.33%	9.56%	9.60%	9.69%	9.62%	9.99%	10.19%	9.98%	
	Turnover - Medical & Dental (12 month)		27.27%	21.81%	18.23%	16.92%	14.16%	11.91%	10.46%	10.54%	11.17%	11.15%	12.55%	12.76%	12.42%	
	Turnover - Nursing & Midwifery (12 month)		6.00%	6.19%	6.26%	6.13%	6.02%	6.13%	6.39%	6.58%	6.83%	6.66%	7.27%	7.51%	7.36%	
	Turnover - Scientific, Therapeutic & Technical (12 Month)		9.39%	9.56%	9.68%	9.69%	9.28%	9.45%	9.03%	8.33%	8.60%	8.76%	9.47%	9.15%	9.69%	
	Turnover - Admin, Clerical & Estates (12 months)		10.60%	11.01%	11.32%	11.57%	11.74%	11.82%	12.64%	12.91%	12.55%	12.55%	12.47%	12.66%	12.33%	
	Turnover - Support Staffing (12 months)		10.23%	10.12%	10.48%	10.55%	10.66%	10.41%	10.65%	10.57%	10.80%	10.68%	10.66%	11.19%	10.56%	
	Stability %		85.97%	85.30%	84.94%	84.88%	84.8%	84.8%	84.8%	85.3%	85.1%	85.6%	85.0%	85.6%	85.7%	
Training and Development	% of appraisals up to date All Staff (AfC Staff and Consultants Only)	90%	68.31%	68.76%	73.23%	77.32%	80.63%	80.18%	81.17%	80.65%	80.00%	79.42%	79.41%	78.91%	78.05%	
	% of appraisals up to date Medical Staff (Consultants Only)	90%	28.28%	36.34%	87.53%	82.47%	90.33%	90.00%	89.04%	89.14%	89.25%	89.28%	88.04%	88.01%	92.24%	
	% of appraisals up to date AfC Staff (excl Medical staff)	90%	71.85%	70.91%	72.28%	76.98%	79.98%	79.53%	80.64%	80.08%	79.37%	78.76%	78.84%	78.32%	77.11%	
	STAM Weighted Average	90%	86.19%	85.35%	86.84%	88.07%	88.73%	88.36%	89.14%	88.40%	88.05%	87.94%	88.73%	90.48%	88.65%	
	% In Date - Fire	90%	84.90%	84.59%	85.73%	86.60%	86.45%	85.76%	87.28%	86.22%	86.10%	85.45%	86.82%	87.78%	86.29%	
	% In Date - Infection Control (Role Specific)	90%	84.83%	84.66%	85.55%	88.14%	87.78%	87.54%	88.74%	88.12%	88.27%	87.60%	88.04%	89.48%	87.09%	
	% In Date - Back Training (Role Specific)	90%	81.28%	83.89%	85.60%	87.11%	88.44%	88.73%	88.85%	88.44%	88.08%	88.04%	88.39%	89.82%	86.96%	
	% In Date - Child Protection (Role Specific)	90%	88.65%	83.18%	86.71%	88.39%	90.81%	90.29%	90.09%	89.94%	88.14%	88.44%	89.16%	92.05%	89.01%	
	% In Date - Information Governance	90%	82.61%	82.45%	84.79%	85.70%	85.32%	84.62%	86.47%	85.34%	85.50%	84.60%	86.21%	87.01%	85.68%	
	% In Date - Adult Protection	90%	90.91%	85.82%	88.74%	90.39%	92.36%	91.85%	91.73%	91.74%	91.15%	91.48%	91.66%	94.50%	91.60%	
	% in Date - Equality & Diversity	90%	91.70%	91.92%	92.42%	93.16%	93.61%	92.67%	93.32%	92.54%	92.24%	92.43%	92.83%	94.61%	93.26%	
	% in Date - Health & Safety	90%	93.21%	93.40%	93.31%	93.77%	93.80%	92.60%	93.98%	92.01%	91.63%	91.93%	93.79%	95.14%	94.18%	
	% in Date - Resus	90%	73.26%	74.63%	74.62%	75.02%	75.64%	77.56%	78.13%	77.70%	77.80%	78.07%	78.03%	80.80%	80.55%	
Capacity	Starters	-	190	189	202	157	140	691	223	369	200	112	491	473	189	
	Leavers	-	156	145	120	124	136	402	183	172	115	119	253	155	126	

University Hospitals Sussex
NHS Foundation Trust

Industrial Action & other risks

University Hospitals Sussex NHS Foundation Trust

Industrial Action

- Industrial action by BMA on RCN managed on 10 – 14 April
- RCN action on 7 & 8 May
- Approach of facilitating the right to strike balanced with safety and minimising impact
- National staff council discussion of pay award on 9 May
- BMA has delayed ballot of consultant staff

People risks (Q1)

- Further Industrial Action
- Recruitment
- Retention and morale
- Louisa Martindale Building opening (training, change management and recruitment)
- Maintaining sufficient staffing for the levels of activity / demand being experienced
- Staff absence / availability
- Staff stretch and the impact of that on their and patients' experiences

University Hospitals Sussex
NHS Foundation Trust

Sustainability

Integrated Performance Report Section

Sustainability True North – Summary

University Hospitals Sussex NHS Foundation Trust

- Achievement of the 2022/23 breakeven financial plan was highlighted previously to be extremely challenging; when taking into consideration the impacts of:
  - Urgent and emergency care pressures,
  - Elective activity requirements,
  - Industrial action and;
  - Excess inflation costs.
- The Sussex ICB reached agreement with the Trust to deliver a £10.4m deficit at the end of March, as part of the System position agreed with NHSE at the start of Q4
- At the end of March 2023, the Trust Financial Performance delivered:
  - £10.39m deficit, in line with ICB agreement.
  - Capital expenditure of £117.6m.
  - £42m of efficiencies.

Sustainability True North – Financial Plan

University Hospitals Sussex NHS Foundation Trust

The Trust's True North domain for sustainability for 2022/23 was 'living within our means providing high quality services through optimising the use of resources'; measured through 4 key financial plan metrics: Income & Expenditure, capital, cash and efficiency programme performance.

- Mitigating actions were deployed to their fullest extent by the Trust resulting in agreement with the System to deliver a £10.4m deficit at year end. Year end financial performance was in line with this agreed deficit plan.
- The year end cash balance of £58.87m was £14.37 less than plan. The cash position is representative of the £10.4m deficit performance and increased payments made to improve our performance against the Better Payments Practice Code.
- Capital expenditure was £1.66m above plan at year end, in agreement with the ICB to offset underperformance elsewhere in Sussex and enabling the overall ICS to break-even. Expenditure for 3T's delivered on plan.
- The efficiency performance has ended the year £5.6m below plan, the majority of which is attributable to productivity savings which have been impacted by emergency care pressures and industrial action throughout the year.

Sustainability Key Metrics

University Hospitals Sussex
NHS Foundation Trust

			A
I&E £k	**YTD Plan**	**YTD Actual**	**Variance**
Income	(1,432,558)	(1,452,114)	19,556
Operating Costs	1,461,729	1,491,683	(29,954)
Finance Costs	20,640	20,319	321
Performance	(49,811)	(49,495)	(316)
Overall performance	0	10,393	(10,393)

The actual position for the full-year is a £10.39m deficit. The year-end deficit was mainly due to the £6.77m estimated impact of inflation above the funded percentage. There were also increased costs of insourcing and outsourcing, to deliver activity, and operational pressures linked to staff availability, flow, and capacity.

This performance is in line with the £10.40m year-end deficit that the Trust agreed with the Sussex Integrated Care Board (ICB), which allows the Sussex ICB to deliver the overall financial trajectory that they have agreed with the NHSE South East region.

			A
Cash £k	**YTD Plan**	**YTD Actual**	**Variance**
	73,240	58,867	(14,373)

Cash is £14.37m 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 to accommodate the year-to-date deficit.

The Trust year-to-date BPPC performance is 91% of invoices (volume), which represents 93% of payments (value), paid within agreed terms with suppliers.

The Q4 year-end BPPC performance was an improvement on the Q3 year-to-date performance, which was 84% of invoices (volume), representing 88% of payments (value), but below the target of 95%.

			A
Capital £k	**YTD Plan**	**YTD Actual**	**Variance**
3T's Phase 1	(26,233)	(26,233)	0
Operational Schemes:			
Medical Devices /	(14,982)	(15,947)	965
Service Developments	(36,600)	(41,875)	5,275
Estates	(37,461)	(32,723)	(4,738)
Charitable	(680)	(843)	163
Overall performance	(115,956)	(117,621)	1,665

The capital expenditure for the year 2022/23 was £117.62m, which was £1.66m above the plan.

The expenditure on the 3T's new hospital scheme was on track.

The Trust had agreed with the ICB that it would overspend by £2.00m against the ICB capital limit (CDEL) to compensate for underspends elsewhere in the ICB.

			A
Efficiency £k	**YTD Plan**	**YTD Actual**	**Variance**
	47,650	42,006	(5,644)

The efficiency programme ended the year £5.64m behind plan, predominantly related to the productivity schemes.

Underperformance against the 2019/20 baseline, coupled with elevated levels of insourcing and outsourcing in comparison to 2019/20, resulted in a loss of productivity savings this year.

Non NHS Income schemes performed below plan, mainly due to private patients capacity being used for NHS patients, to part mitigate operational pressures.

Sustainability-Financial Plan 2023/24

University Hospitals Sussex NHS Foundation Trust

- The 2023/24 financial plan has been developed based on the modelling assumptions set out in the planning guidance and associated consultations which were circulated on 23rd December 2022 by NHSE. The intent being to recover core services and productivity alongside continuing to transform the NHS for the future.

- 2022/23 baseline allocations were the start point for the 23/24 financial plan:

    - The Trust has secured allocations for additional physical bed capacity,
    - Funding for virtual wards, and;
    - Community Diagnostic Centres (CDC's).
    - Covid-19 funding has been further reduced.

- Additional funding (ERF) for elective services recovery will be earned by Systems delivering above 100% of the value of the 2019/20 activity baseline. With System providers there is more flexibility to agree provider targets, but overall the Sussex system must meet the target it has been set.

- The Sussex ICS will be submitting a plan to deliver breakeven on the 4th May, within which the Trust will also submit **a breakeven** plan for 2023/24.

- The 2023/24 Trust plan assumes the following:

    - ERF income received for activity performance above 100% of 19/20.
    - £62m efficiencies to be delivered.
    - £13m income to support additional beds.
    - Pay and non pay inflation in line with National NHSE guidance
    - Revenue funding to support 3T's stage 1.

- The Trust has submitted a Capital plan totalling £108.5m.

Sustainability - Actions & Recommendations

University Hospitals Sussex NHS Foundation Trust

There are no actions required of the Board.

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

- The Trust delivered a £10.4m deficit at the end of 2022/23, in line with ICB agreement.
- The financial framework for the 2023/24 plan; and the further work that is in progress in relation to developing capacity plans for elective activity delivery and maturity of efficiency schemes.
- The financial impact of the challenges faced by the Trust in 2022/23 and the underlying pressures continuing into 2023/24.
- Detailed financial performance information has been shared with Sustainability Committee; who continue to provide oversight on behalf of the Board.

University Hospitals Sussex
NHS Foundation Trust

Systems & Partnerships

Integrated Performance Report Section

Systems & Partnerships Summary Q4

University Hospitals Sussex NHS Foundation Trust

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

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

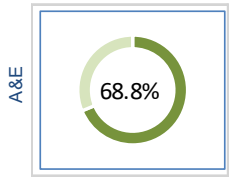
- The overall Trust performance against these measures at the end of March 2023 has remained relatively static in Q4, with significantly increased pressure on operational services as a result of ongoing industrial action, and wider system challenges against these targets.

- There have been improvements made in cancer and longest RTT waits, and improvement continues in diagnostic waiting time performance March-23, in the context of winter and industrial action pressure.

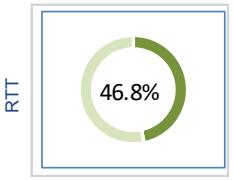
Performance Summary March-23

True North and NHS Constitutional Targets

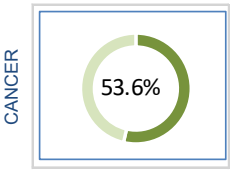
University Hospitals Sussex NHS Foundation Trust



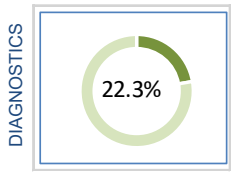
- The Trust treated 68.8% of patients within 4 hours of attending all A&E departments March 2023. National performance was 71.5%
- Winter pressures eased marginally, but Trust capacity constraints were exacerbated due to Industrial Action.



- The Trust has 46.8% of patients waiting longer than the target 18 weeks at the end of March-23. National performance was 58.5% February-23.
- The total number of patients waiting for elective treatment at the Trust was 128,876.
- There were 257 patients waiting over 78 weeks at the end of March, 399 fewer than February. The Trust continues to focus on the elimination of longest waits.



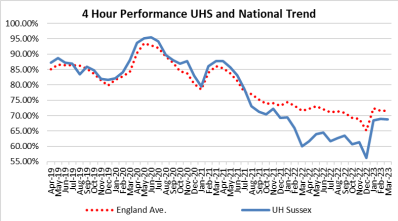
- 53.6% of patients were treated within 62 days in February. National performance was 58.2%.
- There has been a marginal reduction in over 62 and 104 day prospective waits to March, from 331 Feb-23 to 325 March-23 for over 62 day patients, and from 114 patients Jan-23 to 95 patients March 23 over 104 day waits
- FDS performance was 74.3% February, an improvement of 15% since January, and Trust best performance to date.

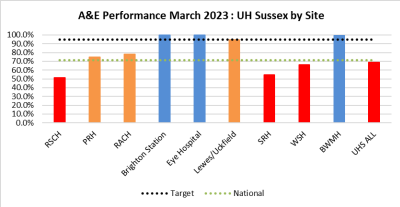


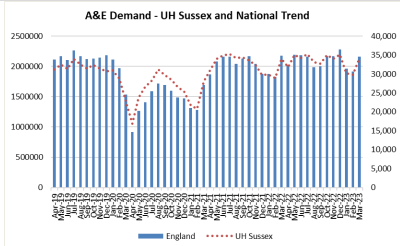
- The Trust had 22.3% of patients waiting more than 6 weeks at the end of March for a diagnostic against a 1% target. This is an improvement of -4.0% since February and -15.3% since Dec-22.
- The National average for January-23 was 25.1%

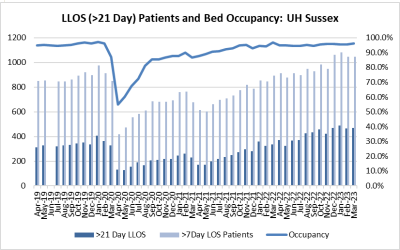
A&E Performance Summary March-23

University Hospitals Sussex
NHS Foundation Trust









- The Trust treated 68.8% of patients within 4 hours of attending all A&E departments March 2023. This is static relative to February-23. National performance was 71.5%

- To ensure patient safety, the time to triage, treatment and mean waiting times are key areas of focus for the Emergency Department teams. Mean waits and time to treatment increased marginally in March, whilst time to triage reduced compared to February. They remain materially better than observed April – December 22

UHSussex	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Time to Triage:	29.1	25.3	21.3	22.2	23.7	21.3	23.2	24.4	23.7	27.8	16.6	19.1	17.9
Time to Treatment:	143.0	130.4	128.1	134.1	142.2	137.5	131.7	142.5	137.9	148.1	96.2	116.7	122.8
Mean Waiting Time:	332.9	319.8	306.4	316.6	332.4	347.3	343.8	373.4	360.5	432.3	335.3	311.8	328.1

- There are high levels of emergency demand but flow is made more complex and delayed by the ‘red/green’ pathway split within ED and the hospitals. 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.

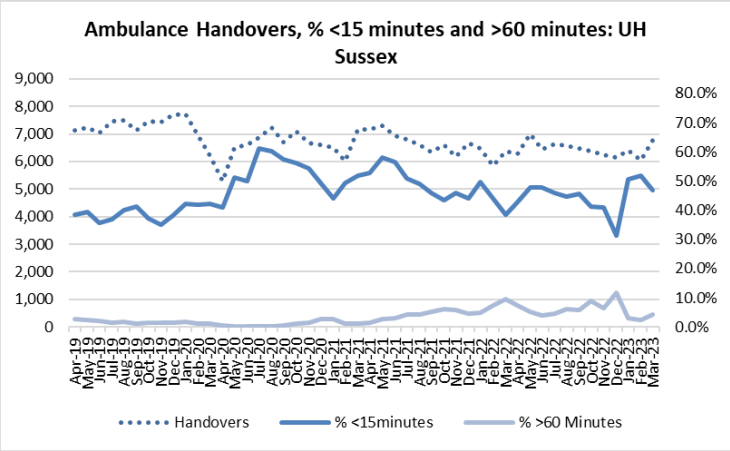
- The Trust is working with system partners whilst also looking at internal processes to balance the discharge profile against the A&E demand. This includes working on morning discharges to expedite capacity to allow admission flow.

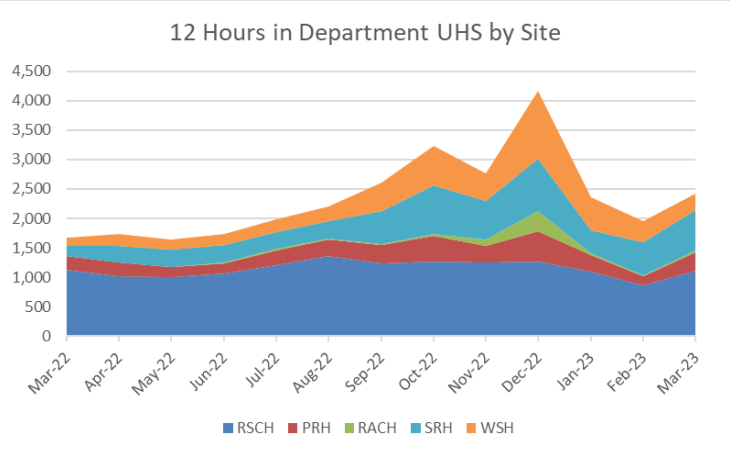
- There have been material increases in the numbers of patients in the Trust’s acute beds who are Long length of stay patients over 21 days, 27% of beds in March-23. A corporate project looking at Length of Stay and how we will work to reduce is underway. There are three workstreams in this project to ensure that all aspects of LoS are covered.

- The key metrics describe overall Trust performance but there has been material variation by site. Largest improvements were observed Worthing 66% March compared to 59.8% February, and RACH 78.3% March compared to 74% February. There was deterioration at SRH from 59.9% to 54.9%, RSCH from 54.4% to 51.5%, and PRH 75.9% March to 74.8% March.

Ambulance Handovers and A&E 12 Hours

University Hospitals Sussex NHS Foundation Trust





- Over 60 minute handovers in March increased to 278 (4.1%) compared to 150 (2.5%) February-23 but favourable compared to 601 (9.4%) in March-22. 215 of these were at the Royal Sussex County Site and 42 at SRH
- The Trust saw a deterioration to 46.9% of handovers within 15 minutes March-23 , compared to 51.9% February-23. This is variable by site, with 22.9% at RSCH, 47% PRH, 61.1% SRH, and 60.8% Worthing
- Patients 12 hours in A&E department increased March-23 compared to February-23 (7.1% compared to 6.6% February) of attendances. Performance is most challenged at RSCH with 15.4% on average of RSCH attendances in department more than 12 hours in March-23 compared to 13.6% Jan-23
- 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 will create capacity on the wards allowing better flow through the ED reducing 12 hr stays and reducing ambulance handover delays

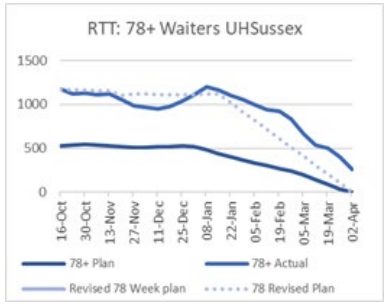
A&E and Emergency Flow: Key Actions

University Hospitals Sussex NHS Foundation Trust

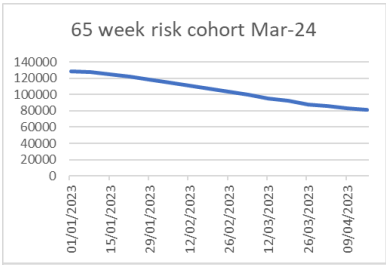
Area of Focus	Action
Emergency Performance Improvement Group	Twice monthly meeting with local teams to review data and recovery plan development
Improvement Trajectory	Local recovery plans against monthly trajectories. Weekly focussed meetings at hospital level to review action plans and track performance against planned trajectory
Long length of stay	Weekly review and reporting to MD of >21 day LOS patients with targeted actions and outputs
Data review	Daily review of previous days performance with DDOs, MD and COO
EICIST Support	Input of EICIST team at RSCH
Data	Review of UEC data requirements and standardisation of reports – Power BI development of Emergency Performance Information Group Dashboard

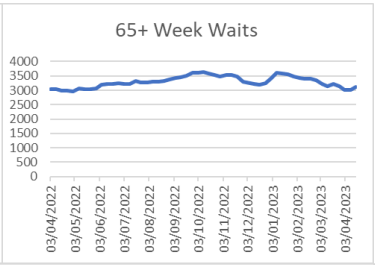
RTT Performance Summary Mar-23

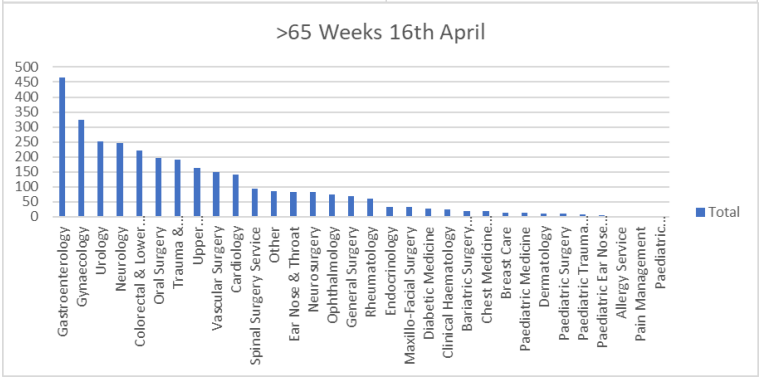
University Hospitals Sussex
NHS Foundation Trust



	> 78 weeks		
	16th Apr	9th Apr	Diff
100 - General Surgery	6	4	2
101 - Urology	17	18	-1
103 - Breast Care	2	2	0
104 - Colorectal & Lower GI Surgery	30	26	4
106 - Upper Gastrointestinal Surgery	26	23	3
107 - Vascular Surgery	25	21	4
108 - Spinal Surgery Service	32	28	4
110 - Trauma & Orthopaedics	17	12	5
120 - Ear Nose & Throat	21	12	9
130 - Ophthalmology	9	10	-1
140 - Oral & Maxillo Facial Surgery	33	28	5
144 - Maxillo-Facial Surgery	2	2	0
150 - Neurosurgery	31	30	1
171 - Paediatric Surgery	1	1	0
301 - Gastroenterology	115	103	12
306 - Hepatology	1	1	0
320 - Cardiology	4	3	1
340 - Chest Medicine (Respiratory)	0	1	-1
400 - Neurology	2	1	1
502 - Gynaecology	25	23	2
TOTAL	412	364	48







- The Trust has 46.8% of patients waiting longer than the target 18 weeks at the end of Mar-23. National performance was 58.5% February-23.
- There were 257 78 week breaches end March-23.
- Progress has been maintained in treating the longest waiting patients, and at the end of Mar-23 there were 18 patients waiting over 104 weeks (compared to 286 December-21), classified as patient choice, clinical reasons or specialist pathways.
- The number of 78 week waits has increased marginally to 16th April as a result of Easter and Industrial Action, and stands at 412
- The Trust has plans to continue to manage down and treat 78 week wait cohort and has the added ambition from operating framework 2023/4 of eliminating over 65 week waits by end March-24. There are 3110 patients waiting over 65 weeks as of the 16th April 2023.
- The plans focus on productivity improvements, internal additional capacity, mutual aid across Sussex and the use of the independent sector. Industrial action and emergency pressure have exacerbated risk of achieving this target.
- The waiting list grew March-23 by 838 patients in March-23. The waiting list has grown by 25% since the end Mar-22. This is mirroring the national trend for increasing patients on the waiting list, and illustrates supply is not keeping pace with increased demand.

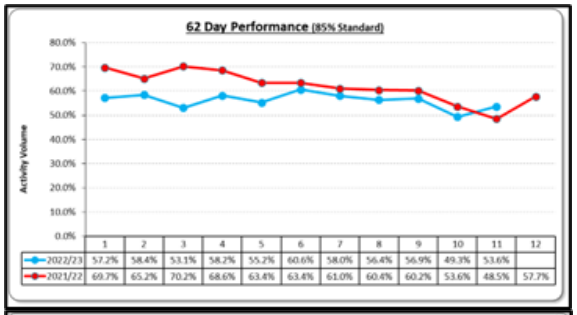
RTT: Key Actions

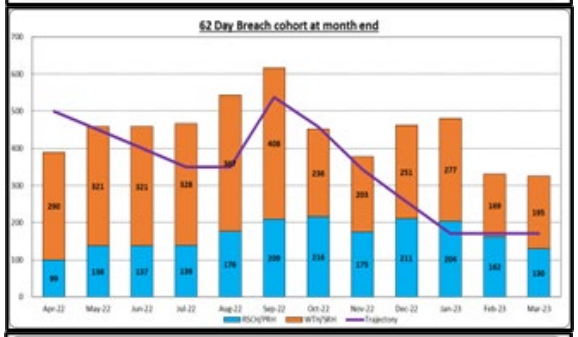
NHS
University Hospitals Sussex
NHS Foundation Trust

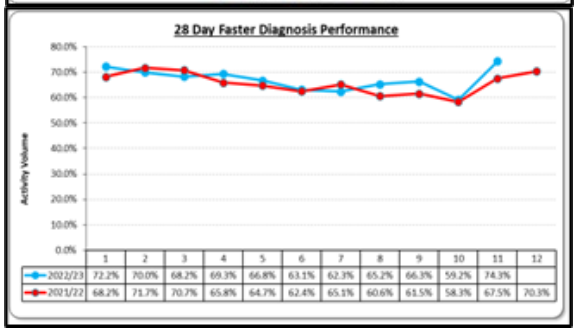
Action Plan		
Action	**Progress**	**Timescale**
Maximise capacity opportunities across the Trust with activity transfers	Pathway transfers happening in Gynae and Gastroenterology.	Ongoing
Mutual aid across Sussex	Weekly meetings in place. Dental and Colorectal activity transfer.	Ongoing
Full patient pathway transfers to the IS	Circa 300 transfers per month in progress.	Continue in Q4
Divisional Oversight/governance	Weekly governance meetings continue, with MD Elective Care, and Performance Director Recruitment underway	Ongoing/Q1
Internal productivity improvement	OP and Theatre utilisation workstreams set up under Planned Care and Cancer improvement steering group.	Ongoing
Action on booking all 78 week risk cohort	Continued ‘man-marking’ focus across the Non-Admitted and Admitted pathways, reviewed daily by operational teams, RTT manager and booking teams across UHSx.	Ongoing
Use of IS capacity for Neurosurgery and Spines	Utilising Independent Sector capacity where case are suitable.	Ongoing

Cancer Performance Summary Jan-23

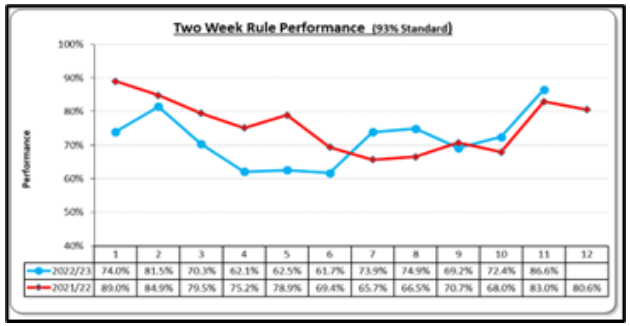
University Hospitals Sussex
NHS Foundation Trust







- Cancer 62 day cancer treatment targets were not met in Feb-23 with 53.6% starting treatment in under 62 days. National performance was 58.1%.
- There has been a marginal reduction in over 62 and 104 day prospective waits to March, from 331 Feb-23 to 325 March-23 for over 62 day patients, and from 115 patients Dec-22 to 95 Mar-23. NB this does not include FDS benign which was 146 reduced from over 1000 in early Jan-23. Trajectory for 23/24 is to have no more than 351 patients waiting over 62 days at end March-24 (inclusive of FDS benign patients).
- FDS performance improved by 15.1% to 74.3% Feb-23 compared to 75.0% Nationally. This is the best performance for UHS for this metric to date. This driven by significant improvement for LGI, breast and gynae anatomical sites.
- 2WR performance also improved February-23 to 86.6% from 72.4% January-23
- Comprehensive action plans by anatomical site are tracked robustly by the cancer divisional leads.



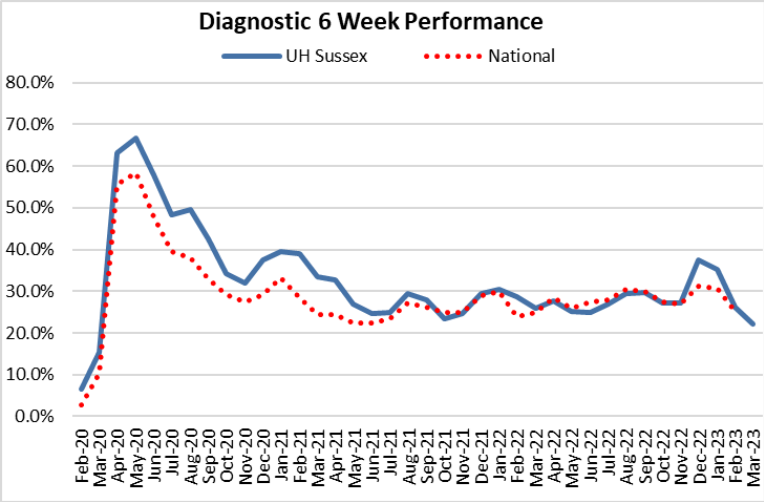
Cancer: Key Actions

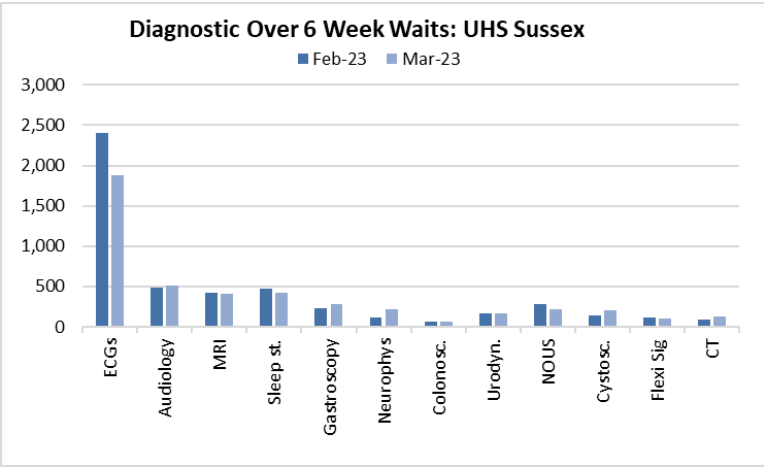
University Hospitals Sussex NHS Foundation Trust

Action	Progress	Timescale
Continue to reduce backlog as per agreed ICB trajectory 23/24 – to now include FDS benign but not evidenced as being informed	• March month end was 325 over 62D – if FDS had been included, this would have added a further 146 therefore totalling 471 • Still under the April trajectory of 550	Ongoing
SSCA premium funding opportunities	• Breast in-sourcing funding £250k approved for H1 for WG • Further bids for LGI (SRH/WG) and likely imaging reporting will go to early March SSCA Delivery Board	On-going
Mother A3 development for 62D% Trust compliance linked to baby divisional pathway A3s to be developed – CMS to flow via CAG	• Mother A3 under development – will focus on pathways which impact non-compliance the most • Divisions are drafting their own A3s to compliment their SDR – monitored via CAG	Q1
Digital Strategy implementation	• Presented to both SSCA & ICB – funding will be required to help migrate both Somerset systems • Standardised suite of reporting to flow via Power BI in development	Ongoing
FDS implementation, governance and recurrent funding	• All FDS to come under the governance of Cancer – responsibility for delivery still joint between all divisions • FDS funding expires in coming 18 months – Cancer division to submit business case Q1	Ongoing
Confirmation of sufficient cancer operative capacity required	• Divisions to confirm weekly cancer operative capacity in place matched to demand requirements to allow no more than 2 weeks from DTT to treatment	Q1
Use of CDCs to promote 62D pathway improvements	• NHSEI asking providers to utilise CDCs for 62D pathway improvements – still in scoping stage – potential for direct access MR for urology as well as potential for a new non-specific symptoms pathway to be established	Q1&2

Diagnostic Performance Summary Mar-23

University Hospitals Sussex NHS Foundation Trust





- UH Sussex achieved 22.3% in March-23 against the diagnostic patients over 6 week target of 1%. This was a significant improvement of 4% since February, and 15.3% improvement since December-22. This compares to 25.1% National performance (Feb-23)
- The number of patients wating over 6 weeks for their diagnostic reduced by 404 in March, whilst the waiting list size grew by 1582, both contributing to the improved performance.
- ECGs (Echocardiograms), and Neurophysiology (sleep studies) have been most impacted by workforce constraints. High emergency pressures have also resulted in significantly higher demand for imaging services in particular.
- Plans are now in operation increasing service capacity for Echocardiography (ECGs) resulting in a reduction of 529 over 6 week waits this month.
- Some areas such as MRI, and gastroscopy have seen significant reductions in 6 week backlog since Mar-22

Diagnostic Actions

University Hospitals Sussex NHS Foundation Trust

Area	Update	Timescale
Imaging: Reporting Capacity	• Request to acquisition of scan much improved. • Cancer Alliance funding has allowed outsourcing of additional routine teleradiology reporting • An initial cohort of 300 routine scans was outsourced, followed by 150 each week until the end of the financial year.	Feb-23
Imaging : Cardiac MR	• Bids submitted to support acquisition and reporting for cardiac MR which make up the bulk of over 6 week waits. • Further support needed into 23/24 after cancer alliance funding completes Mar-23	Awaiting outcome of bid – Apr-23
Pathology	• Significant improvements made in sample processing/cut-up as part of PFIS training attended by staff from both histopathology labs • Cancer Alliance Funding has allowed 300 samples per week from Jan-Mar-23 to be outsourced, which has led to an improvement to 20% of histology waiting over 10 days (from 62% beforehand). A further bid has been submitted to support continued outsourcing into 23/24	Ongoing
Echos	Targeted improvement plan with support from ICB as part of Focus on Diagnostic in March: This comprises: • Recruitment of 2 substantive echo technicians • 2 Locum cover for 16 weeks , • Rental of additional echo machine, to provide additional resilience to existing equipment • Extended weekend working • Comprehensive Validation review of Echo waiters and ongoing maintenance • Plans to increase activity by 85 echos per respective week underway as result of the above.	Jan-23 and May-23 6th March/11th April March-23 19th March Apr-23/ongoing

Summary and Forward Look 2023/24

University Hospitals Sussex NHS Foundation Trust

- Performance in Q4 has continued to be challenged, but there has been good progress with mitigation plans 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 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 Q1 23/24. Executive weekly scrutiny and system support have meant the Trust are on a strong footing to continue to reduce long waiting patients in 23/24. 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.

- Operational planning has concluded with ambition to undertake 107% of 19/20 activity levels in 23/24, to achieve 76% A&E performance by March-24, elimination of over 65 week waits, reduction of over 62 day waits for cancer, and a reduction in over 6 week diagnostic performance to less than 5%. The Trust has constructed plans to target these areas.

- The key risks remains the operational pressures relating to urgent elective and emergency demand, the impact of Covid-19 and the recent industrial action which impact capacity and workforce across all areas of delivery.

NHS
University Hospitals Sussex
NHS Foundation Trust

System Oversight Framework

Integrated Performance Report Section

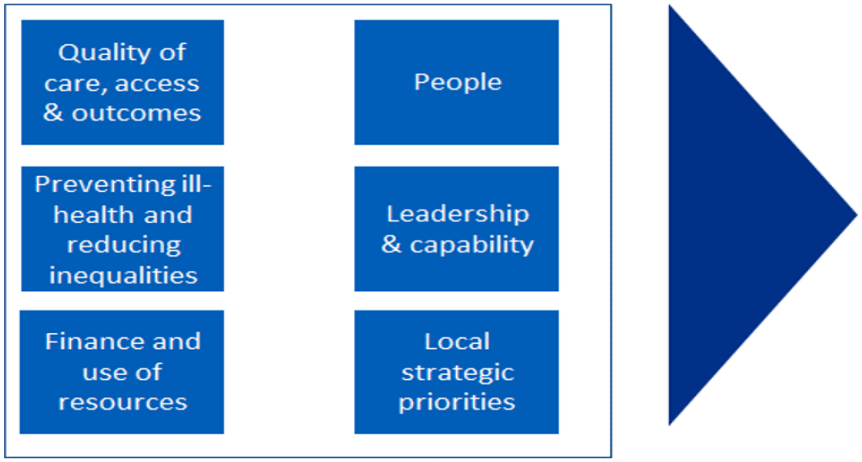
Systems Oversight Framework

University Hospitals Sussex NHS Foundation Trust

The system oversight framework for 2022/23 builds on the 2021/22 framework 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 guidance

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 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

University Hospitals Sussex NHS Foundation Trust

Trust's current rating

The Trust's System Oversight Framework rating for Quarter 3 is Segment 3. The Trust's rating for Quarter 4 has yet to be determined but it is likely it 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 and has received targeted support focusing on the EDs at PRH, SRH and Worthing Hospital

Actions being taken to move from segment 3

The move to Segment 2 will be contingent on delivery of the its operating and financial plan along with the improvements required by the CQC

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 rating remains a 3 for Quarter 3 with the rating for Quarter 4 yet to be determined but unlikely to change.

The Board is asked to **NOTE** that the Trust's move to Segment 2 will be contingent on delivery of the its operating and financial plan along with the improvements required by the CQC.

University Hospitals Sussex NHS Foundation Trust

Agenda Item:	14	**Meeting:**	Board	**Meeting Date:**	4 May 2023
Report Title:	Patient Committee Chair report to Board				
Author(s):			Claire Keatinge, 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		☐

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	☐	Link to Trust Annual Plan	✓
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	☐		
Research and Innovation	✓	Assurances in relation to risks 6.1, 6.2 and 6.3	

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

Regulatory / Statutory reporting requirement

Communication and Consultation:

Executive Summary:

The Patient Committee met on the 25 April 2023 and was quorate as it was attended by two Non-Executive Directors, the Chief Nurse, the Chief Medical Officer and the Chief Executive. In attendance were the Director of Patient Experience, Engagement and Involvement, the Deputy Director of Engagement and Involvement, the Deputy Director for Improvement and Delivery, Clinical Director of Research and Innovation, Director of Clinical Outcomes and Effectiveness, Director of Communications and Engagement and the Company Secretary.

The Committee received its planned items including the Patient True North, Breakthrough, Corporate Project and Strategic Initiative, the quarter 4 patient experience report, the Trust's Welcome Strategy, Patient Car Parking support paper, updates on the Patient First Strategic Initiative, an update on the Trust's work to address Health Inequalities and reports from the Committee's reporting groups along with the Research and Innovation Strategy Development paper. The Committee also considered both the Corporate Risks with a potential patient impact and the BAF risks for which it has assigned oversight.

The key areas of focus at the Committee were, noting the full breath of the meeting's activity is included as an appendix to the paper.

Quarter 4 Patient Experience Report

The Director of Patient Experience, Engagement and Involvement provided the quarter 4 patient experience report. The Committee **noted** the actions taken in response to patient feedback received during quarter 4 for improving patient experience and was assured these are aligned to those areas within the agreed Patient Experience Strategy. The Committee **noted** the increase in positive results provided from the Friends and Family Test (FFT) patient responses, noting that the issue of waiting remains a key comment within negative comments. The Committee noted the data improvements that will flow from the Datix IQ roll out which will see the alignment the Trust's systems for reporting. The Committee was **assured** of the Trust's focus on learning from patient feedback to improve patient experience and noted the enhanced divisional reporting provided from the Trust's new FFT system provider.

Welcome Standards

The Committee **received** a report from the Deputy Director of Patient Experience on the Trust's developed welcome standards, noting their alignment to patient first. The Committee was **assured** that the standards are supported by a comprehensive training programme and monitoring regime. The Committee noted that the central team is working to ensure that this work is incorporated into the divisional standard work for staff joining their teams. The Committee **noted** the co-design of these standards from our staff aligned to learning from others and feedback from our patients and their carer's. The Committee **endorsed** these and their deployment across the Trust recognsing the benefit these will bring to our patients and to our staff. The Committee recognised that there is merit in considering these as a basis for welcoming staff into the organisation.

Patient First Strategic Initiative

The Committee **discussed** the Patient First Improvement Strategic Initiative and recognised the significant level of work undertaken across the Trust supporting the respective improvement projects aligned to the Trust's strategy. Through the work presented by the Deputy Director of Improvement and Delivery to the Committee and this report the Committee remained **assured** that Patient First remains central to the Trust's delivery of improvement, with a focus on divisional strategy deployment meetings including a focus on driver metrics supported the Kaizen Office with examples drawn out for the Committee. The Committee **noted** the Trust's business intelligence work has flowed into improved scorecard reporting supporting the divisional strategy deployment reviews. The Committee **noted** the improvement in access and completion of patient first training.

Health Inequalities

The Director of Clinical Outcome and Effectiveness provided an update on Health Inequalities reflecting on the challenges within our communities and the drivers to address these within the NHS Long Term plan working with those in our system. The Committee **noted** the focus and extended reporting requirements and the increased tracking for the work within the respective Health Inequalities Priorities.

Research and Innovation

The Committee **received** an update from the Clinical Director of Research and Innovation and **noted** the update on the progress being made to the recruitment of patients to open research studies with this recruitment being ahead of the breakthrough objective trajectory. The Committee also **noted** the successes within this programme of work within the last quarter as reported by the Clinical Director.

The Committee **discussed** the work being undertaken in respect of the developing Research and Innovation (R&I) Strategy and noted the impact that not having a R&I strategy is having on the progress within the delivery of work in this domain. The Committee **endorsed** the work being led by the Clinical Director supported by the Chief Medical Officer and Divisions and supported the plan for the development of

the R&I Strategy noting the draft strategy would be reported to the Committee for comment prior to its approval at the Board in the Autumn.

Patient Risks and BAF

The Committee **reviewed** the Trust's key risks with their potential to impact on patient experience and noted those with the highest current score and their alignment to the Patient Strategic Risk which had maintained its score of 16 across quarter 4. The Committee **noted** the work within the Quality Corporate Project will enhance the reporting of risk throughout the organisation through an enhanced focus on the assurance that the established controls are operating as intended along with the progress with the mitigating actions and that they will lower the risk. Whilst work is progressing the Committee reflected on the lag between the updates provided via the divisions on the work being undertaken that is improving the current risk scores and noted that for some of these risks there scores may be overstated. The Committee **endorsed** the work reported to the Audit Committee in respect of corporate support to the Divisions. The Committee **agreed** that the scores relating to BAF risks 1.1, 6.1, 6.2 and 6.3 for quarter 4 were fairly represented.

Referrals to other Committees

The Committee considered the reports and presentations it received at this meeting and **agreed** there were no matters it needed to refer to any other Committee.

Key Recommendation(s):

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

The Board is asked to **NOTE** the outcome of the Committees review of Quarter 4 BAF risks 1.1, 6.1, 6.2 and 6.3 and that the Committee's view is that these risks were fairly represented for the Quarter.

COMMITTEE ACTIVITY REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
Patient Committee	**25 April 2023**	**Claire Keatinge, Committee chair**	**yes**	**no**
			✓	☐

Declarations of Interest Made

There were no declarations of interest made

Activity of the Committee

Item	Presenter	Purpose of the paper	Action Taken
<u>Patient True North</u> Quarter 4 Patient Experience report	Director of Experience, Engagement and Involvement	For assurance	Assurance noted
Welcome Standards	Deputy Director of Experience, Engagement and Involvement	For endorsement	Support provided for these standards to be rolled out
Car Parking patient feedback	Deputy Director of Facilities and Estates	For information	Noted
<u>Patient Breakthrough Objective</u> March's data report	Director of Experience, Engagement and Involvement	To inform the Committee of the proposal to retire this breakthrough objective	Supportive of this progressing to the patient first steering group for final closure
<u>Patient Strategic Initiative</u> Patient First Improvement Report	Deputy Director of Improvement and Delivery	For assurance	Assurance noted
<u>Research and Innovation True North / Breakthrough Objective</u> Quarter 4 report Development of the Research and Innovation Strategy	Clinical Director of Research and Innovation Clinical Director of Research and Innovation	For assurance To inform the Committee on the progress being made in the development of the R&I Strategy	Assurance noted Endorsed the work undertaken and supported the plan for the development of the R&I Strategy
Health Inequalities	Director of Clinical Outcomes and Effectiveness	To provide an overview of the background to the focus on Health Inequalities and	Noted the update

		the work being undertaken by the Trust	
Escalation reports from reporting groups • Patient Experience and Engagement Group (PEEG) • Quality Governance Steering Group (QGSG)	Director of Experience, Engagement and Involvement / Deputy Chief Medical Officer	There were no matters requiring escalation to the Committee from PEEG or QGSG	No action was required
Patient linked risks	Chief Nurse	For support in the Committee's oversight of the BAF	It was noted that there remained a lag in the update of the risks and their scores and that work is to be done during the next month to improve this.
Quarter 4 BAF	Company Secretary	For agreement	Agreed the risks for which it has oversight were fairly represented for quarter 4.
Committee cycle of business	Company Secretary	For agreement that this business cycle supports the Committee to meet its Terms of Reference	Agreed

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	15	**Meeting:**	Trust Board	**Meeting Date:**	May 2023
Report Title:	Quality Committee Chair report to Board				
Sponsoring Executive Director:	Lucy Bloem, Committee Non Executive Chair				
Author(s):	Lucy Bloem, Committee Non Executive Chair				
Report previously considered by:					
Purpose of the report:					
Information	✓		Assurance	✓	
Review and Discussion	☐		Approval / Agreement	☐	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	☐		Staff confidentiality	☐	
Patient confidentiality	☐		Other exceptional circumstances	☐	
Link to ICB / Trust Annual Plan					
Link to ICB Annual Plan	☐	Link to Trust Annual Plan	☐		
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	☐				
Research and Innovation	☐				
Link to CQC Domains:					
Safe	✓		Effective	✓	
Caring	✓		Responsive	✓	
Well-led	✓		Use of Resources	✓	
Regulatory / Statutory reporting requirement					
Communication and Consultation:					

Executive Summary:

The Quality Committee meets monthly and therefore this report covers three meetings in February, March and April 2023. The meetings were quorate, attended by at least two Non-Executive Directors and two executives. In attendance at the meetings were the Trust's Medical Director, along with the Director of Patient Safety and Learning Director of Midwifery and the Director of Infection Prevention and Control (the latter was represented by their Assistant Director (IPC) at the February meeting). The Chief Nurse gave apologies to the February and April meetings and an interim Chief Nurse was in post for the March meeting. At the April meeting, the Committee welcomed the newly appointed Chief Medical Officer.

At each of the meetings the Committee received its planned items including, the quality scorecard, the perinatal quality surveillance dashboards, Serious Incident Reports and Duty of Candour reports and reports from the Committee's reporting group: Quality Governance Steering Group (QGSG) as well as the reports on the respective Patient First Trust Norths, Breakthrough Objectives, Strategic Initiatives and Corporate Projects. The exceptions were the Boarding Policy, Safeguarding Quarter 3 Reports and the Learning from Deaths Quarter 4 report that were deferred from the April 2023 meeting to the Committee's meeting in May.

Quality Dashboard

The Committee at each meeting discussed the key elements within Patient Experience. The Committee **NOTED** that the patient experience data did not show the decline in positive feedback that might had been expected given the extraordinary waiting times and physical space pressures experienced in emergency departments (ED). The Committee received a CQC Action Update from RSCH ED Nursing Leadership in the April 2023 meeting and were impressed by actions taken in the RSCH ED to preserve patient privacy and dignity. The Committee noted the patient feedback continued to be positive and while the Emergency Departments remained the most vulnerable in respect of patient feedback, there had been indications of improvement.

The Committee discussed the key elements relating to Patient Safety trends in incident learning as well as the Trust's performance in the associated processes around incidents including the timeliness of incident investigation, complaince and adherence to duty of candour. It was noted at the March meeting that that there was a reduction in duty of candour compliance (regulalation 20) in quarter 3 in sending the initial Duty of Candour letter alongside a recovery plan. The April meeting received an update on the developments to the incident reporting system that will support timely prompting of the necessary actions and oversight.

The Committee **NOTED** that all clinical effectiveness support processes had continued to face significant resource and capacity pressures due to a period of restructure coinciding with considerable vacancies. The committee recognises that there is gap in formal assurance around clinical guidelines and clinical audits. The newly appointed Director of Clinical Effectiveness has provided updates to the committee on the resourcing of their team and maturing of trust-wide arrangements through which the committee will be able to gain assurance.

Following the approval of the Mental Health Strategy in January and work with system partners in the last quarter, the Committee had received a paper in April on the serious incidents and investigations,metrics and risk and priorities associated with the care of patients with mental health needs and how the Trust is able to manage these needs in our Emergency Departments and in caring for children and young people. The committee also discussed workforce well-being and safety. The committee noted that two reports had been commissioned by the NHS Sussex Integrated Care Board; one covering pathway design and a parallel rapid independent review to explore opportunities for swift system responses. Committee has asked for a further update on the risks raised.

Mortality

The Committee noted that rolling crude mortality continues to rise monthly and the Trust Standardised Hospital Mortality Indicator exceeds the scorecard target, with higher SHMI values at the Princess Royal Hospital (PRH). As previously reported the board is aware of the raised Standard Hospital Mortality Indicator (SHMI) at the over a significant period. The Committee received an external report that explained the underlying reason was the introduction of a same day emergency care (SDEC) within the hospital which had a statistical impact on the reporting measure and was not a safety concern.

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. It also received Perinatal Mortality Review Tool reports for Q3 and Q4 and Regulation 28 Report to Prevent Future Deaths relating to a maternal death. The Committee considered each of the dashboards across each of the domains of; learning from any deaths or incidents; training which had continued to show good compliance levels; and the voice of the service user for which the information in respect of the Trust's friends and family rates and resultant actions are reported to the Patient Committee.

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 discussed the East Kent Maternity Report together with a historic maternity Serious Incident review for Sussex commisoned by the Integrated Care Board with the themes, mitigations and action plan.

The committee discussed challenges for the maternity services including theatre capacity and workforce challenges and impact of this on our workforce. The Committee spent time looking at risks around neonatal services which include the specialist nature of the Trevor Mann Baby unit and the higher risk births that are referred there. The Committee noted a thematic review undertaken had been undertaken by the Health Safety Investigation Branch (HSIB) on a number of neo-natal deaths. While this did not identify a failing leading to deaths, this identified specifics around foetal monitoring and additional learnings for the Trust overall that the committee will bring back to review in how we ensure this feedback is acted upon.

The Committee noted that University Hospitals Trust, Sussex is one of the (30) Trusts in the maternity safety support programme (MSSP) resultant from a past CQC inspection of maternity services and noted the considerable work done to compile actions from disparate plans into a single improvement plan.

Clinical Harm Reviews

The Committee received Clinical Harm Reviews at their February meeting through which assurance was sought around Specialist, Cancer, Emergency Department following the increasing numbers of patients waiting longer for treatment and at risk of harm as a result. The Committee scrutinised the outcomes of reviews undertaken for those patient exceeding the time from referral to treatment standards for planned care and cancer pathways. The committee noted the process whereby findings were then considered by the Serious Incident Review Group (SIRG). Some reviews were overdue due to operational pressures, including the need to redirect surgeons to focus on delivery of clinical activity and their work on surgical pathways.

The committee noted the findings of ED clinical harm reviews and recent inquests that indicated that harm resulting from delays in admission and ambulance handovers. Challenges to Patient flow in the ED were concluded as a source of significant harm for at risk patients and the Committee was encouraged by the reports from the ED nursing leadership of the impact that pressure relieving actions including the Boarding Policy, had on enabling improvement of patient care. It also noted the work undertaken in RSCH ED to stop preventable falls.

The Committee discussed that whilst no significant harms were identified, the report did provide evidence of changes being made as a result of the work on reducing waits for future patients and the report had provided **assurance** regarding the processes followed and their alignment to the national guidance and process governance.

Learning from Deaths

Learning from Deaths - Q4 report was deferred and Committee were updated on the reasons for that which included the start of a new lead and an ongoing review of data and reporting. From the learning from deaths update received it was noted there remained an identified gap in assurance around alignment across sites and a backlog in structured judgement reviews (SJRs) however, the Committee was assured by the clear plan in place to address that.

Safeguarding

At the meeting in April the Committee **received** the quarterly reports for Adults' and Children's Safeguarding activity. The Committee noted information in the Safeguarding reports but have asked for further

assurance. Through the Chief Nurse, the Committee were assured that a number of meetings had been taking place both internally and with system partners however further assurances were sought to come back to the May meeting.

Care Quality Commission (CQC) action plans

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. The Committee scrutinised progress and **noted** significant progress in some of these areas and discussed the approach to their appropriate status recording. General Surgery was a corporate project and the Committee received an update from Surgery update from divisional chief on progress made. The Chief Committee noted the update from the chief executive on the dialogue with CQC around the restriction on the Trust's license to perform upper GI surgery.

Infection Prevention and Control Board Assurance Framework

The reports were received and noted. The Committee noted that surgical site infections (SSI) data had not been included but will be reported to the Committee through 2023/24.

Risks and Board Assurance Framework (BAF)

The Committee reviewed the Trust's key risks with the potential to impact on quality and noted those with the highest current score and their alignment to the areas that the Committee had continued to scrutinise for assurance. The Committee noted the very high number of highly rated risks fall within the Quality Committee remit. These were reviewed at each meeting and used to inform the committee agenda.

The Committee noted the work within the Quality Corporate Project will enhance the reporting of risk throughout the organisation through an enhanced focus on the assurance that the established controls are operating as intended along with the progress with the mitigating actions and that they will lower the risk. Whilst work is progressing the Committee reflected on the lag between the updates provided via the divisions on the work being undertaken that is improving the current risk scores and noted that for some of these risks they may be overstated. The Committee endorsed the work reported to the Audit Committee in respect of corporate support to the Divisions.

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. The Committee supported the continuation of 4.2 at 20 and retaining 4.1 at 16.

Referrals to other Committees

The Committee considered the reports and presentations it received at this meeting and **agreed** there was only one matter it needed to refer to another Committee. This concerned the area where a correction had been required around Perinatal Mortality Data and the committee invited consideration of internal audit for assurance over the robustness of the data capture and processing within spreadsheets.

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.

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Quality Committee	**2 March 2023 (February)** **28 March 2023** **25 April 2023**	**Lucy Bloem**	✓	☐

Declarations of Interest Made
No declarations were raised

Items received at the Committee meeting

Item	Meeting Feb	Mar	Apr	Presenter	Purpose	Outcome Action taken
Focus, Operation and Priorities of the Committee						
QGSG reports	X	X	X	Interim/Deputy Chief Medical Officer	For information	Noted
Quality Dashboard (excl Maternity) Safe, Effectiveness, Experience, Mor	X	X	X	Deputy Chief Medical Officer	For information	Noted
Quality Dashboard Redevelopment	X			Deputy Chief Medical Officer / Chief of Service Women & Children	For information	Noted
Mortality - Summary Hospital-level Mortality Indicator (SHMI)		X	X	Deputy Chief Medical Officer	For information	Noted
Learning from Deaths Assurance Report			X	Mortality & Learning from Deaths Manager	For Assurance	Noted information Defer to May 2023
End of Life Care Review	X			Lead Nurse, Palliative and End of Life Care	For information	Noted Return to Committee and Risk added
Clinical Harms Review	X			Interim Chief Medical Officer	For information	Noted
Harm Counter Measure Summary Reports (True North and Breakthrough)	X	X		Director Patient Safety & Learning	For information	Noted
Serious Incidents Q3, Q4 & Duty of Candour Q3	X	X	X	Director Patient Safety & Learning	For assurance	Assurance Noted

Strategic Initiative - General Surgery			X	Chief of Service Surgery RSCH/PRH	For information	Noted
Corporate Project – Enhancing Quality Governance Counter Measure Summary	X	X		Company Secretary	For information	Noted
Perinatal Quality Surveillance Report and Dashboards	X	X	X	Director of Midwifery	Approved Noted Q3 Correction	Referral to Audit Committee
Prevention of Future Deaths Reg28 Report and Response		X		Deputy Chief Medical Officer / Chief of Service Women & Children	For information	Noted
East Kent Maternity Report -	X			Director of Midwifery	For information	Noted To receive & oversee delivery plan
RSCH Obstetric Theatre Capacity		X		Deputy Chief Medical Officer / Chief of Service Women & Children	For information	Noted - Update to Jul23
Maternity (Historic) Serious Incidents Report	X			Director of Midwifery	For assurance	Noted Assured by Sussex Review
Midwifery Workforce		X		Director of Midwifery	For assurance	Noted Assurance from FFT Requested Update on Sickness rates
Safe, Effective, Caring, Well Led and Responsive						
Item	**Meeting** Feb	Mar	Apr	**Presenter**	**Purpose**	**Outcome /Ref to Action**
Infection Prevention & Control Q3 Report	X			Director of Infection, Prevention & Control	For information	Noted
Infection Prevention and Control Board Assurance Framework	X			Director of Infection, Prevention & Control	To agree	Approved
Venous Thromboembolism Deep Dive	X			AD Patient Safety Director / Jo Habben, Director Patient Safety & Learning	For information	Noted Action to Bring Future thematic reviews
CQC Update / Action Plans	X	X		Interim Chief Medical Officer	For information	Noted

Quality Impact Assessment Q3	X			Interim Chief Medical Officer	Consider Panel Rec-omendation	Endorsed panel view to progress projects
Mental Health Update		X		Deputy Chief Medical Officer	For information	Noted Supported MH Risk to May 23
Medication Governance and Electronic Prescribing and Medicines Administration (EPMA) incidents		X		Chief Pharmacist	For information	Noted
Risk						
Trust Risk Register relating to Quality	X	X	X	Interim Chief Medical Officer	For information	Noted
Board Assurance Framework			X	Company Secretary	For agreement	Agreed risks fairly stated

Actions taken by the Committee within its Terms of Reference

The Committee **AGREED** to recommend the risk score for BAF risks 4.1 and 4.2 to the Board for the start of quarter 1 2023/24.

The Committee received the Adult Safeguarding and Child Safeguarding Quarterly Reports

The Committee received the Infection Prevention and Control Quarterly Reports

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

Learning from Deaths (LFD) 2022/23 Q4 Report was due to be brought to the April meeting but was asked to be brought to the May 2023 meeting in conjunction with the LFD Annual Report

Safeguarding Adults and Safeguarding Children 2022/23 Q3 Reports. The Committee asked for these to be brought back to the Quality Committee in May.

In February 2023 the Committee received an update on the progress in implementation of the Palliative and End of Life Care Strategy for 2022/23, and the associated key ambitions for 2023/24. The Committee NOTED an outstanding approach to End of Life Care and use of the Patient First methodology to the acute care provided to realise the ambitions. The Committee asked that an update comes back in August 2023 and that a risk is recorded within the Quality Risk Register pertaining to the 7-day palliative care nursing service

Boarding Policy (Full Protocol). This had not been brought to Committee when scheduled for February 2023 due to the impact on Urgent and Emergency Care leadership teams during industrial action and is rescheduled for May 2023.

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

Item	Date
Quality Committee invited the Audit Committee to determine, in conjunction with the Trust's internal auditors, if further additional assurance over the robustness of the data capture and processing within spreadsheets is warranted.	**March 2023**

University Hospitals Sussex NHS Foundation Trust

Agenda Item:	16	**Meeting:**	Trust Board	**Meeting Date:**	May 2023
Report Title:	People Committee Chair's Report				
Sponsoring Executive Director:	Patrick Boyle, Non-Executive Director				
Author(s):	Patrick Boyle, Non-Executive Director				
Report previously considered by :					
Purpose of the report:					
Information	✓		Assurance	✓	
Review and Discussion	☐		Approval / Agreement	☐	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	☐		Staff confidentiality	☐	
Patient confidentiality	☐		Other exceptional circumstances	☐	
Link to ICB / Trust Annual Plan					
Link to ICB Annual Plan	☐	Link to Trust Annual Plan	☐		
Implications for Trust Strategic Themes and any link to BAF risks					
Patient	☐				
Sustainability	☐				
People	✓	People Risks 3.1 to 3.4			
Quality	☐				
Systems and Partnerships	☐				
Research and Innovation	☐				
Link to CQC Domains:					
Safe	✓		Effective	✓	
Caring	✓		Responsive	✓	
Well-led	✓		Use of Resources	✓	
Regulatory / Statutory reporting requirement					
Communication and Consultation:					

Executive Summary:

The People Committee met formally at its increased frequency on 3 March 2023 (February meeting) and and was quorate as it was attended by three Non-Executive Directors, as well as the Chief People Officer, the Chief Operating Officer and Chief Executive. In attendance were the Director of Human Resource Management, the Director of Integrated Education, the Director of Workforce Planning and Deployment, Director of Medical Education, and the Associate Director for Leadership, OD and Engagement attended the February Meeting. The Guardian of Safe Working Hours for Worthing and St Richards joined both meetings for their elements 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; the Staff Survey report; a presentation in respect of CSS showing the corporate project oversight for people improvements; updates on health and wellbeing, leadership, culture and development; the Medical Workforce Systems review; workforce scorecard (KPIs), an update on the activity of the Freedom to Speak up Guardian as well as reports from the Guardian of Safe Working Hours.

<u>True North, Staff Engagement</u>

The Committee considered the countermeasure summaries against the People Breakthrough Objective 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, having reference to the associated Board Assurance Framework risks, had a detailed discussion on the Appraisal process and instructions provided to line managers.

The Committee received at the April meeting an update from the Clinical Support Services division that outlined the workforce challenges and opportunities in their services that reflected considerable multi-professional diversity. The Committee gained ASSURANCE through a Spotlight on the Clinical Support Services divisional arrangements which included the practical arrangements for staff engagement and work on inclusion and diversity and managing sickness absence.

The Committee reviewed the developed workforce dashboard and noted its continued development. The Committee noted that the apparent increase in sickness absence. The Committee has taken significant interest in how the Trust can respond to support its staff with the rising costs of living. The Committee heard updates regarding the crisis support hardship which summarises the sector benchmarking, progress to date and the phase 2 next steps.

The Committee acknowledged that staff who could be anticipated to be at greatest risk of hardship might be in roles hardest to reach through traditional corporate communication routes and sought assurance around the arrangements for informing those staff of the available support arrangements, car parking. The Committee asked to see learning from demographic and protected characteristic analysis in respect of staff hardship applications and support provided. While the data received and examined at the April meeting of the Committee showed no disproportionate impact, limited uptake suggested the support arrangements would be further marketed. Learning and the benchmarking of uptake from similar organisations was sought to give further assurance to the Committee that the arrangements were accessible to those in need.

The Committee received a referral from Charitable Funds Committee to confirm the arrangements for scrutiny of volunteers risks visible to the Committee. The Committee NOTED there is development of a Strategy for Volunteers were undergoing consideration by executives that would be brought to the Committee with Strategy together with associated risks.

The Committee noted that the National Staff Survey Results had been shared more contemporaneously than in previous years. The Committee received updates and were ASSURED all divisions had their results, and heard they had shared these with their staff and commenced the action planning stage.

The Committee recognised hot spot areas of discontent and tested through Divisional Presentations the arrangements through which the committee can be assured of staff voices being heard. The Committee noted the imperative for divisional leadership demonstrating their risks associated with tight externally driven timescales, coinciding with business planning and industrial action.

<u>Breakthrough Objective, Staff Voice</u>
Around Staff Voice, the Committee heard Focus Groups had taken place to develop divisional plans and inform Trust plans and were assured that proactive actions were underway to give staff confidence actions would be taken.
Assured Corporate Actions had been completed and were aligned findings with other sources of staff comments including those reaching the freedom to speak up FTSU guardian. Asked to test the validity of the pulse survey and its suitability as a predictor of the staff survey issues.

Through summarised feedback from Divisional focus groups, the Committee heard that the Freedom to Speak Up (FTSU) Guardian function needed wider publicity. The procurement towards a procured Guardian Service pending the Trust's appointment of a lead following an unsuccessful recruitment.

The Committee received a spotlight on the Clinical Support Services divisional arrangements which included the practical arrangements for staff engagement and work on inclusion and diversity and managing sickness absence.

Leadership, Culture and Development
The Committee heard about the process for developing outcome measures on Leadership, Culture and Development and discussed the options considered as measure of inclusions and performance in recruitment process and in exposure to violence and aggression.

Guardian of Safe Working Reports
The Committee in receiving the reports from the Guardian of Safe Working Hours had previously noted the differential oversight at Royal Sussex County and Princess Royal compared to Worthing and St Richards. At the April meeting, a whole Trust lead role was confirmed, supported by two new medical workforce officers. The Guardian of safe working advised that bolstered medicine rotas had led to a considerable reduction in exception reporting in the Quarter. Rota Redesign was highlighted as a particular need at St Richards Hospital and Rota Gaps were a recognised issue at RSCH and trainees highlighted missed breaks. The Committee were assured that the Junior Doctor's forum had been active in the quarter and noted the feedback comments received.

The Committee remained assured by the update from the Guardian of Safe working that the 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 medical workforce officers supporting the whole Trust Guardian had helped to ensure the performance measure around use of funds had improved during the reporting period.

The Committee received the Medical Workforce Steering Group had been convened, chaired by the new Chief Medical Officer. The Medical Workforce report provided progress with the procurement and validation testing of Appraisal rostering system, the rostering system and communications mechanisms. The Committee were ASSURED that the rollout of the new system remained on schedule.

Risks and Board Assurance Framework (BAF)
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. The Committee noted the work within the Quality Corporate Project will enhance the reporting of risk throughout the organisation through an enhanced focus on the assurance that the established controls are operating as intended along with the progress with the mitigating actions and that they will lower the risk. Whilst work is progressing the Committee reflected on the lag between the updates provided via the divisions on the work being undertaken that is improving the current risk scores and noted that for some of these risks they may be overstated. For Strategic Risks on the Board Assurance Framework risk 3.3 was confirmed to remain scoring 20 for Quarter 4.

Referrals to other Committees

The Committee considered the reports and presentations it received at its meetings and **agreed** there were no matters it needed to refer to any other Committee.

Key Recommendation(s):

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

The Board is asked to NOTE 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 4.

University Hospitals Sussex NHS Foundation Trust

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
People Committee	**3 March 2023 (February)** **26 April 2023**	**Patrick Boyle**	✓	☐

Declarations of Interest Made

There were no Declarations of Interest made

Items received at the Committee meeting

Item	Feb	Apr	Presenter	Purpose	Outcome/ Action taken
True North – Staff Survey Results	X	X	Director of Human Resources Mgt	For information	Noted
Divisional Updates		X	Divisional Director of Operations Clinical Support	For information	Noted
Breakthrough Objective – Staff Voice that Counts		X	Director of Human Resources Mgt	For information	Noted
Freedom to Speak Up		X	Chief People Officer	For information	Noted
Strategic Initiative – Cost of Living Demographics/ Response	X	X	Chief People Officer	For information	Noted To come back
Appraisals Update		X	Chief People Officer	For information	Noted
Leadership Culture and Development KPIs - Violence Prevention, Equalities		X	Chief People Officer	For information	Noted
Health & Wellbeing Hub Update	X		Chief People Officer	For information	Noted
Medical Workforce Systems, Corporate Project Charter Quarterly Report		X	Director of Workforce Planning	For information	Noted
Medical Workforce Systems Business Case	X		Director of Workforce Planning	For information	Noted Audit invited
People Scorecard and KPI Report		X	Director of Workforce Planning Helen Weatherill, Director of Human Resources Mgt	For information	Noted
Workforce Planning and Development		X	Director of Workforce Planning	For information	Noted
Guardian for Safe Working Q4 Reports		X	Guardian of Safe Working	For information	Noted

University Hospitals Sussex
NHS Foundation Trust

Item	Feb	Apr	Presenter	Outcome	Ref to Action
Updates from Reporting Groups - Diversity - Integrated Education - NMC		X	AD Leadership, OD & Engagement Martyn Clark, Director of Integrated Education	For information	Noted
Annual Equality Report	X		AD Leadership, OD & Engagement	For information	Noted
Recruitment Deep Dive	X		Director of Workforce Planning	For information	Noted
Updates on Integrated Care System		X	Chief People Officer	For information	Noted
Trust Risk Register relating to People	X	X	Chief People Officer	For information	Noted
Board Assurance Framework		X	Chief People Officer	For agreement	Agreed Risks are fairly stated

Actions taken by the Committee within its Terms of Reference

The Committee **AGREED** to recommend the Quarter 4 score for BAF risks 3.1 to 3.4 to the Board approaching Quarter 1 2023/24

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

1) At the March Trust Strategy Deployment Review the Committee sought correlation between the Pulse Survey and National Staff Survey measures and were ASSURED of the pulse survey validity.
2) The Committee asked for immediate safety concerns to be RAG rated in the Guardian of Safe Working report. This was confirmed to have been actioned in the report received in April 2023.
3) The Committee NOTED the work to enhance the People Scorecard remained work in progress. The staff absence KPI was NOTED to be especially adverse and had represented a peak in March 2023 and would be subject to a Deep Dive in the May 2023 meeting of the Committee.
4) The Committee invited the use of an audit of the system roll out and the application of efficiency tools within the rostering system.
5) The Committee will receive April slides on the Integrated Commissioning Board ICB sees as priorities for the Sussex People Strategy following a meeting at the end of April 2023.

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

Item	Date
The Committee considered the reports and presentations it received at the meetings and agreed there were no matters it needed to refer to any other committee	

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	16	**Meeting:**	Trust Board	**Meeting Date:**	4th May 2023
Report Title:	2022 NHS Annual Staff Survey Results				
Sponsoring Executive Director:	David Grantham, Chief People Officer				
Author(s):	David Grantham, Chief People Officer				
Report previously considered by and date:	People Committee Trust Management Committee				

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

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

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	✓	Link to Trust Annual Plan	✓

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

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

Regulatory / Statutory reporting requirement

Communication and Consultation:

Executive Summary:

The purpose of this paper is to highlight the 2022 NHS Staff Survey results for University Hospitals Sussex Foundation Trust. The paper sets out the steps taken to feedback the results to staff and the methodology and governance arrangements in place to support the development and implementation of the corporate and divisional action plans.

Context

The NHS Staff Survey is one of the largest workforce surveys in the world and has been conducted every year since 2003. 46 % (636,348) NHS staff participated in the survey down 2% on the previous year.

The survey asks NHS staff in England about their experiences of working for their respective NHS organisations.

Over 1.3 million NHS employees in England were invited to participate in the survey between September and December 2022.

Since 2021, the survey questions have been aligned with the NHS People Promise, which sets out in the words of NHS staff the things that would most improve their working experience.

UH Sussex Results

45% (7388) of UH Sussex staff completed the 2022 Staff Survey.

Overall UH Sussex scored lower than average across all people promises except “we work flexibly” which is same as average.

6/9 people promises/themes were lower scores than 2021(3 lower with *statistical significance* and 3 without), and 2/9 were better (with *statistical significance*) - according to testing by co-ordination centre (but apply some caution due to methodological issues)

The Staff Survey results have been shared with staff at Trust wide and divisional level.

Corporate and Divisional plans have been developed using our Patient First improvement methodology and delivery of these plan will be monitored through our People “True North”, Trust and Divisional SDRs and People Committee.

Key Recommendation(s):

The Committee is asked to discuss and note the 2022 Annual Staff Survey Results.

University Hospitals Sussex
NHS Foundation Trust

National NHS Staff Survey 2022

Results summary

David Grantham
Chief People Officer
April 2023

Executive Summary

University Hospitals Sussex NHS Foundation Trust

- The 2022 NHS Staff Survey was conducted in September and October 2022
- Results were published on 9th March 2023
- UH Sussex scored lower than average across all people promises except “we work flexibly” which is same as average
- 6/9 people promises/themes were lower scores than 2021(3 lower with *statistical significance* and 3 without), and 2/9 were better (with *statistical significance*) - according to testing by co-ordination centre (but apply some caution due to methodological issues)
- WRES metrics are mixed vs national results with some slightly higher scores and some slightly lower
- WDES metrics also show a mix but with more lower scores

Participation Summary 2022

University Hospitals Sussex
NHS Foundation Trust

University Hospitals Sussex NHS Foundation Trust

Organisation details

Completed questionnaires	7388
2022 response rate	45%

Survey details

Survey mode	Mixed

2022 NHS Staff Survey

This organisation is benchmarked against:

Acute and Acute & Community Trusts

2022 benchmarking group details

Organisations in group: 124

Median response rate: 44%

No. of completed questionnaires: 431292

People Promise / Themes

University Hospitals Sussex NHS Foundation Trust

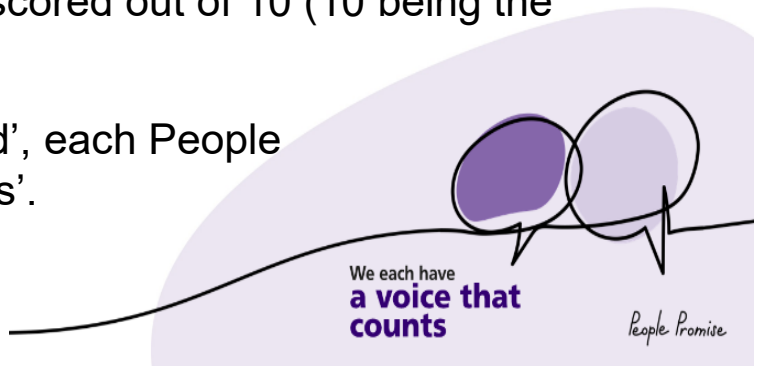
- 2022 National Staff Survey results published on 9th March 2023
- People Promise / Theme scores:

1. We are compassionate and inclusive
2. We are recognised and rewarded
3. We each have a voice that counts
4. We are safe and healthy
5. We are always learning
6. We work flexibly
7. We are a team
8. Staff engagement
9. Morale

7 People Promises

2 Themes

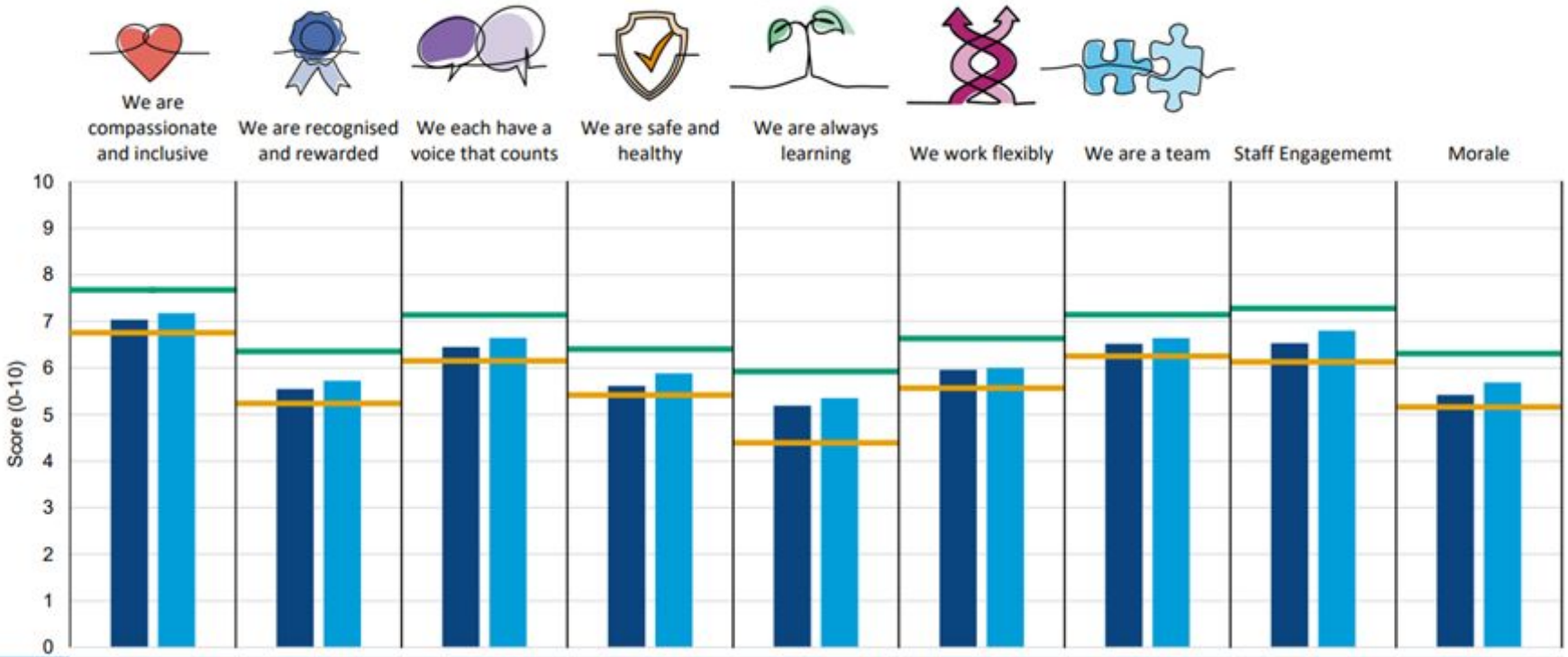
- These are made up of key staff survey questions and scored out of 10 (10 being the highest)
- With the exception of ‘we are recognised and rewarded’, each People Promise / Theme is broken into a number of ‘subscores’.



People Promise / Theme Summary

University Hospitals Sussex
NHS Foundation Trust

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score.**



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	7.0	5.5	6.4	5.6	5.2	6.0	6.5	6.5	5.4
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	7339	7330	7272	7310	6972	7286	7321	7358	7352

Historical Variation

University Hospitals Sussex
NHS Foundation Trust

Comparison of UH Sussex variance from 2021 to 2022 compared to National Sector average variance for 2021 to 2022 for Acute and Acute and Community Trusts.

Highlights are shown for UH Sussex variance (Negative/Positive) against 2021

People Promise / Theme	2021 National Sector average (124 Trusts)	2022 National Sector average (124 Trusts)	Sector Variance 21-22	2021 UHSx	2022 UHSx	UHSx Variance 21-22
We are Compassionate and Inclusive	7.2	7.2	SAME	7.1	7	-0.1
We are recognised and rewarded	5.8	5.7	-0.1	5.6	5.5	-0.1
We each have a voice that counts	6.7	6.6	-0.1	6.5	6.4	-0.1
We are Safe and Healthy	5.9	5.9	SAME	5.7	5.6	-0.1
We are always learning	5.2	5.4	0.2	5	5.2	0.2
We work Flexibly	6	6	SAME	5.9	6	0.1
We are a team	6.6	6.6	SAME	6.5	6.5	SAME
Staff Engagement	6.8	6.8	SAME	6.6	6.5	-0.1
Morale	5.7	5.7	SAME	5.5	5.4	-0.1

Historical changes – UH Sussex

University Hospitals Sussex
NHS Foundation Trust

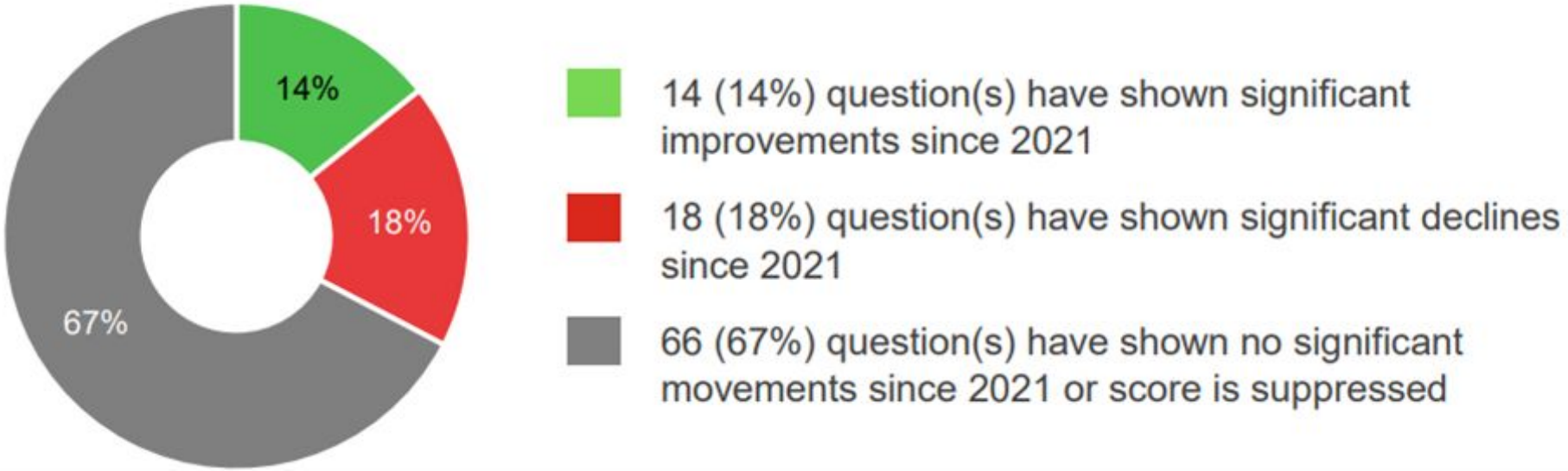
People Promise elements	2021 score	2021 respondents	2022 score	2022 respondents	Statistically significant change?
We are compassionate and inclusive	7.1	8050	7.0	7339	Not significant
We are recognised and rewarded	5.6	8023	5.5	7330	Significantly lower
We each have a voice that counts	6.5	7970	6.4	7272	Not significant
We are safe and healthy	5.7	8006	5.6	7310	Not significant
We are always learning	5.0	7564	5.2	6972	Significantly higher
We work flexibly	5.9	7969	6.0	7286	Significantly higher
We are a team	6.5	8025	6.5	7321	Not significant
Themes					
Staff Engagement	6.6	8057	6.5	7358	Significantly lower
Morale	5.5	8058	5.4	7352	Significantly lower

Please apply caution when referring to these significance tests, they are carried out by the Survey co-ordination centre, but do not appropriate kind of statistical analysis

Significant Questions

University Hospitals Sussex
NHS Foundation Trust

- UH Sussex question scores compared to 2021.
- Summarises questions that have shown statistically significant improvements or declines since the 2021 National Staff Survey (Quality Health significance testing)
- Of the 98 comparable evaluative core questions (6 non-comparable to 2021), 14% of questions have improved since 2021, 18% have declined and have 67% show no significant movement. This shows that the majority of induvial question scores have remained stable since 2021.



The approach of significance testing on individual items taken here by quality Health is not recommended by statisticians/ our in-house data analyst, and is subject to inaccuracies. Therefore, please apply caution when interpreting these results

Staff Engagement

University Hospitals Sussex NHS Foundation Trust

Trust Compared to National Sector - Acute and Acute & Community (124 organisations)

		Q	Staff Engagement Questions	UHSx 2020 %	UHSx 2021 %	UHSx 2022 %	variance 2021 vs 2022	National Sector (n124) Avg 2020	National Sector (n124) Avg 2021	National Sector (n124) Avg 2022	Variance UHSx vs National 2022
Staff Engagement Theme	Subscore 1: Motivation	2a	I look forward to going to work (Often/Always).	58%	47%	47%	SAME	59%	52%	52.5%	-6%
		2b	I am enthusiastic about my job (Often/Always).	72%	62%	62%	SAME	73%	68%	67%	-5%
		2c	Time passes quickly when I am working (Often/Always).	75%	71%	70%	-1%	76%	73%	72.5%	-3%
	Subscore 2: Improvement	3c	There are frequent opportunities for me to show initiative in my role (Agree/Strongly agree).	72%	70%	70%	SAME	72%	72%	73%	-3%
		3d	I am able to make suggestions to improve the work of my team / department (Agree/Strongly agree).	74%	70%	70%	SAME	73%	70%	71%	-1%
		3f	I am able to make improvements happen in my area of work (Agree/Strongly agree).	57%	51%	51%	SAME	55%	53%	55%	-4%
	Subscore 3: Staff Advocacy	23c	I would recommend my organisation as a place to work (Agree/Strongly agree).	67%	54%	49%	-5%	67%	58%	56.5%	-8%
		23d	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	75%	65%	57%	-8%	74%	67%	62%	-5%
		23a	Care of patients / service users is my organisation's top priority (Agree/Strongly agree).	79%	72%	69%	-3%	79%	75.5%	73.5%	-5%
			Staff Engagement Score (True North)	7.0	6.6	6.5	-	7.0	6.8	6.8	-

Divisional People Promise / Theme Scores

University Hospitals Sussex NHS Foundation Trust

Traffic light reporting is based on comparison to **National Average % score**

People Promise and Themes	UHSx %	National Sector (n124) Avg	Cancer Division	CSS Division	Facilities and Estates	Medicine (RSCH & PRH) Division	Medicine (WOR & SRH) Division	Specialist Division	Surgery (RSCH & PRH) Division	Surgery (WOR & SRH) Division	Womens & Childrens Division	Corporate Divisions
	2022	2022	2022	2022	2022	2022	2022	2022	2022	2022	2022	2022
We are compassionate and inclusive	7.0	7.2	7.2	7.0	6.9	6.9	7.1	6.9	6.7	7.1	7.3	7.1
We are recognised and rewarded	5.5	5.7	5.8	5.4	5.7	5.5	5.5	5.4	5.2	5.5	5.5	6.0
We are safe and healthy	5.6	5.9	6.0	5.5	6.3	5.1	5.1	5.4	5.3	5.8	5.4	6.2
We are always learning	5.2	5.4	5.0	5.0	5.1	5.5	5.7	5.2	5.2	5.4	5.2	5.1
We work flexibly	5.9	6.0	6.3	5.7	6.0	6.3	6.0	5.9	5.6	5.9	5.5	6.4
We are a team	6.5	6.6	6.6	6.3	6.2	6.7	6.8	6.4	6.4	6.5	6.5	6.7
Staff engagement	6.5	6.8	6.6	6.4	6.6	6.4	6.6	6.6	6.1	6.7	6.7	6.6
Morale	5.4	5.7	5.8	5.2	5.9	5.2	5.3	5.3	5.1	5.7	5.3	5.7

Key: Greater than, Less than, Equal to the National Average

Divisional People Promise / Theme Scores

University Hospitals Sussex NHS Foundation Trust

Traffic light reporting is based on comparison to **UH Sussex % score**

People Promise and Themes	UHSx %	National Sector (n124) Avg	Cancer Division	CSS Division	Facilities and Estates	Medicine (RSCH & PRH) Division	Medicine (WOR & SRH) Division	Specialist Division	Surgery (RSCH & PRH) Division	Surgery (WOR & SRH) Division	Womens & Childrens Division	Corporate Divisions
	2022	2022	2022	2022	2022	2022	2022	2022	2022	2022	2022	2022
We are compassionate and inclusive	7.0	7.2	7.2	7.0	6.9	6.9	7.1	6.9	6.7	7.1	7.3	7.1
We are recognised and rewarded	5.5	5.7	5.8	5.4	5.7	5.5	5.5	5.4	5.2	5.5	5.5	6.0
We each have a voice that counts	6.4	6.6	6.5	6.3	6.4	6.4	6.6	6.4	6.2	6.5	6.6	6.5
We are safe and healthy	5.6	5.9	6.0	5.5	6.3	5.1	5.1	5.4	5.3	5.8	5.4	6.2
We are always learning	5.2	5.4	5.0	5.0	5.1	5.5	5.7	5.2	5.2	5.4	5.2	5.1
We work flexibly	5.9	6.0	6.3	5.7	6.0	6.3	6.0	5.9	5.6	5.9	5.5	6.4
We are a team	6.5	6.6	6.6	6.3	6.2	6.7	6.8	6.4	6.4	6.5	6.5	6.7
Staff engagement	6.5	6.8	6.6	6.4	6.6	6.4	6.6	6.6	6.1	6.7	6.7	6.6
Morale	5.4	5.7	5.8	5.2	5.9	5.2	5.3	5.3	5.1	5.7	5.3	5.7

Key: Greater than, Less than, Equal to the Trust Average

Workforce Race Equality Standard

University Hospitals Sussex NHS Foundation Trust

Question	Characteristic	UHSx 2021	UHSx 2022	National Sector Avg 2021	National Sector Avg 2022	Variance UHSx 2022 V National 2022
Indicator 5 - Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	31%	32%	25%	27%	5.0%
	BME	37%	38%	29%	31%	7.0%
Indicator 6 - Percentage of staff experiencing harassment, bullying or abuse from Staff in last 12 months	White	26%	25%	24%	23%	2.0%
	BME	29%	28%	29%	29%	-1.0%
Indicator 7 - Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	55%	54%	59%	59%	-5.0%
	BME	46%	50%	45%	47%	3.0%
Indicator 8 - Percentage of staff experiencing discrimination at work from their manager, team leader or other colleagues in the last 12 months	White	8%	8%	6%	7%	1.0%
	BME	15%	16%	17%	17%	-1.0%

* Significance testing still to be carried out

Workforce Disability Equality Standard

University Hospitals Sussex NHS Foundation Trust

Question	Characteristic	UHSx 2021	UHSx 2022	National Sector Avg 2021	National Sector Avg 2022	Variance UHSx 2022 V National 2022
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Disabled (LTC-illness)	36%	39%	32%	33%	6%
	Non-Disabled (without LTC-illness)	31%	31%	25%	26%	5%
Percentage of staff experiencing harassment, bullying or abuse from Manager in last 12 months	Disabled (LTC-illness)	18%	18%	18%	17%	1%
	Non-Disabled (without LTC-illness)	11%	10%	10%	10%	SAME
Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months	Disabled (LTC-illness)	27%	29%	27%	27%	2%
	Non-Disabled (without LTC-illness)	20%	18%	17%	18%	SAME
Percentage of staff saying the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	Disabled (LTC-illness)	46%	48%	47%	48%	SAME
	Non-Disabled (without LTC-illness)	43%	45%	46%	47%	-2%
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	Disabled (LTC-illness)	50%	51%	51%	51%	SAME
	Non-Disabled (without LTC-illness)	54%	54%	57%	57%	-3%
Percentage of staff who have felt pressure from their Manager to come to work, despite nor feeling well enough to perform their duties	Disabled (LTC-illness)	33%	28%	32%	30%	-2%
	Non-Disabled (without LTC-illness)	23%	22%	24%	21%	-1%
Percentage of staff satisfied with the extent to which their organisation values their work	Disabled (LTC-illness)	30%	29%	33%	33%	-4%
	Non-Disabled (without LTC-illness)	38%	37%	43%	44%	-7%
Percentage of disabled staff saying their employer has made adequate adjustments(s) to enable them to carry out their work	Disabled (LTC-illness)	72%	73%	71%	72%	1%
Staff Engagement score	Disabled (LTC-illness)	6.3	6.2	6.4	6.4	0.2
	Non-Disabled (without LTC-illness)	6.7	6.6	7.0	6.9	0.3

* Significance testing still to be carried out

Key Messages

University Hospitals Sussex NHS Foundation Trust

- UH Sussex lower than average across all people promises except “we work flexibly” which is same as national average
- 6/9 people promises/themes were lower in 2022 than 2021 (per scores/10), 2 were better, and 1 was the same
- 3/9 people promises/themes *significantly* lower scores and 2/9 *significantly* better scores according to testing by co-ordination centre but apply caution due to methodological issues
- WRES metrics are mixed vs national results with some slightly higher scores and some slightly lower
- WDES metrics also show a mix but with more lower scores
- Local questions generally show little change between 2021 and 2022.

Action Plan

University Hospitals Sussex
NHS Foundation Trust

Action	When	Lead	Status
Analyse NHS staff survey results	March 2023	Engagement, Health and Wellbeing Manager Data & Reporting Analyst	Completed March 2023
Share Trust wide results with staff	March 2023	Engagement, Health and Wellbeing Manager Communication Team	Completed March 2023
Divisions to share results with Teams	March 2023	Divisional leadership Team HRBP	Completed March 2023
Create a bespoke analytical tool to enable divisional results to be interrogated at a cost centre level	April 2023	BI Team	Completed April 2023
Divisions to determine top 5 areas for improvement and produce action plan	End of April 2023	Divisional leadership Team HRBP	Completed April 2023
Implement Divisional Action plans	May onwards	Divisional leadership Team HRBP	Commenced
Implementation of Divisional Action plans to be monitored through Divisional SDR and Trust SDR	May onwards	Divisional leadership Team	Commence May 2023

Action Plan

University Hospitals Sussex NHS Foundation Trust

Action	When	Lead	Status
Develop corporate workstreams to support Divisional Action plan themes	May 2023	Director of HRM Director of Communications	In progress
Report to People Committee detailing Divisional and corporate action plans	May 2023	Director of HRM	-Due May 2023
Develop plan to significantly increase 2023 staff survey response rate	June 2023	Engagement, Health and Wellbeing Manager	Due June 2023
Implement ongoing Trust and Divisional “You Said, We Heard, We did” communications	May 2023	Director of HRM Director of Communications	In progress

- Action plan also supported by Breakthrough Objective work on ‘staff voice that counts’ and the Leadership, Culture and OD strategic initiative covering leadership, violence prevention and reduction and EDI.
- Progress reporting to People Committee and via Trust and Divisional SDR meetings.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	17	**Meeting:**	Board	**Meeting Date:**	May 2023
Report Title:	Sustainability Committee Chair report to Board				
Committee Chair:		Lizzie Peers, Committee Non Executive Chair			
Author(s):		Lizzie Peers, Committee Non Executive Chair			
Report previously considered by and date:					
Purpose of the report:					
Information		☐	Assurance	✓	
Review and Discussion		☐	Approval / Agreement	☐	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		☐	Staff confidentiality	☐	
Patient confidentiality		☐	Other exceptional circumstances	☐	
Implications for Trust Strategic Themes and any link to BAF risks					
Patient	☐				
Sustainability	✓	Assurances in relation to risks 2.1, 2.2 and 2.3			
People	☐				
Quality	☐				
Systems and Partnerships	☐				
Link to CQC Domains:					
Safe		✓	Effective	✓	
Caring		✓	Responsive	✓	
Well-led		✓	Use of Resources	✓	
Communication and Consultation:					

Executive Summary:

The Sustainability Committee met on the 27 April 2023 and was quorate as it was attended by three Non-Executive Directors, the Chair, the Chief Financial Officer, the Chief Operating 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, the Director for Improvement and Delivery. A deputy was in attendance for the Director of IM&T and apologies were received from the newly appointed Managing Director Planned Care and Cancer.

The Committee received its planned items including the reports on the Sustainability True North, Breakthrough Objective (productivity), Strategic Initiative (environmental sustainability) and Corporate Project (estates strategy and master planning), along with a comprehensive report on the Trust's Financial Performance for the year to end March 2023, the Efficiency Programme, the Capital Programme, an IM&T update, an update on the Commercial team activities including procurement, an ICS finance update and a risk paper and the Board Assurance Framework.

<u>Financial position, year-end forecast and ICB financial update</u>

The Committee noted the Trust had delivered its year end deficit position as agreed with the NHS Sussex Integrated Care Board (ICB). The accounts are subject to external audit. The 2023/24 plan was not presented as this was being taken to the Board for discussion and approval. The CFO provided an update on ICB financial matters.

Efficiency Programme Q4 and 2023/24 plan

The Committee noted the current level of delivery of the year's efficiency. The Committee noted the Trust had delivered 88% of efficiencies against the annual efficiency plan total. The Committee noted that the main areas that did not deliver were around productivity and length of stay improvements. Through the update provided by the Director the Committee NOTED positive engagement with the divisional leaders in respect of the establishing the 2023/24 programme with an updated risk maturity due back to the next meeting. The Committee were assured that there continues to be a well-tested and robust system for delivery of efficiencies.

Capital Programme Q4 and 2023/24 plan

The Committee RECEIVED the Q4 update against the Trust's 2022/23 capital plan. The Committee NOTED the breadth of schemes delivered in the year and NOTED the important patient and staff benefits these schemes bring.
The Committee noted Trust's operational expenditure on capital had exceeded the operational element of the Trust's capital programme by 1.9% as agreed with the ICB, noting there was also necessary rephrasing of some of the schemes. The 3Ts capital expenditure was in line with the plan and funding.

The Committee received the capital plan 23/24 and noted the planned schemes delivering benefits for our patients and our staff across all hospital sites, although the plan is over-programmed and the usual rigorous prioritisation process would need to be applied to reduce this.

Productivity Breakthrough Objective

The Committee discussed the productivity breakthrough objective. The Committee RECEIVED an update from the Chief Finance Officer in the absence of the new Managing Director for Planned Care and Cancer. The Chief Finance Officer provided an update on each of the workstreams, covering Theatres, Outpatients and Speciality elective pathways as well as the ICB productivity workstream. The data for each area indicated clear opportunities for further improvement. The Committee noted that there had been some areas of improvement but also a number of areas where performance had deteriorated or remained unchanged so that overall the BO was not yet sustainably delivering the required improvement. However it was ASSURED from this update that a focus on the control oversight arrangements and the work being done on data analysis and quality will help drive the required improvements and allow the Trust to monitor its delivery in 2023/24. The Committee NOTED the progress made, the further work needed, the associated risks and the importance of increasing activity to the deliver the 2023/24 financial plan.

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 the delivery of the planned interventions to reduce the Trust's carbon emissions.
The Committee was ASSURED over the Trust's engagement with the ICS own green plans.
The Committee asked to receive a closure report to the next meeting on the Environmental Sustainability workstreams for 2022/23 detailing the Trust's measurable delivery against the targets and also the roadmap for 2023/24 and a longer term view.

Corporate Project - Estates Strategy and Master Planning

The Director of Capital presented an update on the Estates Strategy and Master Planning corporate project. The Committee NOTED progress of the initial stages through the established core group to shape the project delivery and to ensure this action is aligned to the Trust's key priorities encapsulated within the clinical strategy, supports the green plan through carbon reduction and the corporate and clinical activity expectations. The Committee NOTED the update and the engagement being undertaken through the launch of the project and its scope especially with the Divisions.

IM&T Programme update

The Committee RECEIVED the quarter 4 IM&T Programme Report on the Trust's wide-ranging IM&T programme of work. The Committee NOTED the update provided by representatives IM&T on the main IM&T work being undertaken over the last quarter. The updated focussed on the key risk areas notably the infrastructure and platform replacement for Clinical Communications starting at the Louisa Martindale Building ahead of opening and other work supporting Cyber Security. The Committee were advised that key risks had been mitigated as far as possible and received confirmation of the current position on addressing the remaining issues arising from PAS deployment.
The report also provided data showing the performance of the IT department itself which confirmed the teams continue to perform well in responding to end user issues.

Commercial Activities Update

The Commercial Director provided an update on the activities of the commercial directorate over the last quarter. The Committee NOTED the Q4 activities, and the wider retail strategy. The Director provided an update on the continued development of the procurement and commercial strategies with new expertise within the team helping to develop metrics for future reporting. The new strategies will align and support the Trust's True Norths especially around the green and research agendas.Project delivery was discussed and included supporting small business research initiatives and restarting cardiac services plans as well as setting up retail concessions in the Louisa Martindale Building. The Committee heard how the commercial team is working up plans for supporting Trust staff through establishing new rest areas and restaurant facilities with 24/7 access for food (Worthing Hospital) . The Committee NOTED the update.

Risk

The Committee **NOTED** the quarter 4 Sustainability Risk Paper on the programme risks which may impact the delivery of the Sustainability True North along with the overarching risks from the respective Strategic Initiative and Corporate Project. The Committee considered this report alongside the respective discussions on risk within the respective Committee items. The Committee **AGREED** the risk paper summary and through the respective discussions **NOTED** the key risks and their linkage to the Committee's oversight of three BAF strategic risks.

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 1 2023/24 scores for risks 2.1 and 2.2 previous increased remained fairly stated and that risk 2.3 remained correctly scored, linked to the reporting provided directly at the Audit Committee.

Key Recommendation(s):

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

The Board is asked to **NOTE** the Committee 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	
Sustainability Committee	**27 April 2023**	**Lizzie Peers**	yes	no
			✓	☐

Declarations of Interest Made

There were no declarations of interest made

Assurances received at the Committee meeting

Item	Presenter	Purpose of the paper	Action Taken
Sustainability True North Financial Performance Report Quarter 4 2022/23	Director of Finance	For assurance	Assurance noted although agency run rate into 2023/24 was a concern. Further detailed reporting of agency spend vs ceiling to come to future Committee.
ICS Financial Report	Chief Finance Officer	For information	Noted workforce collective attention
Sustainability Breakthrough Objective Productivity	Chief Finance Officer	To inform the Committee of the productivity against 2019/20 activity at 2019/20 cost	Noted the deteriorating position and the imperative to drive up activity value while continuing to reduce cost base. Deep dive to be provided at the next Committee.
Sustainability Strategic Initiative Environmental Sustainability	Director of Estates and Facilities	To inform the Committee on the progress being made to reduce the Trust's environmental impact	Noted progress on a multitude of good projects but also need for a step change making the green plan embedded as fundamental across all Trus activity and resourcing. Assurance report to come back on 2022/23 delivery on targets and against the Green Plan
Corporate Project Estate and Master Planning	Director of Capital Planning	To inform the Committee on the progress being made in the development of a Trust Estates Masterplan, in Q4 on foundations to identify priorities,	Noted the update and endorsed the work undertaken in development stage in support the plan toward a Trust Estates Strategy

		opportunities and constraints	2024/25-30 Capital plan. Findings of initial site analysis were noted.
Efficiency & Transformation Programme	Director of Improvement and Delivery	To inform the committee on the update on the 2022/23 plan delivery and developing efficiency programme for 2023/24	Noted the update on the 2022/23 plan delivery and the efficiency programme update for 2023/24 including the approach to maximise focus on scheme delivery. Update on plan maturity to be brought back to next meeting.
Capital Investment Progress	Director of Capital Planning	To update the Committee on the full outturn position at the end of March 2023.	Noted the year end position and changes to the source and application of funds noting the full year capital expenditure was exceeded as agreed by the ICB
Draft Capital Plan 2023/24	Director of Capital Planning	To inform the Committee of work to produce the 2023/24 capital plan and to seek support the prioritised capital plan to be presented to Trust Board in May 2023.	Noted the work done to identify priority areas for capital within the Capital Plan Draft and confirmed support for the prioritised capital plan to be presented to Trust Board. The approach to overprogramming and its scrutiny and oversight was noted
IM&T Progress Report Q4 2023/24	IM&T Programme Manager	To note progress with IT projects linked to the Trusts IM&T Strategy	Noted progress with key projects and mitigation arrangements for key risks. PAS post implementation review to be brought back to a future Committee.
Commercial Update	Commercial Director	To inform the Committee of activities undertaken by the commercial directorate and development of a procurement value proposition and commercial focus areas.	Noted the update. Strategies and metrics to come to future Committees
Sustainability Risk Review	Chief Finance Officer	To note those risks that impact the Sustainability strategic theme and for support in the Committee's oversight of the BAF	Noted status and oversight of risk in the sustainability domain. Agreed to recommend the risks are considered as part of the quarterly BAF review.
Quarter 4 BAF	Company Secretary	For agreement	Agreed the risks for which it has oversight were fairly represented for quarter 4.

Committee cycle of business	Company Secretary	For agreement that this business cycle supports the Committee to meet its Terms of Reference	Agreed

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 the changes to these risk scores in this quarter.

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

The Committee noted a closure report would come to the next meeting on the Environmental Sustainability workstreams for 2022/23 outlining delivery against the defined targets and also the roadmap for 2023/24 and a longer term view.

The return on investment and benefits realised from investments made will be reported back to future Committees and included in the forward cycle of business and terms of refence.

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

Item	Referred to
The Committee recommended to the Board agreement of the Draft Capital Plan 2023/24. Future resourcing of the environmental strategic initiative to be subject to executive review for onward Board discussion.	To Board May 2023

University Hospitals Sussex NHS Foundation Trust

Agenda Item:	18	**Meeting:**	Board	**Meeting Date:**	4 May 2023
Report Title:	Systems and Partnerships Committee Chair report to Board				
Author(s):	Bindesh Shah, 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	☐	
Link to ICB / Trust Annual Plan					
Link to ICB Annual Plan	✓	Link to Trust Annual Plan	✓		
Implications for Trust Strategic Themes and any link to BAF risks					
Patient	☐				
Sustainability	☐				
People	☐				
Quality	☐				
Systems and Partnerships	✓	Assurances in respect of risks 5.1 to 5.3			
Research and Innovation	☐				
Link to CQC Domains:					
Safe	☐		Effective	✓	
Caring	✓		Responsive	✓	
Well-led	✓		Use of Resources	✓	
Regulatory / Statutory reporting requirement					
Communication and Consultation:					

Executive Summary:

The Systems and Partnerships Committee met on the 27 April 2023 and was quorate as it was attended by five Non-Executive Directors, the Chief Operating Officer, the Chief Financial Officer, the Chief Executive and the Chief Governance Officer. In attendance was the Managing Director for Planned Care and Cancer, the Managing Director of Urgent and Emergency Care and the Director of Improvement and Delivery and Company Secretary.

The Committee received its planned items including the Q4 report on the Trust's performance against the key constitutional standards, reports on the respective Breakthrough Objective, Strategic Initiative and Corporate Projects for which the Committee exercises oversight, these being the median hour of discharge, the 3Ts development, reducing length of stay and community diagnostic centres. Further items provided updates on the Trust's work within the ICS, Systems and Partnerships key risks and the Board Assurance Framework.

The key areas of focus at the Committee were, noting the full breath of the meeting's activity is included as an appendix to the paper.

<u>Constitutional Standards Performance</u>

The Chief Operating Officer and the two Managing Directors updated the Committee on the performance against each of the metrics reflecting on the challenges impacting on the Trust's operational performance and the governance oversight over the improvement work. The Committee **noted** 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 the productivity improvement challenges. The Committee **discussed** the various improvement actions being undertaken across each of the aspects of planned care, cancer, urgent care and diagnostics. The Committee was **assured** over the alignment of the actions developed through the reporting from the Chief Operating Officer to secure the improvement trajectories. The Committee reflected on the developing target trajectories to measure improvement and endorsed these being added to the respective performance reporting.

Median Hour of discharge

The Chief Operating Officer as project executive presented an update on this project drawing out the updates to the project charter as it moved from the project initiation into delivery along with the data analysis showing the baseline data and the improvement targets supported by ward level improvement plans. The Committee discussed the discharging process and the analysis undertaken over the areas within this analysis that shows the areas having the biggest impact on delaying discharges. The Committee was **assured** over the improvement plan process through the improving position with an improved earlier median time for discharge for those wards who have developed their own improvement actions. The Committee **noted** that there is a complementary system discharge front runner scheme, and this will support discharges outside those from the simple discharge pathway which this Trust project is focused on.

3Ts Hospital Development

The programme senior responsible officer (SRO), the Director of Improvement and Delivery provided the Committee with a report on the Louisa Martindale Building development. The Committee recognised the significant benefit that this building will bring to patients and staff and through the reports received, was **assured** that the progress is tightly overseen by the programme. The Committee **noted** that the pre-occupation activities are delivering in line with programme plans and discussed the focus for the clinical and operational readiness team for the next period. The Committee **discussed** and **noted** the planned stakeholder engagement that will be undertaken as the project moves through the gateways ahead of occupation. The Committee also **noted** the continued focus on the development of the plans to ensure the expected benefits from the move are realised and any problems identified early and addressed quickly. The Trust continues to engage with the New Hospitals Programme Operational readiness team and they have indicated they have assurance over the Trust's processes. The Committee discussed the levels of training and orientation being undertaken and from updates by the SRO and Executive Lead (the Chief Financial Officer) was **assured** over the activities being taken and support provided to the divisions through dedicated teams.

Reducing length of stay

The Managing Director for Unscheduled Care, as the Senior Responsible Officer (SRO), reported to the Committee and through their report and update **noted** the project update. The Committee **noted** that whilst the Trust's reported performance has seen some improvement this is likely to be from the focus on this through the analysis phase and local immediate actions taken. The Committee was **assured** over the programme management processes applied to this corporate project and noted the high levels of engagement by staff in the workshops to identify and prioritise the areas for improvement. The Committee **noted** the management audit work undertaken to validate the baseline information and scheduled to track future improvement.

Risk and Board Assurance Framework oversight

The Committee reviewed the quarter 4 Systems and Partnership Risk Paper and **noted** the risks detailed with a highly scored current score of 12 were reflective of the Trust. The Committee **endorsed** the work reported to the Audit Committee in respect of corporate support to the Divisions to address the lag between the updates provided via the divisions on the work being undertaken that is improving the current risk scores

which may lead to some of these risks being overstated. The Committee **agreed** that the scores relating to BAF risks 5.1, 5.2 and 5.3 for quarter 4 were fairly represented.

Referrals to other Committees

The Committee considered the reports and presentations it received at this meeting and **agreed** there were no matters it needed to refer to any other Committee.

Key Recommendation(s):

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

The Board is asked to **NOTE** the outcome of the Committees review of Quarter 4 BAF risks 5.1, 5.2 and 5.3 and that the Committee's view is that these risks were fairly represented for the Quarter.

COMMITTEE ACTIVITY REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
Systems and Partnerships Committee	**27 April 2023**	**Bindesh Shah, Committee chair**	**yes**	**no**
			✓	☐

Declarations of Interest Made

There were no declarations of interest made

Activity of the Committee

Item	Presenter	Purpose of the paper	Action Taken
Systems and Partnerships True North Constitutional Standards Performance Report	Chief Operating Officer / Managing Director Planned Care and Cancer / Managing Director Unscheduled Care	To inform the Committee on the Trust's performance and for assurance over the improvement actions being taken.	Assurance over the improvement actions taken and being developed was noted.
Systems and Partnerships Breakthrough Objective Median hour of discharge	Chief Operating Officer	To inform the Committee on the Trust's performance and for assurance over the improvement actions being taken.	Assurance over the improvement plan actions being taken.
Systems and Partnerships Strategic Initiative 3Ts Hospital Development	Director of Improvement and Delivery	To inform the Committee on the progress made with this project.	Progress with this programme of work noted along with the assurance over the programme governance.
Systems and Partnerships Corporate Projects Reducing Length of Stay	Managing Director Unscheduled Care	To inform the Committee on the progress being made in the development of the corporate project.	Assurance over the programme governance processes noted.
Community Diagnostics Centres	Managing Director Unscheduled Care	To inform the Committee on the progress being made.	Project progress noted.
Systems and Partnerships linked risks	Chief Operating Officer	For support in the Committee's	It was noted that there remained a

		oversight of the BAF	lag in the update of the highly scored divisional risks scores and that work is to be done during the next month to improve this.
Quarter 4 BAF	Company Secretary	For agreement	Agreed the risks for which it has oversight were fairly represented for quarter 4.
Committee Terms of Reference and Cycle of Business	Company Secretary	For agreement that the business cycle supports the Committee in meeting its Terms of Reference	Agreed

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	19	**Meeting:**	Board	**Meeting Date:**	April 2023
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	✓	
Research and Innovation	✓	

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

Communication and Consultation:

Executive Summary:

The Audit Committee met on the 20 April 2023 and was quorate as it was attended by five Non-Executive Directors. In attendance was the Chief Financial Officer, the Chief Governance Officer, the Chief People Officer, the Trust's Director of Finance, the Trust's Commercial Director, and the Company Secretary along with the Trust's Internal and External Auditors and Local Counter Fraud team members. The Trust's Deputy Chief Information Officer also attended to present a report on the Trust's actions in respect of 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, Counter Fraud during Quarter 4 of 2022/23, the draft Head of Internal Audit's annual opinion, Trust's draft Annual Governance Statement, the Trust's assessment of compliance with the NHS I Provider Licence and declaration of interests' processes. The Committee received and approved the External Audit, Internal Audit and LCFS plans for 2023/24. The Committee also received its scheduled reports in relation to tender waivers, losses and special payments and the report from the interim Health and Safety Committee chair on the activity of that Committee. The Committee also received information in relation to the Trust's financial statements and that they will be prepared on a going concern basis.

Through these reports the Committee received assurance over various aspects of the Trust's system of internal control, including its systems of internal financial control, systems for preventing fraud, information governance and processes of business conduct. The Committee was also assured that identified internal audit actions were being dealt with.

The Committee noted the developments being made to the 2023/24 BAF reporting structure especially those in relation to the provision of information in respect of assurance received during the quarter and a

summary of the delivery of the planned actions. The Committee discussed the further improvements being planned in respect of the tracking of the impact of actions taken and planned on the Trust's key risks. The Committee agreed to devote more time to the overview of the Trust's BAF and supporting highly scored risk report at next Committee and that to support this work that more executive attendance would be sought to both support the Committee's review of these items and the wider reports presented to the Committee.

Through the reports received especially those of Internal Audit and Counter Fraud the Committee was assured that the Trust's system of internal control, including its systems of internal financial control given the overall positive annual head of internal audit opinion, the positive opinions in respect of the internal audit reports presented at the meeting and in respect of the systems for preventing fraud from the Counter Fraud report and the meeting of the required functional standards.

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, especially those from Internal Audit and Local Counter Fraud.

The Board is also asked to **NOTE** the Audit Committee's endorsement of the draft 2022/23 Annual Governance Statement being incorporated into the 2022/23 Annual Report for External Audit.

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

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COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
Audit Committee	**20 April 2023**	**David Curley**	**yes**	**no**
			✓	☐

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 Quarter 4 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 noted that the BAF included the strategic risks in respect of the research and innovation domain. The Committee **NOTED** the planned enhancements being made to the report structure especially those in relation to the provision of information in respect of assurance received during the quarter and a summary of the delivery of the planned actions. The Committee discussed how the further planned improvements in respect of the tracking of the impact of actions taken and planned will have on the ability of the Trust to achieve their target scores.

The Committee **RECEIVED** the latest risk report providing information on the Trust risks scoring over 15. The Committee noted that the current information being provided through these reports needed to be enhanced with improved reporting on the actions being taken and the level of assurance over the planned review of these risks in compliance with the Trust's risk management policy. The Committee **ENDORSED** the actions planned through the support from the established corporate risk governance team recognsing that these needed to deliver improvements to the current level of risk reporting across the Trust and to each Board Committee.

The Committee **AGREED** to devote more time at its next meeting to review the BAF and associated key risks to assess the impact of the planned developments and **AGREED** to seek wider Executive Director attendance at the Committee to support their review and discussion.

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 positive Internal Audit opinions and conclusions in respect of Trust's 3Ts programme management arrangements, data security toolkit and data quality regarding the Trust's bed state reporting.

The Committee **RECEIVED** a benchmarking report on the previously reported internal audit in respect of the nationally mandated Financial Sustainability Internal Audit and **NOTED** the positive position of the Trust's systems of control within these areas when benchmarked against other NHS providers.

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. In respect of those not yet completed in relation to the Consultant Job Planning the Committee **AGREED** that the respective outstanding action be added to the scope of the audit to be undertaken in 2023/24 to provide assurance of their completion within that report.

Draft Head of Internal Audit Opinion

The Committee **RECEIVED** the draft Internal Audit Head of Internal Audit Opinion for 2022/23 which provided an overall positive opinion and noted that the majority of audits provided positive assurance opinions including

those on the Trust's key audits of key financial systems. Internal Audit concluded that through their work on key audits including key financial systems that in the areas of core assurance the Trust continues to perform strongly. The Committee **NOTED** that this opinion is to be reflected within the Trust's Annual Governance Statement.

2023/24 Internal Audit Plan

The Committee **RECEIVED** the 2023/24 Internal Audit plan which was aligned to Trust's BAF and the mandated areas of Internal Audit activity to enable the delivery of an annual Head of Internal Audit Opinion. The Committee **APPROVED** the initial 2023/24 plan and **NOTED** there remained a continued focus on the use of Internal Audit resource to review areas where activity would accelerate improvement and that the plan continues to contain an element of flexible resource should emergent issues arise where Internal Audit support / review would be beneficial.

Local Counter Fraud

The Committee **RECEIVED** the Local Counter Fraud progress report for Quarter 4 2022/23 in relation to their work undertaken in respect of reported concerns. The Committee was also updated in response to the actions taken in respect of these reported concerns.

The Committee **RECEIVED** the Local Counter Fraud annual report which identified no significant fraud risks and summarised the teams proactive work undertaken, fraud awareness raising work with Trust staff and the Trust functional standard compliance and confirmed the assessed high levels of compliance but noting that work continues in respect of awareness training for our staff.

The Committee was **ASSURED** by the updates provided by the Local Counter Fraud Specialists on their work during the quarter and within their annual report that there were no significant fraud risks which Trust needed to be actioned urgently within the Trust.

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

External Audit Plan

The Committee **RECEIVED** the External Audit plan for their work in relation to the year ending 31 March 2023 noting that the plan describes the external audit risks and the activity they plan to undertake, noting that some work had already been undertaken in these areas. The Committee **NOTED** that the review undertaken by External Audit had not identified any local risks of significant weakness that would require audit work over and above the mandated risks required to be covered by external audit in respect of the Trust's financial statements. The Committee discussed the external auditors work in allowing them to issue their value for money conclusion and their plan for that work to be delivered and concluded at the same time as the work on the Trust's overall opinion. The Committee **APPROVED** this plan.

2022/23 Annual Accounts

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

The Committee **RECEIVED** a report on Management's Going Concern Assessment. The Trust's Finance Director took the Committee through the rationale supporting the assessment that the Trust's financial statements should be prepared on a going concern basis. The Committee **APPROVED** that the Trust's financial statements should be prepared on the going concern based.

Annual Governance Statement

The Committee **RECEIVED** the Trust's draft Annual Governance Statement. The Company Secretary took the Committee through its construction and confirmed its compliance with the FT Annual Reporting Manual Requirements. The Committee **AGREED** subject to a small number of observations that this draft statement be included within the Trust's draft annual report which is to be submitted for External Audit review and opinion in May 2023.

FT Provider Licence – annual declarations

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

Losses and Special Payment Report and Tender Waiver Report

The Committee **RECEIVED** the Trust's Losses and Special Payments registers. The Trust's Director of Finance provided information on those cases in Quarter 4 alongside the overall position for the preceding year, noting that the levels of these cases in quarter 4 were slightly higher than the prior year. 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 4 and the year the numbers were better than the Trust's original trajectory for a reduction which has seen the reduction achieved for the year 2022/23. The Committee, through these reports, was **ASSURED** over the underlying processes applied to manage Trust resources.

Cyber Security Update

The Committee received a report from the Deputy Chief Information Officer though the report in respect of Trust's work in respect of cyber security. The detailed update of the activity undertaken by the IT Department, in respect of device and system security, access controls, local systems oversight and staff awareness programmes provided **ASSURANCE** over the Trust's actions and their positive impact on managing these risks.

Audit Committee Reporting Group – Health and Safety

The Committee received **ASSURANCE** from the Health and Safety Committee Chair's report from its meeting in February 2023. 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 **NOTED** that the report had been adjusted to provide more detail on where the oversight of these risks occurs but asked for enhanced information be provided to provide the Committee's view on the ability of the actions being taken will achieve the target score.

Declarations of Interest Annual Report

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

Committee Terms of Reference and Cycle of Business

The Committee considered its Terms of Reference and **AGREED** to an adjustment being made to reflect the Committee's broader oversight of digital risks and assurances. The Committee agreed that the supporting cycle of business will enable the Committee to meet its Terms of Reference.

Actions taken by the Committee within its Terms of Reference

The Committee **AGREED** the Internal Audit, External Audit and Local Counter Fraud Plans for 2023/24

The Committee **AGREED** for the submission of the Local Counter Fraud Service return for the Trust's compliance levels with the mandated functional standards.

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

The Committee **AGREED** that the Trust should prepare its financial statements for 2022/23 on a going concern basis.

The Committee **REVIEWED** and **AGREED** to an adjustment to its Terms of Reference to extend the Committee's oversight of digital risks.

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

There was one specific item requested for addition to the agenda at the next meeting relating to the level of management assurance in place over the quality of data for reported metrics derived from source spreadsheets rather than corporate business intelligence systems.

The Committee discussed further reporting enhancements in respect of the tracking of the impact of actions against the BAF risk target scores and the linkages of key risks to the BAF reflecting that these will be incorporated in the scheduled reporting for the next meeting.

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

Item	Referred to
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, especially those from Internal Audit and Local Counter Fraud.	Board Meeting May 2023
The Board is also asked to **NOTE** the Audit Committee's endorsement of the draft 2022/23 Annual Governance Statement being incorporated into the 2022/23 Annual Report for External Audit.	Board Meeting May 2023
The Board is asked to **APPROVE** the Trust's assessment of compliance with its Provider Licence based on the recommendation of the Audit Committee (appendix a).	Board Meeting May 2023

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Agenda Item:	15	**Meeting:**	Audit Committee	**Meeting Date:**	20 April 2023
Report Title:	NHS Improvement Provider Licence self-certifications for 2022/23				
Sponsoring Executive Director:	Darren Grayson – Chief Governance Officer				
Author(s):	Glen Palethorpe – Company Secretary				
Report previously considered by and date:					

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

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

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	☐	Link to Trust Annual Plan	☐

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

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

Regulatory / Statutory reporting requirement

Statutory

Communication and Consultation:

Executive Summary:

Each Foundation Trust is required annually to assess its compliance with its NHS I Provider Licence.

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

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

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

Key Recommendation(s):

The Committee is asked to review the draft of the Trust's assessment of its compliance with the NHS I licence and recommend the assessment to the Board for approval, that being, the Trust is complaint with its provider licence conditions.

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Provider Licence – Self Certifications for 2022/23

Introduction

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

Certifications

There three declarations required.

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

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

Declaration 3 - relating to the Training for Governors.

Declaration 1

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

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

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

UHSussex does not have any conditions placed on its Licence and has not entered into any formal undertakings with NHS England. The Trust was judged to be in segment 3 within the NHS system oversight framework and therefore can access support to assist with the its improvement priorities.

In 2021/22 the CQC issued a warning notice in respect of Maternity Services and General Surgery. Upon receipt of information from the Trust and a reinspection by the CQC in April 2022 the warning notice in respect of Maternity Services was removed. There remained a requirement to provide information to the CQC in respect of general surgery at RSCH which was then removed at the end of 2023/24.

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The Trust has received an enforcement notice from the CQC in respect of Upper GI Surgery. The Trust has complied with this notice and has provided information to the CQC on the Trust's improvement actions and is awaiting a decision from the CQC as to the removal or continuation of these conditions.

The CQC undertook a Well Led inspection in early October 2023 but the Trust has yet to receive the report. In the meantime, the Trust has reflected on the verbal feedback provided after the review and has built this into the development of the Trust's improvement priorities specifically within the enhancing quality governance improvement project which is reporting through to the Quality Committee and then as each of its phases conclude a report would be provided to the Board.

The Trust is tracking the delivery of all improvements required by the CQC through a series of action plans. The delivery against each of these actions plans is assured through the Quality Committee with enhanced operational support being provided through the Executive oversight at the respective Strategy Deployment Review meetings.

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

Continuity of Service condition 7 – Availability of Resources

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

Declaration 2

Condition FT4 - Corporate Governance Statement

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

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

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

Each of the Board Committees has terms of reference agreed by the Board. Each ToR includes details of their delegated responsibilities for scrutinising and assurance the Board on mandated governance reports and statements. The Board is undertaking a formal review of the effectiveness of each of its Committees during April 2023, any identified improvements will then be agreed and monitored by the Board.

The Audit Committee membership is drawn from the respective Board Committee Chairs facilitating the ability to cross refer between committees matters where the tracking of improvements in internal control have been identified by Internal Audit, External Audit, Counter Fraud or Management.

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

As part of the creation of the Trust its constitution was confirmed to be compliant with the NHS Act. The constitution has been subject to Board and Council and Governors consideration who approved only minor changes to bring enhanced clarity to sections in respect of the Council of Governors quoracy.

The Trust has established an enhancing quality governance improvement project to further develop its quality governance processes with these improvements reported through the Quality Committee.

The Trust took part in the national internal audit of its internal financial controls which concluded that the Trust has robust systems of internal financial control. Across the wider systems of internal control, the Trust's internal auditors have not identified any significant weaknesses within the Trust's internal financial control. The BAF risk relating to adequacy of systems of internal control reflects the management of these risks with the oversight of this strategic risk undertaken by the Sustainability and Audit Committees.

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

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

The Board through its development programme has engaged with the ICS to understand the changing system landscape and the Trust takes an active role within the ICS both at an Executive Level but also through reporting to each Committee and direct to the Board.

The Board receive updates from the Chief Governance Officer on changes to the NHS governance landscape which included information on the move to the system oversight framework.

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

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

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

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

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

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

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

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

(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;
(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;
(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-

making;
(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
(h) To ensure compliance with all applicable legal requirements.

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

Whilst there have been numerous changes to the NHSE financial frameworks the Trust has complied with these. The Trust has submitted a revised financial forecast and has complied with the requisite requirements including ICB review of the Trust's actions to manage its financial plan. The Trust will deliver a substantial proportion of its the efficiency programme. The national internal audit programme concluded that the Trust has robust systems of internal financial control and the Trust has also taken the opportunity to seek out areas for enhancement through the national benchmarking of the Trust's processes.

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

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

The Board receives and reviews the BAF at each of its meetings, this review is supported by the prior consideration of the BAF segments within each responsible committees complemented by the review at the Audit Committee. Each Committee's review of the BAF is supported by the receipt of information on the key risks pertaining to the respective patient first domain aligned to that Committee's oversight.

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

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

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

University Hospitals Sussex
NHS Foundation Trust

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

(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;
(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
(e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
(f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

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

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

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

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

The Trust has a number of CQC improvement actions the delivery of which delivery is assured by the Quality Committee.

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

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NHS Foundation Trust

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

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

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

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

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

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

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

Declaration 3

Training of Governors

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

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

University Hospitals Sussex
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The Trust has an established Governor Training Programme and Governor Induction Handbook both of which have been used to support new governors elected during 2022/23.

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

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

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

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

Self-Certification Template - Conditions G6 and CoS7

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

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

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

These self-certifications are set out in this template.

How to use this template

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

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates: **2022/2023**

Please complete the explanatory information in cell E36

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

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

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

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

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

EITHER:

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

OR

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

OR

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

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

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

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

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

Signature		**Signature**	
Name	Alan McCarthy	**Name**	George Findlay
Capacity	Trust Chair	**Capacity**	Chief Executive
Date	04 May 2023	**Date**	04 May 2023

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

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

Self-Certification Template - Condition FT4

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

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

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

These self-certifications are set out in this template.

How to use this template

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

Worksheet "FT4 declaration" | Financial Year to which self-certification relates: **2022/2023** | Please Respond

Corporate Governance Statement (FTs and NHS trusts)

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

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Board is assured over its systems of corporate governnce from the work of the Audit Committee, its Internal and External Auditors and their opinions received during the year. The Board's view as to its governance processes is also reflected within the Trust's Annual Governance Statement. #REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Board through its development programme has engaged with the ICS to understand the changing system landscape and the Trust takes an active role within the ICS both at an Executive Level but also through reporting to each Committee and direct to the Board. #REF! The Board receive updates from the Chief Governance Officer on changes to the NHS governance landscape which included information on the move to the system oversight framework.
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	These processes were referred to and their effectiveness was considered by the Accounting Officer when drafting the Trust's Annual Governance Statement with this description then considered by the Audit Committee as it endorsed the AGS for submission to the Auditors. Respective Committee reporting to the Board is operating effectively as evidenced by the regular reports to the Board from each Committee Chair. #REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	There are no conditions placed on the Trust's Licence. Key risks and associated assurance have been reported to the Board during the year through receipt and review of the Trust's Board Assurance Framework. The Board both directly and through its Committee structure has been assured that the Trust's designed systems of internal control have been operating effectively and as intended over the year. Where issues have arisen during the year, for example in respect of operational performance, timely actions have been implement to improve these areas. The Trust has submitted a revised financial forecast and has complied with the requisite requirements including ICB review of the Trust's actions to manage its financial plan. The Audit Committee has recommended based on the information it has received that the Trust can prepare its financial statements on a going concern basis. #REF! Assurance is obtained as to the quality of the data supporting the Trust's performance reporting through the annual internal audit work programm and management reviews. The Trust will deliver a substantial proportion of its the efficiency programme. The national internal audit programme concluded that the Trust has robust systems of internal financial control.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	There is clear leadership and accountability for the delivery of high quality and safe services within the Trust. This is detailed with the Trust's Annual Report and the statements contained therein. The Board both directly and through its Committee structures ensures that a focus is maintained on the delivery of quality services. The Trust's quality priorities continue to be set having regard to feedback from our patients, carers , the Governors and other stakeholders with regular reporting of the delivery against these priorities provided to the Board and the Council of Governors and to our Commissioners. The effectiveness of these processes was again considered by the Accounting Officer in drafting the Annual Governance Statement which in turn was subject to consideration by the Audit Committee prior to its submission to the Auditors and inclusion within the Annual Report.The Trust has a number of CQC improvement actions the delivery of which delivery is assured by the Quality Committee. #REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Trust has established a process that ensures that all Board Members are "fit and proper" persons. This process has been applied to Board appointments made in the year. An annual review of all Board Members continuation as fit and proper persons has been undertaken and reported to the Audit Committee at the end of the year. The Board and its Committees through its receipt of Workforce reports has been assured over the actions being taken to manage the workforce risks in relation to recruitment and retention complimented and the Board's review of people BAF risks. Regular reporting is also provided to the Board on the Trust's compliance with the nursing safer staffing levels and the revalidation of its nursing and medical workforce. All transformation schemes are subject to a detailed quality impact assessment and this rigor includes those schemes which include any workforce reduction and through this process the Board is assured that the Trust retains an appropriately qualified workforce to deliver its services. The Trust has a number of established Executive and Senior Management development programmes and these activities are designed to support and strengthen the personnel on the Board, those reporting to the Board and those within the rest of the Trust. #REF!

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

Signature	Signature
Name: Alan McCarthy	Name: George Findlay

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

A

Please Respond

Worksheet "Training of governors" Financial Year to which self-certification relates: **2022/2023** Please Respond

Certification on training of governors (FTs only)

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

Training of Governors

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

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

Signature		**Signature**	
Name	Alan McCarthy	**Name**	George Findlay
Capacity	Trust Chair	**Capacity**	Chief Executive
Date	04 May 2023	**Date**	04 May 2023

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

A

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	20	**Meeting:**	Trust Board in Public	**Meeting Date:**	May 2023
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	✓	
Research and Innovation	✓	

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 18 April 2023 and was quorate as it was attended by four Non-Executive Directors, the Chief People Officer, the Chief Financial Officer and Chief Governance Officer. In attendance was the Interim Charity Director for the newly established My University Hospitals Sussex Foundation Trust Charity (formerly 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 12 and reports on the planning work toward production of the Annual Report and Accounts, confirmation of the approved Charity merger as well as policy updates. The Committee considered a series of funding requests supporting enhanced patient experience through accelerated investment in additional equipment and facilities.

Key Recommendation(s):

The Board is asked to **NOTE** the activity of the Committee and the assurances received over the stewardship of the funds.

The Board is also asked to **NOTE** the decisions taken by the Committee within its delegated authority to agree the alignment of the respective authorised signatories for both Charities and to support the funding proposals that exceeded the Committee's delegated authority.

University Hospitals Sussex
NHS Foundation Trust

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Charitable Funds Committee	**18 April 2023**	**Lizzie Peers**	✓	☐

Declarations of Interest Made

There were no declarations of interest made.

Assurances received at the Committee meeting

Charity Merger Update

The Committee **RECEIVED** a report confirming the merger of the LYH and BSUH charities has been successfully completed. The BSUH Charity has been renamed 'My University Hospitals Sussex' with effect 01 April 2023. The name change has been registered with the Charity Commission. The signed transfer of assets documentation has been lodged with the Charity Commission noting the closure of LYH and the transfer of its assets to My University Hospitals Sussex. The formal closure notice of LYH has been submitted to the Charity Commission.

The Committee received an update on the work to publicise the new name and accompanying brand character of My University Hospitals Sussex. The update also included an update on the recruitment to the Charity team.

BSUH and LYH Charities Operational Reports for the period January to March 2023
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 had operated 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 implementation of the agreed joint Charities Operating Plan for the period April 22 – March 23

The Committee **NOTED** the delivery against the developed Charity spending plan.

BSUH and LYH Charities Operational Reports for Month 12 (to 31 March 2023)
The Committee **RECEIVED** the report from the Associate Director of Finance which provided assurance over the compliance with the charities' reserves policy and **NOTED** that the level of expenditure remains within the level of donations provided.

The Committee **RECEIVED** information on the performance of the Charities investments noting that fuller information was to be provided later in the meeting by the Fund Manager. The Committee **AGREED** to maintain differential investment risk appetites for the legacy LYH and BSUH investments for the time being.

Charity Bids
The Committee considered a number of bids and assessed these against the expected public/patient benefits and recognised the enhancements made to the quality of bid paperwork. It **RECOMMENDED** these bids to the Trustees for final approval.

Actions taken by the Committee within its Terms of Reference
The Committee **RECOMMENDED** a number of the funding bids presented. The Committee **APPROVED** the following policies within its governance arrangements: - Sponsorship agreement - Charity Ethics Policy - Fundraising Policy - Charity Investment and Risk Appetite & Reserves Policy renewal
Items to come back to Committee / Group (Items Committee / Group keeping an eye on)
The Committee had deferred but **AGREED** to review the Charities' risk appetite again in line with the market forecast update from the investment manager for both Charities and the bank interest paper.
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; and ▪ the assurances received in respect of the stewardship of the donated funds;	

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	21	**Meeting:**	Board	**Meeting Date:**	4 May 2023
Report Title:	2022/23 Quarter 4 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 April				

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

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	✓	Link to Trust Annual Plan	✓

Implications for Trust Strategic Themes and any link to BAF risks		
Patient	✓	The report covers each BAF risk
Sustainability	✓	
People	✓	
Quality	✓	
Systems and Partnerships	✓	
Research and Innovation	✓	

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

Regulatory / Statutory reporting requirement

The BAF supports the Trust's systems of Governance and the Trust's compliance with its Code of Governance

Communication and Consultation:

Report:

1 Introduction

With the development of the Research and Innovation domain the Trust's BAF has been adjusted and now includes 16 strategic risks, three more than in the previous quarter. The BAF has also been refreshed to reflect the outcome of the Trust's strategic priority refresh 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 4 score.

The quarter 4 BAF elements have been considered by the respective Board Committees at their meetings in April 2023.

A Board workshop has been held where the 2023/24 Strategic Risks were discussed and following their formal approval at the Board on 4 May then these will be placed within the 2023/24 BAF.

University Hospitals Sussex NHS Foundation Trust

2 BAF Summary

The table below overleaf shows by risk, their current score and their target risk score. The table shows pictorially the movement in risk between the current score for Q4 and Q3, Q2 and Q1. (⟷ No change, ↑ an increase in risk and ↓ a decrease in risk)

BAF: Strategic Objectives and Strategic Risks (Key: I = Impact L = Likelihood T = Total)	Risk Scores														
	2022/23 Q1			2022/23 Q2			2022/23 Q3			2022/23 Q4			Target		
	I	L	T	I	L	T	I	L	T	I	L	T	I	L	T
1. Patient ***(Oversight provided by the Patient Committee)***															
1.1 We are unable to deliver or demonstrate a continuous and sustained improvement in patient experience resulting in adverse reputational impact and poor patient outcomes	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	5	20 ↑	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	5	20 ↑	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	4	16 ↑	4	3	12 ↓	4	2	8
3. People ***(Oversight provided by the People Committee)***															
3.1 We are unable to develop and sustain the leadership and organisational capability and capacity to lead on-going performance improvement and build a high performing organisation	4	4	16 ↑	4	4	16 ⟷	4	4	16 ⟷	4	4	16 ⟷	4	2	8

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3.2 We are unable to effect cultural change and involve and engage staff in a way that leads to continuous improvements in patient experience, patient outcomes, and staff morale and wellbeing	4	4	16 ↑	4	4	16 ↔	4	4	16 ↔	4	4	16 ↔	4	2	8
3.3 We are unable to meet our workforce requirements through the effective recruitment, development, training and retention of *sufficient* staff adversely impacting on patient experience and the safety, quality and sustainability of our services	4	5	20 ↔	4	5	20 ↔	4	5	20 ↔	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	5	20 ↑	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	3	12 ↓	4	3	12 ↔	4	2	8 ↓	4	2	8
5.2 We are unable to define and deliver the strategic	4	4	16 ↔	4	4	16 ↔	4	4	16 ↔	4	4	16 ↔	4	2	8

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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.	4	5	20	4	5	20	4	5	20	4	5	20	4	2	8
6. Research and Innovation (Oversight provided by the Patient Committee)															
6.1 We are unable to harness its research capabilities thus not being able to meets is stated ambition as high-class research organisation thus impacting on the Trust's ability to attract and retain staff										4	4	16	3	2	6
6.2 We are unable to secure protected research and innovation time within individual job plans of our clinical and support workforce to meet the Trust R&I ambition										4	4	16	3	3	9
6.3 We lack a fit for purpose Clinical Research Facility (CRF) and clinical research space across Trust hospital sites to support the delivery of the R&I True North ambition.										4	4	16	3	2	6

3 The Quarter 4 BAF summary

3.1 Risk scoring

Following review at the end of quarter 3 the Executives have agreed that all risks except risk 5.1 continue to exceed their target score. Risk 5.1 has seen a reduction to its target score given the continued maturity of the processes for system working.

For quarter 4 three risks had their score increased to 20, these being risks 2.1 and 2.2 relating to sustainability and risk 4.2 relating to quality, noting that the increase in the quality risk score is reflective of workforce and performance risks. As described in the next section for these risks the level of assurance reflected in the BAF is current and covered all aspects of the expected assurances documented within the BAF.

Two risks, one relating to People (risk 3.3) and one relating to systems and partnerships (performance risk 5.3) remain at 20.

The risk score for risk 2.3 has reduced in line with that expected and reported to both the Audit Committee and Sustainability Committee it would do following the delivery of the actions following the review into the issues that led to the non-payment of some staff, this would be expected to reduce further to its target score as the divisions deliver their plans.

The BAF for quarter 4 includes the three new risks relating to research and innovation with the assurance over these risks being reported to the Patient Committee, the Committee assigned to have initial oversight of this True North domain, noting that for 2023/24 these risks are being proposed to be incorporated into one more strategically focused risk.

3.2 Assurance Confidence Levels

The Assurance Framework reflects both the level of assurance and the timeliness of this assurance, with the date the planned assurance was either received or is expected.

For *Patient* the assurance received match those expected and each has been received within the last month so is timely giving a high level of confidence for over the score at 16. These assurances have as their source a mix of management, executive and external provided (through FFT) thus strengthening the confidence level of the assurances. These assurances are considered at the Patient Committee but for those relating to FFT and the delivery of the patient experience strategy there is also Governor oversight within their Patient Experience and Engagement Committee.

For *Sustainability* the assurance received match those expected and each has been received within the last month noting that there is a mix of management and executive assurance along with external assurance from Internal Audit. The timeliness and breadth of assurance gives a high level of confidence for over the scores and supports the increase of risk 2.1 and risk 2.2 to 20 (in line with risks described to the Board) and the reduction of risk 2.3 to 12 (in line with the assurances provided to the Audit Committee and Sustainability Committee.

For *People* a number of the key sources of assurance were reported to the Committee during the quarter with the March performance information being reported to the Committee meeting in April. The increasing in frequency of the Committee meetings has enhanced the timeliness of the assurance oversight by the People Committee. with routine assurance reported to the last Committee meeting in January (December performance information). The Executive and People Committee view of the assurances recorded supports no change to any of the people scores leaving risk 3.3 scored at 20 with the other three people risks all scored at 16

For *Quality* the assurance received broadly matched those expected but with the notable exception of clinical effectiveness assurance. Information on the risks and the plans to address these have been reported to the Quality Committee. External assurance in respect of the Trust's clinical coding processes has been provided through an interim report on this work with the final report expected for the next Committee meeting in January. The current score for risk 4.2 has been increased reflecting the inter linkage of this risk and those relating to workforce and performance impacting on the Trust's ability to deliver its improvements in clinical quality at the pace it desires and the need for enhanced assurance in respect to the Trust's processes for sustained high quality outcomes.

For *Systems and Partnerships* the assurance received match those expected noting that a number of assurances have been provided directly to the Board in respect of system working alongside the routine reporting on performance both that the Committee and the Committee SDR meetings. The score for risk 5.1 has been reduced to its target score of 8 with the other scores remaining at the quarter 3 sore for 16 and

20 respectively for risks 5.2.and 5.3. The Committee view of the assurances recorded supported these scores.

For *Research and Innovation* the BAF records the opening score for each of these three risks defined recognsing that these risks would be subject to review and refinement for 2023/24. The listed sources of assurance are overseen through the respective Research Strategy Group which supports their flow of assurance to the Patient Committee during with the first reporting occurring at the Patient meeting in January 2023.

4 Committee review

Each of the respective Board Committee's received reports aligned to the BAF risks allowing each Committee to consider the appropriateness of the current score.

Each Committee within their meetings have endorsed the quarter 4 risk scoring.

5 Supporting Key Risks

Each Committee at their meetings in April considered the respective key risks with the potential to impact on the Committee's relevant patient first domain. These included consideration of the risks in relation to the domain's True North, Breakthrough Objective, Strategic Initiative and Corporate Project along with a consideration of the highly scored risks within datix (noting 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.

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 Risk of harm to staff and patients by violent and aggressive patients in ED Failure to consistently meet access targets and impact on patient experience	Levels of vacancies and an inability to provide consistent nursing & medical cover for escalation/outliers at times of high bed occupancy. Management of adults, young people and children requiring inpatient care for mental health problems RTT waiting times.

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		Inability to consistently access equipment or resources resulting in waits for treatment.
Sustainability		
2.1 We are unable to align or invest in our workforce, finance, estate and IM&T infrastructure effectively to support operational resilience, deliver our strategic and operational plans and improve care for patients 2.2 We cannot deliver ongoing efficiencies and flex our resources in an agile way resulting in an increasing or unmanaged deficit and inefficient, unaffordable and unsustainable services. 2.3 We are unable to meet high standards of financial stewardship meaning we cannot sustain compliance with our statutory financial duties	Operational pressures and workforce constraints are impacting on operational costs and productivity. These, alongside organisational capacity and a financial framework are adding further risk to delivery of financial targets and our efficiency programme The 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 risk for cybersecurity, which is an on-going and known risk requiring continuous oversight.	Capital Developments Cyber Security Financial performance
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	The stretch on staffing and their morale and wellbeing. These pressures are not unique to UHSussex but nevertheless pose a significant risk to delivery. 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 Staff sickness Health and wellbeing Staff stretch and patient experience

adversely impacting on patient experience and the safety, quality and sustainability of our services 3.4 We are unable to consistently meet the health, safety and wellbeing needs of our staff as we recover and restore services in line with CV-19 restrictions		
Quality		
4.1 We are unable to deliver safe and harm free care to reduce non-covid mortality. 4.2 We are unable to deliver service improvements and improve safety, care quality and outcomes for our patients or demonstrate that our services are clinically effective and demonstrate our consistent compliance with regulatory requirements or clinical standards	Operational pressures including Covid-19 and flu, 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. Risk of harm to staff and patients by violent and aggressive patients Patient profile, frailty, mental health, delays to specialist placement (in particular child and adolescent mental health), long waits for pre-hospital assessment (ambulance transfers) reduced care in community and social care placement and primary care capacity.	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 RTT waiting times Inability to consistently access equipment or resources resulting in waits for treatment.
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.	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 corporate projects 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	RTT waiting times Service Demands

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.	Sector capacity to deliver the plan to have no patient waiting more than 65 weeks for treatment.	
Research and Innovation		
6.1 We are unable to harness its research capabilities thus not being able to meets is stated ambition as high-class research organisation thus impacting on the Trust's ability to attract and retain staff 6.2 We are unable to secure protected research and innovation time within individual job plans of our clinical and support workforce to meet the Trust R&I ambition 6.3 We lack a fit for purpose Clinical Research Facility (CRF) and clinical research space across Trust hospital sites to support the delivery of the R&I True North ambition.	The Trust is not able to achieve its ambition within the area of research to realise the full potential of patient benefit.	Lack of dedicated time to pursue research Lack of dedicated research space

7 Changes to the BAF document for 2022/23

Based on feedback provided by the Audit Committee and other Board Committees the BAF document itself will for 2022/23 be updated to include a target score, this being the score that the actions being taken will see the risk reduce to over the 12 month period. The BAF will however retain the risk goal score aligned to the Trust's risk appetite noting that these are not likely to be achieved in on year.

As reported at the last Board a risk confidence grading will be added to allow the Committees and Board to assess the strength of assurance being relied upon when determining the current scores.

The document will also contain a section where significant supporting divisional / corporate risks will be reflected thus making more explicit the link between the BAF and risk registers.

Finally, the document will require an explicit statement on when the current score is expected to change and when the 12 month target score will be achieved and therefore allow the Committees to assess the timeliness the actions will impact on the current risk scores.

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8 Conclusion

The BAF has been considered by the respective Committees all have confirmed that they believe the BAF correctly reflect the risk scores for quarter 4 and that these are appropriate to be referenced within the Trust's annual report.

The Trust has considered the feedback from the Board Committee's especially the Audit Committee and has adjusted it report format which will be applied for 2023/24.

Key Recommendation(s):

The Board is asked to **AGREE** the BAF risk scores be reflected in the Trust's Annual Report for 2022/23.

The Board is asked to **NOTE** the planned refinements to the BAF reporting structure discussed and endorsed by Audit Committee.

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Agenda Item:	21.1	**Meeting:**	Board	**Meeting Date:**	4 May 2023
Report Title:	Risk Management Strategy including the Trust's Risk Appetite Statements				
Sponsoring Executive Director:	Chief Governance Officer				
Author(s):	Company Secretary				
Report previously considered by and date:	The risk appetite statements were considered at a Board workshop in April				
Purpose of the report:					
Information	☐		Assurance	☐	
Review and Discussion	☐		Approval / Agreement	✓	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	☐		Staff confidentiality	☐	
Patient confidentiality	☐		Other exceptional circumstances	☐	
Link to ICB / Trust Annual Plan					
Link to ICB Annual Plan	☐		Link to Trust Annual Plan	✓	
Implications for Trust Strategic Themes and any link to BAF risks					
Patient	✓	This document underpins the Trust's BAF as the respective appetite statements allow for the Trust to determine its target and goals risk scores for each of its strategic risks. This document also supports the level and pace of action for recorded risks that are outside the Trust's risk appetite.			
Sustainability	✓				
People	✓				
Quality	✓				
Systems and Partnerships	✓				
Research and Innovation	✓				
Link to CQC Domains:					
Safe	✓		Effective	✓	
Caring	✓		Responsive	✓	
Well-led	✓		Use of Resources	✓	

Regulatory / Statutory reporting requirement

The Trust is required by the NHS Code of Governance to have effective systems of governance, risk management and internal control. This document codifies the Trust's risk management strategy which is then delivered through the risk management policy.

Communication and Consultation:

The Board has been engaged in its update through a Board workshop in April. Once approved this will replace the previous version on the Trust's intranet.

Executive Summary:

The Trust has undertaken its scheduled review of its risk appetite statements and as a result has updated the risk management strategy where that are contained.

Broadly the appetite statements have not changed, however there has been the addition of explicit appetite statements relating to environmental sustainability (para 4.24)

> *We are committed to the provision of environmentally sustainable services and in having a low carbon footprint therefore we have a **moderate** appetite in respect of service enhancements that may bring an improvement to the Trust's carbon footprint and allow the Trust to be a forefront of environmentally sustainable developments through the pursuit of new / novel actions.*

and research and innovation (paras 4.34 – 4.35).

Research and Innovation *We will collaborate with partners to deliver a wide ranging and dynamic portfolio of research studies across our services for the benefits of our patients and community and support the development of our staff. Overall we have a* ***moderate*** *appetite for risks to the achievement of this objective.*

We have a ***moderate*** *appetite in the development of studies recognising however we through the application of the specific research protocols have a low risk for any quality impacts as a result of the studies.*

The appetite statements in relation to people have been amended to reference explicitly our volunteers making clear we have the same zero levels of tolerance for risks to this valuable resource cohort (sections 4.25 – 4.29). We have also referred to PLACE within the systems and partnership element.

At the same time the document has been updated to reflect that the oversight of the research and innovation domain is being provided by the Patient Committee of the Board (relevant appendix page 15). All adjustments to the document are reflected in red for ease of review.

Following feedback at the workshop in respect to the appetite categories whilst these have remined the same for the statements in the reporting against these within the BAF report both these categories and their description title will be used allowing us to transition over 2023/24 to a common language without disrupting the work undertaken with Datix in establishing our new system. (see para 4.8 on page 7)

Appetite Level	Description:
None	**Avoid**: There is a requirement to avoid risk and uncertainty to deliver an agreed organisational objective
Low	**Minimal**: There is a preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential.
Moderate	**Cautious**: There is a preference for safe delivery options that have a low degree of inherent risk and an acceptance that these may only have limited potential for reward.
High	**Open**: There is a willingness to consider all potential delivery options and choose those which balance acceptable levels of risk with an acceptable level of reward in terms of improvement and/or value for money.
Significant	**Seek**: There is a preference to be innovative and to choose options offering potentially higher business rewards despite greater inherent risk and there is evidence that the organisation is Mature: There is confidence in accepting high levels of risk because we are assured that controls, forward scanning and responsiveness systems are robust.

Key Recommendation(s):

The Board is asked to **APPROVE** this Strategy.

UHSussexFT Risk Management

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RISK MANAGEMENT STRATEGY

Version:	2
Status:	Risk Management Strategy for UHS FT
Category	Corporate Stratgey
Approved by:	Board
Date approved:	April 2021
Name of author:	Company Secretary
Name of responsible committee/individual:	Chief Governance Officer
Date issued:	April 2021
Review date:	March 2027
Target audience:	All staff including: Governors, Executive and Non-Executive Directors, Clinical and Corporate Divisions / Directorates and Divisional Management Teams
Accessibility	This document is available in electronic format only
Linked documents	Risk Management Policy Incident Management Policy H&S Policy

Reference Number:	

Version	date	Author	Status	Comment
1.0	March 2021	Company Secretary	Retired	Transfer of former Trusts' risk mgmt strategy to UHSussexFT. Updates also to reflect revised Board Committee Governance structures
2.0	April 2023	Company Secretary	Live	Updated to reflect Patient Committee's expanded oversight role over Research and Innovation. Updated to reflect outcome of risk appetite discussion at the Board workshop in April

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RISK MANAGEMENT STRATEGY

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Appendix 3: Board Governance Structures

1 Introduction

1.1 The Board of University Hospitals Sussex NHS Foundation Trust (UHSussexFT) is committed to ensuring that risks to the quality, safety, effectiveness and sustainability of it services are identified and managed so that they are reduced to an acceptable level or eliminated as far as reasonably practicable. This Risk Management Strategy sets out the Trust's intentions and approach to risk management. It should be read in conjunction with the Trust's Risk Management Policy which sets out the methods and responsibilities for delivering this strategy.

1.2 The successful management of risk in all aspects of the Trust's business and by all those working within the Trust is fundamental to delivering the Trust's strategic and operational objectives. It also ensures the Trust is resilient and able to deal with unanticipated exposure to risks that could threaten our success. Therefore, the Trust will ensure that effective risk management is an integral part of everyday working practice in all aspects of the Trust's business as part of its overarching strategy and approach to delivering its strategic objectives.

1.3 The Trust is committed to an integrated risk management system, which incorporates all aspects of risk including strategic, clinical, financial, workforce, infrastructure, health and safety, operational, compliance and reputational risk.

1.4 The Trust's governance framework relies on a robust system for managing risk. This strategy describes how the Trust's risk management structures, systems and processes will ensure that the Trust meets its strategic and operational objectives and delivers safe, sustainable, high quality care. This will involve maximising opportunities to achieve objectives, as well as reducing risks.

1.5 The strategy sets out the Trust's approach to risk management which will include the identification assessment, reporting and management of risk. It defines the contribution to be made by key parts of the Trust's governance structures. By managing risk effectively, the Trust aims to:

- ensure that risk management is an integral part of open culture
- identify risks to achieving the Trust's objectives requiring intervention, and
- drive a standardised, strategic, and accessible approach to risk management

1.6 In addition to this Risk Management Strategy there are a range of policies that support the identification and management of risk within the Trust. These include the following policies:

- Risk Management Policy
- Incident Management Policy
- Complaints Policy
- Health and Safety Policy

2 Scope

2.1 The risk management approach described in this strategy applies to all areas and activities of the Trust and to all individuals working within the Trust. The Trust will work in partnership with its staff, service users and stakeholders to ensure it takes a comprehensive approach to risk management and that all opportunities for the identification and management of risk are fully exploited including risk management approaches that can only be delivered in partnership with others.

3 Risk Management approach

3.1 Risk is inherent in all the Trust's activities: for example, treating patients, determining service priorities, project management, record-keeping, communication, staffing, service design, and setting strategy. Equally, there is also risk associated with not taking any action at all.

3.2 The Trust supports a dynamic and proactive approach to risk management, with the aim of identifying and managing potential threats and hazards before adverse events occur. The identification and assessment of risk should be seen as opportunities to improve care quality.

3.3 The Trust's strategy for the management of risk is to integrate the identification, assessment, and control of risk into all areas of the Trust's business so that risk is routinely identified by all staff and appropriate action is taken to reduce risks to acceptable levels. The Trust will support all staff to take an active role in the identification and management of risk and to take responsibility for the health, safety, and wellbeing of patients, visitors, staff and others accessing and using the Trust's facilities and services. This approach will also enable staff to make an active contribution to the management of risks associated with the delivery of services in line with the NHS Constitution, and with the delivery of the Trust's objectives.

3.4 While the Trust Board carries overall responsibility for risk management, the key to success is local leadership. The Trust's divisional structure is fundamental to the risk management system, and divisional leaders and their teams will work with colleagues holding specialist Trust-wide governance remits, and the Trust's Executive directors to ensure it is successfully implemented.

3.5 It is the responsibility of all staff to identify risk and report concerns that may affect the quality, safety and effectiveness of service provision. The Trust aims to work in partnership with staff and support them with their responsibilities by creating a culture of openness and willingness to admit mistakes. The Trust is committed to learning from mistakes, incidents, near misses, complaints and claims and using this learning to improve systems. The Trust is committed to a just culture where the reporting of incidents and concerns is encouraged and staff are supported in delivering their responsibilities for safe care.

3.6 This strategy sets the objectives for risk management within the Trust as follows:

- to take all reasonable and appropriate steps in the management of risk in order to protect patients, staff, the public, its assets and reputation
- to meet statutory, regulatory and legal obligations
- to develop and maintain an effective system to identify, assess, manage and review

risks across the Trust

- to offer staff appropriate training and support in the principles and practice of risk assessment and management
- to provide assurance to the Board via the Audit Committee regarding the effectiveness and robust implementation of the Risk Management Policy and its associated systems and processes
- to manage risk within the risk appetite that has been agreed by the Trust Board

4 Risk Management System

4.1 The risk management system will be an integral part of the Trust's framework for assuring and delivering good governance. It will enable the Trust to identify and monitor risks to its strategic objectives, supports the appropriate management and escalation of these risks and informs the Board whether the systems and process in place are providing effective controls and assurances.

4.2 The key components of the Trust's risk management system will be the risk appetite statement, the Board Assurance Framework, the Highly Scored (Corporate) Risk Register and local risk registers. The production of these components is supported by the Trust's risk management processes

Risk Appetite Statement

4.3 Risk appetite can be defined as the amount of risk or the level of potential impact that an organisation is willing to accept in pursuit of the achievement of its strategic aims and objectives. Risk appetite therefore is at the heart of how an organisation does business and how it wishes to be perceived by key stakeholders including employees, regulators, rating agencies and the public.

4.4 The amount of risk an organisation is willing to accept can vary from one organisation to another and between one type of risk and another depending upon the specific organisational and risk circumstances. Factors such as the external environment, people, business systems and policies will all influence an organisation's risk appetite.

4.5 In order to transfer, treat, terminate, or tolerate risks those staff undertaking risk assessments and making decisions will need to understand what level of risk is acceptable to the Trust's Board

4.6 The risk appetite of the Trust will be defined by the Board. The Board will make a decision on the appropriate exposure to risk it will accept in order to deliver its strategy over a given time frame. In practice, the Trust's risk appetite will address several dimensions:

- The nature of the risks to be assumed.
- The amount of risk to be taken on.
- The desired balance of risk versus reward.

4.7 Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk. The Trust's risk appetite statement will be communicated to relevant staff involved in the management of risk and should be used to determine the target risk rating throughout the risk management process.

Risk Appetite

4.8 The following risk appetite levels, adapted from those developed by the Good Governance Institute (see Appendix 1), form the background to the Board's discussion and decision when defining the Trust's risk appetite. Using this model as guidance the Trust Board will agree an appetite statement that aligns to the Trust's strategic aims. The statement should be then be considered when assessing risk target and tolerances in the Board Assurance Framework, Corporate and Local (Divisional) Risk Registers.

Appetite Level	Description:
None	**Avoid**: There is a requirement to avoid risk and uncertainty to deliver an agreed organisational objective
Low	**Minimal**: There is a preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential.
Moderate	**Cautious**: There is a preference for safe delivery options that have a low degree of inherent risk and an acceptance that these may only have limited potential for reward.
High	**Open**: There is a willingness to consider all potential delivery options and choose those which balance acceptable levels of risk with an acceptable level of reward in terms of improvement and/or value for money.
Significant	**Seek**: There is a preference to be innovative and to choose options offering potentially higher business rewards despite greater inherent risk and there is evidence that the organisation is Mature: There is confidence in accepting high levels of risk because we are assured that controls, forward scanning and responsiveness systems are robust.

Risk Appetite Statement

4.9 The Boards of NHS Trusts are accountable for ensuring the quality, safety and sustainability of the services they provide to patients. University Hospitals Sussex NHS Foundation Trust sets clear expectations for the Trust through strategic objectives.

4.10 The Trust operates in a high risk environment and the day to day management of risk is an expected and integral part of the business of any healthcare provider. Overall, the Board has a **moderate** appetite for risk in relation to the achievement of its objectives and takes active and ongoing actions as part of our daily operational management and strategic planning to reinforce our risk controls in order to minimise risk to a tolerable level.

4.11 Our Board Assurance Framework and risk registers will continue to reflect material risks that may prevent the Trust from fulfilling its role in delivering clinical services which meet regulatory and NHS Constitutional standards and the expectations of our stakeholders and patients. We have defined our appetite for risk in relation to our strategic objectives as follows:

4.12 **Patient Experience:** We make delivering an excellent care experience for our patients our highest priority. However, we will accept **moderate** risks to patient experience if this is

required to achieve patient safety and quality improvements.

4.13 We have a **moderate** risk appetite for actions and decisions that, whilst taken in the interests of ensuring quality, safety and sustainability, may affect the reputation of the Trust or of the wider NHS. Such actions and decisions would be subject to a rigorous risk assessment and be signed off by the Board.

4.14 **Quality**: We will deliver safe, high quality clinical services and demonstrate they achieve optimal clinical outcomes and deliver best practice for our patients whilst ensuring we meet regulatory standards. Overall, our risk appetite for safety is **low**.

4.15 We have a **low** appetite for risks that could result in poor quality care or unacceptable clinical risk, non-compliance with standards or poor clinical or professional practice.

4.16 We have a **low** appetite for risks that may jeopardise patient safety.

4.17 We recognise that we need to have a **moderate** appetite for risks relating to the length patients are wating to be seen. We however expect that the Trust's resources will be targeted based on clinical need and urgency and not only the duration of time on the waiting list.

4.18 We recognise that it can be in the best interests of patients to have a **moderate** appetite for some individual patient care and treatment risks in order to achieve the best outcomes. Therefore, we support our staff to work in collaboration with the people who use our services to develop appropriate and safe care and treatment plans based on assessment of need and clinical risk.

4.19 We will apply strict safety protocols for all of clinical and non-clinical activity, when and wherever possible. We will report, record and investigate our incidents and ensure that we continue to learn lessons to improve the safety and quality of our services.

4.20 **Sustainability**: We strive to use our resources efficiently and effectively for the benefit of our patients and their care and ensure our services are clinically, operationally, and financially sustainable. We will always aim to achieve this objective; however, overall we have a **moderate** appetite for risk in this area.

4.21 We have a **moderate** appetite for some financial risks where this is required to mitigate risks to patient safety or quality of care. We will ensure that all such financial responses deliver optimal value for money.

4.22 We are committed to providing patient care in a therapeutic environment and providing staff with an environment and supporting infrastructure in which to perform their duties. However, we have a **moderate** appetite for some risks related to our infrastructure and estate except where these adversely impact on patient safety, care quality and regulatory compliance

4.23 We will increase our appetite for financial risk to **significant** in some instances and consider all potential delivery options to ensure the delivery of our objectives. Our appetite for risk in this area recognises the financial environment in which NHS trusts are operating, and the requirement to maintain regulatory and constitutional standards. A decision to take this level of risk would be based on a rigorous risk assessment and a review of the robustness of the controls and would require sign off by the Board.

4.24 We are committed to the provision of environmentally sustainable services and in having a low carbon footprint therefore we have a **moderate** appetite in respect of service enhancements that may bring an improvement to the Trust's carbon footprint and allow the Trust to be a forefront of environmentally sustainable developments through the pursuit of new / novel actions.

4.25 **People:** We value and respect all our staff and volunteers equitably, involve them in decisions about the services they provide and offer the training and development they need to fulfil their roles. We will rarely accept risks that would limit our ability to achieve this objective and the Trust's overall risk appetite for workforce related risks is **low**.

4.26 We have a **low** appetite for risks related to the recruitment, retention and training of staff and volunteers to deliver safe, high quality services and good patient experience.

4.27 We have **no** appetite for risks associated with unprofessional conduct, bullying, or an individual's competence to perform roles or tasks safely nor any incidents which may compromise the safety or wellbeing of any staff members and patients or contradict our values.

4.28 We have a **moderate** appetite for risks associated with the implementation of non-NHS standard terms and conditions of employment, innovative resourcing, and staff development models where these enhance or improve patient safety, care quality, service delivery or financial sustainability.

4.29 We have **no** appetite for any risk that could result in staff or volunteers being non-compliant with legislation.

4.30 We have **no** appetite for any risk that could result in us being in breach of our contractual or statutory responsibilities in relation to our staff or in a breach of our staff's employment rights.

4.31 **Systems and Partnerships**: We will collaborate with commissioners, local authorities, our other partners and other care providers to prevent ill health, plan and deliver services that meet the needs of our local population and deliver operational and NHS operational planning standards having reference to the PLACEs we provide our services. Overall we have a **moderate** appetite for risks to the achievement of this objective.

4.32 We have a **moderate** appetite for risk where this results in improvements in the design or delivery of healthcare services for our patients or the population we serve. Our appetite for risk in this area recognises that the Trust operates in a complex environment and is subject to very challenging economic conditions and changing demographics with intense scrutiny. We consider the risks associated with innovation, creativity and clinical research to be an essential part of the Trust's risk profile. We increase our appetite for risk in this area to **significant** in order to maximise the opportunities to improve patient outcomes and the Trust's sustainability. A decision to take this level of risk would be based on a rigorous risk assessment and a review of the robustness of the controls and would require support of the Board.

4.33 We will collaborate with commissioners, local authorities, our other partners and other care providers to prevent ill health, plan and deliver services that meet the needs of our local population and deliver operational and NHS constitutional standards.

4.34 **Research and Innovation** We will collaborate with partners to deliver a wide ranging and dynamic portfolio of research studies across our services for the benefits of our patients and community and support the development of our staff. Overall we have a

moderate appetite for risks to the achievement of this objective.

4.35 We have a **moderate** appetite in the development of studies recognising however we through the application of the specific research protocols have a low risk for any quality impacts as a result of the studies.

Risk Tolerance

4.36 Risk 'tolerance' is the minimum and maximum risk the Trust is willing to accept as reflected in the risk appetite themes above. All risks with a total risk score of 12 and above and those with a consequence/impact score of 5 will be considered as Highly Scored (Corporate) Risks and as such require executive oversight by the Trust Management Committee (TMC). TMC will be responsible for ensuring that these highly scored risks are managed and controlled in accordance with the risk appetite defined by the Board and with the Risk Management Policy.

Board Assurance Framework

4.37 The Board Assurance Framework (BAF) will set out the strategic risks which may threaten the achievement of the Trust's strategic objectives. It will enable the Board to monitor progress in achieving the strategic objectives, attend to key accountability issues, ensure the right issues are debated and that remedial actions are taken to reduce risk, strengthen controls and assurances. All NHS bodies are required to sign a full Annual Governance Statement, and must have the evidence to support this. The BAF brings together a significant part of this evidence

4.38 The BAF will be designed to assess the strength of the internal control measures that are intended prevent these risks occurring and to identify and evaluate sources of assurance. It supports the identification of gaps in control and assurance and enables the Board to monitor progress on the actions being taken to address these gaps.

4.39 The BAF will also describe the assurances and sources of assurance the Board has agreed are necessary to assess the achievement of the Trust's strategic objectives, and will thus drive the cycle of Board and Board Committee work and reporting to the Board.

4.40 The BAF also describes the controls that the Trust's Executive must ensure are effective in order to manage strategic and operational risks and to assess that the adequacy and strength of these controls are aligned to the Board's risk appetite for individual strategic risks.

4.41 The BAF will be regularly review by the Board, Board Committees and TMC as determined by their roles and responsibilities set out in Section 8 tables 1 and 2.

4.42 The assurance alignment within the Trust is shown diagrammatically by Good Governance Institute, see Appendix 2.

Highly Scored (Corporate) Risk Register

4.43 The highly scored (corporate) risk register (CRR) will be comprised of all risks with a score of 12 or above or that has an impact score of 5, and will be compiled from divisional and corporate directorate risk registers. It will be the key tool for the management of risk and will be informed by the Trust's risk escalation process.

4.44 The CRR will be routinely reviewed by TMC and the relevant Management Groups as determined by their roles and responsibilities as set out in their Terms of Reference. This will ensure:

- the right risks are being reported and escalated
- actions are being taken to mitigate risk
- these actions have been effective in reducing the risk level
- risks to strategic objectives are identified
- gaps in control are identified and included in the BAF
- the ongoing integrity of the risk management system

4.45 In addition, the CRR will be routinely reviewed by the Audit Committee when considering the BAF in order to assess the adequacy and effectiveness of the Trust's risk management systems and processes so that the Committee can provide the relevant assurance to the Board.

4.46 The Audit Committee will also assess whether the linkages between the CRR and the BAF are robust and enable the Board to effectively identify gaps in control and assurance. Risks on the CRR may indicate a gap in control or identify that the Board is receiving inadequate, insufficient or incomplete assurances.

Corporate Project / Strategic Initiative (Corporate) Risk Register

4.47 For each Corporate Project and Strategic Initiative, a risk register will be formulated. For those risks scoring over 15 or with an impact score of 5 these will be added to highly scored risk register to formulate the overall corporate risk register.

Local Risk Registers

4.48 The local Risk Registers (RR) will be held at divisional and corporate directorate level and are the mechanism and management tool through which identified risks, controls and actions to mitigate or manage risks are recorded, monitored and managed. RR will follow the same format as the CRR.

4.49 Divisional RR will be routinely reviewed and monitored through the divisional governance structure. Corporate directorate RR will be routinely reviewed and monitored by Executive Directors and their teams.

4.50 In addition the CRR and RR will be reviewed as required by TMC and Management Groups to ensure consistency between all RR in the identification, assessment and rating of risks and to ensure effective management action is being taken to mitigate and control risks.

5 Risk management processes

5.1 The Trust's risk management processes will be described in the Risk Management Policy and will be determined in line with NHS and regulatory requirements and best practice. They will govern how risk is contextualised, identified, analysed for likelihood and impact, prioritised and managed and how risks will be communicated, reported, recorded, monitored and reviewed.

5.2 The Trust's risk management processes will ensure that risk is identified from a wide range of sources both proactively (for example through audit or assessment of provision against clinical guidelines) and reactively (for example through complaints, incidents and claims).

5.3 The Trust will manage identified risk through one of the following approaches:

- **Treat**: control or reduce by taking action
- **Terminate**: remove altogether by stopping practices, or
- **Tolerate**: accept where appropriate and in line with risk appetite
- **Transfer**: move to another organisation or service

6 Governance Structure

6.1 The Trust's governance structures will support the ward to Board management of risk throughout the organisation. The Trust's Governance structure is set out in Appendix 3.

6.2 The Board's is responsible for setting the objectives and strategy for risk management, setting the Trust's risk appetite and assessing the outputs and outcomes of the Trust's Risk Management Systems to ensure that they deliver appropriate levels of assurance and demonstrate that the risks to the Trust's strategic objectives are being effectively managed and controlled The Board delegates some of its responsibilities to its Committees as described below. The BAF is the key tool used by the Board in fulfilling its responsibilities.

6.3 The Trust's management structures will have the responsibility to ensure risk is managed and controlled in line with the Trust's Risk Management Strategy and Policy. Gaps in control will be identified through the management structures, and actions to strengthen controls or address gaps in control will be defined and monitored.

6.4 TMC will be the principal governance forum for the management of risk and will delegate some of its responsibilities to other management groups in order to ensure appropriate levels of scrutiny and action to manage risk. The Risk Management Policy CRR and RR will be the key tools used by the Executive and Trust managers in fulfilling their responsibilities.

6.5 Assurances on the effectiveness of the Trust's risk management system will be developed through the Trust's management systems and will be assessed and scrutinised by the Board and its Committees. The Board and TMC will agree the format and content of management and Board reporting that supports the provision of robust assurance.

Risk escalation

6.6 In order to successfully monitor and manage operational and strategic risk it is essential that high risks, areas of escalating risk, gaps in control and delays in implementing actions to strengthen controls or address control gaps are escalated through the risk management governance structure. The risk escalation process will be described in the Risk Management Policy. In addition to regular reporting to provide assurance it is expected that all component parts of the Trust's risk management governance structure will identify and escalate risks in a timely manner, reporting concerns to ensure awareness and the implementation of strengthened actions.

Learning from the management of risk

6.7 The Trust is committed to continuously developing as a learning organisation and ensuring that it can learn from the outcomes and processes of its risk management system. Learning will include the identification of improvement actions that will enable incremental improvement in the effectiveness of the risk management system, the implementation of effective controls and risk mitigations and the development and delivery of assurance. Learning opportunities will be identified throughout the Trust's risk management process and highlighted to the Board. Plan for risk management improvement will be incorporated into the Risk Management Strategy, Policy and practice.

7 Organisational responsibilities

7.1 In line with the governance structure illustrated in Section 8, Table 1 below describes the key responsibilities of the Board and its Committees. Table 2 describes the roles and responsibilities of the Trust's key management groups for the delivery of the Trust's risk management systems and processes and the development of assurances in relation to the management.

8 Strategy Implementation and monitoring

8.1 The Trust's Risk Management Strategy will be implemented through the mechanisms described in Sections 5 to 7 and through the Risk Management Policy. The Board will review the Risk Management Strategy periodically making any changes required to reflect national and regulatory standards, best practice and learning and improvement opportunities identified by the Trust including through internal or external reviews the of risk management systems.

Table 1: Responsibilities of the Board and Board committees

Group and responsibilities
The **Trust Board** is accountable for • Agreeing the Trust's Risk Management Strategy • Agreeing the key risks to the achievement of the Trust's strategic objectives • Agreeing the Trust's risk appetite in relation to the strategic objectives and the types of risk the trust is managing • Agreeing the BAF; defining the controls, assurances and gaps in control and assurance for each of the key risks that will be the focus of the Board's assurance assessment activity • Ensuring the BAF informs the business of the Board and is taken into account with the determination of the Board agenda • Scrutinising and testing the assurances received on the effectiveness of controls and actions to address gaps in control through the annual cycle of business utilising the work of the Board Committees • Challenging through the Board Committee their review the risk controls and sources of assurance described within the BAF to ensure they are effective and robust • Considering the wider strategic implications of the risks identified, and making recommendations to improve management of risk by taking a strategic corporate approach
The Board delegates responsibility to the **Audit Committee** for: • Assessing the quality and strength of the assurances received on the Trust's risk management, quality and financial governance systems and processes and providing assurance to the Board that the Trust has established and maintains an effective integrated system of governance, risk management and internal controls, across the whole of the Trust's activities (both clinical and non-clinical) and that this supports the achievement of the Trust's objectives • Ensuring there is independent scrutiny of the Trust's risk management and governance systems and processes and of the strength and adequacy of related assurances through internal and external audit work programmes and where necessary testing the integrity and completeness of the risk management system through reviewing the strength of operational and strategic risk management and internal control. • Assessing the work of the respective Committees in relation to their testing of the accuracy, adequacy of the assurances provided on the effectiveness of controls and the actions being taken to address gaps in control processes that indicate the effectiveness of the management of principle risks. • Referring to the respective Committee significant control or assurance gaps identified by Internal Audit, Counter Fraud or External Audit seeking that the respective Committee challenge the impact of these on the BAF. • Reviewing and testing where there are identified gaps in the Trust's processes over the contents of the BAF, CRR,and local RRs. • Reviewing the application of the Trust's Risk Management Strategy, Risk Management Policy and associated policies and making recommendations to the Trust Board on the development and implementation of the Risk Management Strategy and Policy • Reviewing and testing all risk and control-related disclosure statements (e.g. the Annual Governance Statement) to provide assurance to the Board that they are accurate and adequate.

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The Board delegates responsibility to the **Patient Committee** for

- Assessing the quality and strength of the assurances received on the delivery of the Trust's Patient True North, Breakthrough Objectives, Corporate Projects and Strategic Initiatives.
- Assessing the quality and strength of the assurances received on the delivery of the Trust's Research and Innovation True North, Breakthrough Objectives, Corporate Projects and Strategic Initiatives
- Providing assurances to the Board that the Trust has established and maintains an effective system of internal control and risk management over the key risks impacting on the Patient True North and the Research and Innovation True North.
- Regularly reviewing and testing the contents of the BAF, CRR, and local RRs in pursuit of the Patient and escalating concerns about areas of insufficient, incomplete or inadequate assurance to the Board
- Making recommendations to the Trust Board on the development and implementation of the Trust's Patient Strategies.
- Reviewing any referred internal control and assurance gaps from the Audit Committee or any other Committee to challenge their impact on the stated current risk scores within the BAF.
- Reviewing the integrity and completeness of the patient reporting processes and all mandated patient related disclosure statements.
- Escalating concerns about areas of insufficient, incomplete or inadequate assurance to the Board

The Board delegates responsibility to the **Quality Committee** for

- Assessing the quality and strength of the assurances received on the delivery of the Trust's Quality True North, Breakthrough Objectives, Corporate Projects and Strategic Initiatives.
- Providing assurances to the Board that the Trust has established and maintains an effective system of internal control and risk management over the key risks impacting on the Quality True North.
- Regularly reviewing and testing the contents of the BAF, CRR, and local RRs in pursuit of Quality and escalating concerns about areas of insufficient, incomplete or inadequate assurance to the Board
- Making recommendations to the Trust Board on the development and implementation of the Trust's Quality Strategies.
- Reviewing any referred internal control and assurance gaps from the Audit Committee or any other Committee to challenge their impact on the stated current risk scores within the BAF.
- Reviewing the integrity and completeness of the quality reporting processes and all mandated quality related disclosure statements, including the Trust's Quality Account.
- Escalating concerns about areas of insufficient, incomplete or inadequate assurance to the Board

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The Board delegates responsibility to the **People Committee** for

- Assessing the quality and strength of the assurances received on the delivery of the Trust's People True North, Breakthrough Objectives, Corporate Projects and Strategic Initiatives.
- Providing assurances to the Board that the Trust has established and maintains an effective system of internal control and risk management over the key risks impacting on the People True North.
- Regularly reviewing and testing the contents of the BAF, CRR, and local RRs in pursuit of People and escalating concerns about areas of insufficient, incomplete or inadequate assurance to the Board
- Making recommendations to the Trust Board on the development and implementation of the Trust's People Strategies.
- Reviewing any referred internal control and assurance gaps from the Audit Committee or any other Committee to challenge their impact on the stated current risk scores within the BAF.
- Reviewing the integrity and completeness of the quality reporting processes and all mandated people related disclosure statements, including WRES, WDES, Gender Pay Gap, Staff Survey etc.
- Escalating concerns about areas of insufficient, incomplete or inadequate assurance to the Board

The Board delegates responsibility to the **Sustainability Committee** for**:**

- Assessing the quality and strength of the assurances received on the delivery of the Trust's Sustainability True North, Breakthrough Objectives, Corporate Projects and Strategic Initiatives.
- Providing assurances to the Board that the Trust has established and maintains an effective system of internal control and risk management over the key risks impacting on the Sustainability True North.
- Regularly reviewing and testing the contents of the BAF, CRR, and local RRs in pursuit of Sustainability and escalating concerns about areas of insufficient, incomplete or inadequate assurance to the Board
- Making recommendations to the Trust Board on the development and implementation of the Trust's Sustainability Strategies.
- Reviewing any referred internal control and assurance gaps from the Audit Committee or any other Committee to challenge their impact on the stated current risk scores within the BAF.
- Reviewing the integrity and completeness of the sustainability (financial and none financial) reporting processes and all mandated sustainability related disclosure statements including the Trust's financial plan, capital programme, environmental sustainability and use of resources
- Escalating concerns about areas of insufficient, incomplete or inadequate assurance to the Board

The Board delegates responsibility to the **Systems and Partnership Committee** for

- Assessing the quality and strength of the assurances received on the delivery of the Trust's Systems and Partnerships True North, Breakthrough Objectives, Corporate Projects and Strategic Initiatives.
- Providing assurances to the Board that the Trust has established and maintains an effective system of internal control and risk management over the key risks impacting on the System and Partnerships True North.
- Regularly reviewing and testing the contents of the BAF, CRR, and local RRs in pursuit of Sustainability and escalating concerns about areas of insufficient, incomplete or inadequate assurance to the Board
- Making recommendations to the Trust Board on the development and implementation of the Trust's Systems and Partnerships Strategies.
- Reviewing any referred internal control and assurance gaps from the Audit Committee or any other Committee to challenge their impact on the stated current risk scores within the BAF.
- Reviewing the integrity and completeness of the system and partnerships reporting processes and all mandated disclosure statements including Emergency Preparedness, Readiness and Resilience.
- Escalating concerns about areas of insufficient, incomplete or inadequate assurance to the Board

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Table 2: Responsibilities of the Trust's management groups and divisions

The **Trust Management Committee** is responsible for**:**

- Ensuring the effective identification, evaluation and management of operational and strategic risk in all aspects of the Trust's business and providing effective and proactive leadership of risk management within the Trust by implementing the Trust's Risk Management Strategy and Policy and the associated framework of processes, procedures and controls that enable risks to be managed directly and through delegated powers and ensure the Trust meets its strategic objectives
- Ensuring the application of the Trust's Risk Management Strategy and Policy is consistently applied across the Trust
- Reviewing the local RR, CRR and Board Assurance Framework routinely to ensure risks and controls are described clearly and accurately, rated consistently, and managed appropriately to reduce risks to the agreed target level. Recommending the BAF to the Board for approval.
- Identifying gaps in assurance or control and ensuring actions to address these gaps are agreed and delivered in a timely fashion to make the necessary improvements, taking action as required to address delays and enable and support successful delivery
- Escalating risks, gaps in control or gaps in assurance to the Board
- Promoting continuous quality improvement with regard to the management of clinical and non-clinical risk and the control environment throughout the Trust by examining and challenging action plans developed to control risks, and assessing their wider impact.
- Assessing the quality and strengths of the assurances developed through the Trust's quality, financial and performance management systems and their sub-groups to provide evidence of the effectiveness of governance, risk management and systems of internal control within the Trust, taking action to strengthen assurances as required
- Considering the wider strategic implications of risks and themes arising, and opportunities to improve management of risk by taking a corporate approach
- Delegating powers for the management of risk to the appropriate management groups as set out in their approved Terms of Reference.

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Appendix 1: Risk Appetite for NHS Organisations

Risk Appetite for NHS Organisations
A matrix to support better risk sensitivity in decision taking

Developed in partnership with the board of Southwark Pathfinder CCG and Southwark BSU – January 2012

Good Governance Institute

Risk levels ▶ / Key elements ▼	0 Avoid Avoidance of risk and uncertainty is a Key Organisational objective	1 Minimal (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 Open Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 Seek Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 Mature Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	NONE	LOW	MODERATE	HIGH	SIGNIFICANT	

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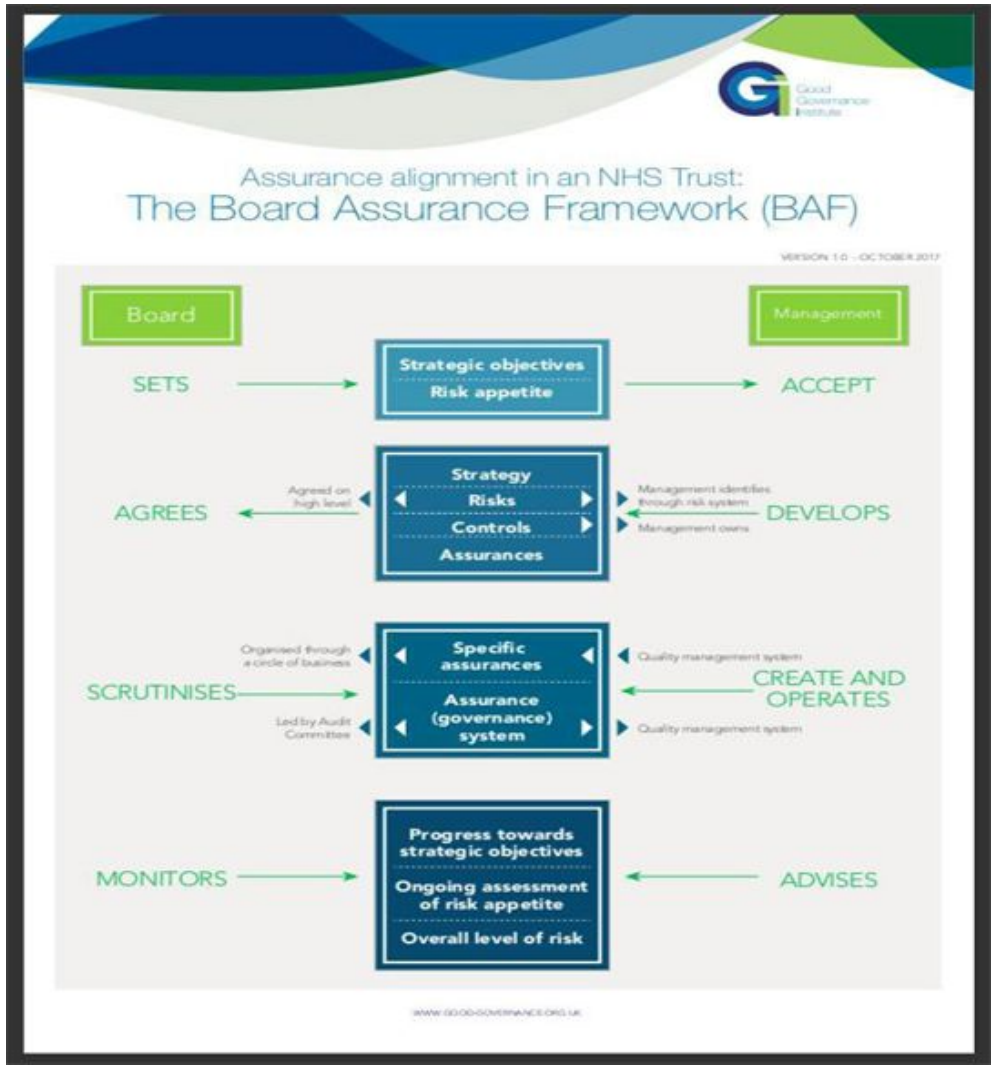
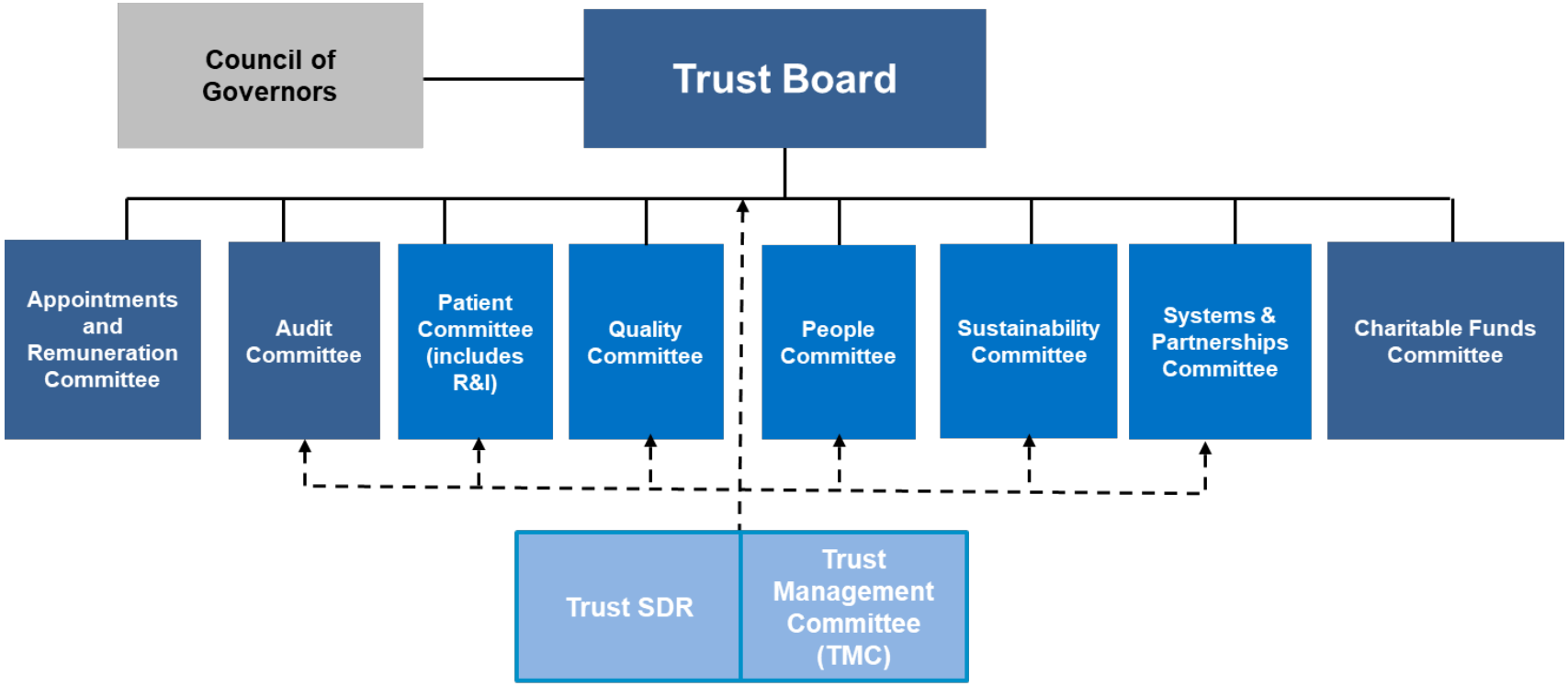
Appendix 2: Assurance Alignment in an NHS Trust – Board Assurance Framework



Appendix 3: Board Governance Structures



University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	21.2	**Meeting:**	Board	**Meeting Date:**	4 May 2023
Report Title:	2023 / 2024 strategic risks				
Sponsoring Executive Director:	Chief Governance Officer				
Author(s):	Company Secretary				
Report previously considered by and date:	The strategic risk descriptions were considered at a Board workshop in April				

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

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

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	☐	Link to Trust Annual Plan	✓

Implications for Trust Strategic Themes and any link to BAF risks		
Patient	✓	The strategic risk descriptions underpin the Trust's BAF
Sustainability	✓	
People	✓	
Quality	✓	
Systems and Partnerships	✓	
Research and Innovation	✓	

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

Regulatory / Statutory reporting requirement

The Trust is required by the NHS Code of Governance to have effective systems of governance, risk management and internal control. Have clearly defined strategic risks underpin these processes.

Communication and Consultation:

The Board has been engaged in its update through a Board workshop in April. Once confirmed then these will form the basis of the 2023/24 BAF.

Report

The Executives have considered the Trust's strategic risk descriptions, and these were shared at a Board workshop for debate and discussion. The strategic risks were also scored for their current score, their target score for the year and ultimately their goal score aligned to the Trust's risk appetites statements.

As expected, many of the Trust's strategic risks have not changed significantly from those of 2022/23 but the Trust has taken the opportunity to have an explicit statement in respect of environmental sustainability and consolidate those relating to research and innovation into one risk whilst the Trust Research and Innovation strategy is finalised over the next few months, noting this may then see a further adjustment to that risk.

23/24 Strategic Risk (by domain and lead executive)	23/24 Cause	23/24 Effect	Opening (current) score I x L	Target score I x L	Goal Score I x L
PATIENT We are unable to deliver or demonstrate a continuous and sustained improvement in patient experience resulting in adverse reputational impact, and poorer patient experience. **CHIEF NURSE**	Rising demand in both elective and unscheduled (urgent) care may as well as high levels of bed occupancy lead to increased waiting times.	Adverse reputational impact, loss of market share, rise in patient complaints and concerns and suboptimal patient experience.	4 x 4 = 16	4 x 3 = 12	3 x 2 = 6
SUSTAINABILITY We cannot continue to deliver efficiencies and increase productivity whilst operating in a financially constrained framework and are unable flex resources to deliver strategic and operational plans. **CHIEF FINANCIAL OFFICER**	Trust capacity is not aligned to demand or is not affordable	The Trust is unable to live within it means and meet statutory requirements for financial balance.	4 x 4 = 16	4 x 3 = 12	4 x 2 = 8
SUSTAINABILITY We are unable to meet high standards of financial stewardship meaning we cannot sustain compliance with our statutory financial duties. **CHIEF FINANCIAL OFFICER**	Poor control environment	Damage to the Trust's reputation, resources not used for patient benefit	4 X 3 = 12	4 x 3 = 12	4 X 2 = 8
SUSTAINABILITY We are unable to deliver the changes required to become environmentally sustainable, reduce our carbon footprint and achieve the ambition to be a net zero carbon organisation. **CHIEF FINANCIAL OFFICER**	Logistical, financial and behavioural barriers prevent opportunity to reduce our carbon footprint.	The Trust is unable to minimise our impact on the environment, delivering care that is net zero carbon	4 x 3 = 12	4 x 3 = 12	4 x 2 = 8
PEOPLE The capability and capacity of leadership across the Trust is insufficient to lead continuous improvement and build a high performing organisation across the breadth of our patient first TN objectives. **CHIEF PEOPLE OFFICER**	Not every leader is developed and supported to a consistent standard, lack of a complete suite of development programmes and the capacity to deliver them, leaders' own capacity is stretched by the breadth of their objectives, expectations and the roles & responsibilities of leaders not all clarified and some leaders' behaviours	Poorer staff satisfaction leading to poorer patient satisfaction, recruitment and retention of staff, and poorer delivery and performance across the range of True North domains	4 x 3 = 12	4 x 2 = 8	3 x 2 = 6

	not consistent with a kind compassionate approach.				
PEOPLE We are unable to develop and embed a culture of continuous improvement built on high staff engagement, inclusion and involvement. **CHIEF PEOPLE OFFICER**	Poor leadership & management of staff & teams, poor people processes and systems, lack of teamwork, poor planning, rostering & staff support, lack of training and development, insufficient focus on Equalities & Inclusion	Staff do not feel valued, negatively impacting staff retention (turnover), recruitment and equality metrics.	4 x 4 = 16	4 x 3 = 12	4 x 2 = 8
PEOPLE We are unable to meet our workforce requirements through effective workforce design (skill mix), recruitment, development, training and retention of sufficient staff adversely affecting capacity to deliver services, continuous improvement and Patient First TNs. **CHIEF PEOPLE OFFICER**	Inability to recruit new staff in an increasingly competitive labour market, poor workforce design, insufficient flexible work options, inability to retain staff through creating a positive inclusive work environment with attractive career development.	Staff cannot be sourced or do not feel valued and retained thus vacancy and turnover rates increase leading to increased bank and agency use and staff stretch.	4 x 4 = 16	4 x 3 = 12	4 x 2 = 8
PEOPLE We are unable to consistently meet the health, safety and wellbeing needs of our staff, particularly impacting minoritized groups usually disproportionately affected, in the context of the lasting long term impact of the pandemic and other post-pandemic challenges such as high inflation, financial hardship leading to high levels of absence and inability to retain staff **CHIEF PEOPLE OFFICER**	The longer term impact of the pandemic on staff remains unclear and new challenges such as the cost of living crisis add to the pressure on colleagues, particularly minoritized staff. H&W support is not always understood, accessible or as relevant as it might be for all, or able to met their expectations.	Staff will continue to need support in maintaining their safety and well-being, specifically in more vulnerable groups, and without it sickness absence will remain high leading to increased bank and agency usage and staff stretch.	4 x 3 = 12	4 x 2 = 8	4 x 1 = 4
QUALITY We are unable to deliver safe and harm free care to reduce mortality and morbidity. **CHIEF NURSE / CHIEF MEDICAL OFFICER**	The backlog of care resulting from the pandemic, the overall demands pressures on hospital and wider nhs and social care services is causing increased waits for Trust services. Long waits for patients to progress through their pathway or their next place of care for both physical and mental	Increased risk to patient outcomes and reputational risk if effective oversight of patients waiting and the implementation of flow improvements are not maintained.	4 x 3 = 12	3 x 3 = 9	3 x 2 = 6

	health pathways contributing increased morbidity and mortality				
QUALITY We are unable to deliver service improvements to improve safety and outcomes for our patients or to demonstrate that our services are clinically effective and comply with regulatory requirements or clinical standards. **CHIEF NURSE / CHIEF MEDICAL OFFICER**	Ineffective or inefficient oversight of regulatory standards and compliance with national audit	Increased risk to patient safety and reputation if the organisation is unable to demonstrate adherence to national and regulatory standards and best practice.	4 x 5 = 20	4 x 3 = 12	3 x 2 = 6
SYSTEMS AND PARTNERSHIPS 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. **CHIEF STRATEGY OFFICER**	ICS is established but yet to define its operating model at place and neighbourhood level	We are not at the forefront of the ICS/ICP development, and benefits for patients, organisation and system are delayed or missed.	4 x 2 = 8	4 x 2 = 8	4 x 1 = 4
SYSTEMS AND PARTNERSHIPS 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. **CHIEF STRATEGY OFFICER**	We fail to update and then implement the clinical strategy for the organisation	Our services become clinically unsustainable	4 x 4 = 16	4 x 4 = 12	4 x 2 = 8
SYSTEMS AND PARTNERSHIPS We are unable to deliver and demonstrate consistent compliance with the 23/24 operational plan and NHS constitutional standards resulting in an adverse impact on patient care and financial penalties and the Trust's reputation. **CHIEF OPERATING OFFICER**	Core capacity doesn't meet demand, including significant backlogs post pandemic, increased volumes of non-elective care diverting resources from elective care / increased demand for cancer care out stripping capacity / and potential winter demands effect elective care	Intervention from NHSE / reduction in patient choice due to longer waits / potential poor experience and/or clinical outcomes for long waiting patients / rise in complaints or reduction in FFT	4 x 5 = 20	4 x 4 = 16	4 x 2 = 8

RESEARCH AND INNOVATION We are unable to fully harness research and innovation capacity and capabilities thus being unable to meet the Trust's stated ambition of being a high-class research organisation. This may impact on our ability to attract and retain staff and provide the highest quality of intervention for patients. **CHIEF MEDICAL OFFICER**	The Trust does not currently have an integrated Research and Innovation Strategy and agreed implementation plan. There is also a lack of a resourced physical environment, developed structure of education and training to support clinical research. Limited system / partner research integration,	We are unable to realise the potential of R+I to attract and retain high calibre workforce, improve patient care, enhance our reputation and attract external research funding.	4 x 4 = 16	3 x 3 = 9	3 x 2 = 6

Key Recommendation(s):

The Board is asked to **APPROVE** these as the opening strategic risks for 2023/24 for inclusion within the Trust 2023/24 BAF noting that as the Research and Innovation Strategy is finalised then the relevant strategic risk narrative may change.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	22	**Meeting:**	Board	**Meeting Date:**	4 May 2023
Report Title:	Company Secretary Report				
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	☐	
Link to ICB / Trust Annual Plan					
Link to ICB Annual Plan	✓	Link to Trust Annual Plan	✓		
Implications for Trust Strategic Themes and any link to BAF risks					
Patient	☐				
Sustainability	☐				
People	☐				
Quality	☐				
Systems and Partnerships	☐				
Research and Innovation	☐				
Link to CQC Domains:					
Safe	☐		Effective	☐	
Caring	☐		Responsive	☐	
Well-led	✓		Use of Resources	☐	
Regulatory / Statutory reporting requirement					
Governor elections are held in accordance with the Trust's constitution.					
Communication and Consultation:					

Report:

This report provides the Council of Governors with an update on matters aligned to the Trust's constitution or other regulatory requirements not covered within other reports.

NHS Code of Governance and Provider Licence

A new NHS Code of Governance has taken effect from the 1 April which sees this code become applicable to NHS Trusts where previously the code was only mandated for Foundation Trusts. The code retains the principles of comply or explain in recognition that Boards may elect to meet the objectives of code through differing processes.

The Code continues to set out its principles and supporting provisions across 5 areas; Board Leadership and Purpose; Division of Responsibilities; Composition, Succession and Evaluation; Audit, Risk and Internal Control; and Remuneration. Whilst there are a number of changes in this code to the previous code in many areas, examples including the areas workforce wellbeing and system working the Trust already has systems in place to comply with these requirements. For some other areas for example the area of digital the Trust in its review of the Board Committees' terms of reference has broadened the oversight of the Audit Committee to encapsulate the wider digital foundation standards to align to the oversight expected through the revised code. For other areas such as the involvement of NHS E and the ICB within Board appointments these would be considered during the appointment process, noting that the Trust has previously engaged with the region and the system within its senior executive appointments processes.

The revised code was mentioned briefly at the last Audit Committee meeting where it was agreed that a Board update would be provided on the changes, recognsing that the fundamental tenants of the code have not changed materially for Foundation Trust's.

A revised provider licence has been issued to Trust's reflecting this applies now to NHS Trust's in the same way it did previously for Foundation Trust's, reflects the duty of collaborate aligned to the NHS Code of Governance and NHS Long Term Plan and removes all reference to NHS Improvement following its absorption into NHS England.

Governor Elections

We completed our election process for the Worthing and Southlands staff governor. The process retuned Sue Shepherd, a matron, who was elected for a three-year term commencing 1 April 2023.

We have commenced elections for the staff governor position for Princess Royal Hospital and the Public Governor positions for Mid Sussex and Brighton and Hove. The nomination process ended on the 2 May with the election process then following with the planned election results to be returned on 21 June 2023. We have held a series of drop-in information sessions for those interested in applying for these positions allowing the role to be explained and to answer any questions.

Associate Non Executive Director retirement

Lillian Philip retired from the Trust as an Associate Non-Executive Director at the end of her term of office on the 19 April 2023.

Key Recommendation(s):

The Board is recommended to **NOTE**

- That a new NHS Code of Governance can into effect from 1 April along with updated licence conditions and that the Trust has taken steps to ensure it remains complaint with both
- the retirement of Lillian at the end of her term of office
- the election result that has seen Su Shephard returned as Staff Governor for Worthing and Southlands
- the ongoing election process for the Staff Governor for Princess Royal Hospital and the Public Governor positions of Mid Sussex and Brighton and Hove.