University Hospitals Sussex
NHS Foundation Trust

Meeting of the Board of Directors

10:00 to 13:30 on Thursday 03 August 2023

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

AGENDA – MEETING IN PUBLIC

Item:1	Time: 10:00	**Welcome and Apologies for Absence** To note	Verbal	Presenter: 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 eight Board members. With a minimum of two Executives and two Non-Executive Directors.*	Verbal	Presenter: Alan McCarthy
Item:2	10:00	**Declarations of Interests** To note	Verbal	Presenter: All
Item:3	10:00	**Minutes of UHSussex Board Meeting held on 04 May 2023** To approve	Enclosure	Presenter: Alan McCarthy
Item:4	10:05	**Matters Arising from the Minutes** NONE	N/A	Presenter: Alan McCarthy
Item:5	10:05	**Report from Chief Executive** To receive and note overview of the Trust's activities	Enclosure	Presenter: George Findlay
Item:6	10:20	**ICS – Sussex Shared Delivery Plan** To receive and note ICS activities	Enclosure	Presenter: George Findlay
		INTEGRATED PERFORMANCE REPORT		
Item:7	10:25	**Chief Executive's Introduction** To receive and note		
Item:8	10:30	**Patient** To receive and note	Enclosure	Presenter: Leanne Mclean
Item:9	10:35	**People** To receive and note	Enclosure	Presenter: David Grantham
Item:10	10:40	**Sustainability** To receive and note	Enclosure	Presenter: Karen Geoghegan
Item:11	10:50	**Quality** To receive and note	Enclosure	Presenter: Leanne Mclean

				Katie Urch
Item:12	11:00	**Systems and Partnerships** To receive and note	Enclosure	Presenter: Andy Heeps
Item:13	11:05	**Research and Innovation** To receive and note	Enclosure	Presenter: Katie Urch Rob Haigh
Item:14	11:10	**Systems Oversight Framework** To receive and note	Enclosure	Presenter: Darren Grayson
Item:15	11:15	*At this point the Chair will invite Board members to ask questions and discuss any pertinent areas of the Integrated Performance Report and agree any necessary actions.*		
Item:16	11:45	**Board Assurance Framework and Corporate Risk Register highlight report** To approve	Enclosure	Presenter: Darren Grayson Glen Palethorpe
	11:50	***5 Minute Break***		
		ASSURANCE REPORTS FROM COMMITTEES		

Item:17	11:55	**Report from Patient Committee *including Research and Innovation***
		To note assurance from Committee and recommendations from the Committee
		- **from the meeting held on the 25 July 2023 including:**
		  - *Annual Patient Experience Report 2022-23*
		  - *Revised Terms of Reference*
			Enclosure	Presenter:
				Claire Keatinge

Item:18	12:05	**Report from Quality Committee**
		To note assurance from Committee and recommendations from the Committee
		- **from the meetings held on the 23 May, 27 June and 25 July 2023 including:**
		  - *Annual Learning from Deaths Report 2022-23*
		  - *Annual Medical Revalidation & Appraisal Report 2022-23*
		  - *Annual Adults Safeguarding Report 2022-23*
		  - *Annual Children's Safeguarding Report 2022-23*
		  - *Clinical Strategy*
		  - *Revised Terms of Reference*
		To approve for submission
			Enclosure	Presenter:
				Lucy Bloem

Item:19	12:25	**Report from People Committee** To note assurance from Committee and recommendations from the Committee - **from the meeting held on the meetings held on the 24 May, and 25 July 2023 including:** - *Annual Equality Report 2022-23 including WRES & WDES* To approve for publication on the Trust Website	Enclosure	Presenter: Paul Layzell

Item:20	12:40	**Report from Sustainability Committee** - **from the meetings held on the 25 May, 29 June and 27 July 2023** To note assurance from Committee and recommendations from the Committee	Enclosure	Presenter: Lizzie Peers
Item:21	12:40	**Report from Systems and Partnerships Committee** - **from the meeting held on the 27 July 2023** To note assurance from Committee and recommendations from the Committee	Enclosure	Presenter: Bindesh Shah
Item:22	12:40	**Report from Audit Committee** - **from the meeting held on the 18 July 2023 including:** - *Annual Audit Committee Report to Board* To note assurance from Committee and recommendations from the Committee	Enclosure	Presenter: David Curley
		WELL LED & COMPLIANCE		
Item:23	13:05	**CQC Update including:** ▪ **Action Tracker** ▪ **Well-Led Action Tracker** To note	Enclosure	Presenter: Leanne Mclean Darren Grayson
Item:24	13:20	**Company Secretary Report** To note	Enclosure	Presenter: Glen Palethorpe
		OTHER		
Item:25	13:25	**Any Other Business** To receive any notified business and action	Verbal	Presenter: Alan McCarthy
Item:26	13:25	**Questions from the public** To receive and respond to questions submitted by the public at least 48 hours in advance of the meeting.	Verbal	Presenter: Alan McCarthy
Item:27	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 09 November 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	Presenter: Alan McCarthy

Minutes

University Hospitals Sussex
NHS Foundation Trust

Minutes of the Board of Directors meeting held in Public at 10.00am on Thursday 04 May 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 *(virtually via MS Teams)*
David Curley	Non-Executive Director
Bindesh Shah	Non-Executive Director
Professor Malcolm Reed	Non-Executive Director
Dr Andy Heeps	Chief Operating Officer and Deputy CEO
Karen Geoghegan	Chief Financial Officer
Leanne Mclean	Interim Chief Nurse
David Grantham	Chief People Officer
Professor Katie Urch	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/05/23/1 WELCOME AND APOLOGIES FOR ABSENCE **ACTION**

1.1 The Chairman welcomed all those present to the meeting.

1.2 Alan McCarthy took the opportunity to thank Lillian Philip, who was retiring from her role as Associate Non-Executive Director, for her contribution over the past three years and wished her well for the future.

1.3 There were apologies for absence received from Maggie Davies, and Sadie Mason.

TB/05/23/2 DECLARATIONS OF INTERESTS

2.1 There were no other interests declared.

TB/05/23/3 MINUTES OF THE MEETING HELD ON 02 FEBRUARY 2023

3.1 The Board received the minutes of the meeting held on 02 February 2023.

3.2 The minutes of the meeting held on 02 February 2023 were **APPROVED** as a correct record.

TB/05/23/4 MATTERS ARISING FROM THE MINUTES OF THE PREVIOUS MEETING

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

TB/05/23/5 Chief Executive Report

5.1 George Findlay began by acknowledging the privilege and responsibility of being Chief Executive at UHSussex and took the opportunity to say thank you to staff highlighting that March, April and May had continued to be challenging months for staff and services due to the affects of flu, Covid and ongoing industrial action. George highlighted that staff had continued to go above and beyond by cancelling holidays and being redeployed to other areas.

5.2 The Board was advised that unfortunately the impact on patients due to the increased operational pressures and ongoing industrial action had been significant. George explained that the Trust had, had to cancel many thousands of patients' appointments but assured the Board that the Trust was working hard to reschedule those cancelled appointments as soon as was possible.

5.3 George drew the Board's attention to the achievements, awards and recognition section of the report and drew out some of the key highlights, including more teams across the Trust graduating from the Trust's Patient First Improvement System (PFIS) some these teams included Ophthalmology at Southlands, Discharge Lounge Teams and Discharge Co-ordinators Trust wide, Referral Hub Teams and Clinical Site Management Teams plus many more. 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. 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.

5.4 George explained that the Trust was continuing to invest with plans agreed to invest £48m at RSCH, to deliver a radical improvement to the Emergency Department (ED) and the way in which the local NHS supports people needing urgent care. In addition, it was noted that the new Louisa Martindale Building (LMB) would be opening soon, George advised that the Trust had slightly revised its opening plans to allow a little more time to commission the building management system.

5.5 The Board was advised that there had been a comprehensive consultation exercise underway in respect of Stroke services at UHSussex. George explained that the Trust was confident that the 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. It was noted that an independent organisation was currently collating all the feedback.

5.6 Alan McCarthy took the opportunity to echo George's thanks to staff adding that he had recently had the pleasure of attending the long-service awards with George to thank and meet staff, which had been an uplifting event.

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

TB/05/23/6 ICS

6.1 George Findlay provided the Board with a brief update in respect of the Trust's work with the ICS noting that the main focus for the ICB over the recent months had been the in the construction of the 2023/24 plan.

6.2 George noted his gratitude to colleagues that had made significant contributions to the UHSussex element of the system wide plan and explained that there was an added level of complexity due to it being a Sussex plan this year. George explained that there would be a transition into 11 workstreams of work that would be the platform for the implementation of the plan, including an Urgent and Emergency Care (UEC) Programme Board which would provide a much wider collaborative way of working to deal with emergency care demand.

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

TB/05/23/7 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/05/23/8 Patient

8.1 Leanne Mclean 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 during Q4 over 37k patients responded to the Trust's FFT returning a 91% positivity rating for the experience they received whilst Maternity returned a 100% over all 4 sites. Leanne explained that the Trust had received 275 complaints during Q4, it was noted that themes in negative patient feedback continue to relate to waiting (on site and for treatment), clinical treatment, communication and staff behaviours and discharge the Board was advised that these themes were the drivers behind the patient experience strategy 2022-25.

8.3 In addition, it was noted that in relation to patient feedback regarding attitude and behaviours the Trust was introducing new welcome standards to support and guide staff with welcoming patients though the organisation.

TB/05/23/9 Research and Innovation

9.1 Katie Urch 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 Katie advised that Board that the Breakthrough Objective for the R&I domain was to increase recruitment to research projects across all specialities which was currently ahead of trajectory. It was noted that the work underway to support this breakthrough objective was the development of the R&I strategy, which by the end of Q2 it is hoped will be fully developed and be able to support the delivery of the UHSussex R&I ambitions.

9.3 Katie explained that the Trust had, had several meetings with the Brighton and Sussex Medical School Health Research Board which will link the Trust's ambitions to being able to meet the needs to of the wider community and the ICB objectives in relation to R&I.

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

9.5 Claire advised the Board that in addition to the standing items on the agenda the Committee welcomed an update on health inequalities from Su Xavier the Trust's Director of Clinical Effectiveness 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.

9.6 The Committee also received an update from the Clinical Director of Research and Innovation on the progress being made to the recruitment of patients to open research studies, Claire noted the engagement and enthusiasm around the new R&I domain. In addition, Claire highlighted to the Board that the Committee had noted the Quality Corporate Project which would enhance the reporting of risk throughout the Trust.

9.7 Patrick Boyle commented that in respect of Patient Experience there had been a marked increase in the number of complaints, Patrick went on to ask if the Trust had the capacity to handle these complaints in a timely way. Leanne explained that the Trust had a robust process in place for dealing with complaints and was assured that the PALs and Customer Complaints teams were working with the Divisions on ensuring they have ownership of their complaints and importantly actioning the learning these provide.

9.8 Patrick asked how the Trust was communicating with patients that were waiting a significant amount of time of treatment, Andy Heeps advised that the Trust regularly validates patient treatment lists to ensure that patients still require the treatment they are waiting for and added that patients have been incredibly understanding and respectful despite the wait they are experiencing.

TB/05/23/10 Quality

10.1 Katie Urch updated the Board on the key messages from the Quality section of the report in respect of the mortality True North.

10.2 Katie advised the Board that the UHSussex crude 12-month rolling mortality rate for non-elective admissions was 3.26% and in month for March was 2.71%. It was noted that both monthly and 12-month rolling crude mortality had been decreasing since December.

10.3 The UHSussex rolling 12-month HSMR is 99.1. Katie explained that this was within the expected range and decreasing. The rolling 12-month HSMR without adjusting for specialist palliative care had remained in the 'very high (>99.8%)' category.

10.4 The UHSussex rolling 12-month SHMI is 111.6 which remains in the expected range. Katie explained that after a spike in December, the 12-Month rolling crude mortality continues to fall Trust wide and at all sites, rolling crude mortality is particularly low at PRH at 2.40%. SHMI continues to be high across the Trust. This is mainly driven by a very high SHMI at RSCH (124.9), whilst SHMI at PRH which had been an issue previously has now fallen every month since May 2022 and now sits at a similar level to SRH and Worthing Hospital.

10.5 Leanne Mclean 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 the highest percentage of reported patient safety incidents are graded as low or no harm which for March 2023 was 69%, this indicates a positive reporting culture at UHSussex. In addition, there had been a 35% reduction in severe harm or death since April 2022.

10.7 Leanne explained to the Board that the Trust had seen an increase in the number of patient falls in month but noted that there were a number of pieces of work underway to prevent this from further increasing with additional risk assessments and ensuring bay-watch is in place to try and prevent unwitnessed falls.

10.8 In respect of staffing fill rates Leanne explained that 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. It was noted that there had been a slight increase in the overall fill rate for both Registered Nurses (RN) 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.

10.9 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.

10.10 Lucy advised the Board that the Committee had met 3 times since the last Board meeting and during those meetings had received an update from the Director of Clinical Effectiveness and the Learning from Deaths manager. It was noted that the Committee had received updates in respect of external feedback with improvements noted including updates in respect of foetal monitoring and the Maternity Voices group.

10.11 Lucy highlighted to the Board that 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 those areas caring for children and young people. The Committee noted that two reports covering mental health 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. The Committee also discussed workforce well-being and safety. Lucy concluded by informing the Board that the Committee has asked for a further update on the quality risks in respect of dealing with patients with Mental Health as well as Physical Health conditions.

TB/05/23/11 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 Trust had received its National Staff Survey results for 2022, 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". David explained that this was below national average of 47.2% compared to 48% (2021). It was noted that the Trust continues to carry out Pulse Surveys with 58.2% of staff responding positively

in month which was above target compared to the 2022 national staff survey average and continues to be an improvement in the monthly score which has increased for the last three consecutive months.

11.3 David explained that the Trust was working on providing staff with feedback if a concern has been raised to ensure that they feel that their concerns are being listened to.

11.4 It was noted that the Trust continues to run a leadership and development programme for all senior and divisional leaders. David advised the Board that the Trust was planning to move staff appraisal to an online format with the hope that it would make it more accessible and support with an improvement in compliance following a deterioration in compliance for non-medical appraisals during March.

11.5 David highlighted the key statistics noting an increase in the in-month staff sickness rates and increase in consultant appraisals and a reduction in the number of HCA vacant posts. In addition, it was noted that there had been a slight deterioration in Statutory and Mandatory training, positively there had been some innovative recruitment with and increase in Registered Nursing (RN) recruitment.

11.6 The Board was advised that the team would be carrying out a deep dive into staff sickness rates with the actions and learning to be shared with the People Committee in May.

11.7 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.

11.8 Patrick advised the Board that the operation of this Committee had progressed with a revised meeting schedule and was maturing well. It was noted that in all the reports received by the Committee reference to the strong divisional engagement with the people agenda had been made. The Committee received a deep dive from the Cancer Division and Clinical Support Services division on their people processes.

11.9 Patrick highlighted that the Committee had discussed the proactive actions being taken in respect of encouraging people to speak up through summarised feedback from Divisional focus groups, the Committee heard that the Freedom to Speak Up (FTSU) Guardian function needed wider publicity following the change to the current delivery model. The progression towards a procured Guardian Service was supported allowing a transition later to a Trust appointment given that the Trust had been unsuccessful in its recruitment to a FTSU guardian.

11.10 David reminded the Board that the Trust had been let down at the last minute by the previously appointed individual for the FTSU Guardian who had elected not to join the Trust for personal reasons. Therefore, the Trust has engaged a service called the guardian service. The Board was advised that this was an approved provider and was supported by the national guardian's office, David explained that the Trust would initially engage them on a fix term basis, and it was hoped that it would be reassuring to staff.

TB/05/23/12 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 Karen advised the Board that it had been highlighted previously that achieving a breakeven position for 2023/2024 would be extremely challenging taking into consideration the impacts of:

- Urgent and emergency care pressures,
- Elective activity requirements,
- Industrial action and;
- Excess inflation costs.

12.3 The Board was advised that the Sussex ICB and the Trust had reached an agreement 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. Karen explained that income & expenditure performance was £10.39m, Capital expenditure for the 2022/23 year was £118m which was £1.66m above plan and the Trust delivered £42m of efficiency savings. It was noted that cash was £14.37 less than plan but this was predominantly due to the Trust making higher than planned payments in order to maintain the Trust's Better Payments Practice Code with performance at 88% against a target of 95%.

12.4 Karen then provided the Board with an update in respect of the 2023/2024 Financial Plan and explained that the 2023/24 financial plan had been developed based on the modelling assumptions set out in the planning guidance and associated consultations which were circulated in December 2022 by NHSE. The intent being to recover core services and productivity alongside continuing to transform the NHS for the future.

12.5 It was noted that the 2022/23 baseline allocations were the start point for the 2023/24 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.

12.6 Karen added that additional funding (ERF) for elective services recovery will be earned by Systems delivering above 100% of the value of the 2019/20 activity baseline. Whilst for System providers there is more flexibility to agree individual provider targets, overall, the Sussex system must meet the target it has been set. It was noted that the Sussex ICS would be submitting a plan to deliver breakeven on the 4 May, within which the Trust would also submit a breakeven plan for 2023/24.

12.7 The Board was advised that 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.

12.8 Karen added that the Trust has submitted a Capital plan totalling £108.5m.

12.9 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.

12.10 Lizzie advised the Board that the 2023/2024 financial plan had been taken directly to the Private Board for approval during April and as such had not been discussed at the Sustainability Committee at the April meeting. It was noted that the Committee had focussed on the challenges and learning for year-end and the underlying deficit position.

12.11 The Board was advised that the Committee had discussed at length the Productivity breakthrough objective noting that length of stay for patients was highlighted and the opportunities to reduce inpatient length of stay will support the Trust's productivity trajectories

12.12 Lizzie advised that the Committee had received the 2023/2024 Capital Plan and discussed the significant number of positive Capital projects completed during the 2022/24 year.

12.13 Alan McCarthy commented that it had been a challenging year for the Trust within a challenging environment, with 2023/24 expected to be equally if not more challenging, Alan highlighted to the Board that the key for UHSussex was the level of Productivity that the Trust can achieve.

TB/05/23/13 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 noting that the Trust was not meeting its trajectory against the three True North components.

13.2 **A&E**
Andy advised the Board that the Trust treated 68.8% of patients within 4 hours of attending all A&E departments during March 2023 against national performance of 71.5%. It was noted that winter pressures eased marginally, but Trust capacity constraints were exacerbated due to Industrial Action.

13.3 Andy explained that whilst the Trust's performance for the number of patients waiting over 12-hours in the emergency department (ED) was improving, although it remained off target. The median hour of discharge was also improving and was now at 13:56 from a baseline of 16:03, length of Stay (LOS) had reduced from 5.9 days to 4.7 days from January to the end of March, Andy noted that whilst there was a seasonal impact to the reduction in the LOS he was confident that the improvement methodology was beginning to embed with further reductions expected.

13.4 **RTT**
The Trust had 46.8% of patients waiting longer than the target 18 weeks at the end of March-23. National performance was 58.5% during February 2023. 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 in February. It was noted that the Trust continued to focus on the elimination of those patients experiencing the longest waits.

13.5 **Cancer**
It was noted that 53.6% of patients were treated within 62 days during February. National performance was 58.2%. The Board was advised that there had been a marginal reduction in over 62-day and 104-day prospective waits in the period up to March 2023, with a reduction from 331 in February 2023 to 325 in March 2023 for patients waiting over 62-day, and from 114 patients in January 2023 to 95 patients in March 2023 for patients waiting over 104-days. Andy explained that the Faster Diagnosis Standard (FDS) performance was 74.3% during February, which was an improvement of 15% since January, and the Trust's best performance to date.

13.6 **Diagnostics**
The Trust had 22.3% of patients waiting more than 6 weeks at the end of March for a diagnostic test against a 1% target. The Board was advised that this was

an improvement of -4.0% since February 2023 and -15.3% since December 2022. The National average for January 2023 was 25.1%

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 a very detailed discussion in respect of the Trust's performance indicators and refreshed trajectories for the coming year and the impact that these would have in relation to the Trust's productivity requirements, Bindesh added that the Committee had acknowledged the possibility of further industrial action and the impact that this would have on the Trust's trajectories.

13.9 The Board was advised that the Committee had received a detailed update in respect of the progress for the opening of the Louisa Martindale Building at RSCH and was assured by the process and approach being taken. Bindesh highlighted that the Committee had also discussed Stages 2 & 3 of 3Ts and the planning that was underway.

TB/05/23/14 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 there had been no change to the position during the quarter and that the Trust remained in segment level 3. 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/05/23/15 Report from Patient Committee Chair *including Research and Innovation* from the meeting on 25 April 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/05/23/16 Report from Quality Committee Chair from the meeting on 28 February, 28 March and 25 April 2023

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

TB/05/23/17 Report from People Committee Chair from the meeting on 26 April 2023

17.1 The Board **RECEIVED** and **APPROVED** the Staff Survey Results for Publication on Trust Website.

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

TB/05/23/18 Report from Sustainability Committee Chair from the meeting on 27 April 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/05/23/19 Report from Systems & Partnerships Committee Chair from the meeting on 27 April 2023

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

TB/05/23/20 Report from Audit Committee Chair from the meeting on 20 April 2023

20.1 David Curley, Chair of the Audit Committee, presented the Chair's report from the meeting held on 20 April and drew out the following key points.

20.2 David advised the Board that the Committee had spent some time discussing the BAF and the risk register and noted the developments being made to the 2023/2024 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.

20.3 It was noted that the Committee had received updates from the Local Counter Fraud Services, the External Auditors who advised that they had begun their testing for year-end, and the Internal Auditors and progress against the plan for the year from which to the Committee took assurance.

20.4 David advised that the Committee had received the annual declarations as part of 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.

20.5 Alan McCarthy thanked David for his update adding that the focus on risk that the Committee is providing was very welcomed.

20.6 The Board **APPROVED** the Trust's assessment of compliance with its Provider Licence, which was included at appendix a of the report, for publication on the Trust website.

TB/05/23/21 Report from Charitable Funds Committee Chair from the meeting on 18 April 2023

21.1 Lizzie Peers, Chair of the Charitable Funds Committee, presented the Chairs report from the meeting held on 18 April and drew out the following key points.

21.2 Lizzie advised the Board that the main focus of the Committee had been in relation to the recent merger of Love your Hospital and BSUH Charity to form the new UHSussex charity 'My University Hospitals Sussex' which had taken effect from 01 April 2023.

21.3 It was noted that the Committee had received and agreed the Charity Strategy and noted the implementation of the agreed joint Charities Operating Plan for the period April 22 – March 23.

21.4 Finally, Lizzie advised that the Committee considered a number of bids and assessed these against the expected public and patient benefits and recognised the enhancements made to the quality of bid paperwork.

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

TB/05/23/22 Board Assurance Framework and Corporate Risk Register highlight report

22.1 Darren Grayson presented the Board Assurance Framework (BAF) and accompanying Corporate Risk Register and explained that the report had been received by the Committees and reflected the views of each Committee responsible for their specific risks.

22.2 The Board was advised that the new and refreshed BAF had been confirmed and would be shared with the Board at its next meeting in August.

22.3 Alan McCarthy commented that it was important that as a consequence of the Committee meetings and the information received during the Board meeting through the information provided in the integrated performance report and Committee Chairs reports, that the Board is satisfied with the scores detailed within the BAF.

22.4 Claire Keatinge commented that as Chair of the Patient Committee she was content that the BAF had been appropriately scrutinised and the referral to the Board for endorsement of the current scores was appropriate.

22.5 Bindesh Shah, Chair of the Systems & partnerships Committee commented that the S&P Committee had discussed, in relation to risk 5.1, wider system working, and that working closely and collaboratively with the system would be key to the Trust delivering its trajectories in respect of both Urgent and Emergency Care and elective care.

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/05/23/23 Risk Management Strategy

23.1 Darren Grayson presented the Risk Management Strategy and highlighted the following areas.

23.2 The Board was reminded that it had been engaged in the review of the risk management strategy and risk appetite statements during a Board Workshop in April, Darren explained that the updated strategy and supporting paper captured the output of the workshop noting that broadly the appetite statements have not changed, however there had been the addition of explicit appetite statements relating to environmental sustainability and research and innovation.

23.3 Darren advised the Board that the revised Risk Management Strategy and Risk Appetite Statements would replace the current documents on the Trust website.

23.4 Alan McCarthy thanked Darren for the updated and confirmed that the Board had collectively spent some time reviewing the Trust's risk appetite statements during a workshop.

23.5 The Board **APPROVED** Risk Management Strategy including the Trust's Risk Appetite Statements for publication on the Trust's public website.

TB/05/23/24 Strategic Risks 2023/2024

24.1 Darren Grayson introduced the 2023/2024 Strategic Risks paper and drew out the following salient points.

24.2 Darren explained that the Executive team had considered the Trust's strategic risk descriptions, these were shared at a Board workshop for debate and discussion during April. It was noted that 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. This will enable the Trust to track improvement in the score and actions being taken to support the achievement of the strategic risk.

24.3 The Board was advised that 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.

24.4 Lucy Bloem commented that she was pleased to see the inclusion of Mental Health in addition to physical health feature within the Trust's quality risks.

24.5 The Board **APPROVED** the 2023/2024 opening Strategic Risks for the Trust.

TB/05/23/25 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 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.

25.3 Glen advised that 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, recognising that the fundamental tenants of the code had not changed materially for Foundation Trust's.

25.4 A revised provider licence has been issued to Trust's reflecting that 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.

25.5 Glen provided the Board with an update in respect of the recent Governor election process and advised that the Trust had completed its 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.

25.6 It was noted that the Trust had 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. Glen advised that the Trust had 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 which had he believed supported members to come forward with nominations.

25.7 Glen informed the Board that there was a typographical error in his report and as had been referenced by Alan earlier Lillian retired as a NED on the 29 April not the 19 April as recorded in the report.

25.8 The Board **NOTED** the Company Secretary Report for Quarter 4.

TB/05/23/26 OTHER BUSINESS

26.1 There was no other business to discuss.

TB/05/23/27 Questions from Members of the Public

27.1 There were no questions from the public.

TB/05/23/28 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/05/23/29 The Chair formally closed the meeting

TB/05/23/30 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 03 August 2023**.

Tanya Nicholls
Board & Committees Manager
04 May 2023

Signed as a correct record of the meeting

…….. Chair

..…… Date

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	5	**Meeting:**	Trust Board	**Meeting Date:**	August 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	Yes	Assurance	N/A
Review and Discussion	N/A	Approval / Agreement	N/A

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

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	N/A	Link to Trust Annual Plan	N/A

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	Yes	
Sustainability	Yes	
People	Yes	
Quality	Yes	
Systems and Partnerships	Yes	
Research and Innovation	Yes	

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

Regulatory / Statutory reporting requirement

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.

CHIEF EXECUTIVE BOARD REPORT

To: Trust Board **Date: August 2023**

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

1. THANK YOU

1.1 The past three months have continued to prove extremely challenging for our staff and services, and once again I wish to take this opportunity to thank colleagues for all their hard work in very difficult circumstances. Continued industrial action, high demand for urgent care and large waiting lists (caused by the pandemic) have all contributed to the persisting difficulties we face.

1.2 Without the stalwart commitment and dedication of our staff, we would not have been able to continue to provide urgent care for those most in need and maintain patient safety in the face of such adversity. Colleagues have pulled together to support one another and have done their utmost to provide high quality care at all times.

1.3 Unfortunately, ongoing industrial action has led to more appointments and elective procedures being rescheduled to ensure we could prioritise patient safety and life-preserving care during these periods of disruption. These decisions are always difficult to take, and we start from a position to continue with as much activity as we can, while managing the significant risks strike action incurs.

1.4 I want to take this opportunity to apologise to all our patients whose care has been affected in recent months and confirm that we are doing our very best to reschedule patients as swiftly as we can, while industrial action for key groups within workforce looks set to continue.

1.5 Despite the ongoing pressure and relentless demands upon our staff, there are also many positive developments and achievements that it is important we take time to celebrate and share. So, while we know we have a long way yet to go to address all our challenges, I am delighted to be able to highlight a broad selection of achievements below that have occurred since our last Public Board meeting at the beginning of May. Well done to all colleagues involved.

2. CELEBRATING OUR PEOPLE – PATIENT FIRST STAR AWARDS 2023

2.1 The dedication and commitment of our staff and volunteers was celebrated on Friday 23 June at our second Patient First STAR Awards. Winners were chosen from more than 1,100 made by colleagues, patients and the public for individuals and teams who had gone above and beyond.

2.2 Our STAR Awards are a fantastic opportunity to recognise the extraordinary achievements of our staff and the difference they make to patient care. The high number of nominations reflects not just how much great work is going on across our hospitals, but also how appreciative people are of the efforts that are made daily.

2.3 Being on the judging panel for these awards is a real privilege as we heard about so many wonderful stories of innovation, passion and dedication of individuals, teams, and volunteers. I

want to take this opportunity to reiterate heartfelt congratulations to all our winners and to everyone who was shortlisted or nominated for an award.

2.4 Our 2023 Patient First STAR Award winners are: Helen Dobbin (Mentor of the Year); Holly Ellis (Environmental Sustainability Champion); Mel Drayton (Innovator of the Year); Baily Ward Team (Clinical Team of the Year); Electrical & Biomedical Engineering Team (Non-Clinical Team of the Year); Caroline Bailey (Compassionate Care Award); David 'Rocky' Rochester (Volunteer of the Year); Gareth Stone (Hospital Hero); Ride across Britain Team (Fundraiser of the Year); Laundry Team (Star of the Year); Maternity Team (Chairman's Award); and Mortuary Team (Governor Award).

2.5 Full details of the event, including video highlights from the awards ceremony, can be found at www.uhsussex.nhs.uk/news/uhsussex-shining-stars-revealed.The awards evening was made possible thanks to charitable funding from the Trust's dedicated charity My University Hospitals Sussex and corporate sponsorship from Willmott Dixon Interiors.

3. ACHIEVEMENTS, AWARDS AND RECOGNITION

3.1 Innovative new knee replacement technology is now available from our Trust with the Sussex region to offer Mako robot technology for knee replacements. Compared to traditional surgery, the robotic-assisted procedure allows the surgeon to remove bone more precisely, and position the new knee more accurately, which can mean better results for patients. A recent operation was featured on BBC South East news to highlight the introduction of the new procedure.

3.2 Women with severe endometriosis can be diagnosed and treated earlier thanks to a dedicated service at Princess Royal Hospital that has maintained its accredited status for the third year running. Sussex Endometriosis Centre (SEC) is the county's first and only centre of excellence for the diagnosis and treatment of endometriosis – a condition where tissue similar to the lining of the uterus grows outside the uterus.

3.3 We celebrated the second National Healthcare Estates and Facilities Day on 21 June, to recognise the invaluable contribution of the 2,000 E&F colleagues who work across the Trust. They provide essential support 24 hours a day, seven days a week, from catering, security, and transport, to portering, car parking, and welcoming receptions – our E&F colleagues are the often the first people patients and visitors meet and talk to, and without them our hospitals and patient services would come to a grinding stop. Over the past year we have welcomed several hundred new colleagues to our E&F family.

3.4 A study led by Professor Martin Llewelyn, consultant in infection at UHSussex and Professor of Infectious Diseases at Brighton and Sussex Medical School, has been linked to a change in antibiotic prescribing behaviour and a national reduction in antibiotic use. His research team introduced a new toolkit called the *Antibiotic Review Kit* which was introduced at 39 hospitals. The study, which was recently published, showed that more than 30,000 people were trained by the researchers on the toolkit and within 12 months hospitals had reduced overall antibiotic use by almost 5%, compared to the previous year.

3.5 We celebrated Volunteers Week from 1-7 June to recognise the wonderful support they provide for our patients, visitors, and staff. In line with the theme 'celebrate and inspire', a range of celebratory lunches and tea parties were held to thank volunteers and highlight those with the longest service. I want to say a heartfelt thank you to all our volunteers for their unwavering dedication and for going above and beyond in their selfless support for our Trust. Visit

www.uhsussex.nhs.uk/patients-and-visitors/volunteer/ to find out more about volunteering with us.

4. INVESTING IN OUR HOSPITALS

4.1 A newly renovated fracture clinic at St Richard's Hospital will allow patients to be seen more quickly as well as reduce the length of time from referral to first appointment. Previously A&E, the Urgent Treatment Centre (UTC) and the trauma and orthopaedic service at St Richard's all shared the same facilities to treat patients. As well as a larger and lighter space, the refurbished clinic includes a plaster room, individual consultation rooms and additional space to allow for physiotherapists and occupational therapists to join clinics on a regular basis.

4.2 The development of a Community Diagnostic Centre at Southlands Hospital has passed significant milestones with the installation of new CT and MRI scanners. The aim of the CDC is to create a true one-stop model of care, where full diagnostic pathways can be delivered away from an acute hospital setting, improving efficiency and patient experience. Following the opening of Phase One to patients in the Autumn, work will start on Phase Two, refurbishing the current radiology department to provide additional on-site ultrasound, gynaecological investigations, lung function testing and echo services.

4.3 A new children's audiology unit has opened at the Royal Alexandra Children's Hospital offering state of the art facilities and equipment that delivers the service in a new and more appropriate, child-centred, and family-friendly accommodation. The new dedicated children's unit is larger and offers great potential for the service to improve pathways, reduce waiting lists and expand services, such as a diagnosis service for children with balance disorders.

5. LOUISA MARTINDALE BUILDING SUCCESSFULLY OPENED

5.1 The first patients were treated in the new Louisa Martindale Building at the Royal Sussex County Hospital in Brighton on 12 June. The historic milestone saw the newest clinical building in the NHS standing next to the oldest, the Barry Building. Walking between the two buildings was a journey of 50 steps and 195 years! Throughout the month of June, dozens of departments and wards took this journey through history as they transferred from the old Victorian architecture to our state-of-the-art, new facilities.

5.2 Following a meticulously planned schedule, those attending Outpatients appointments on the lower floors of the eleven-story Louisa Martindale Building were the first patients to be welcomed by staff. They were soon followed by others, as more and more services moved into the modern, spacious new estate, culminating with Critical Care moving across from the Thomas Kemp Tower.

5.3 By July, all moves were complete, and the triple storey glass atrium called The Welcome Space formally became the hospital's new main entrance, hugely impressing visitors, patient, and staff alike, as well as media teams from regional television news and newspapers who helped celebrate the opening of the new building. An official opening ceremony will take place later this year.

5.4 An opportunity to improve healthcare on the scale of the Louisa Martindale Building comes along once in a generation and it has been a huge privilege to welcome patients into the new building

with all the benefits it will bring to them, their visitors, as well as our staff. Millions of pounds worth of new medical equipment has been installed to serve patients in the new building, including MRI and CT scanners, x-ray units and bi-planar scanners.

5.5 Two thirds of inpatient beds are in single ensuite rooms, with the remainder provided in single sex bays with a maximum of four patients each. Every ward has a communal patient area where patients can socialise and take their meals, and they have been designed to help staff spend more time with patients. All the Outpatients departments have a welcoming reception area and waiting areas, and each has been designed with purpose-built facilities to enhance patient privacy, confidentiality, and dignity.

5.6 The successful opening is a testament to the thousands of people who have worked on the building programme over the years. I would like to thank them all, from the team who started the design process 15 years ago, to our cleaning, estates, planning and operational colleagues who all worked extraordinarily hard to both make the building ready and successfully manage the move.

5.7 Every single one of them can be proud of the part they have played, and I think their care and dedication already shows through in the experience our patients are having in our amazing new building. 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.

6. SUPPORTING OUR PEOPLE

6.1 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.

6.2 In May, we opened the Southview Lounge, a new staff space in Worthing Hospital where colleagues can enjoy free tea and coffee facilities, a relaxation area and decompression activities. This is the latest staff lounge to open, following successful lounge areas at Princess Royal Hospital and Royal Sussex County Hospital.

6.3 Nearly 70 colleagues attended our Menopause Café in June had 68 attendees, which featured guest speaker Dr Rhianydd McGlone, a practicing GP with an Advanced Certificate in Menopause Care. The menopause group now has more than 100 members receiving information and providing peer support on a regular basis.

6.4 We have launched a new *Developing Culture* workstream and completed an initial 12-week discovery phase in support of our strategic goal of making UHSussex a *great place to work*. Drawing upon the expertise of a range of teams, and working with staff to co-design solutions, the workstream will be making a series of recommendations for consideration by the People Steering group and executive team to improve staff engagement and team morale, by directly addressing key findings from the staff survey.

6.5 We are relaunching our *Trust Ambassador Programme* for staff, which was a diverse network of colleagues from all parts of the Trust and levels of seniority who shared a commitment and enthusiasm for creating positive experiences for everyone they encountered while at work. The Ambassador Programme was previously successful at both our legacy organisations but,

unfortunately, it lost momentum during the pandemic. Relaunching the programme will formally establish a new community of highly engaged staff to boost wider engagement, involvement, and communication Trust-wide. More than 80 colleagues have already repledged to the new programme and wider recruitment activities have begun.

6.6 In June, we launched a new Health and Wellbeing Outlook Calendar to provide a handy way for staff to see what is coming up and view live activities in their areas, such as exercise classes and events. For example, in July, two Clinical Hypnotherapy workshops were held at the Princess Royal Hospital Chapel. Karen Neeson, a clinical solution-focused Psychotherapist and Hypnotherapist facilitated the sessions that included tips, tools, and techniques to support staff in dealing with stress and anxiety in the workplace.

6.7 Our *Cost of Living* support service, launched in January, has continued to help colleagues. To date, the panel have allocated more than £41,300 to 198 staff applications to support with cost of living rises, a sudden drop in income or help with an unexpected expense which has caused hardship. In addition, we believe UHSussex is the first Trust to engage a Financial Wellbeing Support Officer. Tracy Cox-Horton joined the Trust in June as our dedicated Financial Wellbeing Support Officer from Wave Community Bank. Funded by *My University Hospitals Sussex Charity*, Tracy will be offering 1:1 appointments to help staff with money management, budgeting, debt advice and saving and loan advice.

6.8 In May, our new 'Freedom to Speak Up Staff Handbook' became available to staff in May and 'The importance of Speaking Up' was featured as 'Theme of the Week' 22–28 July, ensuring we reach our clinical staff through huddles. Staff and manager toolkits, (Raising and Responding to Concerns; Difficult Conversations; and Civility) are available for staff to access, and we are running live 60-min courses for staff and managers focussed on how to use the toolkits, with opportunities for Q&A and coaching, from July to September.

6.9 In August, we welcome the The Guardian Service (TGS) to UHSussex - an external, specialist provider to help support staff who wish to speak up or raise concerns. We have devoted considerable resource to building a system and a culture where people can feel confident and empowered to speak up, whether within their teams, to other members of staff, or to a Guardian, and we anticipate that TGS can help to strengthen that provision still further. I would also like to place on record my thanks to our colleague Dr Varadarajan Kalidasan, who has been our interim *Freedom To Speak Up Guardian*.

6.10 More than 7,000 colleagues have completed our new Conflict Resolution Training since this was introduced as part of our 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.

6.11 We held two staff conferences in May and June, providing opportunities for staff to come together as a team, share best practice and drive engagement. On 19 May, colleagues from Nursing, Midwifery and Allied Health Professionals came together at The Amex in Brighton for a dedicated event. And on 9 June, educators and trainers from across the Trust also came together for our Education and Apprenticeships Conference at The Amex. This was the showcase event at the end of our Education Week, which included webinars, workshops, and teaching events for more than 500 colleagues.

7. INTERESTED TO FIND OUT MORE?

7.1 The news section of our website provides more detail and great images related to some of the events and achievements I have referenced above. Please visit www.uhsussex.nhs.uk/news. We are also very active on social media. Please join the conversation, comment, like and share by searching for @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.

8. RECOMMENDATIONS

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

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	6	**Meeting:**	Trust Board	**Meeting Date:**	03 August 2023
Report Title:	NHS Sussex – Final Shared Delivery Plan				
Sponsoring Executive Director:	Darren Grayson, Chief Governance Officer				
Author(s):	Oliver Phillips, Director of Strategy and Planning				
Report previously considered by and date:					

Purpose of the report:			
Information	Yes	Assurance	N/A
Review and Discussion	Yes	Approval / Agreement	Yes

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

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	Yes	Link to Trust Annual Plan	Yes

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	Yes	The Strategic Delivery Plan is a single plan that incorporates the priority areas of the NHS Operating Plan requirements for 2023/24, and the delivery plan for the five-year Sussex Health and Care Improving Lives Together Strategy. As such it impacts on the full range of the Trust's strategic themes
Sustainability	Yes	
People	Yes	
Quality	Yes	
Systems and Partnerships	Yes	
Research and Innovation	Yes	

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

Regulatory / Statutory reporting requirement

NHS Sussex Integrated Care Board is required to publish a Strategic Delivery Plan, setting out its priorities and delivery plan. As part of the NHS Sussex system, the ICB is seeking all NHS Trusts to endorse the plan.

Communication and Consultation:

NHS Sussex and partners have undertaken significant engagement and consultation with stakeholders, which his set out in the Executive Summary below.

Executive Summary:

1. Introduction/ Background

Following system governance processes and endorsement at the NHS Sussex Integrated Care Board (ICB) (29 March 2023), the first draft of the Sussex Shared Delivery Plan (SDP) was published on the NHS Sussex website and provided to NHS England (NHSE) on 31 March 2023 for informal review. That review and feedback informed further iteration of the plan.

Further stakeholder engagement and feedback informed development of a final Sussex Shared Delivery Plan which was endorsed by partners at the System Oversight Board (SOB) Membership Meeting 25 May 2023 and formally signed-off by the NHS Sussex Executive Committee 5 June 2023.

The SDP will be delivered as a single plan that incorporates the priority areas of the NHS Operating Plan requirements for 2023/24, (which was submitted to NHSE 30 March 2023) and the delivery plan for the five-year Sussex Health and Care Improving Lives Together Strategy. Publication and submission to NHSE before 30 June 2023 constitutes compliance with national guidelines.

2. Shared Delivery Plan - Development process

A core programme team within NHS Sussex has managed and coordinated the process of drawing the plan together. The Senior Responsible Officer (SRO) for this work is the NHS Sussex Chief Transformation, Innovation and Digital Officer (CTIDO).

The programme has utilised existing operational planning infrastructure to bring together the 2023/24 Operating Plan elements and where necessary, additional working groups have been set up to drive strategic priority content including:

- Building integrated community teams and local partnerships
- Growing and supporting our Sussex health and care workforce
- Improving the use of digital technology and information.

Following endorsement of the changes to year 1, and year 2- 5 deliverables at the System Leadership Forum (SLF) Meeting (13 April 2023) and opportunity for further review by the SOB, (previously SLF) on 11 May 2023, further development of the narrative has been undertaken to reflect the request to strengthen the content on Place, Children and Young People, Primary Care, Carers, Safeguarding, Housing, and feedback received from the Joint Health and Wellbeing Boards, e.g. on prevention.

The iterated version was circulated in advance, and then endorsed by system partners at the Sussex Health and Care Partnership Leaders meeting on 25 May 2023, for onward journey through the respective formal NHS and Local Authority (LA) governance routes. The final, Sussex SDP accompanies this report and was formally endorsed and signed off by means of delegated authority by the Chief Executive Officer (CEO) via the NHS Sussex Executive Committee 5 June 2023, to facilitate LA governance routes and submission to NHSE before the mandated timeline of 30 June 2023.

SROs and respective ICB Chief Officer leads have worked collaboratively on achieving the final SDP and engagement with LA leads, together with other key stakeholders has been proactive throughout the process. The SDP emphasises the detail in the strategic priorities and represents previous endorsements of the first draft SDP, which highlights the strategic response to the Integrated Health and Care Strategy, Improving Lives Together whilst also reflecting local stakeholder feedback. For the key operational priorities, (which are fully detailed in the NHS Operating Plan for 2023/24) emphasis is given in the SDP narrative on how these will help to enable longer term improvements in operational areas.

Detailed content in relation to key performance indicators and target dates fall within the work plans and accountability of the respective Delivery Boards, set up to oversee delivery of the component priorities of the plan and will report progress through to the SOB, as per the agreed governance process.

The SOB endorsed (8 June 2023) communications and engagement plan, for the publication of the SDP, showcases the opportunity for combining the formal launch of the SDP with the NHS 75th anniversary celebrations on 5 July 2023 and the one-year anniversary of NHS Sussex on 4 July 2023.

The communications and engagement approach will be carried out across three phases over a six-month period ensure stakeholders are effectively informed and involved: Pre-publication phase (June 2023); Publication phase (July 2023) and On-boarding phase (July-Nov 2023).

The communications and engagement will be focused on demonstrating progress that has been made historically and recently and the difference that the future work and plans will have to local people.

A full suite of publicly accessible versions will be developed to meet the needs of different audiences including:

- Summary Version, including disability accessible and read aloud.
- Easy read

- Animation with subtitles and British Sign Language
- Feedback response overview
- Stakeholder communications toolkit

All will be available in different languages, on request.

3. Implications

Financial implications: As a system, it has been agreed that Sussex will live within its financial allocation and will plan care and services that fit within the financial envelope. It is recognised across the Sussex Health and Care system that there is greater need to start closing our productivity gap to deliver the operational priorities and a breakeven financial position for 2023/24. An Investment Prioritisation and Decision-Making Framework is being finalised to ensure that maximum value is achieved for the Sussex Health and Care system from the financial resources available and that resources are used efficiently and effectively to deliver the core priorities. The framework is built around the four core purposes of an Integrated Care System (ICS).

Legal implications: The Department for Health and Social Care has published guidance for ICBs to develop five-year plans in partnership with other organisations, providing a flexible framework which builds on existing system and place strategies and plans.

NHS Sussex is legally required to prepare a first draft of the SDP by the start of the 2023/24 financial year (1 April 2023).

However, for this first year NHSE has stated the final date for publishing and sharing the plan is 30 June 2023, allowing the process of engagement with the Sussex Health and Care Assembly and Health and Wellbeing Boards, for example.

Other compliance: The Sussex SDP responds to the NHS Operating Planning Guidance for 2023/24. CEO SROs have been allocated to each of the priority areas to ensure that plans are sufficiently robust and provide assurance that the system can deliver the requirements of the planning guidance.

Risks: A full risk and issues log has been developed as part of the programme. Risks are actively managed with associated mitigations on a weekly basis through a core planning process. No exceptions or escalations have been raised as part of this report although areas of consideration include the following:

- Cost pressures across the system continue to be raised as a challenge for year 1 milestones and complexity in planning for years 2-5 due to unpredictable external factors such as government policy and financial operating model for future years.
- Rapid timeline of fully constituted and operational 11 delivery boards to support governance implementation.

Quality and Safety implications: As agreed as part of the Integrated Care Strategy process for developing Improving Lives Together, a full Quality Impact Assessment will be undertaken against each of the priority areas identified in the SDP. Accountability will be overseen through the newly proposed governance framework and respective Delivery Boards.

Equality, diversity, and health inequalities: As agreed as part of the Integrated Care Strategy process for developing Improving Lives Together, a full Equality, diversity, and health inequalities impact assessment will be undertaken against each of the priority areas identified in the SDP. Accountability will be overseen through the newly proposed governance framework and respective Delivery Boards.

Patient and public engagement: National guidance made clear that in the development of the SDP, existing patient, public and workforce insight and feedback should be drawn upon to inform development of the plan. As part of the development of the Sussex Integrated Care Strategy, Improving Lives Together, our engagement approach successfully delivered direct feedback from 18,000 people, face to face and virtual workshops with 420 people, 500 interviews and direct feedback through partners, 1440 survey responses on our ambition priorities, 800 individual conversations in public engagement events and online communication that has reached more than 200,000 people.

In addition to the extensive engagement already drawn upon in the development of the Integrated Care Strategy, an Engagement Planning Oversight Group has been established to ensure that insight from people and communities is appropriately and satisfactorily represented in the plan. The Group will also ensure that there is an ongoing commitment to, and arrangements for, engagement with people and communities. The membership of that group includes NHS Sussex, Community Ambassadors, Healthwatch's in Sussex, Voluntary Community Sector Alliance Members and Voluntary and Community Sector representatives of inclusion groups with a focus on health inequality, and a Young Person Ambassador.

Health and wellbeing implications: In line with national guidance, the SDP reflects the Health and Wellbeing Strategies and their respective plans for each of the three Places in Sussex, (Brighton and Hove, East Sussex, and West Sussex). The iterative development of the plan has taken into consideration the individual feedback from each of the LA Health and Wellbeing Boards prior to final publication.

4. Governance and accountability

The Sussex Health & Care Assembly is responsible for the development of the Sussex Integrated Care Strategy and the oversight of its overall delivery. Now that the Integrated Care Strategy and SDP have been approved, the Assembly's governance and oversight arrangements will be discussed and agreed by the four statutory partners (ie NHS Sussex, Brighton & Hove City Council, East Sussex County Council & West Sussex County Council) in autumn 2023.

The NHS Sussex Executive Committee also provides oversight on the delivery of the SDP through the System Oversight Board (SOB), which provides scrutiny on the work of the 11 SDP Delivery Boards established to implement the strategy.

In addition, the NHS Sussex Board Forward Plan has been updated to include a systematic review of each of the 11 SDP priorities during the year. It is therefore proposed that the relevant Board Assurance Committees should review the SDP priorities in the preceding month to the Board Forward Plan so that the Board can have a fully rounded assurance debate on the effectiveness of the NHS contribution to the delivery of each SDP priority. An increase in the frequency of Board Assurance Committee Meetings has been incorporated into the Terms of Reference for each committee to accommodate this requirement in the next paper on the agenda.

5. Delivery Boards

Governance arrangements for overseeing the delivery of the SDP from 2023/24 are included in the accompanying SDP in Appendix C and have been designed to make best use of resources and concentrate collective effort on key priorities which will make the biggest difference to people working and living in Sussex.

11 Delivery Boards have been established to reflect delivery of the key priorities in the SDP. They will be fully constituted and operational by 30 June 2023.

Each Delivery Board will be Chaired by a system CEO, have a lead SRO Chief Officer from NHS Sussex, and have clinical representation. The Boards will be appropriately resourced with a Programme Director lead and through the course of the Board's work, agree detailed workplans to underpin delivery of agreed milestones and outcomes as set out in the SDP.

Delivery Boards will report monthly to the SOB, supported by central programme management and business intelligence analytics resource, to ensure a consistent system approach to reporting, benefits and outcomes tracking, programme, and transformation approach.

A Strategic Outcomes Framework and Balanced Scorecard will be developed to provide the SOB with system-level oversight in terms of delivery assurance and achievement of outcomes. These will be built up

through the respective Delivery Boards.

6. Next Steps

The graphically designed SDP will be formally launched alongside the NHS Anniversaries celebrations in line with the SOB endorsed (8 June 2023) communications campaign. The communications package includes a summary version, easy read, animation with subtitles and British Sign Language, feedback response overview and stakeholder communications toolkit.

A third system strategy development workshop to develop system architecture in alignment with SDP ambitions, is scheduled for July 2023.

Key Recommendation(s):

The Trust Board is asked to:

- **Note** and **take assurance** from the information provided in relation to the development of and engagement on the Sussex Shared Delivery Plan (SDP).
- **Note** and **endorse** the final draft SDP agreed by the System Oversight Board (SOB) on 8 June 2023.
- **Note** the proposed governance and assurance mechanisms for overseeing NHS Sussex's contribution to the delivery of the SDP.

Sussex Health&Care

Improving Lives Together

Ambition to reality: Our Shared Delivery Plan

Contents

1.

Making our ambition a reality

Our ambition

Our ambition is to improve the lives of everyone living across Sussex now and in the future. We want local people to thrive to be the best they can be; to be healthier and feel supported; and have the best possible services available to them when and where they need them.

Our Integrated Care Strategy, *Improving Lives Together*, represents this ambition and sets out the agreed long-term improvement priorities we will be focusing on across health and care in Sussex that will bring the greatest benefits to local people and our workforce.

We know that currently people across Sussex are not always getting the support and care they need to live the healthiest life possible.

Our Case for Change outlines the issues we face as a health and care system and why health and care services are not always able to meet the needs of our population. This includes population factors such as our growing and ageing population that means more people need more care more often; the wider determinants of health, such as the social and economic environment our local communities are living within; and people's lifestyles. There is also the lasting impact the Covid-19 pandemic has had on both services and health, and the current cost of living crisis that is negatively affecting people's health and wellbeing.

We also have long-standing health inequalities, with communities and groups of people having worse health than other people because of who they are or where they live, particularly those who are most disadvantaged.

In addition, individuals, communities and our workforce have told us that people are not always getting what they need, when they need it due to difficulties accessing services, support and information, and the disjointed and confusing way the 'system' works.

A lot of work has already taken place across health and care over recent years to improve the support, care, and treatment available, and the timeliness of how people access services, and progress has been made that has brought benefits to local people. However, we recognise this has not always gone far enough in many areas and a lot of the issues we face can only be resolved through a more ambitious approach.

Improving Lives Together represents that ambition and has four aims:

- **To improve health and health outcomes for local people and communities, especially those who are most disadvantaged.**
- **To tackle the health inequalities we have.**
- **To work better and smarter to get the most value out of the funding we have.**
- **To do more to support our communities to develop socially and economically.**

We will do this through organisations working closer together and differently with and within our communities to support people through each stage of their lives. We want to:

- **Help local people start their lives well by doing more to support and protect children, young people, and their families.**
- **Help local people to live their lives well by doing more to support people to stay well and to look after their own health and wellbeing.**
- **Help local people to age well by doing more to support older people to live independently for longer.**
- **Help local people get the treatment, care, and support they need when they do become ill by doing more to get them to the right service the first time.**
- **Help our staff to do the best job they can in the best possible working environment by doing more to support their own health and wellbeing and to promote opportunities which ensure people want to work in health and care services.**

We want to achieve our ambition over the next five years and beyond and recognise that we will not be able to do everything at once, with some things taking longer than others to get up and running. So we need to be focused on what we can do and when. We also need to do it in a realistic way, using the money, workforce, and facilities we have available as a health and care system.

By working together across all system partners, and with local people and communities, we now have an opportunity to combine our collective energy, resource, and expertise to make our ambition a reality.

This Shared Delivery Plan sets out how we will do this over the next five years.

Our Shared Delivery Plan

Our Shared Delivery Plan brings together into one place the strategic, operational and partnership work that will take place across our system to improve health and care for our population over both the short and long term. It reflects and responds to national policy and guidance and aims to provide one single vehicle for delivery and focus for our system. It incorporates four delivery areas:

Delivery Area 1:
Long-term improvement priorities
(Section 2)

We will be building on work that is already taking place and taking new actions to progress the long-term improvement priorities that have been agreed across our health and care system. These are:

- **A new joined-up community approach, through the development of Integrated Community Teams;**
- **Growing and developing our workforce;**
- **Improving our use of digital technology and information.**

Delivery Area 2:
Immediate improvement priorities
(Section 3)

We recognise there are immediate improvements that need to be made to health and care services. Our health and care system is continually extremely challenged, due to high numbers of people needing support and care from services, and this means not everyone is always getting the right care, at the right time and in the right place for their needs. This has had an impact on some people's experience of services and their outcomes and has put intense pressure on our hard-working workforce.

A lot of work is taking place to give people better access to, and experience of, services and these are set out in our 2023-24 Operational Plan. From this plan, we are giving specific focus to four areas that need the most improvement:

- **Increasing access to, and reducing variability in, Primary Care;**
- **Improving response times to 999 calls and reducing A&E waiting times;**
- **Reducing diagnostic and planned care waiting lists;**
- **Accelerating patient flow through, and discharge from, hospitals.**

Delivery Area 3:
Continuous Improvement Areas
(Section 4)

To bring about the improvements we want to make to achieve our ambition, there are four key areas that need continuous focus and improvement:

- **Addressing health inequalities that exist across our population to achieve greater equity in the experience, access, and outcomes of our population.** This is a 'golden thread' running through the delivery of all the actions we are taking, and we also have a specific system-wide focus to help bring about short and long-term change.
- **Addressing the mental health, learning disabilities and autism service improvements that we need to make across our system.**
- **Strong clinical leadership is crucial to enable us to make improvements to both health and care services and the health outcomes of local people.**
- **Getting the best use of the finances available.** We will need to get the most out of the money we have available to invest in services and make sure we are working in the most effective and efficient way.

Delivery Area 4:
Health and Wellbeing Strategies and Place-based Partnerships
(Section 5)

Improving Lives Together is built on the Health and Wellbeing Strategies across our three 'places' of Brighton and Hove, East Sussex, and West Sussex. These set out the local priority areas of work taking place to best meet the needs of our diverse populations. Health and care organisations are working together to deliver these strategies, as well as the long-term, immediate, and continuous improvements that need to be made to achieve our ambition.

Figure 1

Overview of our Shared Delivery Plan

Alongside the four delivery areas, we have other areas of focus **(Section 6)** that will be part of, and cut across, all the work we do. This includes a focus on prevention, climate change commitments, supporting social and economic development, maternity and neonatal care, safeguarding and quality of services.

To support the delivery of our Shared Delivery Plan, our statutory organisations responsible for health and care will work together in a new way across four different levels – System level, NHS provider level, Place level, and Local Community Level **(Section 7)**.

Each of the Long-term Improvement Priorities **(Delivery Area 1)**, Immediate Improvement Priorities **(Delivery Area 2)** and Continuous Improvement Areas **(Delivery Area 3)** will be led by a Delivery Board, chaired by a system Chief Executive Officer, and they will have a workstream that will be resourced from across system partners. The work of these Boards and workstreams will be overseen by a System Oversight Board chaired by the Chief Executive Officer of NHS Sussex. The Boards will address the needs of the whole population of Sussex. To ensure we deliver the focus we are committed to on the needs of children and young people, the system Children and Young People Board will contribute to and advise the work of each of the Delivery Boards to ensure that those needs are addressed.

How improvements will be made

The four delivery areas are not mutually exclusive; they support and interrelate with each other with the collective aim of making improvements over the next five years.

The actions taken across our Immediate Improvement Priorities **(Delivery Area 2)** aim to address issues that can be resolved in the short-term this year and make changes that give people better access to services and reduce waiting times. These will be supported and built on both this year and over the next five years across the Long-term Improvement Priorities **(Delivery Area 1)**, the Continuous Improvement Areas **(Delivery Area 3)** and the actions in our Health and Wellbeing Strategies **(Delivery Area 4)** to address some of the deep-rooted and long-standing issues we face. Collectively, this will support longer-term improvement, change and transformation to the way services are delivered, the way organisations are organised and run and the health and wellbeing of local people.

Figure 2

Each of our Delivery Areas combine to make improvements for local people.

YEAR 1
Immediate Improvement Priorities

- **Long-term Improvement Priorities**
- **Continuous Improvement Priorities**
- **Health and Wellbeing Strategies**

Improving lives of local people

- **Healthier communities:** Starting well, Living well, Ageing well
- **Better access to services**
- **Reduced waits**
- **Better joined-up care**
- **Better staff opportunities and support**

PROGRESS AND IMPROVEMENT
YEARS 1-5

2.

Delivery Area 1: Long-term Improvement Priorities

Achieving our ambition is centred on three agreed long-term priorities – a new joined-up communities approach through Integrated Community Teams; growing and developing our workforce; and improving our use of digital technology and information.

Integrated Community Teams

Over the next five years we will be integrating health, social care, and health-related services across local communities in a way that best meets the needs of the local population, improves quality, and reduces inequalities. This will involve us working with local people to build on what works best already, and to create a multi-disciplinary workforce, tailored to the health and care needs of the community. We will do this by developing **Integrated Community Teams**, that are made up of professionals working together across different organisations with local communities, individuals, and their carers. This will involve integration across primary care, community, mental health, local authority partners, voluntary, community and social enterprise organisations and other local partners.

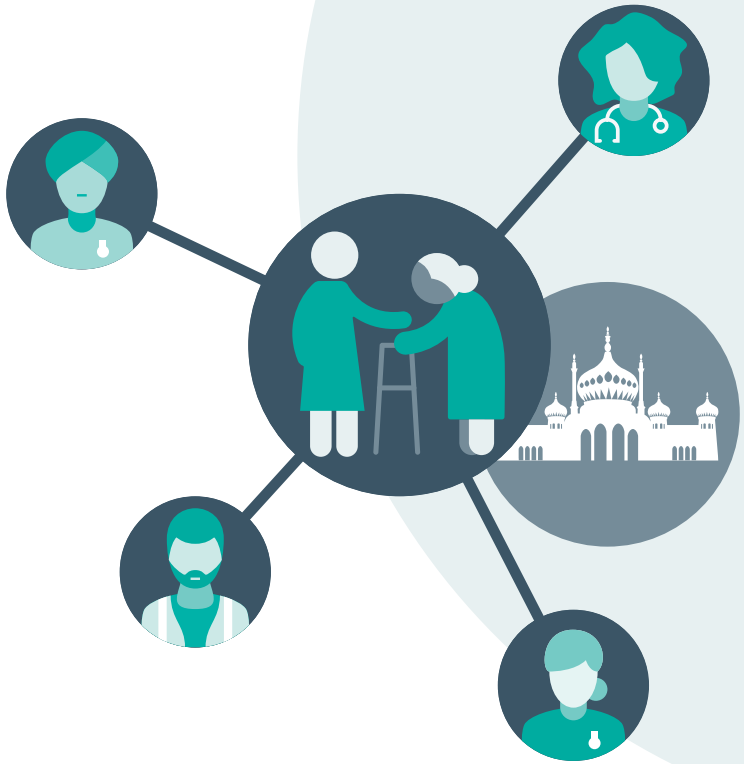
We will develop a '**core offer**' that each Integrated Community Team delivers to everyone, in addition to the individual support and services available to meet the specific needs of different communities. This new service model will be enabled by the delivery of our digital and workforce priorities, meaning our workforce has more time for direct care and to focus on population health management, prevention, and community engagement.

Our Integrated Community Teams will have specific focus on addressing health inequalities, taking preventative and proactive action, and working with local partners that support the wider determinants of health, including housing.

The initial work to progress this priority will build on what is already detailed in our respective Health and Wellbeing Strategies and test new ways of working through innovative programmes in each of our three places – Brighton and Hove, East Sussex, and West Sussex. The learning from these '**Integrated Community Frontrunners**' will be used to shape and inform roll-out of the Integrated Community Team model across our system.

Our Integrated Community Frontrunners

We have selected three programmes at each of our respective Places to be our Integrated Community Frontrunners. These will be tests of change for our new ways of working and our approach to clinical leadership, multi-disciplinary working, the way we use technology and data, and how we will work with local communities to better meet their needs.



Brighton and Hove frontrunner

Across Brighton and Hove, we are working to improve and join-up services to better support people with multiple compound needs and their carers. These are among the most marginalised and vulnerable members of society and face significant health inequalities. There is a 34-year life expectancy gap for people with multiple compound need compared to the general population and they are likely to be living in the most deprived area and specifically Central and East of Brighton.

The aim is for multidisciplinary teams to be working together to better co-ordinate services that are preventative, proactive, responsive, and empowering; enabling individuals to maximise control over their lives. Team members will pool their skills, professional experience, and knowledge to provide a rounded response to the people they are supporting.

The proof of concept started in November 2022 and is benefitting from an independently-led evaluation, monitoring, and learning framework that enables the model to be flexed through an action learning approach. By April 2024, it is planned there will be a reported improvement in the baseline performance metrics for the identified cohort.

East Sussex frontrunner

Hastings has some of the most deprived wards in the country and partners across health and care are currently working with community and voluntary organisations and local people to design and develop services and support in the future. The focus of the initial testing and development phase of the new model is to enhance and integrate our joined-up offer of health, care and wellbeing in communities and neighbourhoods. There are many existing projects and funding streams focussed on reducing the gap in health inequalities, including the gap in life expectancy and the needs of specific groups within this. The programme is intended to build on this to establish a framework for planning and delivering joined-up health, care, and wellbeing services to bring about the most benefit for the local population.

A project called '**Universal Healthcare'** has been underway since June 2022 with a number of community engagement workshops taking place to understand the needs of local people and help shape how they can be better supported in the long-term.

Throughout year one, we will be co-designing a proof of concept and identify early 'quick wins' that can be implemented immediately. By April 2024, we will have an evaluation to support further delivery and improvement and a plan in place to roll-out the approach across other areas of East Sussex.

West Sussex frontrunner

Crawley is one of the most culturally diverse communities in West Sussex and has significant pockets of deprivation where people have poorer health outcomes than other areas of the county.

We have been running a programme of work since 2021 that is an innovative approach to tackling health inequalities and poor outcomes at a borough level. Its aim is to tailor health services and service models to meet the needs of the population with a focus on the most disadvantaged communities.

Phase One of the programme set out to understand what health service developments were required to address health inequalities and improve poor outcomes. We took a local approach to looking at the needs of the population and engaged with local people to understand what barriers they are facing, and what is a priority to help support their health and wellbeing. A range of service developments are being undertaken to ensure they can meet the needs of the local communities.

By April 2024, we will have developed key service business cases and plans and developed the estates strategic outline case.

The actions we are taking this year (2023-24) to progress Integrated Community Teams are:

What we will do	What we will achieve	When
We will define our Integrated Community Teams across Sussex.	We will have a clear footprint for Integrated Community Teams informed by our Joint Strategic Needs Assessments, Health and Wellbeing Strategies, and local population data and insights.	June 2023
We will have data and information in place to support our Integrated Community Teams.	We will be able to measure outcomes that have been agreed at a local level, using a consistent outcomes framework which can be used at a local level and be shared across the Sussex system.	December 2023
We will agree our core offer for communities.	We will define and agree the health and care needs, outcomes and 'core offer' that each Integrated Community Team will deliver to its population.	March 2024
We will test and refine our new ways of working through our three Integrated Community Frontrunners.	We will have learning documented to inform further roll-outs and our approach to clinical leadership, workforce and the use of technology and data.	March 2024

The actions we will take over years 2-5 to deliver Integrated Community Teams are:

What we will do	What we will achieve	When
We will undertake a stocktake and evaluation of year one.	We will understand what is important to local communities, supported by data, and a proposal for the new ways of working.	April 2024
We will further test and refine our new ways of working through our Integrated Community Frontrunners	We will have learning documented to inform further roll-outs and our approach to clinical leadership, workforce and the use of technology and data.	March 2025
Implement a continuous improvement and evaluation approach to improve and refine the way we deliver services within different local footprints.	We will have a continuous learning and improvement approach for Sussex Integrated Community Teams.	March 2027
Rolling out our Integrated Community Team model across Sussex in a series of agreed 'waves'.	We will have a sequential roll-out of Integrated Community teams across Sussex. We will see a steady improvement in patient access, more services delivered locally within different communities, improving patient experience, satisfaction, and outcomes.	March 2027

Difference this will make to local people and how it will be measured

Difference for local people	How it will be measured
Seamless delivery of Proactive Personalised Care.	Reduction in avoidable admissions and increased system capacity and resilience. Patient, carers and stakeholder feedback, qualitative and quantitative datasets, measuring patient journey through the lens of individual patients. Access, waiting time, experience, carer registration and outcome data. Service delivery and efficiency standards.
Tangible reduction in health inequalities, through a focus on prevention and addressing root causes of ill health.	Population Health Management - metrics to be defined to suit local need.
Increased provider resilience with significantly improved collaboration across different organisation boundaries within a patient pathway.	Staff survey results. Workforce evaluation and feedback. Reduced staff turnover. Patient satisfaction surveys.
Increased job satisfaction, career progression and resilience for our workforce.	Workforce evaluation and feedback. Reduced staff turnover.

Growing and developing our workforce

We want to support our staff and volunteers to do the best job they can by growing and developing our workforce. The number of people working in health and care has grown and we need to carry on increasing staff numbers but recruiting more is not the only answer. We need to also get the best out of the staff we already have. There are five objectives we want to achieve:

- **Developing a 'one team' approach across health and care so they can work together and across different areas to help local people get the support and care they need.**
- **We want to support staff to develop new skills and expand the skills they have to allow them to work across different disciplines and areas. We also want to help staff to have more opportunities to progress in their careers.**
- **We want to create a more inclusive working environment that recognises diversity and has a workforce that better represents the population they care for.**
- **We want to encourage, and make it easier for, more young people, students, and people who have never considered a career in health and care, to work with us.**
- **We want to create a culture where people feel valued and supported to develop their skills and expertise. We want to take a 'lifelong learning' approach where people never stop developing their skills throughout their career.**

The actions we are taking this year (2023-24) to better grow and develop our workforce are:

What we will do	What we will achieve	When
We will launch an innovative guaranteed employment scheme, in conjunction with Brighton University and Sussex Partnership NHS Foundation Trust (SPFT).	We will have supported SPFT to achieve an agreed reduction (subject to operational plan) in their registered mental health nurse vacancy rate.	June 2023
We will develop a People Plan with a delivery roadmap for Years 2 to 5. Our approach to ensuring an inclusive culture will be informed by our Workforce Race Equality Standard and Workforce Disability Equality Standard and gender pay gap data.	We will agree one approach to workforce across our system and how this will be implemented.	September 2023
We will agree the model for a single workforce support package across the system.	We will have an agreed single workforce support package in place.	December 2023
We will identify initial communities to test our one workforce approach.	We will begin to roll-out our one workforce approach.	March 2024

The actions we will take over years 2-5 to deliver our workforce aims are:

What we will do	What we will achieve	When
We will develop a digital training programme for Sussex.	Our staff will be better digitally trained.	March 2025
Based on the success of the SPFT and Guaranteed Employment model, we will adapt and adopt this process for an extended number of professions.	Guaranteed employment model will be adapted and adopted to create a pipeline of future workforce.	March 2025
We will review our Equality, Diversity, and Inclusion (EDI) offer across our system to strengthen our consistent approach in tackling inequalities, building on the success of our system Workforce Race Equality Strategy and Statement.	One approach to EDI support in place, taking account of individual organisations or professional context and needs.	March 2025
Build on the work to be undertaken in year one with our pilot Health Care Assistant collaborative bank and our South East regional collaborative with other systems.	Collaborative Bank process established.	March 2025
We will develop a workforce model for Integrated Community Teams.	Integrated Community Teams workforce model agreed.	March 2025
Start transition to new ways of working and provider form.	Colleagues can work in Integrated Community Teams with the same conditions, support inclusive of technology.	March 2026
Review transactional services.	Having a consistent approach to recruitment, payroll and Electronic Staff Record services.	April 2026 – March 2027

Difference this will make to local people and workforce and how it will be measured

Difference for our workforce and local people	How it will be measured
Improved working environment, opportunities, and development.	**For all:** Vacancy rates. Staff survey results. Retention rates. Workforce availability (inclusive of absence rates).
Staff will connect better and form relationships with the community.	Workforce availability (inclusive of absence rates).
Greater opportunities for people to work and have impact in the place they live, with flexible options.	EDI metrics such as WRES, WDES and Gender Pay.
Better use of technology.	Temporary staffing usage.
Inclusive recruitment, with workforce that reflects its community.	Carer registrations among employees.
Opportunities for innovation and research.	

Improving the use of digital technology and information

We need to do much more to harness the potential for the use of digital technology and information. In doing so, we can improve access and join-up our services in a way that will fundamentally transform the experience for our local population and workforce.

We currently have too many disjointed systems, and data that is not shared and available at the point of need and we will be working with our communities and workforce to co-design and deliver long-term improvements.

For our Integrated Community Teams to succeed, we will need to ensure that information can be shared effectively across teams from multiple organisations, in a simple, timely way. We also need to simplify and democratise digital access to services for our population.

To do this, we will Digitise, Connect, and Transform our services.

- **We need to digitise to put the right foundational technology, tools, leadership, and capability in place across our system, and in the hands of our population and workforce. We need to do this in a way that will improve and simplify access for all and reduce the variation we see that leads to inequality and digital exclusion impacting some people and communities more.**
- **We need to connect our population, partners and communities through digital and data services that enable them to play their part in tackling the challenges the system faces and in building trust in the data that informs care, population health management, research, and innovation.**
- **With the right digital and data foundations in place across our system, we need to then transform our services through co-design of more integrated ways of working within our Integrated Community Teams (via our Frontrunners), and across our system; use trusted data and insights to improve, innovate and explore new technologies.**

People and communities will in future be able to choose high quality digital and data services, information, and technologies they have co-designed and can trust; information that supports them to live healthier lives; technologies to help manage their conditions and treatments; and services that communicate and plan with those involved in their treatment and care.

The actions we are taking this year (2023-24) to improve the use of digital technology and information are:

What we will do	What we will achieve	When
We will progress the work to digitise our services by evaluating our baseline position.	A system and provider digital maturity assessment will be completed and nationally benchmarked.	September 2023
We will agree a system-wide digital and data charter, setting out clear design principles and national benchmarking.	We will have 100% of partners formally signed up to the charter.	September 2023
We will establish Digital Centres of Excellence in three providers to lead system improvements and innovation.	We will improve the quality and standard for infrastructure, data intelligence, and innovation across the system.	December 2023
We will map unwarranted variation of inequality of digital access within our population and create a plan to address it. We will establish a People's Panel for digital and data and embed our Digital Inclusion Framework.	We will establish where we have inequality of digital access within our population and better ensure a population-led design approach of digital and data services.	March 2024
We will agree a system-wide data, information, and insight strategy.	A strategy will be in place that will allow us to use data, information, and insight better.	March 2024
We will extend access and enrich services offered through the My Health and Care patient app (integrated with the NHS app).	We will have 65% of patients registered with the NHS App and 33% of patients registered with My Health and Care.	March 2024
We will extend our digital service offering including virtual care technologies, care planning, self-referral, Primary Care accessibility and other capabilities.	We will have an enhanced range of digital service provision and integration across the system.	March 2024

The actions we will take over years 2-5 to deliver improvements to the use of digital technology and information are:

What we will do	What we will achieve	When
Digitise: We will drive improvement across all partners of their digital maturity, cyber security and the commitments agreed in the digital and data charter. We will also work to embed strong digital inclusion practice and reduce unwarranted variation in access and equity of digital services.	Core Electronic Patient Records (EPRs) implemented in all providers.	April 2025
	All Trusts will be consistently good in digital maturity across EPR and cyber security areas of digital maturity.	April 2025
	Quantifiable progress in reducing impacts of digital exclusion and improving design of digital services.	April 2026
Connect: We will co-design, develop and deliver common digital and data platforms and products to enable our population, communities, workforce, researchers, and innovators to have access to the tools and insight they need to improve lives together. Our People's Panel will develop and publish the social rules under which we will operate.	Integrated Community Teams will connect and share data, including with patients, carers and VCSE partners, with 90% of care providers using shared care (Plexus) care record.	April 2026
	NHS App and My Health and Care will be embedded as the "digital front door" in Sussex.	
	Data platform for research and innovation will be fully developed.	
	People's Panel will be publishing a Social Agreement for how we use Digital and Data tools to support their care.	
Transform: We will deliver our digital services through a sustainable model with provider Centres of Excellence; enabling co-design and innovation with our communities; developing our workforce, working in partnership with communities, academia, and industry.	Frontrunner Digital Innovation Lab will be developed.	April 2025
	Digital and Data Science Academy will be launched to tackle long-term. recruitment, development, and retention issues.	April 2026
	Provider Centres of Excellence will be developed in all partner providers across Sussex underpinned by sustainable environmental and financial model.	April 2026
	Digital Innovation Labs will be operating across Sussex.	April 2027

Difference this will make to local people and workforce and how it will be measured

Difference for local people and workforce	How will this be measured
Digitise: We will improve and simplify access to digital technology and services for all and reduce the variation we see that leads to inequality and digital exclusion impacting some people and communities more.	All providers will have consistently good digital maturity across Sussex and across What Good Looks Like domains. Key intervention programmes to tackle digital exclusion and inequity of service have been developed and are having measurable impact. Our population and workforce feel supported to use technology in the best way to suit them and their needs.
Connect: Our population, partners and communities will be connected through digital and data services that informs care, population health management, research, and innovation.	Digital health and care tools and support are established as an everyday service for significant cohorts of patients including those at risk of digital exclusion. People involved with the care and support of an individual (including the individual) share a common view of information and plans and can communicate across the Integrated Community Team.
Transform: Services will be transformed through co-design of more integrated ways of working within our Integrated Community Teams and across our system.	Citizen confidence and trust in digital and data services in Sussex will be improved with strong user experience measures across digital and data services. All providers have achieved core Minimum Digital Foundations safely, through clinically and patient-led implementations with sustainable infrastructure and resourcing in place to continuously improve services.

3.

Delivery Area 2: Immediate Improvement Priorities

Alongside the Long-term Improvement Priorities, there are immediate improvements that need to be made across our health and care services. We have developed and submitted an operational plan for 2023/24 which sets out the key actions that will be taken and how we will ensure best use of finances across our services.

We recognise that all service provision is vital for individuals and communities and work will continue to give people the best possible care and treatment they need in all areas. However, there is a need for us to make greater improvement across four key areas, to improve access to services and reduce the backlog in waiting lists that increased during the pandemic.

Specifically, we need to:

- **Increase access to, and reduce variability in, Primary Care;**
- **Improve response times to 999 calls and reducing A&E waiting times;**
- **Reduce diagnostic and planned care waiting lists;**
- **Accelerate patient flow through, and discharge from, hospitals.**

The actions taken to make improvements in these areas will be carried out this year (2023-24) and will be reviewed, adapted, and built on in the years ahead, according to the effectiveness of the improvements and the needs of local people. The actions will also be supported by the Long-term Improvement Priorities that aim to address many of the issues faced across these areas over time.

Increasing access to, and reducing variability, in Primary Care

GP practices across Sussex work extremely hard to ensure their patients and carers get the timely support, treatment and care they need in the best possible way. In January 2023 alone, there were over 900,000 appointments offered by Sussex practices, which was 97,000 more than the previous month and over 120,000 more than the same time last year.

The growing number of people accessing GP services means it is increasingly becoming difficult for everyone to always get an appointment when the patient wants it. In addition, because each practice works differently, there is variation in how appointments are managed and accessed. This means some people trying to get an appointment can find some systems frustrating and the variation can exacerbate inequalities in access and outcomes.

While general patient satisfaction remains relatively high with GP services, it has declined over recent years and there are some areas where local people find it more difficult than others to access services.

Throughout this year, we will be focusing on increasing capacity across GP services, improving the quality of services and patient outcomes and supporting general practice services to be more sustainable. This includes maximising the benefits of virtual consultations, continuing to improve access to face-to-face appointments and reducing bureaucracy to free-up clinical time. At the end of the year, we expect patient satisfaction and experience to have improved, with patients having increased choice in access to same-day and two weekly appointments via a range of methods.

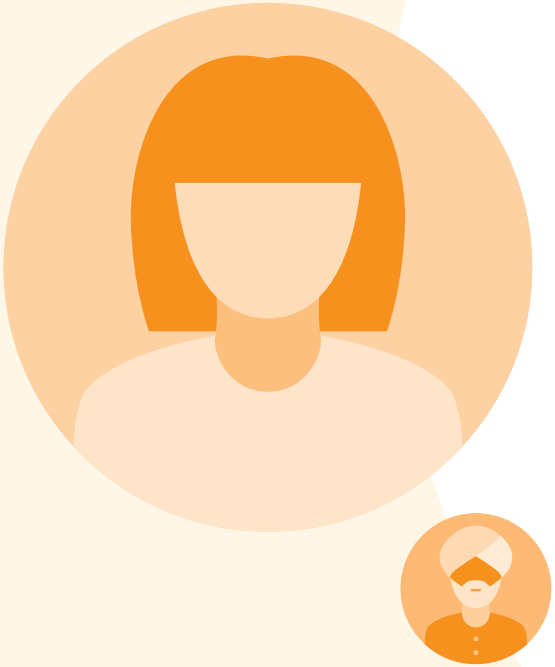
In addition to GP services, we are also focusing on improving access to NHS dentists. Over the last year we have heard significant feedback from local people and Healthwatch around issues with access to dentists across Sussex. This is something that is being experienced across the whole country. Responsibility for dentistry transferred from NHS England to NHS Sussex from April 2022 and we are working locally to make improvements where possible.

This work to improve access will also allow us to deliver continuity of care which is important for people managing multiple long-term conditions. This will be achieved by developing partnerships with the voluntary sector and expanding the roles within the general practice team to include social prescribers, pharmacists, physiotherapists, health and wellbeing coaches and others, to provide people seeking care and support the right contact first time. We will also focus on helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention, building on lessons learnt through the Covid-19 vaccination programme which is an example of how we can develop an Integrated Community Team response to vaccination.

The actions we are taking this year (2023-24) to improve Primary Care access and reduce variability are:

What we will do	What we will achieve	When
Increased coverage of the cloud telephony system to improve service access.	95% of practices will be signed up.	September 2023
Increase people's ability to manage their own health through the NHS App, including booking an appointment.	Target, to be determined once baseline is known (July).	March 2024
Increased practice staff able to provide direct patient care.	245 more staff recruited.	March 2024
Increase referrals to our Community Pharmacist.	We will increase referrals to 17,574.	March 2024
Increased levels of dental activity to improve access. This will include more opportunities for outreach into communities and those living in the most deprived quintiles and making every contact count by aligning the development of dental pathways across the public sector, including early years, health visiting and dental services.	Agree and establish an agreed approach for reporting on all relevant Public Health outcome indicators. Aligned NHS Sussex and Local Authority oral health promotion campaign and commissioning strategy. Improved units of dental activity (UDAs) to 95% of the contract.	September 2023 September 2023 March 2024

Difference this will make to local people and how it will be measured



Difference for local people	How will this be measured
It will be easier for patients to contact practices.	Patient satisfaction scores will improve by 5%.
Patients will be able to access more appointments.	There will be a 2% increase in appointments from the previous year.
Patients will be able to access an appointment within two weeks if they need it.	The number of people obtaining an appointment within two-weeks if they need it will increase by (3.1%) with an additional c.340,188 appointments delivered within two weeks, resulting in an increase from 81.9% during 22/23 to 85% during 23/24.
It will be easier to access a dental appointment.	The number of UDAs delivered compared to pre-pandemic levels (target 100%). UDAs delivered as a proportion of all UDAs contracted (target 95%). This relates to the ambition to improve delivery of contracted activity. Proportion of the Sussex population accessing NHS dental services (provisional target of 47%).

Improving response times to 999 calls and reducing A&E waiting times

Like many systems across the country, we have seen increasing numbers of people using urgent and emergency care services over recent years and this is putting significant strain on our workforce and has impacted on the timeliness for people accessing the care they need.

A lot of work has taken place to continuously look at ways the system can improve responsiveness, quality of care and patient satisfaction. This will be built on, expanded, and taken even further this year and we will be focusing on four key areas to make the biggest improvements:

- **Improving and standardising care to give more of our population access to care which aligns with best practice.**
- **Expanding care outside hospital to ensure people's needs are met sooner and they do not have to end up going to acute hospitals for treatment and care.**
- **Expanding our use of virtual wards to allow more people to be cared for in their own homes when they would otherwise have gone into hospital for care.**

The actions we are taking this year (2023-24) to improve response times to 999 calls and reduce A&E waiting times are:

What we will do	What we will achieve	When
We will undertake a full review of same-day emergency services in Sussex alongside an analysis of the different needs of our population.	We will have a clear understanding of the changes we need to make to ensure all local people have timely access to same-day emergency care.	June 2023
We will increase capacity in our ambulance service, including the roll-out of mental health ambulances, 111 clinical advisory service, virtual wards, non-injured falls service, mental health same- day urgent care services, acute respiratory hubs, urgent community response services and Alternative to Admission Single Point of Access.	A greater number of people will receive rapid assessment and care for physical or mental health conditions in their own home or in the community and therefore avoid a hospital admission.	December 2023
We will support each of our acute hospital sites to undertake improvement work within their emergency departments, including a focus on rapidly streaming patients to the right service.	There will be improved flow of patients and their carers through emergency departments, enabling ambulances to be offloaded and minimising the time that patients spend in departments before being discharged or admitted.	December 2023
We will roll-out clear standardised pathways of care for individuals in Sussex who are at risk of a rapid deterioration in their health, including patients with respiratory illnesses or suffering from frailty.	Vulnerable individuals will spend more of their time in good health and receive rapid, early intervention through joined-up primary, community, and secondary care services when support is required.	March 2024

Difference this will make to local people and how it will be measured

Difference for local people	How will this be measured
More patients will experience shorter waits for treatment in A&E, Urgent Treatment Centres, and Minor Injury Units across Sussex.	We will achieve a minimum of 76% of patients and their carers attending A&E being seen within four hours.
Patients who call 999 with a time critical condition will receive a faster response from the ambulance service.	We will achieve the category 1 response time (90% of calls responded to within 15 minutes) and a better response rate of less than 30 minutes for category 2 (90% of calls responded to within 40 minutes).
More patients will receive medical care closer to home, with admission to an inpatient bed only occurring when absolutely necessary, enabling patients to be cared for in a familiar environment with their carers and the support of friends and family.	We will increase the number of virtual ward beds, reduce the number of ambulance conveyances to hospital (achieving better than the national average), expand 24/7 Mental Health Crisis resolution and home treatment services, increase the number of referrals to urgent community response services and deliver the two-hour urgent community response target of 75%.

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Difference for local people	How will this be measured
Patients at high risk of hospital admission or who are frequent users of healthcare services will be provided with more proactive care and support to enable them to stay well.	We will see a reduction in the number of high intensity service users and a reduction in the number of admissions and length of stay for patients identified as high risk.
Patients waiting for or undergoing emergency treatment or awaiting admission will be cared for in appropriate clinical settings at all times and will either be admitted or discharged more quickly, spending less time in Emergency Departments.	No patients will be cared for in corridors within Emergency Departments while awaiting treatment or admission. The number of patients and their carers waiting in Emergency Departments for more than 12 hours will reduce to below 2%.

Reducing diagnostic and planned care waiting lists

There are currently large numbers of people waiting too long for diagnostic services and planned care, which can cause a deterioration in their condition, impact on their day-to-day lifestyle, and affect their general health and wellbeing. The lockdown restrictions that were put in place during the pandemic meant waiting times in these areas significantly increased and system partners have been working hard to reduce these as quickly as possible.

We will be maintaining and continuing this work this year and over the longer term will transform the way planned care and cancer services are delivered with the aim that no one waits over a year and we see movement towards achievement of the 18-week standard for elective care and 75% of cancers diagnosed at stage 1 or 2

The actions we are taking this year (2023-24) to reduce diagnostic and planned care waiting lists are:

What we will do	What we will achieve	When
We will enhance patient and carers choice and access to treatment for key specialties including Ear, Nose and Throat and Trauma and Orthopaedic. We will establish clinically led workstreams to develop patient pathways that are productive and standardised across Sussex.	We will have agreed clinical pathways across all acute services for our key specialties to provide greater choice and access to patients and reduce waiting time variation across the system.	September 2023
To support patients and their carers who are referred on a cancer pathway, we will ensure referrals are made in-line with standardised referral protocols and local pathways are optimised, enabled by the Ardens Pro system which is in place across all practices in Sussex. We will continue to increase the number of patients referred with a Faecal Immunochemical Test (FIT) result at point of referral for a suspected colorectal cancer.	We will ensure patients are referred into the most appropriate service based on their referral and clinical information, which will reduce two week wait demand by 30%. With full compliance of colorectal referrals with a FIT test completed, we will reduce the number of colonoscopies required by up to 40%.	September 2023
We will make further use of our Community Diagnostics Centres (CDCs) across Sussex, providing greater access to patients who need a test to support a decision for the care they need	We will prioritise direct access for primary care for computerised tomography (CT), ultrasound and Magnetic Resonance Imaging (MRI). We will have as a minimum six day working across our CDCs providing greater flexibility for patients.	December 2023

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What we will do	What we will achieve	When
We will continue to realise productivity opportunities to make the best use of our resources, to provide greater access for patients.	We will increase our theatre utilisation rate to a minimum of 85% across all services. We will deliver at least 85% of surgery as a day case procedure. We will reduce the length of stay for key pathways such as hip and knee replacement surgery in-line with best practice rates.	March 2024
We will improve earlier access to hospital services with a focus on reducing the number of patients that do not attend (DNA) their appointment, continuing to provide virtual clinics to reduce the need for patients to attend the hospital, and provide greater flexibility to patients by increasing the number of 'Patient initiated Follow Up' (PIFU) appointments.	We will reduce our DNA rates across Sussex by at least 2% over the course of the year. We will reduce the number of follow up appointments generated by increasing our PIFU rate from 0.5% to 5% across Sussex. We will ensure at least 25% of outpatient activity is undertaken virtually.	March 2024

Difference this will make to local people and how it will be measured

Difference for local people	How will this be measured
We will continue to reduce our waiting times with a commitment to deliver a maximum wait for treatment for patients referred for elective care.	No patient will wait more than 65 weeks for their elective care treatment.
We will continue to reduce the number of patients waiting over 62 days for cancer treatment.	As a maximum, no more than 548 patients will be waiting over 62 days for cancer treatment by March 2024.
We will enhance access to diagnostics for patients across Sussex with our CDC capacity, improved diagnostics pathway, and capital investment in services.	We will ensure at least 75% of patients by March 2024 referred on a cancer pathway will be diagnosed within 28 days. We will continue to reduce our waiting times across 15 diagnostic modalities with no more than 10% of patients waiting more than six weeks.

Accelerating patient flow through, and discharge from, hospitals

There are currently too many patients being cared for in an inpatient hospital bed when there is no longer a health-related need for them to do so. This results in a lack of available beds across the system that can cause risks to both the patient, as they can deteriorate in hospital and be exposed to infection risks, and those waiting for inpatient care.

We have a good track record of system partnership working to improving discharges and we will be building on this and accelerating existing and new initiatives. Sussex is one of six national systems selected as Discharge Frontrunners, which involves health and social care partners locally working together, and with carers and wider partners, to rapidly find innovative solutions and new approaches which have the potential to make a substantial difference. Discharge Frontrunners use tried and tested improvement tools to find what works, how and why and will make recommendations for how their approaches can be adopted across the country. The objective of our programme is to develop, design and test new approaches and service models for discharges across all settings by focusing on integrated workforce models, deploying new technologies, developing shared business intelligence, and developing an economic and financial model to underpin this sustainably.

Our goal will be to bring together a comprehensive model of integrated hospital discharge to support good system patient flow with reduced lengths of hospital stay, admission avoidance, and better long-term outcomes for local people.

The actions we are taking this year (2023-24) to accelerate patient flow through, and discharge from, hospitals are:

What we will do	What we will achieve	When
We will undertake a comprehensive review of discharge pathways to identify, and put in place, improvement plans for the changes which need to be made to reduce delays to patients being discharged from inpatient and community services.	Health and care partners will have a more proactive approach to discharge planning, minimising delays at each part of the pathway (across pathways 0 to 3) and utilising virtual wards for early supported discharge, with a more seamless interface between health and care.	June 2023
We will evaluate and select a small number of digital innovations which will best support improvements in the discharge pathways, alongside the development of a shared data architecture to provide visibility of patient flow and capacity.	We will support more efficient use of our workforce, improved patient experience and seamless working between health and care colleagues.	September 2023 to select innovations; and March 2024 to roll it out.
We will develop an economic model for discharge in Sussex which enables us to make best use of available funding and supports the care market to expand in a sustainable way.	We will have a clear and affordable plan for the future to ensure we understand where best to invest available funds to grow discharge capacity which will meet the needs of our population.	December 2023
We will develop and mobilise a multi-agency workforce plan based on agreed discharge demand and capacity requirements.	We will develop our model for the health and care workforce to enable us to build the right capacity in home care or post-hospital bedded care to meet the needs of our population.	March 2024

Difference this will make to local people and how it will be measured

Difference for local people and workforce	How will this be measured
Patients and their carers will be involved in planning for their discharge from early in their inpatient stay and will be discharged without significant delay as soon as they are declared medically fit to do so into the most appropriate bed for their needs.	There will be a reduction in the number of patients who no longer meet the criteria to reside in hospital who are not discharged.
Patients will be admitted to an inpatient bed (acute, community or mental health) in the most appropriate department for their condition, without significant delay.	We will reduce bed occupancy to 92%.
Patients and their carers will be discharged earlier but receive ongoing clinical oversight where required using digital innovations such as remote monitoring.	There will be a reduction in hospital length of stay (quantified based on experience of exemplars).

4.

Delivery Area 3:

Continuous Improvement Areas

To support the successful delivery of the actions set out across our Long-term and Immediate Improvement Priorities, and our Health and Wellbeing Strategies, there are four key areas that need continuous improvement:

- **Addressing health inequalities**
- **Mental health, learning disabilities and autism**
- **Clinical leadership**
- **Getting the best use of the finances available**

These areas are part of, and are critical success factors in, all the actions and improvements we are making and, therefore, need constant focus across everything we do.

Addressing health inequalities

There are currently avoidable and inequitable differences in health between different groups of people across Sussex. There are many reasons for this, including disability, employment, where someone lives, income, housing, education, their ethnicity, and their personal situation. We know these health inequalities are particularly seen among our most disadvantaged communities, with people living in deprived areas having worse health and outcomes.

Addressing health inequalities is a core aim of Improving Lives Together and is the driving purpose of developing Integrated Community Teams that better meet the needs of our diverse local communities. Health inequalities is a key priority of all our Health and Wellbeing Strategies and is a key element of all the workstreams of our Shared Delivery Plan and will be embedded within many of the actions outlined. This will be done with the following commitments:

- **Co-production** – we will work with those with lived experience to design and delivering change.
- **Interventions** – we will invest in prevention, personalised care, and other activities to drive reductions in heath inequalities.
- **Funding** – we will focus a greater amount of funding based on need.
- **Design of services** – we will undertake Equality and Health Inequalities Impact Assessments for all service changes.
- **Visibility** – we will ensure every decision we make considers the impact of proposals or decisions.
- **Outcomes and performance** – we will always consider the differences across geographical areas, population groups and other factors in how we set and monitor outcomes and performance.
- **Workforce** – we will actively recruit, develop, and support people from our diverse communities.
- **Net Zero and social value** – we will use our resources and assets to help address wider social, economic, or environmental factors.
- **Data quality and reporting** – we will drive work to both improve and increase the recording and reporting of data by key characteristics.

In addition to, and to support, the work across our workstreams and the Health and Wellbeing Strategies, we are taking the following actions to address health inequalities.

The actions we are taking this year (2023-24) to make progress to address health inequalities are:

What we will do	What we will achieve	When
Working with children and young people (CYP), partners, and young carers to develop a defined work programme around the CYP Core20PLUS5 similar to the adults' Core20PLUS5. This will include: • **Address over-reliance on asthma reliever medication and decrease in number of asthma attacks.** • **Increase access to real time continuous glucose monitoring, and insulin pumps, in the most deprived areas, and from ethnic minority backgrounds.** • **Increase access to epilepsy specialist nurses within the first year for those with learning disabilities or autism** • **Address backlog for tooth extractions for under-10's.** Improve Mental Health access rates for 0–17-year-olds from ethnic minorities and children in greatest areas of deprivation.	Develop CYP Core20PLUS5 baseline and improvement trajectory across each of the five clinical areas.	December 2023
Improve position against 2022-23 baseline on hypertension identification and treatment and increase lipid lowering therapy (LLT) prescription.	**Hypertension:** We will improve from the September 2022 position performance of 57% to 77%. **Lipid lowering:** We will increase from September 2022 position of 53% to 60%.	March 2024

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What we will do	What we will achieve	When
Continue the roll-out of the NHS funded offer of universal smoking tobacco treatment services, across inpatient, maternity, and mental health services and ensure investment at scale and sustainability beyond 2023/24.	Increase proportion of adult inpatient settings offering tobacco dependence services from 0% baseline to 20%. Increase proportion of maternity settings offering tobacco dependence services from 50% to 80%.	March 2024
Address inequalities and improve outcomes in priority clinical pathways for those in deprived geographical areas and with vulnerable or protected characteristics. This includes: • **Reducing waiting times, DNA, and cancellation rates in our most deprived areas and those with protected characteristics.** • **Establishing an inclusion health programme, identify gaps in provision and develop associated commissioning plans.** • **Improve recording of ethnicity recording across all providers.** • **Commissioned baselining of LGBTQ+ and Learning Disability data recording.**	Reduced waiting times, DNA, and cancellation rates for those in deprived geographical areas and protected characteristic groups by 5%. Commissioned dedicated inclusion health network – 60% of providers signed up. Ethnicity recording moved from 65% to 90% data completeness. Data recording baseline achieved for LGBTQ+ and Learning Disability.	March 2024

The actions we will take over years 2-5 to further reduce health inequalities are:

What we will do	What we will achieve	When
Improve position against 2022/23 baseline on hypertension identification and treatment, and lipid lowering therapy prescription.	**Hypertension:** We will continue to improve performance to 80%. **Lipid lowering:** We will continue to improve performance to 70%.	March 2028
Continued support for the roll-out of the NHS funded offer of universal smoking tobacco treatment services, across inpatient, maternity, and mental health services and ensure investment at scale and sustainability beyond 2023/24.	Increase proportion of adult inpatient settings offering tobacco dependence services from 20% to 50% year two and to 80% by year five. Increase proportion of maternity settings offering tobacco dependence services from 80% to 100% by year five.	March 2028
Continue to address inequalities and improve outcomes in priority clinical pathways for those in deprived geographical areas and with vulnerable/protected characteristics.	Build on reducing waiting times, DNA, and cancellation rates in our most deprived areas and those with protected characteristics by reducing further on year one by 5% in years two and three. Dedicated inclusion health network established with 90% of providers signed up by year five. Identified gaps in services commissioned during years two to five. Ethnicity data completeness moving from 90% to 100% data completeness. Data completeness of 50% by year two and 75% by year five for LGBTQ+ and Learning Disability.	March 2028
Dedicated Children and Young Persons (CYP) programme for Core20PLUS5.	5% increase on year one baseline figures by year two and 20% increase on baseline year one figures by year five.	March 2028

Difference this will make to local people and how it will be measured

Difference for local people and workforce	How will this be measured
Improved and equitable access to health care for the population, particularly those in our deprived areas and those with protected characteristics.	Improvement in waiting times and access to treatment times for those from our most deprived areas and with protected characteristics.
Reduced inequalities, and variation in population outcomes.	Reduction in the number of avoidable stroke and cardiac events for adults. Improved access rates to mental health services from areas of deprivation, CYP, males and certain ethnic groups. Improved healthy life expectancy and life expectancy for people with severe mental illness and learning disabilities. Fewer CYP asthma events requiring emergency admissions, improved access to specialist nurse for those with epilepsy, learning disabilities and autism and fewer dental extractions for 0-10 years.
Reduced inequalities in delivery of services, service developments, commissioning, and employment.	Reduction in gaps for health inclusion groups in community service provision, which will reduce requirements for emergency and urgent care and fewer GP appointments.
Inclusive digital pathways.	Focused and reasonable adjustments will be applied to digital pathways to support population groups at risk of digital exclusion.

Mental Health, Learning Disabilities and Autism

Supporting people with mental health, learning disabilities and autism is a key priority across system partners. Although we are working across these areas in one workstream, they are separate areas of focus and will require differing approaches and actions.

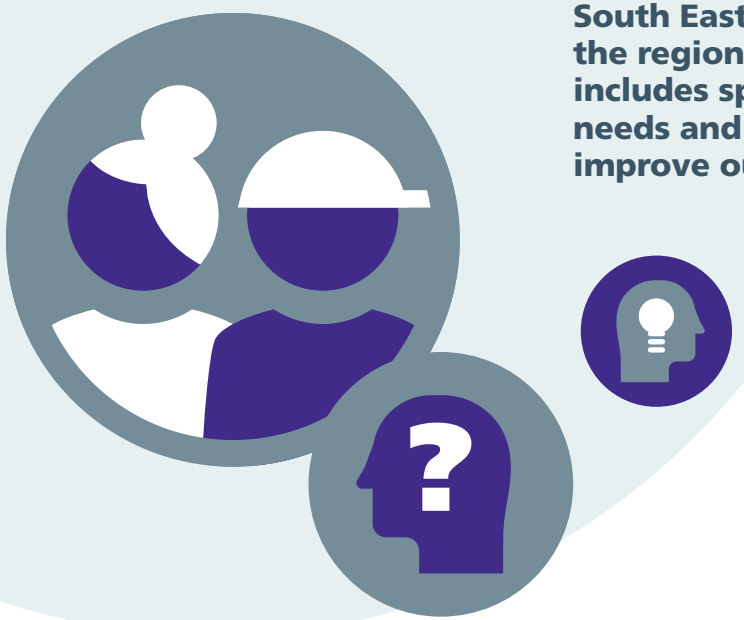
Our aim is to ensure those who are suffering from emotional distress and mental ill health get the support, care, and treatment they need as quickly as possible and can live fulfilled lives within their communities. A lot of work has taken place to improve mental health services, including establishing the specialist perinatal mental health community service, increased physical health checks for those with serious mental illness, and recruitment of additional clinical staff in the eating disorder service. This has been done through consistent delivery of the Mental Health Investment Standard (MHIS) and this will be achieved again in 2023-24 at a level of 7.1%.

Despite funding and staffing levels increasing, the need for mental health services has grown exponentially in recent years, with the pandemic contributing to a rapid rise in emotional distress, depression and anxiety, and many individuals are still facing lengthy waits for assessment and treatment.

We are taking action in response to this growing need through our operational plan this year (2023-24) and over the longer term:

- **We will improve care for those facing mental health crisis through rapid access to crisis services, such as NHS 111 links to the crisis line, Crisis Houses, Safe Havens, and specialist teams that will support the emergency services where an individual with mental health needs is being detained.**
- **We will continue to improve access to support for children and young people, access to talking therapy services for adults and perinatal services.**
- **We will eliminate out of area placements to provide care closer to home.**
- **We will work to increase dementia diagnosis through schemes such as the locally commissioned services in Primary Care.**
- **We will continue to deliver and work towards meeting the commitments detailed within the NHS Mental Health Plan 2019/20-2023/24 across the range of services.**

These key commitments sit within the context of a comprehensive programme of transformation focused on population health and wellbeing and addressing health inequalities.



Alongside our focus on mental health, we are working to improve the care and outcomes for those with learning disabilities and autism. This includes:

- **Working to ensure those with learning disabilities receive an annual health check and action plan.**
- **Reducing reliance on inpatient care, and improving the quality of inpatient care, for those with a learning disability and who are autistic through providing services in the community.**
- **Working with the NHS England South East Regional team on the regional delivery plan which includes special educational needs and disabilities (SEND) to improve outcomes.**

The actions we are taking this year (2023-24) to make progress for those with mental health issues, learning disabilities, and autism are:

What we will do	What we will achieve	When
We will ensure care is offered close to home.	We will eliminate out of area placements.	From June 2023
We will finalise and agree a children and young people's and an adult strategy and approach to neuro developments pathways.	We will have a Sussex-wide agreement and plan to standardise our current assessment and diagnostic services .	From June 2023
Increase the numbers of adults accessing talking therapies (formerly known as IAPT services).	We will increase access by 5%.	March 2024
Increase the number of adults and older people supported by the community mental health team.	We will increase support by 5%.	March 2024
We will develop a locally commissioned service to improve our dementia diagnosis rate.	We will increase the dementia diagnosis rate by 0.3% as a minimum from 22/23.	March 2024
We will improve access to perinatal mental health services.	We will increase access by 1%.	March 2024
We will commence a Child and Adolescent Mental Health Service (CAMHS)/acute pathway programme involving all partners.	We will agree and develop a system approach to children and young people requiring an acute response from CAMHS services as part of the wider support network.	March 2024

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What we will do	What we will achieve	When
We will maintain a strong commitment to reducing reliance on inpatient care for both adults and children with a learning disability and/or who are autistic, consistent with the ambition set out in the NHS Long Term Plan, and to develop community services to support admission avoidance and timely discharge.	30 adult and 15 CYP inpatients per million population,	March 2024
We will increase the number of people on the Learning Disability Register who have received an annual health check and action plan.	We will increase the uptake of annual health checks for those on the Learning Disability Register to 75%.	March 2024

The actions we will take over years 2-5 to further improve the experience of those with mental health issues, learning disabilities and autism are:

What we will do	What we will achieve	When
We will develop a strategy that strengthens commissioning aligned to a collaborative delivery of outcomes; enabling increased lead provider arrangements that deliver whole pathway approaches.	Reduced pathway fragmentation, increased provider sustainability and productivity and improved patient and carer outcomes and experience.	March 2025
Fully implement the community transformation plan within Sussex with an agreed and defined model in each place, including a functional single point of access and developed specialist pathways.	A consistent approach to supporting all people that present with mental health problems at primary care level and more cohesive service offer within Primary Care and secondary care mental health services.	March 2025
Develop closer linking of mental and physical health planning and delivery through the Integrated Community Teams approach.	Increased integrated community-based access to support, reducing reliance on more specialist care and delivering improved health outcomes for local people.	March 2025
We will review the existing successful plans for reducing out of area placements and embed practice as business as usual with continuous review and evaluation.	Continuation of the recent reduction of out of area placements offering better experiences for those that require admission and maintain a 0% tolerance.	March 2025
Agree and formalise a dementia model and strategy for each place that is consistent and meets national best practice with the implementation of locally commissioned Primary Care services to support diagnostic rates.	The memory services will offer a clearer and timelier assessment and diagnostic service that will support the existing pre and post diagnostic support for people with dementia. It will also support wider system strategies.	March 2025

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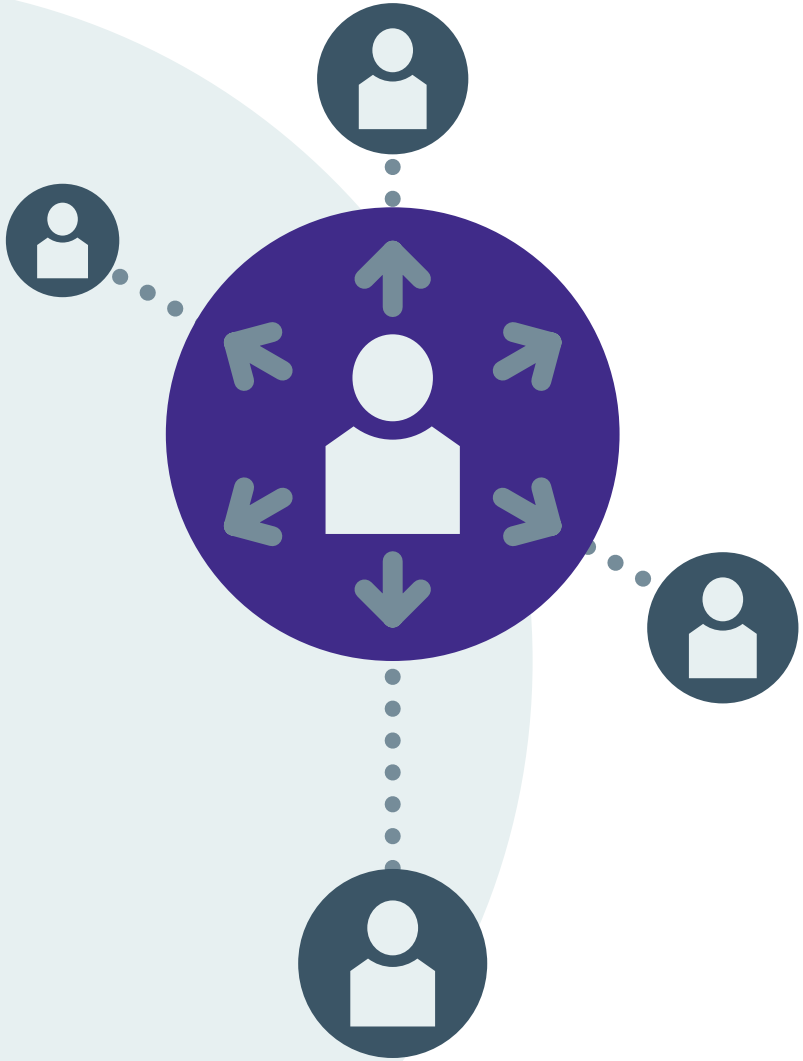
What we will do	What we will achieve	When
Develop and fully embed physical health checks for people with severe mental illness outreach and health improvement support in Primary Care as part of Emotional Wellbeing Service and mental health transformation objectives.	We will maintain completed annual comprehensive physical health checks to 75% of GP severe mental illness (SMI) registers	March 2025
Implement the recommendations of the CAMHS review project.	We will improve timeliness of flow through CAMHS services with a consistent offer for children and young people. It will offer improved patient experience and achieve better outcomes for individuals and improve the offer and links to support education and social care processes.	March 2026
We will review the profile of mental health investment to ensure a balanced approach across children and adult services that reflects population demographic and need.	An enhanced focus on early intervention and wellbeing support that reduces reliance on specialist and bed-based services and addresses inequalities in access and provision.	March 2026
We will support the NHS regional plan to offer a cohesive service within our area and engage within the planning process.	This will allow a wider range of interventions across the region to be provided more consistently and will allow us to maximise our resources better on a larger geographical footprint.	October 2026

Difference this will make to local people and how it will be measured

Difference for local people and workforce	How will this be measured
We will undertake a system-wide participation and co-production strategy review, with local authority, experts by experience and VCSE partners, that will be embedded within all work programmes consistently and at all levels of development, review, and evaluation throughout mental health services.	Development of the participation matrix has been agreed with milestones being reported monthly to the Performance and Assurance Group and to the system multi-stakeholder mental health board.
We will have a mental health workforce that is consistent and suitably trained who feel supported and offered opportunities to develop best practice.	Annual staff surveys with a robust audit of issues raised, with associated recommendations and actions that may impact on this commitment led by chief officers.
We will have health and care services working as one team to provide a holistic offer of support to people with mental health and learning disabilities in the community in which they live.	Increase in the uptake of annual physical health checks. Increase in access to preventative and timely access to treatment services, same level as those without mental health or learning disabilities.

Clinical Leadership



There is clear evidence that strong clinical and care professional leadership is associated with higher productivity, better organisational performance, and improved health outcomes for local people. The delivery of our ambition will only be successful with strong clinical leadership, and it is recognised that this is something in Sussex that needs to be developed and strengthened at every level within the system.

We want to create a culture that systematically embraces shared learning, based on outcome data, to support clinical and care professional leaders to collaborate and innovate with a wide range of partners, including patients and local communities.

The aim is for patients to have a better quality of joined-up care, better clinical outcomes, and better experience. This will require close working across system partners, including social care, housing, education, and other Local Authority colleagues, as well as the NHS.

The actions we are taking this year (2023-24) to make progress in clinical leadership are:

What we will do	What we will achieve	When
We will formally appoint a clinical leader for each of the three Integrated Community Team Frontrunner programmes.	We will formally appoint a clinical leader for each of the three Integrated Community Team Frontrunner programmes.	From June 2023
Establish multi-professional Clinical Reference Groups (CRG) for each of our Shared Delivery Plan priority areas.	Governance structure confirmed and implemented for the Clinical Reference Groups.	From June 2023
Set out benchmarks for improvements in clinical outcomes.	Agree reduction plan in unwarranted variation.	September 2023
Agree an organisational development approach to quality improvement and use of data.	Agree Quality Improvement training and data baseline. Progress training plan in identified Clinical Leadership Group.	September 2023
Put in place a multi-professional Leadership Academy to develop our clinical leaders across the system.	100 leaders will have undertaken the programme.	March 2024

The actions we will take over years 2-5 to further develop, improve, and progress clinical leadership are:

What we will do	What we will achieve	When
Agreement on clinical support for delivery workstreams.	Review function of Clinical Reference Group support for year one delivery priorities for effectiveness.	March 2025
Review the 100 leaders who have undertaken the Clinical Leadership Academy programmes and work on lessons learned and ways to improve.	Ensure that clinical leaders selected for each of the Integrated Community Teams areas are well trained and supported for leadership.	March 2025
Embed delivery of clinical outcomes as related to each Delivery Board.	Improve the clinical outcomes of greatest importance for the population of Sussex to deliver measurable impacts.	March 2027
Develop the model of clinical delivery within our ICTs year-on-year and build on the use of digital and data within our pathways.	Clinicians are able to use the opportunities of digital, data and technology.	March 2027
Clinical leadership to ensure clinical interventions and transformation are being delivered using the highest quality evidence, though multi-professional teams using continuous improvement cycles.	Review of outcomes of Integrated Community Teams across Sussex to ensure impact of clinical leadership for delivering high quality care and evidence by using agreed metrics.	March 2028
Clinician leaders demonstrating their proficiency in using digital, data and technology as a means of improving the clinical interventions.	Clinical leaders will be using clinical interventions and research data to demonstrate the effectiveness of interventions in clinical pathways.	March 2028
Clinical ownership of population outcomes.	Clinical leaders will be able to demonstrate improvements in agreed clinical outcomes in the pathway of care for the community.	March 2028

Difference this will make to local people and workforce and how it will be measured

Difference for local people and workforce	How will this be measured
There will be integrated working within Integrated Community Teams and networking across the system partners, with a greater focus on preventing ill health and on evidence-based impacts of personalised care.	Public satisfaction with services survey.
Sussex will be an attractive place to work for clinicians, attracting and retaining talent who are able to see they are making a positive difference to local people.	Staff survey on satisfaction and engagement for Trusts.

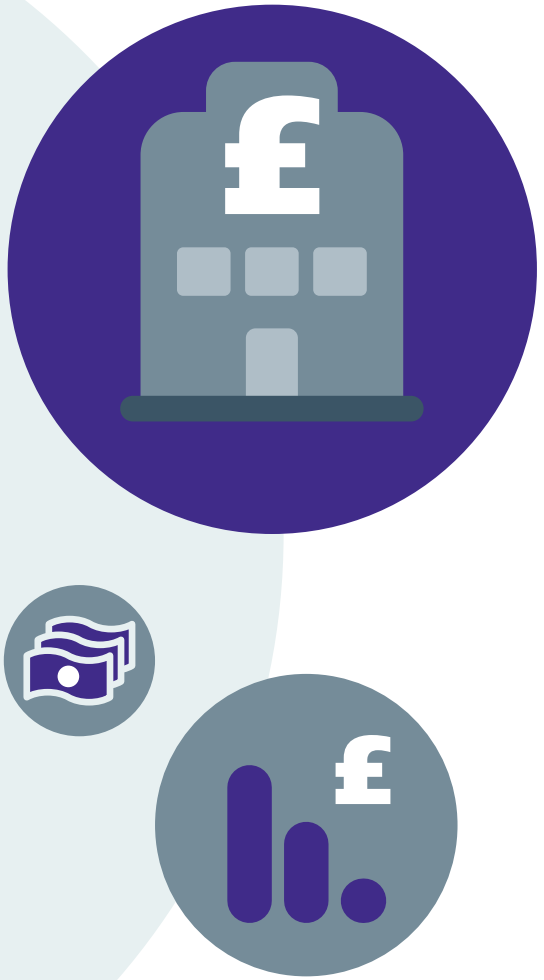
Getting the best from the finances available

Financial sustainability is integral to delivering our ambition as it is a key part of enabling our health and care system to drive improvements to services for local people. We must live within the finances we have available and, to do so, it is crucial that all organisations across our system manages resources effectively, ensuring value for money from every pound spent.

Currently, the NHS across the Sussex system is challenged financially and has a recurrent deficit, which means it is spending more than its allocation. We must therefore work collaboratively across the system to make efficiencies in how we work to get the most out of the money we have available. It also means we must be targeted in our investments, to ensure we are getting most value for local people.

In addition, NHS Sussex is required to make running cost reductions of 20% from 2024/25, with a further 10% reduction from 2025/26.

The Sussex system receives a capital allocation, used to upgrade estates and equipment, and must prioritise all the capital requirements to make sure the funding available is spent in the most effective way. In addition, we receive national capital funding for specific programmes and projects. Over the next five years we will invest in some significant developments which will radically improve patient experience and our productivity. Examples include a new Emergency Department in Brighton, a programme which will eradicate mental health dormitory accommodation, the development of community diagnostic centres and new facilities to deliver elective activity.



A key area of focus for us in improving our finances is productivity, which is the amount of activity we do compared to what it costs. Currently, we are not getting the best use of the money we spend in some areas, such as in our acute hospitals, where current productivity is significantly lower than before the pandemic. To improve our productivity, we have agreed a set of principles and actions across four areas, overseen by a system Productivity Steering Group. These aim to ensure the system is maximising value for money from use of its public funding, expertise, technology, and estates to deliver services. These are:

- **System-led workstreams:** To develop a joined-up Sussex approach and reduce variations across providers across areas such as workforce, procurement, and discharge.
- **Provider-centric workstreams:** To share best practice across providers and identify system opportunities across areas such as theatre productivity, outpatient opportunities and A&E.
- **Integrated approach:** Focusing on productivity opportunities that may impact on both primary and secondary care and potentially areas that impact multiple services/ pathways, including medicine optimisation.
- **Non-pay saving opportunities:** To explore medium-term opportunities in areas like estate optimisation and corporate service.

The actions we are taking this year (2023-24) to get the best from the finances available are:

What we will do	What we will achieve	When
We will create a comprehensive and resourced system productivity plan, with individual workstream targets and milestones and measurable cost reductions demonstrated.	We will have a plan for improving system productivity.	September 2023
We will develop a clinically-led process for optimising some of our clinical models or services, to reduce cost.	Three services or models will be taken forward led by clinicians.	December 2023
We will implement initiatives to improve productivity.	We will see productivity improvement compared to 2019/20 of 10 percentage points, to 7% below 2019/20 for acute Trusts.	March 2024
We will agree a methodology for assessing productivity output for community, mental health, and Primary Care services.	We will have key performance indicators and methodology for productivity across services outside of acute hospitals.	March 2024
We will deliver our 2023/24 system financial plan.	We will meet our financial budget at the end of the year.	March 2024

The actions we will take over years 2-5 to continue to get the best from the finances available are:

What we will do	What we will achieve	When
Model the medium-term financial position of the system including the improvements we would expect as a result of the productivity improvements.	A medium-term financial plan owned by the system.	March 2025
Build a longer-term plan for productivity improvements.	A rolling programme of productivity and efficiency improvements.	March 2025
Review and consider national and international financial frameworks which would support delivery of the Shared Delivery Plan.	A revised financial framework which supports the strategy.	March 2026
Make clinical leadership the natural driver of the productivity improvement programme.	Build enduring clinical leadership into the productivity programme, linking with the Clinical Leadership workstream.	March 2028
Ensure Sussex can live within its financial allocation each year, giving us the freedom to implement our Shared Delivery Plan.	Deliver the annual financial plans.	March 2028
Optimise our capital allocation through prioritising strategic capital requirements.	A prioritised capital plan for 2025/26 onwards (2023/24 and 2024/25 already done).	March 2028
Model and plan the financial impact of all the elements of the five-year plan.	A detailed investment and efficiency plan showing where cost and income will change.	March 2025

Difference this will make to local people and workforce and how it will be measured

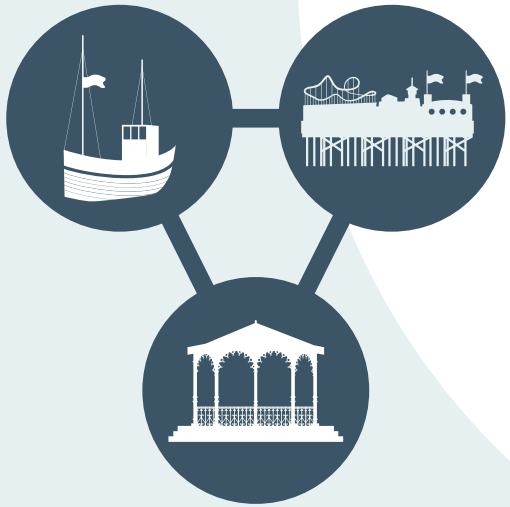
Difference for local people and workforce	How will this be measured
Living within our financial allocation will allow for greater investment in new services and innovation to support and accelerate improvements for local people.	Financial positions across system partners at the end of each financial year.
Greater productivity and efficiency will help people to be seen and treated quicker.	Productivity improvement across the system.
Significant major capital developments which will provide improved facilities and better patient experience.	Capital programmes delivered to time and budget.

5.

Delivery Area 4:
Health and Wellbeing Strategies and developing Place-based Partnerships

Improving Lives Together supports and builds on the three Health and Wellbeing Strategies in place across Sussex.

The Health and Wellbeing Boards in Brighton and Hove, East Sussex and West Sussex have a statutory role to bring together representation from local government; local NHS organisations; Healthwatch; voluntary, community, social enterprise organisations; and other key public services to assess needs and agree plans, focussed on improving health, care and the overall social and economic wellbeing of their populations.

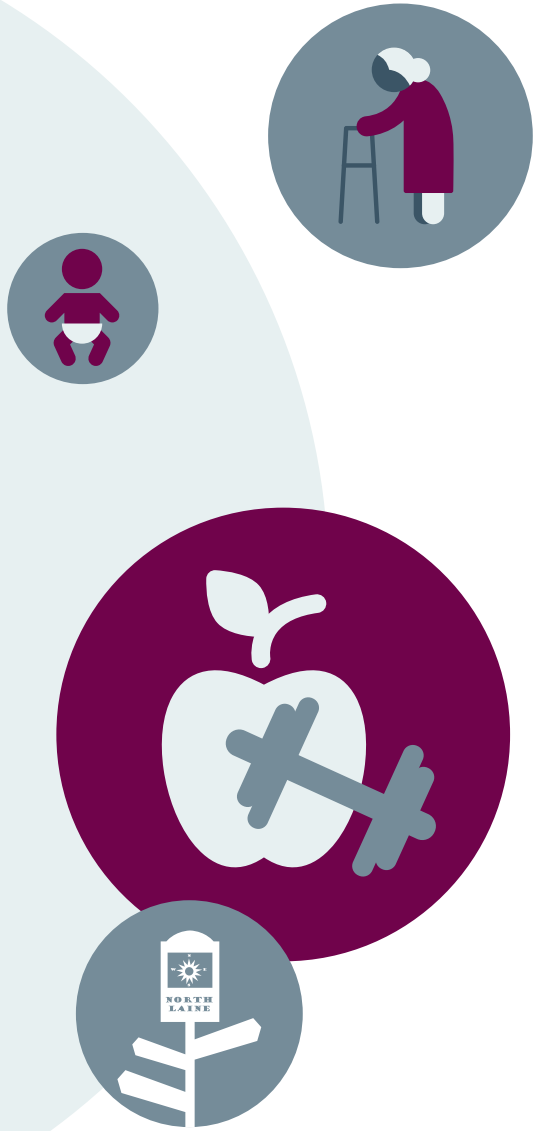


The Health and Wellbeing Strategies use local evidence, data, and insight to set out the priorities for improving health and wellbeing of their populations, responding to the distinct issues and challenges in these places.

Alongside the delivery of the Health and Wellbeing Strategies, one of the key priorities of Improving Lives Together is 'maximising the power of partnerships' and during year one we will be strengthening how partners can work together across our populations in Brighton and Hove, East Sussex, and West Sussex, focussing on the distinct needs and challenges in our local areas. We call this working at 'place', and it is where the local NHS, local government and a wide range of local partners come together to shape and transform health and care and make the most of the collective resources available. We will do this by working in our three Health and Care Partnerships, whose work is overseen by the Health and Wellbeing Boards. Further details of how these partnerships fit into the way of working across our system is in Section 7.

The ways of working and priorities across each of our places are set out below.

Brighton and Hove



Our 2019-30 Health and Wellbeing Strategy focuses on improving health and wellbeing outcomes for the city and across the key life stages of local residents – starting well, living well, ageing well and dying well. Our ambition for Brighton and Hove in 2030 is that:

- **People will live more years in good health (reversing the current falling trend in healthy life expectancy).**
- **The gap in healthy life expectancy between people living in the most and least disadvantaged areas of the city will be reduced.**

Eight principles guide the delivery of our strategy with a focus on health being everyone's business; supporting communities to be more resilient; reducing health inequalities; and making sure that health and care services will provide high quality care, feel more joined-up and will be delivered in the most appropriate place.

The establishment of the Health and Care Partnership Executive Board in January 2020 enables us to build upon the work already started and is now becoming formalised. The firm foundations of the Board enable us to develop and mature service design, delivery, and governance over the coming years.

Our ambitions for improving lives at place

The ambitions set out in our Health and Wellbeing Strategy are:

- Brighton and Hove will be a place which helps people to be healthy.
- The health and wellbeing of young people will be improved. We will have a focus on early years encouraging immunisation; we will address risks to good emotional health and wellbeing; and provide high quality joined-up services which consider the whole family.
- The health and wellbeing of working age adults will be improved. Information, advice, and support will be provided to help people to eat well, move more, drink less and stop smoking to reduce their risk of developing long-term health conditions. There will be easier access to mental health and wellbeing services; sexual health will be improved; and people with disabilities and long-term conditions, and the long-term unemployed, will be supported into work.
- Brighton and Hove will be a place where people can age well. People will be supported to reduce loneliness and social isolation and to reduce their risk of falls and more people will be helped to live independently by services that connect them with their communities.
- The experiences of those at the end of their life, whatever their age, will be improved. We will improve health and wellbeing at the end of life and help communities to develop their own approaches to death, dying, loss and caring. More people will die at home or in the place that they choose and support for families, carers and the bereaved will be enhanced.

How we will deliver our ambition

The Health and Wellbeing Strategy identifies five priority areas for Brighton and Hove:

- **Children and Young People:** We will improve and expand access and existing support to children and young people and their families for mental health, emotional wellbeing, autism, Attention Deficit Hyperactivity Disorder (ADHD), and other neurodevelopmental conditions. We will improve early diagnosis and outcomes for children and young people and increase the identification of, and support for, young carers.

- **Mental Health:** We will implement the key recommendations of our 2022 mental health Joint Strategic Needs Assessment, expanding our support for people with mental health needs and further developing integrated community mental health services, connecting mental health services with community assets. We will do this at local community level and develop integrated systems and increase the provision of supported accommodation and support for people with mental health needs, co-occurring disease, and substance misuse services.
- **Multiple Long-term conditions:** We will improve services to people with long-term conditions to deliver personalised care, tailored to individual needs, strengths, and capabilities. We will aim to better understand the interaction of mental and physical health conditions as a factor to improve outcomes and we will proactively identify and/or support and meet the needs of those at risk of or living with long-term conditions.
- **Cancer:** We will complete the recovery of cancer services affected by the pandemic, improve performance against cancer waiting times standards and deliver the ambitions of the NHS Long Term Plan to diagnose more people with cancer at an earlier stage, with a particular focus on disadvantaged areas and under-served communities where rates of early diagnosis and screening uptake are lower.
- **Multiple Compound Needs:** We will improve and join-up services to better support people with multiple compound needs by delivering an integrated service model, co-produced for and by people with lived experience. We will do this through our Integrated Community Frontrunner programme.

The actions we are taking this year (2023-24) to deliver our Brighton and Hove Placed-based priorities are:

What we will do	What we will achieve	When
Integrated Community Teams frontrunner: Through our multi-disciplinary team pilot we will trial and develop a new integrated model of care and support for people with multiple compound needs and their carers. This will be supported by a clear set of programme objectives, a compact agreement between system partners and an independent evaluation of our pilot project.	We will develop a clear set of programme objectives that supports our aim of increasing life expectancy for people with multiple compound needs. We will establish a compact agreement, across system partners that supports a new integrated model of care and support. We will get an independent evaluation of our pilot project to inform future service design and commissioning.	March 2024
Health inequalities: We will build on the work with Public Health to reduce the spread of blood borne viruses. We will deliver the aims of our current commissioned health inequalities services working with the local population, VCSE and our providers to responds to known areas of health inequalities.	We will build on HIV ED opt- out testing and commence the opt-out blood borne testing. We will improve experience, access, and outcomes for the most disadvantaged communities in Brighton and Hove.	March 2024
Children and young people (CYP): We will implement year one emotional wellbeing action plan priorities for the Foundations for Our Future Place-based Plan. This will include a new emotional wellbeing pathway for CYP and embed training at point of induction for social workers and annual refreshers thereafter.	We will improve the support and interventions for children and young people who are neurodiverse and for children and young people with mental health needs and their carers.	March 2024

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What we will do	What we will achieve	When
Mental health: We will implement the recommendations of the 2022 Mental Health and Wellbeing JSNA ensuring that progress is made across all seven delivery areas - extend and expand the range of emotional wellbeing services to Primary Care Networks, physical health checks for people with severe mental illness, develop suicide and self-harm prevention action plan.	Increase access to community mental health services. Reduce demand on acute and crisis care. Increase the number of people on severe mental illness registers.	March 2024
Cancer: We will build on the work with Public Health, the local population, VCSE and our providers to help to detect cancer at an early stage through promoting uptake of screening programmes, including expanding the targeted lung health checks programme, Faecal Immunochemical Test (FIT) testing and continuing the fibro scanning outreach service (to check for liver inflammation). The programme will ensure it responds to known areas of health inequalities.	Increased screening rates including in areas of deprivation and communities, including BAME communities, people experiencing homelessness, Trans people, and people with learning disabilities.	March 2024
Multiple long-term conditions: We will develop our cardiovascular disease reduction priorities in Brighton and Hove including hypertension case finding and treatment, and the restoration of the NHS health checks programme with health inequalities lens.	The cardiovascular disease reduction action plan will be developed and monitored at the Brighton and Hove Community Oversight Group.	March 2024

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What we will do	What we will achieve	When
Hospital discharge: We will develop our integrated model, implement the 2023-24 hospital discharge transformation plan, and deliver the improvements aligned with the discharge frontrunner programme. Our place-based discharge transformation work will happen to ensure efficiency within current processes.	This will enable us to ensure people who no longer need acute inpatient care can go home or to a community setting to continue recovery with appropriate support for any unpaid family/friend carers who help that patient.	March 2024

The actions we will take over years 2-5 to continue to deliver our Brighton and Hove Place-based priorities are:

What we will do	What we will achieve	When
Integrated Community Teams frontrunner: We will evaluate the impact and results of our multi-disciplinary team pilot project, including the independent evaluation report. This will inform our longer-term redesign of services for people with multiple compound needs.	We will develop a long-term integrated model of service, where partner organisations from across the public and community sector will work together as a multidisciplinary team. Service-users and their carers will experience a joined-up service that best meets their multiple health and social care needs.	March 2028
Health inequalities: We will further develop our prevention programmes, in-line with our Health and Wellbeing Strategy priorities, with an increased focus on reducing health inequalities in identified populations and locations across the city.	We will reduce barriers, increase service use, and improve health outcomes for the most disadvantaged communities in the city.	March 2028
Children and young people: We will implement Year 2-5 action plan priorities for Foundations for Our Future Place-based Plan.	We will improve the support and interventions for children and young people who are neurodiverse and for children and young people with mental health needs.	March 2028

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What we will do	What we will achieve	When
Mental health: We will transform the community mental health system, improving access though provision of holistic care, shifting investment to increasingly focus on CYP as well as prevention. Improve access to stable and secure housing and accommodation-related support for people with serious long term mental health conditions.	We will improve access to community mental health services – both numbers of people accessing and reduction in waiting lists. We will improve access to CYP mental health services – both numbers of people accessing and reduction in waiting lists. We will increase the number of people on the severe mental illness register. We will deliver a reduction in use of avoidable crisis and acute care.	March 2028
Cancer: In-line with the Brighton and Hove wellbeing strategy, we will expand cancer diagnostic and treatment service capacity, enabling earlier diagnosis of cancers through use of community diagnostic centres.	We will achieve the 28 day faster diagnosis standard (75%). We will increase the number of cancers diagnosed at stages 1 and 2. We will reduce under 75 mortality from cancer considered preventable.	March 2028

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What we will do	What we will achieve	When
Hospital discharge: We will further develop and implement efficient admission avoidance and hospital discharge processes, supported by digital automation and engagement with patients and their carers. We will put in place a long-term funding plan for discharge capacity. We will embed efficiency and process learning from transformation programmes into 'business as usual'.	We will have quicker and more effective discharge processes, reducing the length of the time people wait to be discharged and maximise reablement and independence after discharge. We will ensure that more patients are able to return to their usual place of residence following discharge, increasing Home First capacity, and decreasing reliance on bedded capacity. We will ensure discharge pathways allow for greater personalisation to meet the individual need of the patient and their carer.	March 2028
Multiple long-term conditions: We will implement a new integrated intermediate care model for rehabilitation and reablement services including a quality outcomes framework to demonstrate benefits.	We will improve the support for a short time to help more people and their carers to remain in their own home while they recover from a hospital stay.	March 2028

Difference this will make to local people and workforce in Brighton and Hove and how it will be measured

Difference for local people or workforce	How will this be measured
Multiple compound needs: Life expectancy will improve for people with multiple compound needs, reducing the current 34-year gap in life expectancy between this group and the general population. Services for people with multiple compound needs will be integrated and all service-users will have access to a lead professional who coordinates their care and support.	Through a clear outcomes framework, that is consistent across all partner organisations. Through a successful redesign and commissioning of services for people with multiple compound needs.
Health inequalities: Models of health, care and support that focus on prevention, greater independence and choice, self and proactive care including social prescribing through a locality-based integrated neighbourhood team model. This will be tailored to the individual needs within local neighbourhoods and our communities of interest.	Reduction in the numbers of people accessing hospital services in an unplanned way. Reduction in the gap in life expectancy and healthy life expectancy for communities with health inequalities. Reduction in new cases of HIV, with the aim to achieve zero transmission.
Children and young people: We will see a reduction in waiting times for emotional wellbeing treatment and support, with a greater focus on prevention and early intervention.	Reduced waiting times to access services. Reduction in referrals to specialist CAMHS services.

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Difference for local people or workforce	How will this be measured
Mental Health: Life expectancy will improve for people with serious mental illness. Improved experience of people using services by reducing barriers between services and the need to re-tell their story, reducing the potential for re-traumatisation. Increase in availability of preventative support including suicide prevention. Improve access by making it easier and quicker to get support.	Life expectancy data. Patient Reported Outcome Measures (PROMS). Measurement of suicide rate. Reduction in waiting times. Increase in number of people accessing services.
Cancer: Improved take-up rates of FIT testing, including groups with low participation, particularly men, people from minority ethnic backgrounds and people from deprived areas. Targeted lung health checks will lead to an increase in lung cancers being diagnosed at an earlier stage.	Public Health Screening Data. Cancer Action Group Dashboard. Increase take-up rates of FIT testing by 7%. Increase lung cancer stage 1 diagnosis by 47%.

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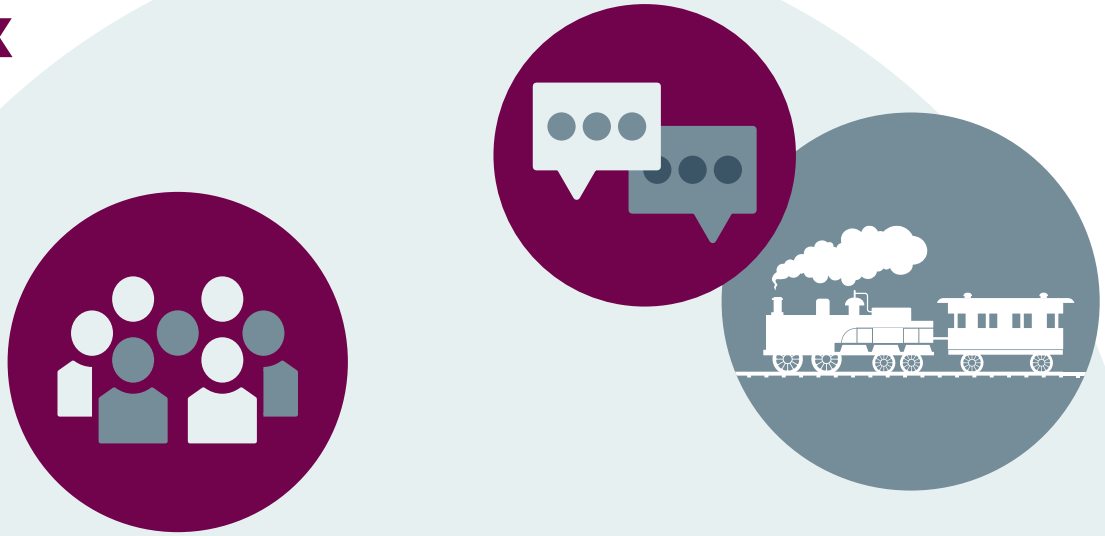
Difference for local people or workforce	How will this be measured
Multiple long-term conditions: Lower levels of mortality and disability due and cardiovascular disease. People will be better supported to remain at home and retain more independence in the community.	Increased levels of independence. 90% of the expected prevalence of Atrial Fibrillation is diagnosed. Reduced time waiting to receive reablement/intermediate care intervention. Reductions in people unnecessarily needing long term care. Reductions in need for care home placements. Increased proportion of care provided at home. Greater personalisation of discharge care and increase in number of personal health budgets and increase in proportion of people living independently at home for longer.
Hospital discharge: Improved discharge process to ensure people return home as appropriately as possible.	Reduction in the length of time between someone being ready to leave hospital and when they do. Maximise the proportion of people who can return home after leaving hospital.

East Sussex



Improving Lives Together and our East Sussex Health and Wellbeing Board Strategy to 2027 align around a shared vision where in the future health and care organisations will work in a more joined-up way with and within communities to better understand and respond to their specific needs. Support and services will be shaped around local people, rather than expect them to fit into the 'system'.

Delivering this requires a collaborative approach across all our organisations to improve health, reduce health inequalities and deliver integrated care for our population. In East Sussex, we have committed to some shared priorities and work based on the needs and assets in our population and the factors that influence people's overall health and ability to stay healthy, in addition to improving outcomes through integrated health and care. The focus of our shared work is aimed at increasing prevention and early intervention and delivering personalised, integrated care.

Our East Sussex Health and Care Partnership brings together the full spectrum of local partners responsible for planning and delivering health and care to our communities. We have comprehensive governance arrangements that support collective accountability between partner organisations for whole-system delivery and performance. The governance arrangements facilitate transparent decision-making and foster the culture and behaviours that enable system working.

Our ambitions for improving lives at place

Aligned to our system ambitions to develop Integrated Community Teams, we will build on our existing work to expand the integrated community model for our population that will better enable health, care and wellbeing for people and families across the whole of life. This will mean designing a model that best enables:

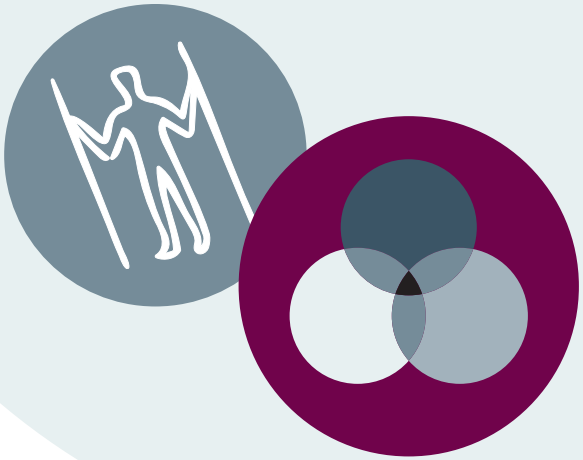
- Working together in our communities across Primary Care, community healthcare, education, social care, mental health, and the full range of local voluntary and community and housing organisations, and using our collective resources driven by a deeper shared understanding of local needs.
- Strengthening our offer of integrated care. For children and young people this will involve working with whole families and linking more closely with early years settings, schools, and colleges. For adults this includes further developing Trusted Assessor roles, rapid crisis response and support with discharges from hospital, as well as exploring ways to build more integrated leadership and roles to deliver better co-ordinated care.
- A clear focus on improving population health overall and therefore the years of life people spend in good health. This includes leisure, housing and environment services provided by borough and district councils and others.

How we will deliver our ambition

Our partnership plans to embed hubs within our integrated communities to help co-ordinate access to local sources of practical support and activities. We also want to develop our plans for using our power as employers and buyers of services to stimulate economic and social wellbeing in our communities. This model will bring:

- Greater capacity in communities to promote mutual support, and deeper levels of joined-up and personalised care, building on the strengths and assets of individuals, families, and communities.
- Greater levels of prevention, early intervention, and ways to proactively respond to prevent situations getting worse.
- New ways to remove the barriers that prevent staff and volunteers working in different teams from working together on the ground.

Accountability through to our Health and Wellbeing Board and strong links into Sussex-wide programmes will enable a clear focus to be retained at Place on our key priority integration programmes across health improvement and reducing health inequalities, and integrated care for children and young people, mental health, and community services.



The actions we are taking this year (2023-24) to deliver our East Sussex Place-based priorities are:

What we will do	What we will achieve	When
Building on the Universal Healthcare initiative and other local programmes, we will have a joined-up approach to planning and delivering health, care, and wellbeing in Hastings, with clear evidence of integrated approaches to improving outcomes for local communities.	A planning and delivery approach agreed by Place leadership board.	March 2024
Service models will be developed and approved for scaling up across the county and an implementation timetable with key milestones agreed.	Service models will be approved by Place leadership board.	March 2024
A comprehensive stakeholder engagement process will take place to help us explore how we can improve health outcomes in cardiovascular disease (CVD) respiratory disease, mental health, and frailty/ageing as significant drivers of poor health and early death in our population.	Improvement plans approved by Place leadership board.	March 2024
Aligned to our discharge workstream, we will develop our integrated hospital discharge model, implement the 2023-24 hospital discharge capacity plan, and deliver the improvements aligned with the discharge frontrunner programme. Our place-based discharge transformation work will happen to ensure efficiency within current processes.	More people will be able to be discharged safely to a community setting.	March 2024

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What we will do	What we will achieve	When
Deliver our children and young people's programme plan with a key focus on priority workstreams to support getting the best start in life; promoting emotional wellbeing and mental health; physical health, needs of children with SEND, and our most vulnerable young people.	Family hubs with additional support for families with young children; strengthened support for long term conditions (Core20PLUS5 for CYP); clearer and improved pathway for mental health support and support for parent carers.	March 2024
We will deliver initial stages of integrated models of community mental health care within local communities, through Primary Care Network based offers and developing plans to support more people who need housing-based support due to their mental health.	In-year plan delivered.	March 2024
Networks will be developed in communities to help co-ordinate access to local sources of practical support and activities, to boost emotional wellbeing and help with loneliness and isolation.	Consolidation of networks providing access and support to local people.	March 2024
Develop our approach as an "anchor" system in East Sussex, including our plans for using our power as employers and buyers of services to stimulate sustainable economic and social wellbeing in our communities.	Approach approved by Place leadership board.	March 2024

The actions we will take over years 2-5 to continue to deliver our East Sussex Place-based priorities are:

What we will do	What we will achieve	When
Refresh and implement further actions in targeted areas to support population health improvement and integrated care in our four target conditions.	Continuation of measurable plans to improve life expectancy and healthy life expectancy and reduce unplanned use of hospital services.	March 2025
Implement the improvements to cardiology and ophthalmology through reconfigured acute hospital services.	Agreed transformation plans fully implemented improving efficiency and outcomes for local people.	March 2025
Appraise and jointly respond to forthcoming national guidance and tools and system opportunities designed to support a joined-up offer of care at Place across Primary Care, community health, adult social care, mental health, public health, and housing services which relate to health and social care.	An agreed plan to further evolve our provider collaboration at Place to support delegated responsibility for services in scope, to deliver shared population priorities for improved population health and integrated care.	March 2025
Develop a reprofiling of resource application to support a widening of emotional wellbeing services for children and young people.	Improved access to emotional health and wellbeing services that support improved experience for children and young people and reduce the need for more specialist care.	March 2026
Enhance support to families to enable the best start in life including continued development of an integrated pre and post-natal offer.	Improved experience and increased opportunities to support our most vulnerable families.	March 2026

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What we will do	What we will achieve	When
Implement integrated community-based approaches for mental health and a wider range of early support for mental health, in-line with Sussex- wide approaches.	Reduced reliance on specialist services and improved population health and wellbeing.	March 2026
Continue phased implementation and evolution of locality-based Integrated Community Teams model.	An approach and model supported by comprehensive engagement and fully owned and embedded with communities that delivers integrated support in local communities.	March 2028
Aligned to the discharge workstream, we will further develop and implement efficient hospital discharge processes, supported by digital automation, with a long-term funding plan for discharge capacity. We will embed efficiency and process learning from transformation programmes into 'business as usual'.	We will have quicker and more effective discharge processes, reducing the length of the time people wait to be discharged and maximise reablement and independence after discharge, ensuring more patients are able to return to their usual place of residence following discharge, increasing Home First capacity, and decreasing reliance on bedded capacity. We will also ensure discharge pathways allow for greater personalisation to meet the needs of individuals and carers.	March 2028

Difference this will make to local people and workforce in East Sussex and how it will be measured

Difference for local people and workforce	How will this be measured
People will be supported to stay healthy for longer and more proactive preventative care will be available for those who need it, across the full range of organisations that can support this.	Reduction in the numbers of people accessing hospital services in an unplanned way. Reduction in the gap in life expectancy and healthy life expectancy.
More children and young people will be accessing assessment and treatment more quickly and will be supported to live healthier lives.	Improvements in health outcomes. Increase in the proportion of children and young people with a diagnosable mental health condition who receive treatment from an NHS-funded community mental health service.
More people will be able to access support with their mental health needs more quickly and closer to home and there will be more intensive bespoke housing-based options for people who need it to ensure people can leave hospital more quickly when they are ready. Staff roles will become more manageable and more enjoyable.	Reduction in the number of inappropriate referrals to mental health secondary services, and an increase in appropriate referrals to secondary mental health services improving outcomes, reducing waiting times and preventing issues from worsening.

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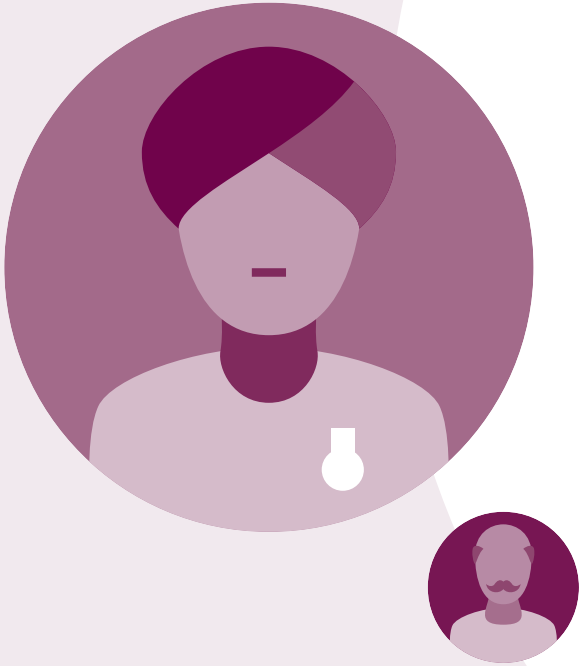


Difference for local people and workforce	How will this be measured
Community care and support will be better co-ordinated to enable people to stay independent for longer, have better onward care after a spell in hospital, and ensure access to local sources of practical support and activities, boost emotional wellbeing, and help with loneliness and isolation.	Increase in the number of people seen within the waiting time target for reablement services. Number of people living at home and accessing support in their communities. Proportion of people with support needs who are in paid employment. Proportion of people who regain independence after using services. Proportion of people and carers who report feeling safe. Reduction in the numbers of people accessing hospital services in an unplanned way. Reduction in the average length of stay in community beds. Reduction in the average length of stay in Discharge to Assess (D2A) commissioned beds and increased use of D2A bed capacity utilisation.

Continued on next page...

Difference for local people and workforce	How will this be measured
People have access to timely and responsive care, including access to emergency hospital services when they need them.	Reduction in waiting times for GP services, community support and care services. Referral times for health treatment. Reduction in the length of time between somebody being ready to leave hospital and when they do.
Digital services and innovation are used to help make best use of resources.	Proportion of people and staff in all health and care settings able to retrieve relevant information about an individual's care from their local system.

West Sussex

Our West Sussex Health and Wellbeing Board has a Joint Health and Wellbeing Strategy 2019-2024 called ***"Start Well, Live Well, Age Well"***. It sets out the Health and Wellbeing Board's vision, goals, and ways in which we will work to improve health and wellbeing for all residents in West Sussex. It was developed in consultation and collaboration with local residents, service users, multi-disciplinary professionals, and partners. It draws on evidence of West Sussex's health and wellbeing needs from the Joint Strategic Needs Assessment (JSNA).

The strategy adopts a life course approach, identifying our priorities across three themes - Starting Well, Living and Working Well and Ageing well. It consists of a few carefully selected priorities that can significantly contribute towards achieving its vision with a focus on:

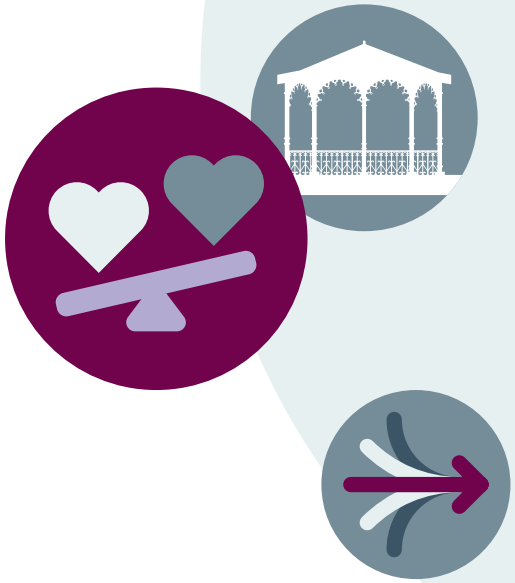
- A whole system approach to prioritise prevention, deliver person-centred care, and tackle health inequalities.
- Harnessing the assets and strengths of local communities to improve health and wellbeing, creating safe, sustainable environments that promote healthy living.

The West Sussex Health and Care Partnership was formed in 2020, bringing together key local health and care partner organisations to work collaboratively to deliver the objectives of the Joint Health and Wellbeing Strategy and the Sussex-wide strategy through a Place-based plan. The partnership leads on delivering shared population health objectives on behalf of the Health and Wellbeing Board.

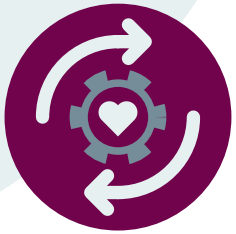
We have developed a model of collaboration that brings changes to people directly within their community, through our Local Community Networks. These are co-located with district and borough footprints and are empowering communities to deliver change through collaborative working between Primary Care, district and borough councils, local Public Health, and voluntary sector enterprises. We will maintain our focus in year one on how Local Community Networks can continue to make the positive changes for people who live in West Sussex, as we develop our Integrated Community Team model across Sussex.

Our ambitions for improving lives at place

Our West Sussex Health and Care Partnership responds to the challenges faced collectively as a group of organisations and the delivery of the priorities set out in *Improving Lives Together*. Our strategic goals are:



- **Address health inequalities:** There are stark inequalities in outcomes, access, and experience of care for maternity and neonatal service users and the opportunities and experience of staff from minority backgrounds and we will tailor our services to target the needs of our local populations and offer a personalised maternity journey that wraps around the individual and their family. We will prioritise the improvement of healthy life expectancy through tackling the key health inequality related conditions and ill health relating to CVD, respiratory and cancer. We will utilise approaches such as tobacco control, cancer screening and health checks and work together with key stakeholders across the area to target our activity and resources where it is needed most based on need and evidence of what works. We will make care more personalised so that people can access health and care services that are more tailored to their needs, make sense to them and focus on what really matters in their lives.
- **Integrate models of care:** We have opportunities to further develop how our services work together to streamline pathways for patients, improve experience and create more integrated approaches. Through integrated services we will remove the unnecessary barriers between our services that are all working to support the same local people and create more sustainable models of care.
- **Transform the way we do things:** We will continue to improve our services where it will have the greatest impact, taking the opportunity to address health inequalities and strengthen our integrated approach. We will continually review our joint transformation priorities year-on-year, systematically improving our services.



How we will deliver our ambition

The West Sussex Health and Care Partnership Place-based Plan uses evidence from the Joint Health and Wellbeing Strategy to determine local priorities and key areas for change agreed across our partners and within the framework of the ambitions outlined on the previous page. To support the delivery of the system-wide priorities and our strategic goals, there are six specific priority areas for change that have been identified from the Health and Wellbeing Strategy for West Sussex:

- **Tackling the wider determinants of health:** We will work together to influence the many determinants of healthy living, such as how services are accessed and how communities can be empowered to support healthy living for their residents.
- **Addressing health inequalities:** We will have a targeted and focused approach for those with most need and who need additional support.
- **Adults Services:** We want to help people 'live the life they want to lead', by remaining independent for as long as possible and maintaining a high quality of life.
- **Children and Young People:** We will improve the existing support to children and young people so they can have the best possible start to life, through our West Sussex Children First programme.
- **Mental Health:** We will expand our support for people with mental health needs to address the growing need, delivering the best standard of physical health checks for people with mental illness, and developing sustainable housing solutions for people living with long-term mental illness.
- **Learning Disabilities and Neurodevelopmental needs:** We will provide greater focus and support for those with a learning disability and neurodevelopmental needs, by reforming our children's and young people's neurodevelopmental diagnosis and care pathway, including social support.

The actions we are taking this year (2023-24) to deliver our West Sussex Place-based priorities are:

What we will do	What we will achieve	When
We will develop and agree a business case and implementation plan for a new Bognor Diagnostics Academic Centre. We will develop education, training and develop courses to support local people in gaining employment in this sector.	We will be able to provide additional capacity for diagnostic tests.	September 2023 March 2024
We will complete a public consultation, produce, and agree a business case and start to mobilise a new model for stroke services in the coastal area of West Sussex subject to the outcomes of the public consultation. We will develop our cardiovascular disease reduction priorities in West Sussex including hypertension case finding and treatment, and the restoration of the NHS health checks programme.	We will be able to become fully compliant with national standards for acute stroke services. The West Sussex Cardiovascular Disease Reduction action plan will be developed and monitored at the West Sussex Cardiovascular Disease Reduction group.	December 2023 March 2024
Aligned to the Integrated Community Frontrunner programme, we will develop new models of care for our priority services in Crawley, produce and agree the business cases (including impact measures) and implementation plans for our four priority service areas and a strategic outline case for improvement to our estates.	We will be able to tailor our services and improve access for the most disadvantaged communities in Crawley. This includes the development of a new Community Diagnostics Centre at Crawley Hospital, and new improved facilities for the Child Development Centre at Crawley Hospital.	March 2024

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What we will do	What we will achieve	When
Aligned to the discharge workstream, we will develop our integrated hospital discharge model, implement the 2023-24 hospital discharge capacity plan, and deliver the improvements aligned with the discharge frontrunner programme. Our Place-based discharge transformation work will happen to ensure efficiency within current processes.	We will be able to ensure people who no longer need acute inpatient care can go home or to a community setting to continue recovery. We will also ensure Place-based discharge pathways are aligned to national best practice and achieving maximum efficiency.	March 2024
We will develop a new integrated intermediate care model for rehabilitation and reablement services and a business case and implementation plan for the new model.	We will be able to ensure people receive rehabilitation and reablement care in a timely manner, through teams working together in reducing unnecessary duplication and handovers.	March 2024
We will create an emotional wellbeing pathway focused on ensuring that the best outcomes are achieved for children and young people and embed training at point of induction for social workers and annual refreshers thereafter.	We will be able to improve the support and interventions for children and young people with autism and or mental health issues.	March 2024
We will review our joint commissioning arrangements for learning disabilities, mental health, and neurodevelopmental services.	A robust and transparent Section 75 agreement which sets outs the joint and pooled commissioning and provider arrangements between West Sussex Adult Social Care and NHS Sussex West Place to meet the needs of residents. This will enable the introduction of new clinical governance measures on Case Review Process to ensure best practice and compliance to new regulations.	March 2024

The actions we will take over years 2-5 to continue to deliver our West Sussex Place-based priorities are:

What we will do	What we will achieve	When
We will implement tailored health services and service models for our priority service areas in Crawley to meet the needs of the population with a focus on the most disadvantaged communities.	We will increase service use by the most disadvantaged communities in Crawley. We will have improved health outcomes for the most disadvantaged communities. We will have co-ordinated utilisation of estates and assets across health and social care.	March 2028
We will deliver the Bognor Diagnostics Academic Centre.	We will contribute to the West Sussex diagnostic programme to enhance access to diagnostics for patients across Sussex with our CDC capacity, improved diagnostics pathway, and capital investment in services. We will increase in numbers of physiological and imaging workforce being trained or being employed.	March 2028
We will create access to a 24/7 acute stroke centre for the coastal area of West Sussex, subject to the outcome of public consultation. We will further develop and implement seamless rehabilitation pathways to ensure people can return home as soon as their acute episode is resolved. We will implement our cardiovascular disease reduction priorities.	We will have a fully compliant stroke pathway from prevention through to hyper-acute care to rehabilitation in place for the population. We will have better long-term outcomes for patients and their carers and reduced mortality/ disability due to stroke and cardiovascular disease.	March 2028

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What we will do	What we will achieve	When
We will further develop and implement efficient hospital discharge processes, supported by digital automation. We will put in place a long-term funding plan for discharge capacity. We will embed efficiency and process learning from transformation programmes into 'business as usual'.	We will have quicker and more effective discharge processes, reducing the length of the time people wait to be discharged and maximise reablement and independence after discharge. We will ensure more patients are able to return to their usual place of residence following discharge, increasing Home First capacity, and decreasing reliance on bedded capacity. We will ensure discharge pathways allow for greater personalisation to meet the needs of the individual and their carer.	March 2028
We will implement a new integrated intermediate care model for rehabilitation and reablement services including a quality outcomes framework to demonstrate benefits.	We will improve the support for a short time to help more people remain in their own home while they recover from a hospital stay.	March 2028
We will implement a new emotional wellbeing pathway to further support and interventions for children and young people with autism and or mental health issues.	We will ensure that within 24 hours of admittance to a paediatric ward due to autism, learning disabilities or mental health concerns, there is a multi-disciplinary plan to ensure a discharge in-line with their best interest.	March 2028

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What we will do	What we will achieve	When
We will continue with our Joint Commissioning Review in West Sussex to further enable delivery of the priorities set out in *Improving Lives Together*, the Adult Social Care Strategy, and the Children First Strategy.	We will reform our joint commissioning governance to support the continued development of integrated health and care partnership working at system, place and local community level. We will realign our strategic and financial joint commissioning arrangements to match our local population health priorities, and the priorities set out in our health and care strategic plans.	March 2028

Difference this will make to local people and workforce in West Sussex and how it will be measured

Difference for local people and workforce	How will this be measured
Improved health outcomes for the most disadvantaged communities in Crawley.	Improved health outcomes across a number of areas including maternity, mental health, and long-term conditions. Improved access across a range of services for our most disadvantaged communities. Increase uptake of translation services, with more service available outside 9-5, Monday to Friday.
Improved access and capacity of diagnostics in Bognor Regis.	People will have access to their diagnostics at more convenient times. Reduced waiting times for diagnostics. Local residents in local university diagnostics related courses. Increased workforce supply, skills mix and new roles across imaging workforce.
Lower levels of mortality and disability due to stroke and cardiovascular disease.	More lives saved 90 days post discharge. Increased levels of independence. 90% of the expected prevalence of Atrial Fibrillation is diagnosed in every practice in West Sussex. 90% of people already known to be at high risk of stroke are adequately anticoagulated.

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Difference for local people and workforce	How will this be measured
Improved discharge process to ensure people return home as appropriately as possible.	Reduction in the length of time between someone being ready to leave hospital and when they do. Reduction in overall number of patients who are ready to leave hospital but cannot. Maximise the proportion of people who can return home after leaving hospital.
People will be better supported to remain at home and retain more independence in the community.	Reduced time waiting to receive reablement/intermediate care intervention. Reductions in people unnecessarily needing long-term care. Reductions in need for care home placements. Increased proportion of care provided at home. Greater personalisation of discharge care and increase in number of personal health budgets. Increase in proportion of people living independently at home for longer.

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Difference for local people and workforce	How will this be measured
Improved outcomes for children and young people with autism and mental health issues	Within 24 hours of admittance to a paediatric ward due to autism, learning disabilities or mental health concerns there is a multi-disciplinary plan to ensure a discharge in line with their best interest. Mental health, autism and learning disability module for social workers at university.
A shared set of strategic priorities and plans with integrated and streamlined commissioning arrangements and use of resources supporting delivery.	By streamlining and strategically aligning the West Sussex Joint Commissioning activities between local government and the NHS to population health priorities for children and young people, people living with a learning disability or neurodiversity or long-term mental illness, we will aim to deliver: • **Care models that enable greater independence, choice, and self-care.** • **Greater technology enabled care to support more people to live independently at home.** • **Better long-term health outcomes by tacking health inequalities experienced by people with learning disabilities, or mental illness.**

6. Other areas of focus

To support the delivery of our ambition and the four delivery areas, there are other areas that will require continued focus, either within the actions of our improvement priorities or as distinct pieces of work.

Prevention

Prevention is a key principle that underpins the delivery of our ambition. This includes supporting good physical health, supporting people to be socially connected, supporting emotional wellness and positive mental wellbeing, supporting people to feel safe in a clean and sustainable environment. The work being undertaken to deliver our Health and Wellbeing Strategies has prevention as a core focus and this will be taken further with the development of our Integrated Community Teams.

We are committed to the delivery of our Sussex Improving Population Health Strategy and the key priorities in the Sussex Strategic Framework for Health Inequalities. We continue to embed Population Health Management methods to identify target populations for health conditions, prevention programmes, racial health disparities and focussed personalised care interventions. We also have a series of programmes of work to address Core20PLUS5 for children, young people, and adults.

Increasing our focus on addressing the needs of children and young people is also an important element of our commitment to prevention. Using the system Children and Young People's Board to ensure that the work of all our Delivery Boards address the needs of children and young people will help us to identify and take opportunities, where we can, increasingly to shift the profile of our investment into prevention while still continuing to provide the health and care needed across our population.

We will measure the success of our prevention work through:

- **An increase in healthy life expectancy for males and females and a reduction in the inequalities in healthy life expectancy.**
- **A reduction in the prevalence of overweight children in reception and year six of primary school.**
- **An increase in the percentage of children and adults meeting the recommended levels of physical activity.**
- **Meeting national targets for vaccinations and immunisations.**
- **A reduction in rates of emergency admissions and subsequent loss of independence due to falls.**
- **More adult social care users and adult carers have as much social contact as they would like.**
- **More people aged 40-74 are offered and are taking up an NHS Health Check.**

Maternity and Neonatal Care

Maternity service reviews undertaken across England identified the need to proactively identify Trusts that require support before serious issues arise. To safeguard Sussex residents using our perinatal services, we must ensure we can identify adverse outcomes early and act swiftly whilst we embed learning from these national investigation reports. The processes and ways of working we have developed across our local maternity and neonatal system (LMNS) partners will continue to support our response to key national reports, including Ockenden and Reading the Signals.

NHS England published the three-year Maternity and Neonatal Delivery Plan which details the national ambition of ensuring that care is safer, more personalised, and equitable and based around the following themes. NHS Sussex is collaborating with the LNMS to develop provider and system plans to respond to these recommendations.

- **Listening to, and working with, women/people and their families with compassion.**
- **Growing, retaining, and supporting the workforce.**
- **Developing and sustaining a culture of safety, learning and support.**
- **Standards and structures that underpin safer, more personalised, and more equitable care.**

Safeguarding

We want to ensure all children, adults, families, and communities across Sussex are safe and free from all forms of abuse and harm. This involves a whole-system multi-agency approach that crosses all ages, places where people live and work, communities, and systems.

NHS Sussex has an agreed strategic approach to maintain safe and effective safeguarding and Looked After Children services and to strengthen arrangements for safeguarding children and adults at risk from abuse and neglect across Sussex.

We are required to demonstrate how our strategic and assurance arrangements enable us to carry out the duties and functions specified under the Care Act (2014) and the Children and Social Work Act (2017). We have an extensive and wide-reaching approach which includes:

- **Clear systems to train staff to recognise and report safeguarding issues.**
- **A clear line of accountability for safeguarding and Looked After Children, reflected in our governance arrangements and overseen by NHS England.**
- **Arrangements to work with local authorities through our Safeguarding Children Partnerships and Safeguarding Adult Boards.**
- **Arrangements to share information between service providers, agencies, and commissioners.**
- **Designated doctors and nurses who are responsible for safeguarding adults, children and looked after children.**
- **A child death review team, who are responsible for reviewing deaths in childhood, including nurses and a designated doctor.**
- **Child Protection Information Sharing (CP-IS), which will continue to be rolled out across Sussex.**

Quality

NHS Sussex has a statutory duty to ensure quality of care is maintained across services and meets the Care Quality Commission minimum standards for quality and safety, and that our health and care organisations have systems in place to check the quality and safety of care provided. Our quality assurance and improvement frameworks support our workforce in ensuring that our populations experience the best possible care. We will know that we are making a difference because:

- **People that inspect our health services will agree that they are safe and the measures for rating our services, such as those set out by the Care Quality Commission (CQC), will have improved.**
- **Our workforce will tell us that our services are improving in quality. By April 2024 we will have co-produced meaningful measures of quality and safety with our people and communities as well as an improvement target for the subsequent five years.**
- **People will report a better experience of contacting our Primary Care services.**
- **Our staff will be able to talk about and report quality and safety concerns freely without fear of speaking up or being criticised.**
- **There will be evidence that we are working more closely and better together to improve quality, responding to complaints more quickly, and running educational events to teach people how to create better quality and safety in our integrated services.**

Supporting social and economic development

Supporting local social and economic development across Sussex is one of the core aims of achieving our ambition. This will be done through our focus on the wider determinants of health across local people and communities, including access to education and skills, good employment and quality, affordable and sustainable homes – all the things that can help people and communities to thrive and prevent the need for medical intervention and give people the best opportunities for improving their lives.

We want to develop our health and care organisations into 'anchor institutions', where they will use their sizeable assets and ways of working to support the health and wellbeing of local communities and help address health inequalities. NHS Sussex is committed to using its evolving anchor role to explore and develop new networks across the region with the intention of establishing a greater understanding of the cross-sector impacts of health inequalities in Sussex and enabling policymakers from the system and wider sectors to come together to share ideas and develop health focused solutions. A growing socioeconomic challenge in the region and a significant determinant of a healthy and happy life is housing, from quality and accessibility to affordability, NHS Sussex will work with established and new partners to explore strategic options to tackle housing challenges.

This represents a new way of working for our system and it is recognised that it will take time to establish how partners can achieve this ambition most effectively together. To support this, in year one we will establish a baseline understanding of current work happening across the system that we can build on over years two to five. This will include:

- **Procurement activity which promotes local supply chains and local employment opportunities with a living wage.**
- **Employment initiatives that can assist with recruitment and retention of staff, as well as supporting the wider economy of Sussex.**

Climate change commitments

Since 2010, the NHS has reduced its emissions by 30%, exceeding its commitments under the Climate Change Act. In doing so, we have learnt that many of the actions needed to tackle climate change will directly improve patient care and health and wellbeing. This is because many of the drivers of climate change are also the drivers of ill health and health inequalities.

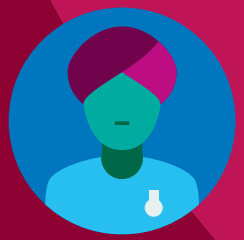
Together to Zero is our plan for a greener NHS in Sussex. The plan sets out how we will work together as partner organisations across our system to reduce carbon emissions and build an NHS more resilient to the effects of climate change. It also sets out a number of key areas for action on climate change that pose the most significant co-benefits for health, and which drive at greater efficiency and productivity. The plan supports the individual organisational plans of our NHS providers and will support the effective delivery of our Integrated Community Teams and Health and Wellbeing Strategies.

Evidence, research, and change methodology

We want to be driven by the best evidence and be at the forefront of improving health and care in our communities. To do this we will generate and use research evidence and create a culture of innovation to bring the best new approaches to Sussex. A new group is being developed called the Innovation and Research Hub, which will aim for the first time to bring together a Sussex-wide approach to Innovation, Research and Evaluation. The Innovation and Research Hub will hold the relationships with academic and research networks, national bodies, universities, local economic groups, and national and local industry groups. The introduction of the Innovation and Research Hub will bring the most progressive approaches in healthcare into Sussex. Having a streamlined approach to evidence finding, impact analysis and implementation will reduce the time lost through the current fragmented approaches but also accelerate the introduction or spread of useful technologies, medicines, or practice.

7.

Developing and delivering our Shared Delivery Plan



Our Shared Delivery Plan meets national guidance and takes account of key national, regional, and local strategies and policies. In-line with guidance, we will review and update the plan before the start of each financial year. We may also revise the plan in-year if considered necessary.

Planning approach and principles

Three principles describing the Shared Delivery Plan's nature and function have been co-developed with systems across the country, Trusts and national organisations representing local authorities and other system partners. These are:

- **Principle 1: Fully aligned with the wider system partnership's ambitions.**
- **Principle 2: Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments.**
- **Principle 3: Delivery focused, including specific objectives, trajectories, and milestones as appropriate.**

Maximising the power of partnerships

Improving Lives Together outlines a commitment to maximising the power of partnerships to ensure organisations responsible for health and care work together in the best possible way for local people.

To enable the most effective delivery of our Shared Delivery Plan, it has been agreed that organisations will work together across four different levels:

- **System level – across the whole of Sussex.**
- **NHS provider level – across NHS organisations.**
- **Place level – across the footprints of our three local authorities.**
- **Local community level – to support the development and delivery of the Integrated Community Teams.**

This way of working will enable better integration of services, use of resources, co-ordination, planning, and decision-making that will lead to better joined-up care for local people and better ways of working for our staff. It also supports national policy and guidance. To enable this to happen, we are developing a new operating model across the system that will have a 'golden thread' of all organisations working in the best possible way for local people and patients. In doing so, we will respect the statutory and corporate accountabilities and responsibilities of all organisations.

This will require every statutory organisation to start to work in a new way across the four different levels from April 2024.

System level

We will continue to work at a Sussex-wide system level through the existing statutory architecture that was established with the formal formation of our Integrated Care System.

The Sussex Health and Care Assembly is the Integrated Care Partnership for Sussex, which is a joint committee established by NHS Sussex, Brighton & Hove City Council, East Sussex County Council and West Sussex County Council in accordance with the constitutions of each body. The membership of the Assembly includes wider partners, including our three Universities, further education, the housing sector, the local enterprise sector, Healthwatch, and the Voluntary Community and Social Enterprise sector. The purpose of the Assembly is to bring a broad section of system partners together to approve and facilitate the strategic direction for meeting the broader health, public health, and social care needs of the population. This allows for partnership and collaborative working to take place across wider partners.

NHS Sussex Integrated Care Board (ICB) is the statutory NHS organisation responsible for the oversight of performance, quality, and resource allocation of NHS services across Sussex. This is done by working with NHS providers and a legal obligation to work with Local Authority partners. The NHS Sussex Board is made up of independent Non-executive Directors, partner members from NHS providers, local authorities, and Primary Care, as well as Executives. The future function of NHS Sussex will change to be predominantly focused on the strategy and planning for the system to achieve improved outcomes for the population. A new operating model will be developed during 2023-24 and will be in place from 2024-25.

NHS provider level

A Provider Collaborative will be established, which will involve NHS providers working together in a more formal, effective, and joined-up way for the benefit of patients and staff. The collaborative will design the service transformation models to deliver the strategic priorities, in co-production with partners, at Place and local community level. The provider collaborative will include Primary Care as part of the membership.

Place level

We will strengthen how our organisations work together across our populations in Brighton and Hove, East Sussex and West Sussex through Health and Care Partnerships and delivery of the Place-based Health and Wellbeing Strategies. Place will be the intermediary tier for the NHS and the primary tier for the Local Authority to discharge its statutory responsibilities to meet residents' needs in their council area. It will oversee and provide leadership for the delivery of services at community level and fulfilment of legal duties in respect of Place-based partnerships including with Health and Wellbeing Boards.

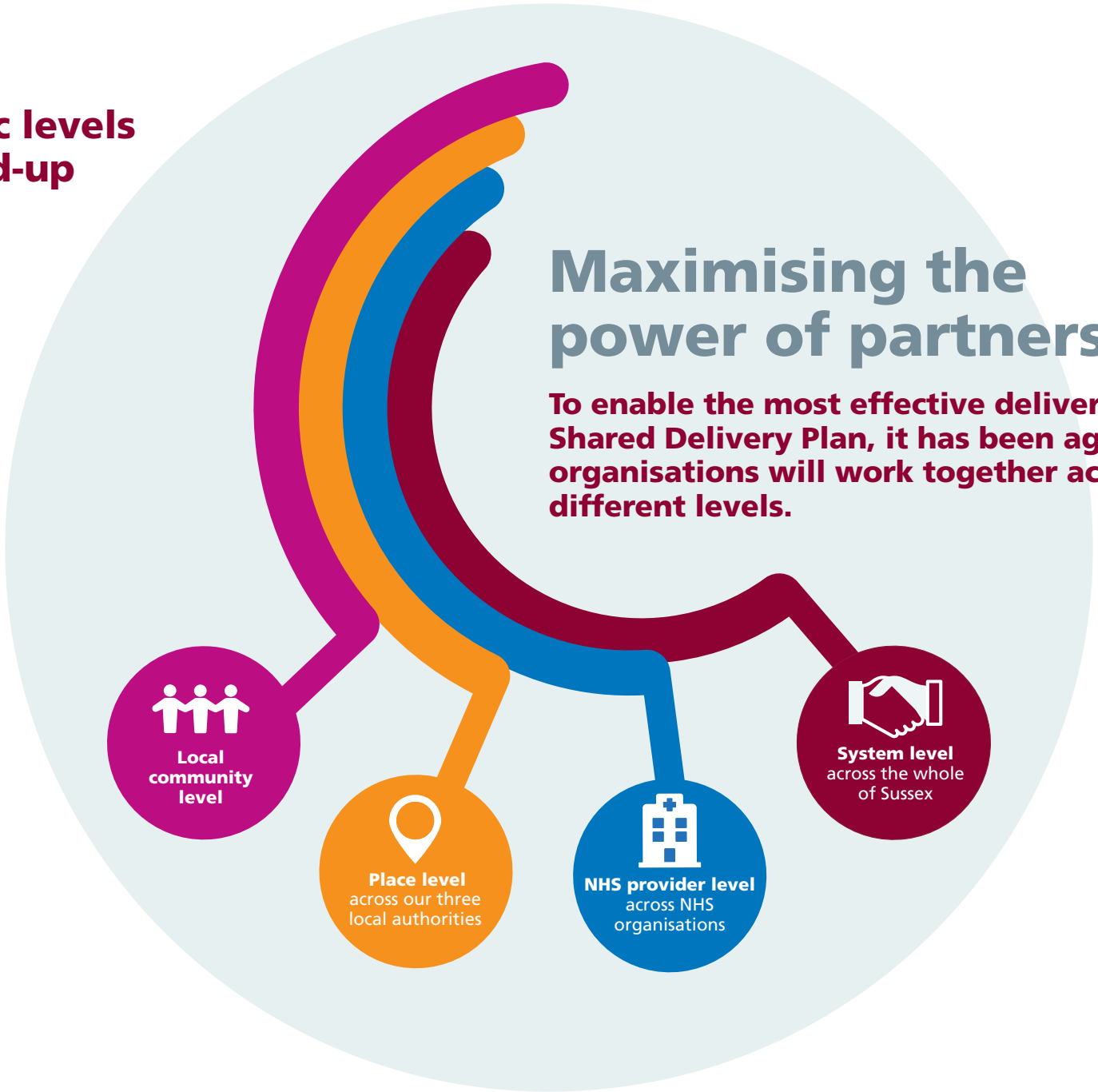
Local community level

We will integrate services and ways of working at a local community level through the formation of Integrated Community Teams. We are consciously using the term 'community', rather than 'neighbourhood' which is also often used to represent integration at a very local level, as we will have a broader focus on people's individual needs that will stretch beyond simply the geographical location they live. By community, we mean both the recognised local area someone lives and communities that people identify with, such as those with the same interest, beliefs or ways of life.

Integrated Community Teams will be the focus for prevention, self-care, and providing support to help people make choices about their care and look after their own health priorities, enabled by strengthened Primary Care and assets-based approaches with communities. They will be supported to develop new approaches across Sussex which will be based on empowering our communities, the promotion of local leadership, equality of partnership between participating organisations, a permission to innovate for local people and for staff, and a different approach to working with people. As our communities across Sussex are all unique, partner organisations will have to work in a pragmatic and flexible way at this level and will be supported to do so. This will involve changes to how partners have worked in the past to ensure they are able to work in an integrated way at a local level.

Figure 3

Strategic levels of joined-up working



Governance and leadership

Governance for delivery

The delivery structure for the Shared Delivery Plan is outlined on page 117. This involves each of our Long-term Improvement Priorities (Delivery Area 1), Immediate Improvement Priorities (Delivery Area 2) and Continuous Improvement Areas (Delivery Area 3) having a Delivery Board to lead the delivery of the agreed actions, chaired by a system Chief Executive Officer. Each will have a workstream that will be resourced from across system partners. The work of these Boards and workstreams will be overseen by a System Oversight Board.

Each workstream across Delivery Area 1 and 2 will give due regard to the continuous improvement areas and ensure they are embedded within the work taking place and all will ensure they are supporting the aims and ambitions of *Improving Lives Together* in:

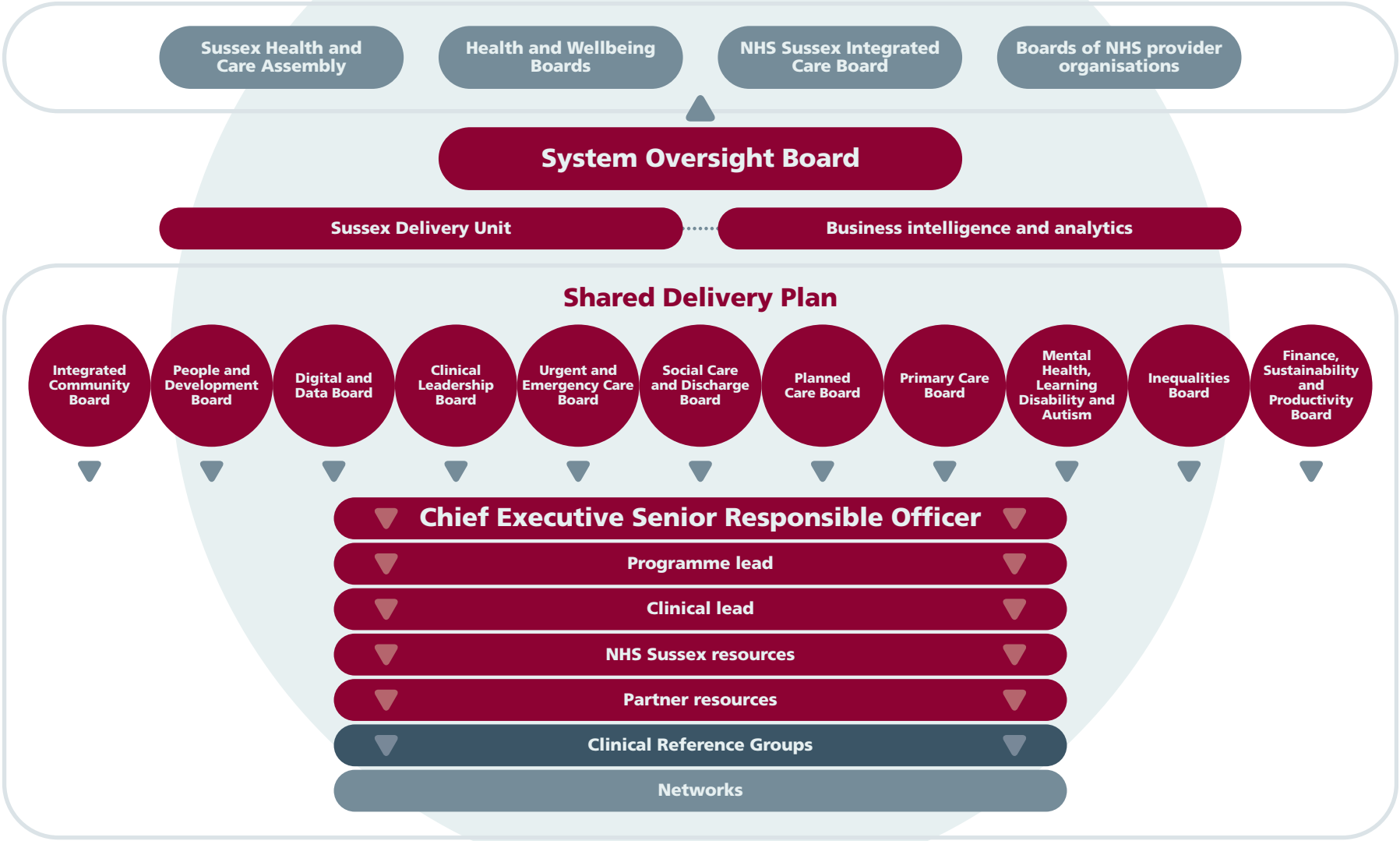
- **Improving health and health outcomes for local people across the life course, with particular focus on children and young people;**
- **Tackling health inequalities;**
- **Working better and smarter;**

  and
- **Supporting communities to develop socially and economically, including sustainability.**

The Delivery Boards will develop detailed workplans and milestones for each workstream and will use insight and data to create outcome frameworks.

Figure 4

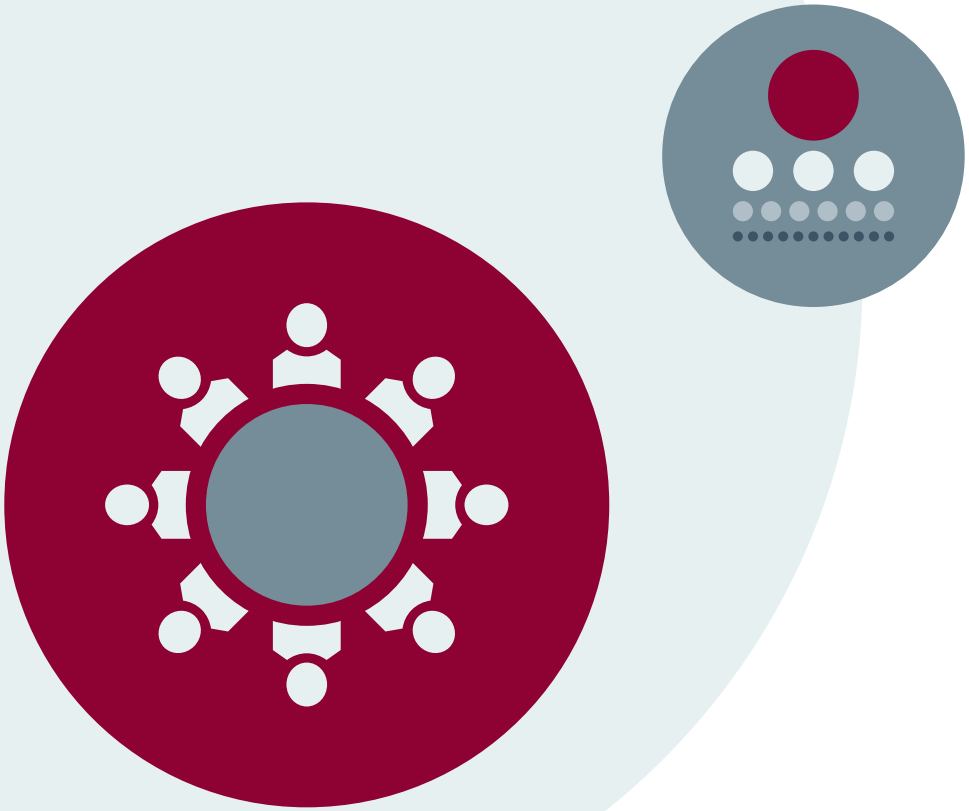
Governance structure for delivery



System Oversight Board

The core functions of the System Oversight Board (SOB) will be to oversee the implementation of the Shared Delivery Plan and to provide leadership with regards to strategy, and resolution of system risk.

SOB will report into the NHS Sussex Executive Committee and onwards to the NHS Sussex Board. Members will be required to report back from SOB through to their respective organisational boards and leadership forums to ensure system alignment. The new SOB replaces the former System Leadership Forum and is made up of Chief Executive Officers from the statutory NHS organisations, GP Federations, and senior representatives from the Local Authorities. This includes the leadership of Surrey and Sussex Healthcare NHS Trust.



Financial strategy and delivery plan

Work has taken place across the system to co-produce a plan to deliver our long-term strategic ambitions. However, it is important to recognise public sector financial constraints over a number of years, which therefore means delivery of this plan is subject to an underpinning financial strategy which will be developed by September 2023. As a result of this there may be further strategic and operational change required to underpin delivery over the next five years, the size and impact of which will need to be captured.

Engagement and partnerships

Our Shared Delivery Plan has been developed across system partners and is informed by national, regional, and local evidence, guidance, and insight. To support the co-development process, we have established an engagement working group, working with:

- **Sussex Health and Care Assembly members**
- **Primary Care providers**
- **Local Authorities and each relevant Health and Wellbeing Boards**
- **Other systems in respect of providers whose operating boundary spans multiple systems**
- **NHS providers**
- **Healthwatch**
- **The voluntary, community, and social enterprise sector**
- **People and communities that will be affected by specific parts of the proposed plan, or who are likely to have a significant interest in any of its objectives, in accordance with the requirement to consult.**

Insight from engagement with people and communities across Sussex over a two-year period underpinned the development process of ***Improving Lives Together***, and thematic analysis of this insight has informed the creation of the Shared Delivery Plan. Enhanced engagement opportunities were also offered via online sessions for Foundation Trust Governors and the public, discussions with members of the Sussex VCSE sector, Healthwatch and with other key partners.

Extensive workforce engagement was also undertaken with insight collated from the national NHS staff survey results and from NHS organisation and Local Authority "pulse" surveys.

As we deliver the actions outlined in our Shared Delivery Plan, we are committed to making sure we continue to reach and hear from as many people as possible across Sussex, and ensuring their experiences, views and suggestions shape and influence our work. Each Delivery workstream will set out how the public and patients will be involved and engaged as part of their workplans for the delivery of the agreed actions. Our Working with People and Communities Strategy outlines our approach to public engagement and how we meet the legal duties around involvement.

Sussex
Health&Care

University Hospitals Sussex
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Agenda Item:	7-14	**Meeting:**	Trust Board	**Meeting Date:**	03 August 2023
Report Title:	Integrated Performance Report				
Sponsoring Executive Director:	Darren Grayson, Chief Governance Officer				
Author(s):	Executive Directors/Corporate Directors				
Report previously considered by and date:					

Purpose of the report:			
Information	Yes	Assurance	Yes
Review and Discussion	Yes	Approval / Agreement	N/A

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

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	Yes	Link to Trust Annual Plan	Yes

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	Yes	
Sustainability	Yes	
People	Yes	
Quality	Yes	
Systems and Partnerships	Yes	
Research and Innovation	Yes	

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

Regulatory / Statutory reporting requirement

The Trust has a statutory requirement to report performance to the board against the NHS National Oversight Framework

Communication and Consultation:

Executive Summary:

I am pleased to introduce the new performance report for University Sussex Hospitals. It shows our performance to June 2023 and sets out the progress we are making to deliver the Trust's Patient First Strategy, the NHS National Oversight Framework and the NHS Operating Plan.

It has been a challenging period for UHSussex and for the NHS as a whole. Whilst the extreme winter pressures of December and January have eased, there have been renewed pressures dealing with long waiting elective backlogs for RTT, cancer and diagnostics alongside continued challenges in the Urgent and Emergency Care pathways. The Trust has also experienced industrial action across a range of professional groups which has had an adverse impact on our planned care activity. Unfortunately, this has continued into July. Whilst this has impacted operational capacity and financially, we have maintained continuity of good quality patient care and we are forecasting financial recovery. There has been progress made in reducing very longest waits (104 weeks and 78 weeks) and the Trust is ahead of its planned recovery trajectory for reducing the number of 62-day cancer patients waiting.

Key Recommendation(s):

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

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Integrated Performance Report

June 2023

Printed on: 27/07/2023 15:09.48 PM

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Chief Executive Summary

I am pleased to introduce the new performance report for University Sussex Hospitals. It shows our performance to June 2023 and sets out the progress we are making to deliver the Trust's Patient First Strategy, the NHS National Oversight Framework and the NHS Operating Plan.

My summary highlights our performance against some of the key metrics, much more detail is provided in the body of the report.

It has been a challenging period for UHSussex and for the NHS as a whole. Whilst the extreme winter pressures of December and January have eased, there have been renewed pressures dealing with long waiting elective backlogs for RTT, cancer and diagnostics alongside continued challenges in the Urgent and Emergency Care pathways. The Trust has also experienced industrial action across a range of professional groups which has had an adverse impact on our planned care activity. Unfortunately this has continued into July. Whilst this has impacted operational capacity and financially we have maintained continuity of good quality patient care and we are forecasting financial recovery. There has been progress made in reducing very longest waits (104 weeks and 78 weeks) and the Trust is ahead of its planned recovery trajectory for reducing the number of 62 day cancer patients waiting.

In June we opened the Louisa Martindale Building at RSCH as part of the 3Ts development which is delivering improved patient and staff experience in this state of the art facility. This will enable us to improve patient flow at that hospital and later this year provide a new model of care for frail patients.

Patient experience as reported through the Friends and Family remains strong at 90.7% in June 23 and Standardised Hospital Mortality was above the 100 index but was within expected range for the 12 months to March-23.

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True North Metrics				
Patient First Domain	Metric	Value	Target	Trend
Patient	Patient experience - To have 90% or more of patients rating FFT surveys as Very Good or Good	90.7%	95.0%	
People	Staff Engagement - To be within the top quartile of acute Trusts for the National staff engagement score	7.00	7.06	
Sustainability	Financial stability - Variance from breakeven plan YTD	-5,693k	0k	
Quality	Clinical outcomes/effectiveness - SHMI equal to or less than 100	109.5	100.0	
Quality	Safety - Reduction of 5% in preventable harm - UHSx approved	485		
Systems & Partnerships	A&E and Emergency flow - % treated and admitted/discharged within 4 hours	71.5%	76.0%	
Systems & Partnerships	Cancer - To achieve the 62 day standard	53.51%	85.00%	
Systems & Partnerships	Planned care - By March 2023, no patient is waiting more than 78 weeks for treatment.	331	0	
Research & Innovation	Within 3 years to be in the top 20 Acute Trusts nationally for patients recruited into portfolio studies	33	35	

Patient

	Metric	Target
True North	Patient experience - To have 90% or more of patients rating FFT surveys as Very Good or Good	90.0%

Patient First Domain

- The Trust's purpose is to deliver excellent care every time and patient experience is central to the delivery of excellent care.
- The true north ambition for patient experience is for patients to have an excellent experience of care and this is measured by the Friends and Family Test (FFT).
- Based on available FFT data, the significant majority of patients (90.5% in Q1) are satisfied that they have a good or very good experience. This is comparable to Q4 2022/23 (91%) and a considerable increase on Q3 (average 86%), with positivity levels influenced by improvement in ED ratings. commencing in January. This improvement was also seen in the national data for which the latest data is for February 23 (national positivity ratings increased from 73% in EDs in December 2022 to 83% in January and 80% in February).
- For UHS, 42,843 patients provided a review in Q1 (an increase on Q4 with 37,125) with an average response rate of 23%.
- The improved positivity ratings are in contrast to the number of complaints received which increased through Q4
- Complaints and PALS: 321 complaints were received in Q1 (up from 275 complaints in Q4 – a 17% increase) with the overall number of complaints increased slightly from Q4. however more complaints were closed than received. The overall pattern for PALS contacts is upwards over the last year and increase in enquiries relating to appointments, missed communications and difficulties getting hold of clinical specialty teams.

University Hospitals Sussex
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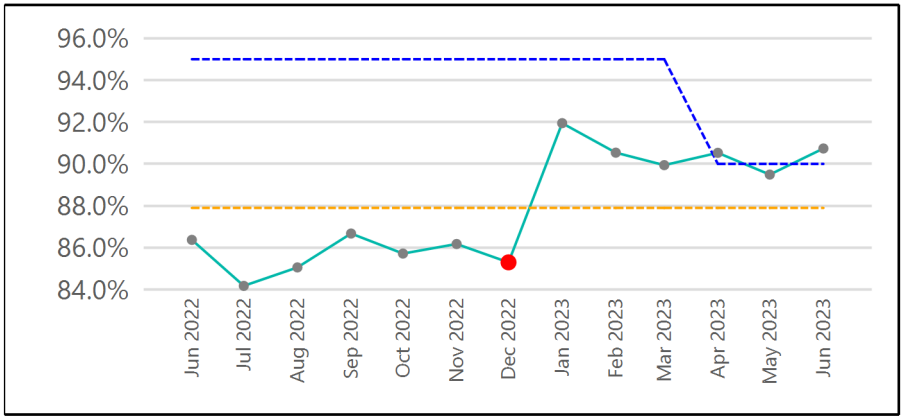
True North

Metric: Patient experience - To have 90% or more of patients rating FFT surveys as Very Good or Good

Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
86.4%	84.2%	85.1%	86.7%	85.7%	86.2%	85.3%	91.9%	90.5%	89.9%	90.5%	89.5%	90.7%

Overview

Positive ratings based on the friends and family test (FFT) have continued to be above the national average for maternity and emergency departments, in line with national average for outpatients and slightly below national average for inpatients. This is based on c13,000 patient surveys completed each month.



What the chart tells us

High positivity ratings for all divisions are maintained through 2023 and are higher than later months in 2022. Although medicine divisions overall ratings are heavily influenced by inclusion of EDs (which have lower positivity ratings locally and nationally) but when removed are above 90% too. Patients rating their care as good or very good is above the national average for EDs and maternity, in line for outpatients but slightly below for inpatients.

Intervention and Planned Impact

In addition to divisional improvement plans, the FFT system is being evolved to better reflect the COM and to be widely utilised to inform divisional priorities using patient feedback. The patient experience strategy is being implemented to address Trust-wide patient experience priorities.

Risks/Mitigations

Inclusion of ED data in the medicine divisions totals distorts overall rating and readings for these divisions should be considered within this context.

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Watch Metrics for Patient

Metric	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Patient experience - Total open formal complaints	266	309	365	338	329	315	317	322	267	253	67	84

People

	Metric	Target
True North	Staff Engagement - To be within the top quartile of acute Trusts for the National staff engagement score	7.06
Breakthrough	Staff engagement - 'Staff voice that counts' Increase the percentage of staff are confident that the organisation would address their concerns if raised	49.0%

Patient First Domain
The Trust relies on it's 16,578 staff across it's sites to treat 1000s of people per day. We monitor a range of staff based metrics which give a top level insight into how they are feeling about the Trust, vacancy rates which can constrain particular services, their adherence to statutory and mandatory training requirements, their health (in terms of sickness absence) and their demographic characteristics. The Trust True North focuses on staff engagement with the aim to be in the top half of acute Trusts for the National Staff Survey. This is monitored via an equivalent Pulse Survey tracked on a monthly basis . This has shown significant improvement since December-22.

University Hospitals Sussex
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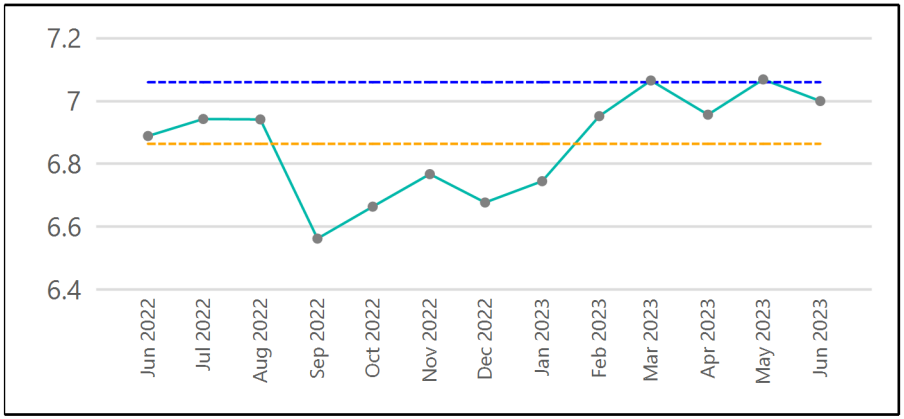
True North

Metric: Staff Engagement - To be within the top quartile of acute Trusts for the National staff engagement score

Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
6.89	6.94	6.94	6.56	6.66	6.77	6.68	6.74	6.95	7.07	6.96	7.07	7.00

Overview

The Trust's ambition is to be an "NHS Employer of Choice" with the most highly engaged staff and students within the NHS, passionate about delivering the best care. The Trust target is to be within the top half of acute trusts in the 2023 staff survey.



What the chart tells us

This shows the number of positive staff engagement scores on average per month, on an index to 10, as received via monthly survey as part of the IRIS training system.
The True North engagement score was 7 in June, which is the fifth consecutive month with a score of 7 or above.
When the data is stratified by staff group, the highest scores are observed in unregistered nursing, Scientific and Technical and Estates and Ancillary staff with 7.4 scored, whilst lowest score is within medical and dental staff groups with 6.3

Intervention and Planned Impact

The divisions for whom True North is a driver metric have implemented A3 Engagement Improvement plans based on their 2022 staff survey results.
Key themes are common across the Trust and actions have been identified to make improvements in the following areas: workforce planning/staffing to fill vacancy gaps; improvements to working environment (often quick wins like repairing or replacing broken equipment)l staff health and well being support (both in department and centrally), opportunities for staff development and enhanced skills to cope with increasing complex and acute patient conditions, reducing sickness absence rates and improving divisional communication methods and visibility of senior teams, as well as working through post-merger issues for cross-site teams to create a 'one UHSussex service".
Divisional comms have been sent out to promote the staff survey results and will be followed with "you said, we did" posters at the end July/beginning of August.
These actions appear to be having a positive impact on the Trust's overall engagement score.

Risks/Mitigations

Operational demands, gaps in leadership teams, staffing and stirke action can take focus away from concentrating on the engagement actions and a loss of momentum may impact on engagement scores in the monthly pulse surveys and this year's National Staff Survey in the autumn.
Mitigations include regular touchpoint meetings with SRO, monitoring of actions via Trust-wide improvement tracker, HR business partner support to divisions and monitoring of performance via divisional and trust Strategy Deployment Review (SDR)

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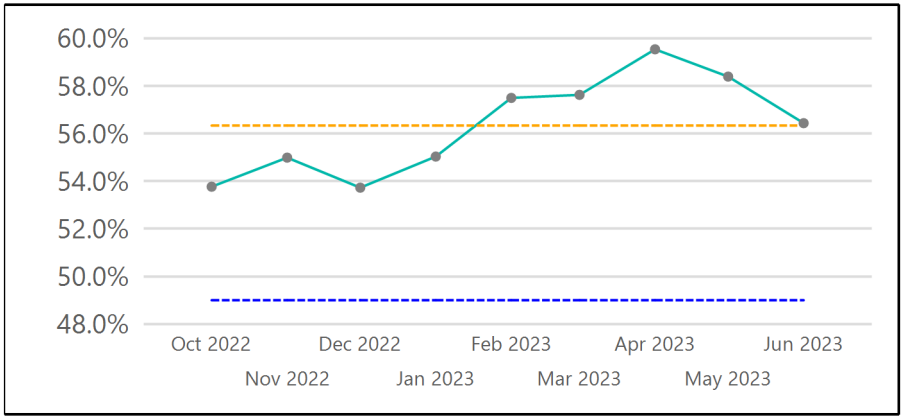
Breakthrough

Metric: Staff engagement - 'Staff voice that counts' Increase the percentage of staff are confident that the organisation would address their concerns if raised

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
53.8%	55.0%	53.7%	55.0%	57.5%	57.6%	59.5%	58.4%	56.4%

Overview

No Data



What the chart tells us

The measure "If I spoke up about something that concerned me", currently stands at 57.2%, down on last month (58.4%) and the high of 59.8% seen in April-23. By staff group the highest rates can be seen within Estates and Ancillary (78.8%) and the lowest rates within Medical and Dental (45.3%)

Intervention and Planned Impact

•Speaking up Q&A toolkit coaching sessions for staff and managers have taken place throughout June and July. Further sessions available during September.
•Resources all available on the intranet and 'speaking up' posters are being printed / distributed across divisions and printed versions of toolkits will be available in key areas such as libraries, health and wellbeing lounges, chapels etc.
•Speaking up Theme of the Week scheduled for 21st July
•New speaking up service agreed for UH Sussex
•Implementation of refreshed new ambassador programme (83 confirmed ambassadors) – target one staff ambassador in every department by Oct.
•Culture workstream established and 12 week discovery phase within org underway to form a current state analysis on the culture through the voice of the staff. Focus groups took place across the 5 hospital sites and cultural assessment questionnaire undertaken. Board interviews to also take place. The use of this data will enable us to learn and identify any barriers that could be restricting the development of UH Sussex's core values. Findings from the discovery phase will support the work already underway in the corporate projects and breakthrough objectives.

Risks/Mitigations
•Risks include low take up of Q&A sessions which means staff and managers may not be fully aware of resources available and how to use them, which could lead to a continuation of staff not feeling able to speak up or believing action will be taken if they do and low attendance at some of the site specific culture focus groups (although high response to online survey and feedback triangulates with feedback gained by HRBPs in their BTO focus groups). •Mitigations include HRBPs continuing to promote the BTO toolkits, materials and sessions and relaunch of Ambassador role, as well as plans to provide outsourced Freedom to Speak Up service/guardian. A number of Divisions are making good progress with their BTO score from the monthly pulse survey which means the metric has been moved from a driver to a watch

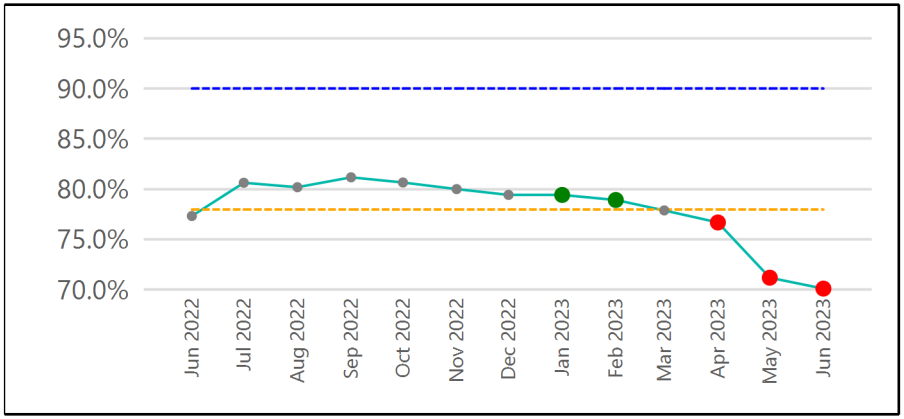
Driver

Metric: Training & development - Appraisals completed

Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
77.3%	80.6%	80.2%	81.2%	80.7%	80.0%	79.4%	79.4%	78.9%	77.9%	76.7%	71.2%	70.1%

Overview

- Trust (non-medical) appraisal rate has been falling steadily since September 2022 (80.64%). In June 2023, compliance was 69.45% (a further fall against 70.79% in May 2023).
- Currently no Clinical or Corporate Division is meeting the 90% target.



What the chart tells us

- Of the 16 Divisions/Directorates, 11 saw a fall in appraisal rate from May to June 2023 – notably Chief Operating Officer (-4.9% points) and Chief Medical Officer (-4.6% points). 5 Divisions/Directorates saw an improvement – notably Chief Financial Officer (+ 1.7% points).
- The best performing Division is Women's & Children's (80.53%).
- Poorest overall performance continues to be Chief Executive (35.48%, a slight improvement of 1.59% points since May 2023), Chief Nurse (50.86%, a fall of 1.82% points since May 2023), Chief People Officer (53.69%, a fall of 3.09% points since May 2023).

Intervention and Planned Impact

- Appraisal compliance continues to be a Driver Metric through the Divisional SDR process.

Risks/Mitigations

- Where appraisals are undertaken, appraisee feedback continues to be very positive:
  - 91% agree they had the opportunity to discuss all the topics they wanted to (6% disagree).
  - 90% agree they felt safe to talk about personal issues (7% disagree)
  - 88% agree the appraisal was a positive experience overall (6% disagree)
  - 78% agreed the appraisal form was about the right length.
  - 76% found the guidance material helpful.

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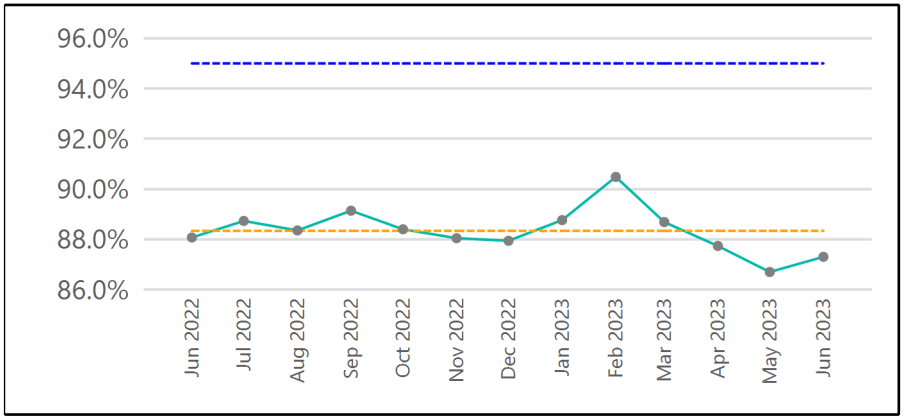
Driver

Metric: Training & development - STAM Weighted Average

Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
88.1%	88.7%	88.4%	89.1%	88.4%	88.0%	87.9%	88.8%	90.5%	88.7%	87.7%	86.7%	87.3%

Overview

Statutory and Mandatory training are required for every member of staff, with a range of domains from health and safety training, to information governance, to children and adult safeguarding. Targets for these metrics are to be at least 95% compliant across the statutory training components



What the chart tells us

UHSussex Trust wide average STAM rates across all STAM training was 87.3% June, up from 86.7% in May-23
Rates by individual competencies remain consistent with the only exception being resuscitation training where rates currently sit at 72.1%. This is the lowest level over the past year, and down from a high of 80.8% seen in February

Intervention and Planned Impact

Work continues to support divisions to increase compliance particularly for modules which require face to face training
Divisions continue to monitor Statutory and Mandatory (STAM) training compliance via A3 work and the Trust SDR performance review process
Statutory and Mandatory Training reports for UHSussex have been developed to assist managers to identify what training is out of date by individual and subject area to help managers to target staff who require updates.
Conflict resolution is being reintroduced as one of the mandatory topics for all staff with a higher level being developed for clinical staff, in direct response to feedback received as part of the Staff Survey Focus Groups.

Risks/Mitigations

Risks of remaining below 90% compliance include not meeting CQC requirements and staff and teams being at risk of not being able to evidence they are up to date with this essential statutory and mandatory requirement for their role and professional registration.
Mitigations include increased availability of Resus training sessions for staff to book, divisions arranging training in-department as part of study days and senior team scrutiny and oversight to drive continued improvements.

University Hospitals Sussex
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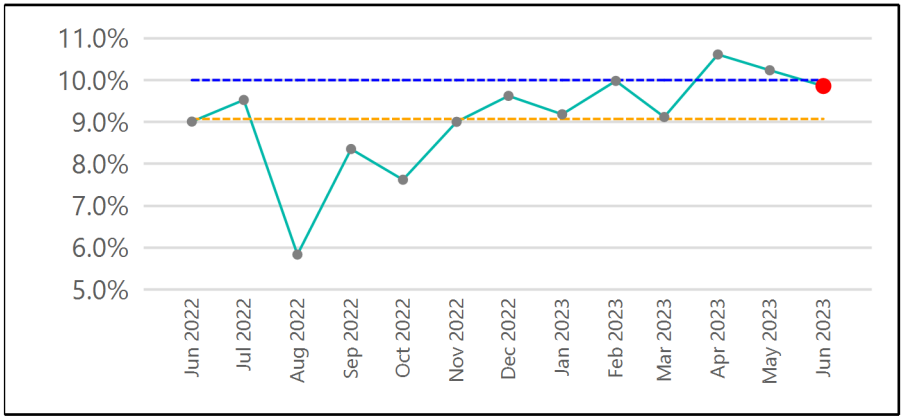
Driver

Metric: Workforce capacity - Vacancy Factor (Substantive contracted FTE) - monthly

Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
9.0%	9.5%	5.8%	8.4%	7.6%	9.0%	9.6%	9.2%	10.0%	9.1%	10.6%	10.2%	9.9%

Overview

Lower vacancies support the delivery of consistent high quality care and reduce the organisation's reliance on costly agency staff. Fully staffed clinical areas improve patient safety, for example support reduction in falls and are likely to provide positive patient experience.



What the chart tells us

This chart shows number of vacant substantive WTE divided by the number of budgeted establishment FTE.
The Trust vacancy rate is 9.86% in June-23 which represent a modest improvement compared to 10.34% in May-23.
The vacancy factor has been relatively stable since November 2022
There is a slightly higher 12% vacancy factor for HCA staff, which compares favourably to just below 21% November-22
Band 5 staff nurse vacancy is 16.1% showing an upward trend
Substantive contracted staff continues to increase month on month

Intervention and Planned Impact

Agreement for funding of 75 IENs to support nurse recruitment, which will be deployed in high cost agency areas/where there are high vacancies
HCA recruitment remains a high priority. Open days have been diarised for the next 5 months, currently 156 WTE candidates in the pipeline and 60 due to start in July. Rolling adverts continue with events being support by DWP.
Resourcing dashboard produced on a monthly basis to monitor progress against the TTR (time to recruit) KPI and Service improvement plan
TTR is currently 43.1 days and this has remained stable for the past 3 months. Daily huddles and monthly meeting are taking place with the recruitment team to monitor performance delivery and address breaches.
Additionally, there is a focus on senior recruitment with several roles currently out to advert, and the role of Deputy Chief Nurse - Workforce and Professional Standards is at offer stage.

Risks/Mitigations

No Data

University Hospitals Sussex
NHS Foundation Trust

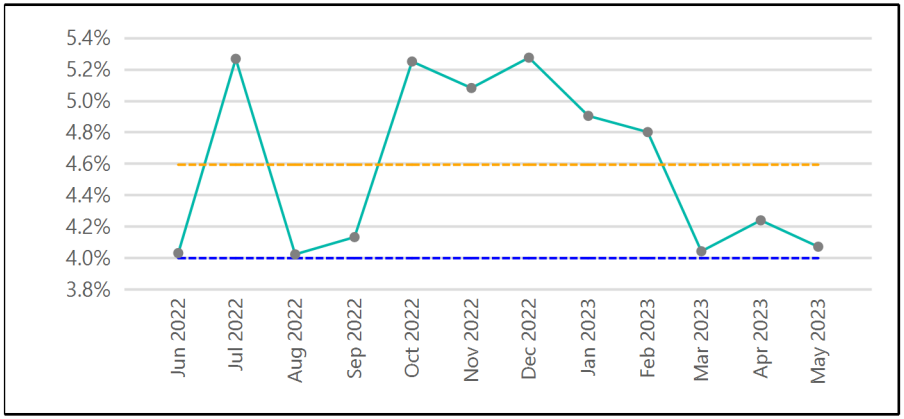
Driver

Metric: Workforce efficiency - Absence Sickness in month

Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
4.0%	5.3%	4.0%	4.1%	5.3%	5.1%	5.3%	4.9%	4.8%	4.0%	4.2%	4.1%

Overview

No Data



What the chart tells us

In May the UHSussex one month Sickness Absence rate was 4.07%, the third lowest individual monthly rate in the past year. The 12 month Sickness Absence rate stands at 5.20%, which is down from the high of 5.37% seen in February 23, but still substantially up on rates at this point last year, which were sitting at around 4.50%. When looking at the 12 month rate by Staff Group, it can be seen that the rise in Sickness Absence rate is predominantly from four main staff types, these are Admin & Clerical (up from 4.2% to 4.9%), Ancillary (up from 7.5% to 8.5%), Registered Nursing (up from 4.6% to 5.6%) and Unregistered Nursing / S,T&T staff (up from 8.5% to now stand at 10.3%). The 12 month rate of 10.3% for Unregistered Nursing / S,T&T staff, is nearly double the overall Trust rate of 5.2%.

Intervention and Planned Impact

•Overall the data is reflecting an improving picture on sickness. This needs to be put in the context that the Spring months historically have generally been better months but the current in month figures for April and May both show improvement on the corresponding 2022 figures.
•The focused A3 work on sickness at both Trust and Divisional level is contributing to this.
•Work continues on implementing the A3 action plan and a particular current focus is working jointly on the Divisional A3s, identifying divisional hotspot areas and targeting interventions to support these areas. This should contribute to sustaining the initial improvements being seen.

Risks/Mitigations

•Potential risks are the longer strike periods during July and the impact this could have on staff health. Continued good planning and supportive management will help mitigate this. A strand of the on-going work is looking at mental health.
•It has also been identified that Junior Doctor absence has been underreported and work is underway to rectify this going forward
•In 2022, July was the highest individual month for absence so there is a risk across what is overall usually a good period for reduced absence.

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Watch Metrics for People

Metric	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
Workforce capacity - FTE Budgeted	16097	16107	16126	16148	16127	16342	16446	16431	16645	16578	16846	16862	16861
Workforce capacity - FTE Substantive contracted	14646	14573	15184	14799	14897	14870	14863	14922	14983	15066	15058	15136	15199
Workforce capacity - FTE Substantive contracted variance from Budget	1450	1534	941	1349	1229	1472	1583	1509	1661	1512	1788	1726	1662
Workforce capacity - Number of leavers	102	107	160	123	121	94	98	175	75	107	99	77	96
Workforce capacity - Number of Starters	108	96	187	133	182	142	88	279	139	131	151	124	107
Workforce efficiency - Absence 12 month sickness rate	4.6%	4.7%	4.7%	4.7%	4.7%	5.4%	5.2%	5.1%	5.4%	5.2%	5.2%	5.2%	
Workforce efficiency - Absence Total in month.	13.4%	14.7%	12.8%	13.4%	14.6%	14.7%	14.6%	17.3%	14.4%	13.8%	14.1%	13.8%	
Workforce efficiency - Turnover (12 month)	9.54%	9.47%	9.39%	9.42%	9.44%	9.54%	9.49%	9.87%	9.68%	9.65%	9.52%	9.33%	8.93%

Sustainability

	Metric	Target
True North	Financial stability - Variance from breakeven plan YTD	0k
True North	Financial efficiency - Variance from efficiency plan YTD	0k
Breakthrough	Productivity - Change in expenditure/Change in activity YTD	

Patient First Domain

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

The delivery of the Trust's financial plan has 6 key components:

1. Income & Expenditure (I&E) Performance: achieving the agree I&E Plan;
2. Cash: maintaining sufficient cash balances;
3. Capital: achieving the agreed capital plan;
4. Efficiency: achieving the required efficiency programme;
5. Productivity; and
6. Agency 3.7% ceiling

There remains a constitutional duty to deliver a breakeven financial performance for each Integrated Care System (ICS). Each constituent Organisation within the Sussex ICB submitted breakeven financial plans for 2023/24.

Trust performance against these measures at the end of June 2023 shows an actual deficit performance of £10.53m against a plan deficit of £4.83m, which is an adverse variance to plan of £5.7m

Financial performance has been impacted by Industrial action, inflationary pressures, continued utilisation of mental health nurses at a premium cost and expenditure relating to junior doctor deployment in urgent and emergency care services.

At the end of June, the cumulative cash position is £60m, which is £9.35m above the £69.4m plan. This balance is higher than planned due to the impact of the IT incident which impeded BACs payments. The plan of £60m does demonstrate the Trust is maintaining sufficient cash balances.

Capital expenditure is £12.93m against a plan of £12.08m. The key driver of the variance to plan is the Community Diagnostics Centre, where costs have been incurred ahead of plan. In aggregate, capital expenditure is forecast to be on plan by year end.

Efficiency performance is £0.4m above plan due to earlier than planned recognition of pay schemes. Efficiency schemes are continuing to be matured with mitigations being developed and deployed for higher risk schemes. The plan is forecast to be delivered in full.

University Hospitals Sussex
NHS Foundation Trust

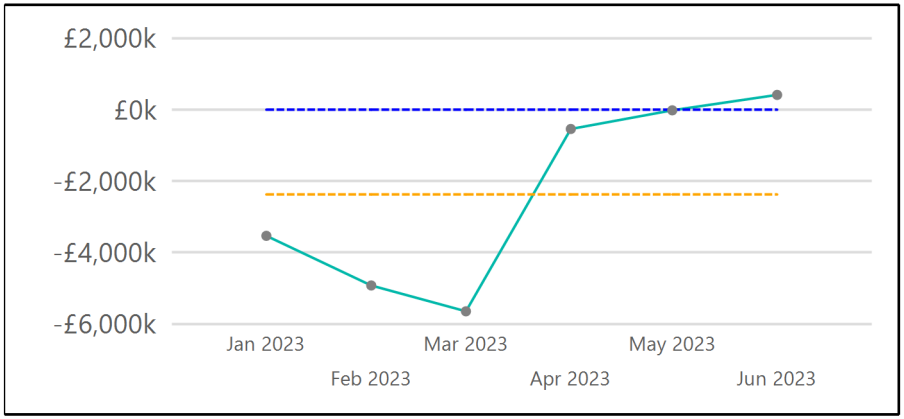
True North

Metric: Financial efficiency - Variance from efficiency plan YTD

Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
-3,531k	-4,921k	-5,644k	-540k	-17k	415k

Overview

Efficiency performance is £0.4m above plan.
The programme is identified in full, the risk stratification has been completed with mitigations being developed for areas of higher risk.
The full year efficiency forecast forms part of the overarching Trust forecast.



What the chart tells us

The graph is detailing cumulative performance of the Trust's £62m efficiency programme.
The efficiency plan at the end of June was to deliver £10.277m efficiencies.
£10.692m efficiencies were delivered, a favourable variance of £0.415m.

Intervention and Planned Impact

The programme is identified in full, the risk stratification has been completed with mitigations being developed for areas of higher risk. Assurance meetings continue to progress and mature schemes. The risk profile has decreased from 42% to 35%.

Risks/Mitigations

Risk that the Trust does not have the capacity to deliver the level of efficiency required in addition to managing Elective Restoration & Recovery in a continuing environment of Industrial action. Mitigation: The plan is fully identified, with joint support from PMO and finance business partners to monitor and mature plans for delivery. This is complemented by tiered financial support meetings and development of recovery plans.

University Hospitals Sussex
NHS Foundation Trust

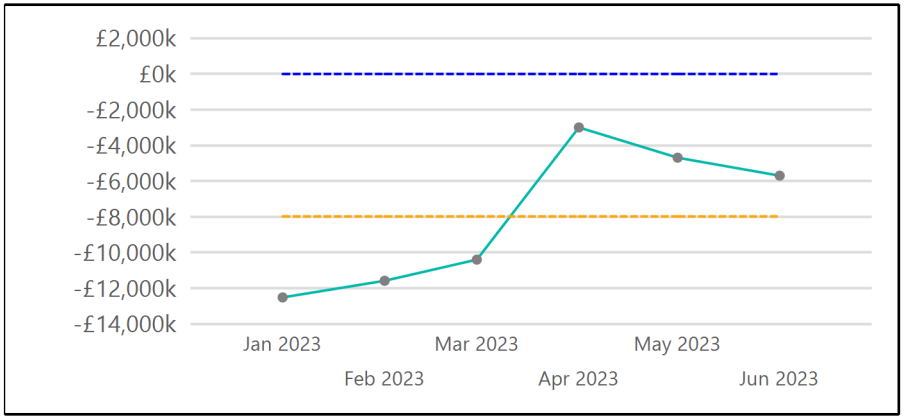
True North

Metric: Financial stability - Variance from breakeven plan YTD

Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
-12,511k	-11,578k	-10,394k	-2,993k	-4,686k	-5,693k

Overview

The Trust submitted a breakeven financial plan for 2023/24; the ytd planned deficit at M3 is £4.83m. The actual deficit is £10.53m, which is £5.7m above plan. Key drivers including the cost of Industrial Action, Mental Health Specialling, inflation and expenditure related to junior doctor deployment in NEL. Note, restoration performance has reduced from 105% as M2 to 103.4% as at M3. The impact on activity performance as a result of IA is 4.7%.
The detailed forecast for 23/24 is being developed and the forecast is maintained at breakeven.



What the chart tells us

The graph details the cumulative financial performance in comparison to the plan. The Trust submitted a breakeven financial plan for 2023/24.
The ytd planned deficit at the end of M3 is £4.83m.
The actual deficit is £10.53m, which is £5.7m above plan.

Intervention and Planned Impact

Divisional development of granular- level forecasts and roadmaps to combine into Trust level overview. Divisions to demonstrate how they will deliver breakeven. Divisional teams to use information provided to support analysis of performance and develop mitigations to bring performance back on plan.
Control environment - we will carry out Gap analysis against full list of NHSE controls (2023/24 Financial Plan Controls) with input from key stakeholders.

Risks/Mitigations
The key risks to the financial position are: Income for 3T's, Excess inflation, impact of Industrial Action, efficiency performance and Divisional performance. Risk that the funding for 3T's will not be allocated by NHSE and / or will be insufficient to cover the costs incurred in 2023/24. Mitigations: Executive level conversations continue with NHSE and ICS, with partial funding (£12m), being identified to date. Risk that the Trust does not have the ability to mitigate the pressures from above inflation price increases. Mitigations: The Trust is working alongside the Sussex ICS to monitor and report inflationary pressures to ensure collaborative solutions are developed to realise economies of scale where possible. Conversations with NHSE and being had regionally and Nationally regarding financial pressures impacting performance. Risk that additional Industrial Action will continue to impact elective activity delivery. Mitigations: Multi disciplinary teams are working together to try and secure Independent Sector Activity, to enable continued elective activity delivery and reduction of 65 week waits. NHSE guidance regarding ERF target amendments is expected, with further discussions taking place between NHSE and the Government. Risk that Divisional performance will not be in line with allocated budgets and the current run-rate will continue without sufficient mitigations to bring expenditure in line with plan. Mitigations: Tiered support meetings continue with the Director of Finance and Managing Directors, good progress is being made in a number of Divisions. Forecasts and recovery actions are being incorporated into a Trust roadmap to review year end delivery options.

University Hospitals Sussex
NHS Foundation Trust

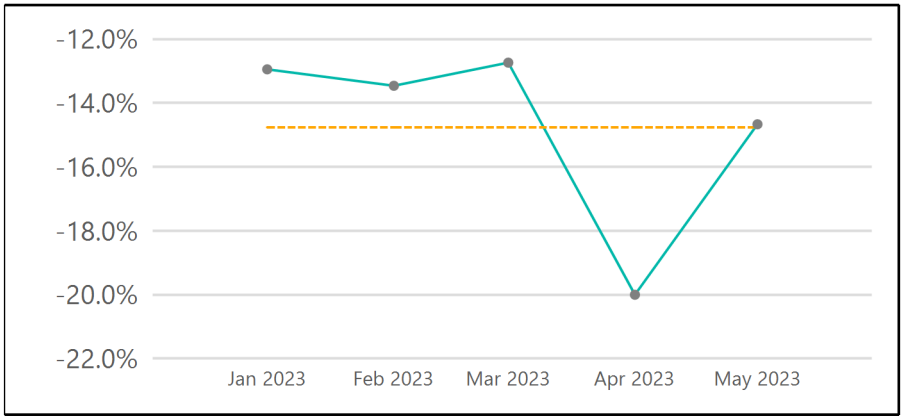
Breakthrough

Metric: Productivity - Change in expenditure/Change in activity YTD

Jan 23	Feb 23	Mar 23	Apr 23	May 23
-12.9%	-13.5%	-12.7%	-20.0%	-14.7%

Overview

Productivity is calculated as the change in expenditure from 2019/20 against the change in value of activity completed from 2019/20, adjusting for inflation to produce an overall change in productivity.



What the chart tells us

The graph shows cumulative productivity performance comparing change in expenditure / change in activity in comparison to 2019/20.
Performance at the end of month 2 shows a 14.7% reduction in productivity.

Intervention and Planned Impact

Monthly productivity and data reporting working group , monitoring productivity at a divisional level and development of mitigating actions to increase productivity.

Risks/Mitigations

Risk that the Trust is unable to recover to 100% of 19/20 activity levels within funded allocation, significant reliance on insourcing and outsourcing in 2022/23. Mitigations: Divisional operational teams continue to provide assurance and oversight of delivery plans, with mitigations to be developed where performance is falling short of plan.

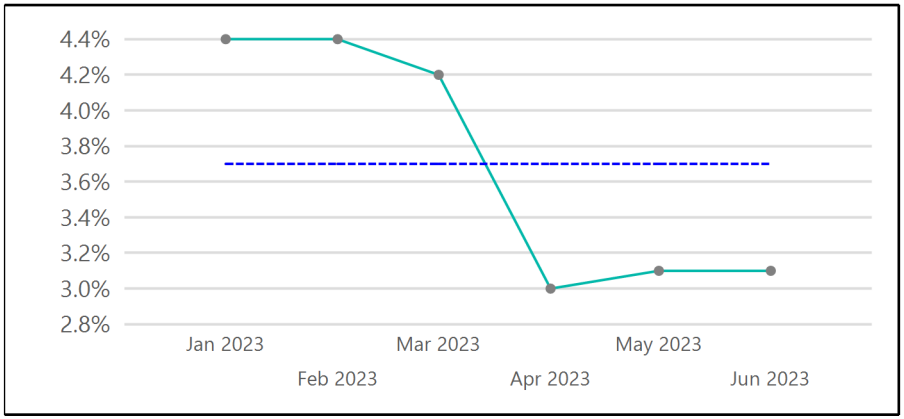
Driver

Metric: Agency spending - Variance to 3.7% target YTD

Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
4.4%	4.4%	4.2%	3.0%	3.1%	3.1%

Overview

Agency expenditure is 3.1% of the pay expenditure, which is £1.01M below the 3.7% ceiling. This excludes the cost of direct engagement.



What the chart tells us

The graph details cumulative agency expenditure as a % comparison to the agency ceiling of 3.7%. This is a new financial target introduced as part of the 23/24 financial framework.
Performance is 3.1% year to date. Agency expenditure is a key opportunity in the Trust's 23/24 efficiency programme with a focus on reducing spend on agency by adherence to controls, recruitment and retention of staff and targeted programmes of work e.g. Mental Health Specialling.

Intervention and Planned Impact

Development of new reporting suite, weekly utilisation reporting and monitoring.

Risks/Mitigations

Risk that the Trust does not have the capacity to deliver the level of efficiency required in addition to managing Elective Restoration & Recovery in a continuing environment of Industrial action. Mitigation: The plan is fully identified, with joint support from PMO and finance business partners to monitor and mature plans for delivery. This is complemented by tiered financial support meetings and development of recovery plans.

University Hospitals Sussex
NHS Foundation Trust

Watch Metrics for Sustainability

Metric	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
Capital spend - Variance from Trust capital plan YTD	-8,820k	-1,450k	1,660k	-710k	140k	850k
Cash - Actual Cash Balance	47,692k	83,400k	58,867k	73,530k	50,255k	69,363k

Quality

	Metric	Target
True North	Clinical outcomes/effectiveness - SHMI equal to or less than 100	100.0
True North	Safety - Reduction of 5% in preventable harm - UHSx approved	
Breakthrough	Safety - To reduce falls whilst in the care of UHSussex by 30%	202

Patient First Domain
Providing our patients with high quality clinical care is our top priority. We know how important it is to patients and their families to know that when they have to come into hospital they are going to receive the best possible care, be safe and cared for in a clean, welcoming and infection free environment. That is why we are continually implementing quality improvement initiatives that further enhance the safety, experience and clinical outcomes for all our patients. We continue to promote a culture of continuous quality improvement and encourage our staff to innovate and adopt 'best practice' in order to deliver the highest standard of care to our patients.

University Hospitals Sussex
NHS Foundation Trust

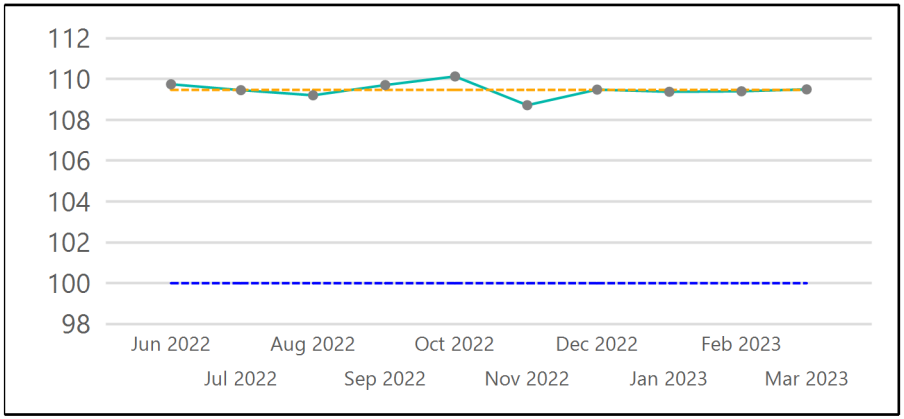
True North

Metric: Clinical outcomes/effectiveness - SHMI equal to or less than 100

Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
109.7	109.5	109.2	109.7	110.1	108.7	109.5	109.4	109.4	109.5

Overview

Mortality due to illness is the single most important and serious outcome measure of care. The reality is that some individuals die despite receiving the best care possible. Measuring standardised mortality rates allows us to determine whether more deaths have occurred than would ordinarily be expected.



What the chart tells us

UHSussex SHMI (which is based on 12 months data up to and including March 2023), is 109.31. This result is not an outlier using a 95% over-dispersed funnel plot but it is an outlier based on the stricter 95% Poisson limits.
All sites are above 100. SHMI is highest at RSCH (119.71).
Out-of-Hospital SHMI at PRH remains high at 129.12 compared to the rate trust-wide (115.10). However, the SHMI has come down significantly in the past 12 months from a high of 175.3
UHSussex HSMR (which is based on 12 months data up to and including January 2023) is 93.8 for Sussex. This result is not an outlier based on the Poisson method.

Intervention and Planned Impact

The Clinical Effectiveness Team is working on a standardised response when the SHMI LCL is above 100 for a diagnostic group or specific hospital site. A flowchart has been developed and is being piloted as a framework for triangulating high standardised mortality rates with other intelligence, for example the Learning from Deaths programme, National audit programme, Model Health System data, etc.

Two pilots of this approach are underway:

The first is reviewing COPD which is one of 7 SHMI diagnostic groups which fall outside an over dispersed 95% poisson funnel plot - SHMI = 138

A second pilot is reviewing high mortality rates at RSCH.

The reports into both of these reviews will be shared later in the summer.

Risks/Mitigations
There is a risk that a backlog in SRJs across all sites resulting in delays to timely learning from deaths. This is being mitigated by recruitment for SJR reviewers and lead SJR reviewer to oversee mortality panels across the Trust Secondly, pituitary surgery show as a possible outlier against the SHMI which warrants further review. These data are difficult to interpret as the numbers involved are very low. Discussions are in place with endocrinology and neurosurgery colleagues to understand the pathway, case selection, morbidity and mortality meetings and outcomes data in more detail.

University Hospitals Sussex
NHS Foundation Trust

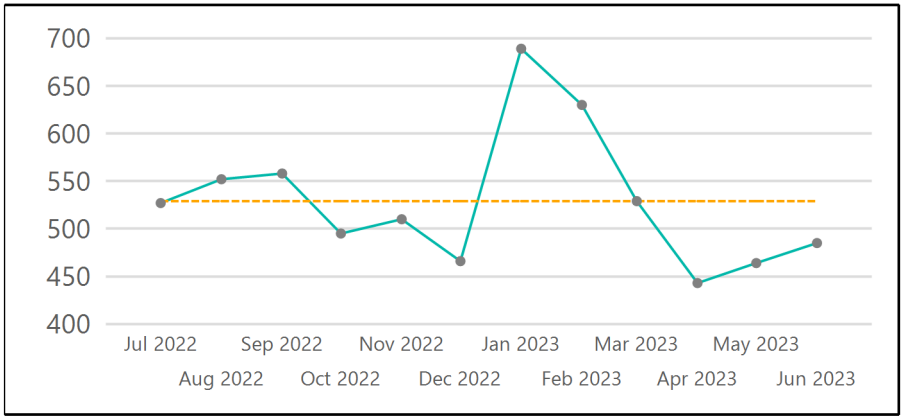
True North

Metric: Safety - Reduction of 5% in preventable harm - UHSx approved

Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
527	552	558	495	510	466	689	630	529	443	464	485

Overview

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 within the wider organisation.



What the chart tells us

For actual harms (approved) graded as low, moderate, severed and death the numbers reported for June are 485 incidents. The highest percentage of reported patient safety incidents are graded as no harm (92% of incidents June-2023). Falls, pressure damage, medication and staffing are the most common themes within the low harms categories.
There is a noted 35% reduction in reported severe harm and death since April 2022 due to the reduction in nosocomial Covid-19 infection.
Emergent themes within the moderate and severe harm/death categories remain patients lost to follow up/referral to treatment and mental health care and treatment within acute care settings. This data correlates with the highest risks noted on the Trust risk register

Intervention and Planned Impact

Please see interventions noted under falls and pressure ulcer metrics

Risks/Mitigations

No Data

University Hospitals Sussex
NHS Foundation Trust

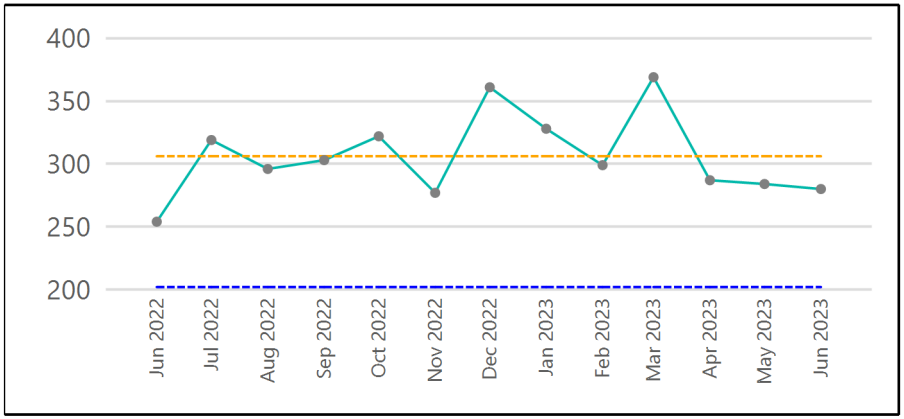
Breakthrough

Metric: Safety - To reduce falls whilst in the care of UHSussex by 30%

Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
254	319	296	303	322	277	361	328	299	369	287	284	280

Overview

This is the trust breakthrough objective for quality and is a key component of harms that happen whilst in the Trust hence a focussed programme of work to target reduction.



What the chart tells us

In June 2023, there were 280 falls reported, which is 4.96 per 1000 beddays; (5.28 rolling 12 month average). This demonstrates an overall reduction in numbers of 30% (17% per 1000 bed days) compared to the peek in March 2023 of 369 falls (6.04 per 1000 bed-days)

Intervention and Planned Impact

In June, 14 wards met their falls reduction targets. The project improvement plan currently has 20 countermeasures. Key updates for June:
1. New Trust-wide After-Action Review (AAR) process implemented
2. The "Baywatch" operational procedure has been revised , with the harm free care team supportig the wards with their implementation
3. A Falls questionnaire for use in the Tendable auditing system now created and installed. Audit trials due to start across the Trust in July

Risks/Mitigations

No Data

University Hospitals Sussex
NHS Foundation Trust

Driver

Metric: Safer Staffing - Average fill rate - registered nurses/ midwives (day shifts)

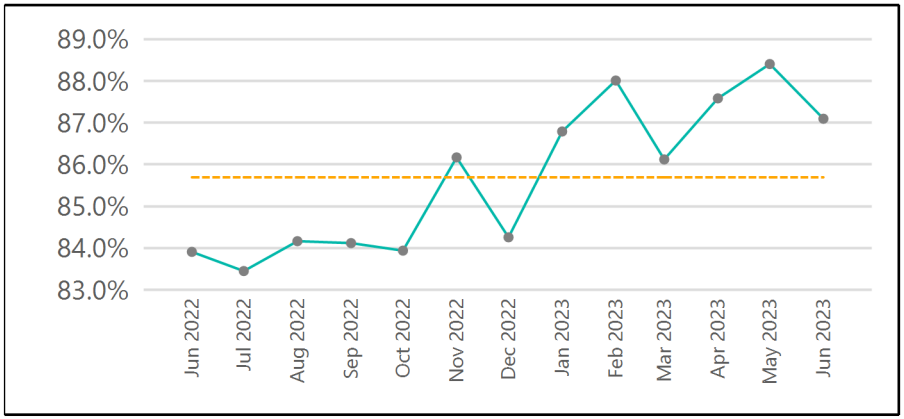
Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
83.9%	83.5%	84.2%	84.1%	83.9%	86.2%	84.3%	86.8%	88.0%	86.1%	87.6%	88.4%	87.1%

Overview

Patients have a right to be cared for by appropriately qualified and experienced staff in safe environments and this is enshrined in the NHS Constitution. There is growing evidence which shows that nurse staffing levels make a different to patient outcomes, patient experience, quality of care, and the efficiency of care delivery. (RCN, 2011, Griffiths and Ball 2021).

Trusts must ensure that they have the right staff, with the right skills in the right place (DOH, 2012, Nursing Quality Board)

Safe levels of staffing and an adequate skill mix are central to the delivery of high-quality care (Volume 2 of the Government response to the Mid-Staffordshire NHS Foundation Trust public enquiry)



What the chart tells us

The chart shows the average per month of filled shifts for registered nurses/midwives across the trust for day shifts. In June-23 there were 87.1% of planned shifts filled which whilst marginally below the May position of 88.4% remained higher than that observed in 2022/23. The fill rate was variable by site with 81.3% RSCH, 84.3% PRH, 91.8% St Richards Hospital and 94% Worthing.

Intervention and Planned Impact

The Trust Nursing and Midwifery Steering Group meet monthly to support the Trust in recruiting , deploying, retaining a nursing and midwifery workforce that are appropriately experienced and qualified to deliver high quality standards of care. The group is also responsible for monitoring and report the associated workforce efficiencies including effective rostering, recruitment, retention strategies and sickness reduction plans.
There has been a focus via the steering group and associated sub-groups to fill substantive registered nurse and HCA vacancies via domestic and international recruitment.
Actions to retain staff include health and well being initiatives, flexible working, compassionate absence management, and focused listening events.

Risks/Mitigations
There is a risk that high volumes of health care assistant and international nurses appointed may have an attrition rate during the recruitment process. We have created waiting lists to counter this risk where there are no vacancies. Where there are significant levels of vacancies we will potentially temporarily over-fill HCA establishments to flex capacity where appropriate/necessary. Staffing is reviewed on a shift basis by matrons to ensure safe staffing is available for each hospital footprint/site and ward.

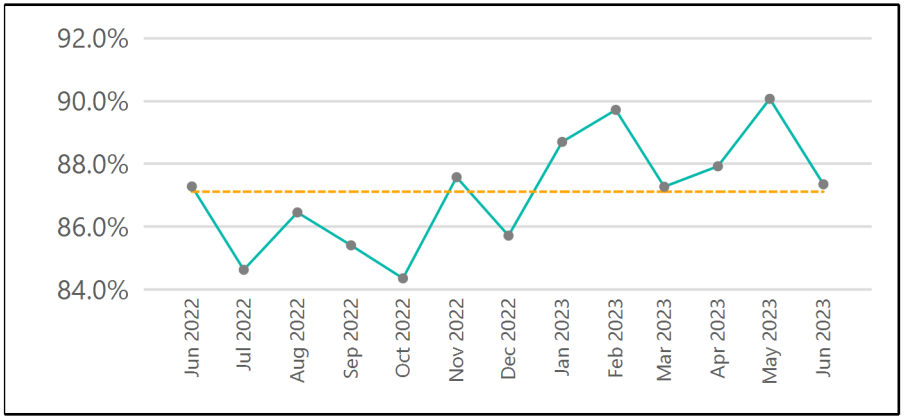
Driver

Metric: Safer Staffing - Average fill rate - registered nurses/ midwives (night shifts)

Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
87.3%	84.6%	86.5%	85.4%	84.4%	87.6%	85.7%	88.7%	89.7%	87.3%	87.9%	90.1%	87.4%

Overview

Patients have a right to be cared for by appropriately qualified and experienced staff in safe environments and this is enshrined in the NHS Constitution. There is growing evidence which shows that nurse staffing levels make a different to patient outcomes, patient experience, quality of care, and the efficiency of care delivery. (RCN, 2011, Griffiths and Ball 2021).
Trusts must ensure that they have the right staff, with the right skills in the right place (DOH, 2012, Nursing Quality Board)
Safe levels of staffing and an adequate skill mix are central to the delivery of high-quality care (Volume 2 of the Government response to the Mid-Staffordshire NHS Foundation Trust public enquiry)



What the chart tells us

The chart shows the fill rate % for registered nurses/midwives for night shifts each month. June performance fell marginally to 87.4% fill rate, but there have been 7 consecutive months above the mean average since April 2022. Performance is variable by main hospital site, with 85.7% RSCH, 86% PRH, 89.3% Worthing, and 89.6% SRH.

Intervention and Planned Impact

The Trust Nursing and Midwifery Steering Group meet monthly to support the Trust in recruiting , deploying, retaining a nursing and midwifery workforce that are appropriately experienced and qualified to deliver high quality standards of care. The group is also responsible for monitoring and report the associated workforce efficiencies including effective rostering, recruitment, retention strategies and sickness reduction plans.
There has been a focus via the steering group and associated sub-groups to fill substantive registered nurse and HCA vacancies via domestic and international recruitment.
Actions to retain staff include health and well being initiatives, flexible working, compassionate absence management, and focused listening events.

Risks/Mitigations

There is a risk that high volumes of health care assistant and international nurses appointed may have an attrition rate during the recruitment process. We have created waiting lists to counter this risk where there are no vacancies.
Where there are significant levels of vacancies we will potentially temporarily over-fill HCA establishments to flex capacity where appropriate/necessary.
Staffing is reviewed on a shift basis by matrons to ensure safe staffing is available for each hospital footprint/site and ward.

University Hospitals Sussex
NHS Foundation Trust

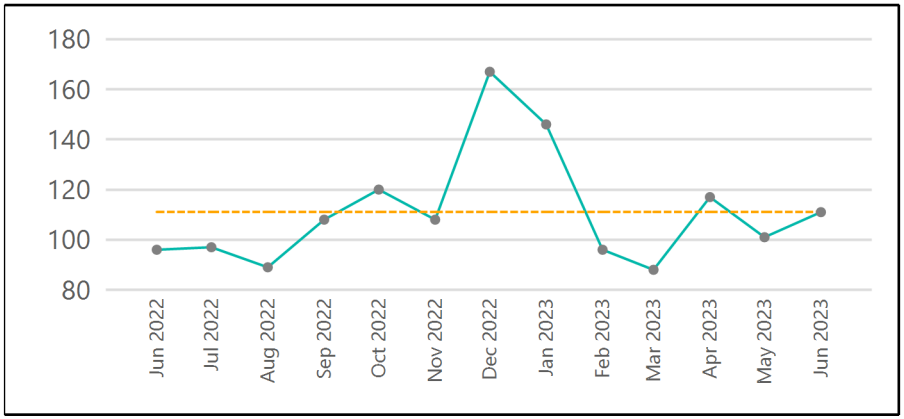
Driver

Metric: Safety - Grade 2+ pressure ulcers

Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
96	97	89	108	120	108	167	146	96	88	117	101	111

Overview

Pressure ulcers are safety incidents the Trust looks to minimise as preventable harms.



What the chart tells us

There was a slight rise in reporting of category 2 and above pressure ulcers in June 2023, There were 111 patients reported, which is 1.97 per 1000 bed days, against a 1.91% rolling 12 month average).
This demonstrate an overall reduction of 44% (30% per 1000 beddays) when compared to the peak in December 2022 of 167 (2.81 per 1000 beddays)

Intervention and Planned Impact

Continence audit has been undertaken to aid improvement work around Moisture Associated Skin Dermatitis (MASD) and deconditioning.
The TVN team in Worthing and SRH have focussed on staff training
The working mattress group across all sites continues to progress to ensure patients are on the correct pressure reliving equipment at the right time.
Worthing and St Richards wards have been provided with information files with TVN pathways and pressure ulcer pathways to improve nurses' knowledge of wound/pressure ulcer management. These have been greatly received.
The quarter one Purpose T audit is underway in order to achieve the Purpose T CQUIN across all sites.
A pharmacy stock/product review is being undertaken Trust wide to review dressings available and streamline Trust processes.

Risks/Mitigations

No Data

NHS
University Hospitals Sussex
NHS Foundation Trust

Watch Metrics for Quality

Metric	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
Clinical outcomes/effectiveness - Timeliness of observations against targets (NEWS2)	69.6%	68.2%	68.7%	67.8%	66.1%	67.7%	65.5%	67.3%	68.1%	67.9%	68.7%	69.3%	68.7%
HCAI - Number of hospital attributable C.diff cases (HOHA/COHA)	8	14	12	12	17	11	4	7	13	12	6	11	9
HCAI - Number of hospital attributable E.coli cases (HOHA/COHA)	9	16	18	18	23	18	11	19	15	18	18	17	20
HCAI - Number of hospital attributable Klebsiella species cases (HOHA/COHA)	6	8	7	11	7	6	6	6	4	3	6	8	8
HCAI - Number of hospital attributable MRSA cases (HOHA/COHA)	0	0	0	2	0	0	0	1	0	0		2	1
HCAI - Number of hospital attributable MSSA bacteraemia cases (HOHA/COHA)	9	4	8	6	14	6	5	15	5	3	3	11	6
HCAI - Number of hospital attributable Pseudomonas cases (HOHA/COHA)	5	3	4	4	4	5	3	4	4	0	1	1	2
Safety - % of Deaths with Comfort Obs in Place	3.5%	14.1%	26.3%	24.2%	28.5%	37.1%	56.7%	65.7%	71.9%	69.1%	73.4%	71.8%	72.5%
Safety - Total moderate, severe or death incidents	50	73	74	61	75	76	80	110	63	67	58	87	91

Systems & Partnerships

	Metric	Target
True North	Cancer - To achieve the 62 day standard	85.00%
Breakthrough	A&E and Emergency flow - Hour of discharge median will be 10am to 10.59am (home for lunch) (Trust Level)	11:00
True North	A&E and Emergency flow - No patients to exceed a 12 hour wait in our emergency departments	

Patient First Domain

The Systems & 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 June 2023 has materially improved relative to Q4 2022/3, and the equivalent months in 2022/3 for ED.

There have been improvements made in RTT over 78 week waits in June, and further improvement is being targeted for cancer and diagnostic waiting times in the context of industrial action impacting capacity for routine elective care.

The Trust treated 71.4% of patients within 4 hours of attending all A&E departments June 2023. National performance was 73.3%. Trust capacity constraints continued to be exacerbated by Industrial Action.

The Trust has 46.1% of patients waiting longer than the target 18 weeks at the end of June-23. National performance was 59.5%. The total number of patients waiting for elective treatment at the Trust was 145,340. There were 331 patients waiting over 78 weeks at the end of June, 66 fewer than May-23. There were 3673 65 week waits June-23 against a plan of 2600. The Trust continues to focus on the elimination of longest waits.

53.4% of patients were treated within 62 days in May. National performance was 58.7%. There has been a marginal increase in over 62 and 104 day prospective waits to June, from 466 May-23 to 484 June-23 for over 62 day patients, and from 88 patients May-23 to 103 patients June-23 over 104 day waits. FDS performance was 69.5% May, a reduction from April 71.83%

The Trust had 25% of patients waiting more than 6 weeks at the end of May for a diagnostic against the 5% March-24 target. This is a deterioration of -1.1% since May due to an increase in 6 week backlog, notably for sleep studies, Echos, and cystoscopies in June. The National average for May-23 was 25.9%

University Hospitals Sussex
NHS Foundation Trust

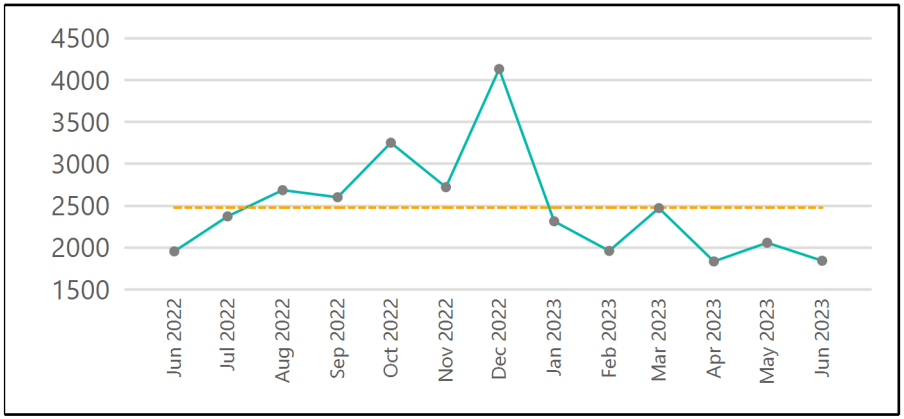
True North

Metric: A&E and Emergency flow - No patients to exceed a 12 hour wait in our emergency departments

Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
1956	2374	2687	2602	3253	2722	4133	2315	1962	2472	1836	2059	1844

Overview

Extended waiting times in A&E are a symptom of constraint to flow for emergency pathways. The Trust monitor 12 hour waits in A&E department, with the aim to materially reduce these extended waits where clinically appropriate.



What the chart tells us

12 hours in the ED reduced in June 23 compared to May 23 (5.3% of attendances compared to 5.7% in May) but remains higher than 5.1% Jun-22. The decrease in 12 hr breaches compared to the beginning of this year is driven by WH with 1.6% of patients remaining in ED for more than 12 hrs.

Performance is most challenged at RSCH with 909 attendances (13.2%) on average of RSCH attendances in department more than 12 hours in June-23 but an improved position compared to 15.2% May-23. However the figure is an improvement on Aug 22 with the overall trend downwards

Intervention and Planned Impact

The project work on length of stay as well as work with system partners aims to ensure discharge processes are as efficient as possible. These schemes will create capacity on the wards allowing better flow through the ED and reduce 12 hour stays.

There is daily review of the previous days performance with divisions and the MD for emergency care, and a twice monthly emergency performance improvement group where performance and breaches are reviewed and recovery plans developed where off track.

The Trust has also sought support from the national ECIST team (Emergency Care Improvement Support team) who have provided input for SRH and RSCH

Risks/Mitigations

Capacity constraints at the end of a patient's acute stay and delays to transfers to more appropriate settings (including home) can cause flow to back up into the A&E department due to unavailability of beds. Similarly a spike in A&E demand either in scale or acuity can also cause A&E delay. The rolling junior and consultant industrial action causes some constraint in staffing capacity which can add to flow constraints. The Trust improvement plans with regard to front door mitigation and alternatives, and expediting discharge earlier via the length of stay corporate project, and cross cover by consultants for industrial action are targeting efforts to maintain continuity and improve flow.

University Hospitals Sussex
NHS Foundation Trust

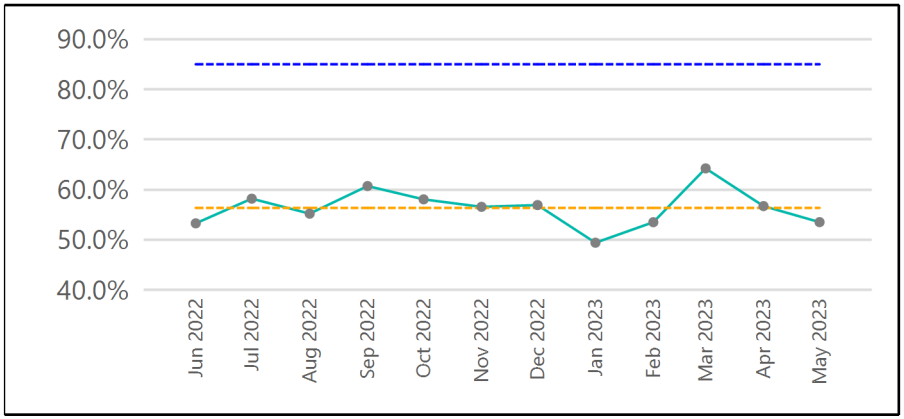
True North

Metric: Cancer - To achieve the 62 day standard

Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
53.27%	58.19%	55.20%	60.70%	58.05%	56.56%	56.91%	49.40%	53.50%	64.23%	56.71%	53.51%

Overview

Cancer 62 day performance is a constitutional standard, with a target of 85% of patients to be referred and commence definitive treatment within 62 days.



What the chart tells us

The chart shows the % of patients who commenced treatment each month within 62 days. Cancer information runs a month in arrears, to allow for collation of shared pathways with tertiary providers and improve the accuracy of reporting.
May-23 performance was 53.5%, compared to 56.7% April, and national performance of 59.5% May-23

Intervention and Planned Impact

The Trust continues to focus recovery plans by anatomical site, on reducing the prospective 62 day backlog as per the agreed ICB trajectory, to achieve no more than 351 across all anatomical sites by March-24.
The Trust has received £250K from the Cancer Alliance to support in-sourcing for breast cancer services, to end July, and has made a further bid for funding for Colorectal to extend insourcing to August 2023 to increase capacity to meet demand.
The Trust has enhanced governance arrangements including a weekly Cancer Access Group (CAG) led by the DDO for Cancer. There is also a weekly deep-dive process, gynae pathways have been reviewed with a draft action plan in place . Skin pathways are scheduled for 28th July. The Trust also reviews monthly via Strategy Deployment Review (SDR) chaired by Executive and reviewed by division with structured counter measure summaries to tackle 62 day backlogs.
The Cancer team are implementing improvements with the Digital Strategy, with funding to support the merge of two existing Somerset cancer information systems, and associated reporting via Power BI. There is also work underway to focus the developments of community diagnostic centres (CDCs) towards 62 day pathways at the Falmer site, with initial plans to focus on breathlessness, Upper GI, Lower GI, skin, gynae and prostate pathways. Consideration is also being given to expand available cancer diagnostic services at the CDCs which could involve Colon Capsule, TNE, Cytosponge and Lumeneye. Non-specific symptoms (NSS) pathways are also being scoped.

Risks/Mitigations
Key risk of constraints in cancer operative capacity in LGI (primarily at RSCH), Gynae (RSCH), Breast and Urology; Theatre improvement work underway to decompress RSCH theatres and secure requisite operating capacity

University Hospitals Sussex
NHS Foundation Trust

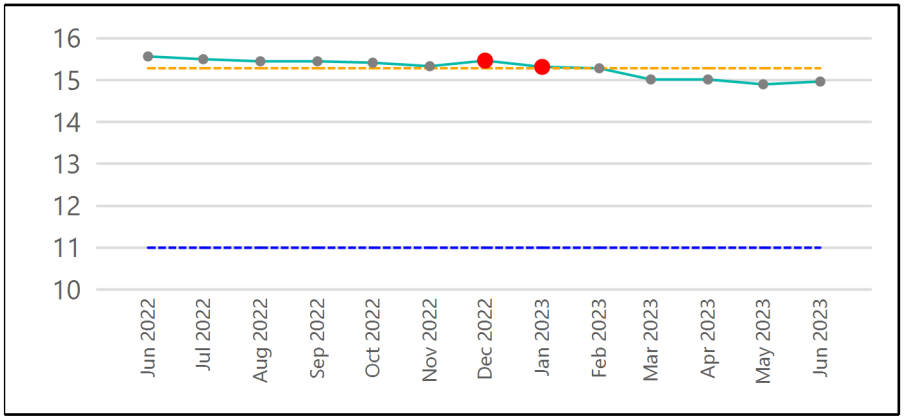
Breakthrough

Metric: A&E and Emergency flow - Hour of discharge median will be 10am to 10.59am (home for lunch) (Trust Level)

Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
15:34	15:30	15:27	15:27	15:25	15:20	15:28	15:19	15:17	15:01	15:01	14:54	14:58

Overview

Emergency flow relies on timely discharge to free up beds for new admissions as required. The Trust breakthrough metric for systems & partnerships focuses on the median hour of discharge for emergency patients, with the aim to drive down average discharge times to expedite flow downstream.



What the chart tells us

The chart shows the median hour of discharge for emergency discharges across the Trust per month. It shows an improvement in the median average from January 2023, which has been sustained for the previous 4 months. There is a marginal uptick in this average in June, with an average of just over 3pm compared to 2:58 in May.
Strike action in June may have had a negative impact on median hour of discharge performance.

Intervention and Planned Impact

Implementation of new improvement plan template to aid clear visuals of ward based improvements metrics and progress of, for example 205 increase in use of discharge lounge.
There has been an 'Ideal State' workshop with PRH Ardingly Ward as part of transformational redesign work stream. This is helping form part of the standardisation pack to be rolled out across all the wards.
A breakthrough objective Executive level visual management one page report has been developed and shared with the executive sponsor.
Beacon ward in Worthing has shared best practice with PRH Balcombe ward, supporting their development of improvements. There is consultant engagement across all sites to encourage MDT approach to improvements.
SRH ACU has confirmed improvements through consultant engagement.
The discharge lounge in the Louisa Martindale building now fully operational supporting the RSCH wards in transferring patients as part of Trust median hour of discharge action plans.

Risks/Mitigations

Understanding and improving medical colleagues key process steps relies on their inclusion and engagement with the project.
Further work is also needed to standardise and ensure attendance of Hospital Directors of Nursing improvement huddles as part of the programme.

University Hospitals Sussex
NHS Foundation Trust

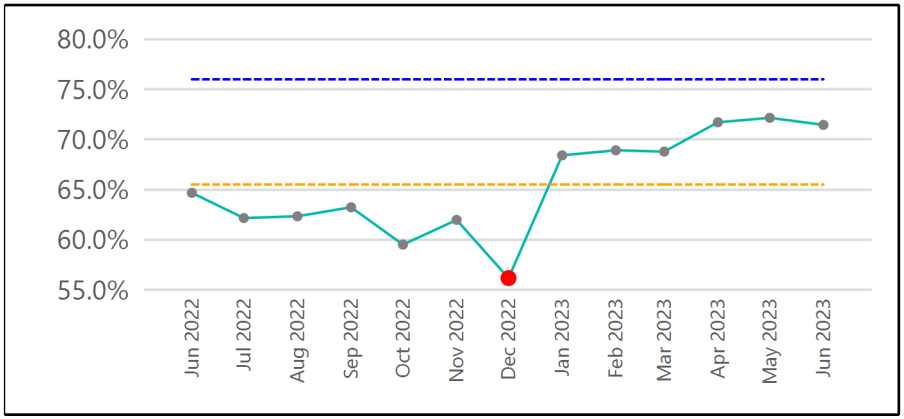
Driver

Metric: A&E and Emergency flow - % treated and admitted/discharged within 4 hours

Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
64.7%	62.2%	62.3%	63.2%	59.5%	62.0%	56.2%	68.4%	68.9%	68.8%	71.7%	72.2%	71.5%

Overview

The A&E 4 hour target is a key constitutional standard for emergency care, and patient experience. The operating framework requirement is to achieve 76% by March-24.



What the chart tells us

The Trust treated 71.4% of patients within 4 hours of attending all A&E departments June 2023 which was a decrease from 72.2% in May. National performance was 73.3%.
There is variation by site. Largest improvements were observed RACH (91% compared to 88.1% May-23, Worthing (71.7%) compared to 70.6% in May 23. RSCH remained stable with 52.8% performance June-23 compared to 52.7% May-23 whilst there was a decline in performance PRH to 73% from 76.1% May, and at SRH from 60.2% May to 57.3% June.

Intervention and Planned Impact

The main driver for long waits is constrained flow out of emergency departments meaning we are unable to admit patients in a timely manner from A&E. The non-admitted performance pathway is being focussed on as is this is less dependent on onward hospital admission flow.
The Trust is working with system partners to improve processes for discharge of complex patients whilst also looking at internal processes to improve the discharge profile against the A&E demand. This includes working on morning discharges to expedite capacity to allow admission flow as well as the length of stay corporate project with the aim to increase discharges and reduce length of stay to free up bed capacity.

Risks/Mitigations

Capacity constraints as the end of a patient's acute stay and delays to transfers to more appropriate settings (including home) can cause flow to back up into the A&E department due to unavailability of beds. Similarly a spike in A&E demand either in scale or acuity can also cause A&E delay. The rolling junior and consultant industrial action causes some constraint in staffing capacity which can add to these constraints. The Trust improvement plans with regard to front door mitigation and alternatives, and expediting discharge earlier via the length of stay corporate project, and cross cover by consultants for industrial action are targeting efforts to maintain continuity and improve flow.

University Hospitals Sussex
NHS Foundation Trust

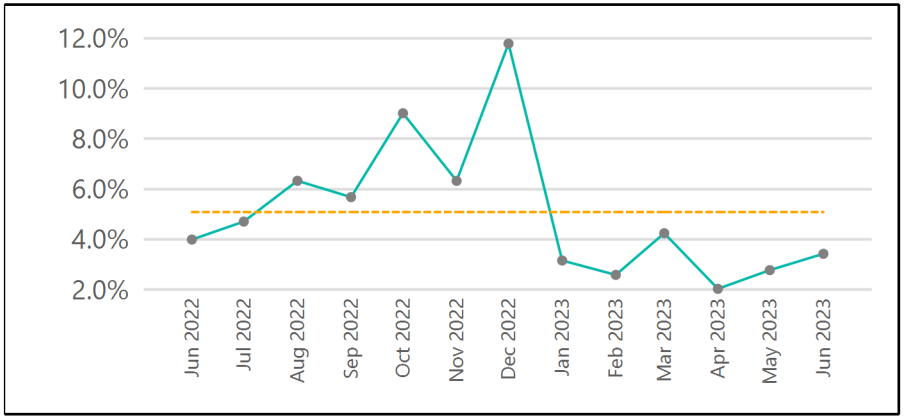
Driver

Metric: A&E and Emergency flow - Ambulance Handovers > 60 minutes

Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
4.0%	4.7%	6.3%	5.7%	9.0%	6.3%	11.8%	3.2%	2.6%	4.2%	2.0%	2.8%	3.4%

Overview

Timely ambulance handovers are important for patient care. The national target for ambulance handovers is for these to have been undertaken within 15 minutes. As part of this ambition, it is important to reduce the number of longest waits over 60 minutes, and is an indication of onward flow constraints.



What the chart tells us

60 minute handovers increased in June to 221 (3.4%) when compared to 195 (2.8%) May-23 however this is better than June-23 which was 255 patients (4% of handovers). This is variable by main hospital site, with 178 of these at RSCH, and 42 at SRH.
SRH, Worthing and Princess Royal are consistently among the best performing hospitals for ambulance handover times in the SE Region. RSCH remains at the bottom of this table and hence is where much of the focussed improvement work re flow is targeted.

Intervention and Planned Impact

The project work on length of stay as well as work with system partners aims to ensure discharge processes are as efficient as possible. These schemes will create capacity on the wards allowing better flow through the ED and reduce 60 minute ambulance handovers.
There is daily review of the previous days performance with divisions and the MD for emergency care, and a twice monthly emergency performance improvement group where performance and breaches are reviewed and recovery plans developed where off track.
The Trust has also sought support from the national ECIST team (Emergency Care Improvement Support team) who have provided input for RSCH

Risks/Mitigations

A&E capacity and flow impacts downstream on the expedition of ambulance handovers, as does the scale and frequency of demand. Work to target improved flow being undertaken by the Trust, and work to react with agility to early indications of demand pressure are expected to help mitigate these risks.

University Hospitals Sussex
NHS Foundation Trust

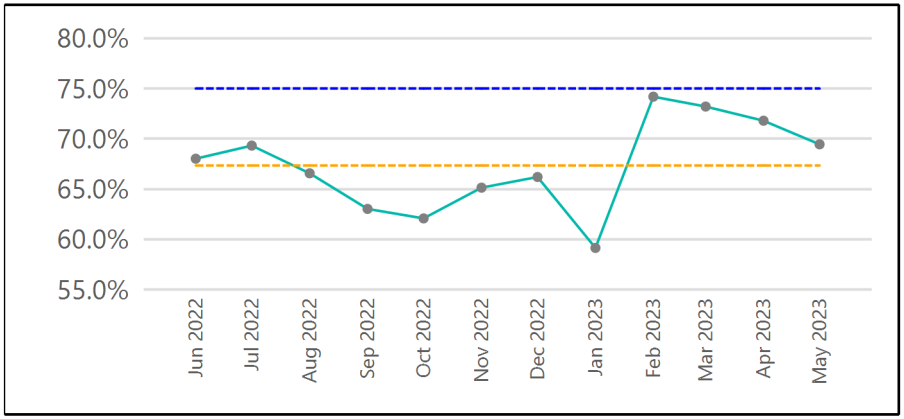
Driver

Metric: Cancer - 28 day faster diagnosis standard

Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
68.02%	69.32%	66.57%	63.02%	62.08%	65.14%	66.20%	59.14%	74.19%	73.21%	71.80%	69.45%

Overview

The 28 day faster diagnosis standard was introduced July 2019, and is an important target for patient experience and as part of expedient cancer pathways. The national target as part of cancer standards, sets a maximum 28-day wait for communication of a cancer diagnosis or ruling out of cancer for patients referred urgently for investigation of cancer (including those with breast symptoms) and from NHS cancer screening, with a 75% target.



What the chart tells us

FDS performance fell marginally May-23 to 69.5% against the 75% target but has continued to exceed the average performance at the Trust over the past 13 months since February despite having not achieved 75%. National performance was 71.3% May-23

Intervention and Planned Impact

There are regular meetings by anatomical site to drive improvements to demand, processes and capacity, and cancer access groups weekly to support tumour-site specific action plans. Weekly deep dives also underway for challenged sites.
There is also funding being used to support the digital transformation for cancer information provision including merge of Somerset cancer systems, and enhanced reporting to drive improved accuracy, standardisation and visibility via Power BI
FDS is being governed via the cancer division, with joint responsibility for delivery with clinical divisions. FDS Alliance funding expires from early 23/24, and a business case being constructed late July

Risks/Mitigations

No Data

University Hospitals Sussex
NHS Foundation Trust

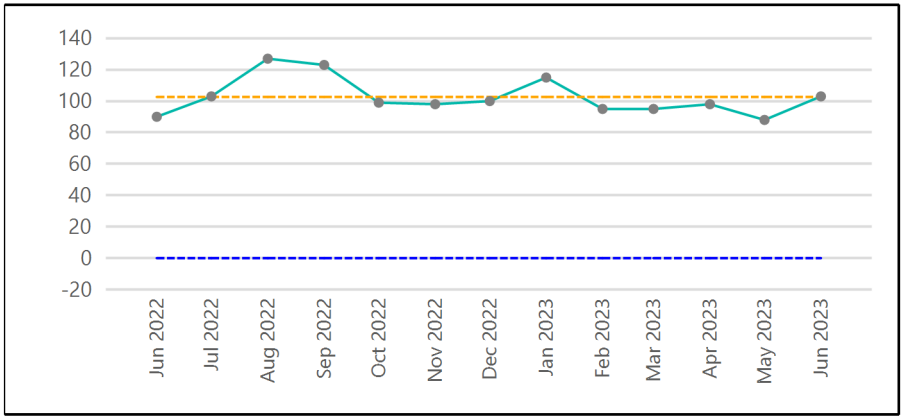
Driver

Metric: Cancer - Number of patients waiting over 104 days for treatment

Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
90	103	127	123	99	98	100	115	95	95	98	88	103

Overview

The NHS operating framework 23/24 requires an improvement in the Trust prospective month end over 62 day patients waiting for treatment with the aim to reduce to 351 patients by the end March-23. This requires increases in current capacity relative to current demand and continued process improvements to reduce waiting times for definitive commencement of cancer treatments. The Trust also aims to reduce longest waits over 104 days this year.



What the chart tells us

The chart shows the number of prospective 104 day waits at the end of each month. It shows a marginal increase to 103 patients waiting over 104 days this month compared to 88 at the end of May 2023. 27 of these relate to colorectal pathways , 18 for urological anatomical sites, and 16 for head and neck patients.

Intervention and Planned Impact

The Trust continues to focus recovery plans by anatomical site, on reducing the prospective 62 day backlog as per the agreed ICB trajectory, to achieve no more than 351 across all anatomical sites by March-24.
The Trust has received £250K from the Cancer Alliance to support in-sourcing for breast cancer services, to end July, and has made a further bid for funding for Colorectal to extend insourcing to August 2023 to increase capacity to meet demand.
The Trust has enhanced governance arrangements including a weekly Cancer Access Group (CAG) led by the DDO for Cancer. There is also a weekly deep-dive process, gynae pathways have been reviewed with a draft action plan in place . Skin pathways are scheduled for 28th July. The Trust also reviews monthly via Strategy Deployment Review (SDR) chaired by Executive and reviewed by division with structured counter measure summaries to tackle 62 day backlogs.
The Cancer team are implementing improvements with the Digital Strategy, with funding to support the merge of two existing Somerset cancer information systems, and associated reporting via Power BI. There is also work underway to focus the developments of community diagnostic centres (CDCs) towards 62 day pathways at the Falmer site, with initial plans to focus on breathlessness, Upper GI, Lower GI, skin, gynae and prostate pathways. Consideration is also being given to expand available cancer diagnostic services at the CDCs which could involve Colon Capsule, TNE, Cytosponge and Lumeneye. Non-specific symptoms (NSS) pathways are also being scoped.

Risks/Mitigations
Key risk of constraints in cancer operative capacity in LGI (primarily at RSCH), Gynae (RSCH), Breast and Urology; Theatre improvement work underway to decompress RSCH theatres and secure requisite operating capacity

NHS
University Hospitals Sussex
NHS Foundation Trust

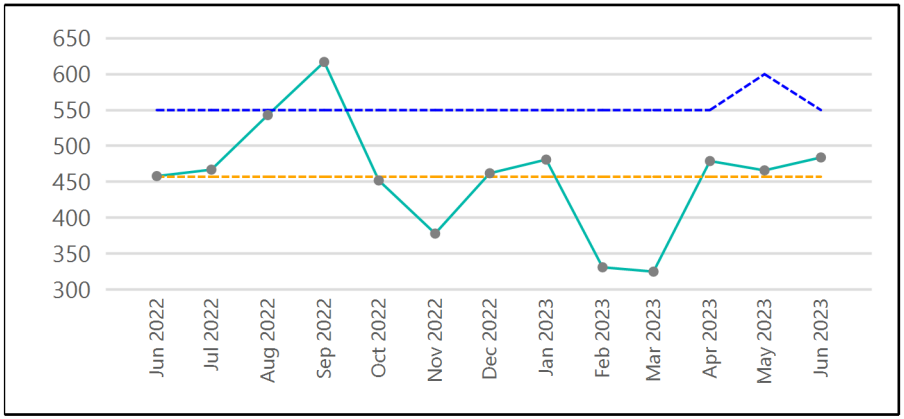
Driver

Metric: Cancer - Number of patients waiting over 62 days for treatment

Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
458	467	543	617	452	378	462	481	331	325	479	466	484

Overview

The NHS operating framework 23/24 requires an improvement in the Trust prospective month end over 62 day patients waiting for treatment with the aim to reduce to 351 patients by the end March-23. This requires increases in current capacity relative to current demand and continued process improvements to reduce waiting times for definitive commencement of cancer treatments.



What the chart tells us

The chart shows the number of patients who have been waiting over 62 days from referral on a 62 day cancer pathway. It shows a marginal increase in over 62 day waits in June to 484, from 466 May. This is below the Trust plan of 550 patients

Intervention and Planned Impact

The Trust continues to focus recovery plans by anatomical site, on reducing the prospective 62 day backlog as per the agreed ICB trajectory, to achieve no more than 351 across all anatomical sites by March-24.
The Trust has received £250K from the Cancer Alliance to support in-sourcing for breast cancer services, to end July, and has made a further bid for funding for Colorectal to extend insourcing to August 2023 to increase capacity to meet demand.
The Trust has enhanced governance arrangements including a weekly Cancer Access Group (CAG) led by the DDO for Cancer. There is also a weekly deep-dive process, gynae pathways have been reviewed with a draft action plan in place . Skin pathways are scheduled for 28th July. The Trust also reviews monthly via Strategy Deployment Review (SDR) chaired by Executive and reviewed by division with structured counter measure summaries to tackle 62 day backlogs.
The Cancer team are implementing improvements with the Digital Strategy, with funding to support the merge of two existing Somerset cancer information systems, and associated reporting via Power BI.
There is also work underway to focus the developments of community diagnostic centres (CDCs) towards 62 day pathways at the Falmer site, with initial plans to focus on breathlessness, Upper GI, Lower GI, skin, gynae and prostate pathways. Consideration is also being given to expand available cancer diagnostic services at the CDCs which could involve Colon Capsule, TNE, Cytosponge and Lumeneye. Non-specific symptoms (NSS) pathways are also being scoped.

Risks/Mitigations
Key risk of constraints in cancer operative capacity in LGI (primarily at RSCH), Gynae (RSCH), Breast and Urology; Theatre improvement work underway to decompress RSCH theatres and secure requisite operating capacity Industrial action has constrained patient and staff capacity in June and is expected to do so further in July.

University Hospitals Sussex
NHS Foundation Trust

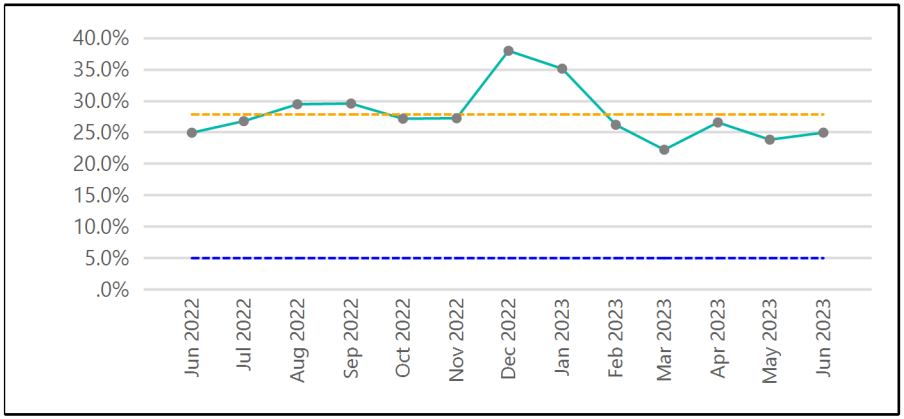
Driver

Metric: Diagnostics - % Breaching 6 week target (DM01 modalities)

Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
25.0%	26.8%	29.5%	29.6%	27.2%	27.3%	38.0%	35.2%	26.2%	22.3%	26.6%	23.9%	25.0%

Overview

Diagnostics are an important phase of elective care for patient care and the decision making as a step towards definitive treatment with the 2023/4 operating framework ambition of achieving no more than 5% over 6 week waits by end March-23. It includes a range of 15 diagnostic tests, ranging from imaging modalities such as CT, MRI and Ultrasound, to physiological measurement, to endoscopic investigations.



What the chart tells us

The Trust achieved 25% in June-23 against the diagnostic patients over 6 week target March-24 of <5% of total prospective ptl. This was a marginally worsened position from May, by 1.1%. This is better than National performance of 25.9% May-23.
The number of patients waiting over 6 weeks for their diagnostic increased by 322 in June whilst the waiting list increased by 362 patients.
Largest growth was observed in sleep studies, echos, and cystoscopies. There was significant improvement in endoscopy modalities in June, reducing by 244 over 6 week waits.

Intervention and Planned Impact

Five diagnostic modalities account for 80% of the diagnostic backlog. These are Echo; Sleep Studies, Non-Obstetric Ultrasound, Audiology, and MRI.
Divisions will undertake demand and capacity modelling using the IMAS national model, to support the development of recovery plans with trajectories for these modalities.
Recovery plans will include effective waiting list management, strengthening of triage of referrals, meeting national expectation on productivity (such as for length of test, tests per clinic and DNA rates)
The Trust has made significant improvements in sample processing and cut up in pathology as part of PFIS work at histopathology labs. Cancer alliance funding has allowed 300 outsourced samples per week which has led to a 20% improvement in histology waiting over 10 days. Funding to continued outsourcing has also been secured.

Risks/Mitigations

No Data

University Hospitals Sussex
NHS Foundation Trust

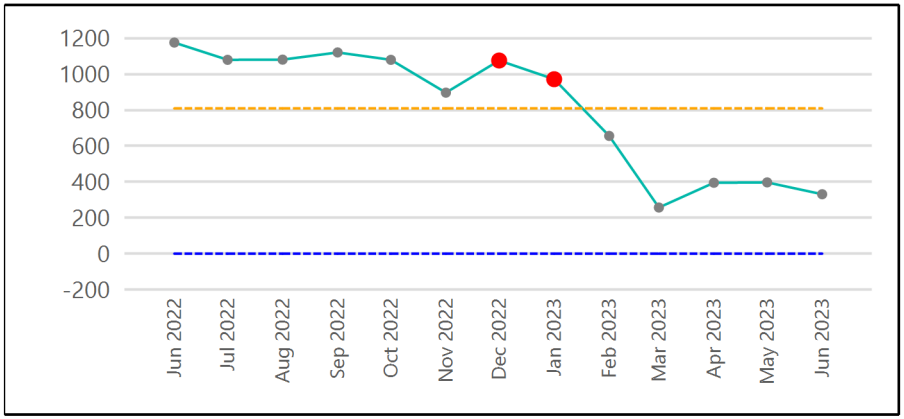
Driver

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

Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
1176	1080	1081	1121	1080	897	1076	972	656	257	395	397	331

Overview

Elective waiting times are a key constitutional target. Elective Waiting times materially increased as a result of the covid pandemic. The 2022/23 operating framework required the elimination of 78 week waits by the end March-23. The 2023/24 target is to go further and look to reduce the number of 65 week waits to zero by the end March-24.



What the chart tells us

The chart shows the number of patients who are waiting over 78 weeks at the end of each month. At the end of Jun-23 there were 331 patients waiting over 78 weeks. This is 66 fewer than May-23.

Intervention and Planned Impact

Key actions include:-
Driving increased activity by : Internal productivity improvement and pathway redesign via outpatient and theatre utilisation workstreams as part of Planned Care and Cancer Improvement steering group. For example reducing unnecessary follow ups by increasing use of Straight to Test pathways and PIFU (Patient Initiated Follow Up)
Increased use of independent sector
Opening 3rd Neurosurgery theatre in the newly opened Louisa Martindale Building
Mutual aid within Trust sites, across Sussex ICB catchment and where possible utilising the Digital Mutual Aid System (DMAS) to seek additional capacity support from beyond the Sussex System
Enhanced operational oversight and governance with divisional leadership and man-marking across non-admitted and admitted pathways reviewed daily by operational and administrative teams across UHSx
MD review of patients waiting over 90 weeks to further expedite their treatment
Refreshed standardised RTT meetings with operational teams to ensure access policy rules are followed and applied, ensure patients are booked in turn, and ensuring outcomes are captured on the information systems.
Central validation of pathways over 52 weeks and continued DQ process re waiting list reporting

Risks/Mitigations
Industrial action and emergency pressures have exacerbated risk associated with 78 week waits. There are also some highly complex pathways, and specialist capacity constraints particularly in neurosurgery/spinal care for example, which have created risk in minimising 78 week numbers. Increases in urgent or 2WR demand which take precedence in terms of clinical priority order can also constrain residual routine waiters capacity.

University Hospitals Sussex
NHS Foundation Trust

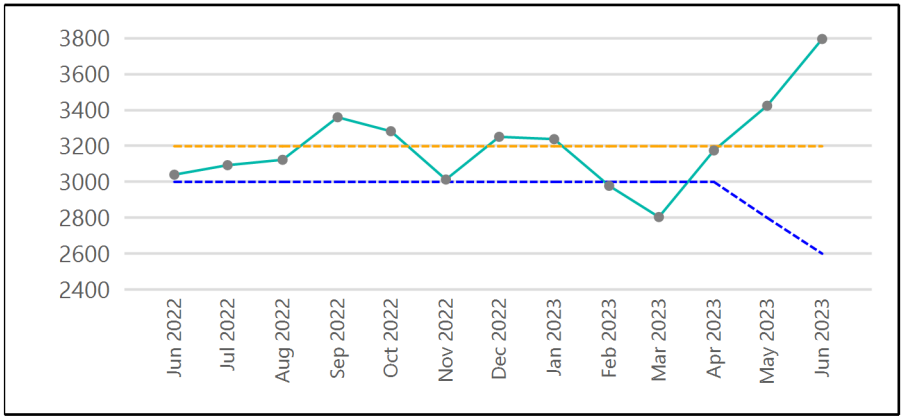
Driver

Metric: RTT Elective care - >=65 Weeks

Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
3040	3093	3123	3360	3282	3013	3251	3238	2978	2804	3175	3424	3796

Overview

Elective waiting times are a key constitutional target. Elective Waiting times materially increased as a result of the covid pandemic. The 2022/23 operating framework required the elimination of 78 week waits by the end March-23. The 2023/24 target is to go further and look to reduce the number of 65 week waits to zero by the end March-24.



What the chart tells us

The chart shows the number of patients waiting over 65 weeks at the end of each month. There has been growth in over 65 week waits since March with the latest value of 3796 (including 123 MSK patients, 3673 excluding). This is above the Trust plan of 2600 by end June.

Intervention and Planned Impact

Key actions include:-
Driving increased activity by : Internal productivity improvement and pathway redesign via outpatient and theatre utilisation workstreams as part of Planned Care and Cancer Improvement steering group. For example reducing unnecessary follow ups by increasing use of Straight to Test pathways and PIFU (Patient Initiated Follow Up)
Increased use of independent sector
Opening 3rd Neurosurgery theatre in the newly opened Louisa Martindale Building
Mutual aid within Trust sites, across Sussex ICB catchment and where possible utilising the Digital Mutual Aid System (DMAS) to seek additional capacity support from beyond the Sussex System
Enhanced operational oversight and governance with divisional leadership and man-marking across non-admitted and admitted pathways reviewed daily by operational and administrative teams across UHSx
MD review of patients waiting over 90 weeks to further expedite their treatment
Refreshed standardised RTT meetings with operational teams to ensure access policy rules are followed and applied, ensure patients are booked in turn, and ensuring outcomes are captured on the information systems.
Central validation of pathways over 52 weeks and continued DQ process re waiting list reporting

Risks/Mitigations
Industrial action and emergency pressures have exacerbated risk associated with 65 week waits. There are also some highly complex pathways, and specialist capacity constraints particularly in neurosurgery/spinal care for example, which have created risk in minimising 65 week numbers. Increases in urgent or 2WR demand which take precedence in terms of clinical priority order can also constrain residual routine waiters capacity.

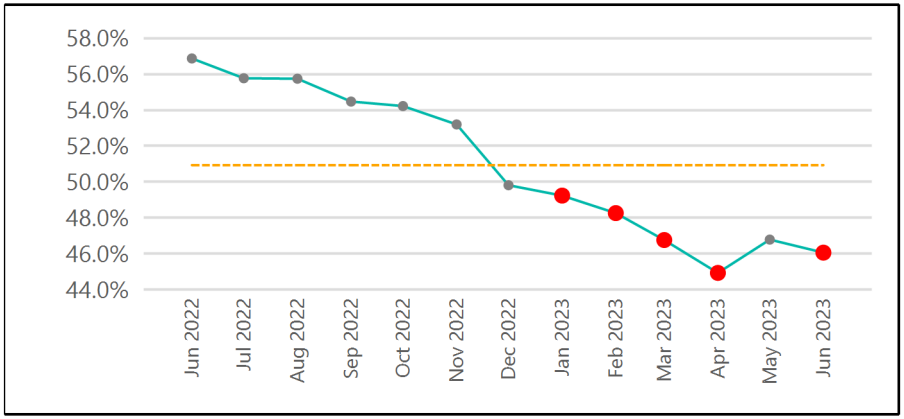
Driver

Metric: RTT Elective care - 18 Week Performance

Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
56.87%	55.77%	55.75%	54.47%	54.22%	53.20%	49.81%	49.23%	48.26%	46.76%	44.93%	46.78%	46.06%

Overview

The Referral to Treatment (RTT) constitutional target is to commence definitive treatment of patients referred via Gp to a consultant led service within 18 weeks of referral, with a target to see 92% within 18 weeks. This has been affected materially during the pandemic due to a reduction in capacity to tackle covid patients and elective patients safely in this context. Reducing long waiters (78+ in 2022/23 and 65+ in 2023/24) has superceded the 18 week target as acute Trusts look to tackle the very longest waits as part of staged recovery to reduced waits for elective care. It remains part of the constitutional targets, and system oversight framework however.



What the chart tells us

The chart shows the % of patients each month who commence definitive treatment (clock stops) within 18 weeks. This has shown steady decline since May-22 as focus has increased to tackle most urgent or 2WR patients and then longest waits in sequential order where possible, and as demand (in terms of clock starting events) has outstripped supply (clock stops/removals for other reasons from the waiting list).

Intervention and Planned Impact

Key actions include:-
Driving increased activity by : Internal productivity improvement and pathway redesign via outpatient and theatre utilisation workstreams as part of Planned Care and Cancer Improvement steering group. For example reducing unnecessary follow ups by increasing use of Straight to Test pathways and PIFU (Patient Initiated Follow Up)
Increased use of independent sector
Opening 3rd Neurosurgery theatre in the newly opened Louisa Martindale Building
Mutual aid within Trust sites, across Sussex ICB catchment and where possible utilising the Digital Mutual Aid System (DMAS) to seek additional capacity support from beyond the Sussex System
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Refreshed standardised RTT meetings with operational teams to ensure access policy rules are followed and applied, ensure patients are booked in turn, and ensuring outcomes are captured on the information systems.
Central validation of pathways over 52 weeks and continued DQ process re waiting list reporting

Risks/Mitigations
No Data

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Watch Metrics for Systems & Partnerships

Metric	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
A&E and Emergency flow - % Patients with a 21+ day length of stay	7.9%	7.2%	8.2%	8.6%	8.3%	8.4%	9.0%	10.4%	8.8%	9.0%	8.8%	8.8%	8.1%
A&E and Emergency flow - A&E 4 Hour Breaches	11777	13324	12495	12062	14204	12992	15370	9542	9280	10606	9087	10012	10123
A&E and Emergency flow - A&E Attendances	33343	35214	33180	32811	35082	34172	35070	30212	29859	33980	32125	35961	35462
A&E and Emergency flow - Ambulance Handovers	7085	7786	7249	7096	7219	7087	6952	6910	6541	7329	7068	7644	7328
A&E and Emergency flow - Ambulance Handovers - % Under 15 mins	47.6%	45.4%	44.5%	45.5%	40.9%	40.8%	31.2%	50.3%	51.9%	46.7%	55.1%	55.8%	60.5%
A&E and Emergency flow - Average LOS (Excl LOS 0)	7.2	6.9	7.5	7.8	7.7	7.9	8.1	8.6	8.1	7.6	7.4	7.8	7.4
A&E and Emergency flow - Bed Occupancy	1562	1588	1620	1603	1659	1657	1670	1674	1672	1671	1650	1668	1617
A&E and Emergency flow - Emergency Admissions > 1 LOS	5441	5340	5222	5064	5285	5399	5389	5318	4930	5762	5396	5622	5516
A&E and Emergency flow - Mean Waiting Time	299	315	333	330	358	344	417	325	299	314	288	290	293
A&E and Emergency flow - Time to treatment in ED (Median time to treatment mins)	75	71	70	61	69	83	89	54	74	77	70	77	77
A&E and Emergency flow - Time to Triage in ED - % seen within 15 mins	48.9%	47.0%	51.9%	48.8%	46.0%	44.9%	42.5%	62.6%	55.9%	52.3%	64.5%	64.5%	59.7%
Cancer - Two week rule performance	70.3%	62.1%	62.5%	61.7%	73.9%	74.9%	69.2%	72.4%	86.6%	87.5%	76.6%	79.6%	
Diagnostics - 6 week backlog	4571	4953	5523	5696	5342	5327	6739	6211	4995	4591	5126	4946	5268
Diagnostics - Activity	33564	33073	34327	34134	34229	39170	29902	32845	31646	35348	34345	31260	29250
Diagnostics - Waiting List size	17421	17391	17464	17940	18413	18350	16599	16675	18102	19634	18293	19768	20081
Elective care - Activity compared to 2019/20											106.6%	114.1%	91.0%
RTT Elective care - >= 52 Weeks	7332	7650	7986	8291	8251	8591	9176	9630	9771	10497	11539	12770	13937
RTT Elective care - >104 Weeks (NHSi Criteria)	27	18	14	26	20	15	15	20	25	18	19	13	5
RTT Elective care - Clock Starts	24214	23097	25707	23720	23856	24920	17961	20465	18788	20858	16381	19690	21668
RTT Elective care - Clock Stops	19486	19168	20260	20820	20873	22269	14775	17117	18865	20325	15321	17754	19396
RTT Elective care - Waiting list size	111034	113283	116749	117756	119522	121200	125572	128990	128034	128872	131872	138874	145332

Research & Innovation

	Metric	Target
True North	Within 3 years to be in the top 20 Acute Trusts nationally for patients recruited into portfolio studies	35
Breakthrough	To recruit additional patients in the next twelve months, with a targeted plan implemented as a result of the R&I Strategy	

Patient First Domain
Research and Innovation (R&I) drive continuous quality improvement in healthcare but very few of our staff and patients (0.58% contribution of national recruitment 20/21) participate in high quality R&I studies. Participating in research improves patient satisfaction with clinical care and patients are missing out on this benefit. Higher numbers of quality R&I studies results in better treatments, as well as improved diagnosis, prevention, care and quality of life for our patients and their families.

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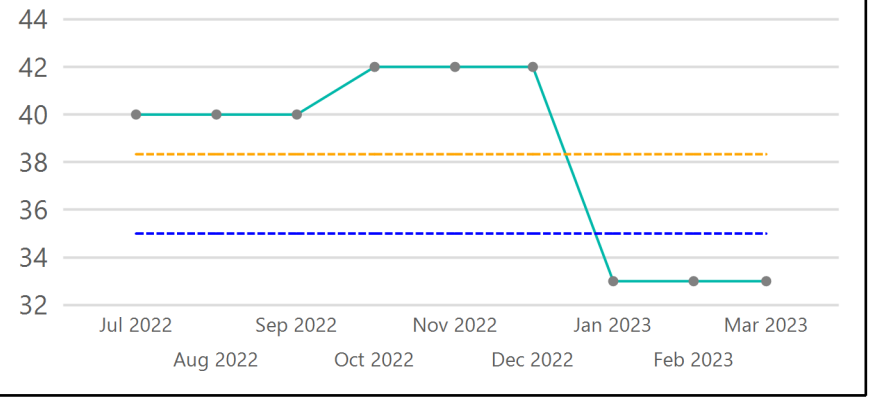
True North

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

Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
40	40	40	42	42	42	33	33	33

Overview

Research and Innovation drive continuous quality improvement in healthcare but very few staff and patients (0.58% contribution of national recruitment 2020/21) participate in high quality studies. Participating in research improves patients satisfaction with clinical care and patients are missing out on this benefit. Higher numbers of quality R&I studies results in better treatments, as well as improved diagnosis, prevention, care and quality of life for our patients and their families.



What the chart tells us

The chart shows the relative Trust rank in terms of study participation compared to other acute Trusts on a quarterly basis from national statistics from the NIHCR website. Data for Q4 2022/23 shows 33rd highest ranked trust, and improvement relative to Quarter 3. This information is subject to change in retrospect, and is finalised on an annual basis, due to data lag for either UHS or other Trusts which can influence relative rank.

Intervention and Planned Impact

The Trust is embedding research and innovation across the Trust with continued engagement re R&I ambition in Specialty mission statements, divisional research lead roles being developed and discussed, and divisional financial reports under discussion.
The Trust is looking to develop measuring and reporting research and innovation delivery, development and impact by scoping a staff survey research engagement measure.
The Trust is delivering research and innovation and establishing a shared research infrastructure, capacity and processes to deliver the strategic ambition, with a focus on commercial research. Latest actions associated with this are an MHRA delay risk review, a commercial research set up timeline review, and scoping of clinical research as part of Estates Master Planning.
The Trust is raising awareness and understanding of research and innovation amongst staff and patients, by research group profiling on website, additional PCIE leadership support identified with HRP, and via a Research Champions Group PCIE planning.
The Trust is also embedding a culture of innovation at the Trust, with a Commercial advisory group established.
The R&I team are reviewing the acute hospitals used as comparator for this metric, to ensure the comparison is meaningful.

Risks/Mitigations
Operational and financial pressures represent a risk for divisional clinical engagement. To mitigate, the team are using the divisional strategy deployment review process (SDR) to drive development of divisional/specialty level mission statements, tracking of participation numbers monthly by division, developing targeted research growth/improvement plans, and developing divisional research lead roles. The Trust needs to develop an integrated Research and Innovation Strategy. Strategy development engagement is underway including partner engagement through the Health Research Partnership. A draft strategy is being developed for board approval September. The Trust R&OI True North and Breakthrough objectives are being promoted alongside the communications plan which is in place. External Regulatory approval is experiencing significant delays to regulatory approval for clinical trials. This is is part due to MHRA reorganisation and staffing levels. Under their rules, applications should be assessed within 30 days of submission, but national data shows this has risen to 92 days April-23. There are 24 studies at the Trust that require regulatory approval, 10 of which are commercial trials. The R&I department aims to open up to 10 of these trials each month but delays mean only 50% are opening as per schedule. Work continues to take place locally to ensure studies can start as soon as pending regulatory approval takes place.

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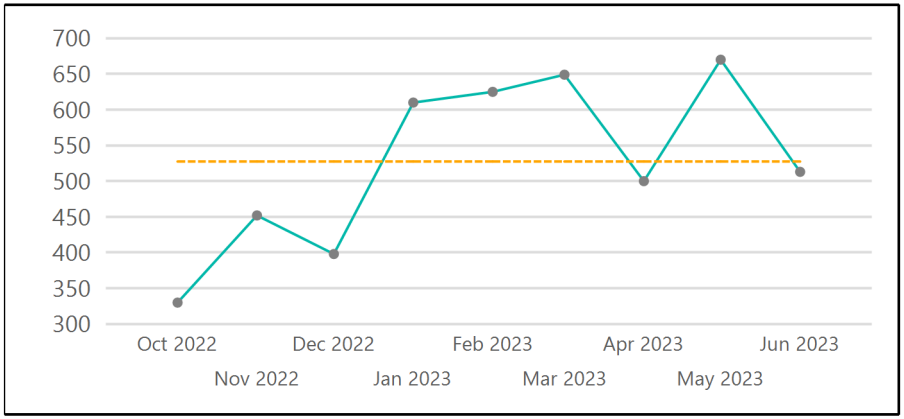
Breakthrough

Metric: To recruit additional patients in the next twelve months, with a targeted plan implemented as a result of the R&I Strategy

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
330	452	398	610	625	649	500	670	513

Overview

Research and Innovation drive continuous quality improvement in healthcare but very few staff and patients (0.58% contribution of national recruitment 2020/21) participate in high quality studies. Participating in research improves patients satisfaction with clinical care and patients are missing out on this benefit. Higher numbers of quality R&I studies results in better treatments, as well as improved diagnosis, prevention, care and quality of life for our patients and their families.



What the chart tells us

This chart shows the number of patients recruited to NIHR portfolio studies per month. The numbers fluctuate from month to month due to various reasons such as opening and closure of studies, staff leave/absence, sponsor issues, regulatory issues, patient availability, patient not meeting inclusion criteria for example.
Total recruitment to studies is above target (which is to increase by 10% from a base of October 2021 to September 2023). The increase is largely driven by high performance for the GBS3 study in the women's and children's directorate.

Intervention and Planned Impact

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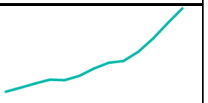
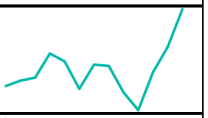
Watch Metrics for

Metric

Oversight Metrics				
Patient First Domain	Metric	Value	Target	Trend
People	Staff Engagement - To be within the top quartile of acute Trusts for the National staff engagement score	7.00	7.06	
Quality	Clinical outcomes/effectiveness - SHMI equal to or less than 100	109.5	100.0	
Quality	HCAI - Number of hospital attributable C.diff cases (HOHA/COHA)	9	11	
Quality	HCAI - Number of hospital attributable MRSA cases (HOHA/COHA)	1	0	
Quality	HCAI - Number of hospital attributable E.coli cases (HOHA/COHA)	20	12	
Quality	Safety - Reduction of 5% in preventable harm - UHSx approved	485		
Systems & Partnerships	Cancer - 28 day faster diagnosis standard	69.45%	75.00%	
Systems & Partnerships	RTT Elective care - >= 52 Weeks	13937	10815	
Systems & Partnerships	RTT Elective care - >=65 Weeks	3796	2800	
Systems & Partnerships	Planned care - By March 2023, no patient is waiting more than 78 weeks for treatment.	331	0	
Systems & Partnerships	RTT Elective care - >104 Weeks (NHSi Criteria)	5	0	

Systems & Partnerships	Cancer - Number of patients waiting over 62 days for treatment	484	550	
Systems & Partnerships	A&E and Emergency flow - No patients to exceed a 12 hour wait in our emergency departments	1844		

Trust's current rating

The Trust's System Oversight Framework rating is Segment 3. The Trust continues to engage with the regional and ICB through the schedule oversight meetings.

Implications of this segmentation

Segment 3 allows the Trust to have access to external advice and support with the development of improvement plans knowing that such access will be supported by NHSE and the ICS. The Trust continues to be in dialogue with the ICB and NHSE on the support available and has received targeted support focusing on the EDs at Princess Royal, St Richard and Worthing Hospitals which has seen performance improvement with more recent work which remains in train focusing on mental health patient pathways.

The lead for the oversight of the Trust's performance remains with the ICB and through the oversight meetings the Trust presents updates on its delivery of its annual plan covering all of the Trust's strategic domains.

Actions being taken to move from segment 3

The Trust continues to progress with its developed plans including those addressing the specific concerns highlighted by the CQC within their various inspections. In order to exit segment 3 the Trust will need to deliver its operating and financial plan along with completion of all the improvements required by the CQC. The Trust does not anticipate exiting segment 3 over the next quarter.

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Agenda Item:	16	**Meeting:**	Board	**Meeting Date:**	3 August 2023
Report Title:	Quarter 2 BAF				
Sponsoring Executive Director:		Chief Governance Officer			
Author(s):		Company Secretary			
Report previously considered by and date:					

Purpose of the report:			
Information	N/A	Assurance	Yes
Review and Discussion	Yes	Approval / Agreement	Yes

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

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	N/A	Link to Trust Annual Plan	Yes

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	Yes	The BAF covers the strategic risk for this domain.
Sustainability	Yes	The BAF covers the strategic risks for this domain.
People	Yes	The BAF covers the strategic risks for this domain.
Quality	Yes	The BAF covers the strategic risks for this domain.
Systems and Partnerships	Yes	The BAF covers the strategic risks for this domain.
Research and Innovation	Yes	The BAF covers the strategic risk for this domain.

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

Regulatory / Statutory reporting requirement

The Trust is required to have an effective system of governance, risk management and internal control for which an effective BAF is key component. Commentary on the effectiveness of these processes is required within the Trust's annual governance statement and is subject to audit review and comment.

Communication and Consultation:

Report:

Attached is the Quarter 2 BAF, showing the Q2 scores and for each risk whether they are at their target score (the score agreed by the Board as the tolerable level of risk for the year 2023/24) and where the achievement of the target score during 23/24 is at greatest risk.

Each of the Board Committees have during their July meetings considered the risks for which they have allocated oversight and agreed the scores reflected in BAF summary being presented to the Board at this meeting. It should be noted that that the Quality Committee and the Systems and Partnerships Committee in their review of their allocated risks agreed that risk 4.1 should be increased and 5.3 should not be reduced from its quarter 1 score, both have been adjusted in the report being presented to the Board.

Recommendations

The Board is asked to **AGREE** the BAF risk scores for the start of Quarter 2 based on the review undertaken by their respective Board Committees and the Board's receipt and discussion of the Trust's Integrated Performance Report.

2023/24 Quarter 2 Board Assurance Framework Report

1 Introduction

1.1 The Board approved the Trust's 14 2023/24 strategic risks alongside their target score for 2023/24 and their longer term goal score aligned to the Trust's risk appetite statements at its Board workshop in April 2023. At the Board meeting in May the Board approved the opening quarter 1 scores for each of its Strategic risks recognising that both the risk descriptor and score for the Research and Innovation risk would likely change during 2023/24 as the Research and Innovation Strategy is finalised.

1.2 As in prior years each Strategic Risk has an Executive lead and is grouped within one of the Trust's six strategic domains with each domain being aligned to their respective allocated oversight Committee.

2 Quarter 2 Overview

2.1 For each segment of the BAF the respective lead executive has considered their risks along with the supporting highly scored and corporate risks when determining the quarter 2 score.

2.2 There is ONE risk for which the quarter 2 score has increased from that at quarter 1, this being.

- Quality – Risk 4.1 We are unable to deliver safe and harm free care to reduce mortality and morbidity. The Quality Committee considered the gap in assurance over the Trust's Clinical Effectiveness and Outcome processes and felt that given this gap in assurance it was prudent to increase this risk until robust systems of assurance are established which are expected to being established in this quarter and will be built upon over the next two quarters giving a confidence that the target score will be achieved. **This risk has an increased score at 16.**

2.3 There are THREE risks achieving their 2023/24 target score but it should be noted that all of these are above their longer term goal score and thus actions to move toward that goal score are being progressed. These risks are

- Sustainability – Risk 2.2 We are unable to meet high standards of financial stewardship meaning we cannot sustain compliance with our statutory financial duties. The score for quarter 2 remains at its target score of 12.

- Sustainability – Risk 2.3 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. The score for quarter 2 remains at its target score of 12.

- Sustainability – Risk 5.1 We are unable to develop and maintain collaborative relationships with partner organisations based on shared aims, objectives, and timescales leading to an adverse impact on our ability to operate efficiently and effectively within our health economy. The score for quarter 2 remains at its target score of 8.

2.4 There remain NINE risks above their 2023/24 target score

The highest of these are

- **Patient – Risk 1.1** We are unable to deliver or demonstrate a continuous and sustained improvement in patient experience resulting in adverse reputational impact, and poorer patient experience. Whilst the Trust's FFT scores have improved through quarter 1 but with the continuing industrial action then the risk score has not been reduced as the action is likely to impact on waits which is a known key issue for negative patient experience. **This risk remains scored at 16.**

- **Sustainability – Risk 2.1** 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. **This risk remains scored at 16 and there is a low level of confidence that this risk will achieve its target score by the end of 2023/24.**

- **People – Risk 3.2** We are unable to develop and embed a culture of continuous improvement built on high staff engagement, inclusion and involvement. Although the Trust has made progress in recruiting to senior leadership roles and in developing and delivering training and development to those leaders it remains challenging delivering appraisal to all staff and associated personal development programmes/plans. There are still challenges releasing staff for development and some recruitment still to be undertaken with the earliest this risk is likely to achieve its target score is quarter 3. **This risk remains scored at 16.**

- **People – Risk 3.3** 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. **This risk remains scored at 16 and there is a low level of confidence that this risk will achieve its target score by the end of 2023/24.**

- **Quality – Risk 4.1** We are unable to deliver safe and harm free care to reduce mortality and morbidity. The Quality Committee considered the gap in assurance over the Trust's Clinical Effectiveness and Outcome processes and felt that given this gap in assurance it was prudent to increase this risk until robust systems of assurance are established which are expected to being established in this quarter and will be built upon over the next two quarters giving a confidence that the target score will be achieved. **This risk has an increased score at 16.**

- **Quality – Risk 4.2** 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. **This risk score remains at 20 and there is a low level of confidence that this risk will achieve its 2023/24 target score.**

- **Systems and Partnerships – Risk 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. **This risk remains at 16** however, enhanced assurance over this work is to flow through the Operational Management Group and it is expected that this work will see a reduction in risk during quarter 3.

- **Systems and Partnerships – Risk 5.3** 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. Following a discussion at the Systems and Partnerships Committee the score was recommended to remain at 20 and it was recognised that given the continuation of industrial action then **there is a low level of confidence that this risk will achieve its target score by the end of 2023/24.**

- **Research and Innovation – Risk 6.1** 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. **This risk remains at 16** but the current risk score is expected to reduce to its target score with the approval of the developing Research and Innovation strategy noting that this may see the risk description be refined.

3 Quarter 2 Summary

Below is a summary against each of the six strategic domains.

3.1 Patient

3.1.1 The Patient Strategic Risk has not been reduced recognsing the impact of industrial action can have on patient experiences in respect of waiting. Management's assessment is that the Committee can have a high level of confidence over the received assurances in respect of the designed and operating controls.

3.1.2 To achieve this risk's target score is linked to a key action being delivered through the Quality Corporate Project which will see the proposed revisions to divisional quality governance seeing an increased focus on learning for the feedback to drive improvements.

3.1.4 Patient summary table is below

BAF: Strategic Objectives and Strategic Risks (Key: I = Impact L = Likelihood T = Total)	Risk Scores											
	2023/24 Q1			2023/24 Q2					2023/24 Target		
	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 poorer patient experience	4	4	**16**	4	4	**16** ⟷	**This risk has yet to reduce to its 2023/24 target score however there is a high degree of confidence that the target risk score will be delivered by quarter 4 of 2023/24**		4	3	**12**

3.2 Sustainability

3.2.1 Two of the three Sustainability Strategic Risks are currently assessed for Quarter 2 at the 2023/24 target score of 12. The other Sustainability Strategic Risk remains at 16 which is above the target score of 12.

3.2.2 Whilst at its target score for two risks, work continues to improve the respective control environment around these risks. For risk 2.2 the outcome of the introduced tiered support

meetings for Divisions/Directorates and the completion of the actions resulting from the HFMA sustainability audit, most specifically those linked to financial education and literacy. The outcome of these actions will also enhance expenditure pay controls ahead of any further national requirements being issued. For risk 2.3 work is ongoing to determine the methodology for measuring CO2 reduction against each of the respective green plan workstreams, to establish trajectories to achieve the 2025 and 2040 goals and to introduce monthly reporting on the actual energy CO2 usage against these trajectories and the previous year.

3.2.3 In respect of Risk 2.1, the risk score has been maintained at 16 as this recognises M1 performance was not consistent with the plan, impact of Industrial Action and the status of the Efficiency Programme. There are a series of actions to both enhance the control environment aswell as improving the level of assurances, these include the outcome of the introduced tiered support meetings for Divisions/Directorates and the completion of the actions resulting from the HFMA sustainability audit, most specifically those linked to financial education and literacy, the maturing of the 2023/24 efficiency programme and improvements with workforce control compliance reporting, and revised approval levels bringing enhanced control. Supporting the assurance levels for this risk is enhanced Trust-wide weekly monitoring of activity performance and timely interventions. For this risk there is high degree of risk to the delivery of the target score during 2023/24; based on internal and external factors.

3.3.4 Sustainability summary table is below:

BAF: Strategic Objectives and Strategic Risks (Key: I = Impact L = Likelihood T = Total)	**Risk Scores**											
	2023/24 Q1			**2023/24 Q2**					**2023/24 Target**		
	I	**L**	**T**	**I**	**L**	**T**			**I**	**L**	**T**
2. Sustainability *(Oversight provided by the Sustainability Committee)*											
2.1 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.	4	4	**16**	4	4	**16** ⟷	**This risk has yet to reduce to its 2023/24 target score and there is high degree of risk to the delivery of the target score during 2023/24**		4	3	**12**
2.2 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** ⟷	**This risk is at its 2023/24 target score**		4	3	**12**
2.3 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	4	3	**12**	4	3	**12** ⟷	**This risk is at its 2023/24 target score**		4	2	**12**

3.4 People

3.4.1 All four of the People Strategic Risks are currently assessed for Quarter 2 above their respective 2023/24 target scores.

3.4.2 Risk 3.1 score has not changed for quarter 2 and remains above its target score. Although the Trust has made progress in recruiting to senior leadership roles and in developing and delivering training and development to those leaders. For the senor leadership (Divisional and Corporate Directors) the 'phase 1' of the development programme has concluded and 'phase 2' will commence on 3 July 2023. This work is supported no by Roffey Park. There has been

progress developing signposting to leadership and other development using IRIS as the Trust's L&D platform. However it remains challenging delivering appraisal to all staff and associated personal development programmes/plans. Divisional and Corporate progress on this is being monitored in SDRs. It is not expected that the risk reduces in Q2 as there are still challenges releasing staff for development and some recruitment still to be undertaken with the earliest this risk is likely to achieve its target score is quarter 3.

3.4.3 Risk 3.2 score has not changed for quarter 2 and remains above its target score. The Trust's monthly measurement of engagement shows positive improvement. Work on TN and the BO of 'staff voice that counts' has been extended to cover more areas of engagement and culture. All Divisions have action plans to address staff survey results which were shared with the People Committee in June 2023. The LCD SI continues to make progress on delivering the EDI plan (year 1) and support for leadership development and violence prevention and reduction. The stability of leadership within Divisions and population of hospital leadership teams with substantive appointees is providing some greater visibility of leaders and points of escalation. The Chief Nurse is reviewing with senior nurse leaders the 'standard work' expected of them to help reinforce leadership presence and expectations. No changes are expected this quarter but the benefits of stable leadership, the improvement actions planned at corporate and Divisional level should yield further improvements in scores, and risk reduction, in Quarter 3 and Quarter 4. These local benefits though may be overshadowed or put at risk by industrial relations difficulties nationally with the industrial action and ongoing dispute about pay affecting nurses, radiographers and medical staff.

3.4.4 Risk 3.3 score has not changed for quarter 2 and remains above its target score. Recruitment remains challenging for the NHS nationally with shortages in some key specialties and roles. The Trust has ambitious recruitment targets within its workforce plan for 2023-24 and will seek to use these to reduce bank and agency usage. The Trust has strengthened the controls and visibility on the use of staffing using HeathRoster for the AfC workforce but has yet to deploy systems to allow similar central oversight of the medical workforce (this will be delivered under the EWD corporate project during 2023-34). There is much more focus with Divisional teams on recruitment needs and activities with some successes in reducing vacancy levels. The Trust is also seeking to tackle retention with its activities to improve staff experience. Further international recruitment is under consideration. It is anticipated that recruitment will though remain challenging throughout 2023-24 and the risk of insufficient staff in some services and specialties at points in time is unlikely to be eliminated and the impact of any winter pressures and extra capacity needed that is not planned for could further stretch staff. Q4 is the earliest that the recruitment risk may reduce.

3.4.5 Risk 3.4 score has not changed for quarter 2 and remains above its target score. The Trust has maintained its Health & Wellbeing activities including staff support for the cost of living crisis (supported by the Trust charity). Reviews of staff support options conducted by the Health & Wellbeing team demonstrate that the level of support offered (Employee Assistant Programme, counselling, staff Mental Health support, the provision of staff rest spaces) are comparable to other NHS organisations. It remains challenging publicising and helping staff avail themselves of all of the support available. Staff appraisal include a wellbeing review to help identify issues and therefore potential for support so it remains important that these are conducted - but the Trust has struggled to ensure this is done consistently with appraisal rates below target. Staff rest areas have now been secured in St Richards and Worthing which means all the main sites will now have dedicated areas for staff and where other support can also be publicised. The Trust does need to review its Mental Health / psychological support offerings to create a consistent level of service and is expected to conclude this review in Quarter 2. An audit of staff rest facilities is also underway to help inform the estates strategy and plan as well as programmes of work/investment to ensure all staff have access to appropriate local facilities. This will also be competed in Quarter 2. If inflation continues to lessen and based on the pay award now made, continuation and enhancements planned to the Health and Wellbeing offers should see the risk

reduce in Quarter 3. However the link to appraisal as a means of signposting support and that these remain below target may continue to limit the effectiveness of the offers available.

3.4.6 People summary table is below:

BAF: Strategic Objectives and Strategic Risks (Key: I = Impact L = Likelihood T = Total)	Risk Scores											
	2023/24 Q1			2023/24 Q2					2023/24 Target		
	I	L	T	I	L	T			I	L	T
3 People *(Oversight provided by the People Committee)*											
3.1 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.	4	3	**12**	4	3	**12** ⟷	**This risk has yet to reduce to its 2023/24 target score and the earliest this risk is likely to achieve its target score is quarter 3.**		4	2	**8**
3.2 We are unable to develop and embed a culture of continuous improvement built on high staff engagement, inclusion and involvement.	4	4	**16**	4	4	**16** ⟷	**This risk has yet to reduce to its 2023/24 target score and the earliest this risk is likely to achieve its target score is quarter 3.**		4	3	**12**
3.3 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	4	4	**16**	4	4	**16** ⟷	**This risk has yet to reduce to its 2023/24 target score and the earliest this risk is likely to achieve its target score is quarter 4.**		4	3	**12**
3.4 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	4	3	**12**	4	3	**12** ⟷	**This risk has yet to reduce to its 2023/24 target score and quarter 3 is the earliest this risk is likely to achieve**		4	2	**8**

3.7 Quality

3.7.1 Both Quality Strategic Risks are currently assessed for Quarter 2 above their respective 2023/24 target scores.

3.7.2 Risk 4.1 score has increased from quarter 2 and remains above its target score. There is a gap in assurance over the Trust's clinical effectiveness and outcomes processes noting specifically there remains work to conclude on the move to proactively reviewing patients waiting for harm, noting that the current review process has not identified those waiting have come to physical harm as a result of waiting. There is work being undertaken through the enhancing quality governance corporate project that will strengthen both the control environment and assurance processes within the clinical effectiveness team. This risk is likely to achieve its target score by quarter 4.

3.7.3 Risk 4.2 score remains at a score of 20 (the highest scored risk for quarter 2). There remains a low level of confidence that the 2023/24 target score will be achieved due to a delay in

the Datix IQ incident module implementation and the continuing work required to improve the Quality Assurance (Clinical Outcomes and Effectiveness) processes both centrally and divisionally.

3.7.4 Quality summary table is below:

BAF: Strategic Objectives and Strategic Risks (Key: I = Impact L = Likelihood T = Total)	**Risk Scores**											
	2023/24 Q1			**2023/24 Q2**					**2023/24 Target**		
	I	**L**	**T**	**I**	**L**	**T**			**I**	**L**	**T**
4 Quality ***(Oversight provided by the Quality Committee)***											
4.1 We are unable to deliver safe and harm free care to reduce mortality and morbidity.	4	3	**12**	4	4	**16** ↑	**This risk has yet to reduce to its 2023/24 target score with the earliest this risk is likely to achieve its target score is assessed as quarter 4.**		3	3	**9**
4.2 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.	4	5	20	4	5	**20** ↔	**This risk has yet to reduce to its 2023/24 target score and there is significant risk to the achievement of the target score by the year end.**		4	3	**12**

3.8 Systems and Partnerships

3.8.1 Two of the three System and Partnerships Strategic Risks are currently assessed for Quarter 2 at their respective 2023/24 target scores, these being 5.1 and 5.3. The remaining System and Partnerships Strategic Risk 5.2 shows no change for quarter 2 and remains above its 2023/24 target score.

3.8.2 Risk 5.1 remains for Quarter 2 at the 2023/24 target score of 8 and whilst this risk is at its target score for the year the Trust has increased integrated working with the system on UEC and discharge. Through the strengthened collaborative relationships with system partners there is work being undertaken across the quarter to develop joint aims and objectives from the multisystem workstreams to support the UEC and discharge goals.

3.8.3 Risk 5.2 the Quarter 2 remains unchanged from the score of the previous quarter. This risk remains at 16 above its target score of 12. Work is being undertaken to ensure that all functions within the Trust which impact on operational performance have an appropriate place to discuss plans with operational colleagues thus allowing alignment of improvement effort. Enhanced assurance over this work is to flow through the Operational Management Group. It is expected that this work will see a reduction in risk during quarter 3.

3.8.4 Risk 5.3 The risk remains unchanged at the end of quarter 1. Following a discussion at the Systems and Partnerships Committee the score was recommended to remain at 20 noting this is one of the highest two highest scored risks and it was recognised that given the continuation of industrial action then there is a low level of confidence that this risk will achieve its target score by the end of 2023/24.

3.8.5 Systems and Partnerships summary table is overleaf:

BAF: Strategic Objectives and Strategic Risks (Key: I = Impact L = Likelihood T = Total)	Risk Scores											
	2023/24 Q1			2023/24 Q2					2023/24 Target		
	I	L	T	I	L	T			I	L	T
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	2	**8**	4	2	**8** ⟷	**This risk is at its 2023/24 target score**		4	2	**8**
5.2 We are unable to define and deliver the strategic intentions, plans and optimal configuration that will enable our services to be sustainable, leading to an adverse impact on their future viability	4	4	**16**	4	4	**16** ⟷	**This risk has yet to reduce to its 2023/24 target score and but it is expected to achieve this in quarter 3**		4	3	**12**
5.3 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.	4	5	**20**	4	5	**20** ⟷	**This risk has yet to reduce to its 2023/24 target score and there is significant risk to the achievement of the target score by the year end.**		4	4	**16**

3.9 Research and Innovation

3.9.1 The Research and Innovation Strategic Risk is currently assessed for Quarter 2 at the 2023/24 target score of 12. Whilst significant progress in developing a new R&I Strategy this quarter and associated delivery plans the risk score has not been reduced until Strategy formally approved and delivery plans fully worked up which is expected to be in September 2023 seeing the risk score to reduce to the 2023/24 target score. It should be noted that once the Research and Innovation Strategy is approved this may see the Trust's Strategic Risk being amended.

3.9.2 Research and Innovation summary table is overleaf:

BAF: Strategic Objectives and Strategic Risks (Key: I = Impact L = Likelihood T = Total)	Risk Scores											
	2023/24 Q1			2023/24 Q2					2023/24 Target		
	I	L	T	I	L	T			I	L	T
6.Research and Innovation (Oversight provided by the Patient Committee)											
6.1 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.	4	4	**16**	4	4	**16** ⟷	**This risk has yet to reduce to its 2023/24 target score and but it is expected to achieve this in quarter 3 with the approval of the R&I strategy.**		3	3	**9**

4 Supporting Key Risks

Each Committee within their meetings in July will be considering their respective key risks with the potential to impact on the Committee's relevant patient first domain. These will include 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 experience.	Operational pressures including acute system pressures, referral to treatment delay, workforce constraints and ageing equipment continue to be raised reporting the risk of impacting on the delivery of the quality and safety of patient care. Patient profile, frailty, mental health, delays to specialist placement (in particular child and adolescent mental health), long waits for pre-hospital assessment (ambulance transfers) reduced care in community and social care placement and primary care capacity.	Levels of nursing vacancies and an inability to provide consistent nursing & medical cover for escalation/outliers if bed capacity full. Management of young people requiring inpatient care for mental health problems Increase in RTT waiting times.
Sustainability		
2.1 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. 2.2 We are unable to meet high standards of financial stewardship meaning we cannot	Operational pressures and workforce constraints are substantially impacting on operational costs and productivity. The cost of mental health support for urgent care remains a significant risk. These, alongside inflationary pressures add significant risk to delivery of financial targets, a continued step-up in elective capacity and	Delivery of the Trust's financial plan Delivery of the capital developments Cyber Security IT systems replacement

BAF	Corporate Themes	Key Risks
sustain compliance with our statutory financial duties. 2.3 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.	delivery of a challenging efficiency programme. The 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 continues to be an increased level of risk for cybersecurity. This is an on-going and known risk requiring continuous oversight. Environmental strategy and adhering to a steeper trajectory to deliver the required 2025 CO2 reduction is now an increasing risk due in part to the increased energy consumption of LMB and diagnostic expansion across all sites.	Delivery of CO2 reduction schemes
People		
3.1 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. 3.2 We are unable to develop and embed a culture of continuous improvement built on high staff engagement, inclusion and involvement. 3.3 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 True Norths. 3.4 We are unable to consistently meet the health, safety and	Operational pressures and workforce constraints continue to impact on people, patient safety and trust operational costs and productivity. Industrial action is a particular risk. Establishments have though been reviewed and in many cases 'outturn' funding has informed budgets in 23-24 and recruitment levels are improving, which should reduce staff pressures. The general pressure on staffing of being able to sustain the levels of workforce needed, is driven primarily by responding to industrial action and its aftermath. The Trust will be planning for Winter 2023-34 in the next few weeks.	Risk of insufficient medical staff and insufficient numbers of registered nurses and health care nurses Absence Future vaccination (flu and Covid) Health and wellbeing including appraisals Staff stretch

BAF	Corporate Themes	Key Risks
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.		
Quality		
4.1 We are unable to deliver safe and harm free care to reduce mortality and morbidity. 4.2 We are unable to deliver service improvements and improve safety and outcomes for our patients or to demonstrate that our services are clinically effective and comply with regulatory requirements or clinical standards.	Operational pressures including acute system pressures, referral to treatment delay, workforce constraints and ageing equipment continue to be raised reporting the risk of impacting on the delivery of the quality and safety of patient care. Patient profile, frailty, mental health, delays to specialist placement (in particular child and adolescent mental health), long waits for pre-hospital assessment (ambulance transfers) reduced care in community and social care placement and primary care capacity.	Levels of nursing vacancies and an inability to provide consistent nursing & medical cover for escalation/outliers if bed capacity full. Management of young people requiring inpatient care for mental health problems Increase in RTT waiting times. Ageing IT systems replacement
Systems and Partnerships		
5.1 We are unable to develop and maintain collaborative relationships with partner organisations based on shared aims, objectives, and timescales leading to an adverse impact on our ability to operate efficiently and effectively within our health economy. 5.2 We are unable to define and deliver the strategic intentions, plans and optimal configuration that will enable our services to be sustainable, leading to an adverse impact on their future viability. 5.3 We are unable to deliver and demonstrate consistent compliance with the 23/23	Operational pressures resulting from the Covid-19 pandemic, increased system demand and delays, and workforce constraints are impacting on all operational capacity and workstreams including delivery of constitutional targets, and indirectly potential risks to the new 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 Sector capacity to deliver the plan	Delivery of the Recovery and Restoration programme. Capacity constraints leading to Increase in RTT waiting times Service Demands Inability to action partial or whole-site lockdown processes across all sites The ability to evacuate one or more sites in the event of an internal or external incident.

BAF	Corporate Themes	Key Risks
operational plan and NHS constitutional standards resulting in an adverse impact on patient care and financial penalties and the Trust's reputation.	to have no patient waiting more than 78 weeks for treatment.	
Research and Innovation		
6.1 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	The Trust is unable to maximise its research and innovation potential.	Resource constraints

5 Conclusion

The BAF continues to record the timely receipt of the planned assurances with a mix of management and executive assurance provided for most risks but for those relating to patient experience, sustainability and quality (mortality) these also include assurances from external sources, including FFT, internal and external audit and an external coding audit.

The 2023/24 BAF document has been adjusted to record the expected reduction in risk during the 12 month period and provides greater clarity over the levels of assurance received through a visual grading system. The document has also been adjusted to record explicitly when actions being taken are intended to achieve the target score allowing for the Board to judge the degree of challenge in meeting these scores during the year.

Each of the Board Committees have during their July meetings considered the risks for which they have allocated oversight and agreed the scores reflected in BAF summary being presented to the Board at this meeting. Noting that the Quality Committee and the Systems and Partnerships Committee in their review of their allocated risks agreed that risk 4.1 and 5.3 respectively should not be reduced from their quarter 1 score as was originally reported to them.

APPENDIX 1

BAF Summary

The table below overleaf shows by risk, their current score and their target risk score. The table shows pictorially the movement in risk between the current score for Q2 and Q1
(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**														
	2023/24 Q1			**2023/24 Q2**			**2023/24 Q3**			**2023/24 Q4**			**2023/24 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 poorer patient experience	4	4	**16**	4	4	**16** ⟷							4	3	**12**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***											
2 Sustainability ***(Oversight provided by the Sustainability Committee)***															
2.1 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.	4	4	**16**	4	4	**16** ⟷							4	3	**12**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***											
2.2 We are unable to meet high standards of financial stewardship meaning we cannot sustain compliance with our statutory financial duties.	4	3	**12**	4	3	**12** ⟷							4	3	**12**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***											
2.3 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	4	3	**12**	4	3	**12** ⟷							4	2	**12**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***											
3 People ***(Oversight provided by the People Committee)***															
3.1 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.	4	3	**12**	4	3	**12** ⟷							4	2	**8**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***											
3.2 We are unable to develop and embed a culture of continuous improvement built on high staff	4	4	**16**	4	4	**16** ⟷							4	3	**12**

engagement, inclusion and involvement.															
Assessed strength of control	***Some weaknesses***			***Some weaknesses***											
3.3 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	4	4	**16**	4	4	**16** ↔							4	3	**12**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***											
3.4 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	4	3	**12**	4	3	**12** ↔							4	2	**8**
Assessed strength of contol	***Some weaknesses***			***Some weaknesses***											
4 Quality ***(Oversight provided by the Quality Committee)***															
4.1 We are unable to deliver safe and harm free care to reduce mortality and morbidity.	4	3	**12**	4	4	**16** ↑							3	3	**9**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***											
4.2 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.	4	5	**20**	4	5	**20** ↔							4	3	**12**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***											
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	2	**8**	4	2	**8** ↔							4	2	**8**
Assessed strength of control	***Operating as intended***			***Operating as intended***											
5.2 We are unable to define and deliver the strategic intentions, plans and optimal configuration that will enable our services to be sustainable, leading to an adverse impact on their future viability	4	4	**16**	4	4	**16** ↔							4	3	**12**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***											
5.3 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.	4	5	**20**	4	5	**20** ↔							4	4	**16**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***											

6.Research and Innovation (Oversight provided by the Patient Committee)															
6.1 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.	4	4	**16**	4	4	**16** ⟷							3	3	**9**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***											

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	17	**Meeting:**	Trust Board	**Meeting Date:**	3 August 2023
Report Title:	Patient Committee Chair report to Board				
Sponsoring Executive Director:	Claire Keatinge, Committee Non Executive Chair				
Author(s):	Claire Keatinge, Committee Non Executive Chair				
Report previously considered by and date:					

Purpose of the report:			
Information	Yes	Assurance	Yes
Review and Discussion	N/A	Approval / Agreement	Yes

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

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	Yes	Link to Trust Annual Plan	Yes

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	Yes	Links to risk 1.1
Sustainability	N/A	
People	N/A	
Quality	N/A	
Systems and Partnerships	N/A	
Research and Innovation	Yes	Links to risk 6.1

Link to CQC Domains:			
Safe	No	Effective	No
Caring	Yes	Responsive	Yes
Well-led	Yes	Use of Resources	Yes

Regulatory / Statutory reporting requirement

Communication and Consultation:

Executive Summary:

The Patient Committee met on the 27 July 2023 and was quorate as it was attended by two Non-Executive Directors, the Chief Nurse, Chief Executive and the Chief People Officer. The Chief Medical Officer had given apologies. In attendance were the Director of Patient Experience, Engagement and Involvement, the 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 Objective, Corporate Project and Strategic Initiative, the quarter 1 2023/24 and patient experience report and the 2022/23 Patient Experience Annual Report, 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 are listed below, noting the full breath of the meeting's activity is included in a table as an appendix to the paper.

Quarter 1 2023/24 Patient Experience Report and 2022/23 Patient Experience Annual Report

The Director of Patient Experience, Engagement and Involvement provided the quarter 1 patient experience report. The Committee **noted** the actions taken in response to patient feedback received during quarter 1 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. The Committee heard the Datix IQ feedback module had gone live Trust wide and noted the data improvements that are anticipated to flow through, aligned with 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.

The Committee **NOTED** that based on available Friends and Family Test (FFT) data, the significant majority of patients responding in Q1 were satisfied that they have a good or very good experience (around 91%). This was comparable to Q4 2022/23 and a considerable increase on Q3 with positivity levels influenced by improvement in Emergency Department ratings from January. The improved positivity ratings from FFT are in contrast to the number of complaints received which had increased through Q4 and which brought a considerable resource pressure on the patient experience team and divisional teams.

The Committee **NOTED** that the increase in the number of complaints and their complexity had been recognised in the Sussex system and also was experienced by the Parliamentary Heath Standards Ombudsman who had also appointed additional staff.

The Committee heard of work to avert concerns escalating to formal complaints through lead Nurse Rounds identifying and addressing patient concerns around their care at an early stage.
The Committee were also updated on direct engagement work around the Trust improvement programme with visiting groups representing those with protected characteristics, including making new clinical environments dementia friendly. It was encouraging that Divisional leaders are using feedback and available content (including through powerBI) for timely insights to shape improvements at ward level.

The Committee discussed the impact of the recently deployed Welcome Standards and the considerable improvement in feedback concerning reception areas following the targeted training.

The Committee **NOTED** the Annual report reflections on the previous year described in previous reports. And incorporating Patient Experience arrangements within the Quality Governance Manual as part of a robust approach to quality. The report also reflected the work of clinical and hospital site teams and efforts towards reaching out to seldom heard groups as well as work with Healthwatch. The report reflected considerable improvement in Maternity services feedback through the year that had received a very positive patient survey.

The Patient Experience Annual Report 2022/23 is included as an appendix to this report.

Working in partnerships, ICS Update

The Committee received an update on work with ICS partners around patients. The Committee **NOTED** the particular work around presentations of patients with primary mental health needs and the work in partnership with Sussex Partnership NHS Foundation Trust to address this.

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 Improvement activities that delivered the assurance requested at the previous meetings. Improvements to scorecards continue to be made to support the divisional strategy deployment reviews and this work remains an area of priority. Following considerable improvement through 2022/23 there was reported to have been some plateauing of Patient First maturity or the depth of embeddedness at Division and care group level. However, the Louisa Martindale Building opening had coincided with considerable progress in improvement work maturity within those services moving into the new facility. The Committee also welcomed the work with the chief registrar to get Doctors in training more engaged with improvement work as a core part of Trust business.

The Director for Improvement and Delivery described the introduction of methodologies to identify efficiency opportunities and associated tools that have also been deployed through standard work and the Committee **NOTED** the improved access and integration of patient first work.

Research and Innovation

The Committee **RECEIVED** an update from the Director of Research and Innovation and **NOTED** update on the progress being made to the recruitment of patients to open research studies with this recruitment having progressed well and the Trust had improved its relative position compared to other Trusts. The Trust had made particular progress in the number of studies open.

The importance of driving research activity and recruitment at Division level was highlighted. The Committee also **NOTED** the successes within this programme of work within the last quarter as reported by the Director.

The Committee **DISCUSSED** the work being undertaken in consulting on the developing Research and Innovation (R&I) Strategy. Members commented on the importance of sustained investment in the personnel and facilities for research. It was noted that driving research within the Trust would require concerted activity with partner organisations in Sussex. There was a discussion how innovation activities could have greater emphasis building on the strong legacy of multi-professional innovative work in the Trust.

The Committee **ENDORSED** the work being led by the Clinical Director supported by the Chief Medical Officer and Divisions, including with ICB system partners, and supported the progressed development of the R&I Strategy noting the updated draft strategy was in its final stages of consultation prior to its approval at the Board in the Autumn.

Patient Risks and Board Assurance Framework (BAF)

The Committee **REVIEWED** the Trust's key risks with their potential to impact on patient experience and **NOTED** the alignment of those with the highest current score to the Patient Strategic Risk. The Committee

noted the executive review of the strategic risk had maintained its score of 16 recognising the impact of industrial action. 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. The Committee **NOTED** further work through the Enhancing Quality Governance Corporate Project around a proposed Risk Group to support the resolution of cross-cutting risks.

The Committee **NOTED** the prevalence of high scored risks with reference to staffing shortages and the need to differentiate workforce establishment risks from those risks arising from recruitment and retention issues and confirmed that this question is considered at the Trust's People Committee and at BAF risk 3.3.

The Committee **AGREED** that the scores relating to BAF risks 1.1 and 6.1 for quarter 1 were fairly represented. It was **NOTED** that BAF risk 6.1 was expected to move towards its risk score once the Research and Innovation Strategy was approved and that this was on course.

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.

Terms of Reference

The Committee reviewed a proposed terms of reference following a previous discussion for the Research and Innovation workstream to have a dedicated Committee. The Committee on receiving the revised terms of reference discussed the value of the Research and Innovation Committee having within its terms of reference the oversight of Health Inequalities recognising that this work would feed into each Committee as does updates from the ICS. The Committee **RECOMMENDED** that the Board consider an amendment of the draft terms of reference for the Research and Innovation Committee to include that Committee having oversight of health inequalities. The draft Terms of Reference for the Research & Innovation Committee are included as an appendix to this report for the Board's approval.

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 1.1 and 6.1, for which it has oversight, that the scores for start of quarter 2 are fairly represented.

The Board is asked to **APPROVE** the Research and Innovation Committee terms of reference subject to consideration of the recommendation from the Patient Committee for the Research and Innovation Committee to have oversight of the Trust's framework for addressing Health Inequalities.

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	**25 July 2023**	**Chair**	Claire Keatinge	**Quorate**	Yes
Declarations of Interest	No declarations were raised				

Items received at the Committee meeting

Patient Experience Report (Q1 2023/24 and 2022/23 Annual Report)	**Jul**	**Presenter** Interim Chief Nurse / Director of Patient Experience, Engagement & Involvement	**Purpose** For assurance	**Outcome /Action taken** Noted
Patient First Improvement Programme	**Jul**	**Presenter** Director for Improvement and Delivery	**Purpose** For assurance	**Outcome /Action taken** Noted.
Research and Innovation True North Quarterly Report	**Jul**	**Presenter** Director of Research and Innovation	**Purpose** For assurance	**Outcome /Action taken** Noted
Research and Innovation Strategy Development	**Jul**	**Presenter** Director of Research and Innovation	**Purpose** For information	**Outcome /Action taken** Noted
Updates from the Quality Governance Assurance Group and Patient Experience Group	**Jul**	**Presenter** Interim Chief Nurse / Director of Patient Experience, Engagement & Involvement	**Purpose** For assurance	**Outcome /Action taken** Noted Return to Committee & Risk added
Risk Report	**Jul**	**Presenter** Interim Chief Nurse / Company Secretary,	**Purpose** For information	**Outcome /Action taken** Noted
Board Assurance Framework	**Jul**	**Presenter** Company Secretary	**Purpose** For agreement	**Outcome /Action taken** 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 1.1 and 6.1 to the Board for the start of quarter 2 2023/24.

The Committee **AGREED** to recommend revised Terms of Reference to the Board (these incorporate matters previously received by the Patient Committee into the Quality Committee and repurpose this committee time to a dedicated Research & Innovation committee.

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

There are no identified items to come back to committee outside the scheduled cycle of business

Items referred to the Board or another Committee for decision or action	
Item	**Date**
The Board is asked to **APPROVE** the Research and Innovation Committee terms of reference subject to consideration of the recommendation from the Patient Committee for the Research and Innovation Committee to have oversight of the Trust's framework for addressing Health Inequalities.	**August 2023**

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	7	**Meeting:**	Patient Committee	**Meeting Date:**	25 July 2023
Report Title:	Patient Experience Annual Report 2022-23				
Sponsoring Executive Director:	Leanne McLean, Chief Nurse				
Author(s):	Nicole Chavaudra, Director of Patient Experience & Engagement				
Report previously considered by and date:					

Purpose of the report:			
Information	Yes	Assurance	Yes
Review and Discussion	Yes / N/A	Approval / Agreement	Yes / N/A

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

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	Yes / N/A	Link to Trust Annual Plan	Yes / N/A

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	Yes	
Sustainability	Yes / N/A	
People	Yes	
Quality	Yes	
Systems and Partnerships	Yes / N/A	
Research and Innovation	Yes / N/A	

Link to CQC Domains:			
Safe	Yes / N/A	Effective	Yes
Caring	Yes	Responsive	Yes
Well-led	Yes / N/A	Use of Resources	Yes

Regulatory / Statutory reporting requirement

Communication and Consultation:

Executive Summary:

This annual report describes the progress against the true north ambition as well as the insights and performance of the trust on patient experience for 2022/23. As with the previous year, 2022/23 was a challenging year for the trust in delivering great care every time, following the pandemic and its impact on demand for healthcare. However, despite the ongoing issues with waiting for elective care and in emergency departments, the year saw some improvements in reported patient experience, in particular through the friends and family test surveys, with improved reported experience correlating with improved performance and waiting times in ED.

Overall complaints and concerns were slightly higher than previous years however the teams responding to these became more stable and relationships with clinical teams following the establishment of the Trust's new clinical operating model have matured. There are many successes to share. The ways in which patient experience is managed and responded have been strengthened within an increasingly clear and effective structure of quality governance. A new system for friends and family test surveys was commissioned and implemented providing increasingly agile data to support the patient voice in service improvement. The patient experience strategy was launched and is being enacted, and relationships with Healthwatch have continued to embed with clear benefits for patients demonstrated.

There is also much to look forward to in 2023/24. This includes:

- The launch of the Datix feedback module will transform how patient experience data is captured from complaints and PALS.
- Transition to the Louisa Martindale Building for PALS on the RSCH site
- Enabling the patient voice to shape major programmes such as the ED redevelopment and stage 2 of the 3Ts programme
- Roll out of the welcome standards
- Development of the heritage project

Key Recommendation(s):

For the Committee to endorse the Patient Experience Annual Report for Trust Board approval.

University Hospitals Sussex
NHS Foundation Trust

Patient Experience Annual Report 2022/23

Contents

1. Introduction

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

'excellent care every time'

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

- Compassion
- Communication
- Teamwork
- Respect
- Professionalism
- Inclusion

'Patient experience' is what the process of receiving care feels like for the patient, their family and carers. It is a key element of quality, alongside providing clinical excellence and safer care. A person's experience starts from their very first contact with the health and care system, right through to their last, which may be years after their first treatment, and can include end-of-life care. The NHS Constitution established the principles and values of the NHS in England. The principles guide the NHS in everything it does and principle four states: 'The patient will be at the heart of everything the NHS does.'

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

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

This annual report describes the progress against the true north ambition as well as the insights and performance of the trust on patient experience for 2022/23.

2. Strategic developments and improvements in patient experience

2.1 Patient experience as a pillar of quality

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

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

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

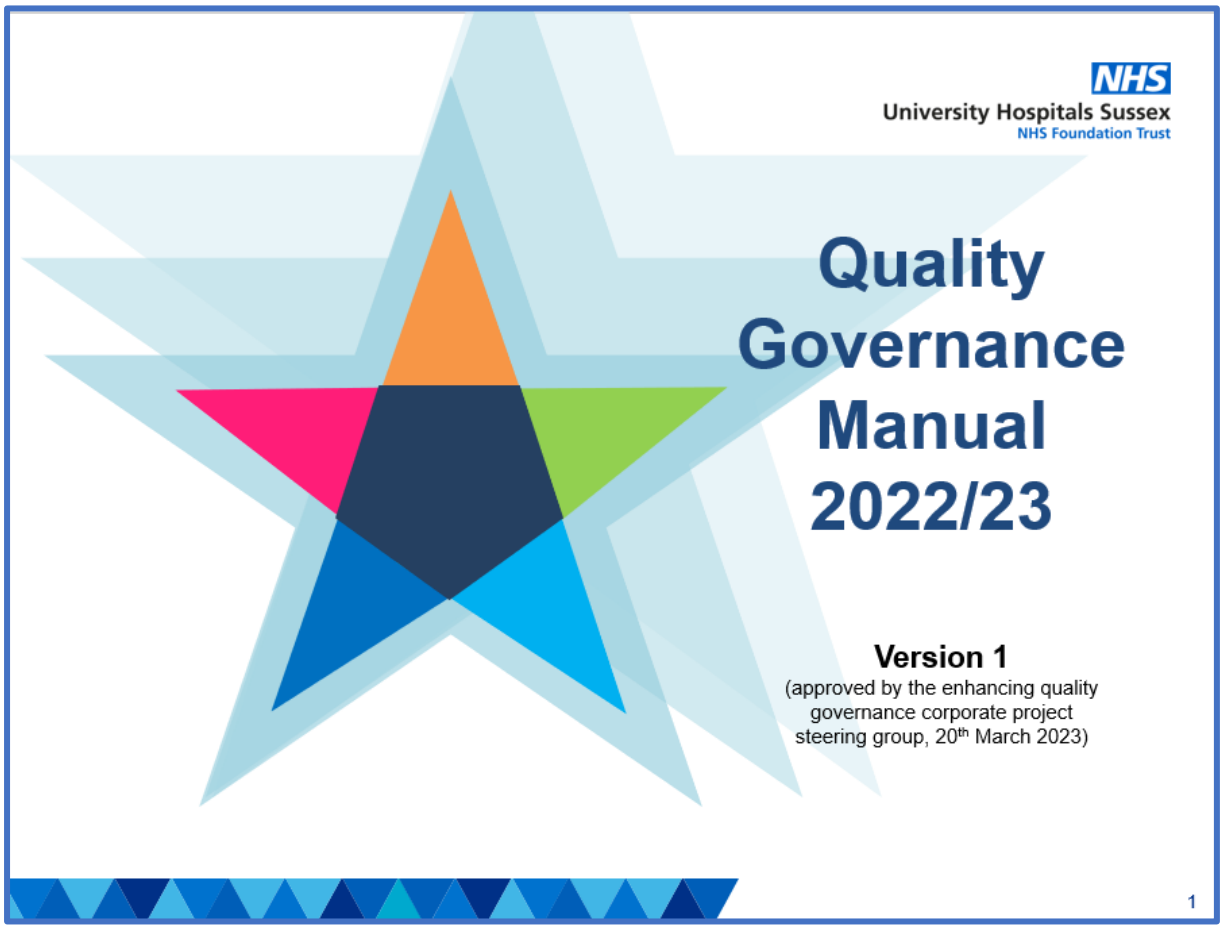
Figure 1: Quality governance domains

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

The application of patient experience as a domain of the trust's quality approach has been developed through the 'enhancing quality governance corporate project' as part of the Trust's strategy for 2022/23. Within the scope of the project in 2022/23 has been:

- Publication of a quality governance manual, which describes the Trust's vision, approach and expectations with regard to quality governance, including roles and responsibilities across clinical and corporate divisions
- Standardisation and maturity of quality governance practice within divisions
- Increasing maturity of risk management practice.

Figure 2: Quality Governance Manual published in March 2023



2.2 Improving how we deliver our patient experience functions

During 2022/23 improvements to the structures and processes within patient experience teams have been implemented. This includes:

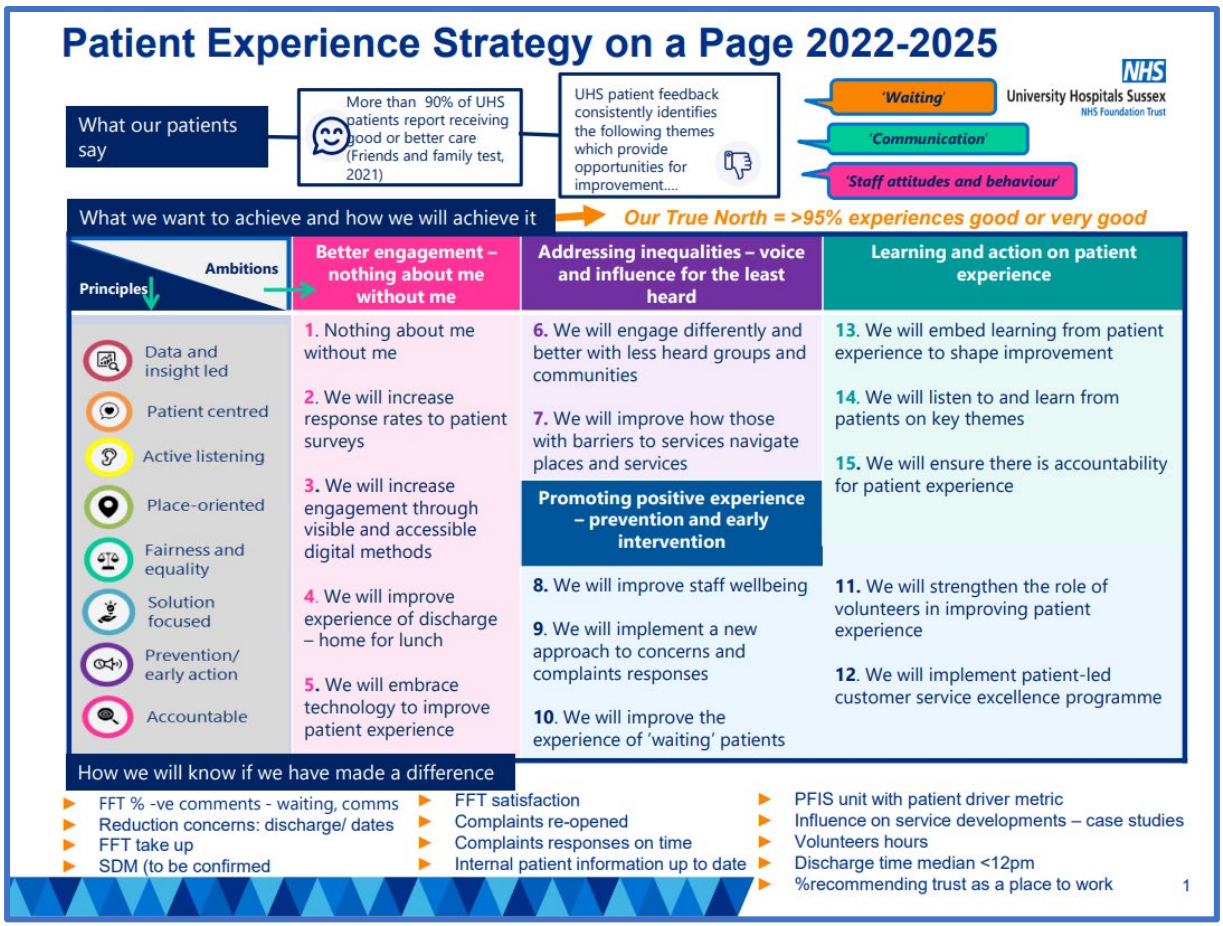
- Following consultation and re-structuring of services integrated patient experience teams have delivered complaints in line with the new clinical operating model and PALS on a site basis. New team members have been appointed and an assistant director to lead on the patient experience strategy has been appointed.
- Frequent production of complaints and PALS data by trust and divisions has allowed progress, risks and issues to be closely tracked
- New standard work for complaints has been applied, following co-production with division of a 'new ways of working' document, prior to the publication of the quality governance manual.
- Integrated approach to patient safety through the serious incident review group with patient experience, safety and clinical effectiveness working in a triangulated way to implement the requirements of PSIRF (patient safety incident response framework)
- Recommissioning of a more responsive and agile friends and family test provider
- Implementing the new DCIQ reporting system for patient feedback, ready for implementation in 2023/24
- Refreshed Patient Experience and Engagement Group (PEEG) forming a core part of the trust's quality governance structures and to act as the programme board for the patient experience strategy

Figure 3: Patient Experience as a domain of an integrated UHSx approach to quality

2.3 Patient Experience Strategy

A key achievement in 2022/23 was the co-production and approval of the Trust's Patient Experience Strategy for 2022-2025, along with a summary strategy on a page.

Figure 4: Patient Experience Strategy on a Page



The Patient Experience Strategy for 2022-2025 sets out how, using Patient First as our long-term approach to transforming hospital services for the better, positive and sustainable change in patient experience will be achieved.

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

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

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

The strategy sets out 15 commitments that the Trust has made, spanning the ambitions of the Trust's strategy including key performance on waiting times and in emergency departments, workforce and use of IT. These are measured by a range of metrics reported quarterly to the patient committee.

Successes throughout 2022/23 include:

- Improved positivity levels from patients using the emergency departments
- Increased response rates to patient surveys through friends and family test
- Increased focus and action on the voice of the less heard groups, including quarterly scanning of patient responses and active follow up where patients report discrimination or potential for action relating to a protected characteristic
- Increased participation in digital solutions that give patients a more active role in their care, including use of 'My Health and Care Record'
- Initiation of the 'Welcome Standards' project (customer service excellence) in response to patient feedback, including successful bid to charitable funds for a small, fixed term team to support the work

Opportunities for 2023/23 aligned to the strategy and across the scope of the executive portfolios include:

- New volunteers' strategy to better support and strategically align volunteering to priorities and patient experience needs
- Improving overall Trust performance on the key contributors to a less positive patient experience, including waiting in the emergency departments and referral to treatment time pathways
- Improving staff wellbeing.

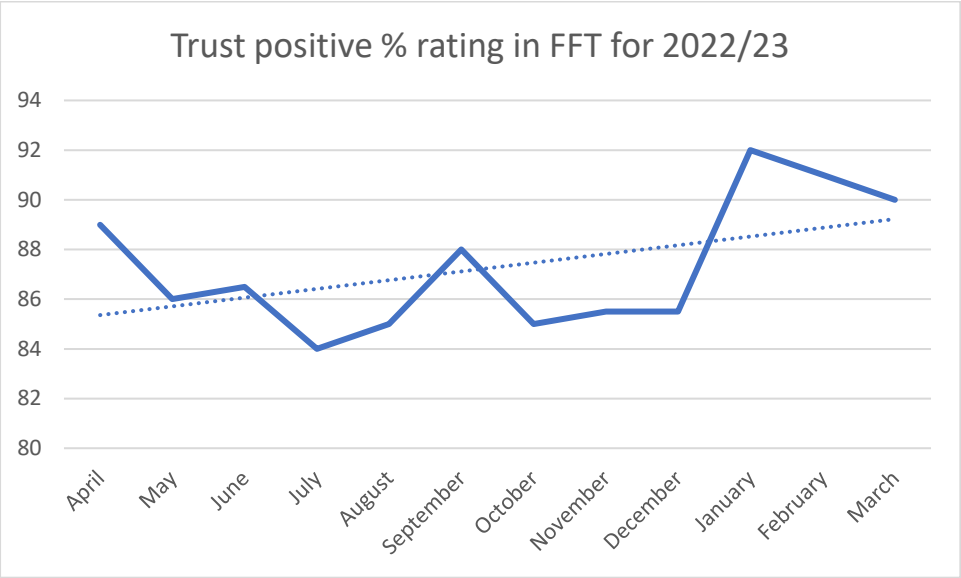
3. ‘Patient’ True and Breakthrough Objective

3.1 True North

Throughout 2022/23 the average overall positive rating for the Trust using the Friends and Family Test (FFT) system was 88.3%. This is lower than the previous year (90%). Each month, the Trust receives over 12,000 survey responses with an average response rate of 24%.

During quarter 2 of 2022/23 patient experience was the most challenged with low FFT positive ratings coinciding with an increase in complaints. However, UHSx saw a substantial increase in positive ratings in January (also reflected in the national data) linked to positive public perception of industrial action.

Figure 5: Trust positive % ratings by month for 2022/23



For the first half of 2022/23 the true north target was the aim of 95% or more of patients rating their care as good or very good. However, this was not achieved as the overall trust percentage is confounded by the emergency departments responses which are lower than other touchpoints (nationally and locally). 44% of all FFT responses are from the emergency departments, which contribute 78% of all negative reviews.

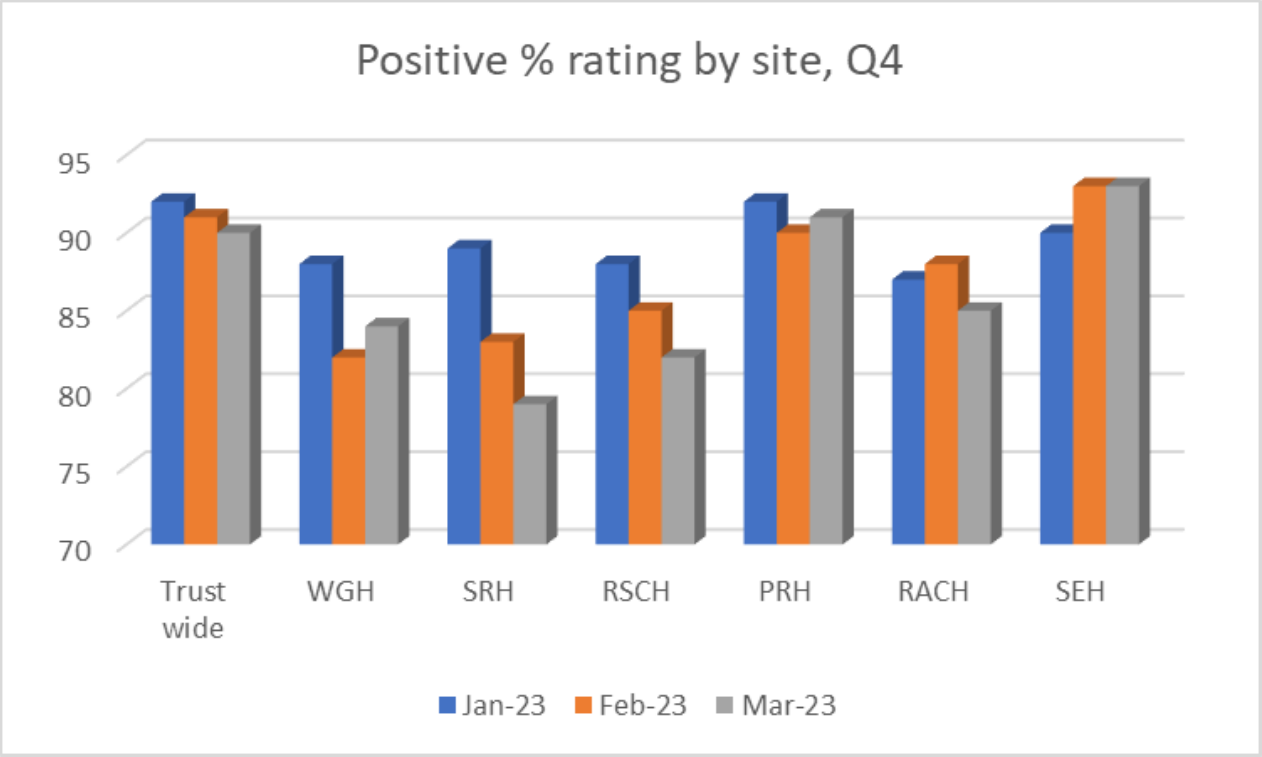
As such, when the trust strategy was reviewed the true north was amended to focus on trust performance in relation to national figures, initially aiming to be in the top quintile, but due to issues with reporting capabilities this has been reviewed and is subject to amendment.

The national average positive % rating for EDs was 75.5% in 2022/23. For UHSx the average was 80.5% (based on full available data from August 2022 to March 2023).

3.1.1 Site

Due to the implementation of the new patient administration system, Careflow, some data was unavailable for inpatient and outpatient areas in 2022, however full reporting capability has been available for Q4 by trust, site and division. The site receiving the highest % of positive ratings is the Sussex Eye Hospital (SEH) followed by Princess Royal Hospital (PRH). Lowest positive rating % is at Worthing Hospital (WGH) and St Richards Hospital (SRH).

Figure 6: Positive % rating by site for Q4



The numbers of negative responses at the RACH increased considerably around the time of the strep A outbreak when demand for paediatric emergency care increased substantially and waiting times were excessive as a result.

It is possible to generate and explore FFT response data for each of the trust's main sites (RSCH, PRH, WGH, RACH, SEH and SRH) across all touchpoints (emergency, maternity, inpatients and outpatients.

Figure 7: FFT positivity and response rates, and themes, by site for 2022/23

Site	Positivity rating	Response rate	Positive themes	Negative themes
PRH	88.5%	27%	Quality of staff, quality of service	Waiting, staffing levels
RSCH	88%	25%	Quality of staff, quality of care	Waiting, staffing levels, pain management
RACH	94%	15%	Quality of staff	Staff attitude
SEH	95.5%	35%	Quality of staff, quality of service	Waiting
WGH	81.5%	23%	Quality of staff, quality of care	Waiting, staffing levels, pain management
SRH	80%	22%	Quality of staff, quality of care	Waiting, staffing levels, pain management

3.1.2 Emergency Departments

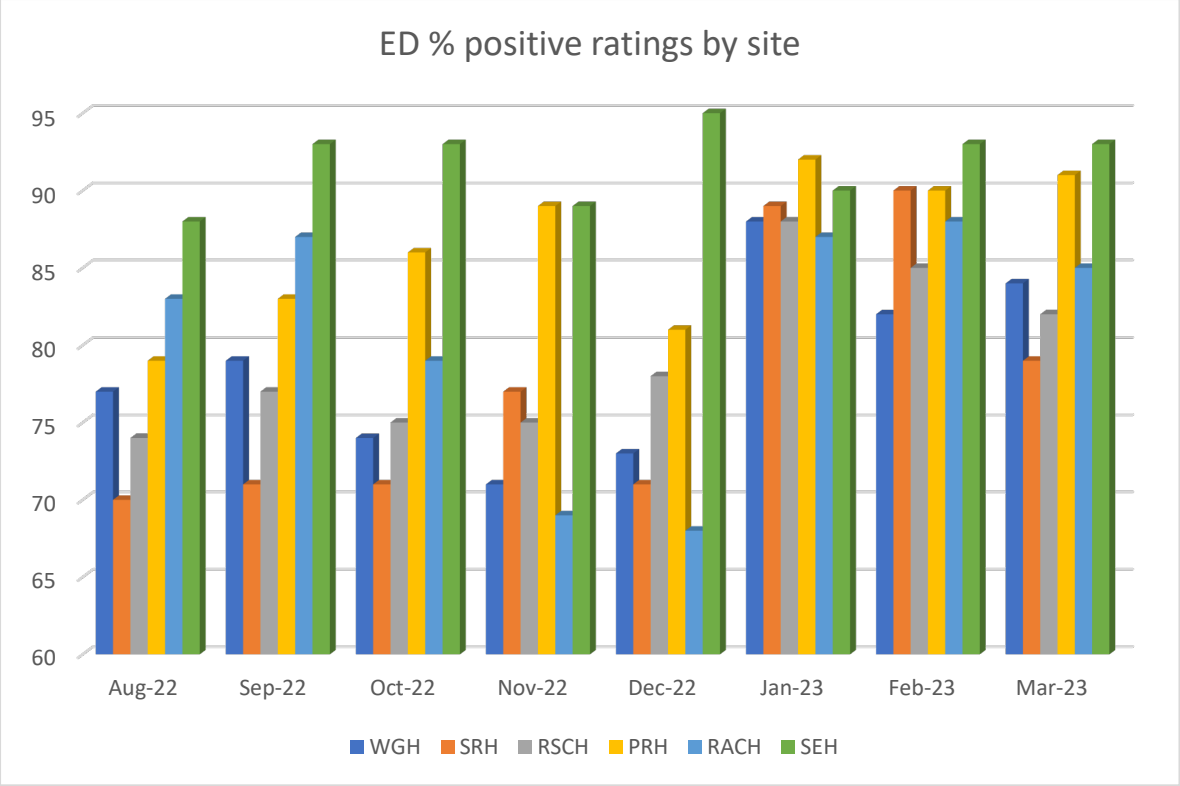
The emergency departments are most prone to fluctuation and are heavily weighted in overall trust figures by which the true north is appraised. Full comparative data for all ED sites using the integrated FFT system is available from August 2022.

The ratings are also variable by site, with most positive patient reported experience at SEH and PRH and lowest at SRH, WGH and Royal Sussex County Hospital (RSCH)

Patient reported positivity with emergency departments closely correlates with performance against key standards including four hour waits.

Favourability increased in January (for UHSx and nationally) which related to public reaction to industrial action by nurses. Whilst this has reduced slightly in February and March 2023 it did not return to the lower levels of positivity in later 2022.

Figure 8: Positive % rating by ED sites for August 2022-March 2023



National average positivity rating for EDs was 75.5% in 2022. There is a delay in production of national data, so 2022 averages are used for the purpose of this report. Overall UHSx average ED positivity ratings for 2022/23 was 80.5% with a 21% response rate. As such the trust was above the national average for 2022.

Figure 9: Number of reviews by rating and month, 2022/23 (partial data April to July)

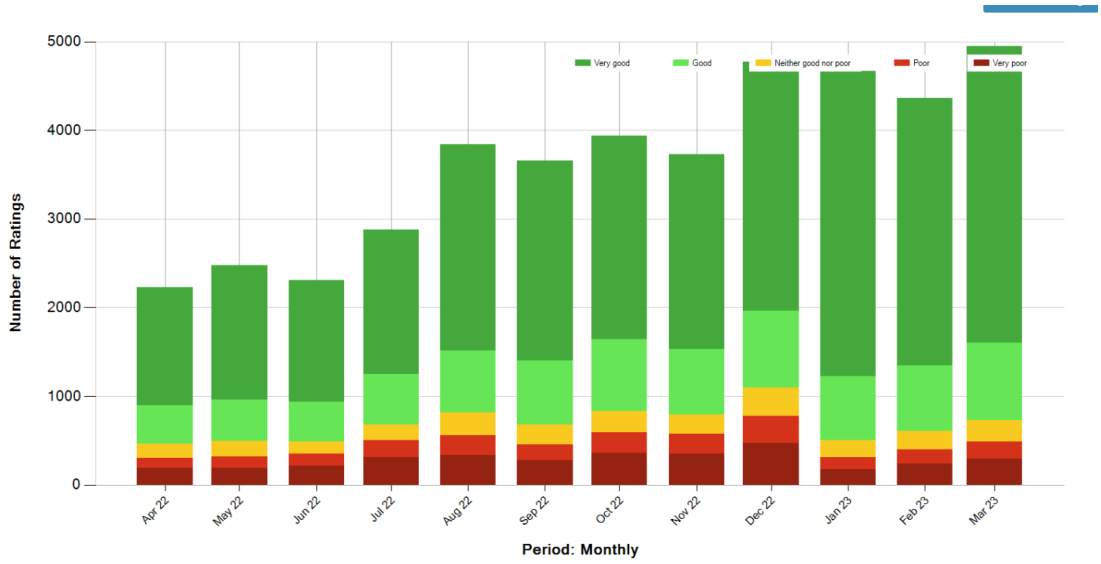
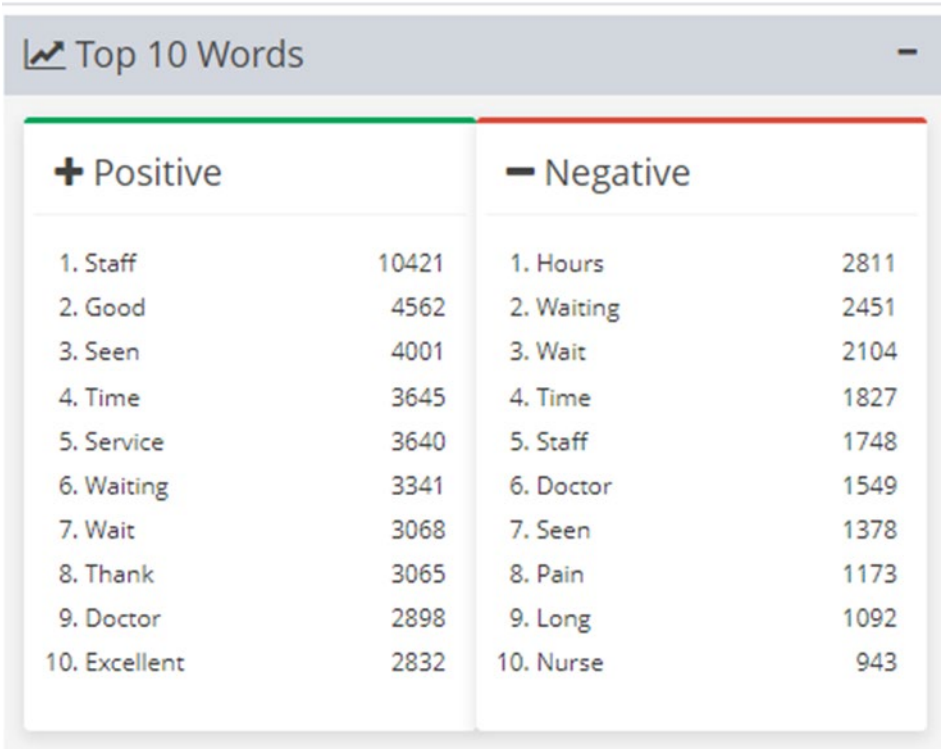


Figure 10: ED department positivity and response ratings by site for 2022/23

Site	Positivity rating	Response rate
PRH	88.5%	27%
RSCH	83%	22%
RACH	80.5%	16%
SEH	92.5%	27%
WGH	81.5%	23%
SRH	80%	22%

As demonstrated by the word prevalence analysis below, the most prevalent reason for providing a positive review was the quality of staffing and care along with efficiency of the service received. The most prevent theme in negative responses by a large margin was waiting time to be seen in the emergency department.

Figure 11: Most prevalent words in positive and negative responses for EDs, 2022/23



3.1.3 Maternity

Overall positive ratings were 94% throughout 2022/23 (national average 90-94% monthly). As such, the trust's performance was in line or better than the national average for maternity services.

Figure 12: Number of maternity responses by rating and month for 2022/23

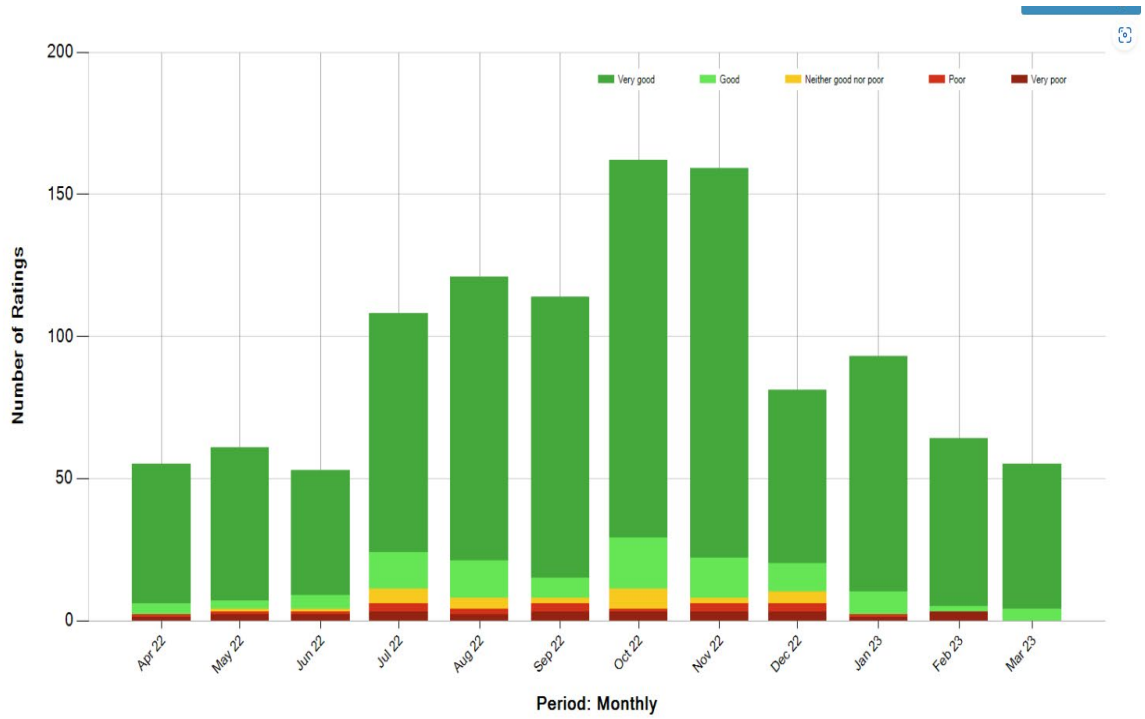


Figure 13: Maternity positivity and response rates by site, 2022/23

Site	Positive responses %	Response rate %
PRH	93	24
RSCH	96	21
SRH	94	27
WGH	90	31

The most prevalent reasons cited for a positive review of maternity services were quality of staffing and quality of care. The most prevalent reasons for a negative review related to concerns about the care provided and perceptions about staffing levels.

Figure 14: Most prevalent words by positive and negative reviews, 2022/23

Examples of patient feedback were as follows:

- *The staff were fantastic, polite, genuine and hugely informative. I felt well Informed at every stage of my birthing experience of who was going to be involved and what was going to happen. We were always told and introduced to staff who were taken over shifts. And anything we werent sure about was quickly supported. Thankyou for a perfect birth experience*. RSCH Apr 22
- *Overall, up to and including the C-section, the service was good and the staff great. It was the service thereafter which was a huge letdown. I was taken into recovery at around 17:00 and told I would be moved to a ward at 19:00.....this did did not happen until 23:50! I asked for the overall measurement of my newborn whilst being wheeled to recovery, which I was told that they would do this for me....this did not happen at all, despite asking on 2-3 occasions. I asked at around 20:30, after no updates were given as to when I'd be moved to a ward.* RSCH May 22

- *The midwives and care team have all been amazing both with myself and my new baby boy. However, on our delivery and discharge days the Ward was severely understaffed which led to me having to wait a long time in pain before being able to go to the labour Ward, me not receiving my meds in recovery and us having to be readmitted. All the staff on shift however were doing their best with limited resources.* PRH July 22

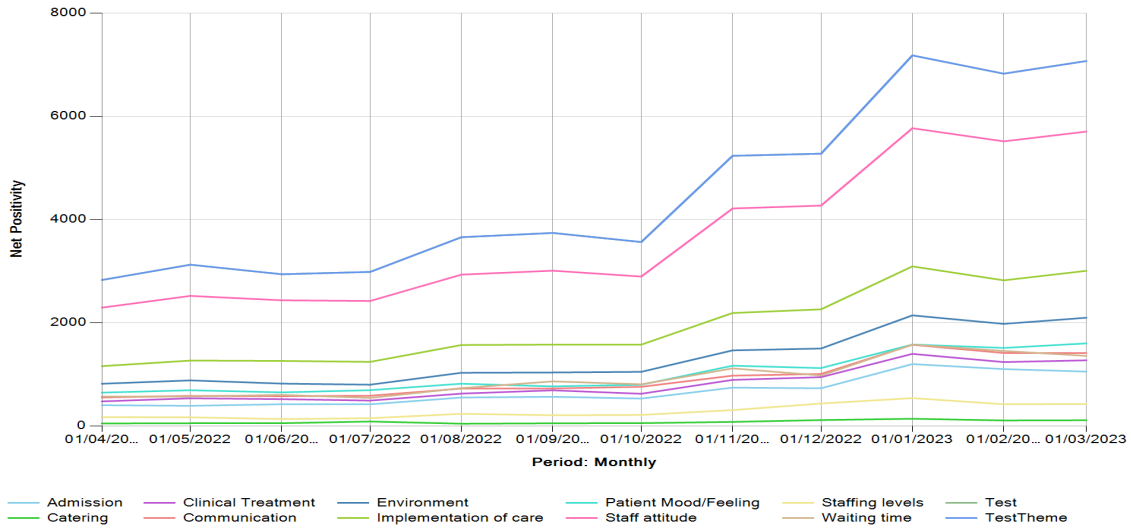
- *For the women who have babies in neonatal care, in my opinion I believe if they are staying in on a shared ward they should be put together in the same room. It broke my heart to have to share a room with women whos babies was sleeping beside them and it being a constant reminder that yours was in special care. One night there was four newborns in the room, every time they cried, I held on a little tighter to my knitted square from my sons incubator. It was really hard.* Worthing, October 22

- *All staff were amazing and friendly, completely put my mind at rest. I had to have an emergency caesarean and all the theatre team were amazing. Can't fault anyone that I had the pleasure of being treated by. 10/10 service from start to finish.* SRH August 22

3.1.4 Themes and insights

Across all trust responses the dominant reason for providing a positive response was the quality of the staff and care, with the dominant reason for a negative response relating to waiting times, followed by staff attitude, communication and clinical care.

Figure 15: Net positivity in FFT feedback by theme, 2022/23



Feedback from patients – examples:

- *'The service from the nurses and Drs was fantastic, friendly, thorough and not rushed. The waiting room was extremely busy and hot with not much space to sit or stand and seemed understaffed. It was quite distressing being in such close contact with so many poorly children with no space to move away and keep our distance.'* SRH ED Dec 22
- *'All the nurses and doctors were doing their best however they were clearly understaffed and needed more help in order to see people quicker and put them in suitable rooms Plus there werent enough rooms for everyone I had to be very sick in the waiting room - not anyones fault just the place needs more rooms but this isnt due to anyone in the hospital | But I am aware they were trying their very best'.* RSCH Apr 22

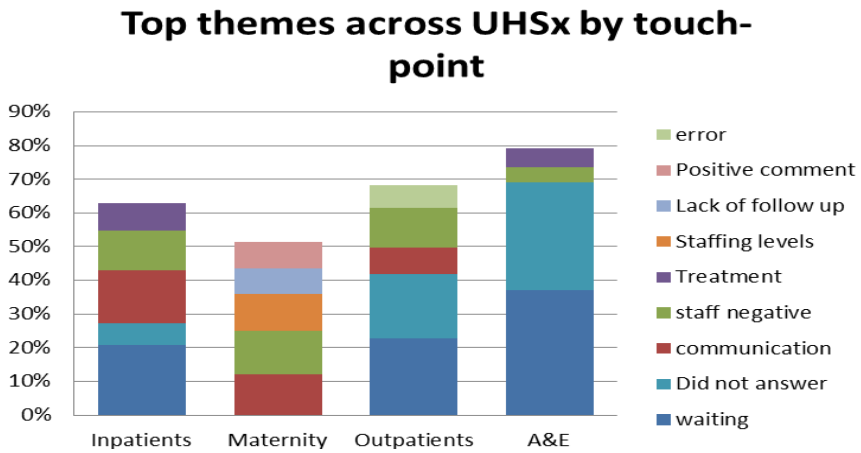
These thematic insights informed the patient breakthrough objective for 2022/23.

3.2 Breakthrough objective

The breakthrough objective seeks to take an 'inch wide mile deep' focus on a key contributor to the true north which if improved would be most effective in shifting the dial towards achievement of the true north ambition. To aid understanding of the contributors to lower satisfaction, more detailed analysis of patient experience data was undertaken to inform the breakthrough objective using previous data as a benchmark as part of the 'measure' phase.

Those themes include waiting (on site for FFT and for appointments/ surgery in complaints and concerns) with waiting time, and information regarding waiting times, most prevalent in concerns; communication; staff attitudes and behaviour; clinical treatment; and delays in results

Figure 16: Themes from FFT feedback by touchpoint



For patient, the key contributor to a negative experience as reported through FFT is waiting time in the emergency departments. However, as this is also the true north ambition for the Strategy and Partnership domain, the second most prevalent contributor was the focus for the patient breakthrough objective. This was negative reviews including staff attitude.

A full analysis of data from September to December 2022 was undertaken to inform this, including by touchpoint, response rates and themes. As demonstrated by figure 17, the largest number of reviews of any touchpoint is the emergency departments which also generate the largest number of negative reviews.

Figure 17: Positive and negative reviews by touchpoint in the breakthrough analysis

	Positive	Negative	Total*	Percent Positive	Percent Negative
Maternity - FFT	409	20	429	95.34%	4.66%
Emergency Department - FFT	8,253	1,682	9,935	83.07%	16.93%
Inpatients - FFT	7,225	394	7,619	94.83%	5.17%
Outpatients - FFT	4,924	145	5,069	97.14%	2.86%

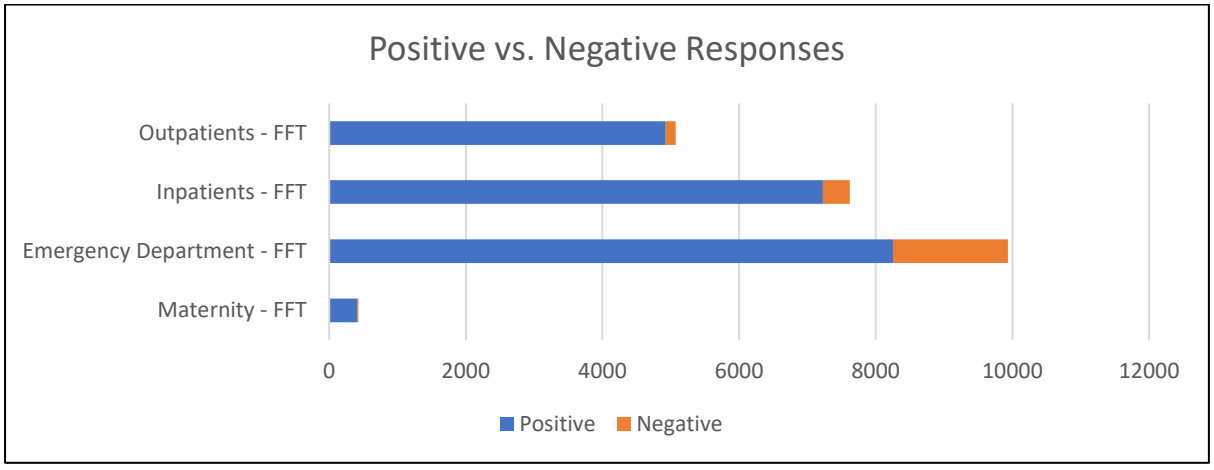
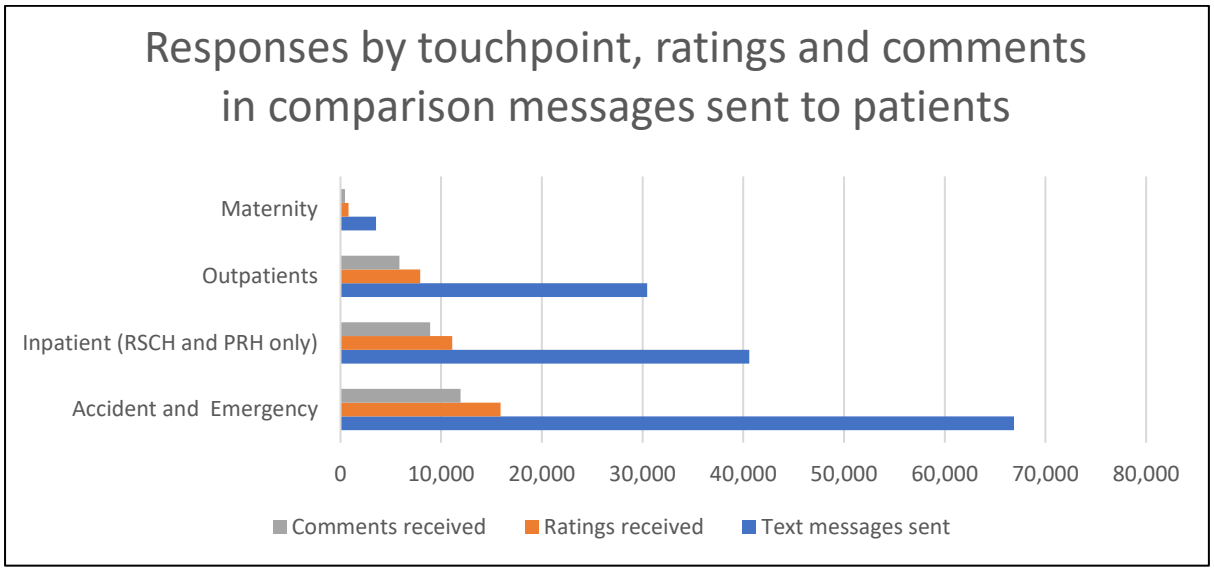


Figure 18 demonstrates that the largest number of surveys are sent to the emergency departments of all the touchpoints, followed by inpatients. As such, the emergency departments provide the greatest opportunity to influence the true north metric.

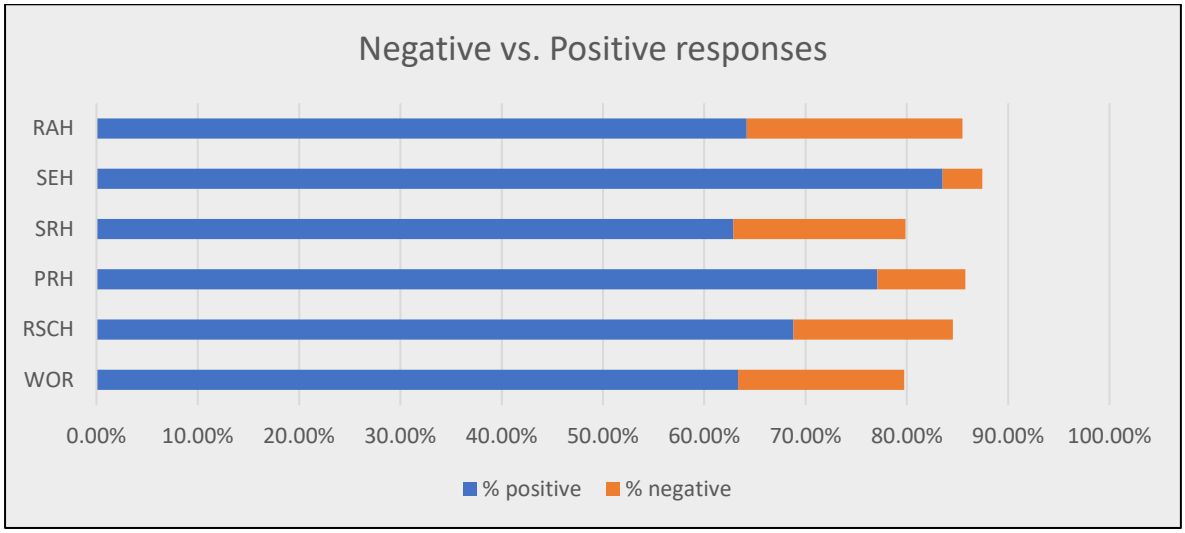
Figure 18: Response rates by touchpoint in the breakthrough analysis



Within the touchpoints there is variability by site. The Royal Alexandra Children's Hospitals (RAH) had the largest proportion of negative responses in the period analysed however this was an outlier period due to increased demand caused by the strep A outbreak. Worthing, SRH and RSCH had the highest proportion of negative reviews otherwise.

Figure 19: Negative vs positive responses by site for breakthrough analysis

Site	0 - No rating	1 - Very Good	2 - Good	3 - Neither good nor poor	4 - Poor	5 - Very Poor	6 - Don't know	Total
WOR	379	1441	433	183	192	293	38	2959
RSCH	242	1547	480	174	181	282	40	2946
PRH	183	1293	410	113	100	92	18	2209
SRH	236	907	325	128	117	216	31	1960
SEH	101	776	141	34	23	20	3	1098
RAH	29	365	135	66	67	99	18	779

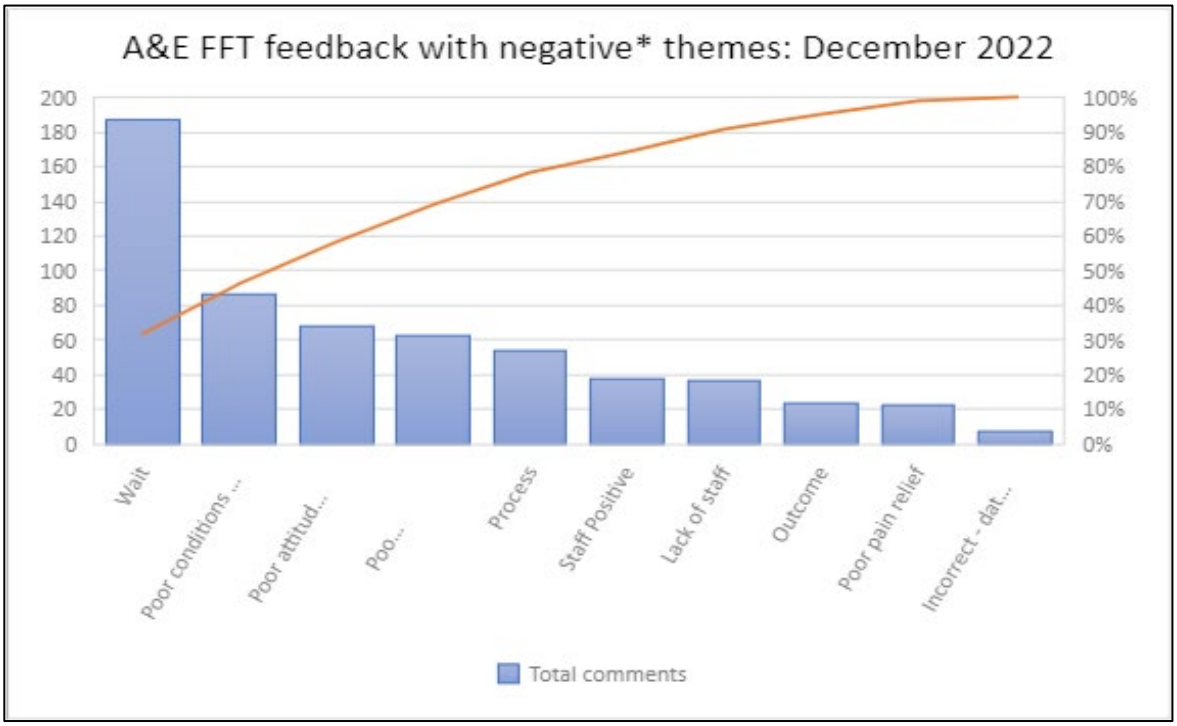


The data was also subjected to a manual thematic analysis

Figure 20: A&E manual thematic analysis for breakthrough objective

A&E FFT feedback with negative* themes: December 2022

Response Theme	Theme 1	Theme 2	Theme 3	Total comments	%
Wait	177	9	1	187	31.9%
Poor conditions / space	48	33	5	86	14.7%
Poor attitude/rudeness	59	8	1	68	11.6%
Poor communication/explanation	45	16	2	63	10.8%
Process	48	5	1	54	9.2%
Staff Positive	14	23	1	38	6.5%
Lack of staff	26	10	1	37	6.3%
Outcome	20	3	1	24	4.1%
Poor pain relief	15	6	1	22	3.8%
Incorrect - data validation	7	0	0	7	1.2%
				586	100.0%



The analysis concluded that A&E negative ratings contribute 75.5% of all negative ratings (4th Sept – 31st Dec 2022). Staff attitude cited in negative A&E comments as a % of total FFT ratings was only 0.5%. Therefore, it is highly unlikely that we will turn the dial on True North by working on staff attitude, even in A&E – the top contributing touchpoint to negative

ratings. As such, the decision was taken to cease the patient breakthrough objective recognising that the key contributor is addressed elsewhere in the trust strategy.

However, the ambition of the breakthrough – to contribute to an excellent experience of care – has continued in line with the ambitions of the patient experience strategy, through the Welcome Standards programme.

3.3 Welcome Standards

Excellent care every time with the patient first is the mission of University Hospitals Sussex, and for the 'patient' domain of the trust strategy, this is measured by feedback from the friends and family test (FFT) system.

Our patient feedback shows how significant the way we welcome and engage with patients is to their experience. As such, ensuring this is of the highest quality is at the heart of the Patient Experience Strategy. Reception colleagues play a vital role in this, too, as indicated in the following quote from a patient (via our Family & Family Test):

> *"Pleasant and helpful reception staff. Surgeon was conversant with my past medical history. Conscious of my situation and generally helpful and polite. Hospital transport drivers were also very competent and helpful. Altogether a very satisfactory appointment"*

The implementation of the Welcome Standards is a new and creative approach to improve patient experience, going beyond business-as-usual care and service by connecting differently with our patients and their representatives with an emphasis on the process of greeting patients and visitors, in line with trust values. It includes a validated standard or 'kitemark' for services, with the aim of socialisation as part of the onboarding process for employees and volunteers at the Trust, spanning pre-application and induction. There are opportunities to further embed the standards such as through supervision, appraisal, and personal and team development events.

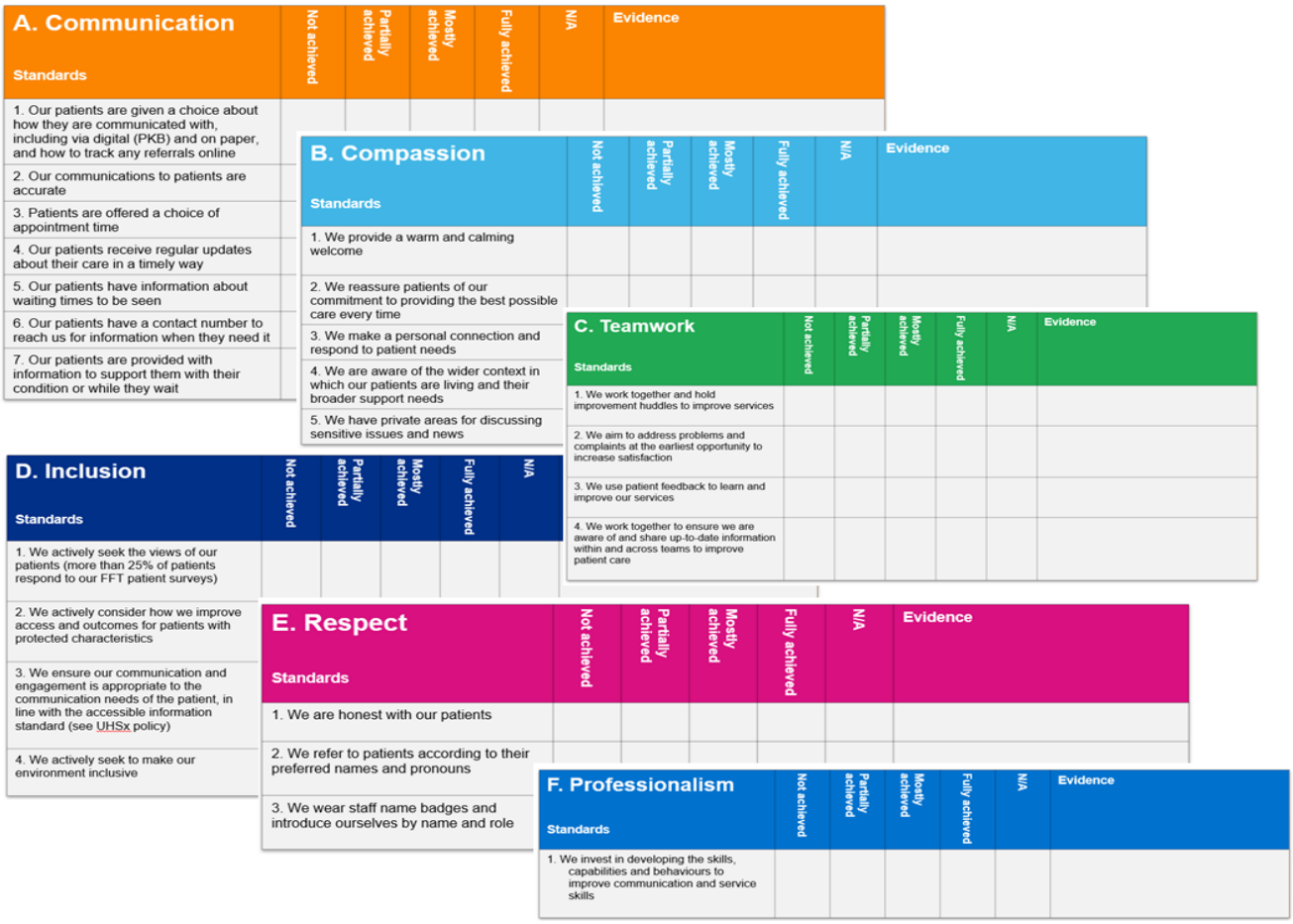
At the heart of the Welcome Standards is the patient voice and tackling the priorities for improving patient experience, as defined by the Trust's patients and their representatives.

The standards were informed by tens of thousands of reviews from patients, patient charter standards from Healthwatch and best practice from the private sector customer service excellence standards, as well as colleagues from Comms and Patient Experience. The

Standards are applied using the head – theory of customer excellence; the heart – staff commitment and values; and hands – theory in practice.

The standards are set out against each of our six values with descriptors for the standards within each value.

Figure 21: Welcome Standards Framework



There are three components to the Welcome Standards:

i. Training – this has been developed and a pilot was delivered in March for colleagues (including volunteers) undertaking reception and greeting roles in preparation for the opening of the new Louisa Martindale Building
ii. Self-evaluation against the standards
iii. Validation

Teams undergo training to understand the standards and then self-evaluate their service against the criteria. For any standards not met staff would review the guidance and take

further actions. When the standards are met the service will undergo a validation process and receive a kitemark to display.

By the end of 2022/23 a team had been recruited and inducted to deliver the Welcome Standards programme, the training was co-designed, and it was piloted with the reception teams and volunteers in the Louisa Martindale Building. The training was well evaluated and informs the roll out of the programme into 2023/24.

4. Complaints and Concerns

4.1 Complaints process and standards

For those wishing to make a complaint about their care, NHS Model Complaints Handling Policy 2021, co-authored by the PHSO, does not define a timescale within which complaints should be completed. Rather it describes a set of quality standards with which to comply:

'We believe at the heart of an effective complaint handling system are four core pillars, which these Standards are based on:

- welcoming complaints in a positive way and recognising them as valuable insight for organisations
- supporting a thorough and fair approach that accurately reflects the experiences of everyone involved
- encouraging fair and accountable responses that provide open and honest answers as soon as possible
- promoting a learning culture by supporting organisations to see complaints as opportunities to improve services.

The Complaint Standards align with all the legal requirements arising from the NHS Complaint Regulations and other subsequent regulations that relate to complaint handling.'

The NHSE complaints policy requires that complaints are acknowledged within 3 days. The policy does not set a timescale for a response rather it describes the processes and quality approaches that will be taken. However, it sets out that if NHS England has not provided a response within six months, they will write to the complainant to explain the reasons for the delay and outline when they can expect to receive the response. At the same time they will notify the complainant of their right to approach the PHSO without waiting for local resolution to be completed.

The trust complies with these standards by:

- Welcoming complaints in a positive way
- Acknowledging complaints within three working days
- Being thorough and fair
- Giving fair and accountable responses

Throughout 2022/23 the creation of an integrated trust-wide complaints team has enabled an increased focus on the quality of complaints responses in line with the national standard. New standard work for complaints, working with clinical teams has been embedded and a new policy on responding to concerns and complaints was approved this year.

The trust also has its own target for complaints – to provide a formal response within 25 working days in 65% or more of cases. However, in line with national policy and standards which require a focus on high quality responses, the Trust approach in 2022/23 has been on ensuring that the quality standards are met. These require clear and open responses to complaints, with the requirement to acknowledge complaints within 3 working days and to respond within six months, or to agree a longer timeframe with the family, to ensure the opportunities to learn from complaints are optimised. 28% of cases were provided with a formal response in 25 days but 99% of complaints were acknowledged within three working days. The Trust will seek to align its complaints reporting with national policy standards in the next year.

The number of complaints and concerns received by the trust increased throughout 2022/23, from an average of under 900 a month in quarter 1 and 2 to just under 1400 in quarter 4. Recognising that there is a national precedent for an increased emphasis on the quality of complaints responses, the local target will be considered in 2023/24.

4.2 Complaints and concerns data and themes

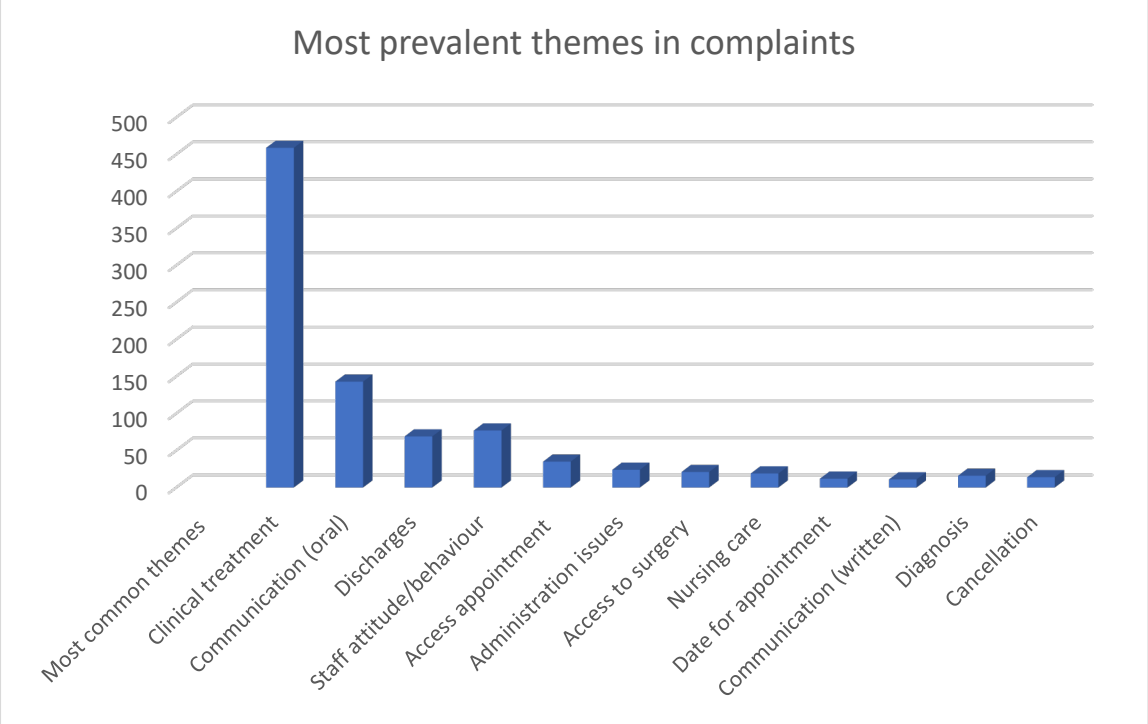
Throughout 2022/23, the Trust received 1,100 new complaints and 247 complaints were reopened. The division which received the largest number of complaints was medicine WGH and SRH.

Figure 22: Number of new and re-opened complaints by divison

	Grand Total	Total new	Total reopened	2022 reopen	2023 reopen
Surgery RSCH PRH	**258**	199	59	35	24
Medicine WGH SRH	**253**	219	34	23	11
Women & Children	**227**	191	36	20	16
Medicine RSCH PRH	**217**	181	36	26	10
Specialist	**131**	96	35	16	19
Surgery WGH SRH	**131**	112	19	13	6
Cancer	**48**	37	11	8	3
CSS	**45**	37	8	6	2
Other	**17**	15	2	1	1
Corporate	**13**	6	7	4	3
Facilities & Estates	**7**	7	0		
Grand Total	***1347***	***1100***	***247***	***152***	***95***

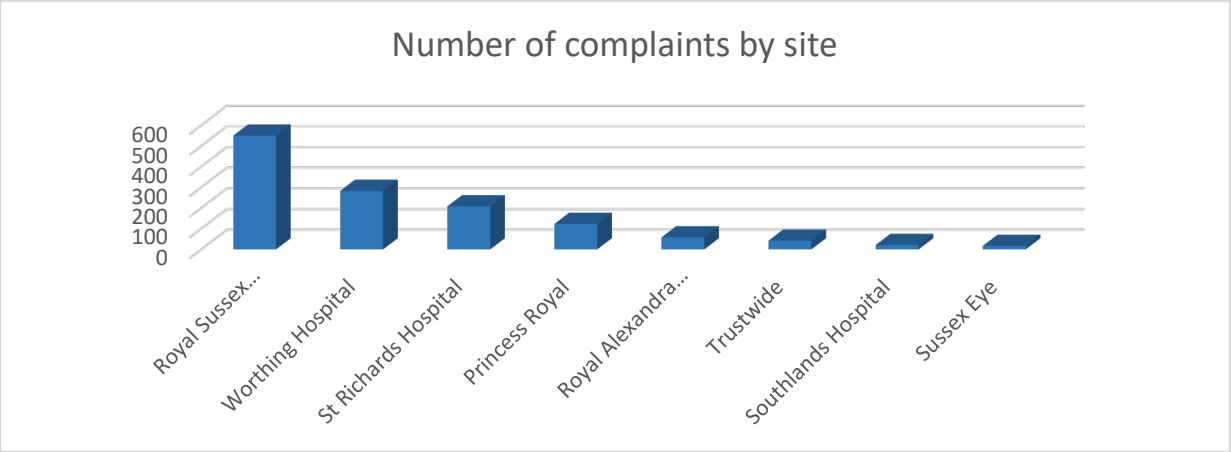
The most prevalent theme in complaints was clinical treatment followed by communication, discharge and staff attitudes and behaviour.

Figure 23: Themes in complaints



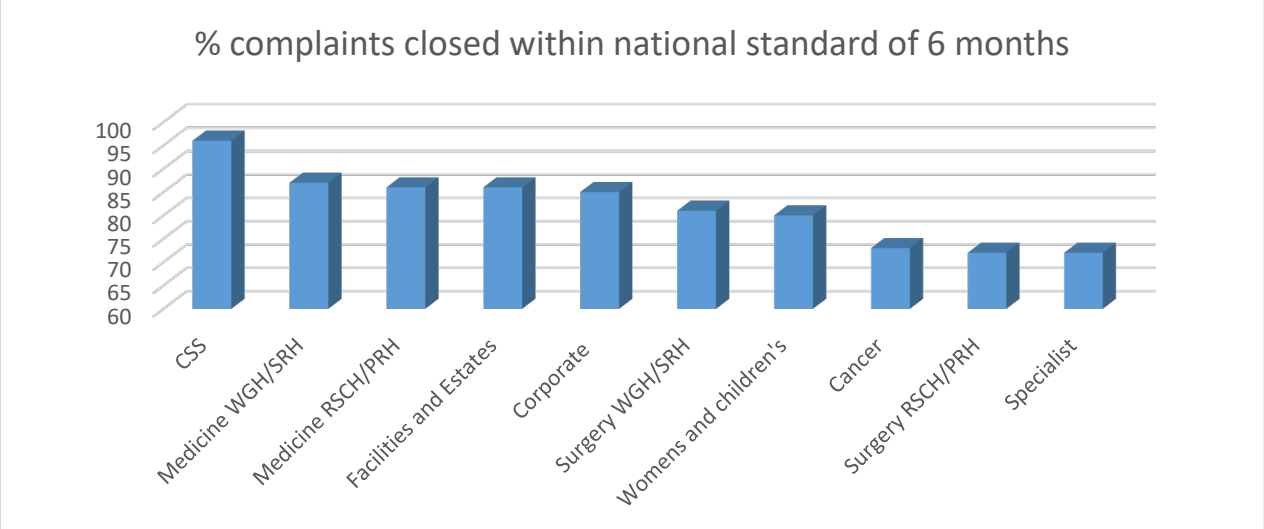
All clinical divisions have quality and safety meetings in which insights from complaints and opportunities for improvement are identified and overseen. The number of complaints varies by site but is largely consistent with a proportionate number of complaints in relation to volume of patients.

Figure 23: Number of complaints by site



The most prevalent reasons for a longer response time to complaints are delays in clinical responses, complaints team caseloads. Delays in clinical responses to complaints vary by division. Despite receiving the highest number of complaints, the medicine WGH/SRH division has the most timely responses.

Figure 24: % complaints closed within national timescale by division



5. National patient surveys

5.1 Maternity Survey 2022

The maternity patient survey runs every year and all eligible organisations in England are required to conduct the survey.

The 2022 maternity survey involved 121 NHS trusts in England. All NHS trusts providing maternity services that had at least 300 live births were eligible to take part in the survey. Women aged 16 years or over who had a live birth between 1st and 28th February 2022 (and January if a trust did not have a minimum of 300 eligible births in February) were invited to take part in the survey. Fieldwork took place between April and August 2022

The response rate for University Hospitals Sussex NHS Foundation Trust was 49.7% with the following demographic profile:

Figure 25: Demographic profile of respondents

Characteristic	Percent
Total respondents	327
Response rate	49.7
Parity	
Primiparous	48.0
Multiparous	52.0
Age	
16-18	0.0
19-24	3.7
25-29	18.3
30-34	35.9
35+	42.1
Ethnicity	
White	92.3
Multiple ethnic groups	1.2
Asian or Asian British	3.1
Black or Black British	1.2
Arab or other ethnic group	0.3
Not known	1.9

The trust's results were much better than most trusts for 1 question, were better than most trusts for 3 questions and somewhat better than most trusts for 4 questions. The trust's results were not worse than for most trusts for any questions.

Figure 26: questions in which UHSx performed better than most

Question	Respondents	2022 Score	2022 Band	2021 Score	Change from 2021
B3. Were you offered a choice about where to have your baby?	272	4.5	Better	4.1	

Question	Respondents	2022 Score	2022 Band	2021 Score	Change from 2021
C14. Did the staff treating and examining you introduce themselves?	317	9.4	Somewhat better	9.3	
C16. Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you?	322	8.0		8.5	
C17. If you raised a concern during labour and birth, did you feel that it was taken seriously?	199	8.7	Much better	7.9	
C18. During labour and birth, were you able to get a member of staff to help you when you needed it?	312	9.0	Somewhat better	9.1	
C19. Thinking about your care during labour and birth, were you spoken to in a way you could understand?	322	9.5	Somewhat better	9.4	
C20. Thinking about your care during labour and birth, were you involved in decisions about your care?	314	9.0	Better	8.9	
C21. Thinking about your care during labour and birth, were you treated with respect and dignity?	323	9.5	Better	9.5	

Question	Respondents	2022 Score	2022 Band	2021 Score	Change from 2021
F12. Were you given information about any changes you might experience to your mental health after having your baby?	300	7.3		7.7	
F13. Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?	273	8.7	Somewhat better	8.1	

In the following questions, results were less positive than in 2021:

- During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?
- During your antenatal check-ups, did your midwives listen to you?
- During your pregnancy, if you contacted a midwifery team, were you given the help you needed?
- Were you involved in the decision to be induced?
- If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?
- Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you?
- After your baby was born, did you have the opportunity to ask questions about your labour and the birth?
- On the day you left hospital, was your discharge delayed for any reason?
- Thinking about your stay in hospital, how clean was the hospital room or ward you were in?
- Were your decisions about how you wanted to feed your baby respected by midwives?
- Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby?
- Did you have confidence and trust in the midwife or midwifery team you saw or spoke to after going home?
- Did a midwife or health visitor ask you about your mental health?
- If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this?

The maternity services team continue to respond to patient feedback as part of their programme of improvement work. This includes:

i. Listening events - these events cover student midwives, bands 2-6 and the labour ward co-ordinators have had their own listening event with band 7s
ii. Hosted a homebirth event following the suspension of homebirths
iii. Monthly safety event chaired by a non-executive director. Topics that are frequently discussed are staffing, safety, culture and staff general well-being. The events are very well attended by all staff including obstetricians and anaesthetic staff.

iv. Since December the service have been recruiting international midwives and so far have recruited 11 midwives predominantly from Africa with further interviews lined up.

v. RGN's have been recruited to on the East and preceptorship roles to support our newly qualified midwives. The service has an "Always open" advert for midwives which continues to attract staff with the Golden Hello and refer a friend, and a recruitment event for newly qualified midwives is being planned.

vi. Co-production work continues with the Maternity Voices Partnership and plans moving forward are for a cross site discharge video and process. The results of the survey will be shared with the MVP to identify further actions from the patient feedback

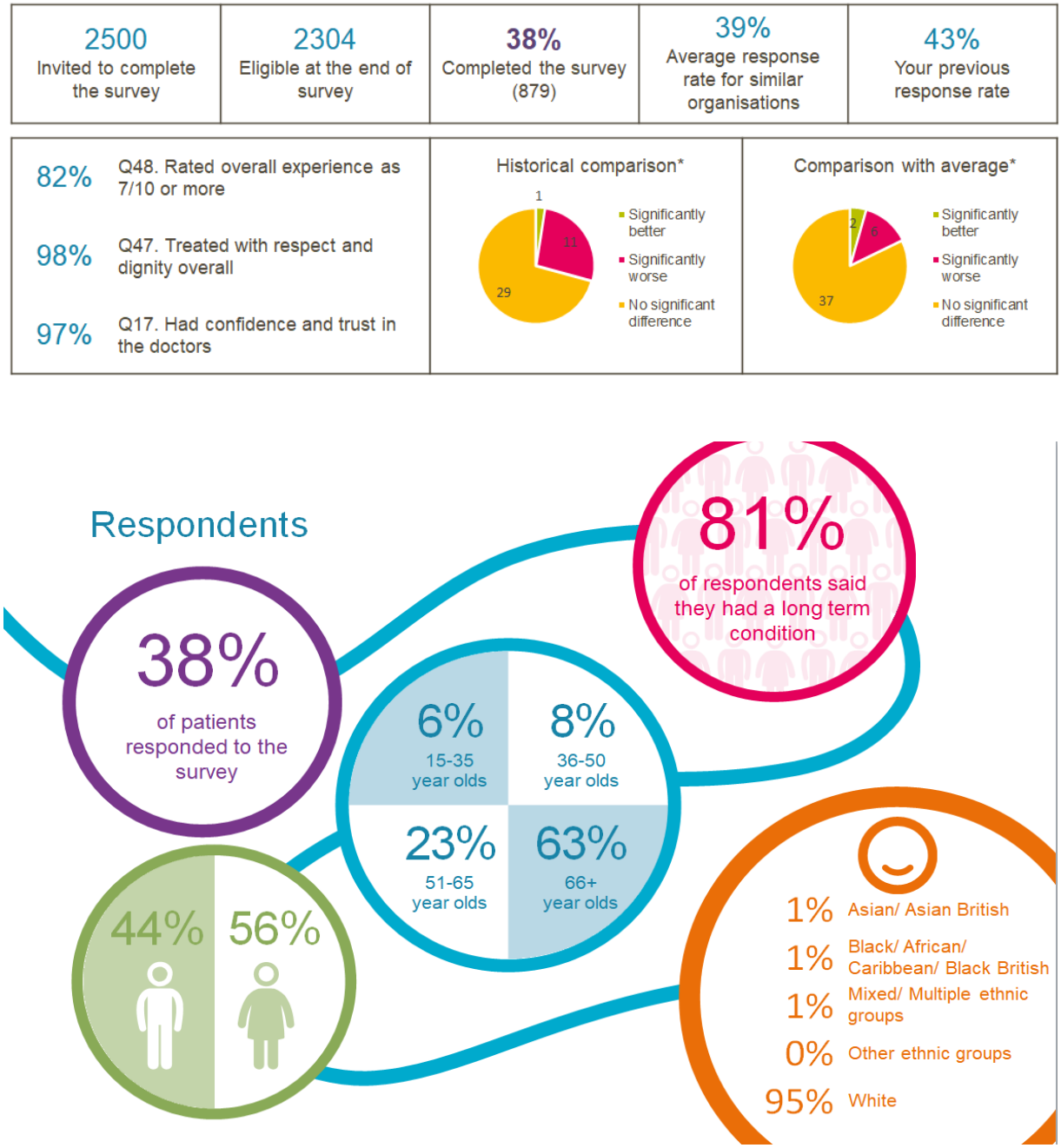
vii. Joint work with Healthwatch Brighton and Hove on a maternal mental health pilot project funded by Healthwatch England

5.2 Adult inpatient survey 2021

The Adult Inpatient Survey runs every year and all eligible organisations in England are required to conduct the survey. The adult inpatient survey 2021 used eligible patients that were discharged from hospital during November 2021 and the results were received in 2022/23. NHS Patient Survey Programme (NPSP) collects feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services. The NPSP is commissioned by the CQC.

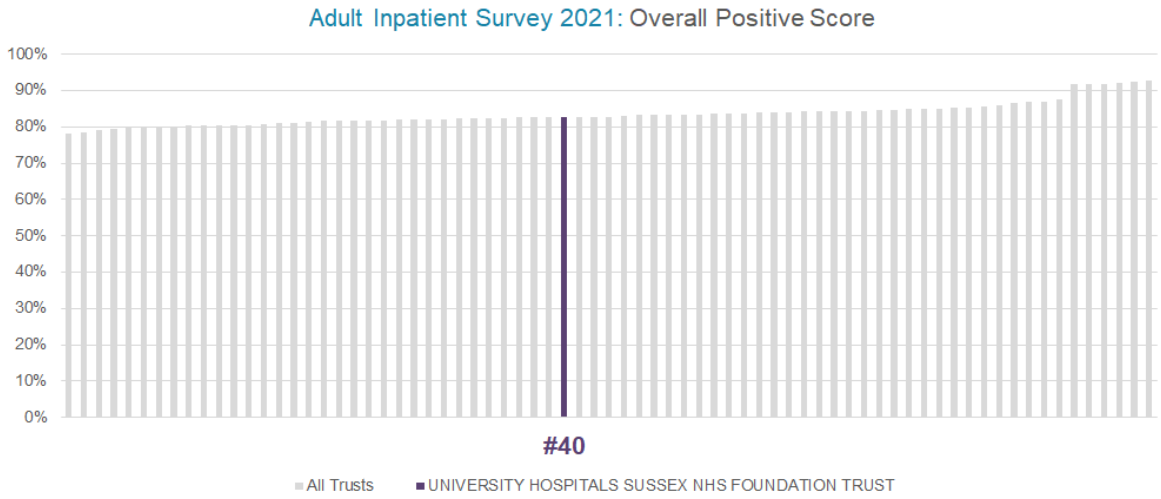
A total of 62 questions were asked in the 2021 survey, of these 45 can be positively scored, with 41 of these which can be historically compared. The results include every question where the organisation received at least 30 responses (the minimum required). This report summarises the findings from the Adult Inpatient Survey 2021 for University Hospitals Sussex, the results of which were released in September 2022. There were 879 respondents (38%) to the survey and the average response rate nationally was 39%. The summary of the findings are shown below:

Figure 27: Survey findings summary



The overall positive score for University Hospitals Sussex is around the national median, with the overall position of the trust compared to the other NHS trusts in England is shown below:

Figure 28: Trust overall positive score



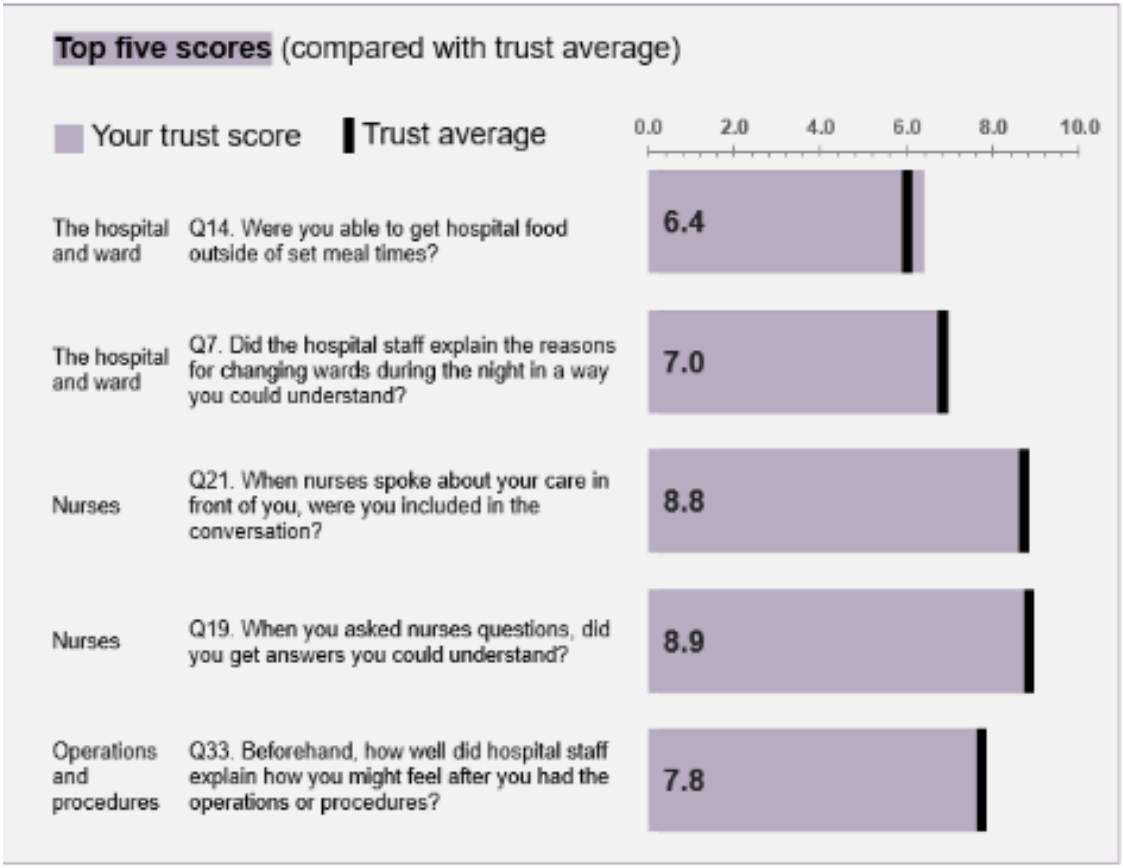
The trust performed well on the following questions:

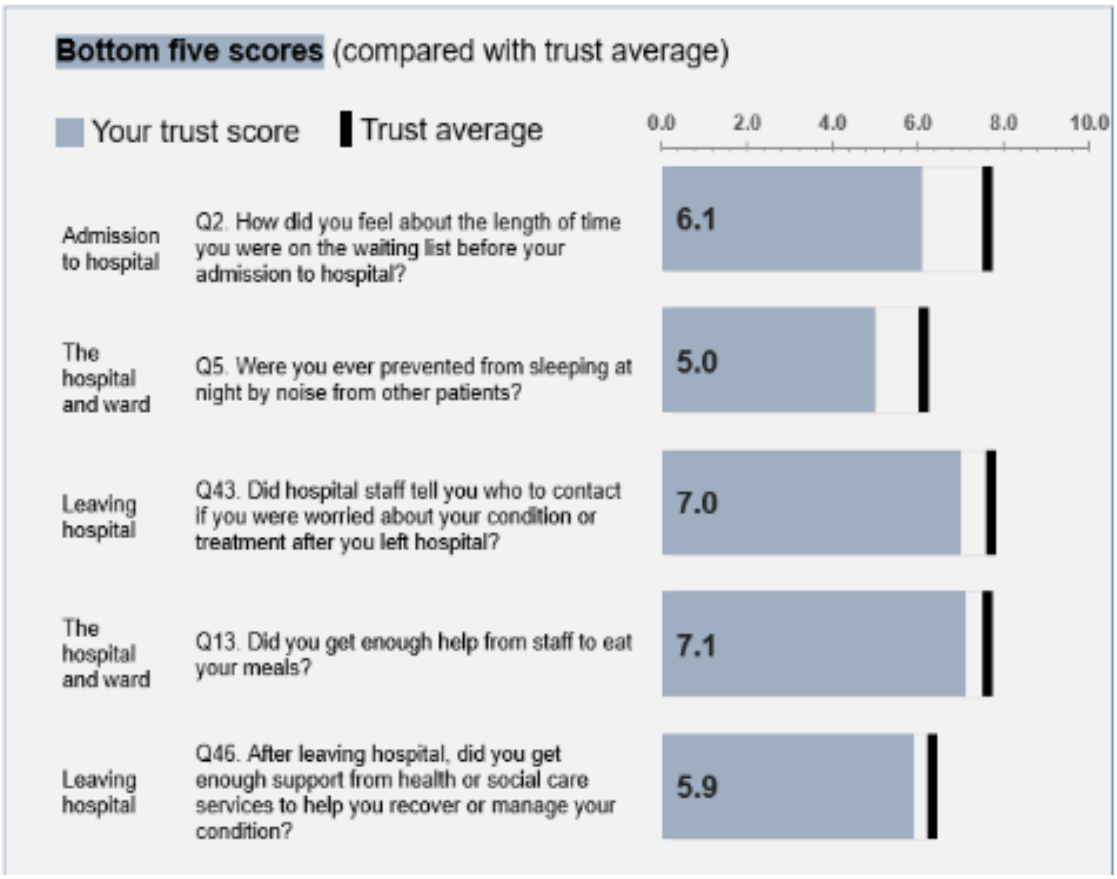
82%	Q48. Rated overall experience as 7/10 or more
98%	Q47. Treated with respect and dignity overall
97%	Q17. Had confidence and trust in the doctors

Q 48 – Overall, how positive was your experience while you were in hospital?
Q47 – Overall, did you feel you were treated with respect and dignity whilst you were in the hospital?
Q17 – Did you have confidence and trust in the doctors treating you?

A further deep dive was completed into the questions which the trust did best and worst against in comparison to other trusts. These questions and scores against other trusts are shown below:

Figure 29: Best and worst scoring questions





On 46 questions the trust has performed about the same as other NHS trusts, however, for one question it scored worse than expected. The trust scored worse than expected in the admission to hospital section. When looking into the questions in this section, the trust scored poorly on:

- *How did you feel about the length of time you were on the waiting list before your admission to hospital?* Scoring 6.1 and the national trust average score was 7.5.

However, the trust scored about the same 6.7 against a national average of 6.8 on the question:

- *How long do you feel you had to wait to get a bed on a ward after you arrived at the hospital?*

The rest of the sections which had questions the trust scored about the same as the trust average nationally.

Where UHS patient experience has been the best is:

- ✓ Food outside set meal times: patients being able to get hospital food outside of set meal times, if needed
- ✓ Changing wards during the night: staff explaining the reason for patients needing to change wards during the night
- ✓ Including patients: patients feeling included in nurses' conversations about their care
- ✓ Answers to questions: nurses answering patients questions in a way they could understand
- ✓ Expectations after the operation or procedure: patients being given an explanation from staff, before their operation or procedure, of how they might feel afterwards

Where UHS patient experience could improve:

- Waiting to be admitted: patients feeling that they waited the right amount of time on the waiting list before being admitted to hospital
- Noise from other patients: patients not being bothered by noise at night from other patients
- Contact: patients being given information about who to contact if they were worried about their condition or treatment after leaving hospital
- Help with eating: patients being given enough help from staff to eat meals, if needed
- Support from health or social care services: patients being given enough support from health or social care services to help them recover or manage their condition after leaving hospital

The lowest scoring site within UHS was most commonly PRH, however, this site did have the fewest responses in comparison to the other sites and some questions it had <30 responses meaning no score was recorded.

Due to the merger, there is no previous data to compare the results with and as such the results of this survey are the benchmark for future reports.

Although the survey was undertaken a year ago, the identified improvement opportunities remain current, with the following actions undertaken in response:

- **Waiting for admission**: the new trust systems and partnerships 'true north' will delivery timely, appropriate access to high quality planned, cancer and acute care as part of the local NHS system. The Trust succeeded in meeting its waiting time target of no patient waiting more than 78 weeks by March 2023 in the significant majority of cases.

- **Discharge, including information on leaving the hospital and support from health and care services**: discharge information for patients has been produced, early discharge discussions are being implemented as part of the access to acute care programme and system working on discharge is supporting improvements to post discharge support – this is a priority for 2023/34

- **Help with eating**: Also raised by local Healthwatch, with actions agreed via the patient experience and engagement group, this has been a priority with a trust-wide food and nutrition policy to be agreed in early 2023/24

- **Noise at night**: this was be escalated for action via the operational management group and is being addressed via hospital site plans to reduce bed transfers.

6. Patient engagement

Patient engagement has remained a priority through 2022/23 with the voice of patients embedded in improvement work. This includes the following examples:

6.1 Patient communication

Healthwatch Brighton and Hove produced a 'communication charter' based on feedback from patients about their experiences of outpatients. The priorities in the communication charter have been embedded in the Trust's Welcome Standards, placing local patient voice front and centre of the approach to greeting patients.

6.2 PLACE

Following the pandemic, PLACE (patient led assessment of the clinical environment) audits have recommenced, with trust governors participating in audits of wards and other clinical areas, providing a patient representative voice in improving facilities and estates on the hospital sites.

6.3 Patient experience and engagement group

This bi-monthly meeting involves partners from West Sussex Healthwatch and Healthwatch Brighton and Hove, providing critical friendship and patient insight to improvement programmes including carer and patient information, dementia, carers and food and nutrition. It also enables insights from Healthwatch engagement to underpin the deployment of the patient experience strategy.

6.4 Maternity Voices Partnership

MVP is a partnership between the Trust and the commission. The Chair's role is to seek out the service user experience of maternity services. Progress in 2022/23 included work on the perinatal equity agenda with a focus on inequality in outcome and experience for people from black, Asian and mixed ethnic backgrounds and those living in the most deprived areas.

6.5 Healthwatch reports

In early 2022 Healthwatch Brighton and Hove published a report about the emergency department at the RSCH. They identified improvement opportunities relating to environmental issues in the department including overcrowding, lack of privacy, long waits, communications and staffing. The report has shaped the ED redevelopment programme which commenced in 2022/23 and continues through 2023/24, with close involvement of Healthwatch in the work. High praise for medical staff and treatment once seen.

6.6 Design of the Louisa Martindale Building

A public engagement exercise was undertaken to identify a name for the new building developed under stage 1 of the 3Ts programme, resulting in the name ‘Louisa Martindale Building’. Patients’ representatives were also involved in scoping and designing the main atrium space in the new building, ensuring it meets the needs of all patients, visitors and staff.

7. Less heard groups and patients

Each quarter the patient committee receive a review of patient feedback on particular protected characteristics or inequalities concern so that specific actions required can be identified.

For example, in January 2023, the committee received a report focused on patients with autism (ASD- autism spectrum disorder) and disabilities using insights from patient feedback. Positive feedback related to the care from the staff, their skill and sensitivity.

Figure 30: Positive feedback from patients with autism

Negative feedback focused on the challenge of waiting for patients with ASD or the parents of children with ASD, including the nature of the waiting environment in A&Es and its impact on people with ASD

Figure 31: Negative feedback from patients with autism

Actions taken include:

- Inclusion criteria within the new ‘welcome standards’
- A focus on inequalities in the ‘voice of the customer’ elements of the patient first improvement training
- Enabling access to patient feedback for all trust services so that inequalities issues raised by patients can receive a local response and improvements implemented
- Close working with Healthwatch to identify emergent concerns in communities
- Specific inequalities considerations built into the engagement method for service pathway redesign
- New accessible information policy
- Accessible patient information leaflets on trust website
- System working on engagement to ensure the voice of less heard groups is sought and has influence

Further trust-wide developments on addressing inequalities in health outcomes and access is a priority for 2023/24.

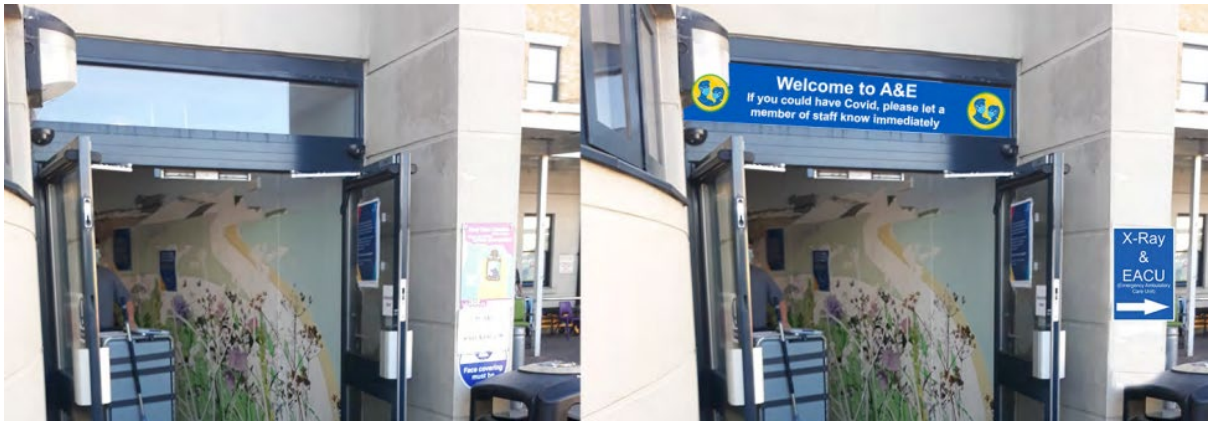
8. Learning and action from patient feedback: You said, we did

Learning and improvement from concerns and complaints occurs at trust-wide, divisional and service or ward level, with the patient first improvement system (PFIS) methods supporting the voice of the customer in influencing improvement. Examples of improvements and changes made as a result of patient feedback included throughout the report and some further examples are included below.

8.1 You said, we did: reducing waiting in emergency departments

Waiting for treatment was consistently identified as the most prevalent reason cited by patients for a negative experience. The trust's strategy relaunched in 2022 placing timely access to care at the forefront of its ambitions, including through the true north and breakthrough ambitions for strategy and partnerships. Reducing waiting through increased adherence to the four-hour standard in accident and emergency departments resulted in improved reported patient experience on all sites in the final quarter of 2022/23. Signage was also improved in the departments, using easy read and icons to ensure accessibility.

Figure 32: Before and after signage example in the emergency department



8.2 You said, we did: children's services

Staff in the Royal Alexandra Childrens hospital have continued to engage their patients using a variety of methods, including 'bed boards', surveys and engagement activities such as transition Groups for young people with diabetes going into year 7 (secondary school) and into adult services, forest school activities and education sessions.

Improvements have included Clinic letters written to the child and young person not to the GP and parents and delivery of wellbeing days for patients and families.

Figure 33: Bed boards

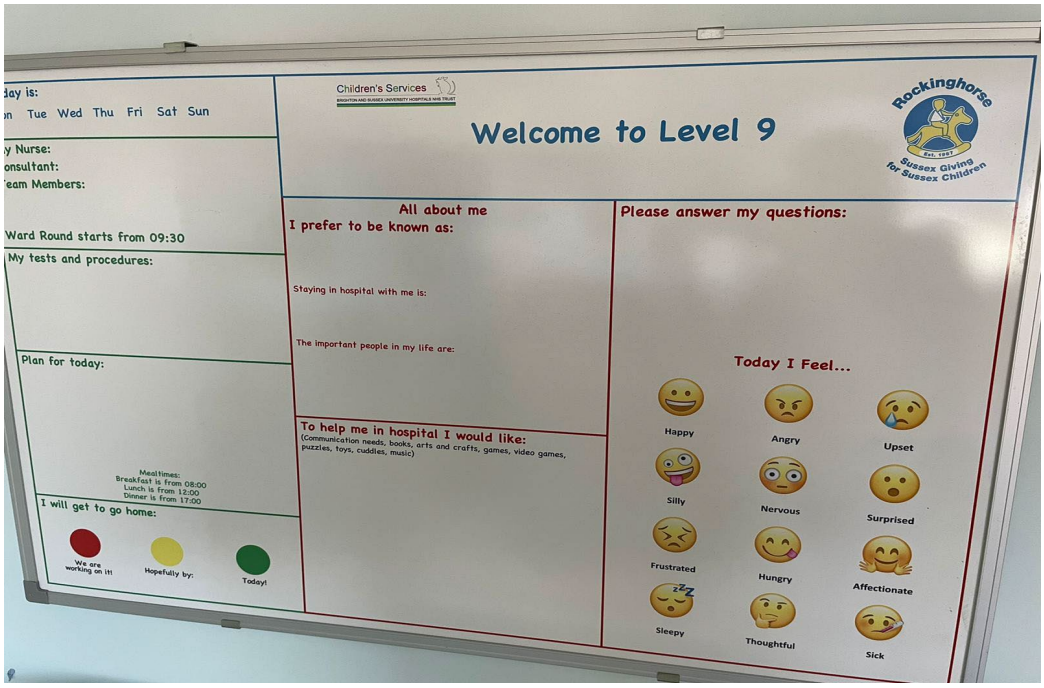


Figure 34: Children's experience survey

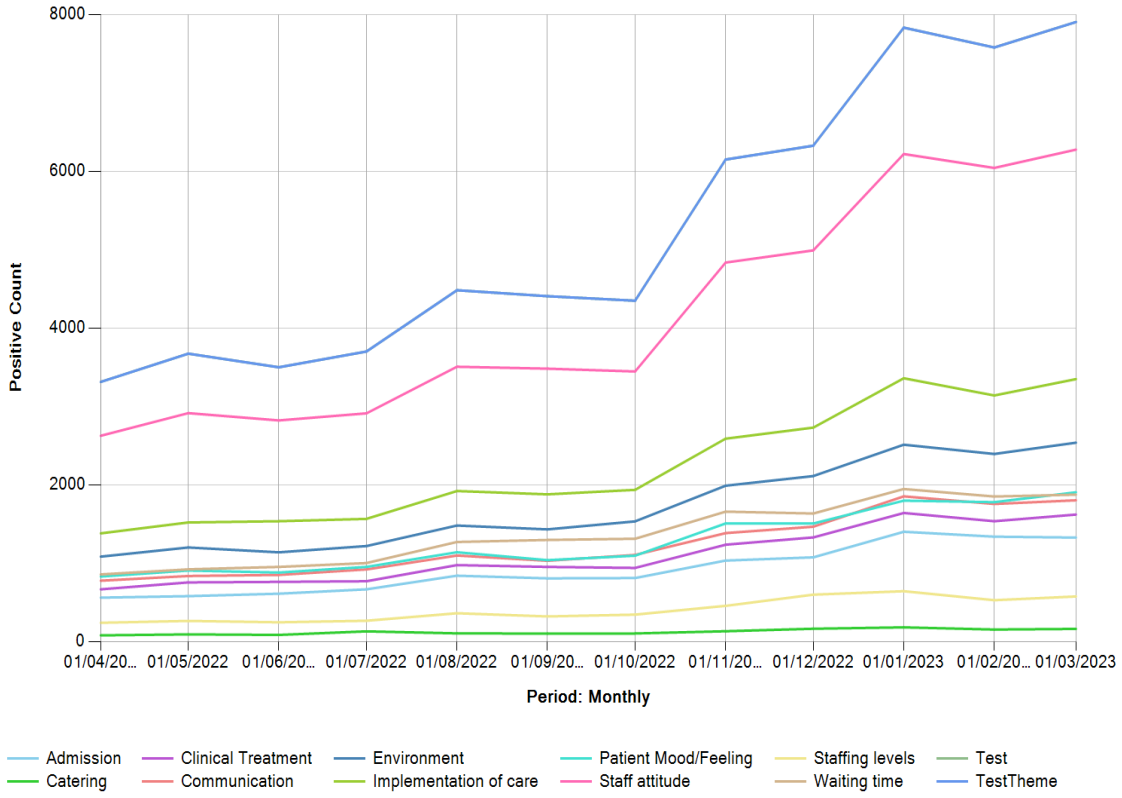
8.3 You said, we did: supporting dementia patients

Communication with dementia patients and their families was raised in several complaints in 2021/22 with action taken in 2022/23 in response. The dementia team have delivered specialist communication training (CAIT) to 158 staff across all bands, divisions and NHS staff groups. As a result, several wards have been benchmarked for key performance measures to include reductions in violence and aggression and security incidents. A carers' passport has also been developed to support families of dementia patients, and other family friend carers.

9. Compliments and plaudits

The trust receives approximately seven times as many positive reviews as negative, reflecting the positive experience of the care they receive from University Hospitals Sussex. Most of these are received through routine patient surveys distributed via the friends and family test. This shows the number of positive reviews increased throughout the year.

Figure 35: number of positive reviews by theme



For the patients who left a positive review, the main themes demonstrated by the word cloud in figure 36 – with staff being the main reason given for a positive experience, followed by timeliness and the quality of clinical care.

Patients also provide plaudits via letter and email to the trust, via social media and through online platforms.

Figue 36: Most prevalent words in positive reviews

Figure 37: example of a thank you card received by a clinical team in 2022/23

To Sophie Beth & everyone who looked after Jo Morrison -

Thankyou for all the love & support you gave her & us - her family -

Many thanks x

10. Summary and Next Steps

As with the previous year, 2022/23 was a challenging year for the trust in delivering great care every time, following the pandemic and its impact on demand for healthcare. However, despite the ongoing issues with waiting for elective care and in emergency departments, the year saw some improvements in reported patient experience, in particular through the friends and family test surveys, with improved reported experience correlating with improved performance and waiting times in ED.

Overall complaints and concerns were slightly higher than previous years however the teams responding to these became more stable and relationships with clinical teams following the establishment of the Trust's new clinical operating model have matured. There are many successes to share. The ways in which patient experience is managed and responded have been strengthened within an increasingly clear and effective structure of quality governance. A new system for friends and family test surveys was commissioned and implemented providing increasingly agile data to support the patient voice in service improvement. The patient experience strategy was launched and is being enacted, and relationships with Healthwatch have continued to embed with clear benefits for patients demonstrated.

There is also much to look forward to in 2023/24. This includes:

- The launch of the Datix feedback module will transform how patient experience data is captured from complaints and PALS.
- Transition to the Louisa Martindale Building for PALS on the RSCH site
- Enabling the patient voice to shape major programmes such as the ED redevelopment and stage 2 of the 3Ts programme
- Roll out of the welcome standards
- Development of the heritage project

University Hospitals Sussex
NHS Foundation Trust

University Hospitals Sussex NHS Foundation Trust

RESEARCH AND INNOVATION COMMITTEE

TERMS OF REFERENCE

1.00 PURPOSE

1.01 The purpose of the Research and Innovation Committee is to support the Trust in **achieving its strategic objective:**

University Hospitals Sussex will be a place where all patients and staff have the opportunity to participate in high quality research and innovation which is relevant to them, and where we work with partners across Sussex to ensure equality of access to the benefits of health and care research and innovation for the whole population.

1.02 The Research and Innovation Committee will do this through;

- Alignment of UHSussex Research and Innovation strategy with NHS Sussex and partner organisations, under the auspices of Health Research Partnership.
- Alignment of the UHSussex Research and Innovation strategy in response to stakeholder and Trust Board input.

Develop an operational plan, including stakeholder to deliver the key strategic domains.

- Ensure the risk register reflects the depth and breadth of risks to delivery of the strategy, with mitigations and actions and alignment of the Trust's Research & Innovation Strategy; and
- Assist the Board in its oversight of achievement of the True North Targets, breakthrough objectives and any aligned strategic initiatives pertaining to the Research and Innovation domain.

2.00 MEMBERSHIP AND ATTENDANCE AT MEETINGS

2.01 The membership of the Committee shall be:

- Chair: a nominated non-executive Director
- Two further nominated non-executive Directors, one of which shall be the Brighton and Sussex Universities nominated NED
- Chief Medical Officer (Lead Executive for the Committee)
- Chief People Officer (Alternate Lead Executive for the Committee)
- Chief Nurse

2.02 The Trust Chair shall propose which non-executive Directors will be most suitable for nomination as Chair and members of the Committee. The Trust Board shall approve the appointment of the Committee Chair and members, based on the Chair's recommendations.

2.03 In the absence of the Committee Chair one of the remaining non-executive members present shall elect themselves to chair the meeting.

2.04 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of meetings. The Committee secretary will maintain a register of attendance which will be published in the Trust's annual report.

2.05 All members of the Committee shall receive training and development support before joining the Committee and on a continuing basis to ensure their effectiveness as members, supported by a performance assessment process, as agreed by the Board of Directors.

2.06 Core Corporate Directors attendees will be those who are presenting reports to the Committee but are not voting members of the Committee. These will include:

- Clinical Director of Research and Innovation
- Director of Operations - Research and Innovation
- Commercial Director
- Director of Integrated Education
- Managing Director of Planned Care
- Chair of Brighton and Sussex Health Research Partnership

2.07 Any member of the Board of Directors shall have the right to attend any meeting of the Committee by prior agreement with the Chair.

2.08 The executive members of the Committee may exceptionally send a deputy to the meeting, but the deputy will not have voting rights at the meeting. Those who are in attendance may exceptionally send a deputy to the meeting.

2.09 Other Trust managers and clinicians may be invited to attend for particular items on the Agenda that relate to areas of risk or operation for which they are responsible.

2.10 The Company Secretary or their nominee shall act as Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

3.00 ROLES AND RESPONSIBILITIES

DELEGATED AUTHORITY

3.01 The Committee shall have the delegated authority to act on behalf of the Board of Directors in accordance with the Constitution, Standing Orders, Standing Financial Instructions, and Scheme of Delegation. The limit of such delegated authority is restricted to the areas outlined in the Duties of the Committee and subject to the rules on reporting, both as defined below.

3.02 The Committee is empowered to investigate any activity within its Terms of Reference, and to seek any information it requires from staff, who are required to co-operate with the Committee in the conduct of its enquiries.

3.03 The Committee should challenge and ensure the robustness of information provided.

3.04 The Committee is authorised by the Board of Directors to obtain independent legal and professional advice and to secure the attendance of external personnel with relevant experience and expertise, should it consider this necessary. All such advice should be arranged in consultation with the Company Secretary.

RESPONSIBILITIES

True North

3.05 Within the Trust's strategic framework, the Trust's True North is defined as putting the patient first and foremost so all improvements ultimately benefit the people the Trust serves. This Committee will therefore operate within that framework, following agreement of the strategy and plans prioritised and agreed by the Board.

3.06 In support of the True North strategy development the Committee will work to ensure the Trust develops and maintains appropriate annual plans which aligns to the Research and Innovation domain True North goals, breakthrough objectives, strategic initiatives and corporate projects and make relevant recommendations to the Board for approval.

3.07 Through discharge of the objectives below the Committee will support the Trust's progress towards achieving its True North goals and overseeing improvement plans when required.

Breakthrough Objectives

3.08 To receive confirmation from the Board on an annual basis, the cascade of the relevant Breakthrough Objectives which are to be held to account by the Committee.

3.09 To obtain assurance that the Breakthrough Objectives, which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, challenging management and escalating to the Board when required.

Strategic initiatives

3.10 To receive confirmation from the Board an annual basis of the Strategic Initiatives for which delivery is being held to account by the Committee.

3.11 To provide assurance that the Strategic Initiatives, which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, challenging management and escalating to the Board when required.

Corporate Projects

3.12 To receive confirmation from the Board an annual basis of the Corporate Projects for which delivery is being held to account by the Committee.

3.13 To provide assurance that the Corporate Projects, which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, challenging management and escalating to the Board when required.

Quality

3.14 To receive incident reporting in relation of clinical trials or research which shows the level of harm and near misses, thus providing a robust picture of the quality of care provided through the research activities of the Trust. Noting the link to the Quality Committees oversight through the high level reporting through the Quality Assurance reporting.

3.15 To receive information and reports to ensure that the patient voice is being used to influence the shape of the research programme.

3.16 To receive reporting in relation to research and innovation activity that the trust sponsors, to ensure that all regulatory responsibilities of 'Sponsor' are met.

3.17 Ensure Trust framework of policies and procedures facilitate compliance with the relevant ethical and regulatory standards.

3.18 To review the themes and trends in research outcomes in order that the learning drives improvements to the Trust's processes.

People

3.19 To link with the People Committee in the oversight of the Trust education and learning plans, in so far as they impact and enhance research and innovation.

Sustainability

3.20 To ensure that there are robust costing and contracting processes applied to research and innovation projects undertaken in the trust, including the management of commercial research and innovation.

3.21 To ensure that effective processes are established and applied for the stewardship and use of research grant income or the provision of grants to others for the purpose of research.

Systems and Partnerships

3.22 Receive and review reports covering the Brighton and Sussex Health Research Partnership and other networks and wider research collaborations the Trust engages and takes part in.

3.23 Review reports on joint working with BSMS in delivery of the UHSussex Research and Innovation strategy.

Well led

3.24 To ensure the Trust's research activities are undertaken in compliance with Mandated standards and requirements.

3.25 That the reputation of the Trust is protected through appropriate due diligence into planned research.

3.26 To maintain oversight of research and innovation activity, ensuring that it is well governed and is focused on and delivers improvement in respect of the Trust's clinical quality priorities.

Risk

3.27 To review regularly the Board Assurance Framework (including through in-depth reviews of specific risks) and the High-Level Operational Risks with a significant potential for impact on the Trust's Research and Innovation objectives.

4.00 REPORTING AND RELATIONSHIPS

4.01 The Committee shall be accountable to the Board of Directors of the Trust.

4.02 The Committee shall make recommendations to the Board of Directors concerning any issues that require decision or resolution by the Board.

4.03 The Committee shall refer to the Audit Committee, Quality Committee, People Committee, Systems and Partnerships Committee or Sustainability Committee any matters requiring review or decision-making in that forum.

4.04 The Committee shall receive reports from all sub-groups setting out any matters requiring escalation to the Research and Innovation Committee.

4.05 On an annual basis the Committee will provide a self-assessment report to the Board detailing how the Committee has discharged its obligations as set out within its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate. This will form part of the assurances which support the Annual Governance Statement and the Annual report disclosures and will be submitted in the first quarter of the following financial year.

4.06 The Committee Chair shall present a report summarising the proceedings of the meeting at the next Trust Board meeting. This should draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

5.00 CONDUCT OF BUSINESS

5.01 The Committee shall conduct its business in accordance with the Standing Orders of the Trust.

5.02 The Committee shall be deemed quorate if there are at least two non-executive Directors and two executive Directors present, one of whom should be the Lead Executive for the Committee, or the alternate Lead Executive for the Committee. A quorate meeting shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.

5.03 The Committee shall meet not less than 4 times in each financial year and dates will be set by the end of the previous financial year.

5.04 The Committee will set an annual plan for its work to form part of the Board's Annual Cycle of Business, and report to the Board on its progress.

5.05 In exceptional circumstances where delaying actions or decisions would have a negative impact on the Trust's business, certain items of business requiring an urgent decision, or the taking of the decision itself, may be conducted outside of formal meetings, in line with the requirements set out within the Trust standing orders. This will normally be agreed by the Committee in advance and executed by either: Chair's action, calling an extraordinary meeting or reaching consensus on a decision by e-mail. Any decisions are to be formally ratified the Committee and/or Board at the next meeting.

5.06 The Committee business may be transacted through virtual media (using either teleconference or other collaboration and meeting tools). At the start of each meeting which is taking place without all parties being physically present the Chair shall be responsible for determining that the quoracy arrangements has been achieved and that members can effectively contribute.

5.07 The Committee Chair, with the support of the Company Secretary, is responsible for taking appropriate actions to manage conflicts of interest (perceived and actual) during a meeting. Members conflicted on any items of business on a committee meeting agenda shall declare their conflict and withdraw from discussions and/or the decision-making as required. Conflicted members are not to be counted for quorum.

5.08 The Company Secretary is responsible for preparing the agenda and collating and circulating papers to Committee Members. Papers should be provided not less than five calendar days before the meeting and the agenda and papers should be circulated not less five calendar days before the meeting, to provide sufficient time for due consideration.

5.09 Proceedings and decisions made will be formally recorded by the Company Secretary in the form of minutes and distributed to Committee Members within 10 working days of the meeting.

6.00 TERMS OF REFERENCE

6.01 The Committee shall review its own performance, constitution and terms of reference at least every two years to ensure it is operating at maximum effectiveness. Any proposed changes to the terms of reference should be agreed by the Trust Board.

6.02 It is the Company Secretary's responsibility to make the necessary updates to the terms of reference.

6.03 Approved by Committee July 2023

6.04 Next full review: by March 2025 (recognising that these will be subject to review during the annual review of Committee effectiveness)

Appendix - Mandated reports considered by the Committee

Below is a list of the minimum reports the Committee would receive over the year

- Annual Research and Innovation Report
- Research incident reports
- Research activity reports
- Research training reports
- Research finance reports

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	18	**Meeting:**	Trust Board	**Meeting Date:**	August 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 and date:					

Purpose of the report:			
Information	Yes	Assurance	Yes
Review and Discussion	N/A	Approval / Agreement	N/A

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

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	Yes / N/A	Link to Trust Annual Plan	Yes / N/A

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	Yes	Links to risk 1.1
Sustainability	N/A	
People	N/A	
Quality	Yes	Assurances in relation to risk 4.1 and 4.2
Systems and Partnerships	N/A	
Research and Innovation	N/A	

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

Regulatory / Statutory reporting requirement

Communication and Consultation:

Executive Summary:

The Quality Committee meets monthly and therefore this report covers three meetings in May, June and July 2023. The meetings were quorate, attended by at least two Non-Executive Directors and two executives. In attendance at the meetings were the Chief Medical Officer or their deputy, the Trust's Director of Patient Safety and Learning, the Director of Midwifery, the Director of Infection Prevention and Control and the Director of Clinical Outcomes and Effectiveness or their nominated deputies. The Chief Nurse gave apologies, and the interim Chief Nurse was in post for each meeting.

During the quarter he Committee received referrals from audit committee on NICE and surgical site infections, and planned items including the Quality Account, quality scorecard, the perinatal quality surveillance dashboards, Patient Safety and Duty of Candour reports, quality, assurance, reports, and 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.

QGSG and Quality Scorecard

The report from QGSG for the first time included divisional assurance, as well as safety and quality domain assurance plus updates against the CQC action plans. This provides the committee with more insight and triangulation with the divisions reporting on patient, safety, risk, quality assurance, and patient experience. The committee sought assurance that there was good engagement at the meeting by clinicians and divisional Chiefs.

The dashboard continues to be developed, however, gaps remain in the availability of data and setting of. Targets. In part this is due to some data being collected manually. The Committee expects to receive a Quality dashboard that can be used for exception reporting by the end of the year.

Patient Safety & Quality Domains

The committee at each meeting discussed the key elements within patient experience and noted an increase in complaints in quarter one which is being seen nationally which brings a considerable resource pressure on the patient experience team and divisional teams. The Committee **NOTED** that based on available Friends and Family Test (FFT) data, the significant majority of patients responding in Q1 were satisfied that they have a good or very good experience (around 91%). This was comparable to Q4 2022/23 and a considerable increase on Q3 with positivity levels influenced by improvement in Emergency Department ratings from January. 'Welcome' training undertaken by reception staff for the Louisa Martindale Building has been reflected in very positive patient feedback.

The Committee discussed the key elements relating to Patient Safety themes and learning as well as the Trust's performance in the associated processes around incidents including the timeliness of incident investigation. Emergent themes include patients lost to follow-up, mental health care and harms following long waits for procedures. Following my update in Q4 Duty of candour compliance has improved in Q1. Following thematic review of incidents relating to Venous Thromboembolism (VTE) work continues to embed the learning through deployment of a VTE strategy and the Patient First methodology.

The Committee received a presentation of a further thematic review which exemplifies the values of this approach. A no harm missed cancer surveillance scan was raised by staff who were concerned that this might not be an isolated incident. The thematic review identified other cases of missed surveillance scans, and each had after action reviews (AAR). Analysis of cross-cutting themes were identified reported, and recommendations made, which include a failsafe officer amongst others. The Cancer Division are planning to take this learning and disseminate it across different areas.

As I escalated in my last board report, all clinical effectiveness support processes have, for a considerable time, faced significant resource and capacity pressure and as a result there was a gap in formal assurance. There has been considerable work done to identify the gaps and plans, and actions are underway to rectify this. In June the Director of Clinical Effectiveness provided a Quality Assurance report that indicated the current status of NICE guideline reviews; National audits, Technology Appraisal, GIRFT review and action plans, CQUIN delivery, Mortality reporting / Learning from Deaths; Organ donation and Health Inequalities.

In July the Committee received an overview of the progress against each area. The Committee noted that this will require dedicated clinical and administrative resources from the Divisions to work with the COEG team. The Committee has asked an update on the plans and resources solution. While a significant gap in assurance remains, the Committee is now **assured** that the nature of that gap is understood and that suitably prioritised plans are in place to rectify this. This is reflected in the Board Assurance Framework recommendation by the Committee.

The Committee **noted** the risk raised in relation to CQIN funding which related to administrative data capture and also re-vascularisation and NEWS scores. This has been referred to the Sustainability Committee given the financial impact.

The Committee discussed the reduced funding from the ICB for smoking cessation services and the significant impact this will have in relation to those most vulnerable to the impacts of Health Inequalities. There has been significant positive impact of smoking cessation in Maternity. In relation to Tobacco dependencies funding, discussions were taking place with Directors of Public Health and the ICB.

Learning from Deaths

The Committee received for **assurance** the Q4 report and the Learning from Deaths Annual Report for 2022/23 and a progress update on the ongoing review of data and reporting. From the learning from deaths update received it was noted the Learning from Deaths framework continues to mature with added emphasis on Structured Judgement Reviews (SJR) and Medical Examiner Officer scrutiny and the SJR backlog has been managed through liaison with the surgical pathway while the scale of backlog meant that some gap in assurance remains. Recruitment of medical examiners and administrative support to rectify this was underway.

Learning Disability SJRs were confirmed to be all up to date. The committee heard the learning from deaths development programme will include a mortality panel for LD deaths that will review the implementation of LeDeR actions. The Trust was Incorporating benchmarking with other Trusts is also part of the development plan

The Learning from Deaths Annual Report 2022/23 is included as an appendix to this report.

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 in Q4 it is now recognised that 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 this adjusts to normal when SDEC coding is taken into account.

Perinatal

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 and this has continued to show the perinatal mortality rate sustained below the national average. Good progress on staffing has resulted in improved ability to support home births. The Committee considered each of the dashboards across each of the domains of; learning from 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 Maternity and Neonatal data and engage with the Healthcare Safety Investigation Branch (HSIB) as required. The Committee welcomed the inclusion of health inequalities data and acknowledged the success of the smoking cessation service for maternity patients.

The impact of industrial action on requirements for CNST year 5 and the ability to deliver training and medical attendance was **noted** and this has been raised with NHS Resolution.

Updates were received from the Maternity Safety Support Programme (MSSP) improvement group and associated recommendations had been agreed. The Division has been working with the Maternity Voices Partnership who had undertaken a number of reviews in maternity that provide valuable feedback from our women and people.

The Committee **NOTED** the Saving Babies Lives v2 Care Bundle was now fully implemented on all four sites and heard updates on the ongoing work required to ensure it is fully embedded in clinical practice in all areas, which is anticipated to positively impact on perinatal mortality rates throughout 2023/24.

The Committee received at their June meeting an update on the foetal monitoring action plan which was produced following a theme of foetal monitoring misinterpretation or delay in escalation which mirrors themes seen Nationally. The Committee heard that funding has been secured to increase the capacity of foetal wellbeing specialist workforce and updated monitoring equipment.

The Committee **NOTED** the contents of the reports and **APPROVED** the scorecards.

The Committee also received an update on neo-natal workforce which identified a number of challenges around both medical and nursing staff and the Committee heard about the work underway to mitigate the impact of this alongside an active recruitment campaign.

Safeguarding

The Committee **received** the Q3, Q4 22/23 and Q1 23/24 quarterly reports for Adults' and Children's Safeguarding activity and the Annual reports for 2022/23.

The Annual Report outlined how the Trust fulfils its safeguarding responsibilities for adults and children, provided an overview of both teams' activity in 2022/23 and priorities for 2023/24. The Committee endorsed the Safeguarding Adults Annual Report 2022/23 and the Safeguarding Children & Looked After Children Annual Report 2022/23 and RECOMMENDED their approval at Trust Board.

The committee noted the focus on data quality and specialised training in the year ahead and a gap of assurance currently exists in these areas. Work is underway with Divisions to ensure appropriate coverage of the training and additional support is being given by the Safeguarding team, in particular for children with mental health needs, looked after children and disadvantaged children.
The Committee noted the higher incidence of mental health presentations to Worthing Hospital and a further understanding of this is required. The Committee was **assured** that the Trust is discharging its statutory duties in partnership working.

Mental Health

Following my previous report, an ongoing focus of the Committee has been the care of patients with mental health needs in our Emergency Departments and for children and young people with mental health needs. Through joint working the Committee received pathway design recommendations following work commissioned by the NHS Sussex Integrated Care Board that identified the significant challenges in these pathways and provided recommendations for partners across the system to improve service delivery. Following this, an agreement has been reached with a mental health care pathway with Sussex Partnership Foundation Trust that will commence in August to support the discharge of patients to an appropriate setting. The Committee has asked for an update on this pathway and other plans given the risk of this area

to the trust and the impact on patients. The Committee welcomed the significant step forward made in this area.

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, RSCH Neurosurgery resulting from CQC inspections noting how the plans have been developed. The Committee scrutinised progress and **noted** progress especially in RSCH ED. The Committee further discussed the approach to their appropriate status recording and **noted** further executive oversight given to this area and the evolution of monitoring and reporting to come through future meetings. General Surgery remains a corporate project and at the July meeting the Committee received an update from the project's Senior Responsible Officer on progress made. The Committee was **assured** that the three remaining red actions were being addressed.

General Surgery Corporate Project

The Committee reviewed the progress against the Improving General Surgery corporate project and an updated Charter was shared with timelines. The Improvement programme continues to progress and the Trust has benefited from external support and noted improvements had been initiated including in the area of MDT processes, leadership and culture workstreams and the operational model.

Strong engagement from the team had been recognised and the Committee heard of substantial improvement of the GMC junior doctor survey. The Committee asked that evidence of improvements in the area of Leadership and Cultural is shared in the next report.

Future plans included completing a governance review of the department using the Good Governance Institute Framework.

Infection Prevention and Control Board Assurance Framework

The reports were received and noted. The Committee noted that surgical site infections (SSI) data had not previously been included and would be included in reports to the Committee from the August 2023 meeting. The Committee has RECEIVED a referral from the Audit Committee to ensure oversight of the SSI data quality action plan.

The Committee noted the Trust was above trajectory for eColi and MRSA and noted the fully recruited team will have a further focus on improved data collection and action to target intervention.
The lag to capture surgical site infection data within routine reports was explained. including issues with the LIMS system on the RSCH/PRH sites. The Committee noted the rolling replacement programme in the capital plan being significant in the infection control area and the positive impact of the new Louisa Martindale Building.

Clinical Strategy

The Clinical Strategy was brought to the Committee before its presentation to the Board. The Committee acknowledged the significant work and will seek assurance of alignment with the ICB strategy, future prioritisation and engagement with the workforce on the strategy.

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. In respect to challenges raised, the Executives outlined and improved process with divisions to support improved articulation and scoring of risks. Updates were reviewed at each meeting.

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.

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 recommend restoring 4.1 to 16 in light of the scale of Clinical Outcomes and Effectiveness and safeguarding remedial work becoming apparent.

Referrals to other Committees

The Committee considered the reports and presentations it received at this meeting and **agreed** to refer the following matter to the Sustainability Committee.

The Quality Assurance report documented some aspects of CQIN funding faced considerable risk to delivery (£2m) and oversight from the Sustainability Committee is recommended given the financial risk non-delivery could represent.

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 2 are fairly represented.

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	**23 May 2023**	**Chair**	Lucy Bloem	**Quorate**	Yes
Meeting Date	**27 June 2023**	**Chair**	Lucy Bloem	**Quorate**	Yes
Meeting Date	**25 July 2023**	**Chair**	Lucy Bloem	**Quorate**	Yes
Declarations of Interest	No declarations were raised				

Items received at the Committee meeting

Focus, Operation and Priorities of the Committee						
QGSG reports	**May**	**Jun**	**Jul**	**Presenter** Chief Medical Officer	**Purpose** For information	**Outcome /Action taken** Noted Action to give assurance on suitability of data flow
Quality Dashboard (excluding Maternity) Safe, Effectiveness, Experience, Mortality	**May**	**Jun**	**Jul**	**Presenter** Chief Medical Officer / Interim Chief Nurse (Jul only)	**Purpose** For information	**Outcome /Action taken** Noted.
Mortality - Counter Measure Summary		**Jun**	**Jul**	**Presenter** Chief Medical Officer/ Interim Chief Nurse (Jul only)	**Purpose** For information	**Outcome /Action taken** Noted Action- to bring back a Mortality fracture neck of femur report
Learning from Deaths Assurance Report (Annual Report 2022/23 to Jul meeting)	**May**		**Jul**	**Presenter** Mortality & Learning from Deaths Manager	**Purpose** For Assurance	**Outcome /Action taken** Noted May report had been deferred from Apr 2023
Clinical Harms Review	**May**			**Presenter** Chief Medical Officer	**Purpose** For information	**Outcome /Action taken** Noted
Harm Counter Measure Summary Reports (True North and Breakthrough)	**May**	**Jun**	**Jul**	**Presenter** Director Patient Safety & Learning	**Purpose** For information	**Outcome /Action taken** Noted
Cancer Surveillance Deep Dive			**Jul**	**Presenter** Interim Chief Nurse	**Purpose** For assurance	**Outcome /Action taken** Assurance Noted
Patient Safety Incidents Q4 & Duty of Candour Q4		**Jun**	**Jul**	**Presenter** Director Patient Safety & Learning	**Purpose** For assurance	**Outcome /Action taken** Assurance Noted

Strategic Initiative – Clinical Strategy Q1			**Jul**	**Presenter** Director of Strategy & Planning	**Purpose** For information	**Outcome /Action taken** Noted
Corporate Project - General Surgery Q1		**Jun**	**Jul**	**Presenter** Chief Medical Officer, Chief of Service Surgery (RSCH/ PRH)	**Purpose** For information	**Outcome /Action taken** Noted
Corporate Project – Enhancing Quality Governance Counter Measure Summary	**May**			**Presenter** Company Secretary	**Purpose** For information	**Outcome /Action taken** Noted
Perinatal Quality Surveillance Report and Dashboards	**May**	**Jun**	**Jul**	**Presenter** Director of Midwifery / Chief of Women & Children Service	**Purpose** Approval	**Outcome /Action taken** Noted June Action to add smoking cessation update to future PQS summary report (pending ICB input)
Overview of Obstetric Medical, Neonatal Medical, Advanced Neonatal Nurse Practitioner & Neonatal Nursing Workforce		**Jun**		**Presenter** Director of Midwifery	**Purpose** For assurance	**Outcome /Action taken** Noted Action to review risk register
Foetal Monitoring Action Plan		**Jun**		**Presenter** Director of Midwifery	**Purpose** For assurance	**Outcome /Action taken** Noted Assurance from FFT Requested Update on Sickness rates
Safe, Effective, Caring, Well Led and Responsive						
Infection Prevention & Control Q4 Report	**May**		**Jul**	**Presenter** Director Infection Prevention & Control	**Purpose** For information	**Outcome /Action taken** Noted
Infection Prevention and Control Board Assurance Framework/ Dashboard		**Jun**		**Presenter** Director Infection Prevention & Control	**Purpose** To agree	**Outcome /Action taken** Approved
CQC Update / Action Plans	**May**	**Jun**		**Presenter** Chief Medical Officer	**Purpose** For information	**Outcome /Action taken** Noted
Quality Impact Assessments Q4		**Jun**		**Presenter** Chief Medical Officer	**Purpose** Consider Panel Recommendation	**Outcome /Action taken** Endorsed panel view to progress projects

Mental Health Update – Safeguarding Mental Health Assurance Report	**May**	**Jun**		**Presenter** Interim Chief Nurse	**Purpose** For information	**Outcome /Action taken** Noted
Safeguarding Adults and Children Report Q3 and Q4 2022/23 (to May). Annual Report & Q1 2023/24 (to July)	**May**		**Jul**	**Presenter** Interim Chief Nurse/ Head of Safeguarding	**Purpose** For assurance	**Outcome /Action taken** Noted
Quality Assurance	**May**	**June**	**Jul**	**Presenter** Chief Medical Officer / Head of Clinical Outcomes & Effectiveness	**Purpose** For assurance	**Outcome /Action taken** Noted, Action: Gap analysis and progress update on improvement workstreams
Quality Accounts	**May**	**June**		**Presenter** Chief Medical Officer / Head of Clinical Outcomes & Effectiveness	**Purpose** For assurance	**Outcome /Action taken** Noted, Recommended Board Approval
Policies (including Boarding Policy)	**May**			**Presenter** Interim Chief Nurse	**Purpose** For information	**Outcome /Action taken** Noted. Boarding Policy withdrawn. Action:Q3 paper on Winter risk management processes at a ward /site level
Medical Appraisal and Revalidation Annual Report			**Jul**	**Presenter** Deputy Chief Medical Officer	**Purpose** For endorsement for Board approval	**Outcome /Action taken** Noted.
Risk						
Trust Risk Register relating to Quality	**May**	**Jun**	**Jul**	**Presenter** Chief Medical Officer / Interim Chief Nurse	**Purpose** For information	**Outcome /Action taken** Noted
Board Assurance Framework			**Jul**	**Presenter** Company Secretary	**Purpose** For agreement	**Outcome /Action taken** 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 2 2023/24.
The Committee received the Adult Safeguarding and Child Safeguarding Annual Reports 2022/23
The Committee received the Infection Prevention and Control Quarterly Reports

The Committee received the Learning from Deaths Annual Report 2022/23

The Committee received the Medical Appraisal and Revalidation Annual Report 2022/23

The Committee undertook a review of its effectiveness and **AGREED** to recommend revised Terms of Reference to the Board (to incorporate matters previously received by the Patient Committee leaving an opportunity to repurpose that committee time to a dedicated R&I committee.)

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

Aspects of Winter Planning that will require oversight

Healthcare Safety Investigative Branch review to come back (from April meeting)

Detail of Neonatal risk mitigations

Quality Assurance Clinical Outcomes and Effectiveness Improvement Plan.

Infection Prevention and Control Annual Report 2022/23

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

Item	Date
Quality Committee invited the Board to **APPROVE** the following: ▪ Annual Learning from Deaths Report 2022-23 ▪ Annual Medical Revalidation and Appraisal Report 2022-23 ▪ Annual Adults Safeguarding Report 2022-23 ▪ Annual Children's Safeguarding Report 2022-23 ▪ University Hospitals Sussex Foundation Trust Clinical Strategy ▪ revised Terms of Reference for the Quality Committee (to include Patient Experience)	**July 2023**

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	16.1.	**Meeting:**	QGSG	**Meeting Date:**	17 July 2023
Report Title:	Learning from Deaths Annual Report 2022-23				
Sponsoring Executive Director:	Professor Catherine (Katie) Urch				
Author(s):	Kim Bailey, Mortality and Learning from Deaths Manager				
Report previously considered by and date:					

Purpose of the report:			
Information	Yes	Assurance	Yes
Review and Discussion	N/A	Approval / Agreement	N/A

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

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	Yes / N/A	Link to Trust Annual Plan	Yes / N/A

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	Yes	
Sustainability	Yes / N/A	
People	Yes	
Quality	Yes	
Systems and Partnerships	Yes / N/A	
Research and Innovation	Yes / N/A	

Link to CQC Domains:			
Safe	Yes	Effective	Yes
Caring	Yes	Responsive	Yes
Well-led	Yes / N/A	Use of Resources	Yes

Regulatory / Statutory reporting requirement

Communication and Consultation:

Executive Summary:

The purpose of reviews and investigations of deaths is to improve understanding and learning about problems and processes in healthcare associated with mortality, share best practice, identify themes and address deficiencies in processes and patient care.

This report is presented as assurance of the efficacy of the Learning from Deaths (LfD) and Learning Disabilities Mortality Review (LeDeR) in adherence to the National Quality Board guidance on Learning from Deaths (2017).

Annual Report focuses on:

- All Deaths (including, SHMI, HSMR, crude mortality)
- Medical Examiner Outputs
- Deaths referred for SJR
- Outcome scores of SJRs
- Outstanding SJRs
- Mortality Panel outputs
- SJR Scores

- Deaths referred to the Patient Safety Team
- SJRs that result in a Serious Incident review
- Embedded learning within clinical specialities as a result of SJR recommendations
- Embedded learning within clinical specialities as a result of LeDeR recommendations
- Deaths referred to His Majesty's Coroner
- Deaths resulting in Inquests.
- Identified Trends and Themes
- Learning outcomes that have been achieved/implemented.
- Quality Improvement Progress
- Excellence
- Achievements
- Risks
- Action plans

Key Recommendation(s):

To note the contents of the report, and endorse for Trust Board approval.

University Hospitals Sussex
NHS Foundation Trust

Learning from Deaths and Mortality Review Annual Report

2022/23

Contents

Learning from Deaths

Introduction

Dying is a natural event for everyone and not every death requires a review or investigation. However, when things do go wrong or the care provided does not meet the standards expected, Universities Hospitals Sussex NHS Foundation Trust (UHSussex) have processes in place to review and/or investigate what went wrong; be open with families and loved ones and learn from what went wrong.

Purpose

The purpose of reviews and investigations of deaths is to improve understanding and learning about problems and processes in healthcare associated with mortality, share best practice, identify themes and address deficiencies in processes and patient care.

This report is presented as assurance of the efficacy of the Learning from Deaths (LfD) and Learning Disabilities Mortality Review (LeDeR) in adherence to the National Quality Board guidance on Learning from Deaths (2017).

Background

The National Quality Board's National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on identifying, reporting, investigating and learning from deaths in care (March 2017) set out key requirements to ensure organisations effectively respond to and learn from patient deaths.

Acute trusts in England were initially asked to set up Medical Examiner (ME) offices to focus on the certification and to provide scrutiny of all deaths that occur in their own organisation on a non-statutory basis. In February 2022, the government published "Integration and innovation: Working together to improve health and social care for all", the white paper which includes provisions for medical examiners to be put on a statutory footing.

ME offices across UHSussex are now fully implemented to allow for the scrutiny all in hospital non coronial deaths. The role of the ME is currently being extended to include all out of hospital non-coronial deaths. Implementation of this next phase will continue to take place incrementally, to allow time for capacity and processes to be put in place.

Governance

The Chief Medical Officer is the responsible executive for Learning from Deaths.

The Trust has a duty to report all deaths that occur as an inpatient or in the Emergency Department. Deaths are reported bi-monthly to the Clinical Outcomes

and Effectiveness Steering Group (COEG); quarterly and annually to the Quality Governance Steering Group (QGSG), Quality Committee (QC) and the Trust Board.

Quarterly Reports

In 2019 Brighton & Sussex Universities Hospitals merged with Western Sussex Hospitals to create a new Universities Hospitals Sussex NHS Foundation Trust (UHSussex). Both pre-merged Trusts had differing processes for learning from deaths. As a merged Foundation Trust it is important that the policies and procedures align across all UHSussex hospitals to provide a consistent, best practice approach to how we learn from the deaths of people in our care.

This report aims to provide information on the mortality rates, learning and incidents associated with mortality at UHSussex for the period on 1st April 2023 – 31st March 2023. The report also provides details of the progress made to align the Learning from Deaths programs along with our aims and objectives for the new reporting period (April 2023 – March 2024).

Mortality Processes

When a person dies receiving care as an inpatient or in the Emergency Department (ED), the doctor caring for the patient will ensure that the information provided for the Medical Certificate of the Cause of Death (MCCD) is accurate. This information is shared with the Medical Examiner Service where independent scrutiny of the deceased patients' notes is carried out by a consultant Medical Examiner (ME) and the cause of death is agreed. Independent Medical Examiner Officers (MEO) will contact the deceased patients' next of kin (NOK) to explain the MCCD and identify any concerns the family may have.

If the ME's, MEO's or the family raise concerns, the ME service may refer the case to the LfD team to feedback to the clinical teams or refer for a Structured Judgement Review (SJR). Details of SJR methodology is explained below. The Medical Examiner team will also identify opportunities for learning and improvement as well as excellence for sharing with the wider Trust.

The Medical Examiner team will refer all deaths that maybe considered unnatural, or if the cause of death cannot be determined, to His Majesty's Coroner. The Medical Examiner team may also make referrals to His Majesty's Coroner if there are serious concerns relating to a persons death.

Deceased patients identified with a Learning Disability (LD) will automatically be referred for a SJR which is considered part of the Learning from Life and Death Reviews (LeDeR). LeDeR is explained below.

Deceased patients with a severe mental Health (SMH) will automatically be referred for a SJR.

Where a SJR identifies concerns in care that may have contributed to a persons death, this will be escalated to the patient safety team for consideration under the Patient Safety Framework. This may also include the consideration of other policies and frameworks such as the Duty of Candour (DoC).

The process regarding SJRs differed across UHSussex. For SRH and WGH - SJRs were completed on a word document with outcome scores and learning themes populated onto an excel spreadsheet for recording and reporting purposes. SJRs that identified concerns is care were reviewed at a bi-weekly mortality Panel and triangulated to the patients safety team and Divisional Quality and Safety Managers (DQSMs).

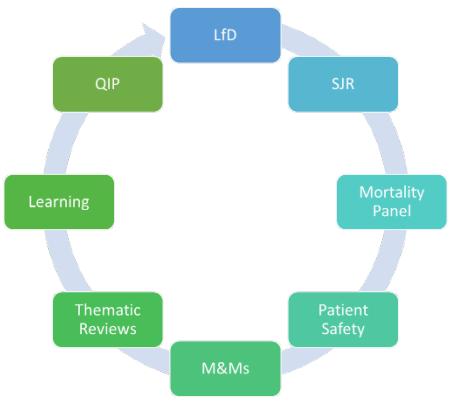
RSCH and PRH sites completed SJRs on an electronic form within PANDA (patient information and management system populated by the patient access system) which is also used to alert the DQSM to those cases requiring an SJR. The DQSM then allocated each case to a trained mortality reviewer to complete and share any findings for learning.

The LfD team will receive regular updates on the progress of any SJR that trigger a Serious Incident (SI) investigation.

Deaths of patients with learning disabilities (LD) are referred to the Learning from Life and Death Reviews previously Learning Disabilities Mortality Review (LeDeR) Programme for independent care pathway review but also undergo local SJR, to ensure timely scrutiny and learning from the inpatient hospital admission, which is then shared to assist LeDeR to complete their review.

Learning from Excellence is considered an essential ingredient in learning from Deaths. The LfD team aim to apply the SJR methodology to deceased patients where excellence in care is identified. In the same way concerns are identified, excellence will be shared with the clinical teams and utilised to inform Quality Improvement Projects (QIPs).

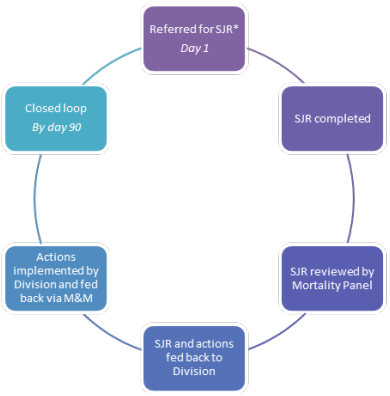
Staff involved in delivering care to people who are at the end of their natural lives strive to ensure those nearing or at the end of their natural life have their needs met, are comfortable and well cared for. UHSussex believe it is important to ensure staff are informed when they deliver excellent care and when a family feel they were well supported during the passing of a loved one. The LfD team will support all learning from deaths whether it is exceptional care or learning from something that didn't go well.



Aligning the Mortality & Learning from Deaths Programs in 2023/24

Aligning the Mortality & Learning from Deaths Programs continues to develop (appendix A & B). Phase one is due to complete in June 2023 with the implementation of a single IT platform that streamlines the Medical Examiner Service with the Learning from Deaths service on all sites. The completed IT platform will enable Medical Examiner scrutiny to be captured and referrals made to the LfD team by pre-populating key information into an SJR form. Once the SJR has been completed by a reviewer, it will then be processed on the platform for escalation to the weekly mortality panel or for thematic review. The IT Platform also captures outputs from the Mortality Panels ready for sharing with Divisions, M&Ms and the Patient Safety team through Datix.

Phase 2 of aligning the Mortality & Learning from Deaths Programs will develop a streamlined, standardised process that supports feeding into M&Ms as well as providing a single point of qualitative and quantitative data for collation of thematic learning and audit. Once the Mortality and LfD programs are fully integrated, the LfD team aim to ensure every death referred for a SJR is reviewed; learning extracted, fed back to the clinical team, reviewed at the relevant M&M and learning implemented within 90 days.



SJRs triggering a Serious Incident are subjected to further investigations and root cause analysis, therefore unlikely to achieve the 90 day aim and will be reported separately in the standard LfD quarterly and annual reports.

Structured Judgement Reviews

Structured judgement review blends traditional, clinical-judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. The result is a relatively short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care. The objective of the review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulty in the care process. In order to answer these questions, there is a need to look at the whole range of care.

Learning from Life and Death Reviews (LeDeR)

Learning from Life and Death Reviews (LeDeR) are an additional layer of scrutiny that reviews the care and treatment of a person who dies and has learning disabilities. LeDeR is conducted by a dedicated team which forms part of the integrated Care Board (ICB).

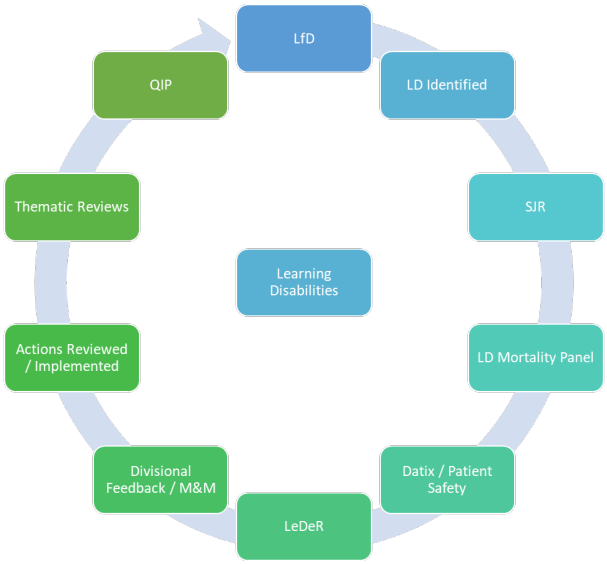
A LeDeR highlights areas of practice that the Trust can learn from. UHSussex have continued to engage and share SJRs with the LeDeR Team.

To improve efficiency and efficacy of learning from Mortality Reviews where a patient with a learning disability dies, Mortality Panel discussion forms and summary SJRs will be shared with the LeDeR team through a newly developed Learning Disabilities Mortality Panel (LDMP).

The LDMP will be made up of a member of the LeDeR team, members of the LD liaison team, SJR reviewers and the Mortality & LfD Manager. Members of clinical teams will be invited to attend accordingly to provide additional context to the reviews. The LDMP will meet monthly to review all LD SJRs. The aim of this new process is to ensure actions arising from both the SJR and the LeDeR team can be considered, shared and actions implemented before the final report is issued.

Once UHSussex have received the LeDeR from the ICB, this will be shared with the relevant clinical division to consider any additional learning points.

The LfD Team will also record and track the learning points as well as excellence to ensure the learning opportunities and excellence is shared with the wider Trust.



Communication and Raising the Profile for 2023/24

The LfD team will publish and distribute a Learning from Deaths Strategy that will support improving Patient Safety and Patient Experience when a person reaches the end of their natural life.

The LfD Team will support developing action plans, initiatives and events to support raising awareness the learning from deaths programs.

The LfD team will use the following methods to achieve this:

- Theme of the Week
- Stakeholder EoLC and Mortality Newsletter
- Trust Noticeboard
- Learning from Deaths Extranet Webpage
- Datix
- SOPs
- Learning from Deaths Policy and Strategy
- National Campaigns where learning has been identified (see Appendix 1)
- Quarterly Divisional Dashboards
- M&M meetings
- Action Plans
- Quarterly Reports
- Annual Report
- Collaboration with the Learning Disability and Liaison Nurse and the LeDeR team

Working closely with internal and external stakeholders including the Medical Examiner Service, Legal team, Bereavement, Palliative and End of Life Care; Patient Safety and Patient Experience teams, the LfD team will increase communication and engagement to support raising awareness and the importance of learning from deaths.

Through creating a culture of learning and improvement the LfD team aim to ensure clinical and non-clinical staff feel safe to engage and embed learning and excellence within their areas of service delivery and beyond.

Quarterly and Annual Reports for 2023/2024

All reports will evaluate and report the following as a minimum

- All Deaths (including, SHMI, HSMR, crude mortality)
- Medical Examiner Outputs
- Deaths referred for SJR
    - Outcome scores of SJRs
    - Outstanding SJRs
- Mortality Panel outputs
    - SJR Scores
    - Deaths referred to the Patient Safety Team
    - SJRs that result in a Serious Incident review
- Embedded learning within clinical specialities as a result of SJR recommendations
- Embedded learning within clinical specialities as a result of LeDeR recommendations
- Deaths referred to His Majesty's Coroner
- Deaths resulting in Inquests
- Identified Trends and Themes
- Learning outcomes that have been achieved/implemented
- Quality Improvement Progress
- Excellence
- Achievements
- Risks
- Action plans

Risks to Achieving Success

The continued lack of resource and uncertainty surrounding the wider Clinical Outcomes and Effectiveness workforce continues to impact negatively on progression of the Learning from Deaths Programs.

Without significant investment into administration and project management staff, an aligned Learning from Deaths service cannot be embedded across all UHSussex hospitals.

UHSussex Mortality Data & Metrics 2022/23

1. Mortality Reviews

Table 1: Number of adult hospital deaths by setting and site

Table 1	SRH		WGH		RSCH		PRH		UHSUSSEX		
Month	Inpatient Deaths	ED Deaths	Inpatient Deaths	ED Deaths	Inpatient Deaths	ED Deaths	Inpatient Deaths	ED Deaths	Inpatient Deaths	ED Deaths	Total
Apr-22	85	6	101	9	106	11	29	4	321	30	351
May-22	87	4	101	7	116	16	44	4	348	31	379
Jun-22	81	7	100	3	81	9	26	1	288	20	308
Jul-22	81	5	106	5	90	6	38	0	315	16	331
Aug-22	74	3	105	9	99	7	25	1	303	20	323
Sep-22	87	7	93	2	95	9	27	1	302	19	321
Oct-22	96	5	104	8	110	10	46	5	356	28	384
Nov-22	69	8	95	10	81	14	32	1	277	33	310
Dec-22	104	3	128	11	101	13	39	2	372	29	401
Jan-23	100	9	116	7	130	12	33	2	379	30	409
Feb-23	82	4	106	5	89	10	35	1	312	20	332
Mar-23	86	6	110	11	93	14	33	1	322	32	354
Total 22/23	**1032**	**67**	**1265**	**87**	**1191**	**131**	**407**	**23**	**3895**	**308**	**4203**

Deaths within 30 days of discharge of UHSussex hospital sites during 2022/23

Table 2: Number of adult inpatients who died within 30 days of being discharged by site of discharge.

Table 2	SRH	WGH	RSCH	PRH	UHSussex
April 2022	43	32	28	25	128
May 2022	32	24	34	20	110
June 2022	37	37	36	27	137
July 2022	16	36	23	12	87
August 2022	41	37	31	20	129
Sept 2022	30	31	29	18	108
Oct 2022	39	47	24	16	126
Nov 2022	32	39	22	11	104
Dec 2022	43	34	39	25	141
Jan 2023	41	45	36	15	137
Feb 2023	34	30	24	14	102
March 2023	52	47	36	19	156
Total 22/23	**440**	**439**	**362**	**222**	**1465**

*Data source: HEDS.

Stillborn, Neonatal and Paediatric Mortality

All Stillborn, Neonatal and Paediatric deaths are subject to rigorous investigation using standard methods. These are reported separately in line with national reporting requirements.

Medical Examiner Office

2. Medical Examiner's Scrutiny

2.1 **Table 3**: Details the percentage of deaths per hospital site, per month during 2022/23 that were scrutinised via Medical Examiners Office

Table 3	SRH	WGH	RSCH	PRH	UHSUSSEX
April 2022	100%	99%	96%	100%	99%
May 2022	97%	100%	96%	97%	97%
June 2022	97%	100%	100%	96%	98%
July 2022	100%	98%	96.0%	97%	98%
August 2022	100%	99%	96.0%	92%	97%
Sept 2022	95%	99%	90.0%	93%	94%
Oct 2022	100%	100%	96.55%	97.78%	98.58%
Nov 2022	100%	100%	95.59%	100%	98.90%
Dec 2022	100%	98.60%	96.97%	92.13%	97%
Jan 2023	100%	99%	100%	100%	99.8%
Feb 2023	100%	100%	100%	100%	100%
March 2023	100%	100%	100%	100%	100%
Total 22/23	99%	99%	97%	97%	98%

Increasing the Medical Examiner and Medical Examiner Officer workforce will continue into 2023/24 with a phased approach between August and November 2023 increasing activity across all sites to ensure 100% scrutiny of all acute and community deaths are achieved by the statutory date of April 2024.

Referral to His Majesty's Coroner

2.2 **Referral to Coroner**

Table 4: Number of deaths per hospital site, per month during 2022/23 that were referred to the coroner

Table 4	SRH	WGH	RSCH	PRH	UHSussex
April 2022	18	18	50	7	93
May 2022	11	18	62	14	105
June 2022	13	17	31	8	69
July 2022	13	21	28	10	72
August 2022	19	22	25	4	70
Sept 2022	21	26	31	7	85
Oct 2022	15	13	42	7	77
Nov 2022	8	14	38	7	67
Dec 2022	13	17	29	9	68
Jan 2023	24	13	33	9	79
Feb 2023	23	19	27	9	78
March 2023	16	20	26	11	73
Total 22/23	**194**	**218**	**422**	**102**	**936**

Deaths Investigated by His Majesty's Coroner

2.3 Investigated by Coroner

Table 5: Number of deaths per hospital site investigated by the coroner's office

Table 5	SRH	WGH	RSCH	PRH	UHSussex
Apr-22	6	9	5	1	21
May-22	4	4	9	0	17
Jun-22	3	7	3	2	15
Jul-22	6	10	19	6	41
Aug-22	9	10	9	1	29
Sep-22	13	7	16	3	39
Oct-22	10	6	23	3	42
Nov-22	6	11	26	3	46
Dec-22	9	4	13	3	29
Jan-23	8	6	13	2	29
Feb-23	14	8	12	3	37
Mar-23	8	7	12	3	30
Total 22/23	**96**	**89**	**160**	**30**	**375**

Table 6: Percentage of deaths investigated by His Majesty's Coroner

Table 6	Percentage of Deaths investigated
SRH	49.48%
WGH	40.83%
RSCH	37.91%
PRH	29.41%
UHSussex	40.06%

Deaths Referred for Structured Judgement Review

2.4 **Deaths referred for structured Judgement review (SJR)**

Table 7: Number of deaths referred for SJR following ME scrutiny.

Table 7	SRH	WGH	RSCH	PRH	UHSussex
April 2022	12	17	9	1	39
May 2022	8	10	10	0	28
June 2022	5	14	4	2	25
July 2022	6	5	6	3	20
August 2022	11	6	7	1	25
Sept 2022	9	17	8	2	36
Oct 2022	9	10	11	3	33
Nov 2022	10	9	12	0	31
Dec 2022	7	9	12	4	32
Jan 2023	10	10	15	3	38
Feb 2023	7	7	11	1	26
March 2023	10	9	12	1	32
Total 22/23	**104**	**123**	**117**	**21**	**365**
% of all deaths referred for SJR	**9.5%**	**9.1%**	**8.9%**	**4.9%**	**8.7%**

Completed Structured Judgement Reviews

3. Completed Structured Judgement Reviews

Table 8: Number of SJRs undertaken per month 2022/23 *

Table 8	SRH	WGH	RSCH	PRH	UHSussex
April 2022	7	13	8	0	28
May 2022	12	11	5	0	28
June 2022	10	4	11	2	27
July 2022	4	10	4	1	19
August 2022	7	10	8	3	28
Sept 2022	6	5	12	2	25
Oct 2022	2	1	2	0	5
Nov 2022	3	2	7	2	14
Dec 2022	4	2	4	3	13
Jan 2023	9	21	1	2	35
Feb 2023	10	8	1	0	19
March 2023	8	10	6	0	24
Total 22/23	**82**	**97**	**69**	**15**	**265**

* Note: Some of the SJRs are completed for patient deaths during previous quarters in 2020/21

Structured Judgement Review Outcome Scores

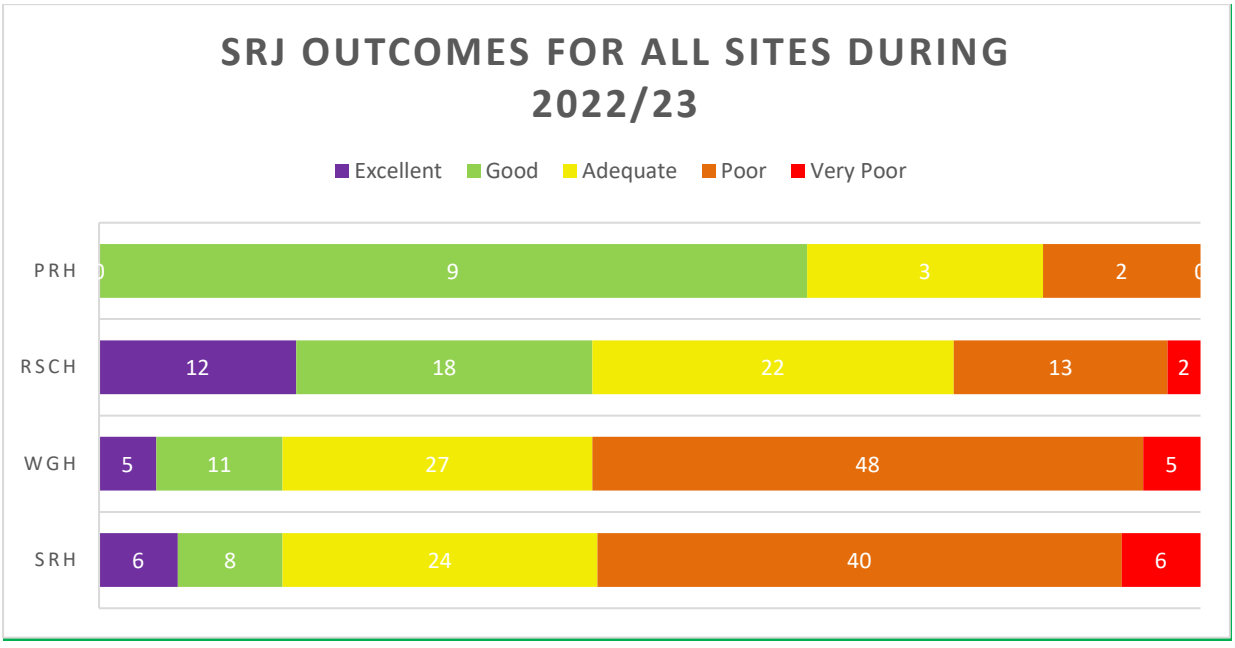
4. Structured Judgement Review outcome scores

Table 9: Details the overall outcome score of SJR per site completed during 2022/23

Table 9 Overall outcome score	SRH	WGH	RSCH	PRH	Total
Excellent	6	5	12	0	23
Good	8	11	18	9	46
Adequate	24	27	22	3	76
Poor	40	48	13	2	103
Very Poor	6	5	2	0	13
Total	**84**	**96**	**67**	**14**	**261**

There are differences in processes applied at RSCH/PRH and WGH/SRH and how SJRs are scored. It is anticipated that this variation will be reduced once dedicated SJR reviewers are appointed and the LfD processes are aligned across all of UHSussex hospitals.

Graph 1: Outcome scores of first SJR on all four sites, completed during 2022/23



Learning from Deaths

5. Learning from deaths

Where deaths are judged to be potentially more likely than not to be due to problems of care a report to the UHSx wide serious incident review group is detailed with the SJR outcome and mortality panel recommendations.

Using a senior multidisciplinary approach, the serious incident review group agrees the appropriate investigation/escalation level under the Trusts serious incident framework with the associated recording and reporting processes.

All other learning from deaths is fed back to clinical teams for divisional level quality improvement opportunities and collated into themes.

Patients identified with a Learning Disability

6. **Structured Judgement Reviews and learning disability (LD) flagged patients**

Table 10: Details the number of SJRs completed for inpatient deaths with a LD flagged during 2022/23

Table 10	SRH	WGH	RSCH	PRH
April 2022	0	2	0	0
May 2022	2	1	0	0
June 2022	0	0	1	0
July 2022	0	1	0	1
August 2022	2	0	2	4
Sept 2022	3	1	1	5
Oct 2022	0	0	2	2
Nov 2022	2	3	0	5
Dec 2022	0	3	6	9
Jan 2023	1	5	0	6
Feb 2023	1	1	2	4
March 2023	2	1	2	5
Total 22/23	**13**	**18**	**16**	**41**

All patients identified as having a LD in the ED or as an inpatient across UHSussex sites underwent ME office scrutiny and a SJR review. The Learning from Life and Death Reviews (LeDeR) programme was notified of all cases, within the agreed timeframe.

All feedback, learning and recommendations for improvement as well as positive action points were shared at the Learning Disabilities Strategy Group.

Learning from Deaths Themes

7. **Learning from deaths themes identified through Structured Judment Review Methodology:**

Following the completion of case reviews over the past year a number of learning themes have been identified:

- Late recognition of end of life leading to lost opportunities for palliative intervention at an earlier stage.
- Occasions where ceilings of care with treatment escalation not recorded or communicated.
- The early identification of deterioration and escalation of patients.
- Patient pathways at the weekend and out of hours.
- Mortality associated with fractured neck of femur.

Learning from Deaths into Action

Actions following our learning

- Merged end of life and mortality groups to form one overarching improvement forum which includes all sites of the Trust.
- Successful business case to extend palliative care services.
- Task and finish group for implementation of treatment escalation plans, includes follow up audits and targeted educational sessions.
- Ongoing review of patient handover processes at weekends and out of hours.
- Structured judgement reviews for all deaths following fractured neck of femur.
- Multi-divisional working group established to review pathway and outcome for fractured neck of femur patients.
- Merged deteriorating patient group now includes all sites of the Trust in one forum.
- Implementation of blood gas results into main results systems for specific markers that inform the identification of deteriorating patients on electronic patient tracking system.
- Further recruitment of Medical Examiners and Medical Examiner Officers to cover the scrutiny of deaths on all sites of the Trust.

The Impact of our Actions

The impact of our actions

- Multiple forums informed by learning from deaths recommendations where progress against improvement plans is reviewed.
- Palliative care consultants appointed at all hospital sites.
- End of life comfort observations recorded on electronic patient system.
- Increasing evidence of treatment escalation plans within patient records.
- Increased learning from deaths opportunities via independent medical examiner reviews of inpatient deaths.

End of Life Care Strategy 2022/23

8. End of Life Care strategy 2022/23

A UHSussex aligned end of life care strategy has been developed with the following key aims:

- To ensure an educated, competent, and confident workforce:
- To provide personalised, dignified end of life care for patients and their families:
- To ensure all patients and healthcare professionals in all four hospitals have access to specialist palliative care advice and support that is evidence based, adequately resourced and available seven days per week:
- To partner with others to provide seamless care for patients approaching the end of life.

Recommendations for the LfD Programs

9. Recommendations:

Develop a Mortality & Learning from Deaths Strategy for 2023/24 – 2024/25 that will adopt delivering a monthly dashboard and a quarterly report to provide assurance that there are closed loop systems and processes supporting Structured Judgement Reviews, learning outcomes and Quality Improvement Plans

Progress actions associated with learning from deaths themes and recommendations informed by the UHSussex End of Life Care strategy to continue to be reviewed and reported via the UHSussex quarterly learning from deaths reports

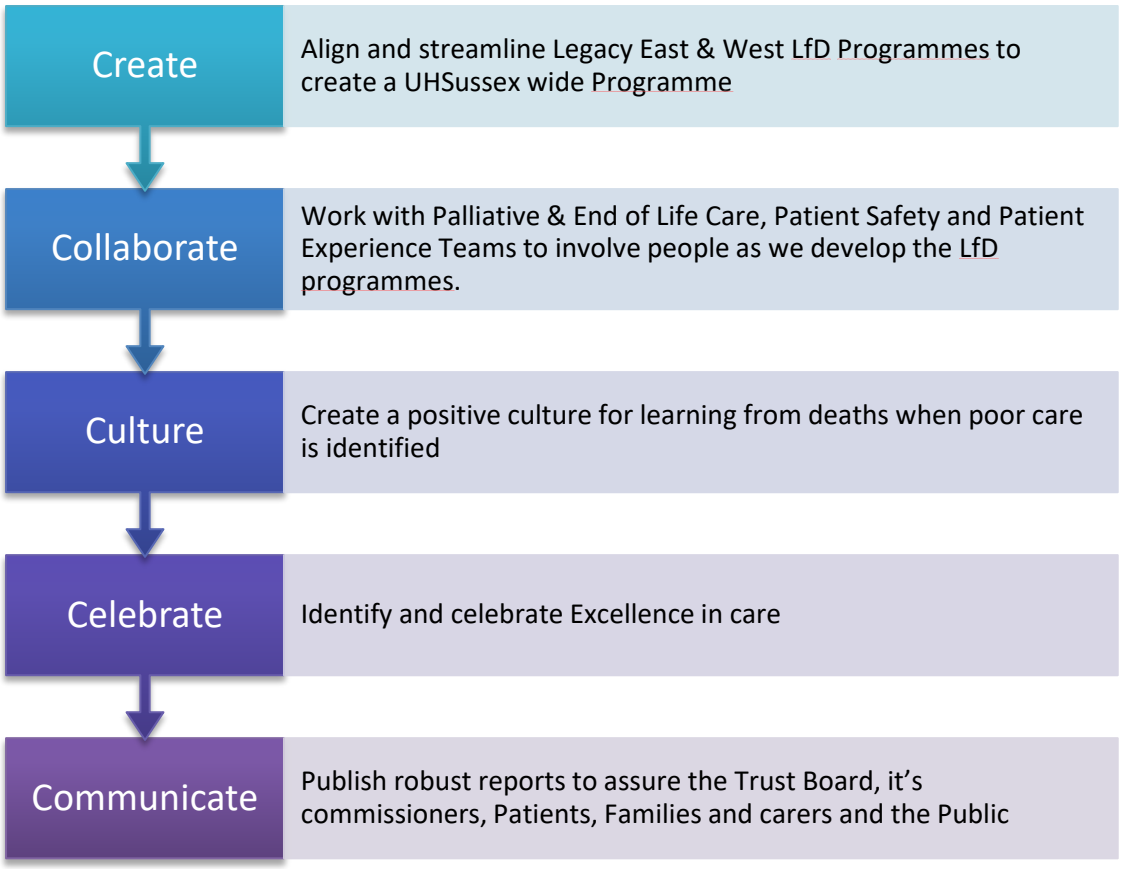
Support restructure of the Clinical Outcomes and Effectiveness Team to secure investment into administration and project management staff, to support a sustainable, aligned robust, Learning from Deaths service.

Appendix A – Actions Year 1 2023-24

Objective	Purpose	By when
Develop Panda IT modules to support Mortality & LfD Programmes	Deliver a streamlined process that captures a 360 degree learning process that provides robust qualitative and quantitative outputs that support Learning and Quality Improvement	April 2023
Recruit 1 wte Project Manager	To support alignment projects and future LfD Programmes.	May 2023
Recruit 1.4 wte Administrator	To support with general admin, service the Mortality Panels and EoLC&M Board.	June 2023
Pilot new Mortality Panels and process using new Panda IT Modules	Ensure process is able to achieve desired outcomes using PDSA cycle.	June 2023
Go live with new Mortality & LfD Programmes	Deliver an aligned, streamlined Mortality and LfD platform across all of UHSx	June 2023
Develop 2 x weekly Mortality panels to review all SJRs scoring poor or very poor care	Ensure poor care is identified, shared, and learned from to improve patient safety and patient Experience.	July 2023
Appoint and train dedicated Structured Judgement Reviewers on all relevant hospital sites.	Dedicated reviewers will ensure SJRs are completed in a timely manner	July 2023
Deliver first Divisional data output and thematic reviews report	Provide divisions with Mortality data insights and identified themes to support Learning from Deaths	September 2023
Engage with M&M Leads to develop an IT platform that supports standardised processes for feeding into M&Ms and capturing learning	Develop a platform where M&Ms receive rich information from SJRs and thematic reviews for discussion at M&Ms	September 2023
Establish regular M&Ms using new processes	Regular M&Ms utilise LfD feedback and provide assurance to the QC that learning is being embedded	December 2023

Appendix B – Actions Year 2 2024-25

Objective	Purpose	By when
Support identifying and implementing two Quality Improvement plans from Mortality Panel outputs	Demonstrate how Mortality Panels can support improving patient Safety, Patient Care and Patient Experience.	April 2024
Deliver first annual report on the new Mortality & Learning from Deaths Programmes	Provide assurance to the Trust board, staff, patients, and the public that UHSussex is learning from all Deaths and making improvements where poor care is identified as well as sharing excellence in care	July 2024
Establish workstreams into GRFT and Health Inequalities Programmes	Utilise LfD and HI Outputs to support GRFT and drive learning.	TBC 2024
Review LfD Programs	Ensure the aligned programs are achieving the desired outputs	July 2024



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University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	**21.**	**Meeting:**	Quality Committee Trust Board	**Meeting Date:**	**July 2023**
Report Title:	UHSussex 2022-23 Medical Appraisal and Revalidation Board Report				
Sponsoring Executive Director:			Katie Urch, Chief Medical Officer		
Author(s):			Dr Rob Haigh, Responsible Officer Neil Cripps, Lead for Appraisal and Revalidation Dr Rachael James, Medical Director Caroline Wiggs, Medical Appraisal and Revalidation Manager		
Report previously considered by and date:					

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

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

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

Communication and Consultation:

Please detail how the report has been prepared i.e. Department in conjunction with Divisional Leads/cross Divisional support and how it links to breakthrough objectives / Efficiency programme.

The report has been prepared by the Medical Appraisal and Revalidation (MAAR) Team in conjunction with the Lead for Medical Appraisal and Revalidation, Medical Director and Responsible Officer.

Executive Summary:

Please provide a brief summary of the what the report relates to and any key points including monetary values that will help inform the Committee/Board recommendation

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

The report updates the Board on the 2022-23 end of year position with regards to medical appraisal and revalidation and seeks Board sign-off of the NHS England statement of compliance.

Key Recommendation(s):

The Committee is asked to ENDORSE this report for Trust Board approval

University Hospitals Sussex
NHS Foundation Trust

UHSussex 2022-23 Annual Medical Appraisal and Revalidation Board Report

Section 1 - General:

As at 31 March 2023, there were **1452** doctors with a prescribed connection to **University Hospitals Sussex NHS Foundation Trust.**

Of **1452** doctors, **1181** medical appraisal meetings have taken place. There were **271** 'approved missed' appraisals, with 75 doctors unable to be allocated a trained appraiser, due to an insufficient number of appraisers. Other reasons for 'approved missed' appraisals included maternity leave, prolonged (approved) leave and sickness absence during the due appraisal window.

191 revalidation recommendations to the General Medical Council were scheduled in 2022-23 and all were carried out in a timely manner.

The requirement to submit a 2022-23 Annual Organisational Audit (AOA) to NHS England was cancelled and is not therefore included within this report.

University Hospitals Sussex NHS Foundation Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

The current Responsible Officer is Dr Rob Haigh. The appointment was made in line with statutory requirements, with appropriate training given.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

The Responsible Officer is supported in their role by Dr Rachael James, Medical Director; Mr Neil Cripps, Lead for Medical Appraisal and Revalidation and the Medical Appraisal and Revalidation (MAAR) Team. A budget for the management and administration of Medical Appraisal and Revalidation is agreed with Finance at the beginning of the financial year.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

The web-based GMC Connect list of prescribed connections to the Trust is continuously updated by the MAAR Team, with new starters and leavers. All policies which support medical revalidation are actively monitored and regularly reviewed.

There is a policy review cycle in place for those policies that support medical appraisal and revalidation.

4. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Legacy BSUH and WSHT appraisal and revalidation processes have been satisfactorily reviewed by the NHS England (South) Higher Responsible Officer Team within the last 5 years.

A further peer review will be undertaken subject to NHS England's cycle of reviews, which have been delayed due to the COVID-19 pandemic.

5. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

All fixed term (locum) doctors are supported in their continuing professional development and governance. Fixed term doctors with a prescribed connection to the Trust are allocated an appraiser and supported with their revalidation. Staff bank and agency doctors are supported according to their relationship with the Trust.

Section 2a - Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Appraisals for doctors with a prescribed connection to the Trust are completed on the Trust's web-based appraisal system, which meets the GMC and NHS England requirements for appraisal. L2P (Licence to Practice) is the legacy BSUH system and Allocate the legacy WSHT system. L2P will be implemented as the single Trustwide appraisal system by 31/07/2023.

Doctors are responsible for ensuring that sufficient supporting information, covering their whole scope of work, is uploaded to facilitate an effective appraisal discussion and doctors sign a declaration within the system to that effect.

Significant events and information held on DATIX and through the complaints team are shared with the doctor prior to the appraisal.

The organisation supports doctors to collect the required supporting information.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

N/A - see above.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

An in-date medical appraisal policy is in place and is aligned with national policy (legacy WSHT policy.)

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

The Trust had **156** trained appraisers during 2022-23.

Unfortunately, a number of appraisers have stepped down from the role and UHSussex currently has insufficient numbers of appraisers to carry out annual medical appraisals for all doctors with a prescribed connection to the Trust.

A review of appraiser remuneration, (including harmonisation between the legacy organisations), recruitment and retention strategies will be implemented to increase capacity.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development

events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Appraisers are supported in their role in the following ways:

- Development and calibration workshops.
- There is open access appraisal and revalidation advice and discussion opportunities as they arise with the Responsible Officer; Medical Director; Lead for Medical Appraisal and Revalidation and/or Medical Appraisal and Revalidation Manager.
- Monthly email bulletins are sent to all doctors with a prescribed connection, detailing local, regional and national medical appraisal developments.
- In order to support their development, appraisers receive an annual report based on 360° feedback from doctors appraised.
- Senior Appraisers and/or the Medical Appraisal and Revalidation Team review the appraisal summaries of new appraisers and provide individual feedback to support development.
- The Responsible Officer; Medical Director; Lead for Medical Appraisal and Revalidation and Medical Appraisal and Revalidation Manager are members of the South East RO network, with events held remotely during the 2022-23 appraisal year.

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Within the last 5 years an independent verification of the Trust's legacy BSUH and WSHT processes has been undertaken by NHS England (South) Higher Responsible Officer Team. A number of areas of good practice were identified. A further peer review will be undertaken subject to NHS England's review cycle. Following appraisal, doctors are asked to complete an anonymised appraisal feedback form. Collated responses are shared with appraisers and any particular issues or themes are discussed and taken forward with appraisers and the Lead for Medical Appraisal and Revalidation. An annual audit of appraisal summaries is undertaken by a Senior Appraiser and/or the Medical Appraisal and Revalidation Team using an NHS England audit tool. General themes and areas for development are taken forward with appraisers and Leads for Medical Appraisal and Revalidation. A Medical Appraisal and Revalidation Report is submitted to the Quality Committee and Board annually.

Section 2b - Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation: University Hospitals Sussex NHS Foundation Trust	
Total number of doctors with a prescribed connection as at 31 March 2021	**1452**
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	**1181**
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	**271**
Total number of agreed exceptions	**271**

Section 3 - Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol:

- There were **191** GMC recommendations due during the 2022-23 year.
- **35** deferral recommendations were submitted due to insufficient supporting information.
- There were no missed or late Responsible Officer recommendations to the GMC.
- There was **1** non-engagement recommendation.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

All revalidation recommendations made to the GMC during 2022-23 were confirmed to the doctors in a timely manner by the Lead for Medical Appraisal and Revalidation and/or Medical Appraisal and Revalidation Manager, on behalf of the Responsible Officer.

The reasons for recommending a deferral or non-engagement are always discussed with doctors before the recommendation is submitted.

Section 4 - Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

The Trust fosters a continuous improvement culture with well embedded and effective governance arrangements in place. There are clear systems in place for reporting and reviewing incidents and complaints. Openness and reporting is encouraged.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

> The Trust's Maintaining High Professional Standards Policy is based on the national Maintaining High Professional Standards in the Modern NHS (MHPS) framework setting out the variety of ways that concerns can come to light and the actions to take when a concern arises. The legacy WSHT policy is due for review in August 2023.
>
> The Trust's Medical Appraisal and Revalidation Policy sets out the process for managing appraisals for a doctor under investigation or subject to a disciplinary process or GMC fitness to practice proceeding.
>
> Doctors with a prescribed connection to UHSussex are provided with an annual DATIX report and/or Annual Medical Appraisal Return (AMAR) for their appraisal.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

> The Trust's Maintaining High Professional Standards Policy sets out the established processes to follow when responding to concerns about doctors.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[2]

> In line with MHPS, a Non-Executive Trust board member is allocated to each case to provide assurance and oversight. The Trust's NHS Resolution Adviser is always approached to provide expert, independent advice, support and critique on handling complex concerns.
>
> The Responsible Officer, Medical Director and Lead for Medical Appraisal and Revalidation meet quarterly with the GMC Employment Liaison Adviser.
>
> Formal performance management processes have been Equality Impact Assessed to minimise potential for bias and disadvantage.
>
> As part of the Race Equality Standard, the Trust analyses the number of BAME staff going through disciplinary processes to assess whether there is a negative impact.

[2] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[3]

Regular and ad-hoc transfers of information requests both to and from the organisation are responded to promptly and in line with national requirements. For Trust doctors on the GP Performers List, the Responsible Officer meets twice yearly with the NHS England (South) Responsible Officer's office and part of the purpose of that meeting is to share any information of note and to ensure a consistent approach to concerns involving GPs. For those doctors with a prescribed connection to another organisation, a year-end audit of appraisals is undertaken. The purpose of the audit is to provide assurance that doctors are engaging in appraisal with their Designated Body. Doctors working for the Trust under a Service Level Agreement are managed through those arrangements.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

See above.

Section 5 - Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Permanent, fixed term and bank appointments are subject to the full NHS Pre-Employment Check Standards. Agency guidelines are in place which includes a medical agency worker pre-engagement checklist for Staff Direct and the authorising managers' use.

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 6 - Summary of comments, and overall conclusion

The 2022-23 end of year medical appraisal completion date for doctors with a prescribed connection for revalidation was **81%**. (Of the **1452** doctors with a prescribed connection to the Trust as of 31 March 2023**, 1181** medical appraisal meetings took place.) There were **271** 'approved missed' appraisals agreed.

The Board is asked to review the content of this report, noting that it will then be shared with the Tier 2 Responsible Officer at NHS England. The Board is asked to note the Statement of Compliance which confirms the Trust as a Designated Body is in compliance with the regulations.

Section 7 - Statement of Compliance:

The Board / executive management team of **University Hospitals Sussex NHS Foundation Trust** has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Official name of designated body: **University Hospitals Sussex NHS Foundation Trust**

Name: Dr George Findlay Signed: _ _ _ _ _ _ _ _ _ _

Role: Chief Executive

Date: _ _ _ _ _ _ _ _ _ _

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	18	**Meeting:**	QGSG	**Meeting Date:**	17 July 2023
Report Title:	Safeguarding Adults Annual Report 2022/23				
Sponsoring Executive Director:	Leanne McLean, Chief Nursing Office				
Author(s):	Sam Page, Head of Safeguarding				
Report previously considered by and date:	Safeguarding Committee, 20/07/23				

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

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

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	Yes / N/A	Link to Trust Annual Plan	Yes / N/A

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	Yes	
Sustainability	N/A	
People	Yes	
Quality	Yes	
Systems and Partnerships	Yes	
Research and Innovation	N/A	

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

Regulatory / Statutory reporting requirement

Care Act (2004)

Communication and Consultation:

Executive Summary:

This Annual Report highlights the work undertaken by UHSussex in respect of its commitment and responsibilities in maintaining the safety and protection of adults at risk of abuse and neglect.
The purpose of this report is to:

- Provide assurance that UHSussex is compliant with its safeguarding duties
- Provide an overview of the UHSussex safeguarding adults team activity in 2022/23
- Outline the key safeguarding priorities for 2023/24

Assurance

The Trust fulfils its safeguarding adult responsibilities in the following ways:
Accountability:

- The Chief Nurse is the executive lead for safeguarding and has oversight of safeguarding activity via the quarterly Safeguarding Committee and Quality Committee. The Head of Safeguarding provides the Safeguarding Committee with a quarterly assurance report.

- The Trust has 2 safeguarding adult leads and a small team of safeguarding professionals.

Partnerships:

- Lead professionals are fully engaged in the 2 Local Safeguarding Adult Partnerships and attend partnership sub-groups.

Training:

- The Safeguarding Adult Team has reviewed and developed a model for Level 3 training. Plans for implementation will be incorporated in an overarching safeguarding training strategy.

Audit:

- Work was undertaken to carry out an MCA audit tool in preparation for the implementation of the Liberty Protection Safeguards (now withdrawn by central government). This demonstrated gaps in knowledge and skills and a review of MCA training will be undertaken with further audit planned.

Practice Reviews:

- The Trust engaged in the relevant Safeguarding Adult and Domestic Homicide Reviews during 2022/23. Learning from reviews was fed back into safeguarding and domestic abuse training.

Policy:

- Safeguarding adult and MCA policies are up to date.

Activity:

- There has been continued focus on Section 42 safeguarding requests for information regarding UHSussex care. A total of 115 enquiries were raised, with most concerns relating to discharge processes. All concerns are shared with Divisional governance leads with feedback regarding the particular concern. Work will be undertaken with Divisional Governance leads to better understand particular areas for focus and to monitor improvement processes.

- Work is progressing to improve data collection and reporting processes across the Safeguarding Adult Team with standardised processes. Future reporting will enable increased sight of activity across each hospital site.

- The number of UHSussex patient being detained under the MHA remains high, and considerable work is being undertaken with the mental health Trust to understand and improve emergency processes. The Safeguarding Adult Team has oversight of MHA implementation via the Datix incident reporting system.

- DoLS applications have increased year on year.

Safeguarding Adult Team priorities for 2023/24

1. Self-neglect

- To work with SAB to thematic Safeguarding Adults Review (SAR) on self-neglect to identify issues, barriers, and themes of recent published self-neglect SARs in Sussex in order to develop an action plan to improve systems, policy, procedure, and practice.

- Following the 2022/23 SAB self-neglect audit, trust to participate on a self-neglect survey for staff across the partnership to identify issues, barriers, and what is needed to better support practice.

- To support SAB to review the Sussex self-neglect policy and procedures including referral pathways. And the Sussex Safeguarding Thresholds Guidance for self-neglect.

- To promote within the trust resources from SAB linked to working with those who self-neglect including; Making Safeguarding Personal (MSP), Mental Capacity Act assessments and Best Interest process, risk assessment, multi-agency practice, and referral to our Multi-agency Risk Management Subgroup (MARM).

- To promote SAB self-neglect in newsletter and feature case study.

2. Embedding learning and assurance

- To promote SAB existing resources with a particular focus on learning from SARs and audits.
- Promote SAB newsletter article on learning from SARs and audits and their available resources.
- Invite SAB staff to share information about SAB, key learning areas from SARs and audits, and promotion of resources.
- To participate on SAB survey for staff following staff briefing sessions to seek understanding of the information shared, how it will affect practice.
- To complete Bi-annual self-assessment that include focussed questions on embedding learning.

3. Audit programme

- MCA / DoLS
- Training – to include CAIT / LD
- Sussex SAB bi-annual self-assessment

Key Recommendation(s):

The Report is noted and endorsed for approval at Trust Board.

University Hospitals Sussex
NHS Foundation Trust

Safeguarding Adults Annual Report 2022-2023

Jo Henderson, Safeguarding Adult Lead

Frank Ungani, Safeguarding Adult Lead

Contents

1. Introduction

University Hospitals Sussex NHS Foundation Trust (UHSussex) has a statutory responsibility to ensure effective arrangements are in place to safeguard and promote the welfare of children and adults at risk of harm and abuse; in line with the statutory requirements of the Safeguarding children, young people and adults at risk in the NHS - Safeguarding Accountability and Assurance Framework (SAAF) (updated 2022); The Care Act 2014 supported by the Care and Support Statutory Guidance, and the Adult Safeguarding Roles and Competencies for Health Care Staff (2018).

In addition, the Trust, as a registered provider with the Care Quality Commission (CQC), must have regard for the Regulations as established under the Health and Social Care Act (2008). In relation to safeguarding, including but not limited to, Regulation 13 and Regulation 17, relating to protecting service users from abuse and good governance respectively.

This annual report provides an overview of the safeguarding arrangements and range of activity undertaken to safeguard and promote the welfare of adults at risk, across University Hospitals Sussex NHS Foundation Trust (UHSx) for the period of April 2022 to March 2023. In doing so, the Trust discharges part of its responsibility for Board-level assurance, scrutiny and challenge of safeguarding practice within the Trust.

2. Background

The Care Act safeguarding duties apply to an adult who:

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

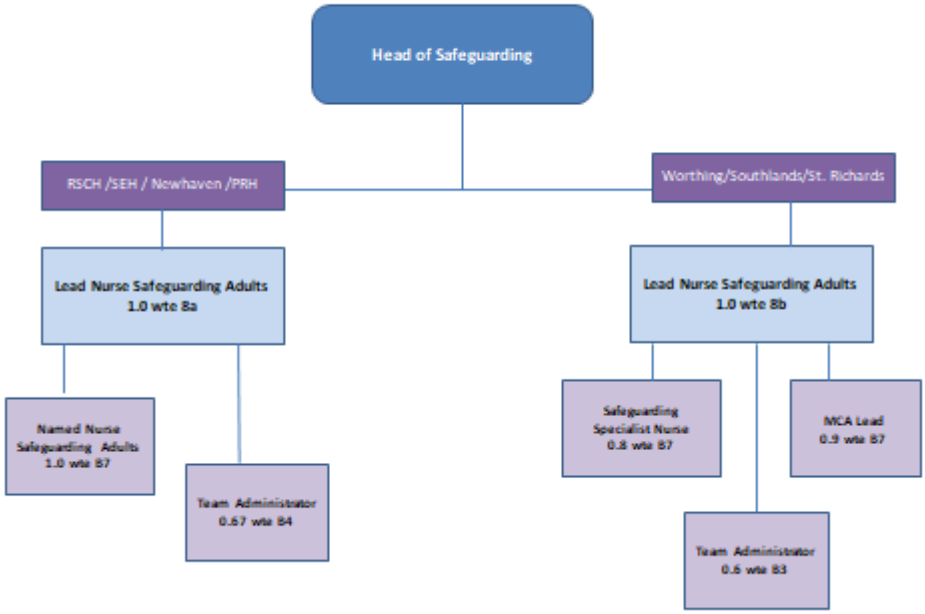
To minimise the risk of abuse, all healthcare professionals working within the NHS need to recognise their individual responsibility to safeguard and promote the welfare of adults who are vulnerable, as well as the commitment of the Trust management and leadership to support them in this. This includes ensuring access to appropriate training, advice and support and supervision in relation to the Care Act (2024), Mental Capacity Act (2005) / Mental Capacity Amendment Act (2019), Mental Health Act (2007), the Domestic Abuse Act (2021) and the Prevent Duty (2015) identified through the Counter-Terrorism and Security Act (2015).

This report aims to:

- Provide assurance to the Trust Safeguarding Strategy Committee and Executive Board that UHSussex is fulfilling its statutory safeguarding responsibilities
- Provide an update on the safeguarding priorities during 2022/23 and identify safeguarding key priorities and risks for 2023/24
- Provide assurance by demonstrating how UHSussex works in partnership with key internal and external stakeholders to deliver a comprehensive, cohesive, safe and effective safeguarding service for the hospital.

3. Current Postion

The chart below shows the current structure of the Safeguarding Adults teams within UHSussex



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

The two Lead Nurses continue to work collaboratively, in partnership with the Lead and Named Nurses for Safeguarding Children, to ensure that the recommendations from regulatory and professional safeguarding standards are implemented across

UHSussex. The leads are strategic in nature but with an operational focus, who work closely with professionals and partner organisations to deliver a comprehensive safeguarding function. They play a key role in providing expert safeguarding leadership across the organisation; providing advice, support, supervision and expertise for other professionals.

The latter part of 2022 – 23 saw the appointment of a new Head of Safeguarding. This appointment will provide more focused cohesive senior leadership support, working closely with the leads to shape the direction of safeguarding within UHSussex.

4. Learning, development and training

A key focus of the safeguarding team is the provision of mandatory training for safeguarding adults and also the Mental Capacity Act and Deprivation of Liberty Safeguards. It is a requirement for all staff working within healthcare to complete Level 1 training in Safeguarding Adults. UHSussex has incorporated this into the all staff induction programmes. Further training for clinical staff is identified through the Intercollegiate Document which provides the competency framework for safeguarding commensurate with staff roles and responsibilities.

Level 2 e-learning was developed during the COVID-19 pandemic to replace the face-to-face training. This remains embedded within staff mandatory training. A particular focus for 2022-23 has been the development and implementation of level 3 training and ensuring an integrated Training Needs Analysis to ensure a consistent approach to the identification of staff requiring this level, within UHSussex. This has met with some challenges due to different learning management systems and processes across the legacy organisations. Moving forward, the development and implementation of an overarching training strategy will remain a priority for 2023-24.

The safeguarding leads are required to achieve Level 4 training. Due to the specialist nature, external training is provided by partners such as NHS Sussex, Local Authority, Victim Support and others, which meet the Level 4 requirements. Opportunities for and compliance with Level 4 training requirements is recorded via the Trust appraisal process.

6. Audit

As part of the preparation for the expected implementation of the Liberty Protection Safeguards that were due to replace the existing DoLS arrangements, an initial audit was completed by the Lead Nurse Safeguarding Adults working in collaboration with the ICB Designated Safeguarding Nurse / LPS lead. A sample of health care records were reviewed, chosen at random from patients known to have been subject to DoLS across RSCH / PRH and a range of clinical specialities to include Speciality Medicine and Surgery.

Documentation from the date of admission to the date of application for DoLS authorisation was reviewed in relation to application of the principles of the Mental Capacity Act. The following findings were noted:

- Limited documentation to show evidence of decision specific mental capacity assessments
- Evidence of discussion with families regarding specific decisions but no supporting capacity assessment to show why patient not involved
- Documented if family member believed to hold LPA but not always confirmed i.e. not seen by staff or copy in notes.
- Use of DoLS suggests not clearly understood – often not requested until patient 'trying to leave'.
- MCA / DoLS questions in single clerking document not completed in all the records reviewed

The Government has now delayed implementation of LPS for the duration of this parliament and it is not known when / if this decision will be reviewed following the next general election. The existing DoLS arrangements remain statutory for NHS organisations. It is important that UHSx continues to build on the work undertaken as part of LPS preparation; to ensure access to robust education and support for clinical staff in relation to MCA and DoLS to ensure consistent application within UHSussex.

A further audit in relation to MCA and DoLS to be undertaken across all sites within UHSussex is to be developed and taken forward in 2023-24

7. Safeguarding Adult Reviews/Domestic Homicide Reviews

The Care Act 2014 states that Safeguarding Adult Boards have a statutory responsibility to arrange a Safeguarding Adult Review (SAR) when an adult dies as a result of abuse or neglect (whether known or suspected), where there is concern that partner agencies could have worked more effectively together to protect the adult. The overall purpose of a SAR is to promote learning and improve practice. It is not to re-investigate or to apportion blame.

UHSussex has been part of three Safeguarding Adult Reviews undertaken this year by the West Sussex Safeguarding Adults Board. Learning from SAR's have been cascaded throughout the Trust and has been included in the 2022/23 SAR/DHR work plan, and is reviewed regularly by the Safeguarding Adults Operational Group and the Safeguarding Strategy Committee

In addition to the West Sussex SARs, UHSussex has participated in two SARs and a Thematic Learning Review with Brighton and Hove SAB and a further two SARs commissioned by East Sussex SAB. Most remain on-going, awaiting final approval by the SAB prior to publication. The Thematic Learning Review has been published and the full report is accessible via the Brighton and Hove SAB website. In addition, the SAB produced a learning briefing for professionals which has been circulated via the Trusts safeguarding governance meetings as well as the trust wide senior team weekly meeting. The learning briefing is accessible via the SAB website. The following key learning for UHSussex has been identified:

- For safeguarding leads to work with multi-agency colleagues to consider how professionals can share training to ensure staff have a better understanding of trauma informed practice and how this may impact on vulnerable people and their engagement with professionals in a range of settings.
- Safeguarding Leads and IDVA to review domestic abuse training to include greater awareness of coercion and control
- Safeguarding training to be reviewed to include awareness of language used by professionals which may appear to be 'victim blaming'.

8. Policies and procedures

8.1 Sussex Safeguarding Adults Policy and Procedures

The policy and procedures set out the approach taken to adult safeguarding across Sussex. They provide an overarching framework to ensure a proportionate, timely and professional approach is taken, and that adult safeguarding is co-ordinated across all relevant agencies and organisations. It has been endorsed by Brighton and Hove, East Sussex and West Sussex Safeguarding Adults Boards. The Sussex Safeguarding Adults Policy and Procedures are accessible to all staff working within UHSussex.

8.2 UHSussex Policies and Procedures

UHSussexx endorses the Sussex Safeguarding Adults Policy and Procedures. In addition, the following internal policies are in place and accessible to all staff working within UHSussex:

	Policy	Approving Organisation	Lead	Approved at	Approval Date	Review Date	Status
1	Safeguarding Adults	UHSx	SGA Leads	TMB	June 2002	June 2025	
2	MCA and DoLS	UHSx	MCA/SGA Lead	TMB	June 2002	June 2025	
3	Prevent	UHSx	SGA	TMB	Sept	Sept	

			Lead		2022	2025	
4	Use of Mental Health Act	UHsx	SGA Lead	TMB	Sept 2022	Sept 2025	

In addition to the above policies, UHSussex has a duty to ensure robust HR recruitment and employment systems and processes are in place which further support safeguarding duties and responsibilities.

Section 2.5 of the Sussex Safeguarding Adults Policy and Procedure sets out the safeguarding requirements for managing allegations against people in positions of trust and references the Care Act 2014 Statutory Guidance on Managing Allegations regarding a Person in a Position of Trust. This will be superseded by a standalone Managing Allegations against Staff Policy, currently with HR for review and ratification. A position of trust can be either a paid or unpaid role when working with adults with care and support needs.

The specific responsibilities of employers include:

- Having a clear internal allegations management procedure in place which sets out the process, including timescales for investigation and support and advice which is available to individuals against whom allegations have been made.
- Codes of professional conduct and / or employment contracts should be followed and should inform management action.
- Ensuring senior leadership and those in management positions are appropriately familiar and confident with the responsibilities their organisation holds regarding both Disclosure and Barring Service (DBS) checks and referrals.
- Making prompt referrals to the Disclosure and Barring Service (DBS) and / or other professional registration bodies where appropriate.
- Maintaining records of the number and nature of allegations made, outcomes of enquiries/investigations and employers should use these to inform service improvement.
- Promoting and maintaining workforce awareness of its Whistleblowing policy.

9. Safeguarding adults enquiries/referrals and incidents

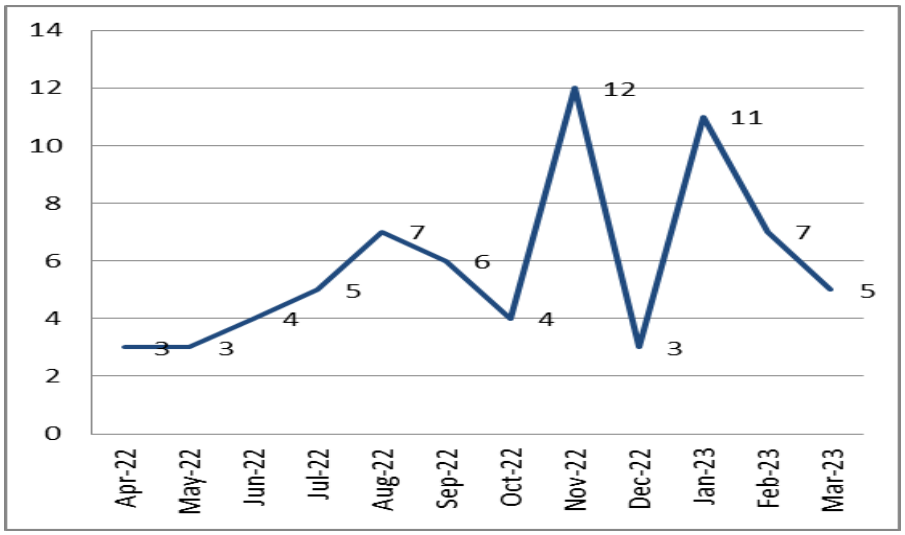
The framework for statutory adult safeguarding set out within the Care Act states that local authorities are required, alongside other duties, to:

- Make enquiries, or ensure others do so, when they believe that an adult is subject to, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to stop or prevent abuse or neglect, and if so, by whom.

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

Fig 1 below shows the number of S42 'Causing others to undertake enquiry' requests received during 2022 - 23 from the three Local Authorities across Sussex, whereby concerns have been reported to them in relation to the care provided by UHSx within the above hospital sites; and it is felt the threshold for a safeguarding enquiry is met.

Fig1: Section 42 enquiries received – Total 70

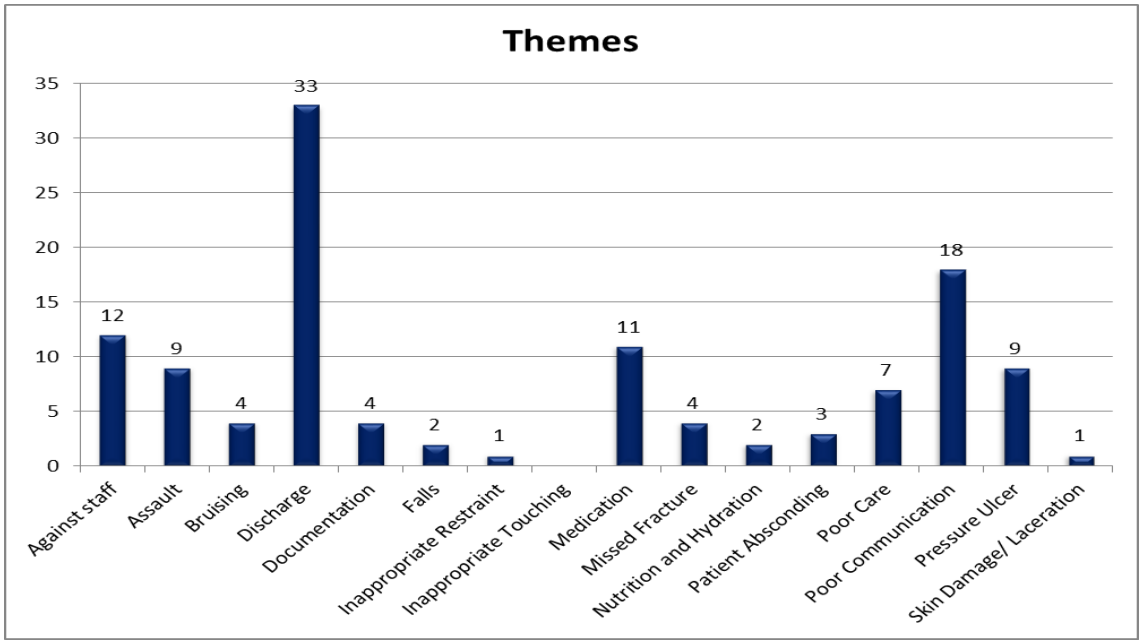


A total of 57 out of the 70 received related to the category of Neglect or Acts of Omission. The remainder were raised in relation to financial abuse, emotional / psychological abuse or physical abuse.

In addition to the categories of harm or abuse identified within the Care Act, the safeguarding adults' team monitor the themes in relation to the specific concerns raised regarding the care provided by UHSussex.

Fig 2 below provides a breakdown of the themes identified and the number of safeguarding concerns in relation to these. One safeguarding enquiry may relate to multiple themes e.g., an allegation of Neglect may relate to the theme of discharge but may also include poor communication or poor documentation which may in turn, relate to changes in medication or lack of wound care plan provision.

Fig 2: Themes



To better understand safeguarding enquiries / referrals and incidents within the above hospital sites, the safeguarding adults' team have expanded their data capture in 2022-23 to include certain protected characteristics. Fig 3 and 4 below show the number of section 42 enquiries received in relation to gender and age, and Fig 6 shows the number of section 42 enquiries received relating to patients with a known diagnosis of dementia, and those known to have a learning disability.

Fig3: S42 Enquiries Received - Gender

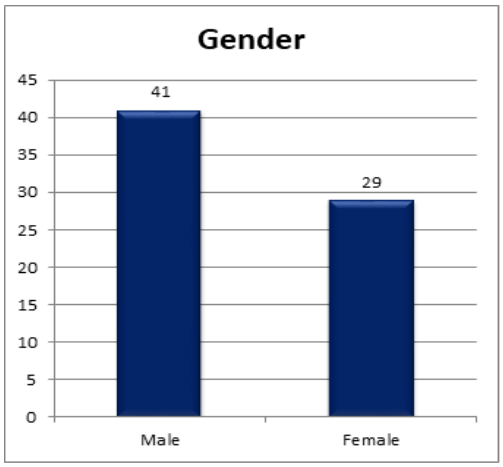


Fig 4: S42 Enquiries Received – Age

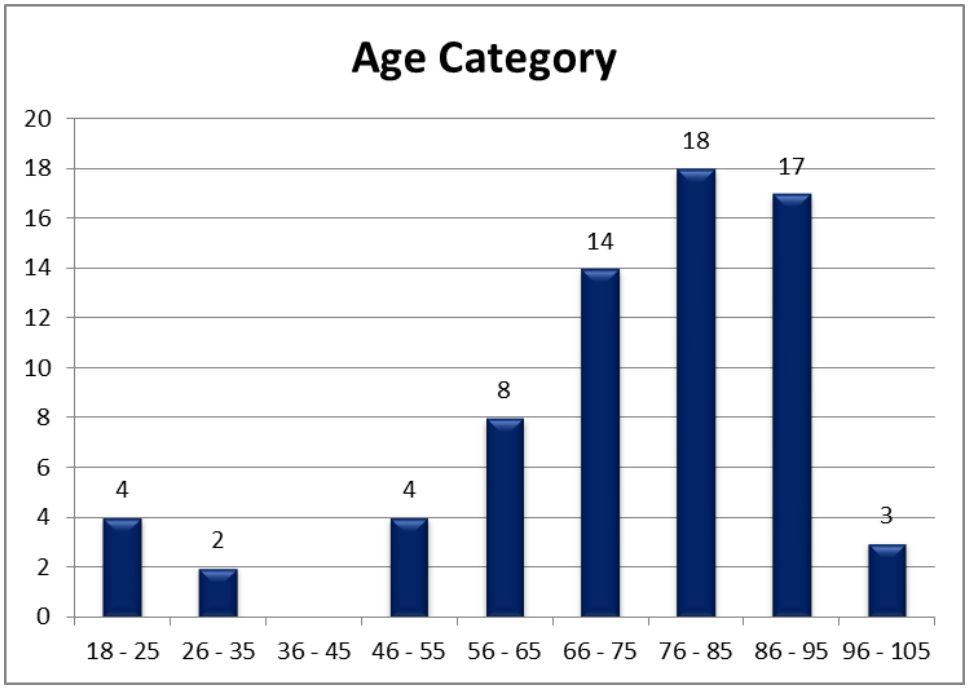
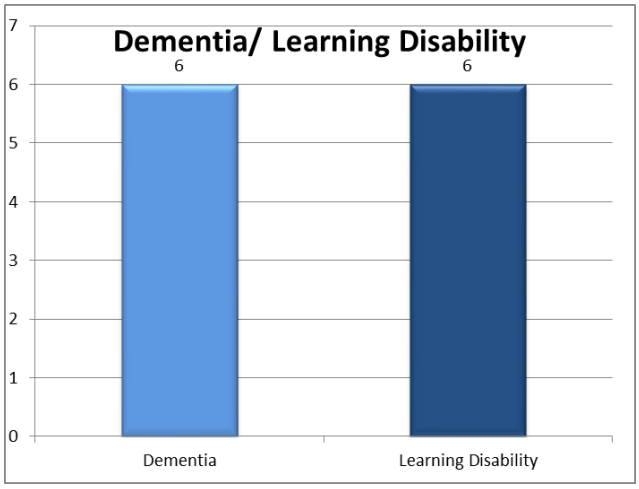


Fig 5: S42 Enquiries Received – Dementia/ Learning Disability



Domestic Abuse

Throughout the COVID-19 pandemic, partner organisations worked together to ensure they maintained their safeguarding functions, with particular focus on domestic violence and abuse. Specialist domestic abuse support across Brighton and Hove is provided by Victim Support. They work closely with the ICB who have commissioned a specialist worker to provide direct support for patients and staff at the Royal Sussex County Hospital. They have three target areas; Emergency Department, Maternity and Sexual Health, although they do offer advice and guidance to other areas including if the person experiencing domestic violence is a member of staff. The post was vacant during the pandemic but a new IDVA was appointed in December 2022.

Domestic abuse can be reported directly to the IDVA or Victim Support. However, it may also be raised via the safeguarding processes to the Local Authority.

Figs 6-9 below show the incidents of domestic abuse raised by staff at RSCH / PRH via the safeguarding route during 2022-23

Fig 6: Domestic abuse – concerns raised

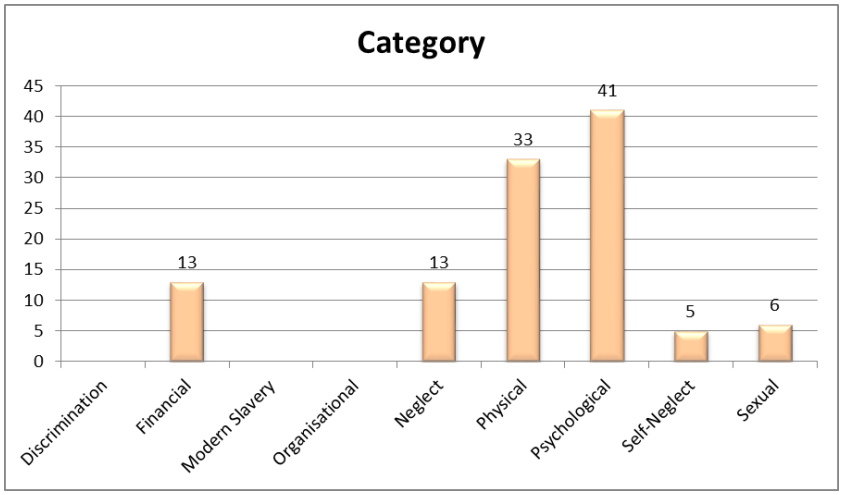


Fig 7: Wards Raising Domestic Abuse Concerns

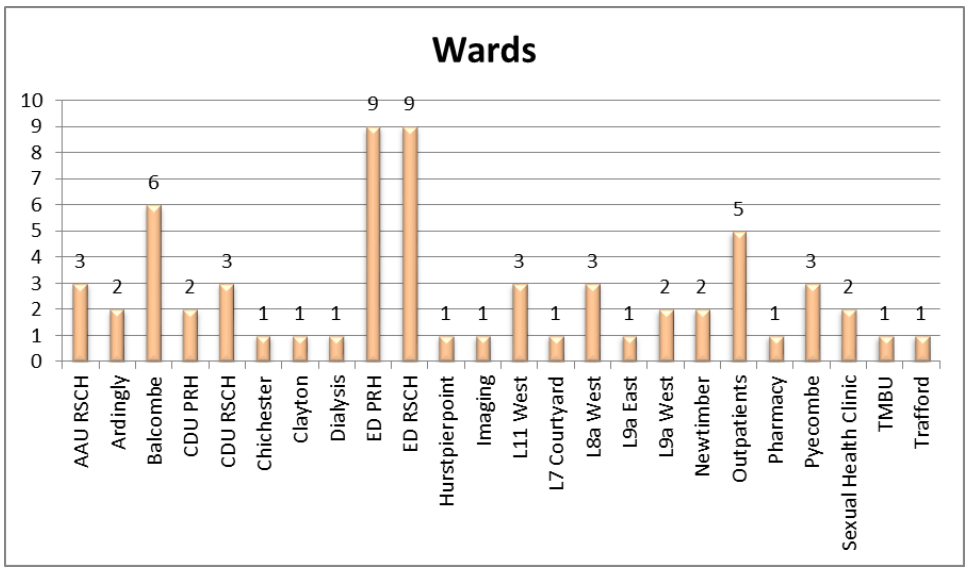


Fig 8: Domestic Abuse Concerns Raised by Gender

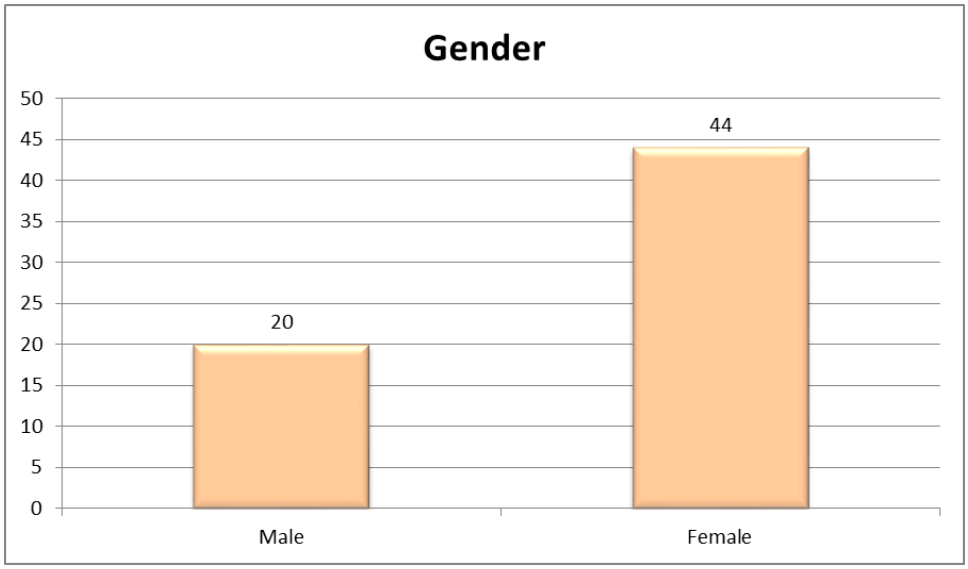
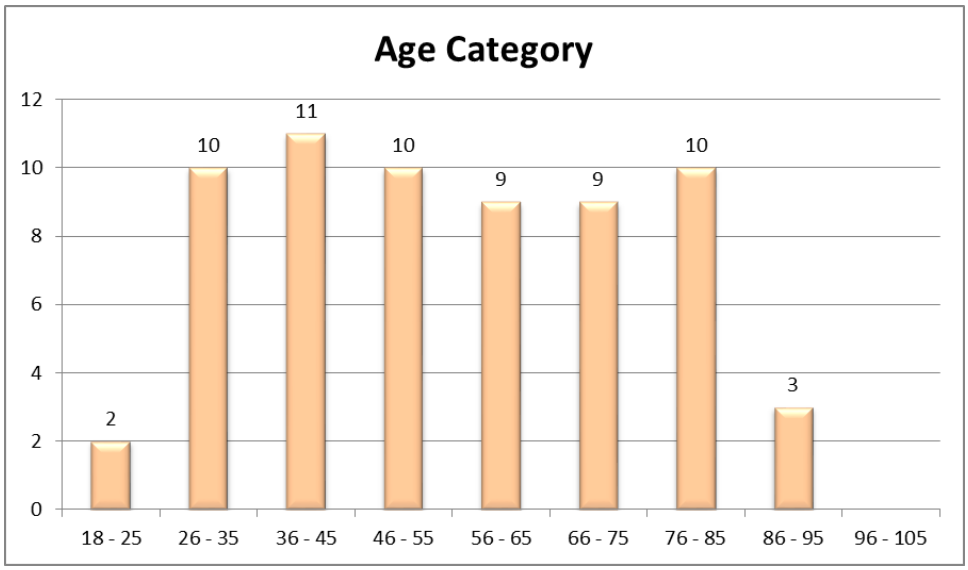


Fig 9 : Domestic Abuse Concerns Raised by Age

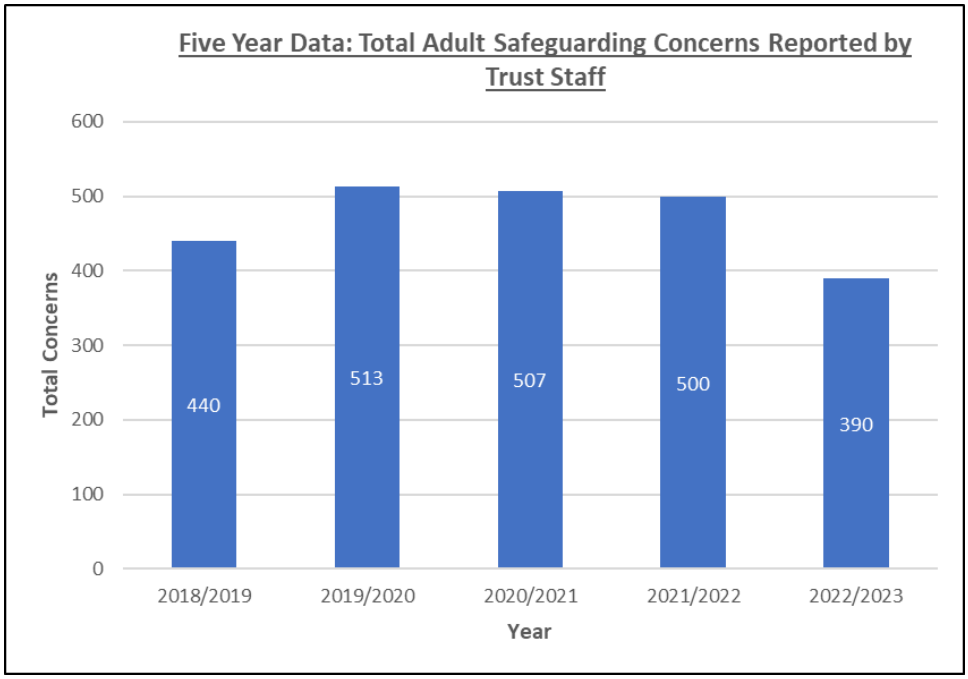


9.2 St Richard's, Worthing, and Southlands Hospitals

Safeguarding concerns in the Trust are monitored by the safeguarding team. Some concerns are managed at ward level by the ward sister/department head and some are more complex which require reporting externally as per national legislation and local policy and procedures. The safeguarding team are involved in providing safeguarding expertise and concerns are analysed to detect trends and themes and to improve safeguarding.

Safeguarding has been 'business as usual' at UHSussex, throughout the COVID-19 pandemic period and after with all staff ensuring that safeguarding was prioritised. The safeguarding service has continued to provide advice and support to our staff across multiple sites. The figure 10 below shows post covid adults safeguarding concerns reported by our staff to the safeguarding adult's hub.

Fig 10: Concerns raised

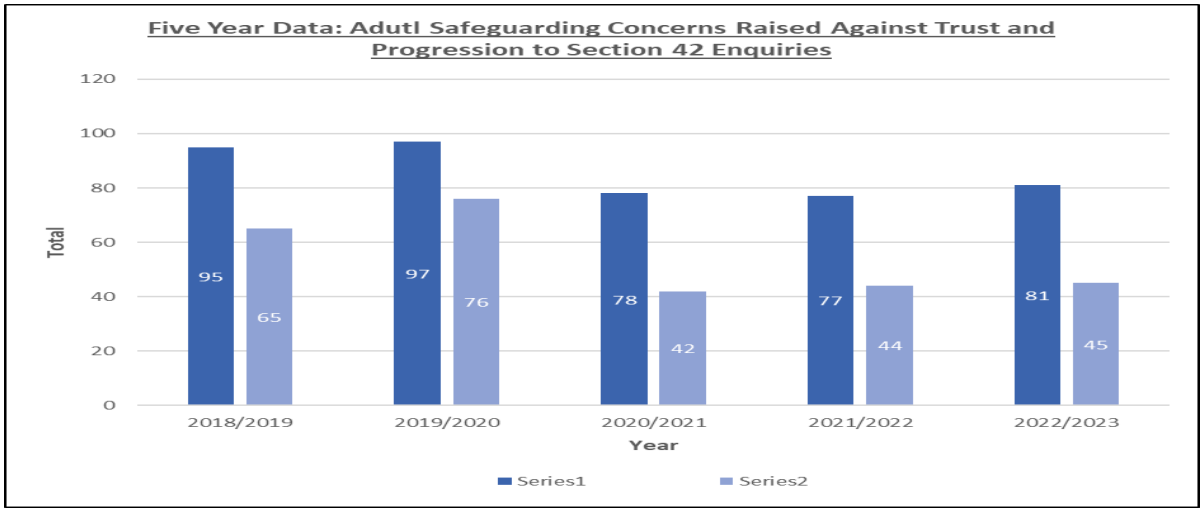


There has been an expected decrease in the number of concerns reported to the adults safeguarding hub in 2022/23. During the pandemic period we saw the impact of Covid-19 on our patients and service users this included increased vulnerabilities. However, since the end of pandemic we have observed a decrease in number of adults safeguarding referrals to Social Care and Police and the referral numbers are returning to those pre-pandemic.

The need to keep vulnerable adults safe is a core priority of our frontline teams however, Covid-19 put huge strain on the workforce and made previous home visiting and monitoring more challenging. There has been a lot of training and awareness around what is safeguarding and what is not. This could also explain the reason for the decrease in the number of referrals made by staff as staff knowledge and skills around safeguarding is much better compared to previous years.

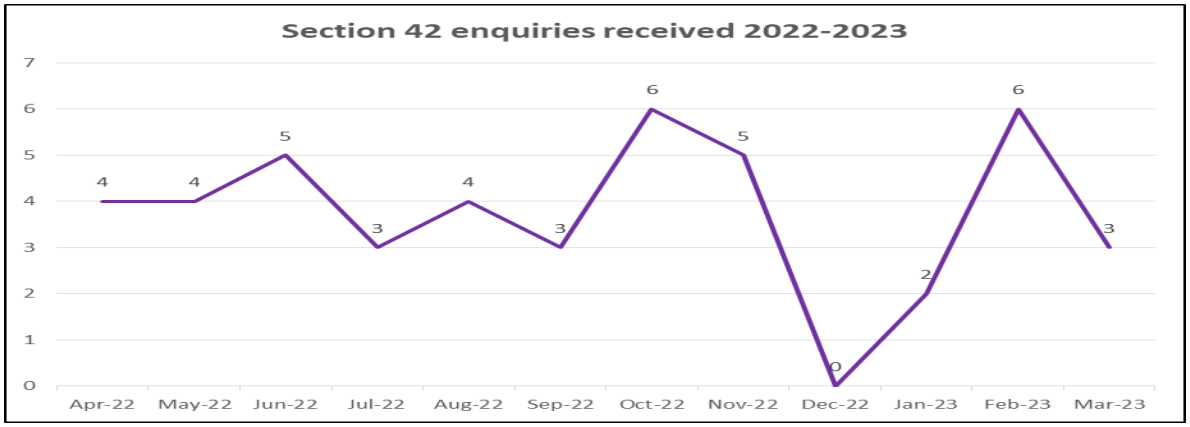
Fig 11 below shows the number of S42 'Causing others to undertake enquiry' requests received from the three Local Authorities across Sussex, whereby concerns have been reported to them in relation to the care provided by UHSussex within the above hospital sites; and it is felt the threshold for a safeguarding enquiry is met.

Fig 11: Section 42 enquiries received - Total 45



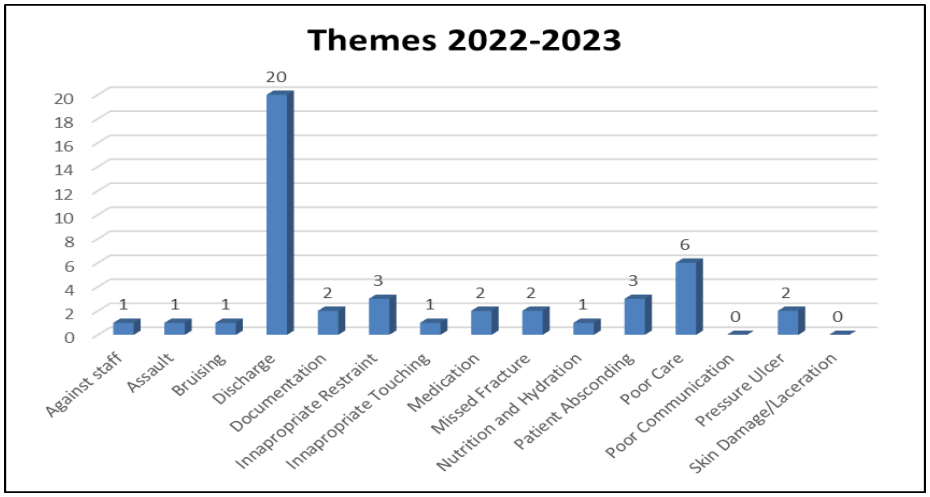
There were 81 safeguarding referrals raised about the Trust, only 45 met criteria to proceed to Section 42 enquiry. The total number of Section 42 referral received over the past three years remains similar. The number of Section 42 referrals has spread across the 12 months period expect for December month where the team did not receive any referrals (See figure 12 below).

Fig 12: Section 42 enquiries received each month



The themes (See figure 13 below) of the concerns raised about the Trust predominantly refer to discharge arrangements in terms of timeliness, completeness of arrangements (i.e., home care package) and communication with carers and families prior to discharge. The outcome of safeguarding investigations has been shared with staff members via ward / department meetings, matron, and ward sister meetings to review and instigate processes/clinical practice to prevent similar incidents from occurring.

Fig 13: Themes



10. Mental Health Act (MHA), Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

10.1. Trust Mental Health Act Activity

UHSussex has a contract with Sussex Partnership Foundation Trust for the administration of the Mental Health Act (MHA) process. This includes the management of the legal papers associated with those patients detained to the Trust under the Mental Health Act (MHA), as well as administration support when patients appeal to a Tribunal against their detention. In addition, the contract includes the delivery of training to staff on the Mental Health Act.

Work has continued this year to improve the process by which detentions are reported and to facilitate the correct completion of the section papers and Datix. The guidance and flowcharts on the MHA process has been updated in conjunction with the Trust Mental Health Act Policy.

Table 14 shows the year-on-year increase in the number of adults and young people detained to UHSx under the MHA between 2019-2023.

Fig 14 – Number of MHA detentions

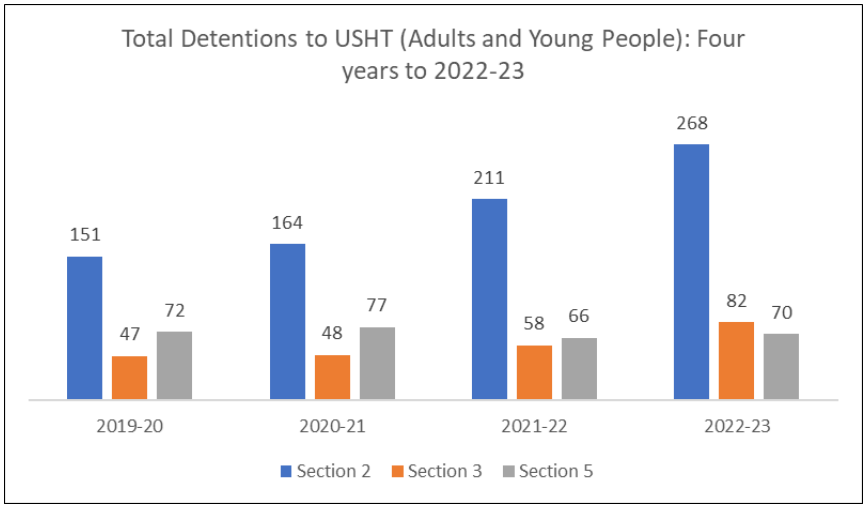


Figure 15 below shows the number of adults detained under MHA

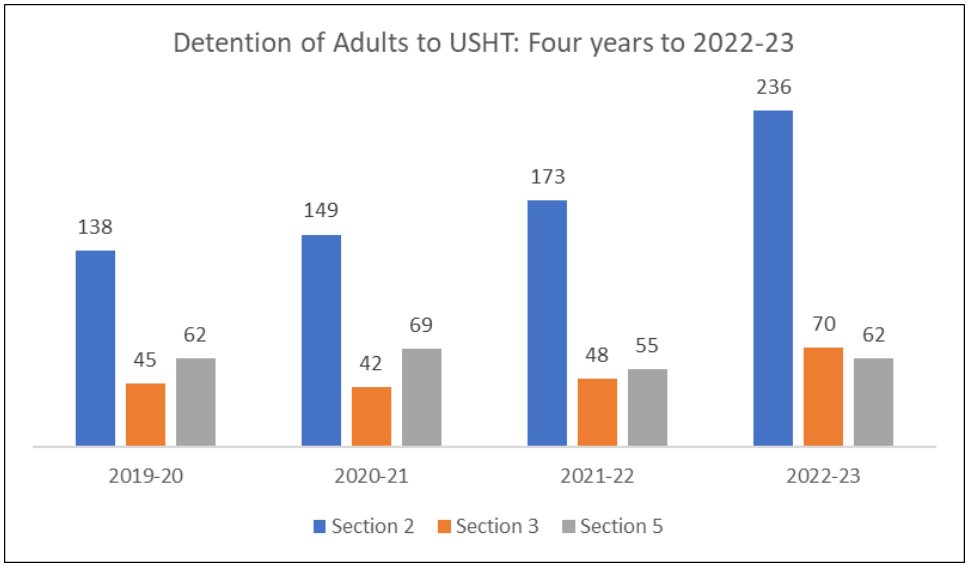
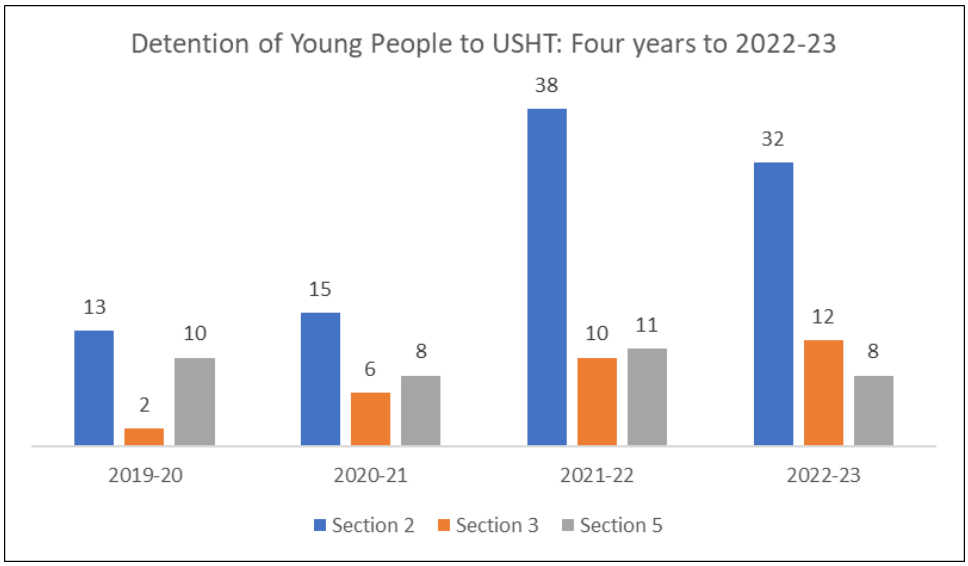


Fig 16 shows the number of children and young people detained under the MHA



The table below shows the number of patients detained across each site within UHSussex throughout 2022-23

Detentions to UHSX, April 2022 to March 2023

	Section 2	Section 3	Section 5	Total Detentions
Princess Royal	40	15	15	**70**
Royal Alexandra	15	4	4	**23**
RSCH	153	44	24	**221**
St Richard's	24	6	6	**36**
Worthing	36	13	21	**70**

The trust has established the Mental Health Strategy and Quality Group (MHSQG) which aim to review and improve the provision of mental health service provision within UHSussex. The group is chaired by the trust medical director. The MHSQG is responsible for the development and implementation of a Trust wide strategy to achieve this aim which will include overseeing the work of various project groups aligned to this. The Group is also responsible for maintaining an oversight of all matters related to quality and safety as they relate to mental health care provision and have the authority to approve policies and guidelines involving mental health on behalf of UHSussex, providing it acts within the remit of its terms of reference and the guidelines conform to the UHSussex template. The group has been leading on implementing recommendations from assessments including from the CQC.

As the part of the group work, a strategy on education programme that provides upskilling/transferable skills for Acute Floor staff related to generic and specialist mental health training was agreed. The education strategy focus on to increasing Acute Floor staff's knowledge of mental health disorders / treatments and MHA by delivering on an annual basis a rolling programme of education, with potential for train the trainer and sustainable in-house provision. The programme is based on a commitment to release staff to attend formal study sessions. Alternative approaches will also be considered e.g. bitesize teaching, use of pre-existing education / clinical governance days.

10.2. Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

In the complex and ever-evolving hospital environment, it remains a priority of UHSussex to implement the principles outlined in the Mental Capacity Act (MCA). As healthcare professionals, our primary responsibility is to protect and uphold the well-being and autonomy of our patients. The MCA serves as a crucial piece of legislation, ensuring the rights of individuals who may lack decision-making capacity are upheld. Nowhere is this more significant than in the realm of informed consent, where the proper application of the MCA establishes a robust framework for respecting patients' autonomy, dignity, and rights.

This section of the report describes the on-going work and the some of the challenges we face in implementing the MCA within our hospitals and sets out our objectives to overcome these.

MCA Education and Training

The withdrawal of the CORTEX training platform unfortunately resulted in the loss of the MCA training video that formed part of Adult Safeguarding Level 2 for legacy WSHT staff. All clinical staff now complete e-learning MCA and DoLS training as part of their e-learning Adult safeguarding Level 2 on the IRIS platform. This provides staff with a basic introduction to the MCA and the application of DoLS within the hospital setting.

Moving forward, a key priority for 2023 – 24 will be a full review of training relating to MCA and DoLS, both e-learning and face to face, is proposed in order to fit with the learning needs of our staff and in line with the Adult Safeguarding Intercollegiate Document (2018), the National Framework for Mental Capacity Act Competences (2018) and the National Institute for Clinical Guidance 108 – Decision making and mental capacity. This review will form part of the training needs analysis for all UHSussex staff.

The Mental Capacity Act Lead for St Richards, Southlands, and Worthing hospitals continues to provide training in understanding the Mental Capacity Act (2005) and its underlying principles. This face to face and TEAMS training, which extends to various wards, specialized departments, and disciplines, equips staff with the necessary knowledge to ensure lawful application of the Act. In addition to general training, targeted Mental Capacity Workshops have been conducted in specific departments and wards, focusing on pertinent topics such as discharge processes, deprivation of liberty and its safeguards, and medical interventions. Through these workshops, participants gain familiarity with relevant case law, its implications for capacity assessments and best interest decisions, and the practical application of this knowledge through engaging case studies. All of these sessions are provided on request, often forming part of training days or clinical governance meetings.

Similarly, the Safeguarding Adults team working across RSCH / PRH and Newhaven have provided bespoke face to face training for junior doctors, nurses, OT’s and physiotherapists in addition to the training accessible through MCA e-learning module and the safeguarding adults e-learning module on IRIS.

A ‘Theme of the Week’ was produced and provided guidance to all staff relating to the legal powers to prevent patients from leaving our hospitals and also when and how to access the services of the Independent Mental Capacity Advocates.

Partnership Working

The MCA Lead has represented the trust in a variety of multi-partnership meetings, including:

- NHS Sussex Integrated Care Board MCA Professionals Meeting
- NHSE MCA/LPS Network Meeting
- Southeast Acute Trusts MCA Forum

Additionally, there has been concentrated working alongside our partnering Trusts and local authorities in developing compatible working processes to support the diverse needs of our patients and specialist skills of respective staff in issues related to mental capacity. As well as on-going close work with POhWER, who provide Independent Mental Capacity Advocates to our patients in eligible circumstances.

Complex Case Work

The past year has continued to see many highly complex situations that relate to mental capacity and best interest decision making, both with adults and young people. These cases require an individualised approach and there remains a constant, and sometimes significant, stream of such cases bought to the Mental Capacity Act Leads attention. The circumstances with these often cross over in to safeguarding work and involve close collaboration with the Local Authority, Community Health Services, and other service providers. Advice and support in these cases is provided directly to practitioners to navigate them through the process, ensure that patients' rights are upheld, the legal framework is followed and that patients at risk are protected.

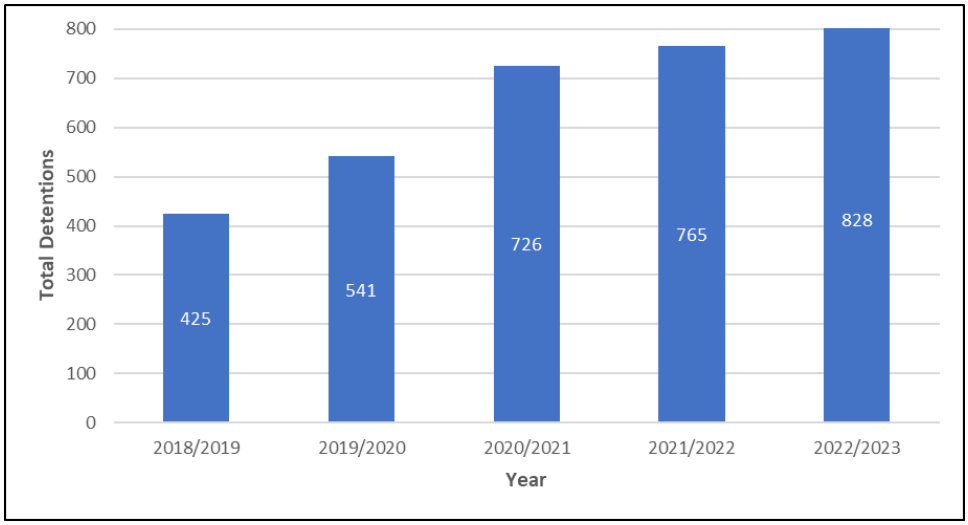
10.3 Deprivation of Liberty Safeguards

UHSussex acts as the 'Managing Authority' when depriving adults of their liberty when they lack the capacity to consent to the arrangements in place, necessary for them to access the appropriate treatment and care. Whilst treatment decisions can be made following the principles of the Mental Capacity Act and Best Interests, authorisation must be sought from the appropriate 'Supervisory Body' - Local Authority – to ensure the measures in place to keep the person in hospital are themselves proportionate and in their best interest. The Trust has a statutory duty to comply with the legal processes in relation to Deprivation of Liberty Safeguards.

10.4 Worthing / Southlands / St. Richards Hospital

As seen in Figure 17 below, there has been consistent and steady increase over the past five years of 95 percent in the number of Deprivation of Liberty Safeguards (DoLS) authorisation requests across both Worthing and St Richards sites combined.

Figure 17: DoLS Authorisation Requests for Past Five Years



In 2022/23 there was over an 8 % increase in the total number of DoLS applications compared to 2021/22. This increase has been demonstrated across both St Richards and Worthing sites and is a reflection of both the complexity of needs, increase in patients attending our hospitals and a greater understanding in our staff groups of when an application to deprive a patient of their liberty is required.

We continue to see a significant discrepancy in DoLS numbers between the St Richards and Worthing sites. However, there has been an increase in reporting across both sites from 2021/22 figures. At St Richards and increase of over 18% has been seen, and for Worthing an increase of just over 5%. The more significant increase from St Richards is attributed to specific training delivered to these sites wards in understanding and applying the definition of a deprivation of liberty, known as ‘the acid test’ laid down in case law in the Cheshire West case (2014).

Figure 18: DoLS Authorisation Requests by Individual Site for Past Five Years.

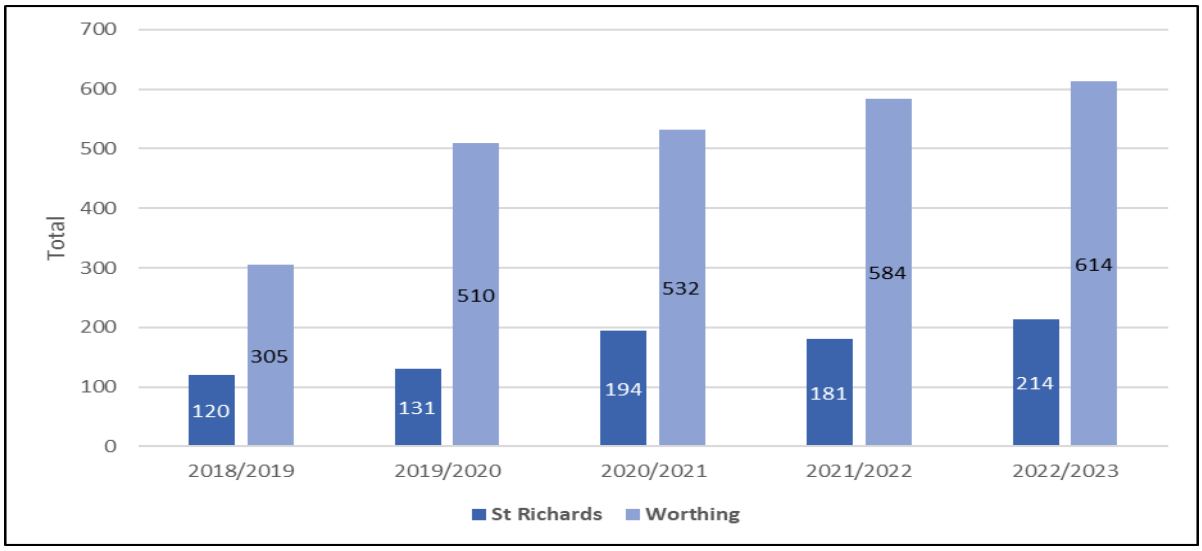


Figure 19 and 20 give a further breakdown of the DoLS applications by individual wards. This is the first year of being able to provide this detail, and thus a

comparative analysis will only be available in 2023/24, however, it does demonstrate significant differences between the two sites Emergency Floor (EF) applications, and thus an area of focus in training for EF at St Richards hospital in the coming year.

Figure 19: Deprivation of Liberty Safeguards Applications by SRH Wards

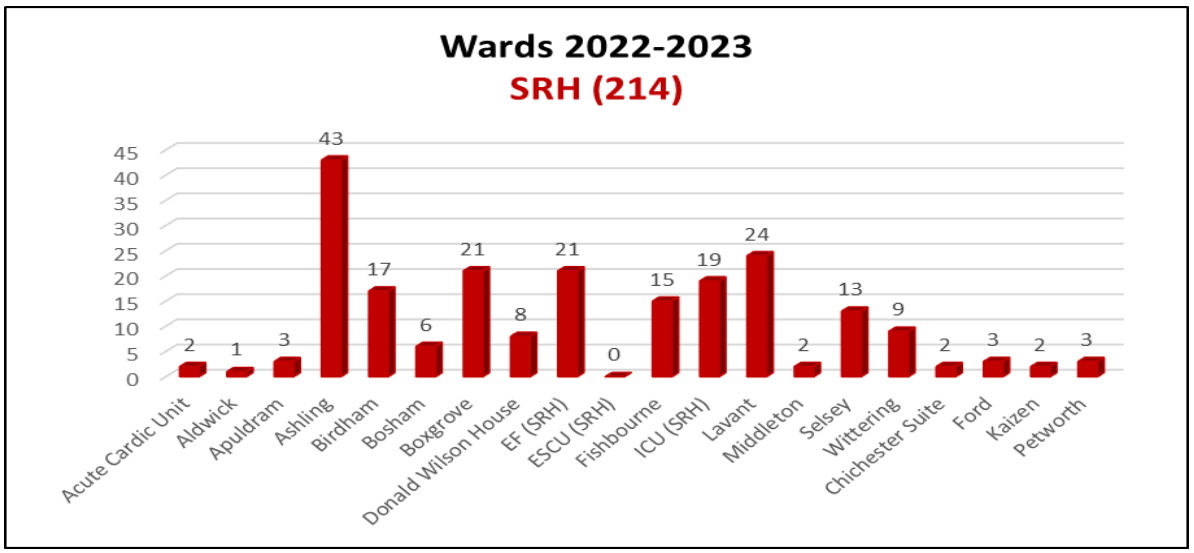
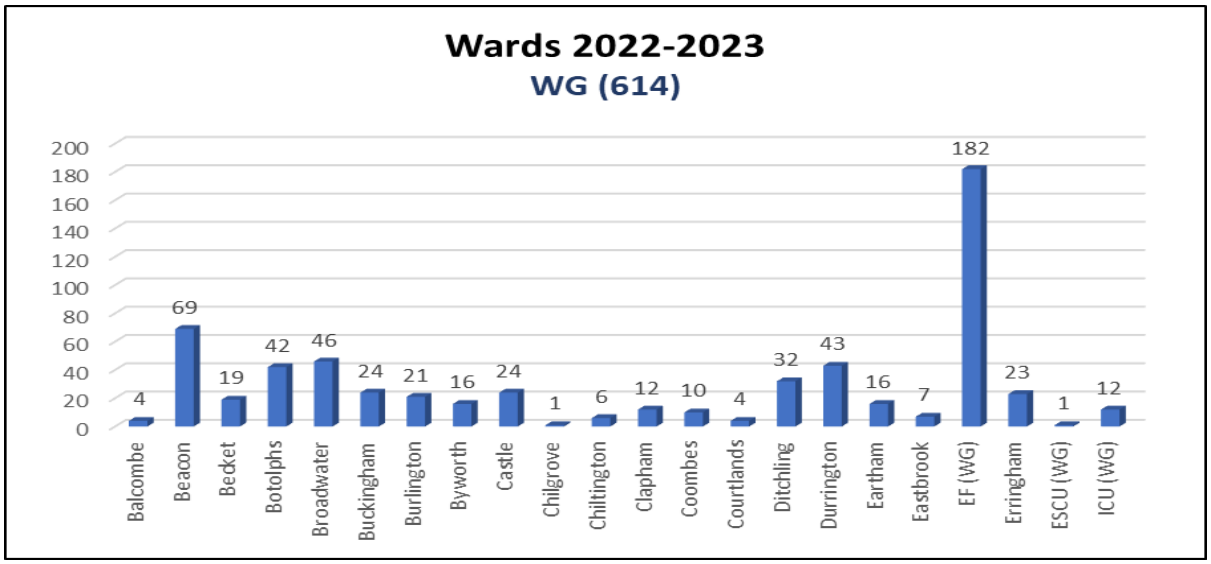


Figure 20: Deprivation of Liberty Safeguards Applications by WG Wards



The Adult Safeguarding Team continue review every application made by UHSussex staff for lawful compliance, involving the returning for amendment as necessary and logging of details for reporting to the Integrated Care Boards, Safeguarding Adults Boards and Care Quality Commission.

All DoLS applications are required to be sent to the patient's resident local authority, who process these and triage to undertake the next steps required to determine if an authorisation can be granted. During 2022/23 there were 14 patients fully assessed by the West Sussex County Council DoLS team compared to only 1 in 2021/22. Whilst many of our patients will no longer require a DoLS beyond the 7 or 14 days

the trust is able to authorise themselves in this legal procedure, there remains a significant shortfall for those patients that do remain and are being deprived of their liberty.

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

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

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

Figures 21 – 22 shows the DoLS activity within UHSx across the above-named hospital sites for 2022 – 23.

Fig 21 : DoLS received per month – Total: 730

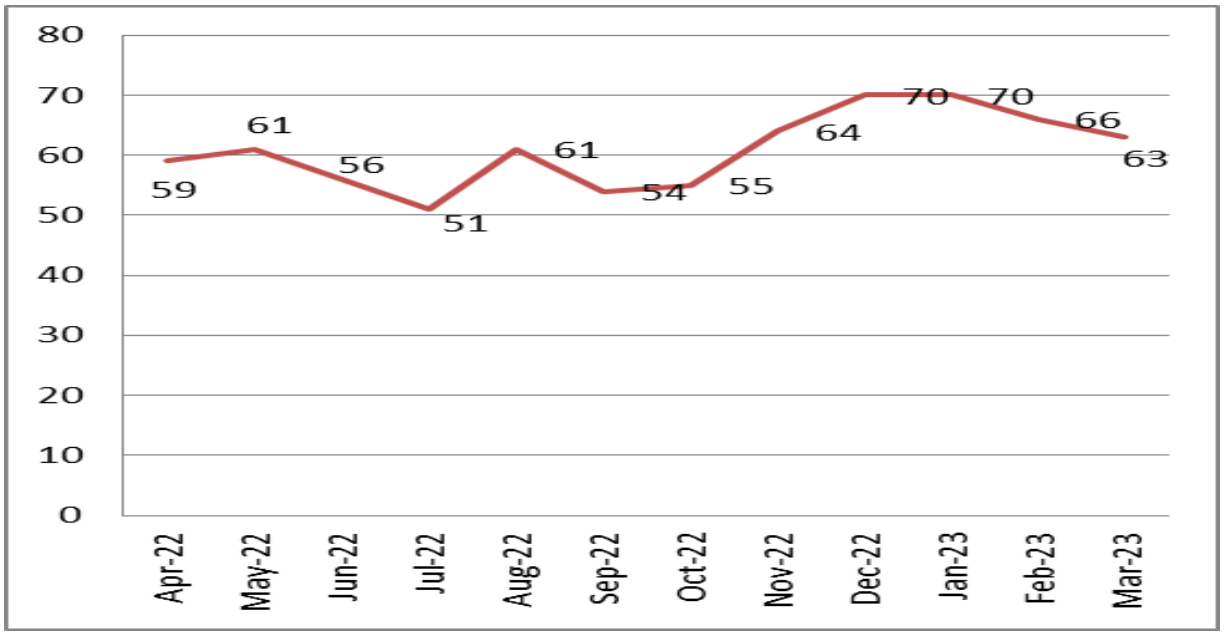


Fig 22 : DoLS raised by clinical area

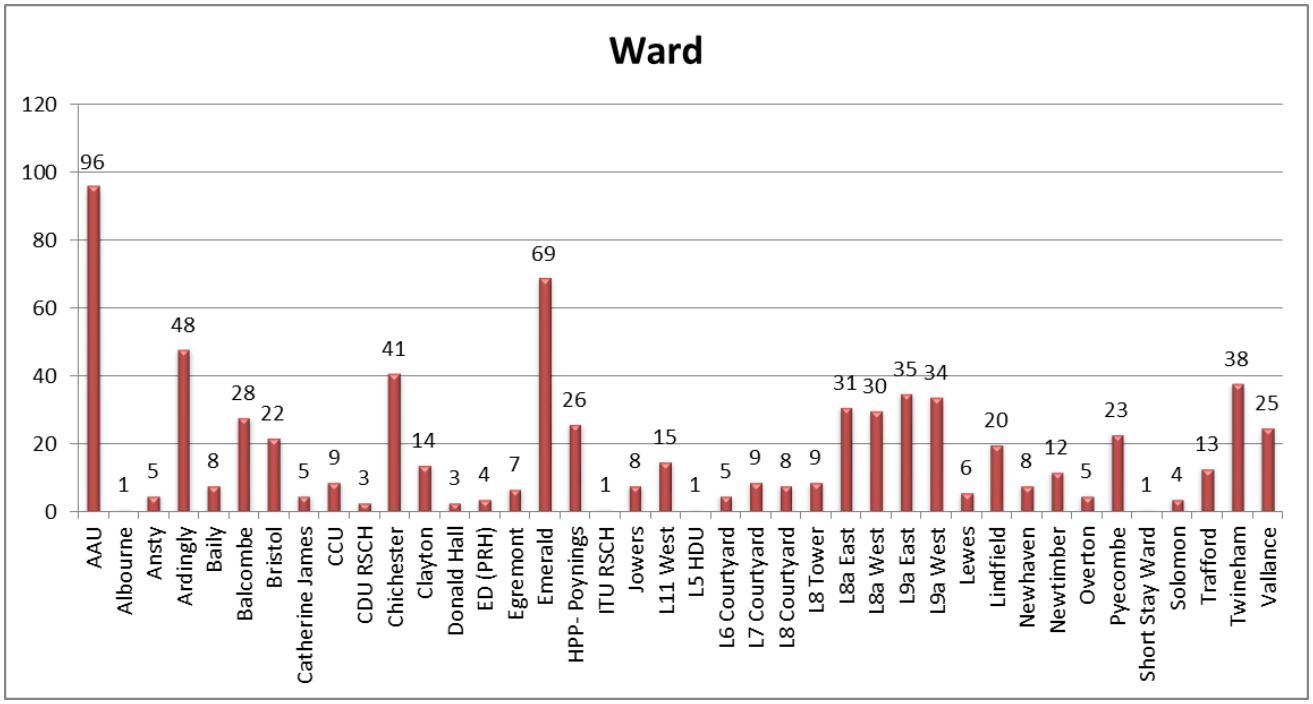
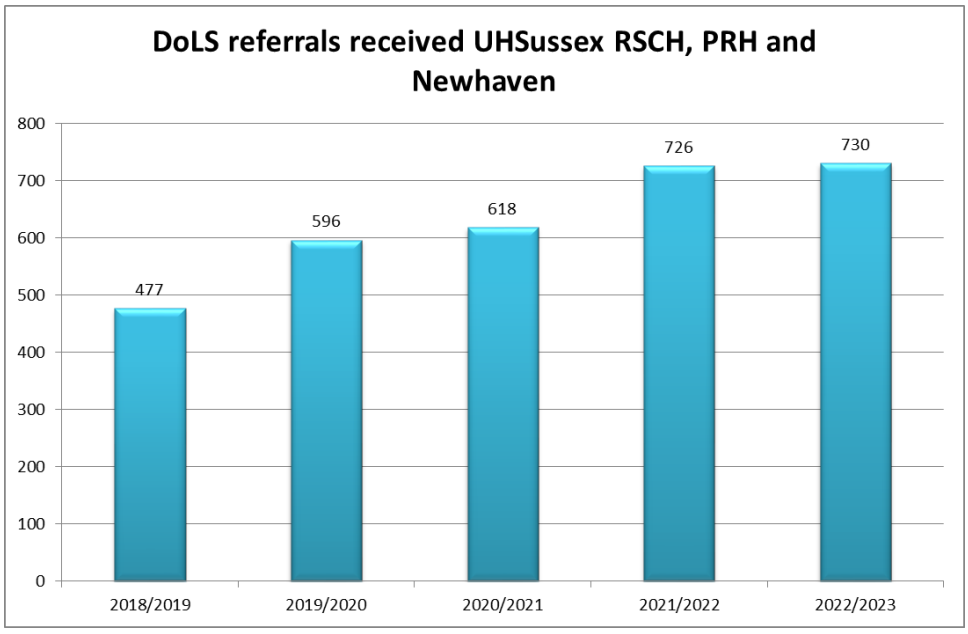


Figure 23 below, shows the five-year comparative date for DoLS applications. As with DoLS applications across Worthing. Southlands and St Richards, local authority review and authorisation of the application in hospital remains low. The safeguarding adults team provide support to clinical areas to ensure any restrictions / deprivation remain in the person's best interests; and liaise with the appropriate Local Authority where it is felt assessment by them needs to be prioritised.

Fig 23: DoLS referrals 1st April 2018 – 31st March 2023



11. Prevent

The Prevent Duty under the Counter-Terrorism and Security Act 2015 requires all specified authorities to have “due regard to the need to prevent people from being drawn into terrorism”; local authorities and their partners therefore have a core role to play in countering terrorism at a local level and helping to safeguard individuals at risk of radicalisation

Under the Duty, NHS organisations are required to provide appropriate training in line with the Prevent Competency Framework; for staff to have an awareness of Prevent and radicalisation and how to spot the vulnerabilities that may lead to a person becoming radicalised. The purpose of Prevent is for staff to identify and report concerns where they believe young people or adults may be vulnerable to radicalisation or exploiting others for the purposes of radicalisation. This may include staff and/ or patients.

The Chief Nurse is the named organisational Prevent lead and is supported by the safeguarding leads in the implementation of the NH Duty within UHSussex. UHSussex is a partner of the Brighton and Hove Prevent Board and is represented at the Prevent Board by the Lead Nurse Safeguarding Adults.

Local Authority led Channel Panels, supported by Sussex Police, are multi-agency panels who meet to discusses the risk posed by vulnerable people who are believed to have become radicalised and threatening extreme violence who have been referred for multi-agency support. For any referrals made by UHSx, the organisational Prevent Lead (or nominated replacement) will be invited to attend the Local Authority Channel panel. There have been no referrals from the Trust to the Channel panel in 2022/23.

The Trust submits a quarterly return to NHS England. The data submitted monitors the key elements of the prevent duties and responsibilities which include Identification of Prevent leads, strategic and operational, delivery of training, the levels of referrals made via the Channel process, representation, and engagement with local and regional Prevent leads.

A basic awareness of Prevent is mandatory for all staff within the NHS. Level 1 Awareness Training is delivered upon induction and through mandatory safeguarding updates. Compliance for 2022-23 is 83%. Level 3 training is provided via a national e-learning module developed in partnership with NHS England. This training is available through IRIS learning platform and the Trust has achieved 88% compliance.

13. Organisational Risks

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

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

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

Datix 1426- Patients being bought to A&E experiencing a mental health issue who are then assessed by Mental Health Liaison Team and are recommended to be detained under Section 2 or 3 of Mental Health Act (MHA), or are recommended to be admitted to a mental health bed but are not requiring section as they are able to consent to the admission, and are agreeing to the admission are remaining in A&E for extended periods of time of many days. One recent June 2023 case was 18 days.

These patients have no legal status under MHA as their section cannot be completed as they are not an admitted patient when in A&E. In addition, these patients have no legal status under the Mental Capacity Act (MCA) Deprivation of

Liberty Safeguards because they are ineligible for this as the MHA is the framework that must apply.

14. Priorities for 2023/2024

1. Self-neglect

- To work with SAB to thematic Safeguarding Adults Review (SAR) on self-neglect to identify issues, barriers, and themes of recent published self-neglect SARs in Sussex in order to develop an action plan to improve systems, policy, procedure, and practice.
- Following the 2022/23 SAB self-neglect audit, trust to participate on a self-neglect survey for staff across the partnership to identify issues, barriers, and what is needed to better support practice.
- To support SAB to review the Sussex self-neglect policy and procedures including referral pathways. And the Sussex Safeguarding Thresholds Guidance for self-neglect.
- To promote within the trust resources from SAB linked to working with those who self-neglect including; Making Safeguarding Personal (MSP), Mental Capacity Act assessments and Best Interest process, risk assessment, multi-agency practice, and referral to our Multi-agency Risk Management Subgroup (MARM).
- To promote SAB self-neglect in newsletter and feature case study.

2. Embedding learning and assurance

- To promote SAB existing resources with a particular focus on learning from SARs and audits.
- Promote SAB newsletter article on learning from SARs and audits and their available resources.
- Invite SAB staff to share information about SAB, key learning areas from SARs and audits, and promotion of resources.
- To participate on SAB survey for staff following staff briefing sessions to seek understanding of the information shared, how it will affect practice.
- To complete Bi-annual self-assessment that include focussed questions on embedding learning.

3. Audit programme

- MCA / DoLS
- Training – to include CAIT / LD
- Sussex SAB bi-annual self-assessment

15. Conclusion

MCA activity has remained extremely high throughout the year. Despite our best efforts, we regrettably fell short of achieving our main MCA goal set forth in the previous year of developing a clear training needs analysis for all staff across UHSussex Foundation Trust.

One significant challenge we faced was a lack of adequate resources, primarily due to staff departures throughout the year. These departures resulted in a shortage of skilled personnel within the team. We have recently recruited to the Adult safeguarding Specialist Nurse role, as well as late in 2022 successfully recruited to our vacant administrative post.

Our key objective remains to review the current training needs analysis from the legacy Western Sussex Hospitals NHS Foundation Trust with that of legacy Brighton and Sussex University Hospitals NHS Foundation Trust to ensure continuity of training across all staff groups in University Hospitals Sussex NHS Foundation Trust.

The MCA Lead will continue to provide direct support to clinical staff in complex situations as well as deliver comprehensive workshop training sessions as requested.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	18a.	**Meeting:**	QGSG	**Meeting Date:**	17 July 2023
Report Title:	Safeguarding Children and Looked After Children Annual Report				
Sponsoring Executive Director:	Leanne McLean, Chief Nursing Office				
Author(s):	Sam Page, Head of Safeguarding				
Report previously considered by and date:	Safeguarding Committee, 20/07/23				

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

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

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	Yes / N/A	Link to Trust Annual Plan	Yes / N/A

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	Yes	
Sustainability	N/A	
People	Yes	
Quality	Yes	
Systems and Partnerships	Yes	
Research and Innovation	N/A	

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

Regulatory / Statutory reporting requirement

Section 11, Children Act (2004)
http://www.legislation.gov.uk/ukpga/2004/31/section/11

Communication and Consultation:

Executive Summary:

This Annual Report highlights the work undertaken by UHSussex in respect of its commitment and responsibilities in maintaining the safety and protection of children and young people.

The purpose of this report is to:

- Provide assurance that UHSussex is compliant with its safeguarding duties
- Provide an overview of the UHSussex safeguarding children team activity in 2022/23
- Outline the key safeguarding priorities for 2023/24

Assurance

The Trust fulfils its responsibilities under Section 11 of the Children Act (2004) in the following ways:
Accountability:

- The Chief Nurse is the executive lead for safeguarding and has oversight of safeguarding activity via the quarterly Safeguarding Committee and Quality Committee. The Head of Safeguarding provides the Safeguarding Committee with a quarterly assurance report.

- The Trust has a full complement of Named Professionals for Safeguarding Children and Looked After Children.

Partnerships:

- Named professionals are fully engaged in the 2 Local Safeguarding Children Partnerships and attend partnership sub-groups.

Training:

- The Safeguarding Children Team have developed a Safeguarding Children Training Strategy which describes safeguarding children training requirements for all Trust staff groups. The training content has been reviewed and updated, and is available via the IRIS system, alongside face-to-face training at Level 3.

- Levels 1 and 2 training uptake at the end of 2022/23 met national targets. Level 3 training uptake falls short of national targets by 12.1%. Work is underway to provide accessible training and to target specific staff groups.

Supervision:

- The Safeguarding Children Team provide individuals and groups with a range of supervision opportunities via, peer review medical supervision, case discussion and group supervision, specialist nurse and MDT supervision, 1:1 supervision.

- A standalone safeguarding supervision policy will be written and will include a reporting template and schedule.

Incidents:

- There were 2 serious incidents relating to safeguarding children during the reporting period.
    - Incident relating to the unexpected death of a child on hospital grounds. The incident is subject to an external review which will report in summer 2023. Early learning has been implemented.

    - Incident relating to the failure in electronic referral to Children's Social Care from the PANDA record keeping system. An electronic solution was found and measures put in place to provide assurance. Periodic checks on the system have not found any repeat of the information sharing failure.

Practice Reviews:

- Child Safeguarding Practice Reviews: the Trust engaged with 6 Practice Reviews over the year resulting in multi-agency audit and the incorporation of learning into training and supervision.

Activity:

- The activity data in Worthing and St Richard's Hospitals demonstrates a year on year increase in the number of children where we identify safeguarding concerns.

- Most presenting safeguarding concerns relate to mental ill-health and considerable work is taking place to ensure safety and best practice in paediatric areas.

- Data from the Royal Alexandra Children's Hospital has been difficult to report on, but what there is reflects concerns regarding mental ill-health.

- Considerable work has taken place to standardise and improve data collection and reporting processes across the Safeguarding Children Team.

Safeguarding Children Team priorities for 2023/24

1	**Support for children and young people with mental ill-health.** Including: • Implementation of learning from the EFD Serious Incident investigation • Recording and reporting on all MHA detentions • Development of additional support to children and clinicians through the enhanced health care assistant programme
2	**Improved governance and reporting** Including: • Standardised reporting processes • Evidence via data reports and audit to demonstrate quality improvement and implementation of learning and best practice
3	**Supporting with vulnerable groups** Including: • Working with the ICB Transition lead to better understand challenges for young people who may need safeguarding support from adult services. • Development of a Safeguarding Transition Policy • Work with the LAC service to ensure that the voice of children and young people in the care of the Local Authority are heard • Improve reporting on Looked After Children who are accessing Trust services • Work with the hospital Independent Domestic Violence advocates to improve response to domestic abuse with clear reporting framework
4	**Embedding safeguarding knowledge in the Trust** Including: • Improving Level 3 training uptake with monthly reporting to clinical services and an improvement trajectory • Continued review of safeguarding children training content • ICB support in a review of content and training delivery • Development and implementation of a Safeguarding Children Supervision Policy with clear reporting and data collation • Standardisation of internal and external facing communications, referral systems, and newsletters

Key Recommendation(s):

The Report is noted and endorsed for Trust Board approval.

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Hospitals Sus
NHS Foundation

Safeguarding Children & Looked after Children Annual Report

2022-2023

Sam Page, Head of Safeguarding

Catherine Coppard, Lead & Named Nurse Safeguarding Children

Contents

1. Introduction

“Safeguarding and promoting the welfare of children and young people is defined as protection from maltreatment and abuse, preventing impairment of health and/or development and ensuring children are growing up in circumstances consistent with the provision of safe and effective care.” Working Together (2018)

University Hospitals Sussex NHS Foundation Trust (UHSussex or the Trust), including all staff and volunteers, have important and distinct duties to ensure that children and young people receiving services, experience safe and dignified care, and that they are safeguarded from harm, abuse, and neglect. This includes ensuring that appropriate action is taken when staff become aware of concerns taking place outside of the Trust.

1.1 Purpose

This Annual Report highlights the work undertaken by UHSussex in respect of its commitment and responsibilities in maintaining the safety and protection of children and young people.

This report covers the period from 1 April 2022 to 31 March 2023 and provides assurance that systems are in place to ensure that our service users are effectively protected, and that staff are supported to respond appropriately where safeguarding concerns arise.

The purpose of this report is to:

- Provide an overview of the UHSussex safeguarding children team activity in 2022/23
- Provide assurance that UHSussex is compliant with its safeguarding duties
- Outline the key safeguarding priorities for 2023/24

1.2 Section 11

Section 11 (s11) of the Children Act 2004 places a statutory duty on key organisations to make arrangements to ensure that in discharging their functions they have regard to the need to safeguard and promote the welfare of children.

It does not give agencies any new functions, nor does it override their existing functions. Instead, it requires organisations to carry out their existing functions in a way that takes into account the need to safeguard and promote the welfare of children.

Section 11 requirements:

1) Senior management commitment to the importance of safeguarding and promoting children's welfare
2) A clear statement of the agency's responsibilities towards children is available for all staff
3) A clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children
4) Service development takes account of the need to safeguard and promote welfare and is informed, where appropriate, by the views of children and families
5) Staff training on safeguarding and promoting the welfare of children for all staff working with, or, depending on the agency's primary functions, in contact with children and families
6) Safer recruitment
7) Effective inter-agency working to safeguard and promote the welfare of children
8) Information Sharing & Data Management
9) Recognition and response to risk

2. Governance Arrangements

The safeguarding service has gone through considerable change over the year, and leadership arrangements continue to develop. The Named Nurse at the Royal Alexandra Children's Hospital (RACH) retired in the second half of the year, and a new Head of Nursing for Safeguarding Children was appointed.

The subsequent appointment of a Named Nurse at the RACH has allowed a Head of Safeguarding function to develop and the safeguarding adult and children teams have come together in one Senior Management Team to provide a joined up approach to safeguarding children and adults across the Trust.

The Safeguarding Children Team has begun a process of integration across the hospital sites which will support team development, capacity management and governance across the service.

2.1 Accountability

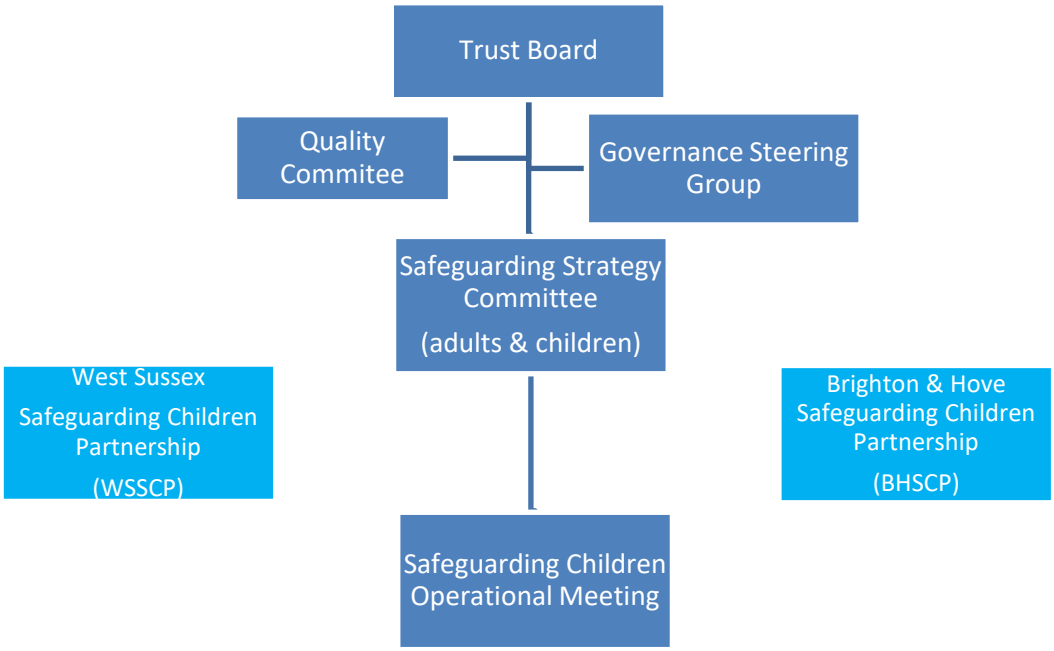
The UHSussex Chief Executive has overall responsibility for the safeguarding of children, young people, and adults at risk. The Chief Nurse has the executive lead for safeguarding, with responsibility to ensure that the Trust contribution towards safeguarding is discharged effectively throughout the organisation.

The Chief Nurse is responsible for:

- Strategic leadership on all aspects of the Trust's contribution to safeguarding
- Ensuring the Trust is represented at Local Safeguarding Adult and Children's Partnerships

- Ensuring that appropriate safeguarding processes are in place, including compliance with all legal, statutory, and good practice requirements

Safeguarding governance and assurance is monitored at the Safeguarding Strategy Committee which is chaired by the Chief Nurse or their Deputy. The Safeguarding Strategy Committee has been established as a sub-committee of the Quality Committee.



The Safeguarding Strategy Committee meets quarterly and seeks assurance that all safeguarding commitments and responsibilities for adults and children are met. It oversees the work of the Operational Groups and ensures that there are suitable processes in place to ensure that safeguarding arrangements are reviewed and updated on a regular basis.

The NHS Sussex Integrated Care Board (ICB) Designated Safeguarding Leads for adults and children have a standing invitation to the Safeguarding Strategy Committee, providing oversight of the Trust's safeguarding work.

The Head of Safeguarding provides a quarterly overview report for safeguarding children which includes:

- Mandatory training and supervision performance
- Partnership working update
- Child safeguarding activity
- Policy development
- Audit planning

- Risk management

The Operational meetings reporting to the Safeguarding Strategy Committee are:

- Safeguarding Children Operational Group
- Safeguarding Adults Operational Group
- Dementia Steering Group
- Learning Disability and Autism Steering Group

2.2 Safeguarding Children Team

Safeguarding activity may be carried out in the context of the administration of patient care directly, or by the Trust participating in multiagency safeguarding practice, such as sharing information with a local authority or attending a multi-agency meetings relating to a specific child.

The Trust's safeguarding duties extend to children and young people who are not patients at the Trust (and who may not be physically seen by the staff member or clinical team providing treatment to the adult). Most commonly, this will occur when an adult patient is receiving treatment, and potential risks to children or young people are identified. For example, if an adult attends for issues related to domestic abuse, substance misuse or poor mental health. We refer to this as a 'Think Family' approach, and this duty applies to all Trust staff including those who seldom or never work with children as part of their day-to-day duties.

UHSussex strives to fulfil its statutory duty by promoting a culture where safeguarding is everyone's business and ensuring practice issues are identified and addressed.

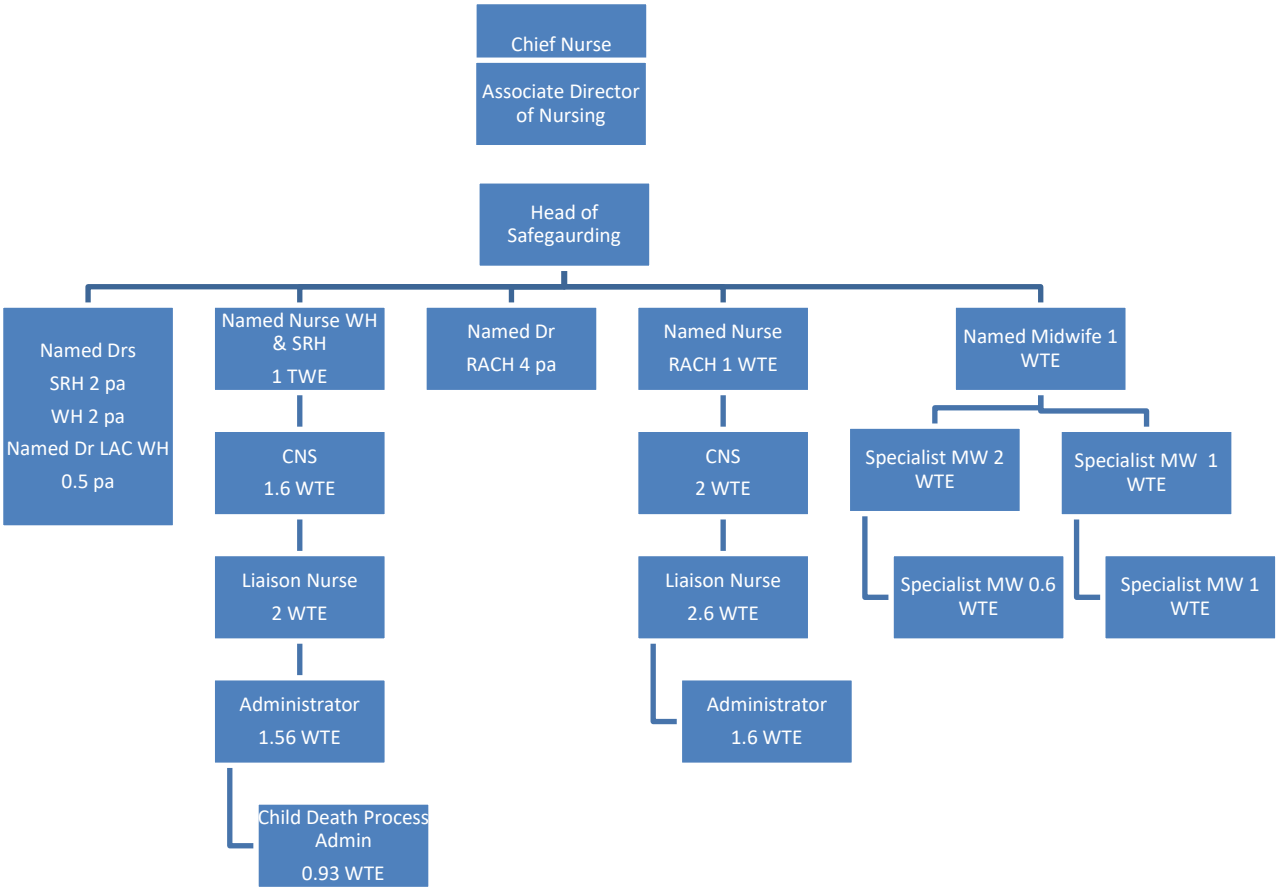
Safeguarding arrangements include:

- Safeguarding structures are in place including the following statutory designated roles:
    - Executive Lead
    - Named Doctor for Safeguarding Children
    - Named Nurse for Safeguarding Children
    - Named Midwife for Safeguarding Children
    - Named Doctor for Looked After Children
- Embedding learning from serious incidents and child safeguarding practice reviews
- A culture of listening to children and taking account of their wishes and feelings when delivering care
- An environment where staff feel able to raise concerns; 'Freedom to speak up'
- Escalation processes are in place for instances when safeguarding

concerns are not being addressed within the organisation or by other agencies

- Arrangements are in place for information sharing
- Safer recruitment practices and policies are in place including when to obtain a criminal record check
- Processes are in place for managing with allegations against people working with children
- Supervision, support and safeguarding training arrangements are in place within a culture of continuous learning
- Working in partnership with other agencies
- Promoting best practice

2.3 Team Structure



The Named Doctors provides support, advice, and leadership to medical staff, primarily to senior paediatricians. They deliver and lead a number of safeguarding

supervision sessions with medical and multi-disciplinary teams.

The Named Nurses have statutory responsibilities, as identified in Working Together to Safeguard Children (2018), to support staff in recognising and championing the needs of children, and in responding to possible abuse or neglect. As senior practitioners, they are experts in child development, child maltreatment and managing safeguarding concerns in a multiagency forum.

The Named Nurses are supported by Clinical Nurse Specialists (CNS) and Paediatric Liaison Nurses for Safeguarding Children. These practitioners have enhanced skills and knowledge in relation to all aspects of safeguarding children work.

The child safeguarding team works together to:

- Identify children and young people who may be at risk of experiencing harm, and put measure in place to protect them
- Ensure the welfare of the child is paramount and the voice of the child is central to all interventions
- Ensure compliance with the local and national Child Protection Procedures
- Implement national and local guidance in relation to safeguarding
- Play an integral part in West Sussex and Brighton & Hove Safeguarding Children Partnerships and subgroups
- Promote best practice throughout the organisation

The Safeguarding Children Team currently sits within the Women & Children Divisions and contribute to their divisional governance board meetings in addition to the following; Patient safety group, Serious Incident Review Group, Mental Health Strategy and Children and Young People's Mental Health Improvement Board. The Head of Safeguarding reports to the Associate Director of Nursing.

2.4 Local Safeguarding Children Partnerships

The safeguarding team contribute to West Sussex and Brighton & Hove Safeguarding Children Partnerships and are engaged in the following subgroups.

West Sussex Safeguarding Children Partnership	Frequency
Improvement and Assurance Group	Bi-monthly
Child Safeguarding Liaison Group	Monthly
Partnership Group (previously Board)	Quarterly
Learning and Development Group	Quarterly
Child Exploitation Group	Monthly
Safer West Sussex Partnership (SWSP) DVSA Steering Group	Quarterly

Children's Health Safeguarding Forum	Bi-monthly
MASH Health Working Group	Quarterly
LAC Operational Group	Quarterly
Children First Board	Quarterly
Brighton & Hove Safeguarding Children Partnership	
Partnership Group	Quarterly
Child Safeguarding Liaison Group	Monthly
Learning and Development Group	Quarterly
Monitoring & Evaluation Group	Bi-monthly
MARAC Steering Group	
Community Safety Partnership Board	Quarterly
Neglect & Poverty T&F Group	
Harmful Practices Strategic Group	Bi-monthly
Procedures	Quarterly
Safeguarding Children System Call	Quarterly
Maternity Safeguarding Forum	Quarterly
PLAC NHS Professionals	Quarterly
ICON Forum	Bi Annually
NHS Professionals LPS Steering Group	Monthly
Children's Health Safeguarding Forum	Bi-monthly
MASH Health Working Group	Quarterly
NHS Sussex ICB	
NHS Sussex (EPRR Team) Contingency Asylum, Refugee, Migrant Maternity & Child Health T&F group	Monthly
Provider Collaborative CAMHS Escalation Calls	Weekly
National and Regional	
National Safeguarding Maternity network	Quarterly
SE Region Safeguarding Maternity Network	Quarterly
Safeguarding Children National Network for Named Professionals	Quarterly

3 Assurance

A considerable piece of work has begun to improve reporting across the Safeguarding Children team. Reporting for the year 2022/23 is poor and it has not been possible to provide a clear picture of activity.

The expectation is to have quarterly reports, building a dataset which provides key information about the children and young people receiving UHSussex services, highlights areas of concern and risk, and demonstrates team activity.

3.1 Learning, Development and Training

Safeguarding children training is underpinned by an Intercollegiate Document published by the Royal College of Nursing on behalf of multiple stakeholders; the Intercollegiate Document for Children & Young People (2019) and Intercollegiate Document for Safeguarding Adults (2018). The documents describe roles and responsibilities, detailing the level of training required.

Each level of training requires that staff need to complete a minimum number of hours training over a three-year period and that these training hours can be met by undertaking a variety of different training interventions.

Level	Staff Group	Method
Level 1	All staff	Mandatory e-learning
Level 2	Clinical and non-clinical staff who have contact with children, young people or their parents/carers	e-learning via the national e-learning programme
Level 3	All clinical staff who are working with children and young people and who could potentially contribute to assessing planning intervening, and evaluating the safeguarding needs of a child and their families. see intercollegiate document for specific roles	Foundation level 3 must be undertaken before refresher. It is face to face or via e-learning
Level 4	Level 4 training applies to senior managers who have been identified as having statutory roles and responsibilities for safeguarding children as set out in Working Together to Safeguard	This is usually a multi-agency training

There have been challenges in the workforce data compliance and evidence the workforce systems have still not yet captured all training that has been delivered. The safeguarding team continue to work through individual enquiries to resolve this issue. There is also evidence that staff groups are not yet aligned correctly for the level of training required for the role, this is being further explored with the Learning and Development team. Once these matters are resolved we expect to see an improvement with the workforce training compliance data.

The children's safeguarding team are delivering on average weekly safeguarding children training for Level 3 throughout the quarter. All staff receive safeguarding children training at the Trust induction.

Level 3 Safeguarding Children training is delivered annually, and content has been updated and is available on Iris, for staff across the Trust, to access. A blended learning offer has been developed in accordance with best practice guidance. The training offer is available for new starters and as a 1 yearly update in the format of e-learning and face to face delivery and includes core competences and shared learning from local and national case reviews.

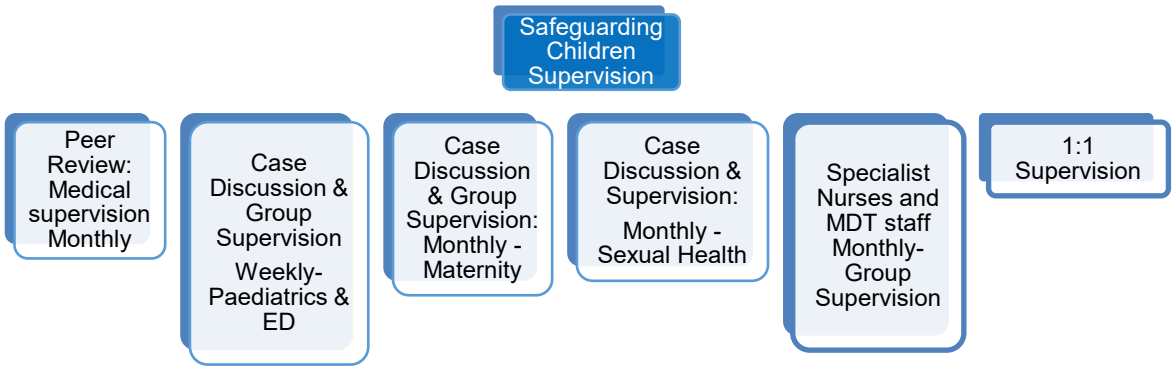
Level 1 and Level 2 training offer and content is currently being updated and it is planned for this to be available at the end of this quarter 1 for staff to access via Iris. Staff are required to update their Level 1 or Level 2 training every 3 years.

Safeguarding Children training levels at the end of 2022/23

Staff Group	Level 1			Level 2			Level 3		
	Heads	Total Up To Date	% Up To Date	Heads	Total Up To Date	% Up To Date	Heads	Total Up To Date	% Up To Date
Add Prof Scientific and Technic	273	236	86.4	196	180	91.8	10	3	30.0
Additional Clinical Services	614	560	91.2	1848	1635	88.5	348	285	81.9
Administrative and Clerical	2945	2825	95.9	13	11	84.6	9	4	44.4
Allied Health Professionals	16	7	43.8	826	766	92.7	19	10	52.6
Estates and Ancillary	1321	1253	94.9	2	2	100	1	1	100
Healthcare Scientists	258	245	95.0	199	72	36.2	5	5	100
Medical and Dental	10	8	80.0	1585	1247	78.7	480	290	60.4
Nursing and Midwifery	7	4	57.1	3258	3036	93.2	1352	1023	75.7
Total	5444	5138	94.4	7927	6949	87.7	2224	1621	72.9

3.2 Supervision

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



3.3 Managing Allegations Against Staff

The Trust has a statutory duty to investigate allegations against staff working with children and this includes allegations relating to a staff member's work or in their private life.

The Head of Safeguarding and the Named Nurse for Safeguarding Children work closely with the West Sussex and Brighton & Hove Local Authority Designated Officer (LADO) to risk assess and agree actions where a member of staff may pose a risk to children.

The Trust has a duty to report to the LADO any instances in which it is alleged that a person who works with children has:

- behaved in a way that has harmed, or may have harmed a child
- possibly committed a criminal offence against or related to a child
- behaved towards a child or children in a way that indicates they may pose a risk of harm to children

This duty applies to allegations relating to the workplace, or in the employee or volunteer's personal life. This is a complex and sensitive area of the Trust's work and involves close liaison between the Human Resource department and the safeguarding team. A new Trust Policy to manage allegations against staff has been written and is with the Human Resources Department before ratification.

During 2022/23 there were a small number of concerns raised with regards to the safety of children and the appropriate action was taken. A new system is in place to ensure that data is collated regarding allegations from across the Trust. This will be included in the quarterly safeguarding report to the Safeguarding Committee.

3.4 Serious incidents

The Trust had 2 serious incidents directly related to safeguarding children during 2022/23.

1) Incident relating to the death of a child on hospital grounds. The incident is subject to an external review and a final report will be received in summer 2023. A number of actions have been taken to reduce the risk on the paediatric wards, and substantial work is in progress with Sussex Partnership Foundation Trust (SPFT) on the emergency mental health care pathway.

2) Incident relating to the failure in electronic referral to Children's Social Care from the PANDA record keeping system. An electronic solution was found and measures put in place to provide assurance. Periodic checks on the system have not found any repeat of the information sharing failure. No incidence of

harm as a result of the failure has come to light.

3.5 Statutory reviews

There are a number of long-standing Practice Reviews which are still in the process of being finalised and closed. The following table outlines the reviews where there was UHSussex involvement, or where learning from the review is applicable across health organisations.

The multi-agency audit programme reflects learning from reviews and the Named Nurses attend the Safeguarding Children Partnerships Learning and Development sub-groups.

West Sussex				
	Child	**Date of review**	**UHSx actions**	**Status**
1	**SCR S**	Jan-17	The WSSCB to request that the BSUHT review the need for midwives to have mobile access to computers in order for them to adequately complete required tasks.	
2	**LCSPR Serin EFD**	Jul-22	Review in progress. Early learning implemented on paediatric wards	
3	**Reflective Overview of Suicides**	Jul-22	Review in progress	
4	**Avocet - Learning review**	Jul-05	Review in progress. Participation in the WSSCP task and finish group - "the myth of invisible men"	
5	**LCSPR Wren**	Jan-23	Review in Progress. Supervision support to include allied health professionals particularly dieticians Safeguarding Supervision for MDT	
Brighton & Hove				
5	**CSPR - Epsilon**	Jun-21	Review in progress	
6	**SPR Delta**	2020	Dissemination of learning in level 3 safeguarding children training across	

3.6 Child Death Reviews

The co-ordination of child death information has been the responsibility of individual departments (Neonates, maternity & paediatrics) in partnership with the Child Death Review nurses based with the Sussex Commissioners. During the year, a new child

death administrator was recruited to the team and they have taken on responsibility for working with departments across the Trust, with one reporting system.

Work continues with the Child Death Review and Child Death Overview processes, led by the ICB.

	Deaths overall	Children over 1 year	Neonates	Expected	Unexpected	Safeguarding
Worthing & SRH	20	14	6	11	9 (triggered a Joint Agency Response)	6 medical safeguarding
RACH	20	8	12	16	4 (triggered a Joint Agency Response)	

The Named Nurse attended a West Sussex learning event January 2023 following a cluster of child deaths and one of our actions was to strengthen safeguarding supervision. The team has been working on this and are now delivering quarterly child safeguarding supervision with various MDTs. In addition, the West Sussex Children's Social Care team is invited to attend the weekly case discussion meeting at Worthing and St Richard's Hospitals, alongside a representative from West Sussex Children's Mental and Emotional Health Team and the CAMHS liaison team. This change has proven to be extremely helpful in sharing information, assessing risk and has helped build good working relationships.

4. Attendance information and activity

The collection of data across the hospitals has been variable and inconsistent in some areas. Consequently, this is an incomplete capture of activity and attendance information.

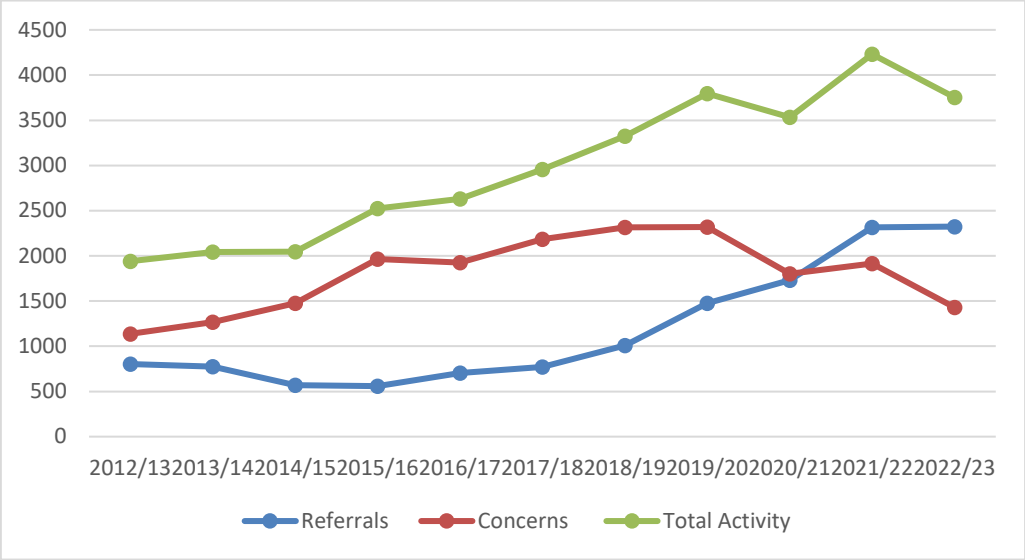
A new method for the collation of data has been developed and is standardised across the team. We expect the 2023/24 reporting to offer a clearer picture of the children and young people who access UHSussex services, and the activity undertaken by the safeguarding team.

4.1 Worthing, St Richards and Crawley Hospitals

Safeguarding activity over time

	Referrals	Concerns	Total Activity
2018/19	1010	2315	3325
2019/20	1477	2319	3796

2020/21	1732	1801	3533
2021/22	2317	1914	4231
2022/23	2324	1430	3754



Presenting concerns

Principal Concern	Year	SRH	WH	Crawley
Think Family Household Dysfunction & Adult Issues: drug/alcohol misuse/ domestic/poverty /mental health/ housing/ young carer/teenage pregnancy	22/23	33	27	2
	20/21	187	267	
	19/20	195	328	<5
	18/19	174	358	<5
Child Mental Health & Emotional Health; anxiety, challenging behaviour, anger management, bullying, self-harm, mental health, eating disorders, online abuse	22/23	436	688	6
	20/21	366	471	1
	19/20	330	639	<5
	18/19	261	533	<5
Child Physical: including perplexing cases, FII, unexplained bruise, injuries, assault, dog bite	22/23	146	144	0
	20/21	97	122	
	19/20	145	169	
	18/19	117	218	
Child Sexual Abuse; CSA, CSE, FGM	22/23	7	18	19
	20/21	8	13	
	19/20	9	9	<5
	18/19	10	23	<5
Risky Behaviour; including drug/alcohol problems, vulnerable, exploitation	22/23	94	195	18
	20/21	121	134	14
	19/20	155	271	46

	18/19	118	341	59
Neglect Concerns; including parenting concerns/ DNA /attachment/supervision/preventable accident/NEET	22/23	423	238	2
	20/21	307	469	
	19/20	428	347	
	18/19	207	362	
Child Protection Medical (Worthing CP medicals include acute and community CDC)	22/23	44	109	0
	20/21	40	83	
	19/20	44	96	
	18/19	24	86	

4.2 Royal Alexandra Children's Hospital and Princess Royal Hospital

It has been extremely difficult to extract reliable data regarding activity at the Brighton Hospital sites. Information on individual children seen by the safeguarding team is good, and it is possible to see the concerns and actions taken. However, it has not been possible to extract and aggregate data for reporting purposes, outside of Child Protection Medicals.

Some quarterly reporting data has been replicated in order to demonstrate activity.

Child Protection Medicals

2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
109	112	112	111	71	48	**90**

Snapshot of RACH activity

2021/2	Jan 22	Feb 22	March 22	April 22	May 22	June 2022	July 2022	Aug 2022		Sept 21	Oct 21	Nov 21	Dec 21
SI	0	0	0	0	0	0	0	0		0	0	0	0
Complaint	0	0	0	0	1	0	0	0		0	0	0	1
Allegation against staff	1	0	0	1	0	0	0	0		0	0	0	1
FGM disclosed	1	3	0	0	1	0				2	0	2	0
YP with MH attending	81	70	81	56	59	56	58	43		84	75	66	62
CP medicals	10	10	14	4	9	6				6	3	1	10
Referral paeds	27	21	14	13	9	6							

New Ward discussions	59	42	52	33	48	44				47	46	50	34
Ward discussions new and existing	165	136	149	94	99	150				184	164	183	173

4.3 Looked After Children and Adoption

Worthing Child Development Centre continues to provide Initial Health Assessments as part of the Sussex Community Foundation Trust (SCFT) Looked After Children hub. This consists of 2 appointments per week for health assessments. This is managed and monitored in liaison with SCFT to ensure statutory time frames are met.

Looked after children training is integrated with children's safeguarding training, with a focus on an introduction to trauma informed care. In addition, Looked After Children will be the focus of a Trust-wide Theme of the Week communication in coming weeks.

5. Safeguarding Children Priorities

5.1 Progress against 2022/23 Priorities

The Safeguarding Children team had 11 key priorities for the year 2022/23.The following describes progress against the priorities and next steps.

Safeguarding Children Team Priorities 2022/23	
1	*Develop a domestic abuse strategy and identify funding to resource and support the delivery of the strategy across all sites* • The Domestic Abuse Policy is currently being consulted on and will be ratified at the quarter 2 Safeguarding Committee. • The ICB funded IDVA post at the RSCH was recruited to during the year and the post holder has been establishing working relationships across the maternity, ED and sexual health services. • The ICB has identified funding for an additional post to support work in West Sussex and the post is in the process of being recruited to. • Both services report to the ICB. Trust domestic abuse activity is reported via the Safeguarding Adults quarterly and annual reports
2	*Update the Safeguarding Children and Looked after Children policy* • Complete
3	*Develop an integrated safeguarding training strategy* • The safeguarding children training strategy has been drafted. This will be further developed to incorporate safeguarding adults, learning

	disability and autism, MCA and dementia.
4	*Work towards integrating safeguarding structures, systems and processes, across the trust, ensuring, place based safeguarding is also strengthened* • Good progress has been made with the integration of the Safeguarding Children team. A whole team meeting brought people together from across all hospital sites and quarterly meetings are planned for 2023/24. These will be used to build relationships across the team and as training opportunities. • Work continues on standardising processes and reporting. A shared database framework will support more coherent activity reporting over the year.
5	*Liberty Protection Safeguards and strengthening MCA* • The Liberty Protection Safeguards implementation plan was paused during the year and a further national review of DoLS processes will take place with updated guidance • The requirement to assess the capacity and work with the Court of Protection for 16/17 year olds remains in place. • Work on better understanding the application of the MCA in paediatric services will continue over 2023/24
6	*Developing a sustainable solution for information sharing and paediatric liaison with the healthy child programme* • Work has started on reviewing processes across all hospital sites to ensure that information is recorded and shared by the clinician responsible for the care of the child
7	*Strengthen safeguarding arrangements for children and young people admitted to hospitals with mental health issues* • Considerable work is taking place to support children and young people with mental ill-health who are in receipt of Trust services. This includes o Reviewing security and safety on paediatric wards o Reviewing guidance for assessing risk o Working with SPFT on risk assessment and care planning o Large scale review of the emergency care pathway
8	*Strengthen the Safeguarding Champions role* • Work is on-going to strengthen the relationship with the safeguarding team and the clinical services. The focus will be on ensuring that all staff understand their safeguarding responsibilities and are confident in taking appropriate action
9	*Strengthen arrangements for Looked After Children across the Trust* • Work will continue during 2023/24 on identifying and supporting our Looked After Children
10	*Increase inclusivity to reflect the diversity of Sussex children and promote 'trauma Informed care'* • Learning from safeguarding reviews included in training opportunities • The Safeguarding Children team will access training to support inclusivity and understanding unconscious bias
11	*Strengthen Transitional safeguarding across the trust* • This is an important piece of work which needs to be carried over into 2023/24

5.2 Priorities 2023/24

A simplified set of priorities has been identified and each will have outcome measures and be monitored across the year.

Safeguarding Children Team priorities for 2023/24	
1	**Support for children and young people with mental ill-health.** Including: • Implementation of learning from the EFD Serious Incident investigation • Recording and reporting on all MHA detentions • Development of additional support to children and clinicians through the enhanced health care assistant programme
2	**Improved governance and reporting** Including: • Standardised reporting processes • Evidence via data reports and audit to demonstrate quality improvement and implementation of learning and best practice
3	**Supporting with vulnerable groups** Including: • Working with the ICB Transition lead to better understand challenges for young people who may need safeguarding support from adult services. • Development of a Safeguarding Transition Policy • Work with the LAC service to ensure that the voice of children and young people in the care of the Local Authority are heard • Improve reporting on Looked After Children who are accessing Trust services • Work with the hospital Independent Domestic Violence advocates to improve response to domestic abuse with clear reporting framework
4	**Embedding safeguarding knowledge in the Trust** Including: • Improving Level 3 training uptake with monthly reporting to clinical services and an improvement trajectory • Continued review of safeguarding children training content • ICB support in a review of content and training delivery • Development and implementation of a Safeguarding Children Supervision Policy with clear reporting and data collation • Standardisation of internal and external facing communications, referral systems, and newsletters

6. Conclusion

The Safeguarding Children team have worked hard to identify and protect children and young people at risk of abuse or neglect, in an environment of organisational change and increasing demand.

The focus has been on ensuring that the Trust statutory responsibilities are met, and measures are in place to provide more robust and regular assurance.

The Safeguarding Children Team are dedicated to the well-being of our children, and support the Trust to fulfil its responsibility to hold the child in mind and to hear their voice.

As governance and assurance processes develop, the team will focus on quality improvement and increasing the understanding of safeguarding children in all settings across UHSussex.

7. Supporting Documents

Working Together to Safeguard Children, 2018
https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

Safeguarding Children and Young People – Intercollegiate Document (2019)\
http://ndht.ndevon.swest.nhs.uk/wp-content/uploads/2012/08/Children-Intercollegaite-Doc- 2019.pdf

Section 11, Children's Act (2004)
http://www.legislation.gov.uk/ukpga/2004/31/section/11

Learning Together https://www.scie.org.uk/children/learningtogether/

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	18.5	**Meeting:**	Board of Directors (Public)	**Meeting Date:**	03/08/2023
Report Title:	Clinical Strategy 2023 - 26				
Sponsoring Executive Director:	Dr Catherine Urch (Chief Medical Officer)				
Author(s):	Oliver Phillips (Director of Strategy and Planning) Rachel Potts (Head of Strategic Planning)				
Report previously considered by and date:	Private Trust Board Seminar 06/07/23 Trust Management Committee 22/06/23				

Purpose of the report:			
Information	N/A	Assurance	N/A
Review and Discussion	Yes	Approval / Agreement	Yes

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

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	Yes	Link to Trust Annual Plan	Yes

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	Yes	
Sustainability	Yes	
People	Yes	
Quality	Yes	
Systems and Partnerships	Yes	
Research and Innovation	Yes	

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

Regulatory / Statutory reporting requirement

N/A

Communication and Consultation:

The Strategy has been developed taking into account the feedback we have already received from patients, public and staff. It has been developed with extensive collaboration with the Chiefs of Service. It has also been informed by the work completed with specialty clinical leads as part of the Mission Statements process.

Executive Summary:

The Trust has developed a Clinical Strategy based on a clear set of principles, setting out a roadmap which prioritises clinical service deliverables, informed by changing national, local, and Trust drivers, as well as the Mission Statements completed to date.

Key Recommendation(s):

- To agree the 2023 – 26 Clinical Strategy for the Trust (summary version, as well as the full length version shown in the appendix)

NHS

University Hospitals Sussex

NHS Foundation Trust

Clinical Strategy

Summary version

2023-2026

Contents

Foreword - Excellent care every time

Welcome to our clinical strategy that sets out our ambitions to improve care over the next few years. It's how we plan to grow our services and strive towards our Trust vision of excellent care, every time for all our patients.

As one of the newest and largest hospital trusts in the country, we can take advantage of our new size and combined resources to make changes that will make the biggest difference to our patients.

From delivering national best practice and developing purpose-built facilities, to expanding access to research and offering new treatments, our clinical strategy is informed by what our patients have told us, what our clinical leaders think, and the health and wellbeing needs of our local population.

We've used our Patient First continuous improvement approach to identify what changes we want to prioritise first. But we've also been clear about not changing the things we know our patients value the most, such as 24-hour access to emergency care and maternity services, as well as outpatients and diagnostic services at all our hospitals.

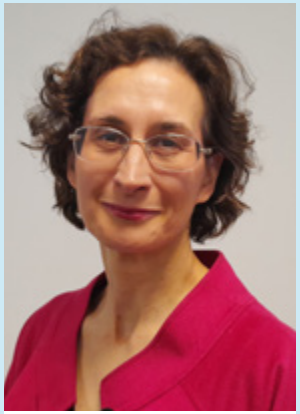
As a large teaching Trust, major trauma centre, and tertiary care provider, we want to expand our specialist services to offer more for people living in Sussex. Our ambitious plans to enhance our research and innovation activities will support this growth and offer both patients and staff the opportunity to benefit from the latest developments in medicine and technology at all our hospitals.

This Clinical Strategy supports the Trust's overarching Patient First improvement strategy, and it aligns with our plans for digital innovation, mental health, environmental sustainability, education, estates planning, partnership working, and research and innovation.

Each of our clinical divisions and specialty teams has identified initial priorities that'll deliver the greatest benefits for patients, in line with our Trust-wide Patient First objectives, such as reducing waiting times and improving clinical outcomes.

The whole NHS is facing similar operational pressures, and our Clinical Strategy is central to how we will address these challenges and improve services for our patients. We are enormously proud of all our staff who work extraordinarily hard for our patients, and we wish to thank colleagues in advance for the invaluable contribution they'll make towards the successful delivery of our Clinical Strategy 2023-26.

George Findlay
Chief Executive



Catherine Urch
Chief Medical Officer

Providing outstanding care to people in Sussex

University Hospitals Sussex NHS Foundation Trust provides outstanding care to the people of West Sussex, Brighton and Hove and parts of East Sussex.

As one of the largest acute trusts in the UK, we provide more than 1.5 million outpatient appointments, A&E visits, and surgery cases every year

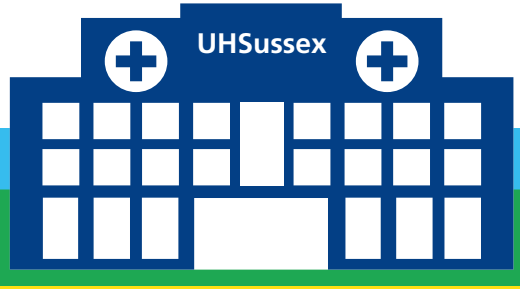
The Trust was formed in April 2021, bringing together Western Sussex Hospitals NHS Foundation Trust (WSHFT) and Brighton and Sussex University Hospitals (BSUH).

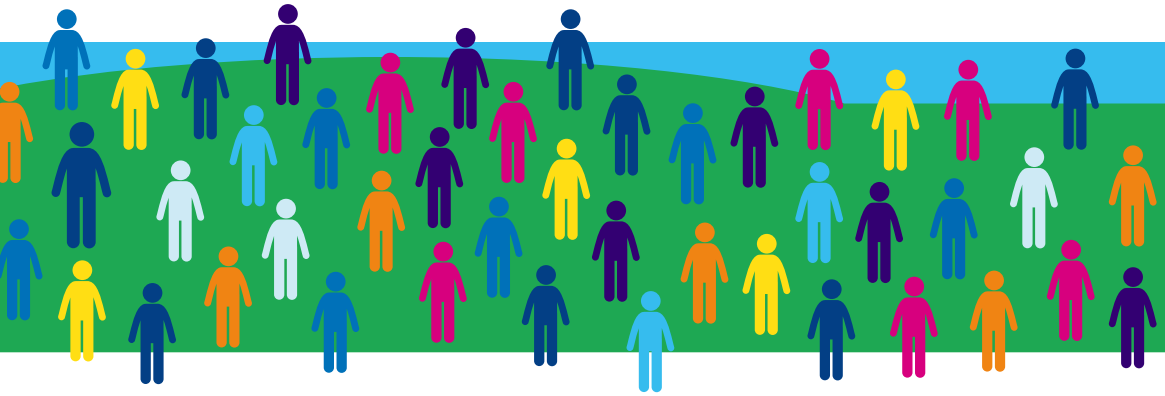
We operate five acute hospitals and deliver multiple services in other satellite and community settings, with an operating budget of more than **£1 billion.**

We employ nearly 20,000 staff across our seven hospitals.

We provide a full range of general and specialist complex care to around 1 million people including the majority of residents within West Sussex, Brighton and Hove, and the Lewes High Weald areas.

UHSussex operates within Sussex Health and Care Integrated Care System and works closely with partner health and social care organisations across Sussex and in each of the three localities or 'places' which are based on Local Authority boundaries: Brighton and Hove, East Sussex and West Sussex.





With a clear focus on continuous improvement, we always put our Patient First.

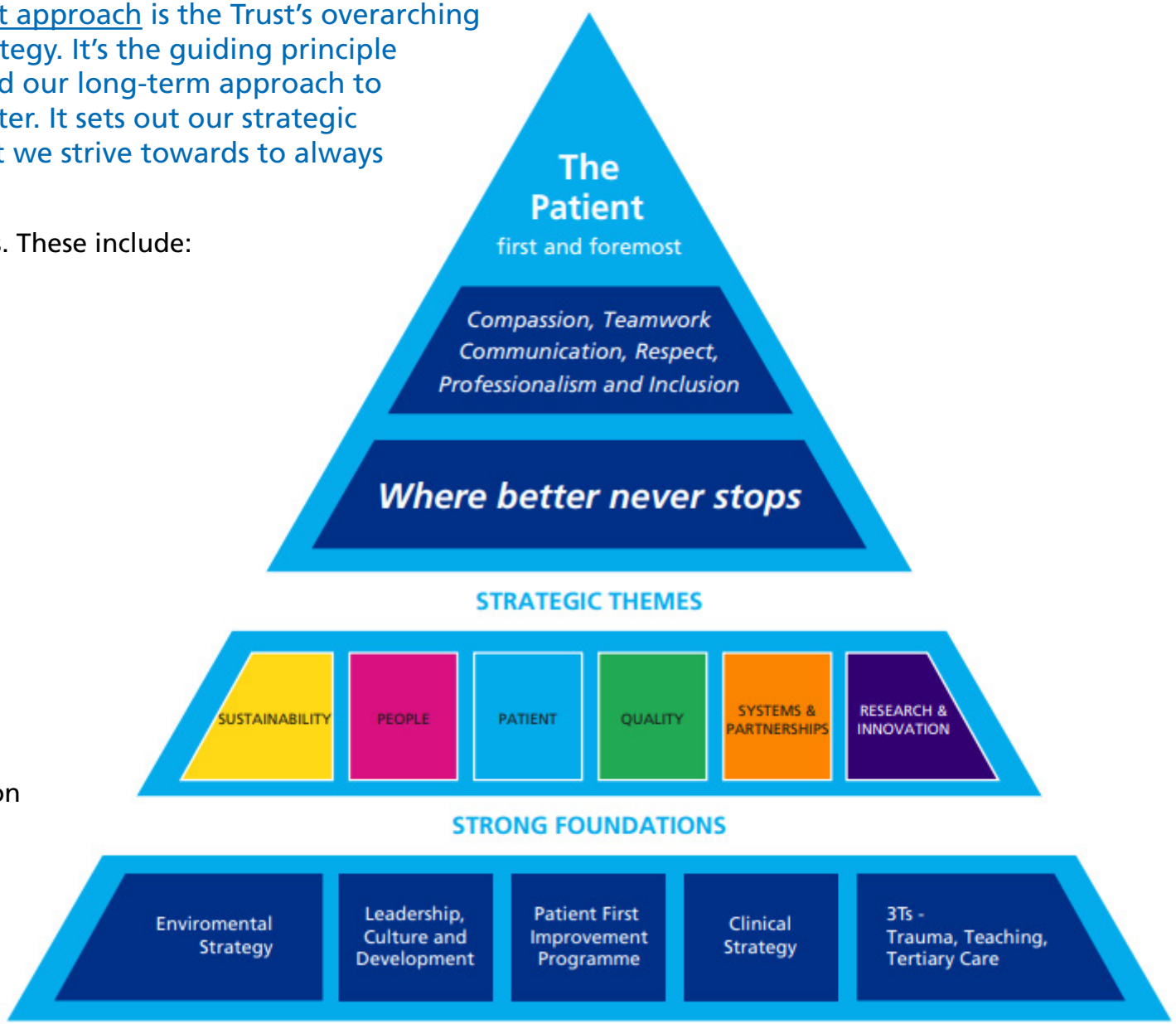
Patient First at the heart of everything we do

Our Patient First continuous improvement approach is the Trust's overarching strategy and is integral to the clinical strategy. It's the guiding principle at the heart of everything that we do, and our long-term approach to transforming hospital services for the better. It sets out our strategic direction, known as our "true north" that we strive towards to always put our patients first and foremost.

Central to this are the six true north domains. These include:

- **Patient Experience**
- **Quality**
- **Our People**
- **Sustainability**
- **Systems and Partnerships**
- **Research and Innovation**

The clinical strategy prioritises action based on the impact the initiatives will have on each of the true north domains.



Patient First at the heart of everything we do

Our vision, goals, breakthrough objectives can be seen here along with the Trust's strategic initiatives and shorter-term corporate projects.

Patient

Vision
Excellent Care Every Time

Goal
Positive experiences for all patients and their families

Sustainability

Vision
Making the most of our resources

Goal
High quality accessible services delivered in budget

Breakthrough
Improving productivity

Our People

Vision
A great place to work

Goal
Supported staff committed to delivering excellent care

Breakthrough
Staff voice that counts

Quality

Vision
Best outcomes

Goals
Zero preventable harm and lowest mortality among similar Trusts

Breakthrough
Fewer falls/ Earlier Intervention

Systems and Partnerships

Vision
Accessible care

Goal
Achieving national standards for planned, cancer and emergency care

Breakthrough
Home for lunch

Research and Innovation

Vision
Evidence-based improvement

Goal
Research and innovation for all patients and staff

Breakthrough
Taking part

Strategic Initiatives

Environmental Strategy
Leadership Culture and Development
Patient First Improvement Programme
Clinical Strategy
3Ts

Corporate Projects

Estates Masterplanning
Reduced Length of Stay
Patient Access Transformation
Community Diagnostic Centres
Medical Workforce Systems
Quality Governance

Clinical strategy principles

Strategic theme	Clinical strategy principles
Patient	• Support personalised care, tailored to individual needs, strengths and capabilities. • Ensure services should be local where possible and only centralised where necessary. • Work in collaboration with system partners to address inequalities.
Quality	• Ensure that national standards are met for all our services. • Improve patient outcomes including those specified in the True North Patient First approach.
Our people	• Focus on workforce modernisation. • Staff feel supported to provide quality clinical services, drawing on their commitment, knowledge and skills.
Sustainablity	• Support the financial and environmental sustainability of our clinical services, linked to our Green Plan. • Enable digital solutions.
Systems and partnerships	• Adhere to the ongoing service commitments specified below. • Enable delivery of the strategic objectives as articulated by the True North Patient First approach. • Support collaboration with system partners to enable joined up provision.
Research and Innovation	• Use Research and Innovation to improve clinical care, and support recruitment and retention of staff.

Developing our strategy - our commitments

When developing the clinical strategy, we've focused on what we most want to achieve for our clinical service, and the actions that will have the biggest impact on improving our services. Some key areas supported our strategic thinking including our commitments to local communities, the opportunities offered by research and innovation, the local and national healthcare context, the vision of our expert leaders and the voice of our patients. We've also made sure that we have the capacity and processes to carry out change through our Patient First methodology.

Keeping our commitments to local communities

- We'll continue to invest in emergency medical care and maternity services at Princess Royal, St Richard's, Worthing, and Royal Sussex County hospitals.
- We'll provide outpatient, day case and rapid diagnostic services all our hospitals, as well as other community facilities.
- We'll provide tertiary services as part of a network of tertiary care providers across the region and nationally, including for major trauma, cancer, paediatric care, stroke and renal services.

Underpinned by cutting edge research and innovation

- We want all patients and staff to have the opportunity to participate in high-quality research and innovation which is relevant to them.
- Research is a key area of growth because we know it helps to improve care and outcomes for patients.
- Our commitment to our teaching hospital status in conjunction with Brighton & Sussex Medical School.

In collaboration with our local partners

- Our strategy supports the five aims in the Sussex Health and Care System's Improving Lives Together strategy. These are to help local people start their lives well, live their lives well, age well, and get the treatment, care and support they need, as well as for staff to do the best job they can in the best possible working environment.
- It aligns with our key Trust strategies for digital innovation, mental health, and sustainability.
- It will help us make best use of our estate and work with our partners in Sussex and the wider region.

Using clinical leaders' vision and patient feedback

- Our clinical strategy is informed by a wealth of patient feedback to ensure the voice of our patients is at the heart of our plans for improvement.
- Specialty teams have used this insight to inform their ambitions and develop initial priorities.

Using our Patient First methodology to drive change

- The clinical strategy supports our overarching Patient First strategy and is fully aligned with our Trust's vision and values.
- It helps us see the opportunities to improve the quality, efficiency and timeliness of our services and for patients to see the right professional first time.
- Our Patient First continuous improvement method will be used by the teams delivering improvements.

Our hospitals

As a large multi-site trust with seven hospitals, we can be responsive to local need and can take advantage of our size with different hospitals developing areas of specialist expertise for the entire Trust. The Clinical Strategy shows how each hospital could be developed over time.

Our hospitals

5. Princess Royal Hospital

1. St Richard's Hospital

2. Worthing Hospital

3. Southlands Hospital

4. Royal Sussex County Hospital and Royal Alexandra Children's Hospital

Key - Integrated Care System place based partnerships (coterminous with our local authorities)

- West Sussex place
- East Sussex place
- Brighton and Hove place

Royal Sussex County Hospital campus

Hospital overview:

- Teaching hospital.
- District general hospital.
- Specialist and tertiary services.
- Major trauma centre.
- Comprehensive stroke centre.
- The Alex Children's Hospital.
- Sussex Eye Hospital.

Future developments and opportunities:

- Acute Floor Reconfiguration.
- New Sussex Cancer Centre.
- Expanded stroke and cardiac services.
- Better pathways for general surgery.

On our Brighton campus, we have three hospitals. The Royal Sussex County Hospital (RSCH), the Royal Alexandra Children's Hospital (the Alex) and the Sussex Eye Hospital.

RSCH is a large teaching hospital that provides both district and general hospital services for local people, as well as more specialist care for Sussex and the wider region. It's a major trauma centre, that also provides specialist neurosciences, cardiac, cancer, renal, and infectious diseases services.

The Royal Alexandra Children's Hospital (the Alex) provides specialist services for younger people, including emergency care and neo-natal intensive care.

The Sussex Eye Hospital provides ophthalmology services, including a specialist emergency department for eye care.

Planned developments

The Royal Sussex County Hospital is being significantly transformed by the flagship redevelopment project, 3Ts (Brighton Trauma, Tertiary and Training). Stage 1, the £500m Louisa Martindale Building opened in June 2023, providing state of the art accommodation for outpatient, ward and specialist services, such as neurosciences and critical care. Subject to public consultation, stroke services will also be expanded within the Louisa Martindale Building.

The second stage of 3Ts will create a purpose-built new Sussex Cancer Centre, where the Barry Building is currently located.

A £48m investment programme is also underway to reconfigure the Acute Floor, including A&E, to modernise and expand the department to create a much-improved environment for patients.

Other opportunities

We'll continue to develop services to support specialist and tertiary services, as well as care for local people. We'll look to expand our cardiac surgery service and enhance pathways across the Trust for general surgery services.

Royal Sussex County Hospital Leadership Team

Peter Lane
Hospital Director

Terece Walters
Hospital Director of Nursing

Princess Royal Hospital, Haywards Heath

Hospital overview:

- Teaching hospital.
- District general hospital.
- Day case focus.
- Surgical robot.
- Orthopaedic focus.
- Rehabilitation centre.

Future developments and opportunities:

- Develop and embed our new training academy.
- Urology investigation unit.
- Theatre admissions and discharge unit.
- More hip and knee surgery for wider catchment area.
- Urgent treatment and same day care improvements.

Princess Royal is an acute teaching hospital that provides district and general services, including emergency care and maternity services. We have a focus on day case surgery and deliver fractured neck of femur and elective and emergency urology services for both Princess Royal and RSCH hospitals.

Our surgical robot enables minimally invasive surgery for complex procedures and we're also home to the Sussex Orthopaedic Treatment Centre and the Sussex Rehabilitation Centre for specialist neuro-rehabilitation. We do not have a trauma unit and children's services are currently limited.

Planned developments

We have plans to significantly increase how much non-emergency care we do at Princess Royal Hospital. We will take steps to ensure that there is sufficient capacity to meet the need for endoscopy alongside provision of training opportunities as part of a new endoscopy academy. A new Urology Investigation Unit opens in 2023 and we will be creating a Theatre Admissions and Discharge Unit.

Other opportunities

We'll look for more opportunities to develop Princess Royal as a thriving centre for elective work. This will include greater use of the Sussex Orthopaedic Treatment Centre to provide hip and knee surgery for more people. We will also maximise the use of robotic surgery.

We will also develop more same day emergency care and urgent treatment to meet the needs of local people. We'll review the level of provision of specialist rehabilitation, including at the Sussex Rehabilitation Centre.

Princess Royal Hospital Leadership Team

Chris Ashcroft
Hospital Director

Edmund Tabay
Hospital Director of Nursing

Worthing Hospital

Hospital overview:

- District general hospital.
- Trauma unit.
- Medical day case unit.
- Urology investigation unit.
- West Sussex Breast Centre.

Future developments and opportunities:

- Urgent Treatment centre.
- Same day emergency care.
- Acute frailty unit.
- Surgical day case unit.
- Robotic surgery.
- Enhancement of critical care.
- Enhancement of specialist surgery.

Worthing Hospital provides a wide range of district and general hospital services. We are a designated trauma unit with adult and children's A&E, critical care, emergency surgery, intensive care, maternity services, children's care and cancer care (with tertiary services largely provided at RSCH).

Amberley Unit, our new purpose-built medical day-case facility provides chemotherapy and holistic care to patients, and our new Urology Investigation Unit transforms the way urology care is provided for patients.

Planned developments

Funding has been secured to develop a new Urgent Treatment Centre at the hospital to expand the provision of GP-led urgent care services.

Subject to public consultation, new clinical space may also become available for repurposing if acute stroke services are moved to St Richard's Hospital.

Other opportunities

We're looking to develop an Acute Frailty Unit and new Same Day Emergency Care facilities to further improve the care we provide. There are also opportunities to make more use of the excellent facilities at the hospital and improve access as other specialties are reviewed, including more specialist surgery.

In the longer term, we'll explore developing a dedicated surgical day-case unit, look to expand the use of robotic surgery and increase the number of procedures.

We'll review how we deliver diagnostic and interventional cardiology services across our hospitals. There're also opportunities to develop the renal service, including the dialysis services across Sussex so patients receive their treatment closer to home.

Worthing Hospital and Southlands Hospital Leadership Team

Stephen Mardlin
Hospital Director

Tori Cooper
Hospital Director of Nursing

Southlands Hospital, Shoreham-by-sea

Hospital overview:

- Outpatients and day surgery.
- Non-emergency care.
- Ophthalmology and ophthalmic surgery.

Future developments and opportunities:

- Community Diagnostic Centre for diagnostic services including MRI and CT scans.
- More day case patients including orthopaedics.
- Develop the dermatology service.

Southlands Hospital in Shoreham-by-Sea provides a wide range of outpatient, diagnostic and day surgery services on a site dedicated to providing non-emergency care. Our purpose-built ophthalmology centre provides specialist eye care and ophthalmic surgery services.

Planned developments

There are several developments taking place at Southlands which will significantly increase the number of patients using the hospital. A large Community Diagnostic Centre is opening in 2023 which will deliver MRI, CT scans, x-rays, ultrasound, and a range of other diagnostic services. The Trust is also looking to increase the number of surgery patients seen as day cases at Southlands through a refurbishment of the day case unit

Other opportunities

We'll look to further increase day case capacity exploring the potential to see more ophthalmology cases. We'll also look to bring more day case orthopaedic work to Southlands. We'll also explore further developing the dermatology service.

Worthing Hospital and Southlands Hospital Leadership Team

Stephen Mardlin
Hospital Director

Tori Cooper
Hospital Director of Nursing

St Richard's Hospital, Chichester

Hospital overview:

- District general hospital.
- Trauma unit.
- Centre of Excellence for bariatric and metabolic surgery.
- Hip and knee replacement elective surgery hub.
- Neuro-rehabilitation centre.

Future developments and opportunities:

- Acute Stroke Centre (subject to public consultation).
- Acute frailty services.
- Same day emergency care.
- Paediatric A&E.
- Develop orthopaedics, cardiology, ENT, urology maxillo-facial, gynaecology and critical care services.

At St Richard's Hospital we provide a wide range of district and general hospital services including A&E, critical care, emergency surgery, intensive care, maternity services, paediatric care and cancer care (with tertiary services at Portsmouth Hospitals University NHS Trust).

St Richard's is a designated trauma unit, that also specialises in bariatric care and hyperbaric medicine. The campus is home to a specialist neuro-rehabilitation service at Donald Wilson House.

Planned developments

Subject to public consultation, acute stroke services may move from Worthing Hospital to St Richard's Hospital with the development of a new acute stroke centre. To support this development, imaging and therapeutic support for stroke patients would also need to be strengthened.

Other opportunities

We want to develop our acute frailty services, same day emergency care and urgent treatment provision, and paediatric facilities within our A&E department.

There are also opportunities to further develop orthopaedics, cardiology, ENT, urology and maxillo-facial services, as well as in gynaecology for day patients, ambulatory, early pregnancy and outpatients.

We want to improve critical care and review how we deliver diagnostic and interventional cardiology services.

St Richard's Hospital Leadership Team

Charlotte Freeman
Hospital Director

Pam Stephens
Hospital Director of Nursing

The Clinical Operating Model

To successfully manage such a large trust covering a wide geographical area, there are two managing directors with one focusing on planned care and one on unscheduled care. Each of the main sites (St Richard's Hospital, Worthing Hospital, Southlands Hospital, Princess Royal Hospital and Royal Sussex County Hospital) has a hospital director and site nurse lead.

Huw Edwards
Managing Director
Planned Care and
Cancer

Siobhan Murray
Managing Director
Unscheduled Care

The clinical services are divided into eight divisions:

- Medicine and Urgent Care (St Richard's and Worthing)
- Medicine and Urgent Care (Princess Royal and the Royal Sussex County)
- Surgery (St. Richard's and Worthing)
- Surgery (Princess Royal and the Royal Sussex County)
- Women and Children
- Cancer
- Specialist Services
- Clinical Support Services

The divisions are led by a chief of service, divisional director and divisional director of nursing, midwifery or allied health professional.

We also have a chief pharmacist working within the Clinical Support Services. This team will be integral to the delivery of the clinical strategy.

Medicine

We provide Emergency Department (A&E) services from four acute hospital sites with St Richard's, Worthing, and RSCH able to respond to a full range of medical and surgical emergencies.

We also provide a wide range of medical specialties including care of the elderly, dermatology, diabetes and endocrinology, respiratory medicine, infectious diseases, HIV services, and sexual health and contraception (SHAC).

Our ambition

We'll provide high quality emergency care on our four main acute sites with a consistent model to deliver excellent urgent care services, frailty, and acute medicine, as well as same day emergency care.

Royal Sussex County Hospital will remain a Level 1 Trauma Centre, and Worthing and St Richard's as Trauma Units.

In collaboration with community providers, we'll deliver multi-disciplinary care that's centred around communities and provide timely access to a range of high-quality medical subspecialties.

Patients will be able to join in high impact research and innovation as part of the care they receive.

Our initial priorities

- Improve access to same day emergency care and urgent treatment centres.
- Explore options to standardise frailty services across the Trust.
- Complete the Acute Floor Reconfiguration Programme at RSCH.
- Explore new workforce options such as increasing use of advanced care practitioners, physician associates and other practitioners.
- Explore configuration of pathways for respiratory services.
- Develop a dermatology strategy that aligns with the Integrated Care Board.

Divisional leaders

Worthing and St Richard's Hospital

Steven Kriese
Chief of Service

Sean Kedzia
Divisional Director of Operations

Julie Thomas
Divisional Director of Nursing

The County and Princess Royal Hospitals

Mark Edwards
Chief of Service

Gordon Houliston
Divisional Director of Operations

Josephine Kerr
Divisional Director of Nursing

Women and Children

We provide gynaecology, obstetrics, neonatal care, paediatric medicine and paediatric surgery across Royal Sussex County Hospital, Princess Royal Hospital, Worthing Hospital and St Richard's Hospital.

Our ambition

We want to provide world class services that are led by the latest research and innovation. To achieve this, we'll develop an ambitious programme for women, children, young people and their families that is focused on three key areas:

- delivery of the highest quality maternity and neonatal care
- modernised services for children and young people
- timely provision of gynaecology that improves the patient experience.

We'll work collaboratively with our patients, teams, and partner organisations, embedding high quality governance and making the best use of our estate to meet the needs of our patients and families.

We'll embed research and innovation into clinical care and take opportunities to create research and innovation roles in job plans.

Our initial priorities

- Review neonatal care services making sure they meet national standards, and that capacity and demand are managed across the system and supported by the right workforce.
- Improve the service model and workforce requirements for paediatric services, including emergency provision.
- Review the model and estate needed for the best provision of gynaecology day, ambulatory, early pregnancy, and outpatient units across all four sites including a focus on patients experiencing early and mid-trimester pregnancy loss.
- Implement the Maternity Improvement Plan agreed with the Maternity Safety Support Programme, along with the national three-year delivery plan for maternity and neonatal services.
- Improve pathways for planned and emergency caesarean sections.
- Transfer children's audiology services to the Alex children's hospital.
- Address the mental health needs of children in the care of the Trust.

Divisional leaders

Tim Taylor
Chief of Service

Hugh Jelley
Divisional Director of Operations

Claire Hunt
Divisional Director of Nursing

Emma Chambers
Divisional Director of Midwifery

Clinical Support Services

We provide a full range of clinical support services to our acute hospitals (Royal Sussex County, Princess Royal, Worthing and St Richard's hospitals), primary care and the wider Integrated Care System. This includes the community diagnostics centres and services within pathology, therapies, pharmacy, radiology, and imaging.

Our ambition

Our efficient, state of the art services will support patients in a timely way through their pathways, seven days a week. We'll provide access to these services equitably, giving outstanding care close to home for patients.

The high quality services we provide will improve flow through the hospitals and help reduce admissions. Our services will be able to respond to changing demand and we'll make sure there's enough resources in divisional business cases for successful support services.

We'll support patients on cancer pathways with timely access to cancer diagnostics and reporting, innovative treatment delivery pathways through our aseptic pharmacies as well as access to therapy and dietetic pathways.

We'll support the UHSussex research and innovation agenda through high-quality studies and the development of research and innovation roles within our multidisciplinary workforce.

Our initial priorities

- Agree the Point of Care Testing Strategy across UHSussex.
- Redesign clinical pharmacy services to support efficiency and safety.
- Develop the case for seven-day services across all key areas including pharmacy, radiology, and physiotherapy.
- Determine the future model of interventional radiology and nuclear medicine, including PET-CT services, across UHSussex.
- Work towards establishing the Sussex Pathology Network.
- Complete the roll out of the electronic prescribing and medicines administration (EPMA).
- Open the Community Diagnostic Centre at Southlands Hospital and support new partner CDCs at Falmer and Bognor.

Divisional leaders

John Laurie
Chief of Service

Yannick Raimbault
Divisional Director of Operations

Cate Leighton (DDAHP)
Divisional Director of Nursing

Mike Cross
Chief Pharmacist

Surgical Services and Critical Care

We provide a wide range of surgical services including general surgery, ear nose and throat (ENT), ophthalmology, maxillofacial surgery, trauma and orthopaedics, urology, bariatric surgery, critical care, and perioperative care.

We also deliver audiology, rheumatology and chronic pain services within the surgical divisions and manage multiple theatre complexes and the central sterilisation services.

Our ambition

We'll provide safe, excellent and timely care that incorporates modern technologies and techniques, alongside learning from clinical excellence such as Getting It Right First Time (GIRFT) programme. Research and innovation will be integral to the work we do, with research leadership and roles established as clinical services are developed. We will take steps to optimise post-operative outcomes.

We'll make sure that our services support excellent patient experience and outcomes, as well as the development of vibrant hospital sites. Our services will make the best use of our estate through the development of seven-day services.

Our initial priorities

- Optimise key general surgery pathways across UHSussex, particularly for colorectal surgery and upper GI surgery, considering elective access, perioperative care, and robotic surgery.
- Undertake a review of the configuration of orthopaedic services to support the delivery of safe and excellent quality provision across UHSussex and improve productivity.
- Standardise critical care outreach services across UHSussex.
- Open the new Urology Investigation Unit at Princess Royal.
- Review the model of urology provision across UHSussex.
- Review maxillo-facial services taking into account Sussex-wide provision.
- Take steps to ensure the future of major knee revision surgery.
- Increase day case provision at Princess Royal and Southlands.
- Develop a single Patient Tracking List for ENT.
- Develop the peri-operative service.

Divisional leaders

Worthing and St Richard's Hospital

Colin Spring
Chief of Service

Nicky Sullivan
Divisional Director of Operations

Kim Cheetham
Divisional Director of Nursing

The County and Princess Royal Hospitals

Steven Drage
Chief of Service

Paul Silvester
Divisional Director of Operations

Margaret Flynn
Divisional Director of Nursing

Digestive Diseases

UHSussex provides both specialist medicine and surgery for digestive diseases. This includes gastroenterology, endoscopy and hepatology.

Our ambition

We'll provide excellent care for our patients through collaborative work with system partners to improve pathways and models of service. This will help us to have the right capacity to meet the needs of our local population.

We'll take steps to ensure that there are is sufficient capacity to meet the need for endoscopy services particularly at the Princess Royal Hospital. We'll develop our regional endoscopy training academy for junior doctors, growing our regional training offer.

We'll ensure ongoing accreditation of our services, for example maintaining Joint Advisory Group (JAG) accreditation on all four acute sites and achieving Improving Quality in Liver Services (IQILS) accreditation.

We'll embed research and innovation across our services and continue to build on the hepatology research programme within UHSussex and our university partner.

Our initial priorities

- Launch an Endoscopy Training Academy Programme.
- Take steps to ensure that there is sufficient capacity to meet the need for endoscopy.

Divisional leaders

Worthing and St Richard's Hospital

Steven Kriese
Chief of Service

Sean Kedzia
Divisional Director of Operations

Julie Thomas
Divisional Director of Nursing

The County and Princess Royal Hospitals

Steven Drage
Chief of Service

Paul Silvester
Divisional Director of Operations

Margaret Flynn
Divisional Director of Nursing

Cancer Care

We provide a range of cancer care including oncology, clinical haematology, systemic anti-cancer therapy (SACT), radiotherapy, screening management, palliative care, and integrated breast services. Site specific cancer surgery is reviewed under the specific surgical specialties.

We provide tertiary and secondary cancer care, for local people and the wider population of Sussex. The Sussex Cancer Centre at Royal Sussex County Hospital is the tertiary centre for patients requiring specialist oncology treatment in Sussex and is part of the wider Surrey and Sussex Cancer Alliance. Tertiary oncology services for Chichester are currently provided by Portsmouth Hospitals University NHS Trust.

Our ambition

We want to be recognised locally, nationally, and internationally for excellence in the delivery of high quality, safe cancer care that is underpinned by education and research.

Our staff will feel valued and supported to fulfil their potential in an inclusive and kind working environment.

We want to make sure that all patients and staff have the equality of access to high-quality research and innovation that's relevant to them.

Our initial priorities

- Develop and implement a cancer strategy that determines the requirements for inpatient beds, acute assessment units, workforce for all our sites, as well as future provision of radiotherapy.
- Develop and implement a plan for a research unit to increase access to clinical trial opportunities.
- Design the configuration of services within the Stage 2 3Ts development to create a new Sussex Cancer Centre at RSCH.

Divisional leaders

Sarah Westwell
Chief of Service

Dominic Clarke
Divisional Director of Operations

Lisa Barrott
Divisional Director of Nursing

Specialist Services

We provide a wide range of specialised tertiary services across multiple sites. These include cardiac surgery, cardiology, neurosurgery, spinal surgery, plastic surgery, major trauma, vascular services, renal services, neurology, stroke services and specialist rehabilitation.

Our ambition

As a regional teaching hospital, we recognise our responsibility to support and develop specialised services to ensure that patients from Sussex and beyond have access to these without the need for referral elsewhere.

Our vision is to create an environment where specialised services can flourish, delivering safe and effective care to everyone who needs it in a timely way.

We'll further develop a plan for research and innovation, reflecting the important benefits to patients and staff, and making sure our patients have the opportunity to join in high impact research and innovation as part of the care they receive.

We'll also continue to work closely with network partners in Sussex and the region.

Our initial priorities

- Review the Diagnostic and Interventional Cardiology services across the Trust.
- Expand the Mechanical Thrombectomy Service at Royal Sussex County Hospital.
- Complete the consultation on stroke services in West Sussex.
- Open the helideck for the major trauma centre.
- Secure the development and expansion of the Cardiac Surgery service.

Divisional leaders

Ryan Watkins
Chief of Service

Maria Emmanuel
Divisional Director of Operations

Louise Skelt
Divisional Director of Nursing

Next steps

The launch of our Clinical Strategy is an exciting moment that maps out our path ahead to improve services for patients. With the patient voice at its heart, the vision of our clinical leaders driving us forward, and Patient First providing rigour to our approach, we're confident this strategy sets us up for success.

But the real journey begins from now, as our clinical divisions focus on the initial priorities they've set out in the strategy and implement the improvements that'll make the biggest difference to our patients over the next three years. Our Patient First approach will be used consistently, empowering frontline teams to develop solutions and lead the change process.

The Clinical Strategy encompasses every specialty and clinical team within the Trust, and each is developing their own mission statement that describes how they'll contribute to the delivery of the strategy and our aligned Patient First objectives.

Those specialties making large changes will use a standard specialty review process and we'll use established strategic change processes, such as corporate projects and strategic initiatives within the trust, and projects and partnership programmes within the Sussex Health and Care System, to increase our capacity for improvements and maximise benefits for patients.

As priorities are implemented, benefits for patients will be evaluated, and new proposals and priorities refined through the Clinical Strategy Steering Group and our wider Patient First strategy deployment processes. Over time the Clinical Strategy will see services for patients improve as our staff and hospitals flourish and work together to deliver our Patient First goals through our new clinical ambitions.

Our next steps

- Our Patient First methodology will empower frontline teams to develop solutions and lead the change process as set out in the clinical team mission statements.
- Our strategy deployment review process will join up clinical improvements with other corporate projects and strategic initiatives to gain best efficiencies.
- A Clinical Strategy Steering Group will oversee the proposals and how benefits will be made for our patients.

NHS
University Hospitals Sussex
NHS Foundation Trust

Clinical Strategy
2023-2026

Contents

Foreword

We are delighted to introduce the clinical strategy for University Hospitals Sussex NHS Foundation Trust. The strategy will help our patients and communities have access to excellent clinical services, when they need them. Our 'True North' approach has been fundamental to the way we have developed the strategy. This is the term we use to describe our overarching goal of constantly improving standards of patient care, and putting the patient first and foremost. This strategy will play a key role in attaining our True North objectives, relating to patient experience, quality, our people, sustainability, systems and partnerships, as well as our new True North domain, research and innovation.

The strategy has been developed within a clear set of principles and keeps to our agreed commitments to maintain investment in key areas of clinical service delivery. It is inclusive of all our clinical specialties and sets out the vision for each of our clinical areas with a focus on both maintaining and achieving national standards.

The implementation of the strategy will take full advantage of our size and combined resources, whilst ensuring that we maintain and further develop our vibrant individual hospital sites that serve the needs of our local communities.

It will support our joint work with system partners to improve the health and wellbeing of our communities, alongside improving access to both emergency medicine and elective services.

The implementation of our clinical strategy begins at a time of huge operational pressures. In this context, we are enormously proud of the commitment our staff show to delivering excellent clinical services every day, for the benefit of our patients and communities. We wish to thank all our staff for the contribution they make to delivering the best clinical services possible.

George Findlay
Chief Executive

Catherine Urch
Chief Medical Officer

Introduction

Welcome to the 2023-26 clinical strategy for University Hospitals Sussex NHS Foundation Trust. The strategy sets out the priorities and actions that we will take to improve the quality of the clinical services. The strategy will also drive sustainability of those services, whilst supporting delivery of emergency care and elective recovery following the COVID-19 pandemic.

The strategy has been developed through detailed discussions with each of our clinical divisions and has a clear roadmap that will support its implementation. It is designed to support delivery of all our True North goals and is firmly rooted in the continuous improvement approach of Patient First, where we aspire to give excellent care, every time and "Where better never stops".

Context

The implementation of the strategy is starting during a period of significant operational pressures. The strategy is a key element of our plans to address these challenges. It also takes account of the wider strategy of Sussex Health and Care Integrated Care System, and aligns with the Trust's other key strategies relating to digital innovation, mental health and environmental sustainability. The clinical strategy will also inform our plans for how we will best use and develop our buildings and estate. We refer to that as estates master planning.

Patient experience

Hearing and responding to the voice of our patients will be vital to how we implement our clinical strategy. Patient feedback from a range of sources such as the Friends and Family Test, compliments and complaints provides a wealth of information that gives us insight into what is important to our patients. All our specialties will draw on this when implementing the strategy, as well as engaging directly with key patient and stakeholders.

Our improvement methodology provides a rigorous approach to capturing and acting on what matters to patients, staff and other stakeholders. It ensures that improvement starts from the patient's point of view and allows us to turn patient comments or feedback into measureable outcomes that we can then monitor to ensure that services are better.

Where we need greater understanding of the experience and views of our patients, particularly for those people with diverse needs and protective characteristics, we will use a range of approaches. This may include surveys, interviews and focus groups to help us understand what is most important to our patients, as well as what adds or takes away from effective patient pathways. We will also involve patients in the design and assessment of potential solutions and use their input to help us define our options appraisal criteria.

Introduction

Workforce development

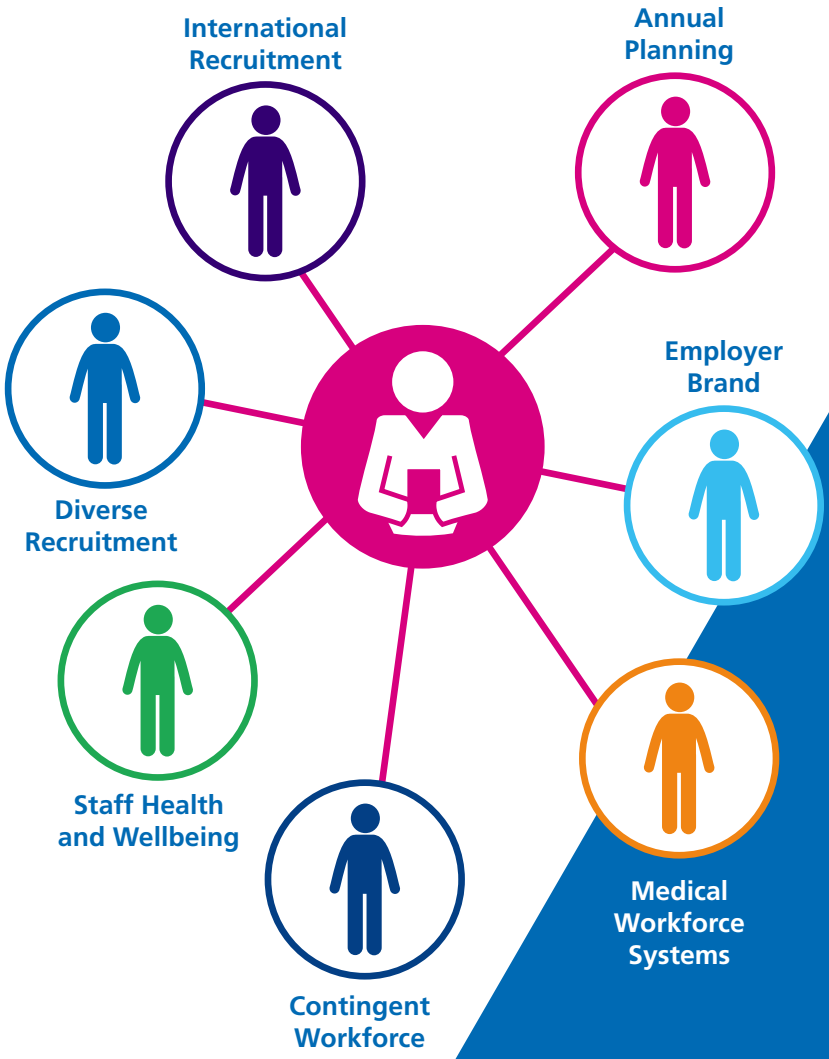
We are committed to making UHSussex a great place to work. Supporting the development of our workforce is integral to the future of all our clinical services. In turn, the implementation of the clinical strategy will be a key element for supporting our staff to have fulfilling and rewarding roles. It will enable staff to feel supported to provide quality clinical services, drawing on their commitment, knowledge and skills. Workforce planning will focus on a range of areas including international recruitment, annual planning, employer brand, medical workforce systems, contingent workforce, diverse recruitment, as well as staff health and wellbeing.

Role diversification and staff training will be of particular relevance to the clinical strategy. Advanced clinical practitioner, nursing associate and physician associate roles will continue to form part of the workforce strategy, and clinical divisions will be asked to consider how the diversification of roles will help support the delivery of high-quality patient care. The apprenticeship levy will support the development of new and emerging roles and there is potential to further broaden the use of levy funding, for example via the expansion of the nursing associate role to create a pipeline of future fully registered nurses.

The strategy will also require a flexible workforce, providing seven days a week care, across the traditional acute, primary, and community boundaries.

The scale, pace, and complexity of change in the NHS provides many challenges for us to ensure that patients receive the best care, making it necessary to constantly, learn, develop, and change. We need to develop career pathways that do not just rely on traditional routes such as colleges and universities but look to using innovation in creating apprenticeships and on the job training.

The development of an education strategy in 2023 will support the clinical strategy with a workforce that has the right skills and knowledge to meet these challenges whilst continuing to deliver patient focused high quality care.



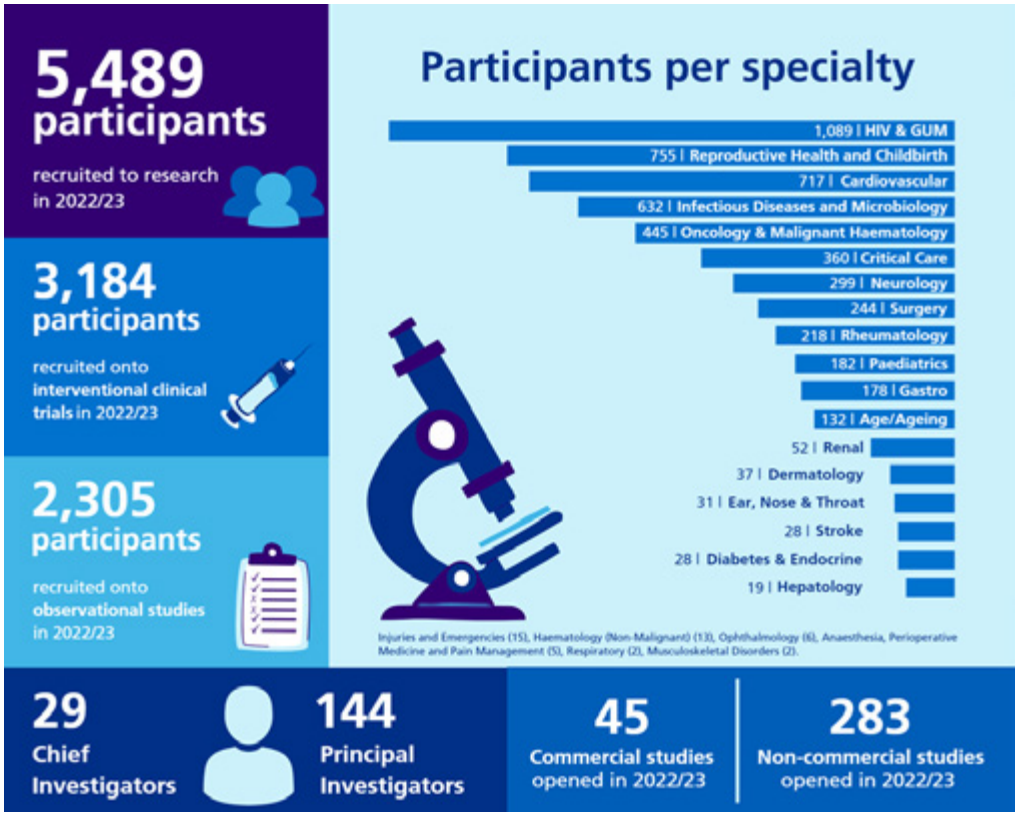
Research and innovation

Our vision

UHSussex will be a place where all patients and staff have the opportunity to participate in high-quality research and innovation which is relevant to them. We will also work with partners across Sussex to ensure equality of access to the benefits of health and care research and innovation for the whole population.

Research and Innovation is now one of our six True North themes. This is because we recognise that it is one of the most powerful means by which we can improve the care we provide. Through research and innovation we learn how to better prevent, diagnose and treat illness. Research and Innovation tell us what doesn't work; helping us improve practice and focus resources on doing what delivers the greatest benefits. Importantly, the positive impact of research and innovation is not confined to those who participate. NHS trusts that are highly research active have better outcomes for patients across all their services.

We have a strong tradition of participation in research and are the largest contributor to National Institute for Health and Care Research (NIHR) portfolio studies in Kent, Surrey and Sussex and we lead nationally and internationally recognised research in cardiology, oncology, HIV and infectious diseases. We also have excellent patient and public involvement in research and run a successful programme of NIHR research training.



Research and innovation

We will achieve our vision for research and innovation by:

- Embedding this in the experience of our patients and the working lives of our staff.
- Delivering this through a supported, multi-professional workforce.
- Ensuring this is inclusive of all our patients and staff, considering the diverse needs of our patients.
- Aligning this to our strategic priorities, continuous improvement methodology and the clinical services we deliver.
- Ensuring that our approach is patient-centred, driven by the needs of our patients.
- Making sure the physical and staffing infrastructure is in place to deliver our vision for research and innovation.
- Building streamlined and efficient processes, empowered by data and analytics.
- Integrating this with the health and care research of our NHS and academic partners across Sussex.
- Developing distinctive excellence, establishing a national and international reputation for the contribution made by UHSussex.
- Our clinical strategy will make a significant contribution to driving forward these ambitions. Research and innovation is integral to the vision and priorities for each of the clinical areas that we set out in our strategy.

Aligning with our other strategies

Digital Strategy

The Trust's digital and data strategies, alongside the implementation of a new Trust-wide electronic patient record will be key to the success of the clinical strategy. Joined up digital solutions will help make sure patients get the right care, in the right place, at the right time. It will help us better share resources, innovate and support more specialist input to services. It will help our clinical services to be more efficient and drive improved safety and quality of our provision. It will also support increased collaboration across system partners that will help patients to access advice or care more easily. The implementation of the digital strategy will be informed by the many organisational priorities including the priorities set out within this clinical strategy.

Mental Health Strategy

When implementing our clinical strategy, we will take into account the commitments that we made to our patients and communities within our 2023-28 mental health strategy. The implementation of the clinical strategy will contribute to the goals of the mental health strategy and help with equal parity between mental health and physical health care, and reduce stigma for our patients who have mental health needs and require access to our clinical services. The clinical strategy will also help to further develop integrated, holistic care, addressing the mental health and physical health needs of all our patients.

The Trust

University Hospitals Sussex NHS Foundation Trust provides outstanding care to the people of West Sussex, Brighton and Hove and parts of East Sussex. As one of the largest acute trusts in the UK, we handle more than 1.5 million outpatient appointments, A&E visits, and surgery cases every year - and we employ nearly 20,000 staff across our seven hospitals.

With a clear focus on continuous improvement, we always put our Patient First. We provide a full range of general and specialist complex care to around 1 million people including the majority of residents within West Sussex, Brighton and Hove, and the Lewes High Weald areas. The Trust was formed in April 2021, bringing together Western Sussex Hospitals NHS Foundation Trust (WSHFT) and Brighton and Sussex University Hospitals (BSUH). We operate five acute hospitals and deliver multiple services in other satellite and community settings, with an operating budget of more than £1 billion.

UHSussex operates within Sussex Health and Care Integrated Care System and works closely with partner health and social care organisations across Sussex and in each of the three localities or 'places' which are based on Local Authority boundaries: Brighton and Hove, East Sussex and West Sussex.

The Trust is responsible for all district general acute services for Brighton and Hove, west and mid Sussex and parts of East Sussex. It is also responsible for specialised and tertiary services across Sussex and the South East including neurosciences, arterial vascular surgery, neonatology, paediatrics, cardiac, cancer, renal, infectious diseases and HIV medicine.

Our population

We are developing our clinical strategy based on an understanding of the changing demographics and diverse needs of our local population including the inequalities in health outcomes they experience. Our older population is set to grow significantly over the next five years and our clinical strategy will make sure we're best placed to meet the changing needs of the population we serve. Our population spans both urban and rural communities and is highly diverse in terms of age, ethnicity, religion, deprivation and health.

Appendix 1 provides more information about the population we serve.

The Trust

5. Princess Royal Hospital

1. St Richard's Hospital

2. Worthing Hospital

3. Southlands Hospital

4. Royal Sussex County Hospital and Royal Alexandra Children's Hospital

CRAWLEY
East Grinstead
Horsham
MID SUSSEX & HORSHAM
Crowborough
Southwater
Haywards Heath
5
HIGH WEALD, LEWES & HAVENS
Billingshurst
Midhurst
Uckfield
Heathfield
Rye
Burgess Hill
HASTINGS & ROTHER
Battle
Storrington
Henfield
COASTAL WEST SUSSEX
Steyning
Lewes
Hailsham
1
2
3
BRIGHTON & HOVE
Hove
4
Hastings
Chichester
Arundel
Polegate
Bexhill
Shoreham by-Sea
Brighton
Newhaven
EASTBOURNE, HAILSHAM & SEAFORD
Littlehampton
Worthing
Seaford
Eastbourne
Bognor Regis
Selsey

Key - Integrated Care System place based partnerships (coterminous with our local authorities)

- West Sussex place
- East Sussex place
- Brighton and Hove place

The Clinical Operating Model

To successfully manage such a large trust covering a wide geographical area, there are two managing directors with one focusing on planned care and one on unscheduled care. Each of the main sites (St Richard's Hospital, Worthing Hospital, Southlands Hospital, Princess Royal Hospital and Royal Sussex County Hospital) has a hospital director and site nurse lead.

The clinical services are divided into eight divisions:

- Medicine and Urgent Care (St Richard's and Worthing)
- Medicine and Urgent Care (Princess Royal and the Royal Sussex County)
- Surgery (St. Richard's and Worthing)
- Surgery (Princess Royal and the Royal Sussex County)
- Women and Children
- Cancer
- Specialist Services
- Clinical Support Services

The divisions are led by a chief of service, divisional director and divisional director of nursing, midwifery or Allied Health Professional.

We also have a chief pharmacist working within the Clinical Support Services. This team will be integral to the delivery of the clinical strategy.

Vision, values and true north

Our Patient First approach is the Trust's overarching strategy and is integral to the clinical strategy. It's our guiding principle at the heart of everything that we do. It's also the long term approach to transforming hospital services. It sets out that our true north is the 'patient first and foremost'. This is supported by the values of compassion, teamwork, communication, respect, professionalism, and inclusion.

Central to this are the six true north domains. These include:

- **Patient Experience**
- **Quality**
- **Our People**
- **Sustainability**
- **Systems and Partnerships**
- **Research and Innovation**

Vision, values and true north

Our vision, goals and the shorter term breakthrough objectives for each true north domain are summarised aside. This also shows the strategic initiatives and shorter term corporate projects that will help achieve these goals.

The clinical strategy will help us achieve the mission of excellent care, every time and 'where better never stops'. It is one of the strategic initiatives and will inform, and be informed by, the other corporate projects and strategic initiatives. Additionally, all specialties will use the consistent Patient First improvement methodology when carrying out changes.

The clinical strategy has been developed taking into account a set of principles that have been informed by our True North vision and values. The strategy prioritises action based on the impact the initiatives will have on each of the True North domains.

Patient

Vision
Excellent Care Every Time

Goal
Positive experiences for all patients and their families

Sustainability

Vision
Making the most of our resources

Goal
High quality accessible services delivered in budget

Breakthrough
Improving productivity

Our People

Vision
A great place to work

Goal
Supported staff committed to delivering excellent care

Breakthrough
Staff voice that counts

Quality

Vision
Best outcomes

Goals
Zero preventable harm and lowest mortality among similar Trusts

Breakthrough
Fewer falls/ Earlier Intervention

Systems and Partnerships

Vision
Accessible care

Goal
Achieving national standards for planned, cancer and emergency care

Breakthrough
Home for lunch

Research and Innovation

Vision
Evidence-based improvement

Goal
Research and innovation for all patients and staff

Breakthrough
Taking part

Strategic Initiatives

Environmental Strategy
Leadership Culture and Development
Patient First Improvement Programme
Clinical Strategy
3Ts

Corporate Projects

Estates Masterplanning
Reduced Length of Stay
Patient Access Transformation
Improving General Surgery
Community Diagnostic Centres
Medical Workforce Systems
Quality Governance

Principles

Domain	Principle
Patient	• Support personalised care, tailored to individual needs, strengths and capabilities. • Ensure services should be local where possible and only centralised where necessary. • Work in collaboration with system partners to address inequalities.
Quality	• Ensure that national standards are met for all our services. • Improve patient outcomes including those specified in the True North Patient First approach.
Our people	• Focus on workforce modernisation. • Staff feel supported to provide quality clinical services, drawing on their commitment, knowledge and skills.
Sustainablity	• Support the financial and environmental sustainability of our clinical services, linked to our Green Plan. • Enable digital solutions.
Systems and partnerships	• Adhere to the ongoing service commitments specified below. • Enable delivery of the strategic objectives as articulated by the True North Patient First approach. • Support collaboration with system partners to enable joined up provision.
Research and Innovation	• Use Research and Innovation to improve clinical care, and support recruitment and retention of staff.

Principles

Our commitments to our patients (strategic boundaries):

- Access to emergency medical care and A&E services 24 hours a day, 7 days a week on the Princess Royal Hospital, Royal Sussex County Hospital, St Richard's Hospital and Worthing Hospital sites.
- Maternity services at the Princess Royal Hospital, Royal Sussex County Hospital, St Richard's Hospital and Worthing Hospital sites
- A teaching hospital in conjunction with Brighton & Sussex Medical School.
- Outpatient, day case and rapid diagnostic services across the Trust including on the non-acute sites.
- Tertiary service provision as part of a network of tertiary care providers across the region and nationally.
- Trauma services as part of a Trauma network that includes a major trauma centre on the Royal Sussex County Hospital site along with all the supporting services this requires.
- A wide range of cancer services across Sussex including the Sussex Cancer Centre on the Royal Sussex County Hospital site.
- Maintaining and developing the specialist services for paediatric care, combined with a neonatal intensive care service and paediatric cancer services from the County site in Brighton.
- Provision of a comprehensive stroke centre and acute stroke centre as part of a Sussex wide stroke provision.
- Specialist renal care, including dialysis and other services across East and West Sussex.
- The system wide benefits of the opening in Brighton of the Louisa Martindale Building and stage 2 3Ts development, in line with Sussex Integrated Care System Long Term Plan.

Collaborative working

National context

This strategy takes account of the new operating framework issued by NHS England (NHSE) in October 2022. This sets out a range of requirements for NHS providers including that they will:

- contribute to effective system working via ICS strategies and plans
- deliver some of these accountabilities and responsibilities with the support of provider collaboratives.

The clinical strategy informs and is informed by the Integrated Care Partnership strategy, Improving Lives Together - Developing our ambition for a healthier future.

Local context

As part of delivering the clinical strategy, we're committed to working with system partners to improve the lives of local people, supporting them to live healthier for longer, making sure they have access to the best possible services when they need them.

Sussex Health and Care Integrated Care System have identified the actions that will make the most difference to our communities, namely:

- a joined-up community approach to health and care; growing and developing our workforce
- improving the use digital technology and information
- maximising the power of partnership working.

Through the clinical strategy, UHSussex will support these goals with both collaborative clinical leadership and pathway redesign. The clinical strategy will also be implemented in a way that supports the goal to reduce health inequalities. Sussex Health and Care highlight that there are avoidable and unfair differences in health between different groups of people across Sussex that we need to reduce.

We can make a significant contribution to address this through preventative work such as accessible health screening programmes, and by supporting the most vulnerable in our communities to access our services, for example through our work with children and young people, and unpaid carers, as well as those affected by issues such as homelessness, drug and alcohol, mental health difficulties.

Collaborative working

Our clinical strategy is aligned with and will support the priorities as set out in Sussex Health and Care's Improving Lives Together strategy. This includes their 2023-24 priorities, place based plans, as well as the overarching aims as set out below:

Help local people start their lives well

for example by improving mother and baby health and wellbeing, especially for those most in need.

Help local people to age well

for example by helping older people to stay healthy and live independently for longer, reducing the number of older people who suffer falls, helping people receive good quality care at the end of their lives and to die at a place of their choosing.

Help local people to live their lives well

for example by supporting people who have physical disabilities, learning disabilities and mental health conditions, to have good health and joined-up care and support.

Help local people get the treatment, care and support they need

when they do become ill by tailoring care to support people in their own homes, or as close to home as possible; supporting the health and wellbeing of carers; giving them access to the most appropriate and best experts and professionals as early as possible that best suits their needs; managing risk factors for long-term conditions.

Help our staff to do the best job they can in the best possible working environment

providing more support to them and creating a more diverse, inclusive and healthier working environment.

Developing the clinical strategy

When developing the clinical strategy, we have taken into account what has already been learnt from patient, staff and public engagement, for example considering the staff and patient survey completed as part of the Trust merger.

The strategy has also been developed with the leadership of each of the clinical divisions. This comprises of the chief of service, chief of pharmacy, divisional director of operations and the divisional director of nursing, midwifery or Allied Health Profession. Discussions focussed on each division's vision, challenges and opportunities faced, and the changes required to drive improvements in each of the six True North domains. These discussions were informed by current performance and attainment of the True North goals and metrics.

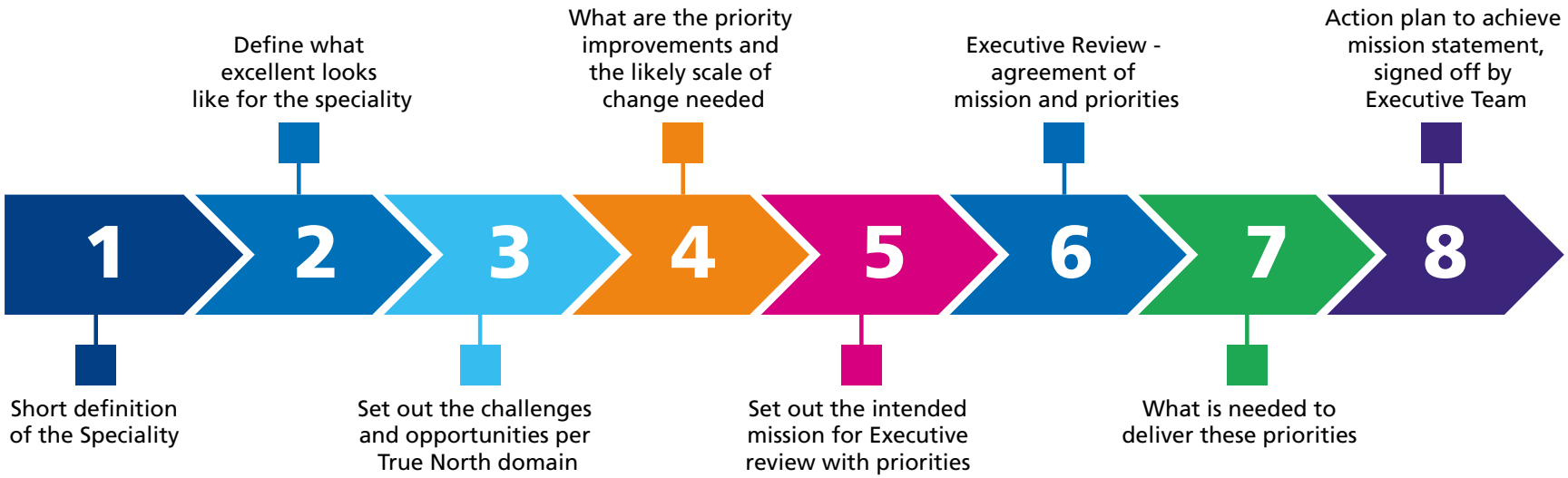
Mission statements

Each specialty is developing a mission statement which sets out their aims and objectives for the next three to five years. Figure 1 show the steps that are taken to develop these. Clinical leadership within the specialty is integral to this process. Completed mission statements have informed the actions within this strategy.

Enhancing productivity

The development of the strategy has highlighted that there are often opportunities within our clinical services to improve and enhance our clinical pathways and the configuration of our services, both to enable services to be of higher quality, more efficient and timely, as well as ensuring patients see the right professionalfirst time. Addressing these opportunities across our specialities is a key focus of the strategy.

Figure 1



Developing the clinical strategy

Setting our vision and agreeing our priorities

When developing the clinical strategy, we have given careful consideration to what we most want to achieve for our clinical services. We have also given detailed thought to the actions that will have the biggest impact on improving our services.

A robust process has been followed with our executive team and chiefs of service to assess the contribution that potential initiatives identified as part of the development of the strategy could have on each of our True North domains: patient experience, quality, our people, sustainability, systems and partnerships and research and innovation.

We have considered the organisation's capacity to carry out change in a joined up and considered manner that will make sure the plans are successful. From this process, our vision and a set of key priorities have been identified for each of our clinical areas.

Medicine

Our service

We provide Emergency Department (A&E) services from four acute hospital sites, of which St Richard's, Worthing Hospital, and The County are able to respond to a full range of medical and surgical emergencies. We also provide a wide range of medical specialties across UHSussex including care of the elderly, dermatology, diabetes and endocrinology, respiratory medicine, infectious diseases, HIV services, and sexual health and contraception (SHAC).

Our vision

We will continue to provide high quality emergency care on all four main acute sites, with Royal Sussex County remaining a Level 1 Trauma Centre, and Worthing and St Richard's hospitals as Trauma Units. We will drive to ensure there is a consistent model of care across these sites that deliver excellent urgent care services, frailty and acute medicine, as well as Same Day Emergency Care.

We will work in collaboration with community providers to deliver multi-disciplinary care that is centred around communities. We will also provide timely access to a range of high quality medical sub-specialties. Within each of these subspecialties we will make sure our patients have the opportunity to join in high impact research and innovation embedded in the care they receive.

Our initial priorities

- Improve front door access to Same Day Emergency Care and Urgent Treatment Centres across all sites.
- Explore options for the implementation of frailty services across the Trust.
- Complete the Full Business Case for the expansion of the Emergency Department at Royal Sussex County Hospital.
- Optimise the medical workforce, exploring diversification.
- Explore configuration of pathways for respiratory services.
- Develop an Integrated Care Board aligned Dermatology Strategy.

Divisional leaders

Worthing and St Richard's Hospital

Steven Kriese
Chief of Service

Sean Kedzia
Divisional Director of Operations

Julie Thomas
Divisional Director of Nursing

The County and Princess Royal Hospitals

Mark Edwards
Chief of Service

Gordon Houliston
Divisional Director of Operations

Josephine Kerr
Divisional Director of Nursing

Women and Children

The services

We provide gynaecology, obstetrics, neonatal care, paediatric medicine and paediatric surgery across four of the acute sites.

The vision

Our aim is to provide world class services, underpinned by research and innovation.
To achieve this, we will embark on an ambitious programme to optimise our services for women, children, young people and their families.

This will have a particular focus on three key areas: delivery of the highest quality maternity and neonatal care; modernised services for children and young people; and timely provision of gynaecology that enhances patient experience.

To achieve our goals, we will work collaboratively with our patients, teams and partner organisations, embedding high quality governance and making the best use of our estate, ensuring that this is designed to meet the needs of our patients and families.

We will seek to embed research and innovation into clinical care and take opportunities to create research and innovation roles in job plans.

Our initial priorities

- Review neonatal care services to ensure they meet national standards and that capacity and demand are managed across the system supported by optimal workforce.
- Review and enhance the service model and workforce requirements for paediatric services across the Trust including for emergency provision.
- Review model and estate required for the optimal provision of gynaecology day, ambulatory, early pregnancy and outpatient units across all four sites including a focus on patients experiencing early and mid-trimester pregnancy loss.
- Implement the Maternity Improvement Plan agreed with the Maternity Safety Support Programme, along with the national three year delivery plan for Maternity and Neonatal services. Improve the maternity pathways for planned and emergency caesarean sections.
- Transfer of Paediatric Audiology services to the Alex children's hospital.
- Address the mental health needs of children in the care of the Trust.

Divisional leaders

Tim Taylor
Chief of Service

Hugh Jelley
Divisional Director of Operations

Claire Hunt
Divisional Director of Nursing

Emma Chambers
Dir. of Midwifery

Clinical Support Services

The services

We provide a full range of clinical support services to our acute hospitals, primary care and the wider Integrated Care System. This includes the community diagnostics centres, Pathology (Biochemistry, Haematology, Histopathology, Immunology and Microbiology), Therapies (Dietetics, Physiotherapy, Occupational Therapy, and Speech and Language Therapy), Pharmacy, and Radiology and Imaging (including Interventional Radiology, Nuclear Medicine, Paediatrics, Radiology and Sonography).

The vision

We will provide efficient, state of the art services to our patients, supporting timely progression through their pathways, seven days a week. We will provide access to these services equitably, regardless of location in Sussex. We will provide high quality services across the Trust and the system partners to enhance flow through the hospitals, promote admission avoidance when appropriate, and provide outstanding care close to home for the patients.

We will enable our services to flex their capacity to respond to fluctuating demand and ensure adequate resources for support services are recognised in the divisional business cases to ensure their success. We will support patients on cancer pathways with timely access to cancer diagnostics and reporting, innovative treatment delivery pathways via our aseptic pharmacies as well as access to therapy and dietetic pathways.

We will support the Trust's research and innovation agenda through the provision of high-quality studies within our directorates whilst supporting clinical studies in other divisions. Our services will be compliant with national standards and support the Trust and individual divisions in achieving the True North goals and breakthrough objectives. We will support the development of research and innovation roles across UHSussex's multidisciplinary workforce.

Our initial priorities

- Agree Point of Care Testing Strategy across the Trust.
- Redesign clinical pharmacy services to support efficiency and safety.
- Develop the case for seven day services across all key areas including pharmacy, radiology and physiotherapy.
- Determine the future model of Interventional Radiology and Nuclear Medicine, including PET-CT services, across the Trust.

Divisional leaders

John Laurie
Chief of Service

Yannick Raimbault
Divisional Director of Operations

Cate Leighton (DDAHP)
Divisional Director of Nursing

Mike Cross
Chief Pharmacist

Surgical Services and Critical Care

Our services

We provide a wide range of surgical services including general surgery, ear nose and throat (ENT), ophthalmology, maxillofacial surgery, trauma and orthopaedics, urology, bariatric surgery, critical care, and perioperative care. We also deliver audiology, rheumatology and chronic pain services within the surgical divisions and manage multiple theatre complexes and the central sterilisation services.

Our vision

We will provide safe, excellent and timely care that incorporates modern technologies and techniques, alongside learning from clinical excellence such as Getting It Right First Time (GIRFT). Research and innovation will be integral to the work we do, with research leadership and roles established as clinical services are developed. We will take steps to optimise post-operative outcomes.

We will ensure that our services are configured across UHSussex in a manner that supports excellent patient experience and outcomes, as well as the development of vibrant hospital sites. Our services will make the best use of our estate through the development of seven day services.

Our initial priorities

- Optimise key general surgery pathways across the Trust, particularly for colorectal surgery and upper GI surgery, considering elective access, perioperative care and robotic surgery.
- Undertake a review of the configuration of orthopaedic services to support the delivery of safe and excellent quality provision across the Trust and improve productivity.
- Standardise critical care outreach services across the Trust.
- Review the model of urology provision across the Trust.
- Review maxillo-facial services taking into Sussex wide provision.
- Seek to secure the Trust as a Major Joint Revision Centre.
- Participate in the Sussex MSK procurement.
- Complete the Ophthalmology Specialty Review and introduce the Electronic Health record.
- Open the new Urology Investigation Unit at Princess Royal Hospital.
- Increase daycase provision at Princess Royal Hospital and Southlands.
- The development of a single Patient Tracking List for ENT.
- The development of the peri-operative service.

Divisional leaders

Worthing and St Richard's Hospital

Colin Spring
Chief of Service

Nicky Sullivan
Divisional Director of Operations

Kim Cheetham
Divisional Director of Nursing

The County and Princess Royal Hospitals

Steven Drage
Chief of Service

Paul Silvester
Divisional Director of Operations

Margaret Flynn
Divisional Director of Nursing

Digestive Diseases

Our services

UHSussex provides both specialist medicine and surgery relating to digestive disease. This includes gastroenterology, endoscopy and hepatology.

Our vision

We will provide excellent care for our patients through collaborative work with system partners to improve pathways and models of service. This will enable us to ensure we have sufficient capacity to meet our population need. We will optimise the use of the proposed new Endoscopy unit at the Princess Royal Hospital. We will continue to build on our regional endoscopy training academy for junior doctors, growing our regional training offer. We will ensure ongoing accreditation of our services, for example maintaining Joint Advisory Group (JAG) accreditation on all four acute sites and achieving Improving Quality in Liver Services (IQILS) accreditation.

We will embed research and innovation across our services and continue to build on the hepatology research programme within UHSussex and our university partner.

Our initial priorities

- Launch the endoscopy training academy programme.
- Design and build of the Endoscopy Unit at Princess Royal Hospital.

Divisional leaders

Worthing and St Richard's Hospital

Steven Kriese
Chief of Service

Sean Kedzia
Divisional Director of Operations

Julie Thomas
Divisional Director of Nursing

The County and Princess Royal Hospitals

Steven Drage
Chief of Service

Paul Silvester
Divisional Director of Operations

Margaret Flynn
Divisional Director of Nursing

Cancer Care

Our services

We provide a range of cancer care including oncology, clinical haematology, systemic anti-cancer therapy (SACT), radiotherapy, screening management, and palliative care and integrated breast services. Site specific cancer surgery is reviewed under the specific surgical specialties.

We provide tertiary and secondary cancer care, for the local population and the wider population of Sussex. The Sussex Cancer Centre at Royal Sussex County Hospital is the tertiary centre for patients requiring specialist oncology treatment in Sussex and is part of the wider Surrey and Sussex Cancer Alliance. Tertiary oncology services for the Chichester population are currently provided by Portsmouth Hospitals University NHS Trust.

Our vision

We want to be recognised locally, nationally, and internationally as a renowned organisation of excellence for the delivery of high quality, safe, patient cancer care, underpinned by education and research, where staff are valued and supported to fulfil their potential in an inclusive and kind working environment. We want to ensure that all patients and staff have the opportunity, and equality of access to high-quality research and innovation that is relevant to them.

Our initial priorities

- Develop and implement a cancer strategy that determines the requirements for inpatient beds, acute assessment units, workforce for all our sites, as well as future provision of radiotherapy.
- Develop and implement a plan for a research unit to increase access to clinical trial opportunities.
- Design the configuration of services within the Stage 2 3Ts development.

Divisional leaders

Sarah Westwell
Chief of Service

Dominic Clarke
Divisional Director of Operations

Lisa Barrott
Divisional Director of Nursing

Specialist Services

The services

We provide a wide range of specialised tertiary services across multiple sites. These include: Cardiac Surgery, Cardiology, Neurosurgery, Spinal Surgery, Plastic Surgery, Major Trauma, Vascular Services, Renal Services, Neurology, Stroke services and Specialist Rehabilitation.

The vision

As a regional teaching hospital, we recognise our responsibility to support and develop its specialised services to ensure that patients from Sussex and beyond have access to specialised services without the need for referral elsewhere.

Our vision is to create an environment where the specialised services can flourish, allowing them to deliver safe and effective care to everyone who needs it in a timely way. We will further develop a plan for research and innovation, reflecting the important benefits to patients and staff, ensuring our patients have the opportunity to participate in high impact research and innovation embedded in the care they receive. We will also continue to work with the network partners in Sussex and the region.

Our initial priorities

- Review the Diagnostic and Interventional Cardiology services across the Trust.
- Expand the Mechanical Thrombectomy Service at Royal Sussex County Hospital.
- Complete the consultation on Stroke Services in West Sussex.
- Open the helideck for Major Trauma.
- Secure the development and expansion of the Cardiac Surgery service.

Divisional leaders

Ryan Watkins
Chief of Service

Maria Emmanuel
Divisional Director of Operations

Louise Skelt
Divisional Director of Nursing

Our hospital sites

One of the key intentions of the clinical strategy is to support the further development of vibrant hospital sites that are responsive to local community need.

Our hospital sites will also take full advantage of our status as a multi-site Trust, with each site holding an area of specialist expertise for our entire Trust.

Our vision for each of our key sites is set out over the following pages.

Royal Sussex County Hospital/ Royal Alexandra Children's Hospital

Existing provision

The Royal Sussex County Hospital is an acute teaching hospital. The Brighton campus also includes the Royal Alexandra Children's Hospital and the Sussex Eye Hospital. The County delivers district general hospital services for our local communities, specialised and tertiary services for Sussex and the south east of England, these include neurosciences, neonatal, paediatrics, cardiac, cancer, renal services, infectious diseases and HIV medicine. The County is also the major trauma centre for Sussex and has a comprehensive stroke centre.

Planned developments

The Royal Sussex County Hospital is being significantly transformed by the flagship redevelopment project, 3Ts (Brighton Trauma, Tertiary and Training), the first stage of which is the opening of the Louisa Martindale Building in June 2023. This provides state of the art accommodation across 11 floors for outpatient, ward and specialist services such as neurosciences and critical care. Plans are also in place to operationalise the helideck.

The second stage of 3Ts will create a purpose built new Sussex Cancer Centre. A £48 million investment plan is underway to transform emergency and urgent care, which will be expanded and redesigned in line with national best practice to create a much improved environment for our emergency care provision.

Subject to public consultation, stroke services on the site will be expanded within the Louisa Martindale Building.

Other opportunities

We will continue to develop services at the Royal Sussex County Hospital to support its role both as our specialist and tertiary centre, and to provide secondary services to the local population. We will be seeking to develop and expand our cardiac surgery service, and will be looking to optimise pathways across the Trust for general surgery services.

Princess Royal Hospital

Existing provision

Princess Royal Hospital is an acute teaching hospital, providing district and general services for its local adult population including emergency services and maternity services. It has a day case focus and delivers the centralised services for both Princess Royal and The County for fractured neck of femur and all elective and emergency urology services (including Lithotripsy). It has a surgical robot that enables minimally invasive surgery for complex procedures. It also hosts the Sussex Orthopaedic Treatment Centre and the Sussex Rehabilitation Centre for specialist neuro-rehabilitation. It is not a trauma unit and currently provides limited paediatric services.

Planned developments

We have plans to significantly increase the volume of non-emergency care at Princess Royal Hospital. This includes the development of a new endoscopy unit on the site, which will also provide training opportunities as part of an Endoscopy Academy. We are creating a Theatre Admissions and Discharge Unit, and are opening a new Urology Investigation Unit in 2023.

Other opportunities

We will look for further opportunities to develop Princess Royal Hospital as a thriving centre for elective work. This will include greater use of the Sussex Orthopaedic Treatment Centre hip and knee surgery for a wider catchment. We will maximise the use of robotic surgery on the site.

We intend to further develop same day emergency care and urgent treatment provision on the site to meet the needs of the local population.

We will review the level of provision of specialist rehabilitation including at the Sussex Rehabilitation Centre.

Worthing Hospital

Existing provision

Worthing Hospital is a trauma unit and provides a wide range of district and general hospital facilities including A&E, critical care, emergency surgery, intensive care, maternity services, paediatric care and cancer care (for which the access to tertiary services is largely at Royal Sussex County Hospital) for its local population. There is also a new purpose built Medical Day Case Unit which provides chemotherapy supporting the delivery of holistic care to patients, as well as a new Urology Investigation Unit transforming the way the service provides care for patients.

Planned developments

Subject to public consultation, acute stroke services may move from Worthing Hospital to St Richard's, freeing up estate which will be repurposed for other priorities.

Other opportunities

Worthing Hospital will remain a vibrant, busy hospital providing excellent care to its local population. We are seeking to develop the Acute Frailty Unit, Same Day Emergency Care and Urgent Treatment Centre on the Worthing site to improve the care we provide.

We will look to make best use of the excellent facilities at the hospital. Across the Trust, there are opportunities to improve access and flow through an internal review of general/upper GI/colorectal surgery, in particular for colorectal surgery patients. In the longer term, we will explore the feasibility of developing a dedicated surgical day case unit on the site. Consideration will also be given to expanding the use of robotic surgery to the Worthing site. We wish to improve and reconfigure Critical Care in order to meet national standards and provide a high quality of care for patients, and reflect the increased critical care requirements resulting from movement of additional surgical cases to Worthing.

There is an opportunity to review how we deliver diagnostic and interventional cardiology services across our hospital sites to improve clinical effectiveness, patient access, experience and efficiency and to meet national standards and recommendations. There are also opportunities to develop the renal service including the dialysis services across Sussex in order to ensure patients receive their treatment as close to home as possible.

Southlands Hospital

Existing provision

Southlands Hospital in Shoreham-by-Sea provides a wide range outpatient, diagnostic and day surgery services on a site dedicated to providing non-emergency care. Southlands provides a purpose-built ophthalmology centre for eye patients for both the Worthing and Shoreham areas.

Planned developments

There are a number of developments taking place at Southlands which will significantly increase the volume of patients using the hospital. A large Community Diagnostic Centre is opening at Southlands in 2023 delivering MRI, CT scans, x-rays, ultrasound and a range of other diagnostic services. The Trust is also seeking to double the volume of patients seen as day cases at Southlands through a comprehensive refurbishment of the daycase unit.

Other opportunities

We will look to further increase daycase capacity exploring the potential to deliver increased volumes of Ophthalmology cases at the Hospital. We will also look to bring more daycase orthopaedic work to the site We will also explore the opportunity of further developing the dermatology service on the Southlands site.

St Richard's Hospital

Existing provision

St Richard's is a Trauma Unit and provides a wide range of district and general hospital facilities including A&E, critical care, emergency surgery, intensive care, maternity services, paediatric care and cancer care (for which the access to tertiary services is largely at Portsmouth Hospitals University NHS Trust). It also provides bariatric care, hyperbaric medicine and has a specialist neuro-rehabilitation service at Donald Wilson House.

Planned developments

Subject to public consultation, acute stroke services may move from Worthing Hospital to St Richard's with the development of an acute stroke centre. This will require the strengthening of imaging and therapeutic support for stroke patients.

Other opportunities

We wish to further develop St Richard's as a flourishing acute hospital site serving its local population. To support this we wish to develop the Acute Frailty services, Same Day Emergency Care and urgent treatment provision on the St Richard's site. As part of this there is an opportunity to review the paediatric facilities within the St Richard's A&E department, with a view to providing improved paediatric space within the department.

There are opportunities to further develop the excellent services we deliver from St Richard's Hospital, including our orthopaedic services, cardiology services, ENT and maxillo-facial services. We also intend to review model and estate required for the optimal provision of gynaecology day, ambulatory, early pregnancy and outpatient units at the St Richard's site.

We wish to improve and reconfigure Critical Care in order to meet national standards and provide a high quality of care for patients. There is also an opportunity to review how we deliver diagnostic and interventional cardiology services across our sites to improve clinical effectiveness, patient access, experience and efficiency and to meet national standards and recommendations.

Specialty content

Working with each of the clinical divisions, careful consideration has been given to the vision for each area, as well the challenges and opportunities faced for each of the specialties. This consideration, alongside the prioritisation process with our executive team, has identified the priority areas for action.

These are set out over the next set of pages for each clinical area.

Medicine

The service

UHSussex provides Emergency Department (A&E) services from four acute hospital sites, of which St Richard's, Worthing Hospital, and The County are able to respond to a full range of medical and surgical emergencies. We also provide a wide range of medical specialties across UHSussex including care of the elderly, dermatology, diabetes and endocrinology, respiratory medicine, infectious diseases, HIV services, and sexual health and contraception (SHAC).

The vision

We will continue to provide high quality emergency care on all four main acute sites with the Royal Sussex County remaining a Level 1 Trauma Centre, and Worthing and St Richard's Hospital as trauma units. Over the coming years the services will drive to ensure a consistent model of care across these sites to manage our urgent care services, frailty and acute medicine and same day emergency care. The service will work in collaboration with community providers to deliver multi-disciplinary care centred around communities. The service will also provide timely access to a range of high quality medical sub-specialties. Within each of these sub-specialties we will make sure our patients have the opportunity to join in high impact research and innovation embedded in the care they receive.

Challenges and opportunities

Across all our specialties, we'll look for opportunities to optimise the medical workforce so we can respond effectively and efficiently to demand, as well as combining rotas for some specialties to reduce the burden for those staff groups.

Emergency care

The current emergency departments and acute services on occasion struggle to deliver timely care, in the context of growing demand, as well as a number of physical, structural and workforce constraints. We are introducing a number of steps to improve this, including:

- Working with system partners to make sure that patients who are ready to go home are able to access community services promptly.
- Improvements in the pathway for the care of patients requiring urgent assessment and treatment through the further development of urgent treatment centres (UTCs), working collaboratively with the Integrated Care Board to ensure these are supported by joined up commissioning arrangements across system partners.
- Building on the development of Same Day Emergency Care and Virtual Ward capacity, ensuring these are provided in suitable environments across our sites and in the community, preventing inappropriate admissions.
- Ensuring that the right integrated range of services, such as pharmacy and therapies, is available seven days a week to emergency departments and acute services throughout UHSussex.
- Reviewing bedded capacity and pathways to optimise flow from the emergency departments.
- Reducing length of stay for unplanned admissions which is supported through a corporate project.

Medicine

A key strategic issue that we will address is the size and environment of the Emergency Department at the Royal Sussex County. Plans are in development for a significant expansion and refurbishment of the department to ensure that it can adequately meet the demand for both local emergency and tertiary services. We will also review the estates at Worthing Hospital, St Richard's Hospital and Princess Royal Hospital to support the effective delivery of adult and paediatric emergency care, Same Day Emergency Care, as well as urgent treatment centres.

In Brighton, the environment for medical patients will be significantly improved with the opening of the Louisa Martindale Building. This will transfer medical beds from the outdated Barry Building into new state of the art facilities, the creation of a frailty unit, more short stay acute care capacity, and additional bespoke facilities for respiratory patients. This will not only provide improved facilities and better models of care, it will support flow from the Emergency Department at the Royal Sussex County and reduce pressure on emergency services, including the ambulance service.

We standardise and streamline pathways, particularly at Worthing Hospital and St Richard's, for patients who present at our emergency departments and have a potential cancer diagnosis to give timely access to specialist services. For those with life limiting illness the service will support with access to community based palliative care.

Care of the elderly

We provide excellent care for elderly and frail patients across UHSussex, and aim for equity in patient experience and outcomes across all the four main sites. Worthing and Royal Sussex County hospitals have well established acute frailty services. We will further improve our care through a dedicated acute frailty unit at the new Louisa Martindale Building at The County. Options for adding similar frailty services at St Richard's Hospital and Princess Royal Hospital are in active development.

Acute medicine and same day emergency care

Acute medicine specialists receive patients from emergency departments and primary care. Their role is to make diagnoses and provide initial treatment for a wide range of medical conditions. Much of this treatment may be delivered out of the hospital environment as an alternative to admission. We will be providing a new environment for this service at Royal Sussex County Hospital and seek to further develop services at St Richard's, Worthing, and Princess Royal hospitals in order to improve the timeliness and quality of care for patients with these conditions.

Medicine

Dermatology

UHSussex provides dermatology services across a range of sites, including Southlands and Brighton General Hospital. A significant proportion of dermatology services are now provided in the community. We will work with the Integrated Care Board and system partners to standardise the commissioning approach across UHSussex, along with pathways from primary care. The service will focus on hospital-based dermatology provision and specialist dermatology services, including teledermatology. The service will also work more collaboratively across UHSussex to enhance patient care.

Respiratory medicine

Following the COVID-19 pandemic, we have reviewed the provision of respiratory medicine services across our four acute sites and will be introducing additional respiratory facilities in both acute and community settings. At the Royal Sussex County Hospital, this will be enabled by the move to the Louisa Martindale Building supporting rapid assessment and treatment of respiratory patients. We will explore options for streamlining the care of outpatients to increase efficiency and improve the patient experience. The configuration of our services will also be examined so that more of our services can be provided closer to home, whilst also looking at opportunities to centralise particular specialist services. We will also continue to work with colleagues across the health economy to maximise the use of virtual wards for respiratory and other patients.

Diabetes and endocrinology

We will ensure that there is robust governance for inpatient diabetes care to meet the requirements of the national inpatient Diabetes Care Accreditation Programme including establishment of a Trust diabetes safety board. We will continue to expand specialist diabetes services to meet growing demand, including a comprehensive diabetes technology service and a NICE-compliant multidisciplinary foot care service. We will continue to work with community teams to provide seamless diabetes care across the region, and continue to develop tertiary specialised endocrine services including gender, obesity, pituitary and adrenal.
The Diabetes and Endocrinology department will provide high-quality teaching and training, and develop the research and development programme.

The respiratory, diabetes and endocrinology services will develop research strategies that will maximise the benefit of UHSussex's large and diverse recruitment base, alongside our four hospital sites.

Sexual Health/HIV services

The sexual health services are experiencing significant growth in demand, driven by a range of factors including reduced access to primary care, increasing complexity in sexually transmitted infection management, and undertaking additional work with unresolved commissioning arrangements (e.g. Mpox vaccination) or non-commissioned (coils for non-hormonal indications). There are also differing commissioning arrangements across the two legacy organisations.

We intend to engage with the Integrated Care Board and NHS England on the future commissioning of sexual health services across the Trust that supports care closer to home. We have already expanded the digital offer and online testing and intend to develop partnership working with other health and social care sector organisations. We plan to increase collaborative working cross the whole of UHSussex to deliver postgraduate and undergraduate education, facilitate regional research, and link HIV testing strategies with Brighton (a 'Fast Track City' for HIV testing).

The Brighton HIV team is internationally renowned for its research output and innovative patient services. We will build on the successes to date to further enhance the research capacity of the service.

Infectious diseases

The Brighton Infectious Diseases department has been made a designated Specialist Regional Infectious Diseases Centre (SRIDC). This is a prestigious development meaning that UHSussex will be the main infection hub for the south east of England outside London for infectious diseases. The service will provide colleagues in regional hospitals and primary care with an easily accessible source of advice, clinical support and tertiary expertise in the management of complex or challenging infection-related problems including diagnosis and specialist treatment. The service will offer expertise in solving complex diagnostic problems, management of tropical and other imported infections, tuberculosis, HIV, bone and joint infections, infection control and hospital epidemiology as well as in antibiotic stewardship.

The expectation is that we will also have the capability to provide 'surge capacity' and regional clinical leadership for significant infectious disease outbreaks requiring admission of patients needing isolation facilities, as has been the case with COVID-19, influenza outbreaks and the mpox outbreak.

The new status will help strengthen the services training programme and contribute to attracting future high calibre applicants. This will be further enhanced by participating and leading research and innovation.

Medicine - the changes we want to make

Immediate priorities:

- Successfully transfer a range of medical services to the Louisa Martindale Building, introducing a number of changes including the Acute Frailty Unit, expanded acute short stay facilities, and an acute respiratory unit.
- Improve front door access to same day emergency care services and urgent treatment centres across the sites.
- Optimise the medical workforce, particularly at Worthing and St Richard's hospitals, exploring further diversification of the work-force, including increased use of advanced care practitioners, physician associates and other non-medical practitioners. Grow and retain our high quality workforce by incorporation of research roles.
- Take steps to ensure that there are an integrated range of services, including support services available seven days a week to emergency departments and acute services throughout UHSussex.
- Explore options for the implementation of frailty services at St Richard's Hospital and Princess Royal Hospital, introducing a standardised model across the Trust.
- Explore the configuration of pathways and services for respiratory services to drive improvements and support partnership working including via the Virtual Wards.
- Complete the Full Business Case for the expansion of the Emergency Department and associated services at Royal Sussex County Hospital, and look to begin the construction works.
- Develop a Trust wide dermatology strategy that aligns with the Integrated Care Board strategy.

Longer Term priorities:

- Embed and strengthen the Trust's SRIDC (specialist regional infectious diseases centre) for infectious diseases.
- Build on the recommendations for change in dermatology services following review via the mission statement process.
- Across all our services we will embed research and innovation in the care we provide to make sure our patients and staff have opportunities to benefit from a research active culture. We will build research and innovation roles into job plans across the workforce. We will include research and innovation in our divisional performance monitoring.

Women and Children's Services

The services

UHSussex provides gynaecology, obstetrics, neonatal care, paediatric medicine and paediatric surgery across four of the acute sites.

The vision

Our aim is to provide world class services, underpinned by research and innovation. To achieve this, we will embark on an ambitious programme to optimise our services for women, children, young people and their families. This will have a particular focus on three key areas: delivery of the highest quality maternity and neonatal care; modernised services for children and young people; and timely provision of gynaecology that enhances patient experience.

To achieve our goals, the service will work collaboratively with our patients, teams and partner organisations, embedding high quality governance and making the best use of our estate, ensuring that this is designed to meet the needs of our patients and families. We will seek to embed research and innovation into clinical care and take opportunities to create research and innovation roles in job plans.

Challenges and opportunities

Gynaecology services

Plans are required to ensure equity of access and patient experience across the four sites that address significant backlogs, drive efficiency, whilst putting the patient first. This will focus on several areas, including the model and estate required for the optimal provision of gynaecology day units, early pregnancy, ambulatory care and outpatients that meet national standards and requirements for Same Day Emergency Care and planned day surgery, equitably across all four sites. It will also focus on timely access to care, receiving the right procedure in the right place, taking steps to reduce 68 week waits.

The provision of colposcopy will be reviewed to ensure that the service consistently meets national quality standards, particularly at St Richard's and The County. It will consider the provision of gynaecology in-patient provision at Worthing Hospital and St Richard's.

The plans will also focus on the delivery of excellent care and the emotional wellbeing of those patients experiencing early and mid-trimester pregnancy loss, where the care is currently delivered alongside maternity services at St Richard's and Worthing, which is distressing for patients.

Pathway improvements will also be supported by the provision of diagnostic procedures as part of phase 2 of the Southlands Community Diagnostic Centre development.

Women and Children's Services

Maternity services

We are committed to continuing to provide maternity services at all four acute sites, alongside the provision of home delivery and community midwifery services. With an ongoing focus on quality, we will implement the Maternity Improvement Plan agreed with the Maternity Safety Support Programme, along with the national three year delivery plan for maternity and neonatal services. We will ensure that there is the necessary workforce to build resilience of services. Alignment of the Maternity Information System across all the sites will further enhance safety. The quality and safety of urgent maternity will be supported through the separation of the delivery of elective caesarean sections from the labour facilities.

The Trust currently provides a co-located midwifery led unit at St Richards. We will consider the recommendation that co-located midwifery led units should be offered as a choice at the other three sites.

Neonatal services

Our neonatal services will continue to be delivered on all four sites. We will review these to ensure that they are able to meet the national standards set out in the Neonatal Critical Care Transformation Review and national three-year delivery plan for maternity and neonatal services and that capacity and demand are managed across the system. There is a need to review and develop the workforce, in particular the advanced nurse practitioner model to support the further expansion of advanced clinical practice across all four sites.

Women and Children's Services

Paediatric services

The paediatric services are currently responding to a significant growth in demand and acuity, particularly at the Royal Alexandra Children's Hospital (The Alex) in Brighton. To respond effectively to this growth in need, the service model across UHSussex will be reviewed with our teams. This will look at implementing joined up solutions across our Trust, that maximise the benefit of collaborative working across all our sites, whilst also making the best use of our children's hospital – The Alex. We will also take account of the changing demographics in the Haywards Heath area and review the provision of children's services at Princess Royal to reflect the growing need. At St Richard's, a dedicated paediatric area with sufficient capacity is required to achieve national standards.

We will also work with primary care to build a collaborative integrated child health system, supporting and upskilling general practice to deliver more care closer to home. This will incorporate the review and standardisation of models of care for emergency provision, to support system wide effort to respond to peaks in activity.

Inpatient paediatric services will continue to be provided on three acute sites – Worthing, St Richard's, and The Alex in Brighton. Additionally, the care of children and young people with mental health needs is critical and will be a focus for improvement.

The provision of paediatric surgery will be reviewed to make sure there is sufficient capacity to meet demand across Sussex and strengthen the networked relationships.

The relationship between the Child Development Centre and UHSussex in the Chichester area requires resolution. We will also consider the potential to further develop the specialised paediatric services at The Alex. The Paediatric Audiology service at the Royal Sussex County Hospital is being relocated within The Alex.

Teenagers and young people

We are seeking to enhance provision for teenagers and young adults with cancer, ensuring that it is age appropriate, responsive to their needs and informed by research and innovation. We will also look to standardise and improve transitions between children and adult services across the Trust.

Palliative care

We will work collaboratively with system partners and hospice providers to enhance the provision of care to children and young people with life-limiting conditions, involving children, young people and their families in decisions about their care, and improving the support that is available to them throughout their lives.

Dentistry and orthodontics

Paediatric dentistry and orthodontic services are provided at The Alex and St Richard's, including the laboratory facilities. There is an opportunity to review and support the development of these services to ensure they are meeting the needs of children and young people.

Women and Children's Services - the changes we want to make

Immediate priorities

- Develop a long-term strategy for maternity and neonatal services and for children services including maximising the benefit of the Royal Alexandra Children's Hospital.
- Review and enhance the service model and workforce requirements for paediatric services across UHSussex.
- Review and standardise models of care for emergency provision for paediatric services, collaborating with community providers.
- Review model and estate required for the optimal provision of gynaecology day, ambulatory, early pregnancy and outpatient units across all four sites, considering options for an early pregnancy assessment clinic and gynaecology assessment unit at St Richard's Hospital.
- Consider the provision of care for those patients experiencing early and mid-trimester pregnancy loss.
- Implement the Maternity Improvement Programme, and the national three year maternity and neonatal delivery plan.
- Improve the maternity pathways for planned and emergency caesarean sections.
- Review neonatal care services to ensure they meet the three year maternity and neonatal delivery plan to implement national standards, and that capacity and demand are managed across the system supported by optimal workforce.
- Transfer of paediatric audiology services to the Royal Alexandra Children's Hospital.
- Address the mental health needs of children in the care of UHSussex.

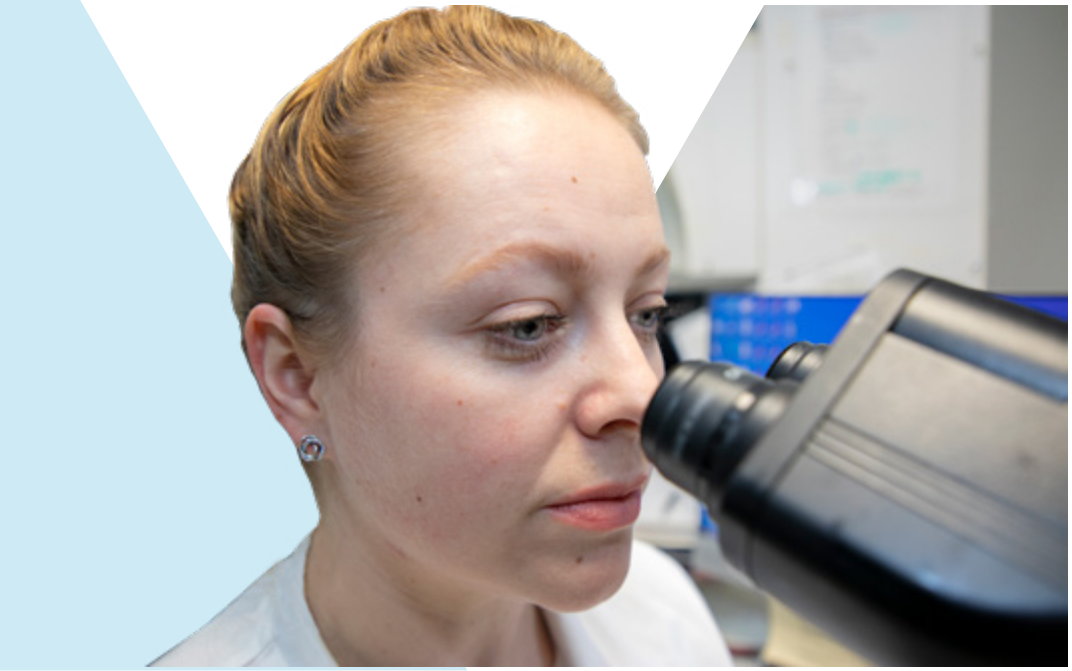
Longer term priorities

- Review and develop the foetal medicine service pilot.
- Implement the long term strategy for maternity and neonatal services and for children services including maximising the benefit of the Royal Alexandra Children's Hospital.
- Review provision of colposcopy particularly focussing on the environment at St Richard's and the Royal Sussex County, taking account of pathway improvements supported by the provision of phase 2 of Southlands Community Diagnostic Centre development.
- Work with the local authority to agree the clinical and contractual relationships with the Child Development Centre.
- Explore introduction of gynaecological diagnostic facilities at Southlands as part of the Community Diagnostic Centre.
- Review the further provision of tertiary paediatric services at the Royal Alexandra Children's Hospital and the potential for further repatriation from Sussex and Kent / Surrey patients to UHSussex.
- Explore delivery of a model of maternity care which includes the option of a midwifery led unit for the catchment.
- Complete the review of tertiary links to Portsmouth and Southampton.

Clinical Support Services

The services

Our Clinical Support Services provide a full range of clinical support services to our acute hospitals, primary care and the wider Integrated Care System. This covers the community diagnostics centres, Pathology (Biochemistry, Haematology, Histopathology, Immunology and Microbiology), Therapies (Dietetics, Physiotherapy, Occupational Therapy, and Speech and Language Therapy), Pharmacy, and Radiology and Imaging (including Interventional Radiology, Nuclear Medicine, Paediatrics, Radiology and Sonography).



The vision

We will provide efficient, state of the art services to our patients, supporting timely progression through their pathways, seven days a week. We will provide access to these services equitably, regardless of location in Sussex. We will provide high quality services across the Trust and the system partners to enhance flow through the hospitals, promote admission avoidance when appropriate, and provide outstanding care close to home for the patients.

We will enable our services to flex their capacity to respond to fluctuating demand and ensure adequate resources for support services are recognised in the divisional business cases to ensure their success. We will support patients on cancer pathways with timely access to cancer diagnostics and reporting, innovative treatment delivery pathways via our aseptic pharmacies as well as access to therapy and dietetic pathways.

We will support the Trust's research and innovation agenda through the provision of high-quality studies within our directorates whilst supporting clinical studies in other divisions. The services will be compliant with national standards and support the Trust and individual divisions in achieving the True North goals and breakthrough objectives. The service will support the development of research and innovation roles across UHSussex's multidisciplinary workforce.

Clinical Support Services

Challenges and opportunities

Pathology services

The pathology departments will ensure timely access to investigations and results to efficiently and sustainably meet the system's growing clinical needs. This will be enabled by utilising innovation in technology, national accreditation, and a skilled multidisciplinary workforce, to provide state of the art services on a 24/7 basis.

The formation of the Sussex Pathology Network is a key enabler, allowing us to standardise work across the laboratories, use resources efficiently and reduce outsourcing. UHSussex is working with partners collaboratively to develop the network, with an aim to provide:

- Target Operating Model which will redesign the location and provision of pathology services across Sussex.
- Single Laboratory Information Management System (LIMS), allowing for seamless integration of laboratory functions and reporting.
- Single Managed Service Contract (MSC) providing access to state-of-the art equipment which will increase efficiency, expand our test repertoire and improve turnaround times.
- Digital Histopathology (DHP) solution – providing a state-of-the-art digital reporting solution for histopathology samples, improving efficiency, reporting times and enabling the development of Artificial Intelligence (AI) supported reporting.
- Develop a regional point of care testing (POCT) strategy, for a governing committee and ensure networking with Trust reporting systems.

We shall support the use of patient portals allowing access to their results allowing for innovative pathway formation and patient empowerment. We will provide timely access to cancer diagnostics and results to support national and Trust targets, improve patient pathways. We will develop and champion the use of genomics in all of our disciplines to ensure state of the art diagnostics inform care and support access to treatment.

Clinical Support Services

Imaging services

The Imaging and Radiology directorate will support patients through the timely provision of diagnostic and therapeutic imaging modalities within our hospitals and the community diagnostic centres. We will work to address the mismatch between capacity and demand to ensure patients have access to the right test at the right time with a view to providing key imaging modalities on a seven-day basis to support flow in both unscheduled and planned care. We will develop a skilled multi-disciplinary workforce to ensure a robust service across all of our sites. We aim to procure a managed service contract for imaging to ensure access to state of the art equipment for our patients in a sustainable way. The service will champion collaborative working within the regional imaging network to improve efficiency, share resources and allow access specialist reporting regionally.

We will embrace digital solutions that allow remote reporting, innovative multidisciplinary team working and direct patient access to results to support self-directed care. The service will support UHSussex's research and innovation agenda running national and local clinical studies in radiology whilst supporting research projects in other divisions. We will champion the use of AI in radiology to support rapid reporting.

A new strategy for interventional and intervention neuro-radiology will be championed to support secondary and tertiary services across the entire footprint of UHSussex allowing equitable access of care to patients regardless of location.

We will review the provision of both diagnostic and therapeutic nuclear medicine services and access to PET-CT to meet the growing needs of the patient population of Sussex.

We will work collaboratively with our paediatric colleagues to develop a sustainable service model for paediatric radiology that meets the service needs and allows development of new tertiary care pathways.

Clinical Support Services

Community diagnostics centres

As a corporate project for the Trust, the community diagnostic centre (CDC) hub and spoke model across Sussex will provide improved access to the seven nationally specified diagnostic modalities for patients. This will look to address health inequalities across Sussex whilst providing direct access to imaging modalities for primary care colleagues. We will develop innovative, efficient pathways alongside primary care colleagues that support decision making, reduce waiting times and provide expanded access to cancer pathways closer to home.

Therapies and Dietetics

For future planning the services will link with all the Patient First strategic themes. Supported by the formation and implementation of the Trust's Allied Health Professional strategy, we will:

Patient:

- Ensure all services are enrolled with suitable data platforms to demonstrate service delivery and patient feedback.
- Embed governance processes to theme complaints and PALS feedback into service innovation systems.
- Ensure standard processes across all Therapy and Dietetic services for better process communicating with all divisions around patient delivery and care.

Sustainability:

- Provision of seven day services to support flow, maximise rehabilitation, decrease deconditioning, reduce falls and pressure damage and support earlier discharge processes with appropriate investment and standardisation of services.
- Therapy input for Stroke services will be strengthened to meet the national requirements (SSNAP and UKROC) with service innovation and workforce re-design.

People:

- Ensure job planning across all Therapy and Dietetic staff is completed and compared with national templates to enable implementation. This includes a platform for e-job planning for greater visibility and workforce/service innovation ensuring more accurate workforce planning.
- Development of visible career pathways and career pipelines at all levels.
- Develop better advanced clinical practitioners, consultant and apprenticeship profiles and pathways for all professions enabling improved delivery of care with a new and sustainable workforce, e.g. Royal Sussex County Hospital Emergency Floor extension and new workforce models.

Quality:

- Work across divisions to be part of the implementation of their divisional clinical strategy to deliver the patient care they envisage such as boosting of dietetic services for upper GI cancer services and SLT within Cranial Neurosurgery.
- Be actively involved in cross-divisional action plans and business cases for decreasing harm such as a rehabilitation model to decrease falls and de-conditioning, and decreasing length of stay.

Clinical Support Services

Systems & Partners:

- Place based recruitment and partnership recruitment, improving system and community partnership working with and exchange of skill base for better patient pathway care.
- In partnership with Sussex Community Foundation Trust, design innovative pathways to enhance discharge processes, maximising admission avoidance and provide care closer to home.
- Recovery of Musculoskeletal Physiotherapy Outpatient services to a more enhanced and productive activity level.
- Good working relationships with commissioners to ensure appropriate investment in patient pathway changes such as Community Dietetics.

Research & Innovation:

- Encourage increased applications to the Chief Nurse Fellowship scheme.
- Develop research and innovation champions within Therapy and Dietetic Services.
- Assign a Therapies and Dietetic portfolio lead to embed better patient effectiveness and outcomes standard systems and processes to improve service delivery and learning.

Pharmacy and medicines optimisation

Pharmacy services will be redesigned to further support patient care throughout our hospitals and the community, with a focus on avoidance of medication errors, and the safe and efficient transfers of care between the different care settings.

We will strengthen our governance of medicines and continue to be a top performer in the control of medicines expenditure whilst ensuring good access to effective medicines. We will support the Trust's True North goals and breakthrough objectives such as the reduction in length of stay and the median hour of discharge projects. We will use digital solutions to improve medicines safety, stewardship and expense whilst reducing wastage through the universal rollout of electronic medicines prescribing, pharmacy automation, and discharge documentation. The department will support the closer integration of medicines management across the Integrated Care Board.

A strategy for the robust provision of aseptic services will be produced addressing the national shortage, whilst allowing us to expand in house services, develop innovative systemic anti-cancer therapy (SACT) care pathways and reduce dependency on outsourcing.

The Pharmacy department will support the Trust's research and innovation True North goal, working alongside the universities of Sussex and Brighton to promote cutting edge research in all areas of therapeutics including cancer.

Clinical Support Services - the changes we want to make

Immediate priorities

Divisional:

- Work with clinical divisions to ensure that their plans for redesign and expansion align with our capacity in a sustainable and affordable way.
- Develop the case for seven day services across all key areas.
- Capitalise on the benefits afforded by pathway improvements and relocation of services into the Louisa Martindale Building.

Pathology:

- Formalise the establishment of the Sussex Pathology Network.
- Begin the rollout of the LIMS (laboratory information management system).
- Design of the Point of Care Testing strategy.

Imaging:

- Determine the future model of provision for Interventional and Interventional Neuro-Radiology, Paediatric Radiology and Nuclear Medicine, including PET-CT services, across the Trust.
- Ensure the successful opening of the Community Diagnostic Centre at Southlands Hospital and subsequent spoke development at Falmer and Bognor Regis.

Therapies and Dietetics:

- Define new models of care in line with Trust's stroke service redesign.

Pharmacy:

- Redesign clinical pharmacy services to support step changes in efficiency and safety.
- EPMA rollout completion.

Longer term priorities

- Develop data collection tools to collate departmental activity for Therapies and Dietetics.
- Roll out electronic job planning and rostering to all departments for Therapies and Dietetics.
- Scope future aseptic services provision and present strongly researched options.
- Realise the benefits of the new LIMS and MSC for the Pathology Network.
- Review and gain acceptance of a reconfiguration of the Aseptic Units across UHSussex.
- Rollout of re-designed clinical pharmacy service.
- Implement service day services across key areas.
- Develop the case for an MSC for Imaging.
- Finalise Point of Care Testing service.
- Develop Artificial Intelligence systems in Radiology and Histopathology.

Surgical and Elective Care

The services

UHSussex provides a wide range of surgical services including general surgery, ear nose and throat (ENT), ophthalmology, maxillofacial surgery, trauma and orthopaedics, urology, bariatric surgery, critical care, and perioperative care.
We also deliver audiology, rheumatology and chronic pain services within the surgical divisions and manage multiple theatre complexes and the central sterilisation services.

The vision

We will provide safe, excellent and timely care that incorporates modern technologies and techniques, alongside learning from clinical excellence such as Getting It Right First Time (GIRFT). Research and innovation will be integral to the work we do, with comprehensive performance measures, and research leadership and roles established as clinical services are developed. We will take steps to optimise post-operative outcomes. We will ensure that our services are configured across UHSussex in a manner that supports excellent patient experience and outcomes, as well as the development of vibrant hospital sites. Our services will make the best use of our estate through the development of seven day services.

Challenges and opportunities

Outpatients

We will develop plans to enhance the experience of the significant volume of patients that access outpatient services. This will also improve the efficiency of provision, through effective use of technology and building on initiatives such as patient initiated follow up.

Elective access

Following the COVID-19 pandemic, UHSussex has a very significant backlog of patients waiting for planned treatment, and there continues to be a gap between the demands for surgical services and the capacity we are delivering. We are mapping the ongoing gap between capacity and demand and will address this gap through a range of approaches, including enhancing seven day working. We will consider the optimal service model that supports the principle of care closer to home where possible, alongside centralising services where this will drive quality improvements and tangible patient benefits. We will also use the Patient First approach to support the improvement and modernisation of services, with increased productivity and flow. Beyond this, there will be a need to ensure there is sufficient capacity to meet longer term requirements.

Surgical and Elective Care

Trauma and Orthopaedics

We will do a review of the service model of trauma services to support the delivery of safe and excellent quality provision across UHSussex. This will initially focus on achieving timely access to theatres at Worthing Hospital and St Richard's for those patients with frailty fractures. Further Trust wide work is required to improve access to ambulatory trauma. We will also explore the opportunities to improve productivity through internal configuration at sub-specialty level within Orthopaedics. This will consider greater use of the Sussex Orthopaedic Treatment Centre at Princess Royal Hospital for hip and knee surgery for a wider catchment, and opportunities to centralise hand and shoulder surgery, potentially making greater use of Southlands day surgery unit.

We will review models of provision for elective orthopaedic surgery particularly at Princess Royal Hospital and St Richard's, enabling sustained backlog reduction and repatriation of outsourced work from the independent sector.

We will play a central role in the forthcoming procurement for Musculoskeletal (MSK) services in Sussex and will seek to ensure that sufficient elective orthopaedic volumes flow to UHSussex to provide financial and clinically sustainable services. We will also work with commissioners to support a sustainable model of care for chronic pain.

Rheumatology

We have seen a significant growth in referrals for this service, which does not match the capacity. We will work with partners to develop improved pathways with a robust triage function that ensures patients access the most appropriate service first time. This will allow us to focus on delivery of excellent patient care for those experiencing complex rheumatology, clinical immunology and severe systemic diseases.

Ophthalmology

Waiting times for treatment and care remain a significant issue in Ophthalmology and will be the first speciality to undergo a full specialty review process. This will develop a prioritised portfolio for standardising, improving and redesigning pathways, considering how we can best work together across UHSussex, to improve access and optimise our workforce. We will look to maximise elective capacity across our hospitals, including the potential to deliver more high volume, low complexity activity at the Ophthalmology unit at Southlands Hospital. The service will consider how out of hours working can be joined up across the Trust.

Surgical and Elective Care

Urology

Following the successful introduction of a Urology Investigation Unit (UIU) at Worthing, a further UIU at Princess Royal Hospital will open in 2023. We will look at the opportunity to extend this model to St Richard's Hospital, which could address current capacity issues. Further work on the configuration of inpatient services across UHSussex is required to improve access for patients, which will be explored through the mission statement process. With regard to urological cancer services, the Trust does not currently offer prostrate resection services. We intend to work with the Integrated Care Board to review the delivery of this provision for Sussex patients

Audiology

This service is provided at Royal Sussex County, Princess Royal and Worthing hospitals, with Portsmouth Hospitals University NHS Trust providing a service at St Richard's. There is an opportunity to harmonise the service across UHSussex and agree a future approach to 'Improving Quality in Physiological Services Accreditation (IQIPS)', supported by UKAS.

Ear Nose and Throat (ENT) Services

This service is provided at Royal Sussex County, Princess Royal and Worthing hospitals, with Portsmouth Hospitals University NHS Trust providing a service at St Richard's. There is an opportunity to harmonise the service across UHSussex and agree a future approach to 'Improving Quality in Physiological Services Accreditation (IQIPS)', supported by UKAS.

Head and Neck Cancer

ENT and Maxillofacial services will continue to work collaboratively, to strengthen our capacity to undertake major head and neck cancer surgery within UHSussex, bringing back some of the activity from other trusts.

Maxillo-Facial Services

Maxillofacial surgery is provided at St Richard's, Worthing and Royal Sussex County hospitals. A review of the model of care across Sussex is needed to ensure capacity is maximised and a sustainable model of care is developed. Where suitable, this will include diverting some of our trauma activity to Queen Victoria Hospital.

Day Surgery

We intend to strengthen our day surgery provision across the Trust in line with our principle of delivering services locally where possible. This will build on the dedicated day case facilities at St Richard's and Southlands hospitals, and shared facilities at our other sites, including the dedicated elective and daycase Orthopaedic service at Princess Royal. The current day case capacity restricts the level of this activity we can undertake productively. We intend to increase the volume of daycase activity at Southlands, as part of the national High Volume Low Complexity (HVLC) programme. We are working on plans to develop day case capacity at Princess Royal, and in the longer term would wish to see a dedicated facility at Worthing Hospital.

Surgical and Elective Care

General /Upper GI/Colorectal surgery

Following the concerns regarding patient experience and training within General Surgery at the Royal Sussex County Hospital, a major improvement programme has been put in place as one of the Trust's corporate projects. We are addressing these issues through a range of measures, including a new model of care, and improved clinical leadership.

Across UHSussex, there are opportunities to improve access and flow through internal configuration, in particular for colorectal surgery patients. Patients are currently benefitting from improved access to colorectal surgery via temporary cross site working between Royal Sussex County and Worthing hospitals. A longer term strategy is to be developed for the general inpatient surgical services across UHSussex.

Bariatric surgery

We will review the Bariatric service delivered across UHSussex to enhance integrated working across community services, including the introduction of weight loss medication.

Critical Care

We will continue to provide critical care services at all four main sites in order to support unscheduled and emergency services, as well as elective care. The service at Royal Sussex County Hospital will be moving into purpose-built accommodation in Stage 1 of the 3Ts building. The facility at St Richard's and in particular Worthing, is in need of significant improvement and reconfiguration in order to meet national standards and provide a high quality of care for patients. Any movement of additional surgical cases to Worthing will necessitate an increase in critical care capacity. At Princess Royal Hospital, a detailed review of critical care provision is required due to the low volume of patients currently treated in the unit. Critical care outreach needs to be standardised across our hospitals with the provision of 24 hour cover. We are writing a more in-depth strategy for critical care which will seek to address these issues and support the service to achieve the standards set out in Guidelines for the Provision of Intensive Care Services (GPICS).

Surgical and Elective Care

Prehabilitation, perioperative services and theatres

We will develop and implement a system of early screening, risk assessment and health optimisation for patients waiting for surgery, to include establishment of a multidisciplinary, multispecialty perioperative care team, in line with the stated ambition of the elective recovery plan, with a view to be a leading centre for prehabiliation. This should also include improving the delivery of post-operative care, especially for frail patients with multiple comorbidities. We also intend to develop an anaemia strategy to enhance quality of care.

We operate theatres and provide anaesthetic care across all sites, not only at the four main sites, but also at Southlands and Lewes Victoria hospitals. Theatre capacity across UHSussex is currently extremely limited which impacts timely access. A review of theatre provision is required in order to increase capacity, making the best use the theatre space available, supported by seven day working optimal workforce and equipment. This is linked to the breakthrough objective relating to productivity.

We will develop a consistent pathway across the Trust, that is digitally enabled, taking into account national best practice.

Robotic surgery

There is a growing evidence of the efficacy of robotic surgery. As such, we will develop a robotic strategy, building on the implementation of the first robot that is now operational at Princess Royal Hospital. The strategy will identify opportunities to expand robotic surgery across all of our main sites and align with the future configuration of wider surgical services.

Surgical and Elective Care - the changes we want to make

Immediate priorities:

- Optimise key general surgery pathways across UHSussex, particularly for colorectal surgery and upper GI surgery, considering elective access, perioperative services, critical care requirements and robotic surgery.
- Undertake a review of the configuration of orthopaedic services to support the delivery of safe and excellent quality provision across the Trust and improve productivity.
- Right-size the bed base at St Richard's and create year round 'ring-fenced' capacity to achieve sustained backlog reduction for elective orthopaedics and repatriate work being undertaken in the independent sector.
- Implement the Critical Care Strategy and standardise critical care outreach services across the Trust.
- Review maxillofacial provision of services across Sussex (including Queen Victoria Hospital and East Sussex).
- Take steps to ensure the future of major knee revision surgery.
- Participate in the Sussex MSK procurement to ensure the sustainable provision within the Trust.
- Complete the ophthalmology specialty review and implement agreed actions.
- Introduce the Electronic Health record in ophthalmology.
- Open the new Urology Investigation Unit at Princess Royal Hospital.
- Review the model of urology provision across UHSussex to consider future requirements of Urology Investigation Units.
- Develop the model of care for increased day case provision at Princess Royal and Southlands.

Longer term priorities:

- Across all our services we will embed research and innovation in the care we provide to ensure our patients and staff have opportunities to benefit from a research active culture. We will build research and innovation roles into job plans across the workforce as a means to develop and retain a high quality workforce and to meet our True North for research and innovation. We will monitor our growth in research and innovation through our performance measures.
- Explore provision of ENT services in the Chichester area (currently provided by Portsmouth Hospitals University NHS Trust).
- Widen the use of robotic surgery within UHSussex.
- Do further work on the configuration of urology inpatient services across our hospitals to improve access for patients.
- Implement the agreed outcomes of the review of theatre provision across all of the sites.
- Explore ways of more effectively delivering daycase activity at Worthing Hospital
- Implement any required changes to maxillofacial provision of services across Sussex (including Queen Victoria Hospital and East Sussex)

Digestive Diseases

The services

UHSussex provides both specialist medicine and surgery relating to digestive disease. This includes gastroenterology, endoscopy and hepatology.

Challenges and opportunities

Endoscopy

Endoscopy services at Princess Royal and Royal Sussex County hospitals do not currently have sufficient capacity to meet demand. Consequently, the service currently depends on significant insourcing and outsourcing. The service is also provided in an environment that needs improvement. We will look to review and improve pathways and models of service, exploring the use of an endoscopy network to support and drive those improvements in pathways, demand management and efficiency. Maintaining the Joint Advisory Group (JAG) accreditation on all four acute sites remains a key strategic requirement.

We will also look for opportunities to expand services for those Sussex patients requiring gastrointestinal endoscopic mucosal resection, and Barrett's oesophagus services, that currently have to travel to other hospital trusts.

In 2022, we established a regional endoscopy training academy for junior doctors, and once established we will look to expand this to include consultant and clinical endoscopist training. The academy will be delivered across all four training endoscopy units within UHSussex.

Gastroenterology/Hepatology

The Gastroenterology service will build on faster diagnosis initiatives in upper GI cancer, harmonising pathways across the Trust and adopting efficient ways of working, including for referral assessment services.

We also host a highly successful Hepatology Network that is focused on elimination of hepatitis C. Opportunities to extend the remit of the network to other areas of hepatology will be explored. It is also anticipated that a pilot to do liver surveillance for patients accessing drug and alcohol services will be expanded to increase the reach of liver surveillance both within UHSussex and within other community provision. The service also intends to achieve Improving Quality in Liver Services (IQILS) accreditation and will continue to build on the hepatology research programme within UHSussex and our university partner.

Digestive Diseases - the changes we want to make

Immediate priorities

- We will take steps to ensure that there are is sufficient capacity to meet the need for endoscopy services particularly at the Princess Royal Hospital.
- Launch the endoscopy training academy programme.

Longer term priorities

- Review the provision of gastroenterology across the Trust.
- Expand the endoscopy training academy.
- Take opportunities to embed research roles as means to develop and retain a high quality workforce and to meet our True North for research and innovation.

Cancer Care

The services

We provide a range of cancer care including oncology, clinical haematology, systemic anti-cancer therapy (SACT), radiotherapy, screening management, and palliative care and integrated breast services. Site specific cancer surgery is reviewed under the specific surgical specialties.

We provide tertiary and secondary cancer care, for the local population and the wider population of Sussex. The Sussex Cancer Centre at the Royal Sussex County Hospital is the tertiary centre for patients requiring specialist oncology treatment in Sussex and is part of the wider Surrey and Sussex Cancer Alliance. Tertiary oncology services for the Chichester population are currently provided by Portsmouth Hospitals University NHS Trust.

The vision

To be recognised locally, nationally, and internationally as a renowned organisation of excellence for the delivery of high quality, safe, patient cancer care, underpinned by education and research, where staff are valued and supported to fulfil their potential in an inclusive and kind working environment. To ensure that all patients and staff have the opportunity, and equality of access to high-quality research and innovation that is relevant to them.

Challenges and opportunities

Our immediate challenge is to improve access to diagnostics and specialist treatment for our patients to ensure that we can diagnose and start treatment for patients with malignancy within 62 days. This includes ensuring that the Faster Diagnosis Standards are met, as well as improving access to breast screening.

We are developing a model for faster diagnosis. This will be refined, with consideration given to opportunities to extend this approach to other pathways. The service will develop a Trust wide approach to cancer workforce provision, and increase the level of clinical nurse specialist and AHP provision, with role diversification, advanced clinical practice role development and staff support to maximise professional development and foster talent.

We will ensure SACT services meet the need of the population across Sussex, delivering timely, high quality, world class treatments as close to home as possible.

We will ensure adequate capacity within our radiotherapy units and radiotherapy physics teams to deliver innovative, timely, high quality, state of the art radiotherapy treatments supported by robust quality assurance and a new technology development plan as close to a patient's home as possible.

We will ensure all patients on a cancer pathway have early access to a clinical nurse specialist to provide expert advice and support.

We will ensure that all cancer patients requiring nutritional support will have timely access to expert dietetic support.

We will review the provision of our acute cancer assessment services at the Trust so that we can respond more quickly and effectively to the acutely unwell patients, providing urgent unplanned specialist

care, enhancing patient experience, and avoiding emergency department attendance and unnecessary admissions.

We will establish the optimal inpatient bed model for UHSussex for cancer services, exploring the option of a combined oncology and haematology inpatient unit, alongside a cancer assessment unit, at Royal Sussex County Hospital, and reviewing haematology provision across all our sites. The service will seek to provide seven-day palliative care services across all UHSussex sites. Working with community providers we will develop the optimal model for the delivery of palliative care for the population and support access to community provision where appropriate.

Working with partners, we will develop a world class academic research unit embedding research throughout all cancer disciplines and expand the offer to patients and staff in research and innovation, with improved access for patients to clinical trials.

We will also work with partners to improve access and coverage of screening services for the population of Sussex, particularly for our deprived communities.

Across the entire pathway we need to explore new ways of working that will:

- Drive equity of access to a wide and comprehensive range of treatment modalities, care and support.
- Reduce variation across pathways.
- Fully embed personalised care, enable patients to be informed and understand what is happening with their pathway.
- Make use of clinical and digital innovation to support service sustainability including make better use of virtual clinics, integration with the new community diagnostic centres, and growing patient stratified follow up.

We will also consider how to best provide longer term survivorship support, identification of recurrence, increase curative treatments, with the roll out of patient stratified follow up programmes.

We are planning for the move of cancer services in the Royal Sussex County Hospital to bespoke modern facilities in Stage 2 of the 3Ts build in 2026/27.

Cancer Care - the changes we want to make

Immediate priorities

- Determine the future provision of cancer services, including inpatient beds across all hospital sites, acute assessment units, workforce plan and optimal provision of radiotherapy.
- Develop a plan for a research unit to increase access to clinical trial opportunities.
- Ensure the delivery of the 62-day cancer standard through improved and streamlined multidisciplinary team working.
- Embed research in the performance measures for the service, establishing research leadership and roles in these teams as clinical services are developed.

Longer term priorities

- Implement seven day palliative care services across all acute Trust sites.
- Plan and take action to improve access for screening including breast.
- Work with our digital partners to develop technology to support the capture of patient outcomes which are essential for understanding the future direction of service improvements.
- Make plans to support equity of access to a wide and comprehensive range of treatment modalities, care and support.
- Plan and take action to provide longer term survivorship support.
- Work with community providers to develop the optimal model for the delivery of palliative care for the population.
- Review the ongoing relationship with Portsmouth Hospitals University NHS Trust for cancer provision in the Chichester area and also with East Sussex Healthcare NHS Trust for oncology provision to East Sussex.
- Fully embed personalised care for patients.
- Complete preparations for the move to Stage 2 of 3Ts in Brighton.
- Scope new models of working to manage demand on the SACT day units.

Specialist Services

The Services

UHSussex provides a wide range of specialised tertiary services across multiple sites. These include: cardiac surgery, cardiology, neurosurgery, spinal surgery, plastic surgery, major trauma, vascular services, renal services, neurology, stroke services and specialist rehabilitation.

The vision

As a regional teaching hospital, we recognise our responsibility to support and develop its specialised services to ensure that patients from Sussex and beyond have access to specialised services without the need for referral elsewhere. Our vision is to create an environment where the specialised services can flourish, allowing them to deliver safe and effective care to everyone who needs it in a timely way.

We will further develop a plan for research and innovation, reflecting the important benefits to patients and staff, ensuring our patients have the opportunity to participate in high impact research and innovation embedded in the care they receive.

We will also continue to work with the network partners in Sussex and the region.

Challenges and opportunities

Cardiac surgery and cardiology

Our cardiac surgery service is the smallest in England but is crucial to supporting the Trust's other specialist services, including cardiology and the major trauma centre. There are significant opportunities to broaden the capacity and scope of the current service, enabling the repatriation of patients from London and Southampton providers. For cardiology, there is an opportunity to review how we deliver diagnostic and interventional services across our sites to improve clinical effectiveness, patient access, experience and efficiency and to meet national standards and recommendations. There are also opportunities to work with Medicine to optimise the chest pain pathway.

Neurology

the move to the new estate in the Louisa Martindale Building will allow us an opportunity to develop local and regional neurology services to meet the needs of Sussex patients including urgent access, working with the teams at Worthing Hospital and St Richard's Hospital to do this. We will also continue to work with the partners at East Sussex Healthcare NHS Trust in a Sussex neurology network. The Trust will continue to develop the specialist services for multiple sclerosis and other neurological conditions in collaboration with network partners, NHSE and the Integrated Care Board.

Specialist Services

Stroke services

Two of our sites, Worthing and St Richard's, do not meet the national standards expected of acute stroke centres, both in terms of the minimum numbers of strokes required, and access to multi-disciplinary team care seven days a week. To address this, we will be reconfiguring the services on these sites. At the Royal Sussex County Hospital we will develop a comprehensive stroke centre service and expand our mechanical thrombectomy service accepting patients from a wider geography.

Specialist rehabilitation

There is a need to review provision for specialist rehabilitation given that some patients have to be referred out of county for their care, as the Sussex Rehabilitation Centre at Princess Royal Hospital is not currently designated by commissioners to provide Level 1 care. We will work closely with specialist commissioning services to review the level of provision across the specialist rehabilitation services at Donald Wilson House at St Richard's Hospital and the Sussex Rehabilitation Centre at Princess Royal.

Cranial neurosurgery and spinal surgery

The move to the Louisa Martindale Building will allow us the opportunity to develop these services to meet the needs of all Sussex patients and bring back services from other providers. It will drive clinical effectiveness, improve patient access, experience and efficiency. These improvements will be further supported by new patient pathways across primary, secondary and tertiary care.

Major trauma centre (MTC) and plastic surgery

Royal Sussex County Hospital is now an established major trauma centre. This needs to be further strengthened, with a new medical model, specialist consultant rota and improved access to theatres. We will deliver the plan to open the helideck. The links with Queen Victoria Hospital for plastic surgery support to the Major Trauma Centre need to be reviewed and strengthened to improve the ortho-plastic support.

Vascular services

We will be looking to further strengthen the Vascular Network and enhance our leadership role across Sussex and ensure that there is sufficient operational capacity to meet current and future demand across all sites.

Renal services

The Sussex Kidney Centre is the hub for renal services for Brighton, East Sussex, Worthing, and Crawley areas. Demand for the service is impacted by transplant wait times of other providers. We will work to strengthen our relationship with those other transplant services. There is a need to review and to expand dialysis capacity, particularly in the Worthing area, which will enable more patients to receive care closer to home.

Specialist Services - the changes we want to make

Immediate priorities

- Review the diagnostic and interventional cardiology services across UHSussex.
- Expand the Mechanical Thrombectomy service at Royal Sussex County Hospital.
- Complete the consultation on stroke services in West Sussex.
- Open the helideck for major trauma.
- Secure the development and expansion of the Cardiac Surgery service.

Longer term priorities

- Expand cranial neurosurgery and spinal surgery to enable the move to the Louisa Martindale Building and explore improvements to patient pathways across primary, secondary and tertiary care.
- Embed research in the performance measures for the services, establishing research leadership and roles in teams as clinical services are developed.
- Complete the reconfiguration of stroke services across the Trust to meet the national standards.
- Expand the neurosurgery and spinal surgery service to enable the repatriation of patients referred to centres outside of Sussex.
- Review and develop the neurology service to improve access and patient experience, developing a regional service for multiple sclerosis.
- Develop the renal service including the dialysis services across Sussex in order to ensure patients receive their treatment as close to home as possible.
- Strengthen the Major Trauma Centre service to ensure it is fully compliant with national standards.
- Review the links with Queen Victoria Hospital for plastic surgery support to the Major Trauma Centre.
- Provide level 1 specialist rehabilitation in Sussex at the Sussex Rehabilitation Centre.
- Undertake actions to strengthen the Vascular Network across Sussex ensuring sufficient capacity to meet future demand across all sites.

Next steps

The clinical strategy will drive further improvements to our clinical services, both in terms of quality and access. It will help to ensure that we have vibrant hospital sites that are responsive to local need, whilst also maximising the benefit that can be derived by the large size of our trust. The strategy will help us achieve our True North goals including in relation to our newest True North objective: research and innovation. It will support our workforce to have rewarding and interesting roles.

When implementing the strategy, we will use a programme of change alongside the Patient First continuous improvement to methodically work with our staff and our partners to develop solutions. Throughout this work, the voice of the patients will be central to the approach.

Each clinical specialty will have a mission statement that will inform how they will contribute to the overarching clinical strategy alongside wider strategic deployment and business planning. Those specialties embarking on large changes will also use the specialty review process to ensure that changes are data driven; patient focussed and support pathway improvements.

We will join up across the strategic deployment including our corporate projects and strategic initiatives so that we can make best use of the transformation and improvement capacity and drive the benefits for patients, as well as with the projects and programmes within the Integrated Care Board.

As our clinical services begin to implement their plans, the benefits will be monitored and proposals and priorities refined through the Clinical Strategy Steering Group and our wider Strategy Deployment Review system. In this way we will ensure that improvements in our clinical services are realised for our patients and communities.

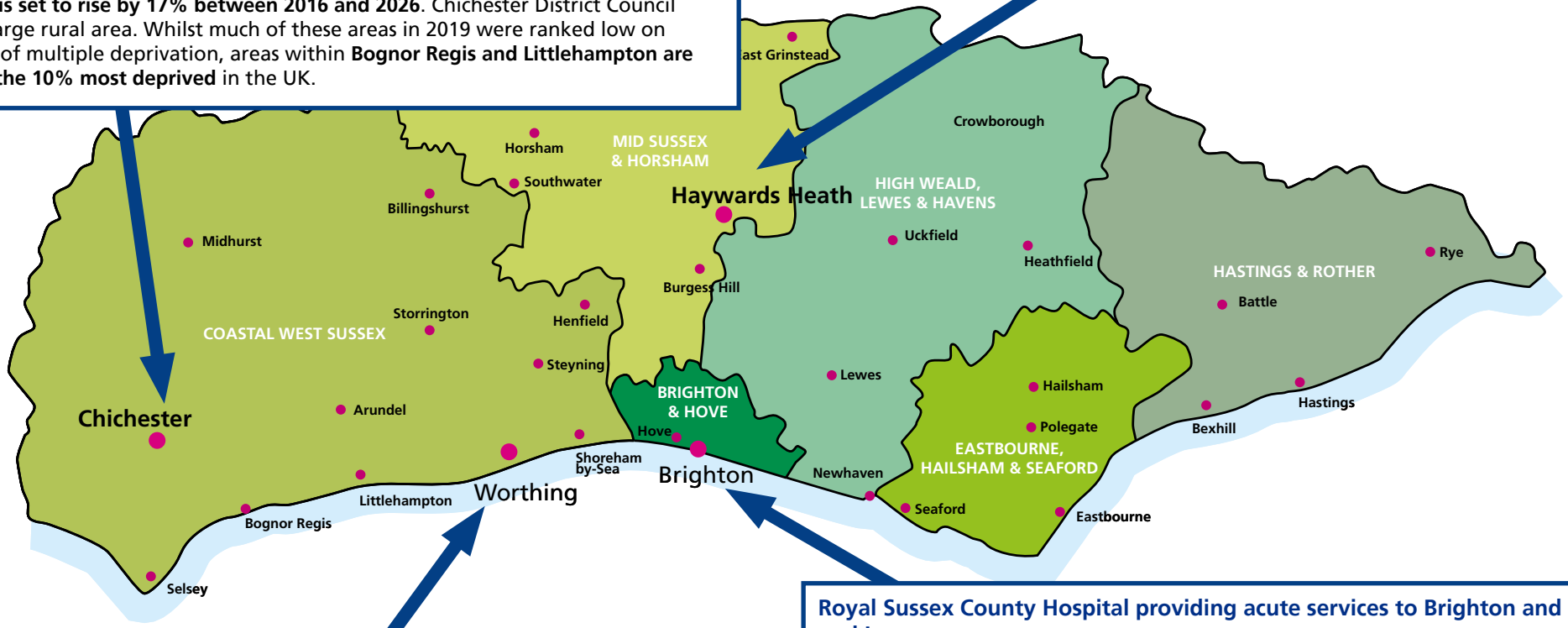
Appendix 1

St Richard's Hospital providing acute services to Chichester District and parts of Arun

The population has an older age structure than the rest of England with **26% of the population over 65*.** The **over 75s population is set to increase by 35%** between 2016 and 2026. The number of 0-4 year olds is set to fall by 2% but the number of **10-14 year olds is set to rise by 17% between 2016 and 2026**. Chichester District Council covers a large rural area. Whilst much of these areas in 2019 were ranked low on the index of multiple deprivation, areas within **Bognor Regis and Littlehampton are amongst the 10% most deprived** in the UK.

Princess Royal Hospital providing acute services to communities within Mid Sussex

The population has an older age structure than the rest of England with **20.4% of the population over 65*. The over 65s population is set to increase by 13% between 2018 and 2028.** Most of these areas are ranked low on the index of multiple deprivation in 2019.



Worthing Hospital providing acute services to Worthing, Adur and parts of Arun

25% of the Worthing and Adur population are over 65*.
The over **65s population is set to increase by 17%** between 2018 and 2028, with significantly higher increases in the over 75s. The numbers of under 16 year olds is set to fall slight between 2018-28, but in Adur **the number of 10-14 year olds is set to rise by approx. 23%**. Whilst much of these areas in 2019 were ranked low on the index of multiple deprivation, **a number of wards are amongst the 10% most deprived** in the UK.

Royal Sussex County Hospital providing acute services to Brighton and Hove and Lewes

The **over 65s population is set to increase from 13.3%* to 15% in Brighton and Hove,** and **25.5%* to 28.3% in Lewes** between 2018 and 2028. The population of **Brighton and Hove has a younger age structure** and Lewes has an older age structure. Brighton and Hove has key health challenges around mental health, alcohol and drug misuse, with one of the highest suicide rates in the country. There are an estimated 144 rough sleepers, which is the highest outside of London. These trends reflect Brighton's large areas of urban deprivation with some wards amongst the 10% most deprived in the UK. There are though also wards in Brighton and Lewes in 10% least deprived.
Men in the Brighton and Hove have a slightly lower life expectancy than nationally†.

*As compared to 18% in the UK | † in all other areas life expectancy for men and women exceed national averages

University Hospital Sussex NHS Foundation Trust

QUALITY COMMITTEE

TERMS OF REFERENCE

1.00 PURPOSE

1.01 The purpose of the Quality Committee is to support the Trust in achieving its quality strategic objective; "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."

1.02 The Quality Committee will do this through;

- Providing input and recommendations to the Board for the development of the Quality Strategy and Clinical Framework and Strategy, ensuring there is alignment between the two;
- Assisting the Board in its oversight of achievement of the True North Targets, breakthrough objectives and strategic initiatives pertaining to the Quality domain;
- Ensuring robust clinical governance structures, systems and processes are in place across all services and in line with national, regional and commissioning requirements;
- Driving a culture of learning and continuous improvement across the organisation;
- Obtaining assurance that the quality strategy is being implemented; and
- Review of soft intelligence, narrative and data relating to the NHS Quality Assurance Framework and Darzi principles of quality (patient and family experience, patient safety and clinical effectiveness) to enable integrated quality performance reporting to the Board.

2.00 MEMBERSHIP AND ATTENDANCE AT MEETINGS

2.01 The membership of the Committee shall be:

- Chair: a nominated non-executive Director
- Three further nominated non-executive Directors
- Chief Medical Officer (Lead Executive for the Committee)
- Chief Nurse (Alternate Lead Executive for the Committee)
- Chief Governance Officer

2.02 The Trust Chair shall propose which non-executive Directors will be most suitable for nomination as Chair and members of the Committee. The Trust Board shall approve the appointment of the Committee Chair and members, based on the Chair's recommendations.

2.03 In the absence of the Committee Chair one of the remaining non-executive members present shall elect themselves to chair the meeting.

2.04 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of meetings. The Committee secretary will maintain a register of attendance which will be published in the Trust's annual report.

2.05 All members of the Committee shall receive training and development support before joining the Committee and on a continuing basis to ensure their effectiveness as members, supported by a performance assessment process, as agreed by the Board of Directors.

2.06 Core Corporate Directors attendees will be those who are presenting reports to the Committee but are not voting members of the Committee. These will include:

- Medical Directors
- Director of Clinical Effectiveness
- Director of Patient Safety and Learning
- Director of Patient Experience, Involvement and Engagement
- Associate Director of Infection Prevention and Control
- Director of Communications and Engagement
- Director of Nursing
- Director of Midwifery

2.07 Any member of the Board of Directors shall have the right to attend any meeting of the Committee by prior agreement with the Chair.

2.08 The executive members of the Committee may exceptionally send a deputy to the meeting, but the deputy will not have voting rights at the meeting. Those who are in attendance may exceptionally send a deputy to the meeting.

2.09 Other Trust managers and clinicians may be invited to attend for particular items on the Agenda that relate to areas of risk or operation for which they are responsible.

2.10 The Company Secretary or their nominee shall act as Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

3.00 ROLES AND RESPONSIBILITIES

DELEGATED AUTHORITY

3.01 The Committee shall have the delegated authority to act on behalf of the Board of Directors in accordance with the Constitution, Standing Orders, Standing Financial Instructions, and Scheme of Delegation. The limit of such delegated authority is restricted to the areas outlined in the Duties of the Committee and subject to the rules on reporting, both as defined below.

3.02 The Committee is empowered to investigate any activity within its Terms of Reference, and to seek any information it requires from staff, who are required to co-operate with the Committee in the conduct of its enquiries.

3.03 The Committee should challenge and ensure the robustness of information provided.

3.04 The Committee is authorised by the Board of Directors to obtain independent legal and professional advice and to secure the attendance of external personnel with relevant experience and expertise, should it consider this necessary. All such advice should be arranged in consultation with the Company Secretary.

RESPONSIBILITIES

True North

3.05 Within the Trust's strategic framework, the Trust's True North is defined as putting the patient first and foremost so all improvements ultimately benefit the people the Trust serves. This Committee will therefore operate within that framework, following agreement of the strategy and plans prioritised and agreed by the Board.

3.06 In support of the True North strategy development the Committee will work to ensure the Trust develops and maintains appropriate annual plans which aligns to the Quality domain True North goals, breakthrough objectives, strategic initiatives and corporate projects and make relevant recommendations to the Board for approval.

3.07 Through discharge of the objectives below the Committee will support the Trust's progress towards achieving its True North goals and overseeing improvement plans when required.

Breakthrough Objectives

3.08 To receive confirmation from the Board an annual basis the cascade of the relevant Breakthrough Objectives which are to be held to account by the Committee.

3.09 To obtain assurance that the Breakthrough Objectives, which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, challenging management and escalating to the Board when required.

Strategic initiatives

3.10 To receive confirmation from the Board an annual basis of the Strategic Initiatives for which delivery is being held to account by the Committee.

3.11 To provide assurance that the Strategic Initiatives, which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, challenging management and escalating to the Board when required.

Corporate Projects

3.12 To receive confirmation from the Board an annual basis of the Corporate Projects for which delivery is being held to account by the Committee.

3.13 To provide assurance that the Corporate Projects, which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, challenging management and escalating to the Board when required.

Statutory requirements

3.14 Review the annual quality report.

External reviews

3.15 The Quality Committee shall receive assurance from other significant assurance functions, both internal and external to the organisation, on its review of the findings and consider the implications to the organisation. These will include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors.

3.16 To monitor the Trust's responses to all relevant external assessment reports and the progress of their implementation, including the reports of the Care Quality Commission.

3.17 To receive exception reporting from sub-groups regarding the CQC's insight report in respect of any potential changes to the Trust's quality risk profile.

Safe

3.18 To obtain assurance that there are effective systems and processes in place which embed learning from incidents and near misses in a way that reduces risk thereby improving outcome measures and quality of care.

3.19 To receive a summary reports, using a standard template, which includes identification of areas of concern and escalations from the Committee's determined sub-groups.

3.20 To receive triangulated reports and review the themes, trends, management, and improvements relating to serious incidents, 'never' events, post-mortem reports, medico-legal cases and to seek assurance that remedial action plans are being implemented and learning is embedded and shared across the organisation. Assurance to be obtained through incident reports, Learning from Deaths, HSMR Action plan, Duty of Candour audits and Patient safety reports.

3.21 Review and monitor Equality and Quality Impact Assessments (EIA) (QIA) relating to Efficiency and Transformation programmes to gain assurance that there will be no unforeseen detrimental impact on quality of care for patients.

3.22 Obtain assurance that the Trust is compliant with the Mental Health Act and its associated Code of Practice and the Mental Capacity Act.

3.23 Obtain assurance that robust safeguarding structures, systems and processes are in place to safeguard children and young people and vulnerable adults.

3.24 To consider reports from the Committee's reporting groups, e.g. Safeguarding, in the context of quality risks and assurances over the Trust's system of internal control as reflected within the BAF.

3.25 Review the annual infection prevention and control report.

3.26 Obtain assurance over the safe delivery of the Trust's children's services

3.27 Obtain assurance over the Trust's maternity services including receipt of reports from the Executive Maternity Champion and the relevant maternity safety and performance dashboards

3.28 Obtain assurance over the safe delivery of the Trust's Palliative and End of Life Care Services

3.29 Obtain assurance over the safe delivery of the Trust's Resuscitation services

3.30 Obtain assurance over the safe delivery of the Trust's Dementia strategy

3.31 To receive of relevant reports from national bodies in relation the standards or practice of clinical care.

3.32 To receive reporting from the Committees established reporting groups and ensure that the patient voice is being used to influence, change and shape practice.

3.33 To approve the Trust's patient and public engagement plans and the patient experience plans/strategy and ensure that these plans are incorporated into the quality and clinical governance teams across the Trust.

3.34 Receive assurance that appropriate safeguarding arrangements are in place and effectively monitored.

3.35 To consider reports from the Customer Relations Team, the Patient Advice & Liaison Service and other sources of feedback (such as Healthwatch) on all formal and informal patient feedback, both positive and negative, and to consider action in respect of matters of concern.

3.36 To consider the results the issues raised and the trends in all patient surveys (including real-time patient feedback systems), of in-patients and out-patients activities (e.g. Inpatient, Cancer, Maternity and ED) and estate surveys such as PLACE that may impact on clinical quality, and to gain assurance of the development of robust improvement plans and the subsequent completion of action taken to address issues raised.

Effective

3.37 To ensure there is a comprehensive clinical audit programme in place to support and apply evidence-based practice, implement clinical standards and guidelines, and drive quality improvement, including through approving and monitoring progress against the Clinical Audit Strategy.

3.38 In response to requests from the Board, or where appropriate as decided by the Committee, monitor the implementation of action/improvement plans in respect of quality of care, particularly in relation to incidents and similar issues.

Well-led

3.39 To receive and consider the Trust's clinical governance and risk management reports and agree recommendations on actions for improvement.

3.40 To monitor and obtain assurance as to the effectiveness of the processes, systems and structures for good clinical governance at the Trust, and to seek their continuous improvement.

3.41 To consider reports from Service Governance Reviews, to ensure that the reviews are effective and that actions arising from them are addressed in a timely and appropriate manner.

3.42 To ensure that board assurance framework reflects the assurances for which the committee has oversight, and that risks highlighted are appropriately reflected on the risk registers.

Responsive

3.43 To obtain assurance that clinical recommendations resulting from complaints including those investigated by the Parliamentary and Health Service Ombudsman have been implemented.

3.44 To review the complaints procedure in conjunction with the periodic review of the complaints policy.

3.45 To seek assurance that complaints are managed in a way that promotes a culture of openness, learning and continuous improvement across all divisions.

3.46 To review the themes and trends in complaints and the learning and improvements made relating to complaints raised and trends identified.

ICS and system collaborations

3.47 To receive and review reports from the ICS meetings, Sussex Acute Collaboration Network and Sussex Health and Care Partnership meetings.

Sub-Groups

3.48 To oversee and scrutinise the performance of relevant sub-groups through a range of formal and informal activities.

3.49 The Committee shall approve all sub-groups' terms of reference annually or as recommended otherwise by the Trust Company Secretary.

Risk

3.50 To review regularly the Board Assurance Framework (including through in-depth reviews of specific risks) and the High Level Operational Risks with a significant potential for impact on the Trust's quality risk appetite, and promote continuous quality improvement with regard to the management of quality risk and the control environment throughout the Trust.

4.00 REPORTING AND RELATIONSHIPS

4.01 The Committee shall be accountable to the Board of Directors of the Trust.

4.02 The Committee shall make recommendations to the Board of Directors concerning any issues that require decision or resolution by the Board.

4.03 The Committee shall refer to the Audit Committee, People Committee, Patient Committee, Systems and Partnerships Committee or Sustainability Committee any matters requiring review or decision-making in that forum.

4.04 The Committee shall receive reports from all sub-groups, which set out any matters requiring escalation to the Quality Committee and provide assurance of effective standards and performance in their respective Departments.

4.05 On an annual basis the Committee will provide a self-assessment report to the Board detailing how the Committee has discharged its obligations as set out within its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate. This will form part of the assurances which support the Annual Governance Statement and the Annual report disclosures and will be submitted in the first quarter of the following financial year.

4.06 The Committee Chair shall present a report summarising the proceedings of the meeting at the next Trust Board meeting. This should draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

5.00 CONDUCT OF BUSINESS

5.01 The Committee shall conduct its business in accordance with the Standing Orders of the Trust.

5.02 The Committee shall be deemed quorate if there are at least two non-executive Directors and two executive Directors present, one of whom should be the Lead or Alternate Lead Executive for the Committee, the Chief Medical Officer or Chief Nurse. A quorate meeting shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.

5.03 The Committee shall meet not less than 10 times in each financial year and dates will be set by the end of the previous financial year.

5.04 The Committee will set an annual plan for its work to form part of the Board's Annual Cycle of Business, and report to the Board on its progress.

5.05 In exceptional circumstances where delaying actions or decisions would have a negative impact on the Trust's business, certain items of business requiring an urgent decision, or the taking of the decision itself, may be conducted outside of formal meetings, in line with the requirements set out within the Trust standing orders. This will normally be agreed by the Committee in advance and executed by either: Chair's action, calling an extraordinary meeting or reaching consensus on a decision by e-mail. Any decisions are to be formally ratified the Committee and/or Board at the next meeting.

5.06 The Committee business may be transacted through virtual media (using either teleconference or other collaboration and meeting tools). At the start of each meeting which is taking place without all parties being physically present the Chair shall be responsible for determining that the quoracy arrangements has been achieved and that members can effectively contribute.

5.07 The Committee Chair, with the support of the Company Secretary, is responsible for taking appropriate actions to manage conflicts of interest (perceived and actual)

during a meeting. Members conflicted on any items of business on a committee meeting agenda shall declare their conflict and withdraw from discussions and/or the decision-making as required. Conflicted members are not to be counted for quorum.

5.08 The Company Secretary is responsible for preparing the agenda and collating and circulating papers to Committee Members. Papers should be provided not less than five calendar days before the meeting and the agenda and papers should be circulated not less five calendar days before the meeting, to provide sufficient time for due consideration.

5.09 Proceedings and decisions made will be formally recorded by the Company Secretary in the form of minutes and distributed to Committee Members within 10 working days of the meeting.

6.00 TERMS OF REFERENCE

6.01 The Committee shall review its own performance, constitution and terms of reference at least every two years to ensure it is operating at maximum effectiveness. Any proposed changes to the terms of reference should be agreed by the Trust Board.

6.02 It is the Company Secretary's responsibility to make the necessary updates to the terms of reference.

6.03 Approved by Committee April 2022

6.04 Next full review: by March 2025 (recognising that these have been reviewed at the end of the first year of operation of this Committee and will be subject to review during the annual review of Committee effectiveness)

Appendix - Mandated reports considered by the Committee

Below is a list of the mandated reports the Committee the Committee would receive over the year

- Annual Quality Report
- Annual Mental Health Act Compliance Report
- Adult Safeguarding Annual Report and Quarterly Reports
- Child Safeguarding Annual Report and Quarterly Reports
- Infection Prevention and Control Annual Report
- Learning from Deaths quarterly and annual report
- Annual Incident Report
- Duty of Candour Compliance Report
- External Reviews Report
- CQC Reports
- Annual Complaints Report
- Quality Dashboards, covering Maternity and Key Indicators (List)
- Dementia Strategy
- Children & Young People
- Resuscitation
- Palliative and End of Life Care
- Patient Survey Reports
- PLACE Reports
- Ombudsman Reports
- HealthWatch Reports
- Annual Patient Experience Report

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	19	**Meeting:**	Trust Board	**Meeting Date:**	August 2023
Report Title:	People Committee Chair's Report				
Sponsoring Executive Director:	Paul Layzell, Non-Executive Director				
Author(s):	Paul Layzell, Non-Executive Director				
Report previously considered by and date:					

Purpose of the report:			
Information	Yes	Assurance	Yes
Review and Discussion	N/A	Approval / Agreement	N/A

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

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	N/A	Link to Trust Annual Plan	N/A

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	N/A	
Sustainability	N/A	
People	Yes	People Risks 3.1 to 3.4
Quality	N/A	
Systems and Partnerships	N/A	
Research and Innovation	N/A	

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

Regulatory / Statutory reporting requirement

Communication and Consultation:

Executive Summary:

The People Committee met on the 24th May and 26th July 2023 and was quorate as it was attended by two Non-Executive Directors, as well as the Chief People Officer and the Chief Operating Officer. The Chief Nurse, Chief Executive and Chief Finance Officer had given apologies to the May and July meeting. In attendance were the Director of Human Resource Management; Director of Integrated Education; Director of Medical Education; Head of Equalities and Inclusion and the Company Secretary. The Associate Director of Leadership, Culture and Development gave apologies to the May meeting and was deputised but attended in July. The Guardian of Safe Working Hours joined the Committee in July to present this element.

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.

The key areas of focus at the Committee are listed below, noting the full breath of the meeting's activity is included in a table as an appendix to the paper.

True North, Staff Engagement

Reports to the Committee confirmed the Trust had remained above the national average for staff survey completion and noted the continued effort to further improve the response rate in the upcoming 2023 survey. Through detail publicised around the co-created responses to issues raised in the 2022 Survey and Pulse Survey, there was optimism of divisional colleagues able to report demonstrable responsiveness. There would be continued focus on local promotion of the 2023 survey, alongside corporate promotion.

At each meeting the Committee received an Integrated Education update that outlined practice development for clinical education offering healthcare support workers a clear pathway to qualified nurse roles with positive uptake of Trainee Nurse Associate roles and, Nurses and Allied Health Professionals having joined the preceptorship programme.

The Committee had a discussion about proactive talent management and ensuring the robust foundations of integrated education. The connection to Equality Diversity and Inclusion and support to retention of international medical personnel was acknowledged The Committee will seek to bring this matter back as a future item through which the Committee would seek assurance of suitable arrangements to give oversight of impact.

The Committee **NOTED** the creation of an education sub-group which would allow the Committee to focus on more strategic oversight.

The Committee received updates and continued to be **ASSURED** all divisions had their Pulse and Staff Survey results and heard they had shared these with their staff and had commenced action the action planning stage. The continued focus on appraisals had seen most Divisions raise this as a driver metric and with notable success a number of Divisions had since moved to a watch metric.

The Committee received a presentation from the Medicine Division (Worthing, Southlands & St Richards Hospital) that confirmed the considerable progress made against people scorecard measures. The Committee was **ASSURED** by the Divisional nursing structures in post that included the early adoption of new staffing models including trainee nurse associates. Fragility of medical structures were acknowledged and included vacancies in Clinical Director roles. The Committee heard about the emerging relationships between the Division and the new Hospital Leadership teams.

The Committee **NOTED** that participation from Trust medics in the GMC Survey had decreased and noted initial results consistent with national negative trends around reported wellbeing, burnout and feeling undervalued. The Committee heard there was consideration of extending the Doctors in Mind initiatives across the Trust

Breakthrough Objective, Staff Voice

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.

Around Staff Voice, the Committee heard Focus Groups had continued take 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 in response to concerns.

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 received the Freedom to Speak Up (FTSU) Guardian Annual Report and recorded it thanks to the Appointed Inclusion Governor who has provided this role pending the introduction from early August 2023 of a new procured Guardian Service and the Committee looks forward to receiving reports with the provider's insights.

Leadership, Culture and Development

The Committee heard about the continued progress on the measures of inclusion and performance in de-biasing the recruitment processes. The Committee noted the alignment of Trust plans to national actions. National guidance had been delayed and, after receipt in July 2023, was used to brief the Board and Governors through a workshop. It was noted that some tolerances for escalation have not yet been fully defined.

The Committee received updates on the status of network groups and while the diversity matters steering group was up and running, the group for minoritized ethnic staff had not met. Support had been given to the chair and work had taken place across steering groups to standardise the expectations of networks and their coordination. The Committee were **ASSURED** by the Chief People Officer that the cross-cutting nature of Equality, Diversity and Inclusion initiatives were launched in concert with other People Directorates including recruitment teams.

Guardian of Safe Working Reports

The Committee received reports from the Guardian of Safe Working Hours, a post that had been Trust-wide since April 2023. The Guardian of Safe Working advised how the Health Rota rollout had benefited junior doctors through aiding flexibility and giving early warning of pinch points and vulnerability.

The Committee remained **ASSURED** by the update from the Guardian of Safe working that 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 and were used for positive benefits including welcoming international medical recruits.

The Medical Workforce report provided a progress updated on the procurement and validation testing of Appraisal system, the rostering system and communications mechanisms. The Committee were **ASSURED** that the rollout of the new system remained on schedule for mid-September implementation and governance arrangements included steering groups and highlight reporting and had provided updates to the Audit Committee.

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. HR Business Partners are also directed to support Divisions in clearer articulation of risks, in particular whether staff shortage risks refer to increased activity

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 1 going in to Quarter 2 since although there had been progress

and three months of positive data, due to the challenge of multiple factors including industrial action the position was considered to be fragile.

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.

The Committee discussed a previous referral from the Charitable Funds Committee around the accountability and oversight of risks associated with the Volunteers function. The Committee received assurance from the Chief Governance Officer that oversight for risks in the Volunteers service is provided by himself and the Director of Charities. The Committee was informed by the Director of Workforce Services that existing controls for volunteer recruitment included DBS checks where appropriate but **agreed** that any volunteers risks should be brought to the People Committee.

Key Recommendation(s):

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

The Board is asked to **NOTE** 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 2.

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	**26 July 2023**	**Chair**	Paul Layzell	**Quorate**	Yes
Declarations of Interest	No declarations were raised				

Items received at the Committee meeting					
True North – Staff Survey Results	**May**	**Jul**	**Presenter** Director of Human Resources Mgt	**Purpose** For information	**Outcome /Action taken** Noted
Divisional Updates Medicine (WH/SRH)		**Jul**	**Presenter** Divisional Director of Operations Clinical Support	**Purpose** For information	**Outcome /Action taken** Noted
Reward & Recognition Core Plan	**May**	**Jul**	**Presenter** Chief People Officer	**Purpose** For approval	**Outcome /Action taken** Supported in principle (May) Endorsed at July meeting
Breakthrough Objective – Staff Voice that Counts	**May**	**Jul**	**Presenter** Director of Human Resources Mgt	**Purpose** For information	**Outcome /Action taken** Noted
Freedom to Speak Up Update	**May**	**Jul**	**Presenter** Chief People Officer	**Purpose** For information	**Outcome /Action taken** Noted
Strategic Initiative – Cost of Living Support	**May**	**Jul**	**Presenter** Chief People Officer	**Purpose** For approval	**Outcome /Action taken** Noted Approved Sanitary Product scheme for those in need
Integrated Education Update	**May**	**Jul**	**Presenter** Director of Integrated Education	**Purpose** For information	**Outcome /Action taken** Noted
Violence Prevention & Reduction Update;	**May**		**Presenter** Chief People Officer	**Purpose** For information	**Outcome /Action taken** Noted
Equalities Diversity & Inclusion Update	**May**	**Jul**	**Presenter** Chief People Officer	**Purpose** For information	**Outcome /Action taken** Noted
Medical Workforce Systems, Update	**May**	**Jul**	**Presenter** Director of Workforce Planning	**Purpose** For information	**Outcome /Action taken** Noted
People Scorecard and KPI Report	**May**	**Jul**	**Presenter** Director of Workforce Planning Director of Human Resources Mgt	**Purpose** For information	**Outcome /Action taken** Noted

Workforce Plan		**Jul**	**Presenter** Director of Workforce Planning	**Purpose** For information	**Outcome /Action taken** Noted
Guardian for Safe Working Q1 Reports		**Jul**	**Presenter** Guardian of Safe Working	**Purpose** For assurance & approval	**Outcome /Action taken** Noted & Approved
Nursing & Midwifery Workforce Workstream Highlight Report		**Jul**	**Presenter** Deputy Chief Nurse (Workforce)	**Purpose** For information	**Outcome /Action taken** Noted
Employee Relations Update		**Jul**	**Presenter** Chief People Officer	**Purpose** For information	**Outcome /Action taken** Noted
Updates from Reporting Groups - Diversity Matters Steering Group - Health & Wellbeing Steering Group - Joint Negotiation & Consultation Committee		**Jul**	**Presenter** AD Leadership, OD & Engagement, Chief People Officer	**Purpose** For information	**Outcome /Action taken** Noted
Annual Workforce Equality Data Report	**May**		**Presenter** AD Leadership, OD & Engagement	**Purpose** For information	**Outcome /Action taken** Noted
Annual Equality Report including: - Gender Pay Gap - Workforce Race Equality Standard (WRES) Annual Report - Workforce Disability Equality Standard (WDES) Annual Report		**Jul**	**Presenter** AD Leadership, OD & Engagement	**Purpose** For approval	**Outcome /Action taken** Recommended for Approval and Publication
Sickness Absence Deep Dive	**May**		**Presenter** Director of Human Resources Mgt	**Purpose** For information	**Outcome /Action taken** Noted
Updates on Integrated Care System		**Jul**	**Presenter** Chief People Officer	**Purpose** For information	**Outcome /Action taken** Noted
Risk Report		**Jul**	**Presenter** Interim Chief Nurse / Company Secretary,	**Purpose** For information	**Outcome /Action taken** Noted
Board Assurance Framework		**Jul**	**Presenter** Company Secretary	**Purpose** For agreement	**Outcome /Action taken** 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 3.1 to 3.4 to the Board for the start of quarter 2 2023/24.
Items to come back to Committee / Group (Items Committee / Group keeping an eye on)
There are no identified items to come back to committee outside the scheduled cycle of business

Items referred to the Board or another Committee for decision or action	
Item	**Date**
None	

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	19.1	**Meeting:**	Trust Board	**Meeting Date:**	03 August 2023
Report Title:	Annual Equality Report 2022/23				
Sponsoring Executive Director:	Chief People Officer				
Author(s):	Head of Equality and Inclusion				
Report previously considered by and date:	People Committee meeting 26 July 2023				

Purpose of the report:			
Information	N/A	Assurance	Yes
Review and Discussion	N/A	Approval / Agreement	Yes

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

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	Yes	Link to Trust Annual Plan	Yes

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	Yes	
Sustainability	N/A	
People	Yes	Equalities & Inclusion forms part of the LCD (Leadership, Culture & Development) Strategic Initiative. There is a strong evidence base linking Equalities & Inclusion with the range of Patient First strategic themes. Staff Engagement (People True North) and 'Voice that counts' (People Breakthrough Objective).
Quality	Yes	
Systems and Partnerships	N/A	
Research and Innovation	N/A	

Link to CQC Domains:			
Safe	N/A	Effective	N/A
Caring	N/A	Responsive	N/A
Well-led	Yes	Use of Resources	N/A

Regulatory / Statutory reporting requirement

This report aims for compliance with the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 (inclusive of the Gender Pay Gap reporting duty). It is also our Workforce Race Equality Standards (WRES) report, including our Medical WRES and Bank WRES reports, and our Workforce Disability Equality Standard (WDES) report as required under the standard NHS contract.

Communication and Consultation:

Board seminar. Discussion with staff network chairs and staff side representatives.

Executive Summary:

This Annual Equality Report 2022/23 is for assurance about where we and where we need to go next towards advancing equality of opportunity at work. It supports our 'Voice that counts' Trust People Breakthrough Objective.

Each of its seven sections includes key findings about equality for our diverse workforce population groups, and recommendations to inform our equality, diversity, and inclusion actions for 2023-24. In summary, to:

- Improve inclusive recruitment and selection policies and processes.
- Strengthen senior leadership accountability for equality performance.
- Develop senior leader sponsorship of staff networks.
- Analyse pay gap data to take better targeted policy actions.

• Improve identification and delivery of reasonable adjustments for staff.
Key Recommendation(s):
Approve the document for publication

University Hospitals Sussex
NHS Foundation Trust

Annual Equality Report

If you would like this report in another format (e.g., large print) please contact uhsussex.equality@nhs.net

Contents

Introduction

Welcome to our Annual Equality Report 2022-23

This report demonstrates our strengths and where we need to continue working towards equality in our mission *where better never stops*, and to deliver our Patient First approach at University Hospitals Sussex NHS Foundation Trust.

Our new equality, diversity, and inclusion (EDI) programme supports the delivery of 'Our People' vision to be a *great place to work* and our breakthrough objective that *staff voices count*.

The report includes seven sections, the first six are: race, gender (inclusive of pregnancy and maternity, sex, and gender identity), disability, sexual orientation, religion and belief, and age equality within employment.

- Each section begins with key findings including measures of equality, in particular representation, recruitment, and engagement.
- There are then measures of our work to eliminate discrimination, including harassment.
- Each section ends with key recommendations for the organisation to address the findings over the forthcoming year.

The seventh section takes a different format and covers our Armed Forces Community's key achievements over 2022-23.

Compliance

This report complies with our specific duty to publish information about the performance of our general duty to advance equality (Equality Act 2010), including our duty to publish gender pay gap information (on page 21). It also meets our contractual obligations relating to publishing information about the workforce race equality standard (WRES; on page 2), including the Bank WRES and the Medical WRES, and the workforce disability equality standard (WDES; on page 23).

Privacy

The report does not publish counts of fewer than five staff where someone might be identifiable, to preserve privacy, except where publication is a regulatory or a contractual requirement. Equality in employment is based on data from electronic staff records (ESR), employee relations case-trackers, the NHS Staff Survey and the Trust's recruitment management system, TRAC.

Definitions and scope

Please note that references to very senior managers (VSM) are not based on pay scales and instead follow definitions laid down in equality reporting guidance from NHS England. Please also note that Associate Non-Executive Directors (NEDs) are included in Board counts, but not workforce counts.

Employees with an element of substantive work in their contract are counted, except where bank workers are specifically indicated, in which case staff who work solely on the bank are counted.

Contractors, or staff on honorary contracts, or secondees, or shared appointees, or volunteers are excluded from this report.

Race

KEY RACE FINDINGS

Ethnicity workforce representation (WRES 1)

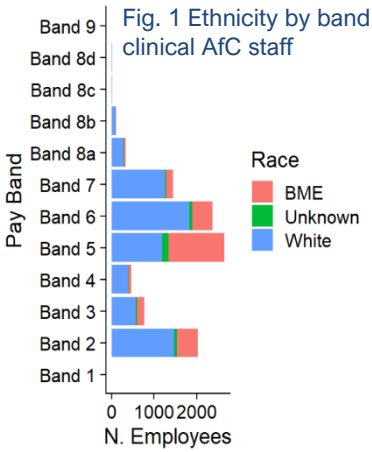
1.1. The number (n.) of people from minoritised ethnic groups in the workforce on 31 March 2023 was 4,205, or 24% of the permanent workforce overall (n. 17,461) compared to nine percent of the resident population in Sussex at the last census (2023, ONS).

1.2. Minoritised ethnic staff are 2.7 times more likely to be working both substantively and on the Trust's staff bank in clinical agenda for change (AfC) roles than white staff overall, compared to the substantive-only workforce and when compared to the bank-only workforce (Bank WRES 1).

Clinical Agenda for Change Staff

- 47.8% of minoritised ethnic people (n. 1,296) in the clinical Agenda for Change (AfC) workforce (n. 10,114) were at pay band 5.
- White staff were 4.8 times as likely to be in senior clinical roles (AfC bands 8+) than minoritised ethnic staff, compared to their representation in support or newly qualified roles (AfC bands 1-5).
- White staff were 2.8 times more likely to be in specialist or advanced clinical roles (AfC bands 6-7) than minoritised ethnic staff, compared to their representation in support or newly qualified roles.

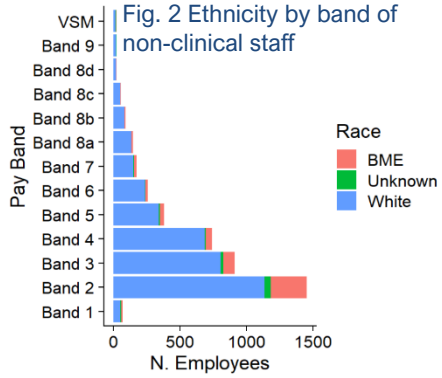
Fig. 1 Ethnicity by band of clinical AfC staff



Non-Clinical Staff

- The majority (52.5%) of minoritised ethnic people (n. 272) in the non-clinical workforce (n. 4,351) were in pay band 2.
- White staff were 1.9 times more likely to be non-clinical senior managers (AfC bands 8+) than minoritised ethnic staff, compared to support and entry level roles (AfC bands 1-5).
- White staff were 1.5 times as likely to be junior managers (AfC bands 6-7) than minoritised ethnic staff, compared to support and entry level roles.

Fig. 2 Ethnicity by band of non-clinical staff

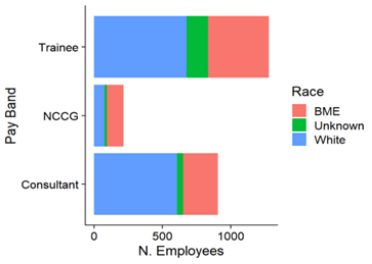


Medical and Dental (M&D) Staff

1.3. There were 2,885 staff in medical and dental roles. 62.6% of minoritised ethnic doctors and dentists were in trainee grades (n. 612).

1.4. White staff were 0.7 times less likely than minoritised ethnic staff to be in non-consultant career grades (NCCG) than in trainee M&D grades. White staff were 2.9 times as likely to be consultants than minoritised ethnic staff compared to their proportions at NCCG, and twice as likely when compared to their proportions in trainee grades.

Fig. 3 Ethnicity by medical / dental group

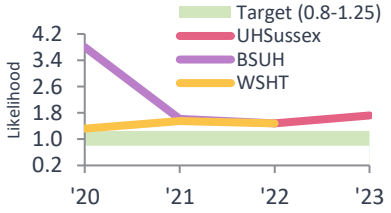


1.5. Eligible white doctors and dentists were just as likely to have a Clinical Excellence Award (CEA) as minoritised ethnic staff (MWRES 2).

Ethnicity shortlisting-to-appointment relative likelihood (WRES 2)

1.6. UHSussex appointed 234 minoritised ethnic people and 917 white people across the year. White people were 1.7 times more likely to be appointed from short-listing than minoritised ethnic people.

Fig. 4 Ethnicity shortlisting-to-appointment relative likelihood



1.7. White doctors and dentists were 3.3 times as likely to be appointed than minoritised ethnic doctors and dentists (MWRES 3) overall. White doctors and dentists were 4.6 times as likely to be appointed than doctors in the ethnicity 'not known' group.

Non-mandatory training by ethnicity (WRES 4)

1.8. White people (n. 7,277) were as likely (0.93 times) to access non-mandatory training as staff from minoritised ethnic groups (n. 2,596) in 2022-23.

Formal disciplinary likelihood by ethnicity (WRES 3)

1.9. Seven people from minoritised ethnic groups were formally disciplined, that is 0.8 times less likely than it was for the 26 white people formally disciplined, when compared to the overall workforce. This is down (improved) from last year's score (1.7 times).

Non-mandatory training by ethnicity (WRES 4)

1.10. White people (n. 7,277) were as likely (0.93 times) to access non-mandatory training as staff from minoritised ethnic groups (n. 2,596).

Bullying from patients or public by ethnicity (WRES 5)

1.11. 38% of minoritised ethnic staff experienced harassment, bullying or abuse from patients, relatives, or the public in 2022; one point higher (worse) than in 2021. 32% of white staff in the Trust also reported this in the NHS staff survey 2022, with the percentage point (pp) gap between these static over time.

Bullying from colleagues by ethnicity (WRES 6)

1.12. 28% of minoritised ethnic staff reported experience of harassment, bullying or abuse from managers or other colleagues in 2022; one point lower (improved) than in 2021. 25% of white staff in the Trust also reported this in the NHS staff survey 2022, with the gap decreasing by half a point.

Equality of opportunity for career progression or promotion (WRES 7)

1.13. 49.6% of minoritised ethnic staff and 54.3% of white staff reported equal opportunities for career progression or promotion. This is three points higher (better) than in 2021 for ethnic minoritised staff (46.2%), and one point lower (worse) for white staff (55.1%). The gap with white staff (54%) was four points in 2022, smaller than the nine-point gap in 2021.

Discrimination from manager or colleague (WRES 8)

1.14. 16% of minoritised ethnic staff experienced discrimination at work from their manager, team leader or colleagues, 1.2 points higher (worse) than in 2021. This was eight points greater than for white staff and one point lower (better) than the acute trust benchmark.

Fig. 5 Board ethnicity representation

Board ethnicity composition (WRES 9)

1.15. One board member (5%); in a non-voting, non-executive role, shared they were in an under-represented minority ethnic group, compared to 24% in the workforce and 9% in the Sussex resident minoritised ethnic population. No voting or executive members shared they were from an under-represented ethnic group. Five members (26%) did not specify an ethnicity on their staff record, compared to 5% in the overall workforce.

Race equality recommendations

R1. Introduce new inclusion and equality interventions targeted at our consultant level, senior management (AfC 8+), and very senior management (VSM) recruitment processes.
R2. Embed shortlisting-to-appointment relative likelihood by ethnic group metric within SDRs (Strategy Deployment Reviews) for our senior leadership.
R3. Agree senior sponsorship of our SOAR Network (SOAR stands for Safe space; Opportunity, equity, and empowerment; Amplify voices; Re-dress the balance) for minoritised ethnic staff.
R4. Improve the handling of racist incidents, complaints, concerns, and grievances.

Gender

KEY GENDER FINDINGS

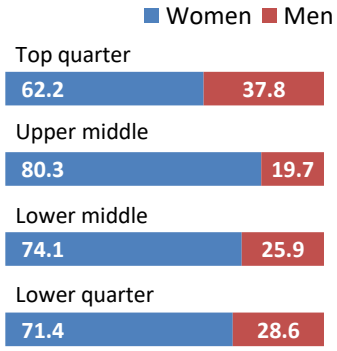
Gender workforce representation

2.1. Out of 17,461 staff, 72% (n. 12,492) were recorded as female and 28% (n. 4,969) as male on their staff record.

2.2. The national Electronic Staff Records (ESR) system only records binary sex. 0.5% of the 7,342 people who answered the gender question on the 2022 national staff survey identified as either non-binary or preferred to self-describe, about double their respective national survey averages.

2.3. Male staff (n. 1,550) were 2.5 times more likely represented in the top pay quartile (Q4) than female staff (n. 2,555), relative to the males (n. 810) and females (n. 3,298) in the middle-upper pay quartile (Q3).

Fig. 6 % sex in each pay quartile

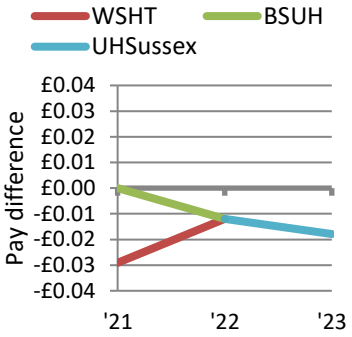


Gender pay gap

Hourly wages pay gap

- Women earned ninety-eight pence for every £1 men earned when comparing median hourly wages.
- Accounting for outliers, the two pence gap between men and women in hourly earnings; at the midpoint of the pay distribution, is one penny less (worse) than in 2022.
- Comparing mean hourly wages, women earned eighty-three pence for every £1 men earned, one penny more (better) than in 2022.

Fig. 7 Female's hourly median pay difference from males.



Gender bonus gap

- 249 staff received a bonus payment in 2023, inclusive of eighty-three women and 166 men.
- Women earned thirty-three pence for every £1 that men earned in median bonus pay, four pence less (worse) than in 2022.
- When comparing mean bonus pay, women earned fifty-three pence for every £1 men earned, one penny less (worse) than in 2022.
- Women are less likely to receive bonuses, and those bonuses they get are more likely to be of lesser value.

Flexible working opportunities

2.4. 53.1% of respondents were satisfied or very satisfied in the national staff survey 2022 with their opportunities for flexible working, varying to 49% of males, and 54% of females. Parents of children 0-17 years were at 61% compared to 48% for those who were not.

2.5. Doctors and dentists in training had the lowest satisfaction with flexible working opportunities (33%) of any occupational group, followed by operating department practitioners (35.9%) and pharmacists (36%).

Fig. 8 Female's hourly median bonus pay difference from males.

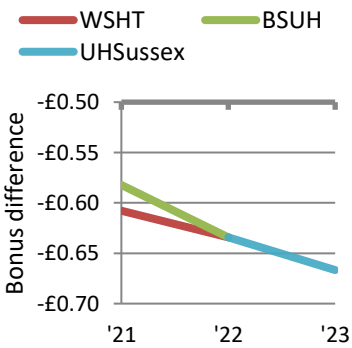
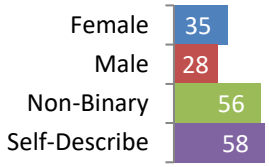


Fig. 9 Patient / public-on-staff harassment by gender (%)



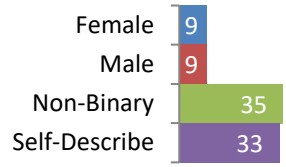
Harassment, bullying or abuse from patients by gender

2.6. There were 32.1% of our staff reporting in the national staff survey experience of harassment, bullying, or abuse from patients, relatives, or members of the public.

2.7. There was a six-point difference between the proportion of females (34.5%) reporting it over males (28.2%).

2.8. There were also 55.6% of non-binary staff who reported it, which is 23.5 points higher than the organisational average for all staff.

Fig. 10 Discrimination from managers, or colleagues (%)



Discrimination from managers, team leader, or colleagues

2.9. There were 9.4% of our staff reporting in the national staff survey experience of discrimination from managers, team leaders, or colleagues in the preceding 12-month period.

2.10. There was no significant difference between the proportion of females (9.2%) reporting it than males (9.2%).

2.11. 23.1% of staff reported experiencing gender discrimination in 2022, no different from 2021, and three points higher than the 20.3% reported in the acute benchmark group.

Board gender composition

2.12. There was eight females (42%) and eleven males (58%) on the board. Two females and five males were executives, whilst the non-executives were gender-balanced at six females and six males. Six females (37.5%) and 10 males (62.5%) had voting rights.

Gender equality recommendations

G1. Analyse and understand our gender pay data within directorates or divisions, and by ethnicity and other protected characteristics, and by occupational group, including for doctors and dentists.

G2. Understand our pay gaps by grade of doctor, and by agenda for change pay band for other staff.

G3. Analyse future gender pay gap data by comparison with gender breakdowns of recruitment, staff survey, and staff development data.

G4. Set up a workplace gender equality project group to deliver plans to address the gaps.

G5. Engage with women, trans and non-binary staff in the development of resources for managers to tackle sex, sexual, and gender-based harassment, bullying, or abuse.

Disability

KEY DISABILITY FINDINGS

Disability workforce representation (WDES 1)

3.1. There were 905 disabled people in the workforce, or 5.2% of the substantive workforce overall (n. 17,461) compared to 18.3 percent of the resident population in Sussex at the last census (2023, ONS). 17.2% of the workforce (n. 2,995) did not share a disability status on their staff record.

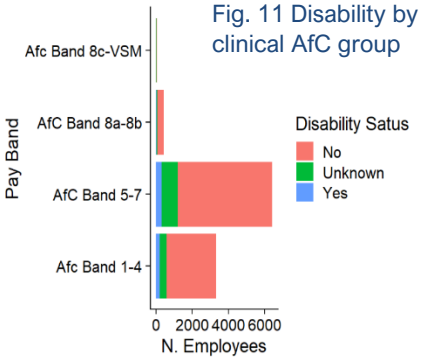
Clinical Agenda for Change Staff

3.2. There were 10,218 clinical staff on agenda for change (AfC) terms and conditions.

In clinical AfC band 5-7 roles overall, non-disabled staff (n. 5,246) were 1.3 times more likely represented than disabled staff (n. 296), relative to band 1-4 roles.

3.3. For all other clinical AfC band groups, staff who were recorded as disabled were more likely to be represented in more senior grades than non-disabled people.

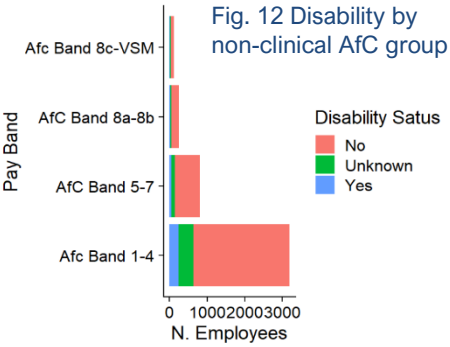
Fig. 11 Disability by clinical AfC group



Non-Clinical Staff

- There were 4,462 non-clinical staff on agenda for change terms and conditions.
- The majority (77.7%) of disabled people (n. 254) in the non-clinical workforce were in bands 1-4.
- Non-disabled staff (n. 671) were 1.4 times more likely in clinical AfC band 5-7 roles than disabled staff (n. 44), relative to their proportions in band 1-4 roles.

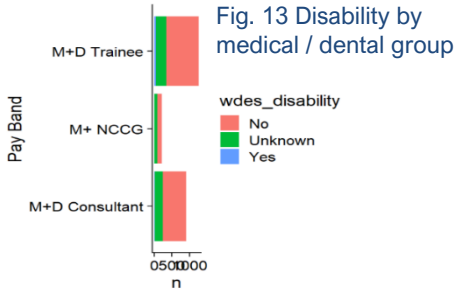
Fig. 12 Disability by non-clinical AfC group



Medical and Dental (M&D) Staff

There were 2,885 staff in medical and dental roles. 71.2% of disabled doctors and dentists (n. 47) were in trainee grades. Non-disabled staff were 2.2 times more likely to be a consultant than disabled staff, relative to their sizes within non-consultant career grades (NCCG). Non-disabled consultants were twice as likely represented than disabled consultants relative to trainees. 37% of all doctors and dentists' disability status is unknown affecting the accuracy of workforce representation and progression.

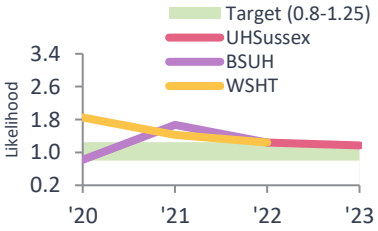
Fig. 13 Disability by medical / dental group



Disability shortlisting-to-appointment relative likelihood (WDES 2)

3.4. UHSussex appointed 95 disabled people and 1,046 non-disabled people in 2022-23. The Trust was just (1.17 times) as likely to appoint non-disabled people from short-listing as disabled people, within the upper limit of the equality range (0.8-1.25), which suggests further adjustments may be needed to remove barriers within recruitment.

Fig. 14 Disability shortlisting-to-appointment relative likelihood



Formal capability likelihood by disability (WDES 3)

3.5. Zero disabled people entered a formal capability process this year (the same as last year), compared to four non-disabled people and two who did not declare or define a disability status.

Fig. 15 Patient / public-on-staff harassment by disability status

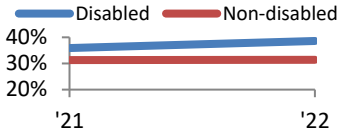


Fig. 16 Equal opps. for promotion

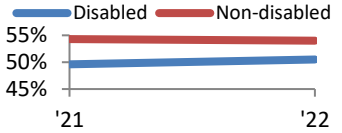
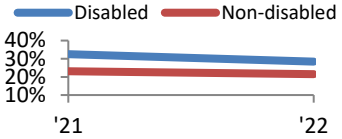


Fig. 17 Pressure to work unwell



Harassment, bullying, or abuse by disability status (WDES 4)

3.6. 38.6% of disabled staff experienced harassment, bullying, or abuse from patients, relatives, or members of the public, compared to 31.4% of non-disabled staff; a gap of 7.2 points. The rate for non-disabled staff was the same as in 2021, the rate for disabled staff increased by three-points.

3.7. 18.1% of disabled staff experienced harassment, bullying, or abuse from managers; and 28.8% from other colleagues. Rates for disabled and non-disabled groups remained largely unchanged year-on-year.

Disability and equal opportunities for promotion (WDES 5)

3.8. 51% of disabled staff felt the Trust provided equal opportunities for career progression and promotion, compared to 54% of non-disabled staff. Staff were less likely to report this than nationally, regardless of disability status.

Pressure to work from manager when unwell (WDES 6)

3.9. Disabled staff (28.4%) were 6.9 points more likely to report having felt management pressure to come to work when not feeling well enough compared to non-disabled staff (21.5%). Scores for both groups were close to the national benchmarks, and both fell on last year's scores.

Staff satisfaction that Trust values their work (WDES 7)

3.10. There were 28.6% of disabled staff who felt the Trust valued their work, compared to 36.9% of non-disabled staff. Regardless of disability status, staff were less likely to feel satisfied the organisation values their work.

Adequate adjustments for disabled people (WDES 8)

3.11. Disabled staff (73.4%) were slightly more likely than the national acute benchmark (71.8%) to report having adequate workplace adjustments.

Disabled staff engagement (WDES 9)

3.12. The staff engagement score was lower compared to the benchmark scores regardless of disability status. Disabled staff had a slightly lower score than non-disabled staff at UHSussex.

Board disability composition (WDES 10)

3.13. None of the nineteen board members shared a disability on their staff record. Seven members reported an "unknown" disability status (37%) an overrepresentation of 22 points relative to its size in the overall workforce.

Disability equality recommendations

D1. Embed completion of inclusion health passports for all staff within workforce information systems and develop a suitable leading key performance indicator(s) for future reporting.

D2. Agree a funding model for staff reasonable adjustments and develop budget processes.

D3. Agree senior sponsorship of our Disabled Staff Network.

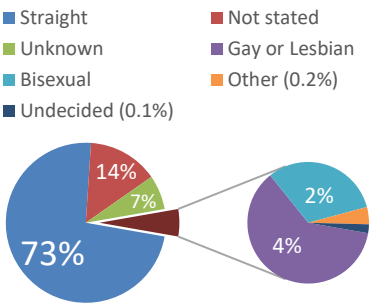
D4. Introduce new guidance on reasonable adjustments within recruitment and selection for recruiters and for applicants.

Sexual orientation

KEY SEXUAL ORIENTATION FINDINGS

Sexual orientation workforce representation

Fig. 18 Workforce by sexual orientation



4.1. Six percent (n. 982 people) of the substantive workforce identify as either lesbian, gay, bisexual, or another sexual orientation, or as undecided (LGB+) on their staff record. Seven percent of workers who solely work on the staff bank identify as LGB+.

Non-Clinical Staff

- Five percent (n. 246) of the non-clinical workforce identify as LGB+.
- Straight people were 1.5 times more likely to be in pay cluster 8a-8b than LGB+ people, compared to pay cluster 5-7.
- Straight staff were under half (0.41 times) as likely to be in senior non-clinical roles (AfC bands 8C-VSM) than gay or lesbian staff, compared to their representation in AfC bands 1-4.

Clinical Agenda for Change Staff

- Six percent (n. 628) of the clinical AfC workforce identify as LGB+
- Straight people were just as likely to be represented in clinical roles as LGB+ people compared between different pay clusters, any differences being within confidence levels (0.8-1.25 times).

Medical and Dental (M&D) Staff

- Six percent (n. 108) of the medical and dental workforce identify as LGB+
- Straight doctors and dentists are 1.5 times more likely to be in non-consultant career grades than LGB+ doctors and dentists, relative to their sizes in medical and dental trainee grades.

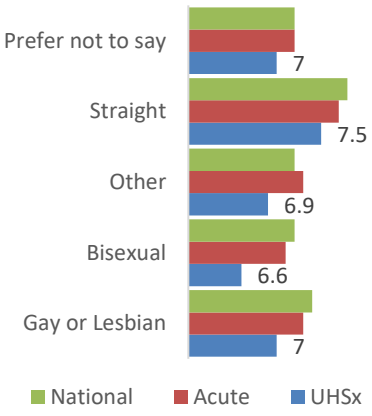
Sexual orientation shortlisting-to-appointment relative likelihood

4.2. UHSussex appointed 121 LGB people and 956 straight people in 2022-23:

- Straight people were 0.84 times more likely to be appointed from short-listing than people from LGB groups.
- When disaggregated, bisexual people were just as likely (1.0 times) to be appointed as straight people.
- Straight people were 0.6 times as likely to be appointed as people who identified as 'Other'.

Negative experiences by sexual orientation

Fig. 19 Negative experiences score (sexual orientation)

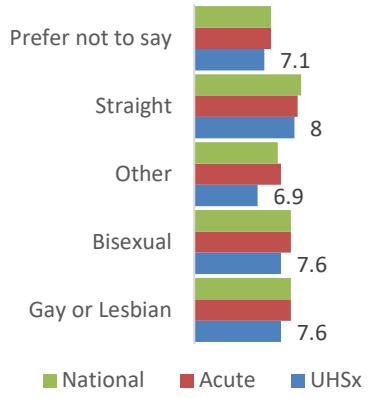


4.3. The average 'negative experiences' score for all respondents to the national staff survey was 7.4 out of 10.

4.4. Lesbian, gay, bisexual and staff who identified their sexual orientation as 'other', reported lower (worse) scores (6.9) than heterosexual or straight staff (7.5) in the Trust.

4.5. The Trust negative experience scores for staff of all sexual orientations, except 'other', were lower (worse) than the acute benchmark and the national average amongst those same groups.

Fig. 20 Diversity and equality score (sexual orientation)



Sexual orientation diversity and equality score

4.6. The average diversity and equality score for all respondents to the national staff survey was 7.9 out of 10, slightly lower than the acute benchmark average of 8.1 out of 10.

4.7. Staff of all minority sexual orientations responding to the staff survey questions on diversity and equality scored lower than the Trust average, and lower than for straight respondents at 8 out of 10.

4.8. The 60 respondents identifying in the 'other' (i.e., other than LGB, straight, or prefer not to say) group on average scored lower than any different sexual orientation, and lower than the benchmark average and lower than the national average for that group, at 6.9 out of 10.

Board sexual orientation composition

4.9. Thirty-seven percent of the board had an unknown sexual orientation on their staff record, compared to 21% unknown in the overall workforce. Fifty percent of non-executive directors did not share their sexual orientation. Forty-four percent of voting members did not share.

Sexual orientation equality recommendations

SO1. Agree senior sponsorship of our LGBTQIA+ staff network.

SO2. Engage with LGBQIA+ staff in the development of resources for managers to tackle sexual orientation biased harassment, bullying, or abuse.

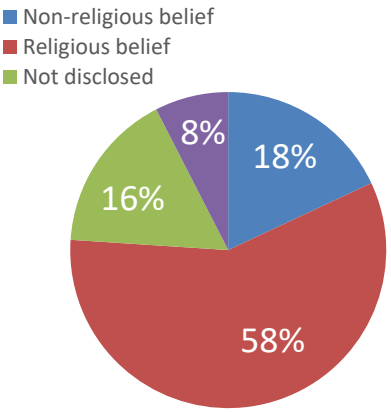
SO3. Publicise more profiles and stories of LGBTQIA+ staff members' lived experiences in clinical specialist or advanced clinical roles, junior manager roles, and medical and dental roles.

Religion and belief

KEY RELIGION AND BELIEF FINDINGS

Workforce religion and belief representation

Fig. 21 Workforce by belief group



5.1. The number of people sharing their religion or belief with us on 31 March 2023 was 13,553, or 76% of the workforce. Staff in agenda for change (AfC) pay band 5 had the largest proportion of any grade identifying as religious at 70% (n. 2,124), compared to 58% in the workforce overall.

5.2. Christianity was the largest belief group at 41% (n. 7,332), followed by the non-religious group at 18% (n. 3,216). Eleven percent (n. 1,971) of staff shared their religion or belief as 'Other' on their staff record, compared to 1.8% on the staff survey 2022.

Non-Clinical Staff

- Fifty-nine percent (n. 2,675) of the non-clinical workforce identify as religious, and 17.6% (n. 797) identify with atheism on their staff record.
- Atheists were 1.9 times more likely to be in pay cluster 5-7 than religious people, compared to their representation within pay cluster 1-4.
- Atheists were 2.5 times more likely to be in pay cluster 8c-VSM than religious people, compared to their representation within pay cluster 1-4.
- Atheist staff were just as likely to be represented as religious staff in non-clinical roles compared between middle pay clusters 5-7 and 8a-8b, any differences being within confidence intervals (0.8-1.25 times).

Clinical Agenda for Change Staff

- Sixty-two percent (n. 6,366) of the non-clinical workforce identify as religious, and nineteen percent (n. 1,902) identify with atheism on their staff record.
- Atheists were 1.6 times more likely to be in pay cluster 8c-VSM than religious people, compared to their representation within pay cluster 1-4

Medical and Dental (M&D) Staff

- Forty-two percent (n. 1,294) of the medical and dental workforce identify as religious, and seventeen percent (n. 517) identify with atheism.
- Atheist doctors and dentists were about a third (0.34 times) as likely to be in non-consultant career grades as doctors and dentists with religious beliefs, compared to trainee grades.
- Atheist doctors and dentists were nearly twice (1.94 times) as likely to be consultants as doctors and dentists with religious beliefs, compared to trainee grades.

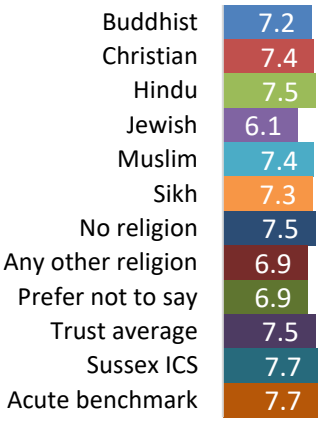
Religion and belief shortlisting-to-appointment relative likelihood

5.3. UHSussex appointed 666 people with religious beliefs and 355 people with atheist beliefs in 2022-23:

- Religious people were 0.7 times less likely to be appointed from shortlisting than atheist people.
- Atheists were 3.8 times more likely to be appointed than Hindus, 3.4 times more likely than Jews, 2.5 times more likely than Muslims, 1.7 times more likely Buddhists, and 1.4 times more likely than Christians.

Negative experiences by religion and belief

Fig. 22 Negative experiences score (religion and belief group)



5.4. Staff responses to nine questions from the national staff survey 2022 are aggregated to give a score for negative experiences. These relate to personal experience of harassment, bullying or abuse, physical violence, and of health and wellbeing. The higher the score the better.

5.5. The Trust average score for all staff was 7.5 out of 10, slightly less than the acute provider benchmark, and higher than the 7.7 score for all staff in the Sussex Integrated Care System (ICS).

5.6. The belief group with the lowest Trust score was Jewish at 6.5 out of 10, lower than the Sussex ICS average at 7.0 out of 10, and lower than the 7.7 out of 10 in the acute benchmark for Jewish staff.

5.7. Hindu staff (7.5) and staff with no religion (7.5) were the only belief groups to score the same as the Trust average. All groups score lower than those groups' respective Sussex ICS scores and their acute provider benchmark scores.

Religion and belief diversity and equality score

Fig. 23 Diversity and equality score (religion and belief group)

5.8. Responses to four questions taken from the national staff survey 2022 are aggregated to give an overall score for diversity and equality. These relate to equal opportunities in career progression, discrimination at work and respect for individual difference.

5.9. The Trust average score for all staff was 7.9 out of 10, lower than the acute provider benchmark (8.1), and lower than the Sussex ICS average (8.1).

5.10. Staff with no religion (8.1), were the only belief group that scored higher than the Trust average score (7.9). This is lower than the staff with no religion score in the acute provider benchmark (8.3) and the no religion score in the Sussex ICS (8.3).

Board religion and belief composition

5.11. Forty-two percent of the board had an unknown religion or belief on their staff record, compared to 24% unknown in the overall workforce. Fifty-eight percent of non-executive directors did not share their religion or belief. Forty-four percent of voting members did not share.

RELIGION AND BELIEF EQUALITY RECOMMENDATIONS

RB1. Introduce new inclusion and equality policy interventions targeted at our consultant level, senior management (AfC 8+), and very senior management (VSM) recruitment processes.

RB2. Engage with religious staff in the development of resources for managers to tackle religious harassment, bullying, or abuse.

RB3. Improve the handling of religious discrimination incidents, complaints, concerns, and grievances.

RB4. Publicise more profiles and stories of religious staff members' lived experiences in non-clinical roles, and in senior clinical AfC leadership roles, and in consultant roles.

Age

KEY AGE EQUALITY FINDINGS

Workforce age representation

6.1. The non-clinical workforce is an older demographic than the clinical AfC workforce. Twenty-five percent of the clinical workforce is 51 years or over, compared to forty-six percent in the non-clinical workforce, and eighteen percent in the medical and dental workforce.

Non-Clinical Staff

- The largest age band at 14.8% of the non-clinical workforce is the 51–55-year-olds (n. 660).
- 4.4% of the non-clinical workforce (n. 195) is 25 years or younger.
- 4.2% of the non-clinical workforce (n. 189) is 66 years or older.

Clinical Agenda for Change Staff

- The largest age band at 17.6% of the clinical workforce is the 31-35-year-olds (n. 1,776).
- 7.9% of the clinical workforce (n. 801) is 25 years or younger.
- 1.3% of the clinical workforce (n. 129) is 66 years or older.

Medical and Dental (M&D) Staff

- The largest age band at 20.1% of the medical and dental workforce is the 31–35-year-olds (n. 581).
- The single grade with the most staff in the 31-35 years age band (n. 115) is Senior House Officer (MSHO), although there are 417 people in all specialty registrar training grades in that age band.
- 4.5% of the M&D workforce (n. 129) is 21-25 years.
- 1.2% of the substantive M&D workforce (n. 35) is 66 years or older.

Fig. 24 AfC Workforce by age band

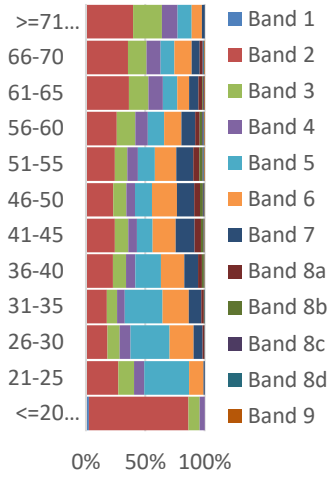
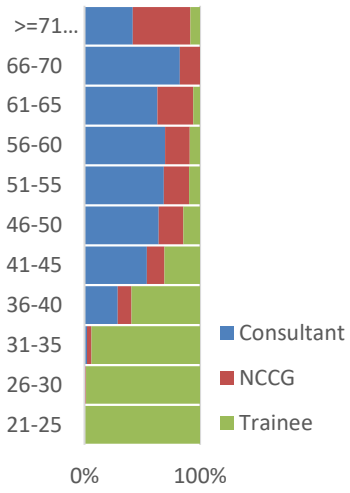


Fig. 25 M&D Workforce by age band



Age shortlisting-to-appointment relative likelihood

6.2. The relative likelihoods for each age band being appointed from shortlisting, compared to the average, are within the recommended confidence intervals (0.8-1.25) except for the under 20-year-olds and the over 65-year-olds.

- On average, all people were 1.5 times more likely to be appointed from shortlisting than people in the under 20 years age band.
- On average, all people were 1.6 times more likely to be appointed from shortlisting than people in the 65 and over years age band.

Negative experiences by age

6.3. The average composite score for negative experiences from responses to the staff survey 2022 for all staff was 7.5 out of 10. Higher scores are desirable on this measure.

6.4. The age group with the lowest score was the 21–30-year-olds (7.1), followed by the 31–40-year-olds (7.2). Staff 51 years and older were less likely to report experiencing negative behaviours than the average overall.

Fig. 26 Negative experiences score by age band

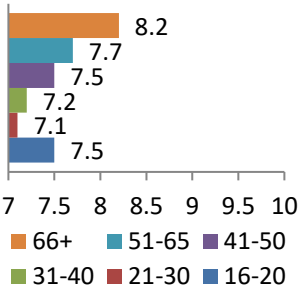
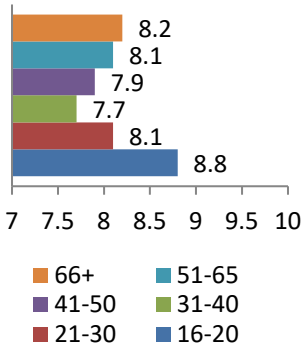


Fig. 27 Diversity and equality score by age band



Age diversity and equality score

6.5. The staff survey aggregates four questions taken from the staff survey 2022 to create a composite score for diversity and equality.

6.6. The Trust average score for all staff was 7.9 out of 10, lower than the acute provider benchmark (8.1), and lower than the Sussex ICS average (8.1).

6.7. The only age band lower than the Trust average score was the 31–40-year-olds. Most age bands were the same as or higher than the acute provider benchmark and the Sussex ICS average scores, except staff aged 31-50 years.

Board age composition

6.8. Eighty-four percent of the board was 51 years or older, compared to twenty-nine percent in the overall workforce. No board member was in an age bracket younger than 31-35 years, at the 31 March 2023. 86% of executive directors and 83% of non-executives were 51 years or older. Eighty-eight percent of members with voting rights were 51 years or older.

AGE EQUALITY RECOMMENDATIONS

A1. Develop an improvement plan to address health inequalities within the workforce, including targeting by age.

Armed Forces Community

KEY ARMED FORCES ACHIEVEMENTS

7.1. Our Armed Forces Community had a busy year packed supporting serving personnel, veterans, and their families – including within our workforce:

- The Veteran Aware accreditation was submitted in November 2022 and the feedback was that the submission was **"exemplary"**
- UHSx is one of the few Trusts in the country to have a Chavasse Clinic, a Trauma and Orthopaedic Clinic specifically for Armed Forces patients provided by Lt Col Ben Caesar.
- In June 2022, Lt Col Ben Caesar presented at the Grand Rounds – *"UHSx NHS Foundation Trust is Veteran Aware, but are you? (The Chavasse Clinic is just one piece of the puzzle)"*
- A presentation of UHSussex Armed Forces Community achievements was shown at the NHS Veteran Covenant Healthcare Alliance - Best Practice Symposium, in August.
- In September, Prof Mansoor Kahn presented at the Grand Rounds *"Medical Advances during Times of Conflict"*
- Members of the team visited and assisted current inpatients who needed assistance with signposting, befriending, and liaising with charities to purchase items they needed for their stay in hospital.
- The Careflow patient administration system has been updated with an Armed Forces criteria added on the patient information screen.

Armed Forces Week

7.2. During Armed Forces Week – the Comms Team put out daily profiles of the Armed Forces Community group and messages. George Findlay, Chief Executive, provided his support in a message broadcast to the Trust on YouTube.

7.3. Seaside Hospital Radio based at Southlands Hospital had an hour-long radio show on the Armed Forces fundraising bike ride between Balmoral and Buckingham Palace and veteran awareness which was replayed during Armed Forces Week 2023.

7.4. The Armed Forces Week flag flew above our hospitals during Armed Forces Week. The flags supplied by donations from our Armed Forces Community.

7.5. A daily staff drop-in at the Audrey Emerton Building during Armed Forces Week, encouraged staff to sign-up to our Armed Forces Community.

7.6. A presentation was made to Lt Col Ben Caesar and the Trust of a poppy painting for the Chavasse Clinic waiting area in the Louisa Martindale building. The painting shows many poppies with each petal being a red ink fingerprint of a veteran.

7.7. Lt Col Ben Caesar was awarded with a Service Champion Award by the Lord Lieutenant of East Sussex (pictured).

Armed Forces Commemorative Garden

7.8. Groundwork is underway for a new Armed Forces Commemorative Garden following designs produced pro bono by award winning garden designer, Juliet Sargeant.

7.9. Fundraising by the Armed Forces Community for the garden has included a recent bike ride from Balmoral Castle to Buckingham Palace, a Christmas Raffle and other fundraising activities over the last two years raising thousands of pounds for the garden.

Remembrance

7.10. Wreaths were laid in memory of Queen Elizabeth II at the Armed Forces Memorial, the Dyke Road Barracks and Buckingham Palace supplied with donations from the UHSx Armed Forces Community.

7.11. The Armed Forces Community organised an Act of Remembrance Service with the Chaplaincy Team which was broadcast live on Teams on the 11 November 2022. There were 510 people in attendance.

7.12. On 11 November 2023 – a wreath was laid at the Memorial Service and a curry lunch for our UHSussex Armed Forces Community organised by UHSussex Charities. Wreaths purchased by donations from the UHSussex Armed Forces Community.

Data appendix

WORKFORCE RACE EQUALITY STANDARD DATA APPENDIX 2023

WRES 1: Ethnic representation

10.1. The Workforce Race Equality Standard (WRES) was introduced in 2015 by NHS England and aids in compliance with NHS and UK Government pledges and legislation around improving race equality.

10.2. The WRES is made up of nine indicators and makes use of a variety of workforce data including the National NHS Staff Survey, ESR data, and Trac recruitment data.

Table 1 Clinical staff (non-medical or dental) by broad ethnic group

Broad ethnic group	AfC Band	n	%
Minoritised Ethnicity	Band 1	12	2.37
Minoritised Ethnicity	Band 2	271	53.56
Minoritised Ethnicity	Band 3	87	17.19
Minoritised Ethnicity	Band 4	46	9.09
Minoritised Ethnicity	Band 5	29	5.73
Minoritised Ethnicity	Band 6	15	2.96
Minoritised Ethnicity	Band 7	20	3.95
Minoritised Ethnicity	Band 8a	11	2.17
Minoritised Ethnicity	Band 8b	7	1.38
Minoritised Ethnicity	Band 8c	3	0.59
Minoritised Ethnicity	Band 8d	3	0.59
Minoritised Ethnicity	VSM	2	0.40
Unknown	Band 1	5	4.55
Unknown	Band 2	45	40.91
Unknown	Band 3	19	17.27
Unknown	Band 4	10	9.09
Unknown	Band 5	8	7.27
Unknown	Band 6	7	6.36
Unknown	Band 7	4	3.64
Unknown	Band 8a	2	1.82
Unknown	Band 8b	1	0.91
Unknown	Band 8c	1	0.91
Unknown	Band 9	4	3.64
Unknown	VSM	4	3.64
White	Band 1	53	1.42
White	Band 2	1135	30.39
White	Band 3	807	21.61
White	Band 4	686	18.37
White	Band 5	343	9.18
White	Band 6	237	6.35
White	Band 7	149	3.99
White	Band 8a	134	3.59
White	Band 8b	84	2.25
White	Band 8c	51	1.37
White	Band 8d	20	0.54
White	Band 9	19	0.51
White	VSM	17	0.46

Table 2 Non-medical Clinical Staff by broad ethnic group

Broad ethnic group	AfC Band	n	%
Minoritised Ethnicity	Band 2	490	17.99
Minoritised Ethnicity	Band 3	170	6.24
Minoritised Ethnicity	Band 4	68	2.50
Minoritised Ethnicity	Band 5	1312	48.16
Minoritised Ethnicity	Band 6	477	17.51
Minoritised Ethnicity	Band 7	156	5.73
Minoritised Ethnicity	Band 8a	42	1.54
Minoritised Ethnicity	Band 8b	9	0.33
Unknown	Band 2	66	18.49
Unknown	Band 3	18	5.04
Unknown	Band 4	9	2.52
Unknown	Band 5	150	42.02
Unknown	Band 6	70	19.61
Unknown	Band 7	29	8.12
Unknown	Band 8a	10	2.80
Unknown	Band 8b	4	1.12
Unknown	Band 8d	1	0.28
White	Band 1	4	0.06
White	Band 2	1468	20.56
White	Band 3	579	8.11
White	Band 4	389	5.45
White	Band 5	1192	16.70
White	Band 6	1825	25.56
White	Band 7	1263	17.69
White	Band 8a	281	3.94
White	Band 8b	98	1.37
White	Band 8c	21	0.29
White	Band 8d	16	0.22
White	Band 9	3	0.04

Table 3 Medical and Dental Clinical Staff by broad ethnic group

Broad ethnic group	AfC Banding	n	%
Minoritised Ethnicity	Consultant	252	30.77
Minoritised Ethnicity	Non-Consultant Career Grade	123	15.02
Minoritised Ethnicity	Trainee Grades	444	54.21
Unknown	Consultant	46	20.81
Unknown	Non-Consultant Career Grade	16	7.24
Unknown	Trainee Grades	159	71.95
White	Consultant	607	44.60
White	Non-Consultant Career Grade	78	5.73
White	Trainee Grades	676	49.67

WRES 2: Relative likelihood of staff being appointed from shortlisting across all posts.

Table 4 Recruitment staging by broad ethnic group

Broad ethnic group	Number Shortlisted	Shortlisted from Applied %	Number Appointed	Appointed from Interview %	Appointed from shortlisted %	White appointed / shortlisted	Minoritised Ethnicity appointed / shortlisted	Relative Likelihood
White	3,713	60.44	917	41.19	24.70	24.7	14.37	1.72
Minoritised Ethnicity	1,628	9.67	234	25.49	14.37	24.7	14.37	1.72
Unknown	228	60.80	129	67.89	56.58	24.7	14.37	1.72

WRES 3: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

Broad ethnic group	No. Cases	Percentage %	Headcount	% White cases	% Minoritised Ethnicity cases	Relative Likelihood
White	26	72.22	12,287	0.21	0.17	0.81
Minoritised Ethnicity	7	19.44	4,071	0.21	0.17	0.81
Not stated	3	8.33	796	0.21	0.17	0.81

10.3. 0.21% of the white workforce entered formal disciplinary proceedings compared to 0.17% of the minoritised ethnicity workforce, meaning in this case that the relative likelihood of minoritised ethnicity staff entering the formal disciplinary process compared to White staff is 0.81. Minoritised ethnicity staff were therefore less likely to enter formal disciplinary proceedings than white staff.

WRES 4: Relative likelihood of staff accessing non-mandatory training and CPD

Broad ethnic group	No. attendees	% White attendees	% Minoritised Ethnicity attendees	Relative Likelihood
Minoritised Ethnicity	2,596	59.23	63.77	0.93
Unknown	652	59.23	63.77	0.93
White	7,277	59.23	63.77	0.93

59.23% of white staff accessed non-mandatory training or continuous professional development (CPD) compared to 63.77% of minoritised ethnicity staff accessed non-mandatory training or CPD. Therefore, the relative likelihood of white staff accessing non-mandatory training and CPD compared to minoritised ethnicity staff is 0.93. White staff were 0.93 times as likely to access non-mandatory training compared to minoritised ethnicity staff.

WRES 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months.

10.4. The data for the following few sections comes from the National NHS staff survey.

Broad ethnic group	Year	Organisation Score (%)	Benchmark Score (%)	Percentage Difference vs benchmark	Percentage Difference vs group
White	2021	31.3	26.5	4.8	5.7
White	2022	32.0	26.9	5.1	6.1
Minoritised Ethnicity	2021	37.0	28.8	8.2	
Minoritised Ethnicity	2022	38.1	30.8	7.3	

10.5. These results suggest that minoritised ethnicity staff are more likely to experience harassment, bullying or abuse, being more than six points more likely to experience this kind of experience compared to white staff this year. This is slightly higher than last year when there was a 5.7% gap. The table also shows that UHSussex reports more experiences of harassment, bullying or abuse across every ethnic category, compared to the acute benchmark. However, there was a yet greater disparity between UHSussex and the benchmark for minoritised ethnicity staff compared to white staff (7.3% vs 5.1%).

WRES 6: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

Broad ethnic group	Year	Organisation Score (%)	Benchmark Score (%)	Percentage Difference vs benchmark	Percentage Difference vs group
White	2021	25.6	23.6	2.0	3.3
White	2022	25.0	23.3	1.7	2.8
Minoritised Ethnicity	2021	28.9	28.5	0.4	
Minoritised Ethnicity	2022	27.8	28.8	-1.0	

10.6. These results suggest that minoritised ethnicity staff are more likely to experience harassment, bullying or abuse from staff, with minoritised ethnicity staff being over two points more likely to experience this kind of discrimination compared to white staff this year. However, minoritised ethnicity staff did score lower than the benchmark this year, and the percentage difference between minoritised ethnicity and white staff within UHSussex lowered from last year (3.3 in 2021 to 2.8% in 2022) suggesting that there may have been some improvement in this area.

WRES 7: Percentage believing that the trust provides equal opportunities for career progression or promotion.

Broad ethnic group	Year	Organisation Score (%)	Benchmark Score (%)	Percentage Difference vs benchmark	Percentage Difference vs group
White	2021	55.1	58.6	-3.5	-8.9
White	2022	54.3	58.6	-4.3	-4.7
Minoritised Ethnicity	2021	46.2	44.6	1.6	
Minoritised Ethnicity	2022	49.6	47.0	2.6	

10.7. Minoritised ethnicity staff were more positive about the trust providing equal opportunities for career progression/promotion than the benchmark group, but less so than White UHSussex staff. Although, there was progress made this year as there was only a 4.7%-point gap between minoritised ethnicity and white UHSussex staff scores this year, compared to a gap of 8.9% last year.

WRES 8: In the last 12 months have you personally experienced discrimination at work from Manager/team leader or other colleagues.

Broad ethnic group	Year	Organisation Score (%)	Benchmark Score (%)	Percentage Difference vs benchmark	Percentage Difference vs group
White	2021	8.1	6.7	1.4	7.3
White	2022	8.0	6.5	1.5	8.2
Minoritised Ethnicity	2021	15.4	17.3	-1.9	
Minoritised Ethnicity	2022	16.2	17.3	-1.1	

10.8. 8.2% more minoritised ethnicity staff reported experiencing discrimination at work from colleagues/managers than white staff, which is a greater disparity than last year (7.3%). However, minoritised ethnicity staff did score lower than the benchmark suggesting that the situation at UHSussex is slightly better than at most acute NHS trust employers.

WRES 9: Percentage difference between the organisations' Board membership and its overall workforce

10.9. The tables here show the number and percentage of white and minoritised ethnicity staff who are members of the board, compared to the organisation. The first table shows the overall board, and the second two tables further disaggregate by voting membership of the board and executive membership of the board respectively.

Combined Board Voting

Broad ethnic group	Headcount	Board Member Headcount	Headcount %	Board Member Headcount %
Minoritised Ethnicity	4,052	1	23.70	4.35
Unspecified	783	8	4.58	34.78
White	12,259	14	71.72	60.87

Voting Membership

Broad ethnic group	Non-Voting Board Member	Voting Board Member	Org. Headcount	Headcount %	Non-voting %	Voting %
Minoritised Ethnicity	1	4,052	0	23.70	6.67	NA
Unspecified	6	783	2	4.58	40.00	25
White	8	12,259	6	71.72	53.33	75

Executive Membership

Broad ethnic group	Non-exec Board Member	Exec Board Member	Org. Headcount	Headcount %	Non-exec %	Exec %
Minoritised Ethnicity	1	4,052	0	23.70	7.14	NA
Unspecified	6	783	2	4.58	42.86	22.22
White	7	12,259	7	71.72	50.00	77.78

10.10. Across all tables minoritised ethnic staff are underrepresented at Board, and unspecified staff are over-represented.

Medical WRES

	2021-22					2022-23				
	White	Black	Asian	Other	Not known	White	Black	Asian	Other	Not known
Medical directors	1	0	0	0	0	1	0	0	0	0
Clinical directors (directors of clinical teams)	24	1	2	1	1	24	1	2	1	1
Number of staff eligible to apply for Clinical Excellence Awards	489	18	131	37	129	498	16	125	38	66
Number of staff who applied for Clinical Excellence Awards	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Number of staff awarded Clinical Excellence Awards	489	18	131	37	129	493	15	125	37	66
Number of applicants	NA	NA	NA	NA	NA	130	12	134	75	11
Number shortlisted	NA	NA	NA	NA	NA	44	3	78	38	7
Number appointed	NA	NA	NA	NA	NA	29	1	15	8	1

10.11. The Local Clinical Excellence Awards (LCEAs) were awarded on an equal distribution basis in both years and therefore there are no figures for the applications received section.

10.12. Trac recruitment management system data is only kept for 400 days so 2021-22 figures for applicants, shortlisted, and appointed are not presented.

GENDER PAY GAP DATA APPENDIX 2023

10.14. The Gender Pay Gap (GPG) reporting shows the difference in average hourly pay and bonus payments between men and women. The reporting here is a snapshot as of the 31 March 2023.

10.15. All Public Sector organisations listed in Schedule 2 of The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 are subject to the regulatory GPG reporting requirements if they have more than 250 employees under a contract of employment. This includes all staff under Agenda for Change, Medical & Dental, and Very Senior Managers (VSM).

10.16. GPG reporting shows the difference in average hourly pay and bonus payments between men and women, to assess and improve:

- The level of gender equality
- The balance of male and female employees in each of the four salary range quartiles
- How effectively talent is being maximised and rewarded.

Ordinary Pay Analysis

Mean and Median hourly pay gap by gender

	2022						2023					
Gender	Mean	Median	Mean Difference	Median Difference	Mean Pay Gap %	Median Pay Gap %	Mean	Median	Mean Difference	Median Difference	Mean Pay Gap %	Median Pay Gap %
Female	17.78	16.32	4	0.2	18.38	1.2	18.77	16.84	3.87	0.31	17.08	1.79
Male	21.79	16.52	4	0.2	18.38	1.2	22.64	17.15	3.87	0.31	17.08	1.79

10.17. There is a 17.08% difference in favour of male employees when looking at mean hourly rate. This figure is lower than last year 18.38%. The median this year was 1.79% which is higher than last year 1.20%).

Proportion of male and female staff in each quartile band

Quartile	Gender	2022 Number of Employees	2022 % of Employees (by gender/quartile)	2023 Number of Employees	2023 % of Employees (by gender/quartile)
1	Female	3,070	72.84	2,926	71.40
1	Male	1,145	27.16	1,172	28.60
2	Female	3,183	74.75	3,039	74.14
2	Male	1,075	25.25	1,060	25.86
3	Female	3,432	80.85	3,298	80.28
3	Male	813	19.15	810	19.72
4	Female	2,730	64.31	2,555	62.24
4	Male	1,515	35.69	1,550	37.76

Bonus Pay

Mean and Median bonus pay gap by gender.

10.18. Table 3 includes employees who received a bonus in 2022 and 2023, the majority of these are Medical and Dental employees who received a Clinical Excellence Award (CEA).

Gender	2022 Mean	2022 Median	2022 Mean Difference	2022 Median Difference	2022 Mean Pay Gap %	2022 Median Pay Gap %	2023 Mean	2023 Median	2023 Mean Difference	2023 Median Difference	2023 Mean Pay Gap %	2023 Median Pay Gap %
Female	8,482.54	3,769.94	7,247.62	6,536.25	46.07	63.42	7,334.63	3015.96	6457.64	6032.04	46.82	66.67
Male	1,5730.16	1,0306.19	7,247.62	6,536.25	46.07	63.42	13,792.27	9048.00	6457.64	6032.04	46.82	66.67

10.19. The mean bonus pay gap was slightly higher in 2023 (46.82 %) compared to 2022 (46.07 %), as was the median pay gap (2023 66.67 %, 2022 63.42 %)

Proportion of males and females receiving a bonus payment

Gender	2022 Number of Employees	2022 % of Employees (by gender)	2022 Total Employees	2022 % of Total Employees (by gender)	2023 Number of Employees	2023 % of Employees (by gender)	2023 Total Employees	2023 % of Total Employees (by gender)
Female	79	31.23	14621	0.54	83	33.33	14621	0.57
Male	174	68.77	5419	3.21	166	66.67	5419	3.06

10.20. A total of 249 received a bonus payment in 2023. This is shown in Table 4 split by gender, the percentage of males and females in this group, and the percentage of relevant employees in the workforce, alongside the data from 2022 to allow for comparison.

WORKFORCE DISABILITY EQUALITY STANDARD DATA APPENDIX 2023

10.21. The Workforce Disability Equality Standard (WDES) was introduced in April 2019 by NHS England and aids in compliance with NHS and UK Government pledges and legislation around improving equality for disabled people. The WDES is made up of ten indicators and makes use of a variety of workforce data including the National NHS Staff Survey, ESR data, and Trac recruitment data.

WDES 1: Percentage of staff in AfC pay-bands or medical and dental subgroups and very senior managers (VSM) compared with the overall workforce.

10.22. The tables below give the figures for the percentage of staff identifying as having a disability or not respectively across: Medical and Dental roles; Clinical Agenda for Change roles; and Non-Clinical Roles.

10.23. Across all these roles the data is given by pay-band groups:

- Cluster 1: AfC Band 1, 2, 3 and 4
- Cluster 2: AfC Band 5, 6 and 7
- Cluster 3: AfC Band 8a and 8b
- Cluster 4: AfC Band 8c, 8d, 9 and VSM
- Cluster 5: Medical and Dental staff, Consultants
- Cluster 6: Medical and Dental staff, Non-Consultant Career Grade
- Cluster 7: Medical and Dental staff, trainee grades

10.24. Across these three tables when comparing the percentage of non-disabled to disabled bands it's clear that there is underrepresentation of disabled individuals in non-clinical AfC bands 5-8b, clinical AfC Band 5-7, and medical and dental NCCG and Consultant bands.

Medical and Dental Clinical Staff by pay band groups.

Disability Status	AfC Banding Group	n	%
No	M&D Consultants	664	38.58
No	M&D NCCG	127	7.38
No	M&D Trainees	930	54.04
Unknown	M&D Consultants	231	38.37
Unknown	M&D NCCG	83	13.79
Unknown	M&D Trainees	288	47.84
Yes	M&D Consultants	14	21.54
Yes	M&D NCCG	3	4.62
Yes	M&D Trainees	48	73.85

Clinical Agenda for Change Staff by pay band groups.

Disability Status	AfC Banding Group	n	%
No	AfC Band 1-4	2,713	32.65
No	AfC Band 5-7	5,208	62.68
No	AfC Band 8a-8b	360	4.33
No	AfC Band 8c-VSM	28	0.34
Unknown	AfC Band 1-4	395	28.58
Unknown	AfC Band 5-7	916	66.28
Unknown	AfC Band 8a-8b	60	4.34
Unknown	AfC Band 8c-VSM	11	0.80
Yes	AfC Band 1-4	201	38.14
Yes	AfC Band 5-7	299	56.74
Yes	AfC Band 8a-8b	23	4.36
Yes	AfC Band 8c-VSM	4	0.76

Non-Clinical Staff by pay band groups.

Disability Status	AfC Banding Group	n	% *
No	AfC Band 1-4	2,556	72.53
No	AfC Band 5-7	671	19.04
No	AfC Band 8a-8b	208	5.90
No	AfC Band 8c-VSM	89	2.53
Unknown	AfC Band 1-4	387	73.57
Unknown	AfC Band 5-7	94	17.87
Unknown	AfC Band 8a-8b	21	3.99
Unknown	AfC Band 8c-VSM	24	4.56
Yes	AfC Band 1-4	246	76.16
Yes	AfC Band 5-7	46	14.24
Yes	AfC Band 8a-8b	23	7.12
Yes	AfC Band 8c-VSM	8	2.48

Note: * % within disability and pay group

WDES 2: Relative likelihood of non-disabled people being appointed from shortlisting relative to disabled people.

Disability Status	N. Shortlisted	Shortlisted from Applied %	N. Interviewed	N. Appointed	Appointed from Interview %	Appointed from shortlisted %	Not Disabled appointed / shortlisted	Disabled appointed / shortlisted	Relative Likelihood
Disabled	510	52.52	305	95	31.15	18.63	21.72	18.63	1.17
Non-disabled	4,816	21.85	2,818	1,046	37.12	21.72	21.72	18.63	1.17
Not Stated / Unknown	243	71.47	211	139	65.88	57.20	21.72	18.63	1.17

10.25. 21.72 % of the non-disabled applicants were appointed after being shortlisted for a job compared to 18.63 % of disabled applicants. Therefore, the relative likelihood of non-disabled staff being appointed from shortlisting compared to disabled staff is 1.17; non-disabled staff were therefore 1.17 times more likely to appointed from shortlisting than disabled staff.

WDES 3: Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process.

Disability Status	No. Cases	Headcount	Percentage %	% Non-disabled cases	% Disabled cases
Disabled	0	919	0%	0.03	0
Not Declared / Undefined	2	2,645	33%	0.03	0
Not Disabled	4	13,595	67%	0.03	0

10.26. 0.03% of the non-disabled staff entered the formal capability process compared to 0.00% of disabled staff. The relative likelihood could not be calculated (due to there being zero cases), but nonetheless these findings suggest there being no evidence of disability discrimination in the formal capability process.

WDES 4: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse.

10.27. The following metrics make use of the NHS National Staff Survey data, which is published here: nhsstaffsurveys.com. The first table displays the percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse: from managers; from other colleagues; and from patients/service users, their relatives, or other members of the public.

Disability Status	Year	Group	Organisation Score (%)	Benchmark Score (%)	% Difference vs benchmark	% Difference vs group
Disabled	2022	Managers	18.1	17.1	1.0	8.1
Disabled	2022	Other Colleagues	28.8	26.9	1.9	10.7
Disabled	2022	Patients service users, their relatives, or other members of the public	38.6	33.0	5.6	7.2
Non-disabled	2022	Managers	10.0	9.9	0.1	
Non-disabled	2022	Other Colleagues	18.1	17.7	0.4	
Non-disabled	2022	Patients service users, their relatives, or other members of the public	31.4	26.2	5.2	

10.28. These results suggest that disabled staff are more likely to experience harassment, bullying or abuse across every category, with disabled staff being over 7% more likely to have these negative experiences compared to non-disabled staff. The table also shows that UHSussex reports more experiences of harassment, bullying or abuse across every category (both disabled and non-disabled individuals). Regardless of disability status, UHSussex staff reported more than 5% greater harassment, bullying, or abuse from patients and relatives compared to the acute benchmark.

10.29. This second table shows the percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

Disability Status	Year	Organisation Score (%)	Benchmark Score (%)	Percentage Difference vs benchmark	Percentage Difference vs group
Disabled	2021	46.2	47.0	-0.8	3.1
Disabled	2022	48.4	48.4	0.0	3.6
Non-disabled	2021	43.1	46.2	-3.1	
Non-disabled	2022	44.8	47.3	-2.5	

10.30. UHSussex disabled staff were just as likely to report the discrimination as the benchmark, but non-disabled staff were more likely to report the discrimination compared to the benchmark. Both groups scored higher this year, meaning that they said they were more likely to report the discrimination compared to last year, and disabled individuals were ~3% more likely to report the discrimination than non-disabled staff.

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

Disability Status	Year	Organisation Score (%)	Benchmark Score (%)	Percentage Difference vs benchmark	Percentage Difference vs group
Disabled	2021	49.6	51.4	1.8	4.7
Disabled	2022	50.5	51.4	0.9	3.5
Non-disabled	2021	54.3	56.8	2.5	
Non-disabled	2022	54.0	57.3	3.3	

10.31. UHSussex staff were less likely to believe that the trust provides equal opportunities for career progression and promotion compared to the benchmark, across the board regardless of disability status. Disabled staff were 3.5% less likely to state this than non-disabled staff, although this gap is smaller than last years' when disabled staff were 4.7% less likely to believe the trust provides equal opportunities in career progression.

WDES 6: Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

Disability Status	Year	Organisation Score (%)	Benchmark Score (%)	Percentage Difference vs benchmark	Percentage Difference vs group
Disabled	2021	32.5	32.2	0.3	9.4
Disabled	2022	28.4	30.0	-1.6	6.9
Non-disabled	2021	23.1	23.7	-0.6	
Non-disabled	2022	21.5	20.8	0.7	

10.32. Disabled staff were 6.9% more likely to agree they have felt pressure to come to work when unwell compared to non-disabled staff. However, this is a reduction compared to last year when the gap between disabled and non-disabled staff was 9.4%. Scores across the board were relatively close to the benchmark.

WDES 7: Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

Disability Status	Year	Organisation Score (%)	Benchmark Score (%)	Percentage Difference vs benchmark	Percentage Difference vs group
Disabled	2021	30.3	32.6	-2.3	8.1
Disabled	2022	28.6	32.5	-3.9	8.3
Non-disabled	2021	38.4	43.3	-4.9	
Non-disabled	2022	36.9	43.6	-6.7	

10.33. Across the board staff were less likely to feel satisfied that the organisation values their work, with benchmark scores being higher than UHSussex scores for both disabled and non-disabled staff. Within UHSussex disabled staff were 8.3% less to feel satisfied, which was like the previous year.

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

Disability Status	Year	Organisation Score (%)	Benchmark Score (%)	Percentage Difference vs benchmark
Disabled	2022	73.4	71.8	1.6

10.34. There was no legacy data for this question, but the findings showed that UHSussex disabled staff were slightly more likely than the benchmark to have adequate workplace adjustments.

WDES 9a: The staff engagement score for Disabled staff, compared to non-disabled staff.

Disability Status	Year	Organisation Score	Benchmark Score	Point Difference vs benchmark	Point Difference vs group
Disabled	2021	6.3	6.4	0.1	0.4
Disabled	2022	6.2	6.4	0.2	0.4
Non-disabled	2021	6.7	7.0	0.3	
Non-disabled	2022	6.6	6.9	0.3	

10.35. The staff engagement score was lower across the board compared to the benchmark score (i.e.., regardless of disability status). Disabled staff had a slightly lower score than non-disabled staff and the percentage difference (0.4%) did not change compared to last year.

WDES 9b: Staff engagement

10.36. In February 2019, the Trust signed off a Terms of Reference for the Disability Staff Network; from that point forward, the network was formally recognised by the Trust. The network aims to provide an avenue for staff to discuss disability-related issues. In 2021, disability network from both predecessor organisations merged, to ensure the representation of all UHSussex staff. The network reports to the Equality Steering Group. The Chair of the Disability Staff Network also attends the HR Policy Group Forum, which is responsible for the development and review of non-Medical HR policies on employment issues.

WDES 10: Percentage difference between the organisation's Board voting membership and its organisation's overall workforce.

10.37. The tables below show the number and percentage of disabled staff who are members of the board, compared to the organisation. The first table shows the overall board, and the second two tables further disaggregate by voting membership of the board and executive membership of the board respectively.

Disability Status	Headcount	Headcount %	Headcount %	Board Member Headcount %
No	13,555	12	79.30	52.17
Unknown	2640	11	15.44	47.83
Yes	899	NA	5.26	NA

Voting Membership

Disability Status	Non-Voting Board Member	Voting Board Member	Org. Headcount	Headcount %	Non-voting %	Voting %
No	6	6	13,555	79.30	40	75
Unknown	9	2	2640	15.44	60	25
Yes	0	0	899	5.26	0	0

Executive Membership

Disability Status	Non-exec Board Member	Exec Board Member	Org. Headcount	Headcount %	Non-exec %	Exec %
No	5	7	13,555	79.30	35.71	77.78
Unknown	9	2	2640	15.44	64.29	22.22
Yes	0	0	899	5.26	0	0

10.38. Across all three tables disabled staff are unrepresented on the board, and having an “unknown” status is overrepresented, suggesting people are not declaring their status (either from missing data, or from opting to not declare status).

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	20	**Meeting:**	Trust Board	**Meeting Date:**	August 2023
Report Title:	Sustainability Committee Chair report to Board				
Sponsoring Executive Director:	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	Yes	Assurance	Yes
Review and Discussion	N/A	Approval / Agreement	N/A

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

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	Yes	Link to Trust Annual Plan	Yes

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	N/A	
Sustainability	Yes	Assurances in relation to risk 2.1, 2.2 and 2.3
People	N/A	
Quality	N/A	
Systems and Partnerships	N/A	
Research and Innovation	N/A	

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

Regulatory / Statutory reporting requirement

Communication and Consultation:

Executive Summary:

The Sustainability Committee meets monthly and therefore this report covers three meetings in May, June and July 2023.

The May and June meetings were quorate, attended by at least two Non-Executive Directors and two executives including the Chief Finance Officer, Chief People Officer and Chief Governance Officer and were attended by the Finance Director, the Director for Improvement and Delivery, the Director of Improvement and Delivery and the Managing Director, Planned Care & Cancer. The Commercial Director attended the June meeting. Both the May and June meetings focused on the financial position, the efficiency programme and the productivity breakthrough objective. The July meeting was a full quarterly Committee and covered all areas within the Committee's remit.

The Sustainability Committee of 27 July 2023 was also quorate as it was attended by two 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 Estates and Facilities, the Commercial Director, the Director for Improvement and Delivery and a deputy on behalf of Director of

Capital Development & Property. The interim Chief Information Officer was in attendance and apologies were received from the Managing Director Planned Care and Cancer for the July meeting.

The July Committee received its planned items including reports on the Sustainability True North, Breakthrough Objective (productivity), Strategic Initiative (environmental sustainability) and Corporate Project (estates strategy and master planning), including a performance report at Quarter 1 2023/24 together with a financial forecast, followed by updates on the Efficiency Programme, the Capital Programme, IM&T Programme, Commercial team activities including procurement, an ICS finance update and a risk paper and the Board Assurance Framework. Three investment decisions were also considered and approved.

The work on the Medium-Term Financial Plan was introduced and will form part of a system-wide financial plan. This will be brought to a future Board meeting for review.

The key areas of focus of the Committee during the period are listed below while the full breath of the meeting's activity is included in a table as an addendum to the paper.

True North Financial Performance Report
Quarter 1 2023/24 Financial position

The Committee received finance updates at each meeting of the three meetings and were advised by the Finance Director that the Trust had adverse year to date variance against the income and expenditure measure. The Committee discussed and **NOTED** the in-month and year to date drivers of the adverse position that included the impact of industrial action both on activity and staffing costs, inflation, and mental health specialling costs. These are the areas that were flagged as key areas of risk in the Trust's break even financial plan for the 23/24 year.

ICS Financial Report

The July Committee received an update on the ICS Finance Leadership Group system that focussed on the financial position of individual providers and the System as a whole (a deficit), as well as the national context. The Committee noted the Trust had been relatively more impacted by Industrial Action than others. The Committee also noted the tiered control environment that the System is subject to as a result of its financial forecast which is the lowest level of oversight. The Committee also noted the emerging productivity ICS workstream.

Productivity Breakthrough Objective

The Committee discussed the productivity breakthrough objective. In the July meeting the Committee **RECEIVED** an update from the Chief Finance Officer in the absence of the Managing Director for Planned Care and Cancer for the position at Month 3. The Committee undertook a Deep Dive on Productivity at the May meeting where the Managing Director detailed the best practice processes being implemented including theatre booking and scheduling and heard how this and other key pillars of productivity are supported by a refreshed Data and Reporting Group to ensure accurate and consistency of reporting. The Committee welcomed the work to avoid short notice cancellations and considerations around the scheduling of theatre maintenance.

While the BO was on trajectory for the year, areas of vulnerability were recognised and the Committee heard the executive will further discuss capacity with recognition of the impact of dropped lists. The Committee remained **ASSURED** from the updates that the continued focus on the control oversight arrangements will help drive the required improvements and allow the Trust to monitor its delivery in 2023/24. The Committee asked for the productivity dashboard to be brought for review at the next meeting. The Committee **NOTED** the progress made, the further work needed, the associated risks and the importance of delivering the required levels of elective activity to deliver the 2023/24 financial plan.

Strategic Initiative- Environmental Sustainability

An update was provided on progress in completing the 22/23 Annual Report which would be available shortly. Current year progress was noted and updates were provided for each of the workstreams. As agreed at the June meeting a multi -year road map to delivering the required targets including the resources needed to achieve this would be reported to a future Committee.

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 well received engagement being undertaken with the Divisions through the launch of the project. The Committee **NOTED** the 6 facet survey results are awaited for Trust sites and discussed that, following the engagement workshops, it would be necessary to understand affordability issues and develop a detailed risk profile. The Committee acknowledged the importance of an agile plan that could meet changing needs.

Efficiency and Transformation Programme Quarter 1

The Committee **NOTED** the current level of delivery of the year's efficiency programme and that the year to date delivery had been ahead of trajectory while the increasing delivery risk given the majority of savings to be realised are weighted towards Quarters 3 and 4, was also recognised. Through the update provided by the Director the Committee **NOTED** continued positive engagement with the divisional leaders with the Efficiency steering group well attended and sustained ownership of escalated issues.

The Committee were **ASSURED** that there continues to be a well-tested and robust system for delivery of efficiencies and that the Trust has modelled and can evidence length of stay reductions through standard work that enables bed closures. The Committee **NOTED** that the impact of Winter pressures on escalation beds remained a risk. The Committee also heard about the limited income schemes that will need to deliver.

Capital Investment Progress Report Quarter 1

The Committee **RECEIVED** the Q1 update against the Trust's 2023/24 capital plan.
The Committee **NOTED** the forecast outturn is in line with the overall capital plan. The Committee **NOTED** that external factors outside the Trust control e.g. Stroke consultation had impacted on the timeline.

The Committee **NOTED** the work to mitigate the overprogramming of the agreed Capital Plan through rephasing of some schemes. The Committee NOTED the Capital Plan remained overprogrammed and **NOTED** IT costs associated with the critical incident could add further pressure to the capital plan

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.

IM&T Programme update

The Committee **RECEIVED** the Quarter 1 IM&T Programme Report on the Trust's wide-ranging IM&T programme of work. The Committee **NOTED** the update provided by the interim Chief Information Officer that included project status and the pipeline of works, KPIs of the IT department itself and an update on the Critical Incident in June 2023.A full Incident Report and learning was underway.

Commercial Activities Update

The Commercial Director provided an update on the activities of the Commercial Directorate over the last quarter that included how Pharm@Sea, the Trust's wholly owned subsidiary, can further support delivery of the Trust's strategy. The Committee **NOTED** the wide ranging Q1 activities against the areas of priority that included innovating with Partners. A procurement update was also including setting out activities and achievements in Quarter 1. More detailed metrics and key risks relating to commercial and procurement work would be provided at future meetings.
The Committee **NOTED** the update.

The Committee **NOTED** formal closure of the payroll hub project and move to business as usual working. Detailed metrics and feedback were provided demonstrating the positive impact of the move to the hub. A full benefits realisation review would be brought back to the Committee. In respect of the Payroll Hub, the Committee **NOTED** escalation arrangements within the contract and additional mitigations deployed during the risk period of health roster merger. It was confirmed that there were sufficient client side resources to manage the contract as BAU.

National Cost Collection Submission Pre-Submission Report
The Committee were advised that the Trust is required to submit to NHSE an annual return of its unit costs and activity for clinical services and give assurances about the methodology and resources used to compile the submission. Having delegated authority from the Trust Board around Costing, the Committee **APPROVED** the Trust's response to the National Cost Collection Pre-Submission Report that confirms that a plan is in place to produce the required costing return(s) by the required deadline, together with the associate confirmation, validations of accuracy, production of information gap analysis.

The Committee **NOTED** the Trust is well placed to meet these requirements for the 2022/23 submission, with an experienced costing team using a well-established Patient Level Costing System (PLICS) provided by a company with specialist expertise. The Committee **NOTED** a timetable has been created for the preparation and review of the national cost collection submission, including investigating outliers and validation errors up to the final submission day. For planning purposes, the draft submission window commencing 18th September is being used.

Risks and Board Assurance Framework (BAF)

The Committee NOTED the quarter 1 Sustainability Risk Paper on the programme risks which may impact the delivery of the Sustainability True North along with the overarching risks from the respective Strategic Initiative and Corporate Project. The Committee considered this report alongside the respective discussions on risk within the respective Committee items. The Committee **AGREED** the risk paper summary and through the respective discussions **NOTED** the key risks and their linkage to the Committee's oversight of three BAF strategic risks. The Committee **NOTED** that the broader environment had meant the number of risks across the sustainability domain scoring 12+ had increased considerably, particularly with escalation of previously lower scored estate risks.

The Committee reviewed the BAF risks it has oversight of, 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, 2.2 and 2.3. remained fairly stated.

Referrals to other Committees

The Committee considered the reports and presentations it received at this meeting and **agreed** there were no matters that they wished to refer to other Committees.

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.

SUSTAINABILITY COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	**25 May 2023**	**Chair**	Lizzie Peers	**Quorate**	Yes
Meeting Date	**29 June 2023**	**Chair**	Lizzie Peers	**Quorate**	Yes
Meeting Date	**27 July 2023**	**Chair**	Lizzie Peers	**Quorate**	Yes
Declarations of Interest	No declarations were raised				

Items received at the Committee meeting

Sustainability True North Financial Performance Report Quarter 1 2023/24 Updates Provided in May and June on Month 1 and Month 2 respectively	**May**	**Jun**	**Jul**	**Presenter** Director of Finance	**Purpose** For assurance	**Outcome /Action taken** Noted position and key risks. Assured by Division engagement and responses to tiered support arrangements
Financial Forecast			**Jul**	**Presenter** Director of Finance	**Purpose** For information	**Outcome /Action taken** Noted. Reviewed mitigated forecast outturn and key risks
Medium-Term financial plan			**Jul**	**Presenter** Director of Finance	**Purpose** For information	**Outcome /Action taken** Noted. Introduced to work on the Medium-Term Financial Plan to form part of a system-wide financial plan. This will be brought to a future Board meeting for review
ICS Financial Report			**Jul**	**Presenter** Chief Finance Officer	**Purpose** For information	**Outcome /Action taken** Noted system work on financial gap, and national context. Noted UHSx is subject to Level 1 tiered control environment
Sustainability Breakthrough Objective Productivity Updates provided in May and June on Month 1 and Month 2 respectively	**May**	**Jun**	**Jul**	**Presenter** Chief Finance Officer / Managing Director-Planned Care (except Jul)	**Purpose** To inform the Committee of the productivity against 2019/20 activity at 2019/20 cost	**Outcome /Action taken** Noted programme is on track but faces challenges. Productivity Dashboard to be brought back

Sustainability Strategic Initiative Environmental Sustainability			**Jul**	**Presenter** Director of Estates and Facilities	**Purpose** To inform the Committee on the progress being made to reduce the Trust's environmental impact	**Outcome /Action taken** Noted progress on projects but despite considerable carbon reduction noted energy usage increase and increase relating to changing Trust footprint. Need to set 2023/4 trajectory and the schemes contributing in year. Assurance report still to come back on 2022/23 delivery on targets and against the Green Plan and multi-year roadmap with resourcing required to deliver.
Corporate Project Estates Strategy & Master Planning			**Jul**	**Presenter** Deputy Director of Capital Development and Property	**Purpose** To inform the Committee on the progress being made in the development of a Trust Estates Masterplan, in Q1 on foundations to identify priorities, opportunities and constraints	**Outcome /Action taken** Noted the update and endorsed the work undertaken in development stage toward a Trust Estates Strategy 2024/25-30 Capital plan. Recommended a review against the risk register and affordability
Use of Resources						
Efficiency & Transformation Programme. Updates Provided in May and June on Month 1 and Month 2 respectively	**May**	**Jun**	**Jul**	**Presenter** Director of Improvement and Delivery	**Purpose** To inform the committee on the update on the 2023/24 plan delivery	**Outcome /Action taken** Noted the update on the 2023/24 plan delivery and maturity. Noted Trust is ahead of plan but also risks from delivery weighted toward Q4.
Capital Investment Progress Report Q1 2023/24			**Jul**	**Presenter** Deputy Director of Capital Planning	**Purpose** To update on the implementation of the 2023/24 capital plan, and set out the actual position at Q1 end and revised full-year forecast outturn position.	**Outcome /Action taken** Noted the source of funds and those to be secured. Noted year to date expenditure ahead of plan. Noted agreed overprogrammed capital plan has been mitigated but remains over - programmed with future

						pressures to be subject to prioritising and scrutiny
Commercial Progress Report Q1 2023/24			**Jul**	**Presenter** Commercial Director	**Purpose** To inform the Committee of activities undertaken by the commercial directorate and upcoming areas of opportunity	**Outcome /Action taken** Noted the wide ranging procurement and commercial activities in Q1 and how these aligh to our Trust strategy. Metrics and risks to be provided in future reports.
Project Closure Report – Payroll Hub			**Jul**	**Presenter** Commercial Director	**Purpose** For information	**Outcome /Action taken** Noted the closure report and the business as usual escalation arrangements and contract management resourcing.
IM&T Programme Progress Report Q1 2023/24			**Jul**	**Presenter** Interim Chief Information Officer	**Purpose** For information	**Outcome /Action taken** Noted the programme update and noted the update on the Network Critical Incident. Full incident report and learning to be brought back.
National Cost Collection Pre-Submission Report			**Jul**	**Presenter** Chief Finance Officer	**Purpose** To note the Trust is required to approve an annual return of its unit costs and activity for clinical services to NHSE and give assurance about the methodology and resources used to compile the submission.	**Outcome /Action taken** Approved. Confirmed the Plan is sufficient to produce the required costing submission by the deadline of 18 September and agreed the response and stated assurances provided.
Investment Decisions						
Same Day Emergency Care Unity – St Richards				**Presenter**	**Purpose** To Approve	**Outcome /Action taken** Approved (within Committee delegated limit)
Urgent Treatment Centre – Worthing				**Presenter**	**Purpose** To Approve	**Outcome /Action taken**

						Approved (within Committee delegated limit)
Hot Water Phase 1 Works - RSCH				**Presenter**	**Purpose** To Approve	**Outcome /Action taken** Approved (within Committee delegated limit)
Risk						
Trust Risk Register relating to Sustainability			**Jul**	**Presenter** Chief Finance Officer	**Purpose** For information	**Outcome /Action taken** Noted and discussed. Confirmed the risks and scores across individual areas in the Sustainability domain were scored appropriately given the risks and issues set out in the papers presented at the meeting.
Board Assurance Framework			**Jul**	**Presenter** Company Secretary	**Purpose** For agreement	**Outcome /Action taken** Agreed risks fairly stated

Actions taken by the Committee within its Terms of Reference
The Committee **AGREED** to recommend the quarter 2 score for BAF risks 2.1 to 2.3 to the Board, noting the changes to these risk scores in this quarter The Committee **APPROVED** the following Investments within the Committee's delegated limits: ▪ **Same Day Emergency Care Unit – SRH** ▪ **Urgent Treatment Centre - Worthing** ▪ **Hot Water Phase 1 Works – RSCH** The Committee **APPROVED** the Trust's response to the National Cost Collection Pre-Submission Report and confirm that a plan is in place to produce the required costing return(s) by the required deadline, together with the associate confirmation, validations of accuracy, and production of information gap analysis.
Items to come back to Committee / Group (Items Committee / Group keeping an eye on)

The Environment Sustainability roadmap for 2023/24 and future years with resourcing requirements was still to return to the Committee.

The Productivity Dashboard was requested for the next meeting of the Committee

An Extraordinary Meeting of the Committee will be convened to receive the Electronic Patient Record Outline Business Case

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 reference

Items referred to the Board or another Committee for decision or action	
Item	**Date**
None	

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	21	**Meeting:**	Trust Board	**Meeting Date:**	August 2023
Report Title:	Systems and Partnerships Committee Chair's Report				
Non Executive Director:	Bindesh Shah, Non-Executive Director – Committee Chair				
Author(s):	Bindesh Shah, Non-Executive Director				
Report previously considered by and date:					

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

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	Yes	Link to Trust Annual Plan	Yes

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	N/A	
Sustainability	N/A	
People	N/A	
Quality	N/A	
Systems and Partnerships	Yes	Oversight of BAF risks 5.1 to 5.3
Research and Innovation	N/A	

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

Regulatory / Statutory reporting requirement

Communication and Consultation:

Executive Summary:

The Systems and Partnerships Committee met on the 27 July 2023 and was quorate as it was attended by two Non-Executive Directors and the Trust Chair, as well as the Chief Finance Officer, the Chief Operating Officer, Chief Governance Officer and Chief Executive. In attendance was the Managing Director of Urgent and Emergency Care, the Director of Improvement and Delivery and Company Secretary.

The Committee received its planned items including the Q2 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 taken and considered at the meeting included a Diagnostics Performance deep dive, the 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 Managing Director for Unscheduled Care updated the Committee on the performance against each of the metrics reflecting on the challenges impacting on the Trust's operational performance. The Committee **discussed** the various improvement actions being undertaken

across each of the aspects of planned care, cancer, urgent care and diagnostics, recognsing the significant improvement in the number of ambulance handovers undertaken in 15 minutes. The Committee continued to be **assured** over the governance oversight arrangements in place over the improvement actions being taken and the alignment of the actions developed through the reporting from the Chief Operating Officer to secure the improvement trajectories.

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 reflected on the strengthening the assurance these reports provide through the inclusion of target trajectories to achieve the planned performance measures and benchmarking data where it is available. This request was agreed to be included for future performance reporting.

Median Hour of discharge

The Chief Operating Officer as project executive presented an update on this project. The Committee **noted** the positive impact this project is having on supporting patients to leave earlier in the day. The Committee was **assured** over the project improvement actions through the improving position with an improved earlier median time for discharge for all those wards who were the pilot wards for this project. 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. The Committee **noted** the interrelationship of the performance in this project is having on length of stay project.

The Committee reflected on the strengthening the assurance this report provides through the inclusion of target trajectories. This request was agreed to be included for future performance reporting. The Committee also reflected how improvements in medical workforce engagement with this project will support improvement.

3Ts Hospital Development

The programme senior responsible officer (SRO), the Director of Improvement and Delivery provided the Committee with a report on the opening and use of the Louisa Martindale Building. The Committee recognised the significant benefit that this building has brought to patients and staff and through the feedback received in the first months of operation. The Committee **noted** the developed first 100 days plan for the building which will support the Trust in tracking the delivery of the planned benefits from the use of this building as well as the closure of all the respective workstreams established that supported the move. The Committee **noted** that a post project evaluation will be brought to a subsequent Committee meeting.

The Committee noted the work has mobilised on the development of phase 2 and phase 3 of 3Ts noting for these stages work is at an early stage.

Reducing length of stay

The Managing Director for Unscheduled Care, as the project Senior Responsible Officer (SRO), reported to the Committee and through their report and update the Committee **noted** the established governance framework established to oversee and co-ordinate the projects workstreams. The Committee **noted** the management audit work undertaken to enable the development of a standardised operating process when considering or making patients moves between wards given its impact on the length of their overall length of stay.

The Committee reflected on the strengthening the assurance this report provides through the inclusion of target trajectories. This request was agreed to be included for future performance reporting. The Committee also reflected how improvements in medical workforce engagement with this project will support improvement.

The Committee was **assured** over the programme management processes applied to this corporate project and noted the high levels of engagement by nurses, therapists and pharmacists in the project workstreams to enable actions identified can be implemented swiftly to reduce the risk of the need to use escalation spaces.

Diagnostic Deep Dive

The Committee **received** the first of scheduled deep dive reports over the Trust's constitutional standards with this report covering diagnostics. The Committee **noted** the drivers of the challenge to achieve the national performance standard and considered the performance against each of the respective modalities. The Committee noted the planned improvement next steps to address those areas where there are backlogs including work to increase capacity and productivity to meet rising demands. The Committee noted the overview of the respective challenges and agreed that the respective performance reporting to future meetings include details of the specific improvement plans.

Risk and Board Assurance Framework oversight

The Committee reviewed the quarter 1 Systems and Partnership Risk Paper and **noted** the risks detailed with a highly scored current score of 12 and endorsed that there were reflective of the Trust's position.

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.

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 and 5.2 for the start of quarter 2 were fairly represented endorsing the reduction of risk 5.1 based on the enhanced working relationships with system partners with increased multisystem working. The Committee reflected that given the impact of Industrial Action on the Trust's capacity to deliver against the constitutional standards this risk was **agreed** to remain at 20 rather than reduce.

Referrals to other Committees

The Committee considered the reports and presentations it received at its 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 of the Committee within its terms of reference.

The Board is asked to **NOTE** that the Committee considered and **agreed** the risk scores for BAF risks 5.1 and 5.2 are fairly stated for quarter 2 including the reduction of risk 5.1 to its target score. The Committee **agreed** that risk 5.3 should remain at a score of 20.

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	**27 July 2023**	**Chair**	Bindesh Shah	**Quorate**	Yes
Declarations of Interest	No declarations were raised				

Items received at the Committee meeting			
True North – Constitutional Standards Performance Report	**Presenter** Managing Director of Unscheduled Care / Chief Operating Officer	**Purpose** For information and assurance	**Outcome /Action taken** Noted and agreed that the reporting format be enhanced with the inclusion of trajectories
Breakthrough Objective – Median Hour of Discharge	**Presenter** Chief Operating Officer	**Purpose** For information and assurance	**Outcome /Action taken** Noted the positive impact this project is having on patients going home earlier
Strategic Initiatives – 3Ts Hospital Development Report	**Presenter** Director of Improvement and Delivery	**Purpose** For information and assurance	**Outcome /Action taken** Noted the successful move to the LMB
Corporate Project – Reducing Length of Stay	**Presenter** Managing Director of Unscheduled Care	**Purpose** For information and assurance	**Outcome /Action taken** Noted the developed delivery workstreams
Corporate Project – Community Diagnostic Centres	**Presenter** Managing Director of Unscheduled Care	**Purpose** For information and assurance	**Outcome /Action taken** Noted this project remains on track
Diagnostics Deep Dive	**Presenter** Director of Integrated Education	**Purpose** For information	**Outcome /Action taken** Noted
Risk Report	**Presenter** Deputy Chief Executive	**Purpose** For information	**Outcome /Action taken** Noted
Board Assurance Framework	**Presenter** Company Secretary	**Purpose** For agreement	**Outcome /Action taken** Agreed strategic risks fairly stated

Actions taken by the Committee within its Terms of Reference
The Committee **AGREED** to recommend the risk score for BAF risks 5.1 and 5.2 to the Board for the start of quarter 2 2023/24 and that risk 5.3 should remain at a score of 20.

The Committee provided their thanks to Jeannie Baumann who is retiring for all the work she has undertaken across the various roles she has held at UHSussex and its former Trusts.
Items to come back to Committee / Group (Items Committee / Group keeping an eye on)
There are no identified items that the Committee requested return outside of the Committee's scheduled cycle of business.
Items referred to the Board or another Committee for decision or action
There were no referrals made to another Committee for action.

Agenda Item:	22	**Meeting:**	Board	**Meeting Date:**	3 August 2023
Report Title:	Audit Committee Chair's Report				
Author(s):			David Curley – Audit Committee Chair		
Report previously considered by and date:					

Purpose of the report:			
Information	Yes	Assurance	Yes
Review and Discussion	N/A	Approval / Agreement	N/A

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	Yes	Link to Trust Annual Plan	Yes

Implications for Trust Strategic Themes and any link to BAF risks		
Patient	Yes	The Committee provides oversight of the process supporting each aspect of the BAF
Sustainability	Yes	The Committee provides oversight of the process supporting each aspect of the BAF
People	Yes	The Committee provides oversight of the process supporting each aspect of the BAF
Quality	Yes	The Committee provides oversight of the process supporting each aspect of the BAF
Systems and Partnerships	Yes	The Committee provides oversight of the process supporting each aspect of the BAF
Research and Innovation	Yes	The Committee provides oversight of the process supporting each aspect of the BAF

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

Regulatory / Statutory reporting requirement

There is a requirement to break even

Communication and Consultation:

Report:

The Audit Committee met on the 18 July 2023 and was quorate as it was attended by four Non-Executive Directors. In attendance was the Chief Financial Officer, the Chief Governance Officer, the Trust's 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 Interim Chief Information Officer also attended to present a report on the Trust's actions in respect of information governance as did the Director of Workforce Planning & Deployment for the Health Roster Merger Programme Update.

<u>Risk Register and BAF reports</u>

The Committee considered, reviewed and discussed the Quarter 2 BAF report and risk register. The Committee through the discussion on the BAF noted the levels of Executive confidence that the target score would be achieved through the delivery of the planned actions to mitigate the respective risks. The Committee recognised the enhancements made to the detail of the document 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 but

in discussing the structure of the report sked that a further refinement to the document be made to include a single summary incorporating each strategic domain the BAF risks, their score their movement and the underpinning risks and their movement, by quantum within the respective risk hierarchy of extreme to low. It was agreed that the review as to how the structure of the BAF and risk register report will provide such assurance going forward and this review would be with the Chair of Audit before next Committee meeting.

The Committee in discussing this document was assured over the underpinning processes for the oversight and management of these strategic risks.

Internal Audit activity

The Committee considered 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 through receipt of the substantial positive opinion on the Trust's cash handling processes was assured over these systems and the work undertaken to maintain and harmonise these systems post merger.

The Committee on review of the Internal Audit Reports covering the Trust's processes for dealing with NICE guidance and the recording of Surgical Site Infections agreed to refer these to the Quality Committee to secure their support with the oversight of the agreed improvement actions.

The Committee heard and noted the Internal Auditor's view that there had been an uptick in engagement from the Trust with their work this year which has already seen an improved level of action taken in respect of previous recommendations.

Local Counter Fraud

The Committee considered the Local Counter Fraud progress report for Quarter 1 2023/24 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 any reported concerns. Through this report and the update provided by the Trust's Local Counter Fraud Specialists the Committee noted there were no significant fraud risks which Trust needed to be actioned urgently.

The Committee on review of the Trust's Fraud Risk Assessment undertaken by the Local Counter Fraud Specialist agreed this was fairly representative of those risk and noted the actions and sources of assurance identified against each risk.

Health Roster Merger

The Committee received information on the designed oversight and governance arrangements in place for this project noting these mirrored those established for the payroll hub project. The Committee endorsed the involvement of Internal Audit within the programme to enable timely assurance to be provided as the project is delivered. The Committee recognised that the formal delivery of this programme would be reported to the People Committee through the dedicated executive led programme oversight and steering group.

Key Recommendation(s):

The Board is asked to **NOTE** the assurances received especially those from Internal Audit and the Local Counter Fraud Specialist and the actions taken by the Committee in accordance with its terms of reference.

The Board is asked to **NOTE** the annual report on the activity of the Committee (included as an appendix to this report) demonstrating delivery of the Committee's terms of reference.

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate
Audit Committee	18 July 2023	David Curley	**Yes**

Declarations of Interest Made

There were no declarations of interest made.

Matters received at the Committee meeting

Item	Presenter	Purpose of the paper	Action Taken
Board Assurance Framework (BAF)	Chief Governance Officer / Company Secretary	For review and discussion to consider any referrals to other Committees for their oversight of actions and current scores.	The Committee discussed the BAF. The Committee recognised the enhancements made to the document and asked for a one-page summary overview to be provided at the start of future reports and the structure of this be discussed with the Audit Committee chair prior to the next meeting.
Risk Management Policy Compliance Report	Chief Governance Officer / Deputy Company Secretary	For assurance over Trust's process.	The Committee noted the assurance the report provided on the improving levels of compliance within the divisions on their timely review of risk, but action continues to be required to ensure that all the fields in relation to the risks are completed.
Internal Audit Reports - Activity Progress Report - Recommendation Follow Up Report	BDO (Internal Auditors)	For assurance over respective areas of internal control	The Committee noted the substantial positive opinion on the Trust's cash handling processes and reflected on the work undertaken to maintain and harmonise these systems post merger. Both the Internal Audit Reports covering the Trust's processes for dealing with NICE guidance and the recording of Surgical Site Infections were referred to the Quality Committee for oversight of the agreed improvement actions. The Committee noted the Internal Auditors view that there had been an uptick in engagement from the Trust in their work this year as seen by the improved level of action taken in respect of previous recommendations.

Counter Fraud Reports - Activity Progress Report - Fraud Risk Assessment	RSM (LCFS)	For assurance over respective areas of internal control and for information on the Trust's fraud profile and links to LCFS work	The Committee agreed the Fraud Risk Assessment and noted the activity being undertaken by the LCFS and others (Int Audit / Management etc) to provide assurance over the mitigations of these risks. The Committee noted this work will support the Trust risk register where fraud risks are recorded.
External Audit Update	GT (External Audit)	To note status of the External Audit work	The Committee noted that the 2022/23 audit had been concluded and work on the 2023/24 audit had yet to commence.
Annual Review and Report to the Council of Governors on the External Auditors	Chief Financial Officer / Director of Finance	To review and recommend to the Council of Governors	The Committee noted the positive performance of the External Auditors and that this would be reported to the Council of Governors.
Losses and Special Payments Register	Director of Finance	To note the report and the assurance it provides over the Trust's processes.	The Committee took assurance from the low level of these and that none of these identified any significant system weaknesses.
Tender Waiver Report	Commercial Director	To note the report and the assurance it provides over the Trust's processes.	The Committee noted the continuing low level of these and that the use of these were appropriate.
Information Governance (Data Protection Toolkit) Progress Report	Interim Chief Information Officer	To note the progress and consider	The Committee noted the Trust's assessment of compliance that being "approaching standards" and this was due to a small number of standards requiring evidence to be obtained as to their compliance. The Committee noted the high confidence level provided by management that all standards will be achieved by December 2023.
Health Roster Merger Programme update	Director of Workforce Planning & Deployment	For assurance over the governance processes established for the oversight of this programme.	The Committee noted the designed oversight and governance arrangements in place for this project and that the involvement of Internal Audit within the programme to enable timely assurance to be provided as the project is delivered.
Health and Safety Committee Chairs Report	Company Secretary	Provision of information on the activity of this Committee and review	The Committee noted the assurance provided over the management of the respective H&S risks.

		of the Committee's view of the Trust's Health and Safety risks.	
Audit Committee Report to Board	Audit Committee Chair	To provide assurance to the Board on the operation of the Committee.	The Committee agreed the report was a fair reflection of the activity of the Committee over the 2022/23 year and that it should be presented to the Board.

Actions taken by the Committee within its Terms of Reference

The Committee **AGREED** to recommend the Board the Committee's annual report (included as an appendix to this report).

The Committee **AGREED** to share the outcome of the review of the External Auditors positive performance during 2022/23 with the Council of Governors in support of their duties with regard to the external audit appointment.

The Committee **AGREED** the Fraud Risk Assessment undertaken by the Local Counter Fraud Service.

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

The Committee **AGREED** there were no specific matters from the meeting that required tracking outside of the routine business that would be presented to the next meetings.

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

Item	Referred to
The Committee endorsed the request of the Quality Committee Chair to review the continuing gap in assurance in respect or strategic risk 4.1. The Committee agreed that the support of the Quality Committee in respect of tracking the delivery of the actions from the NICE and SSI Internal Audit reviews would be beneficial ahead of the formal follow up by Internal Audit later in the year.	Quality Committee at its July meeting Quality Committee for review at its August meeting.

University Hospitals Sussex
NHS Foundation Trust

To: Board via the Audit Committee

Date: July 2023

From: Chair of the Audit Committee

ANNUAL REPORT FROM THE AUDIT COMMITTEE TO THE BOARD 2022-23

1.0 INTRODUCTION

1.01 The purpose of this report is to formally report to the Board on the work of the Audit Committee during the period 1 April 2022 to 31 March 2023 and to set out how the Committee has met its terms of reference and key priorities.

1.02 The Audit Committee's Terms of Reference require it to report annually to the Board outlining the work it has undertaken during the year and where necessary, highlighting any areas of concern.

2.00 EXECUTIVE SUMMARY

2.01 The Audit Committee has the delegated authority to act on behalf of the Board in accordance with the Constitution, Standing Orders, Standing Financial Instructions and Scheme of Delegation. It follows best practice guidance as set out in the NHS Audit Committee Handbook providing a form of independent check upon the management of the Trust.

2.02 The Committee is responsible for providing assurance to the Board that appropriate systems of internal control and risk management are in place covering all corporate and clinical areas of the Trust. In carrying out this work the Audit Committee obtains assurance from the work of the Internal Audit, External Audit and Counter Fraud Services.

2.03 The Committee independently reviews, monitors, and reports to the Board on the attainment of effective control systems and financial reporting processes supported by assurance from Internal Audit, External Audit, the Local Counter Fraud Service and Management through the BAF.

2.04 The Committee reviews the financial year-end Annual Report, Annual Accounts and Annual Governance Statement with the External Auditor prior to Board approval and sign off.

2.05 The Committee continues to drive forward developments to the structure of the Trust's Board Assurance Framework to better support the work of each Board Committee with their assurance reporting to the Board.

2.06 The Audit Committee through the membership of the respective Committee Chairs has been able to note the continuation of a quarterly risk review of the risks pertinent to each individual Board Committee, during their quarterly Board Committee meetings.

2.07 The Audit Committee was presented with a clear Internal Audit plan that was aligned to the Trust's Board Assurance Framework.

2.08 The Audit Committee over 2022/23 has engaged with the Company Secretary to enhance the format of the Board Assurance Framework to make clearer the impact of actions of the current risk scores and the development of an in-year target risk score to allow for better focusing of attention on those risk outside the yearly target score. The adjusted format is being used from April 2023 onwards.

3.00 COMMITTEE MEMBERSHIP AND MEETINGS

3.01 The Audit Committee comprises solely of independent Non-Executive Directors in line with the Code of Governance for Foundation Trusts. There are five Non-Executive Directors who are allocated to the Committee although all Non-Executive Directors, except for the Chair who attends by invitation only, can attend the meetings.

3.02 The Audit Committee, who play a pivotal role in providing assurance over the risk management processes of the Trust, has a membership of only Non-Executive Directors. Through the Non-Executive Chairs and the Audit Committee membership the Committee works with the other Board Committees to allow them to challenge robustly the Trust's management of risk and through the BAF that the Committees each seek reasonable assurance over the adequacy of the respective controls.

3.03 In order to share learning and to ensure linkages are made across Trust Committees the membership of the Audit Committee includes the Chair of the Quality Committee (Lucy Bloem), the Chair of the People Committee (Patrick Boyle), the Chair of the Patient Committee (formerly Jackie Cassell, now Claire Keatinge), the Chair of the Systems & Partnerships Committee formerly Patrick Boyle, but at the end of year moved to Bindesh Shah) and the Chair of the Sustainability Committee (Lizzie Peers).

3.04 The Chief Financial Officer, Chief Governance Officer, Director of Finance, Company Secretary, Local Counter Fraud Services, Internal and External Auditors are regular attendees at meetings of the Committee. Other Executives and Senior Managers also attend Committee meetings for specific items at the Committee's request usually linked to Internal Audit activity but in the latter part of 2022/23 to also engage with the Committee's ability to enhance the review of the Trust's BAF.

3.05 The table below details the membership and attendance of Committee members in respect of the period 1 April 2021 to 31 March 2022.

Name	***Apr***	****Jun***	***Jul***	***Oct***	***Jan***	***Total***
Jon Furmston (Non-Executive Director and Committee Chair) *Left the Trust 30 June 2022*	✓yes	✓yes	N/A	N/A	N/A	2 of 2
David Curley (Non-Executive Director and Committee Chair) *Joined the Trust on 1 July 2022*	N/A	N/A	✓yes	✓yes	✓yes	3 of 3
Lizzie Peers (Non-Executive Director)	✓yes	✓yes	✓yes	✓yes	✓yes	5 of 5
Lucy Bloem (Non-Executive Director)	✓yes	✓yes	× no	× no	✓yes	3 of 5
Joanna Crane (Non-Executive Director) *Left the Trust 30 June 2022*	✓yes	× no	N/A	N/A	N/A	1 of 2
Patrick Boyle (Non-Executive Director)	✓yes	✓yes	✓yes	✓yes	✓yes	5 of 5
Jackie Cassell (Non-Executive Director)	✓yes	× no	✓yes	× no	✓yes	3 of 5
Claire Keatinge (Non-Executive Director) *Committee Chair from January 2022*	N/A	N/A	N/A	N/A	✓yes	1 of 1
Bindesh Shah (Non-Executive Director) *Committee Chair from December 2022*	N/A	N/A	N/A	N/A	× no	0 of 1

*Annual Accounts Audit Meeting

4.00 CYCLE OF BUSINESS

4.01 The Audit Committee agenda is based upon an agreed forward work plan which is reviewed and approved at the start of the financial year.

4.02 Internal Audit activity is agreed jointly by both the Executive and the Non-Executive Committee members at the start of the year and are focused on areas of perceived highest risk alongside those required by the Head of Internal Audit to formulate his opinion. The Audit Committee receives the reports of these Internal Audits and tracks the implementation of recommendations at each of its meetings.

4.03 In order to maintain independent channels of communication, the members of the Audit Committee hold a private meeting collectively with External Audit, Internal Audit and Counter Fraud ahead of the April Audit Committee. This provides all parties the opportunity to raise any issues without the presence of management.

4.04 The Committee followed its agreed annual work plan throughout the year and received a series of executive presentations around Internal Audit, External Audit and Local Counter Fraud Services and dedicated additional time at each meeting to scrutinise in detail the Board Assurance Framework, Corporate Risk Register and Risk Management Compliance

5.00 INTERNAL AUDIT

5.01 Internal audit provide an independent and objective opinion on the degree to which risk management, control and governance support the achievement of the Trust's objectives.

5.02 The Trust's Internal Auditor for the year was BDO. In January 2023 the Committee approved a one-year contract extension for Internal Audit services from 01 July 2023 to 30 June 2024.

5.03 The Internal Audit plan for 2022/23 was approved by the Audit Committee in April 2022 as part of the wider three-year Strategic Audit Plan for 2022-2025. The plan was based upon discussions held with management and the Audit Committee and was constructed in such a way as to gain a level of assurance on the main financial and management systems reviewed.

5.04 The Head of Internal Audit presents a progress report to each of the Committee's meetings. The report sets out progress against the agreed audit plan, and the principal outcomes from audits completed in the period since the previous meeting. The Committee also receives a summary of all reports together with the full report of any audit with a Limited Assurance rating.

5.05 During the year the Audit Committee received 8 finalised Internal Audit reports, with those in draft and in progress being carried forward to 2022/23. Internal Audit Reports receive two Assurance ratings; one relates to the Design of the system being reviewed whilst the other relates to the Effectiveness of the system being reviewed. Internal Audit can provide Assurance Levels of: 'substantial', 'moderate', 'limited' or 'no' assurance. Of the audits relevant to this period four received an assurance level of either substantial or moderate, whilst one received an assurance level of limited on one aspect of effectivenss. Three of the Audit Reports we advisory in their nature and did not have an assurance rating. However, the Head of Internal Audit reflected in his opinion that UHSussex has, "a sound system of internal control, designed to meet the Trust's objectives and that controls are being applied consistently.".

5.06 Based on work undertaken during the period of this report the Head of Internal Audit has stated in his Head of Internal Audit Opinion that "Overall, we are able to provide moderate assurance that there is a sound system of internal control, designed to meet the Trust's objectives and that controls are being applied consistently".

5.07 In forming their opinion Internal Audit took into account that, the Trust had delivered its revised financial outturn of £10.4m deficit in-line with the forecast position from Month 10, that the majority of audits provided moderate assurance including the key audits of Key Financial Systems & Budgetary Control, Data Quality and Data Security & Protection Toolkit. In respect of all recommendations made, the Head of Internal Audit noted that "We have closed all but three prior year (2021/22) recommendations that have fallen due" but assured the Audit Committee that management are proactive in agreeing plans to address the risks identified in the 2022/23 audits.

6.00 LOCAL COUNTER FRAUD SERVICE (LCFS)

6.01 The Counter Fraud service was a hybrid provision combining the resources of the Trust's respective Counter Fraud Services, an internal provision, and an external provider RSM, who worked closely together and report quarterly to the Committee. In October the Committee approved the award of a 3-year contract for the period 01 November 2022 to 31 October 2025 to RSM. The team is responsible for day-to-day awareness and activities. The quarterly reports describe proactive work to prevent or deter fraud and also set out the results of reactive work undertaken in response to referrals about suspected fraud.

6.02 A work plan for 2023/24 was agreed with the Finance Director and approved at the Audit Committee in April 2023. The work plan outlined the core Local Counter Fraud Specialist (LCFS) activities to be undertaken during the financial year within the agreed resources. Key activities undertaken include areas of strategic governance, inform, and involve, prevent and deter and hold to account.

6.03 During the year the LCFS participated in a number of proactive projects to prevent or detect fraud. The LCFS also advised on improvements to policies and procedures, to reduce the risk of fraud.

6.04 The Local Counter Fraud Specialist reports annually on behalf of the Trust to the Counter Fraud Authority in relation to compliance against the Government Functional Standards. The Trust was rated as green for the last Self Review Tool which was fully compliant with the Standards and demonstrating the impact of work undertaken.

7.00 BOARD ASSURANCE FRAMEWORK

7.01 The Committee continues to drive forward developments to the structure of the Trust's Board Assurance Framework to better support the work of each Board Committee with their assurance reporting to the Board.

7.02 During the course of the year the Committee dedicated a substantial amount of focus on ensuring that the BAF was used to structure the assurances that the Committee sought through its meetings. In conjunction with the BAF the Committee received the Risk Management Compliance report which further supported the reporting and assurances received through the BAF.

7.03 The Audit Committee over 2022/23 has engaged with the Company Secretary to enhance the format of the Board Assurance Framework to make clearer the impact of actions of the current risk scores and the development of an in-year target risk score to allow for better focusing of attention on those risk outside the yearly target score. The adjusted format is being used from April 2023 onwards.

8.00 YEAR END REPORTING

8.01 The Committee reviewed and approved the Annual Report and Accounts and the Annual Governance Statement allowing the Audit Committee members to be appropriately engaged in the preparation of the Annual Report and Accounts.

8.02 The Committee also received information from the Chief Financial Officer and Finance Director that enabled the Committee to be assured that there were no matters that had not been disclosed to the Auditors.

8.03 The Committee received a report on the Trust's processes for registering declarations of interest, the receipt of gifts, hospitality, and sponsorship along with the compliance with the fit and proper persons' regime. The Committee was informed of the high return rate across the Trust with 831 of 837 consultants making a declaration, of those consultants that did not provide a return none had any budgetary responsibilities.

8.04 The submission of the 2022/23 Accounts and Annual Report took place on the 28 June 2023. This was in line with the national timetable.

9.00 EXTERNAL AUDIT

9.01 External Audit report to the Trust on the findings from their audit work, in particular their review of the financial statements and the Trust's economy, efficiency, and effectiveness in its use of resources.

9.02 Grant Thornton reported quarterly to the Committee. These reports included approval of the approach to the audit of the financial statements. The table below summarises the key elements of external audit work undertaken during the year:

Area of Work	Conclusion
Opinion on the Trust's:	
Financial statements	Unqualified opinion – Grant Thornton completed their audit of the financial statements and issued an unqualified audit opinion on 28 June 2023, following the Audit Committee meeting on 21 June 2023.
Parts of the remuneration and staff report to be audited	Grant Thornton had nothing to report in this regard.
Consistency of the annual report and other information published with the financial statements	Grant Thornton recommended that the Annual Report was updated to include more detail on the findings of the recent CQC report together with the Trust's plans to address key issues raised in the report, that it was also updated to include the Trust's key actions to assist with reducing waiting lists. These changes were made and included in the final submitted annual report. Grant Thornton had nothing further to report in this regard.
Reports by exception:	
Value for money arrangements	For 2022/23 within the Value for Money Conclusion the External Auditors provided a conclusion within three areas these being financial sustainability, governance and improving economy, efficiency, and effectiveness. In the area of governance, the conclusion reflects there is a significant weakness in the area of quality governance. For the other two areas no significant weaknesses were identified. The Annual Audit Report was provided at the Committee meeting on the 21 June 2023.
Consistency of Annual Governance Statement	Grant Thornton recommended that the Trust reflect on the recent CQC report upon reporting that there are no significant internal control weaknesses. The Trust updated the Annual Governance Statement. Grant Thornton had nothing further to report in this regard.
Referrals to the NHS Regulator	Grant Thornton have not referred any issues to the NHS Regulator for UHSussex.

Area of Work	Conclusion
Public interest report and other auditor's powers	Grant Thornton have not issued a Public Interest Report
Reporting to the Trust on their consolidation schedules	Grant Thornton concluded that the Trust's consolidation schedules agreed to the Trust's audited financial statements.
Reporting to the National Audit Office (NAO) in line with group instructions	Grant Thornton had nothing to report in this regard.

9.03 It is normal practice for there to be a full debrief to the Audit Committee following the submission of the year-end accounts. The Audit Committee noted the positive engagement and the pragmatic approach to completing the audit.

10.00 Reporting to the Trust Board

10.01 The Committee reported to the Trust Board after each meeting. A summary of the key points of discussion at each meeting, for example highlights of the internal audit reports or any formal recommendations were provided to the Board.

11.00 Engagement with the Council of Governors

11.01 The Chair of the Audit Committee is scheduled to report to the Council of Governors on the work of this Committee and the engagement made by External Audit. This reporting supported the Governors discharge their responsibility for the appointment of the Trust's External Auditors.

12.00 Conclusion

12.01 The Audit Committee of University Hospitals Sussex NHS Foundation Trust is of the view that it has taken appropriate steps to perform its duties as delegated by the Board and it has no cause to raise any issues of significant concern with the Board arising from its work during 2022/23.

12.02 In making this statement, the Committee members acknowledge the support given to it by management, in particular the Chief Financial Officer, Chief Governance Officer, the Director of Finance, and the Company Secretary, and that given by the internal and external auditors along with the local counter fraud specialist.

12.03 During 2023/24, the Committee will continue to drive forward the risk management and board assurance agenda with extended time being devoted within the Committee to the review of the impact of the actions to the Trust's strategic risks. Through the Audit Committee membership, the Committee will continue to use the inter committee referral processes to drive the respective Board Committee's ability to provide strengthened assurance to the Board on the Trust's risk profile. This will be supported through the introduction of a defined annual target risk allowing the Board to better understand where risk outside the Board appetite is identified.

13.00 Recommendation

13.01 The Board e is asked to **NOTE** the activity of the Audit Committee

David Curley
Chair of the Audit Committee
July 2023

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	23.1	**Meeting:**	Trust Board Meeting	**Meeting Date:**	July 2023
Report Title:	CQC divisional action plans compliance report				
Sponsoring Executive Director:	Leanne McClean, Interim Chief Nursing Officer				
Author(s):	Amanda Feest, CQC Registration and compliance Manager				
Report previously considered by and date:	Jo Habben, Director of Patient Safety and Learning				

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

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

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	N/A	Link to Trust Annual Plan	Yes

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	Yes	
Sustainability	Yes	
People	Yes	
Quality	Yes	
Systems and Partnerships	Yes	
Research and Innovation	N/A	

Link to CQC Domains:			
Safe	Yes	Effective	Yes
Caring	N/A	Responsive	Yes
Well-led	Yes	Use of Resources	N/A

Regulatory / Statutory reporting requirement

CQC Regulations

Communication and Consultation:

Dissemination of any actions or escalation by membership of the group.

Executive Summary:

This report has been developed following the CQC inspections as listed below:

- Royal Sussex County Hospital unannounced inspection on 26th September 2021 to Surgery (main theatres) and Maternity (Inpatient services) and re-inspection on 26th & 27th April 2022
- Princess Royal Hospital unannounced visit to Maternity (Inpatient services) in October 2021 and re-inspection on 26th April 2022
- Worthing Hospital, Maternity (Inpatient services) on the 26th & 27th April 2022
- St. Richards Hospital, Maternity (Inpatient Services) on the 26th and 27th April 2022
- Royal Sussex County Hospital, Urgent and Emergency Services on 26th & 27th April 2022
- Royal Sussex County Hosptial, Gastro-Intenstinal Surgery and cancer Care – unnanounced inspection on 15th August 2022
- RSCH, Neurosurgery Services – unnanounced inspection October 2022

The interim chief nursing officer (CNO) has met with the divisional directors of nursing (DDONs) to review current status with their action plans and shared these with the CQC as requested. The review focused on the following:

- if actions are closed is there evidence to support this and how has oversight moved into Business as Usual (BAU)?
- If not achieved what are the outstanding actions and by when will these be closed? In the meantime, who has oversight of the risks and how these are monitored and mitigated?

The interim CNO recognises that the next step is to review the evidence against the 'completed' actions. It should be noted that there are a number of actions for which previously agreed 'close by dates' will not be achieved as they are by nature 'ongoing'. For example, those relating to staffing as this can change and close attention needs to be paid consistently. Further discussions need to be had to move these actions to a position of Business as usual (BAU) monitoring through divisional governance and to reflect this in future updates of this report.

The interim CNO recognises that the next step is to review the evidence against the 'completed' actions. It should be noted that there are a number of actions for which previously agreed 'close by dates' will not be achieved as they are by nature 'ongoing'. For example, those relating to staffing as this can change and close attention needs to be paid consistently. Further discussions need to be had to move these actions to a position of Business as usual (BAU) monitoring through divisional governance and to reflect this in future updates of this report.

The content of the report summarises the CQC 'Must do' and 'Should do' actions listed on published CQC inspection reports with the division's status of compliance to these; for the purpose of ongoing assurance to the group. The table below represents the summary of actions completed or on track, actions in progress and actions outstanding for each division:

Divisional 'must do' and 'should do' actions	Total no Actions	Actions on track / complete	Actions in progress	Actions awaiting plan
Surgery 2022 ' Must do' actions	7	3	4	0
Surgery 2022 'Should do' actions	5	4	1	0
Maternity RSCH 2022 'Must do' actions	2	1	1	0
Maternity RSCH 2022 'Should do' actions	1	1	0	0
Maternity PRH 2022 'Must do' actions	1	1	0	0
Maternity PRH 2022 'Should do' actions	3	2	0	0
Maternity WTG 2022 'Must do' actions	1	1	0	0
Maternity WTG 2022 'Should do' actions	10	7	3	0
Maternity SRH 2022 'Must do' actions	1	1	0	0
Maternity SRH 2022 'Should do' actions	3	3	0	0
Emergency Department, RSCH 2022 'Must do' act	6	3	3	0
Emergency Department, RSCH 2022 'Should do a	6	3	3	0
Upper GI Surgery, RSCH 2022 'Must do' actions	10	8	3	0
Upper GI Surgery, RSCH 2022 'Should do' actions	0	0	0	0
Neurosurgery, RSCH 2023 'Must do' actions	9	4	5	0
Neurosurgery, RSCH 2023 'Should do' actions	5	5	0	0

Key Recommendation(s):

The Board are asked to note the content of the divisional action plans and current compliance.

1.0 Introduction

Further to the Care Quality Commission (CQC) inspections to our Maternity Inpatient Services (Trust-wide), Surgery services at The Royal Sussex County Hospital (RSCH), our Emergency Department at RSCH, the Upper Gastro-Intestinal Surgery and cancer Care services at RSCH and Neurosurgery services, RSCH, the CQC have published report findings including necessary actions that the Trust 'Must do' to comply with its legal obligations.

Alongside of these are the provision of 'Should do' actions. These are noted as the Trust "*not seen to be doing something required by a regulation, but it would be deemed disproportionate for the CQC to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services".*

The interim CNO has met with the divisional DDoNs to review current status with their action plans and shared these with the CQC as requested. The review focused on the following:

- if actions are closed is there evidence to support this and how has oversight moved into Business as Usual (BAU)?
- If not achieved what are the outstanding actions and by when will these be closed?
- In the meantime, who has oversight of the risks and how these are monitored and mitigated? Monitoring of monthly action plan updates will be through divisional governance with a report into Quality Governance Steering Group, Chaired by the iCNO and CMO. The report is further presented and discussed at the Trust Management Committee.

The iCNO recognises that the next step is to review the evidence against the 'completed' actions.

It should be noted that there are a number of actions for which previously agreed close by dates will not be achieved as they are by nature 'ongoing'. For example, those relating to staffing as this can change and close attention needs to be paid consistently. Further discussions need to be had to move these actions to a position of BAU monitoring through divisional governance and to reflect this in future updates of this report.

1.2 Compliance report to Quality Governance Steering Group

To maintain central oversight, the CQC compliance team will request monthly submissions of the divisional action plans via the divisional triumvirate, copying in the associated hospital directors, hospital directors of nursing and the executive team.

The action plans include the CQC 'must do' and 'should do' actions, identified gaps in controls or assurance with risks associated to these, a brief narrative where actions are outstanding and planned dates for action closure. The action plans will be RAG rated as follows with clear dates of actions completed or due completion:

Actions on track or completed	Actions partially complete or plan in place with date for completion	Awaiting action plan

Non-submissions of action plans will be identified in the report and escalated by the Quality Governance Steering Group. The content of the report will be summarised and shared with the Quality Committee and Trust Management Board.

2.0 UHSussex Action plans

RSCH Surgery Action plan 2022 – update July 2023 (submitted to CQC on 21/07/2023)

'Must do' action – RSCH Surgery 2022	Date raised	RAG Status	Due date for completion / completion date	Gaps in assurance / Current Performar
The trust must monitor the risk of harm and outcomes for patients who experience cancellations of surgery. Regulation 12 (2) (a) (b)	July 2022	**Actions partially complete or plan in place with date for completion**	Will continue to monitor for harm	A corporate project has begun to identify opportunities to redistribute surgical services across the entirety of UHSussex to create emergency and elective capacity where it is required. All trauma delays are reported on Datix and discussed at SIRG. A process is in place to review delays in trauma surgery post operatively and following first OPD appointment, led by the lead clinician. Duty of candour process is followed if harm identified.
The service must ensure that there is enough staff with the right skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Regulation 18 (1)	July 2022	**Actions partially complete or plan in place with date for completion**	Ongoing	Agency staff are being block booked 8 weeks in advance to meet the demands of theatres. There are now less Datix's relating to staff shortages. Rotational Band 6 position is being advertised. The Divisional Director of Nursing is engaged with the wider Trust senior nursing team in developing new ways of working and facilitating the future growth, development and retention of our workforce. To support retention, we have recruited 14 staff to additional 'flexible Band 6' posts, starting between July and September. To further support recruitment we have centrally agreed that RSCH Theatres will be a focus for international recruitment. Plans

				in place to put further staff on the Associate Theatre Practitioner course. The corporate project identified the need for further consultants, a business case is in development. The new rotational posts have been popular, and all have successfully been recruited to and due to success of the Band 5 rotational post a further 2 jobs will be advertised (RSCH/SEH/Neuro). The next couple of months will require locum support in theatres whilst we are waiting on new recruits to join.
STAM: The service must ensure staff complete their mandatory training and each module meets their compliance targets. Regulation 12 (2) (c)	July 2022	**Actions partially complete or plan in place with date for completion**	Compliance monitoring BAU.	STAM at June 2023 is at 86.1% for the division of surgery. RSCH Theatres = 94%. After analysing the data, the team have picked out the areas that need addressing by subject and staff groups and are targeting those to improve compliance by holding managers to account for delivery on improvement.
Delays: The service must ensure that patients receive surgery when they need it and do not experience delays, placing patients at risk of deterioration and harm. Regulation 12 (2) (a) and Regulation 12 (2) (b)	July 2022	**Actions partially complete or plan in place with date for completion**	Ongoing review	The Trust & RSCH site particularly has been in Opel 3 or 4 for the last 3 months affecting timely delivery of surgery. Clinical operations representative is always rostered to help co-ordinate bed availability and maximise theatre utilisation. Recent doctor and nursing strikes have led to cancellation of elective surgery. A corporate project has been set up to develop a strategic plan for surgical services across UHSussex, ensuring all resources are utilised to improve RTT performance.
Recovery Flow: The service must ensure it improves flow in the hospital and theatres to reduce the time patients spend in the recovery unit waiting for a bed in the hospital. Regulation 12 (1)	July 2022	**Actions completed**	Completion date TBC	N/A

HDU/ ITU: The service must ensure it has suitable facilities to care for patients requiring high dependency or intensive care. Regulation 12 (2) (b)	July 2022	**Actions completed**	Completion date TBC	N/A
Theatre Training: The service must ensure that staff working in theatres and recovery have the qualifications, competence, skills and experience to keep patients safe. Regulation 12 (2) (c)	July 2022	**Actions completed**	Completion date TBC	N/A

RSCH Action plan 2022

'Should do' action – RSCH Surgery 2022	**Date raised**	**RAG Status**	**Due date for completion / completion date**	**Gaps in assurance / ongoing actions**
Governance Process: The trust should monitor the governance processes of all surgical disciplines to ensure they are able to assess, monitor and improve the quality and safety of the service. Regulation 17 (2) (a)	July 2022	**Actions partially complete or plan in place with date for completion**	December 2023	For general surgery the corporate project has reviewed all governance processes and a new framework has been introduced, along with the appointment of governance leads. All directorates utilise a standard reporting template for their reports to Divisional Governance covering all the domains of governance. July 2023 - Good Governance Institute maturity assessment been undertaken and along with changes in Trust reporting the division will look to move this action to business as usual by December 2023.
CPD: The service should ensure it provides continuous professional development to all staff. Regulation 18 (2) (b)	July 2022	**Actions on track or completed**	Due date TBC	Theatre Appraisals 81% -Data at May 2023 Weekly reviews undertaken with those areas not reaching over 90% to support compliance. Plans to achieve 90% by the end of September in place with managers held to account through divisional reporting for delivery.

				Very positive feedback from ODP students and newly inducted staff on the quality of development and support.
WHO Audits Theatres: The service should ensure all parts of the with World Health Organisations (WHO) '5 Steps to safer surgery' checklist process are adhered and monitored to ensure compliance. Regulation 17 (2) (f)	July 2022	**Actions on track or completed (CQC warning notice)**	On Track Monitored as BAU	JUNE 2023 Data: RSCH 100% Neurosurgery Obstetrics RSCH 100% Sussex Eye - 100% PRH Theatres JUNE No Submission JULY Data 100% Obstetrics PRH - JUNE No submission JULY data is 100% HWP - 100% SOTC - 100% LVH 100%

Warning Notice actions RSCH Surgery	**Date raised**	**RAG Status**	**Due date for completion / completion date**	**Gaps in assurance / ongoing actions**
Staffing - Emergency surgery: In main theatres, at RSCH we found a lack of sufficient and suitably trained staff to provide an emergency surgery service (RSCH – Surgery)	December 2021	**Actions partially complete or plan in place with date for completion**	Not stated	Ongoing recruitment and staff development processes in place for RSCH Theatres. 14 new staff starting over the next 3 months. Daily risk mitigated by risk assessment process.
Staffing - Skill Mix Theatres: There isn't a system to determine the number of staff and range of skills required in order to meet the needs of service users in main theatres (RSCH – Surgery)	December 2021	**Action complete**	Completed July 2023	Appraisal rate at 81%. This is mainly due to all new staff within the first 3 months been added to the list. Plans in place to get back on track by the end of September. This is monitored fortnightly by the DDON and HRBP. STAM is at 96%.

AfPP Theatre Staffing: Between April - September 2021 a total of 406 theatre lists ran with the staffing below the Association for Perioperative Practice (AfPP) guidelines (RSCH – Surgery)	December 2021	**Action complete**	Completed July 2023	July 2023 - Five locum anaesthetists have been recruited which should improve the situation over the next few months. We have had to cancel 2 lists recently due to theatre staff availability, again we have 14 staff waiting to start who will improve the situation.
Recovery skills: Staff did not have the skills or competencies to provide this care safely (RSCH – Surgery)	December 2021	**Action complete**	Completed July 2023	Recovery staffing = 28 members of staff 96% (27 out of 28) recovery staff completed initial recovery course (target 100%) - remaining staff member to join next available course (awaiting date confirmation). 54% recovery staff completed recovery competencies (target 100%) & 33% are underway. 6 recovery staff critical care trained, with 1 further starting course Sept 22 to achieve required target (target 25% = 7 staff). 2 staff starting CC course in Sep 23. Recovery course is currently being revised.
Recovery usage: The recovery area in main theatres at Royal Sussex County Hospital was not being used for its intended purposes or for additional purposes agreed to meet demand during busy times (RSCH – Surgery)	December 2021	**Actions partially complete or plan in place with date for completion**	Due April 2024	Ongoing daily review. New Critical Care Unit (CC) opened in LMB - SOP revised in conjunction with this opening. Renewed effort to ensure CC discharges are prioritised. Recognise there may be occasions when there is a need for patients to remain longer than best practice in the recovery. Actions in the SOP are followed in this situation.
Recovery escalation: Staff did not know that the recovery area was an escalation area for service users during busy times and were using the area to care for service users with high-dependency or intensive care needs (RSCH – Surgery)	December 2021	**Action complete**	Completed July 2023	Recovery escalation board in use. 8am Safety Huddles highlighting overnight Recovery escalation.
Recovery time: We also found service users were cared for this in this area for extended lengths of time. For example, service users were in this area between 41 minutes and 41 hours (RSCH – Surgery)	December 2021	**Actions partially complete or plan in**	Due April 2024	SOP has been revised with the hospital director and lead nurse to ensure that critical care discharges are prioritised. This

		place with date for completion		will be monitored through audit, but initial feedback has been very positive. Before closing this action, we want to be assured that the number of patients staying an extending period of time is consistently at a minimum.
Resus Trolley: On Level 9 one resus trolley did not have a safety check on ten occasions in a four-week period (RSCH – Surgery	December 2021	**Actions completed**	Completed July 2023	N/A
Incidents Backlog: There was a backlog of 56 incidents in theatres at the Royal Sussex County Hospital that had not been reviewed or investigated.	December 2021	**Actions partially complete or plan in place with date for completion**	Ongoing BAU	Ongoing review of Datix compliance through divisional and directorate governance meetings. Managers held to account for delivery on closing.
Incidents Feedback: Although there was a system in place to provide feedback following incidents staff did not receive feedback from all incidents or have an opportunity to learn from them (RSCH – Surgery)	December 2021	**Actions completed**	Completed July 2023	Ongoing process for feedback on incidents in place. BAU.
Incidents - Investigation Training: In theatres at the Royal Sussex County Hospital incidents were not thoroughly investigated by staff who had received training in how to investigate incidents.	December 2021	**Actions completed**	Completed July 2023	HSIB trained investigators in Surgery East: Two. Current no. of low/no harm RSCH Theatres investigators:16
Local Clinical Guidelines - Clinical guidelines reviewed during the inspection where significantly out of date and referred to incorrect national guidance (All Sites – Surgery E)	December 2021	**Actions partially complete or plan in place with date for completion**	Due November 2023	July 2023 - Ongoing review of guidelines clinical with clinical leads assigned to each one out of date. Working with central COEG team to centralise all clinical guidelines. Once all updated there will be a continuing process through directorate and divisional governance to maintain currency.

Identified risks in implementing actions:

- Datix ID 2383 / 31: Surgical Division RTT Performance below accepted standards (2383)
- Datix ID 29: Delayed Emergency and Cancelled Elective surgery due to staffing at RSCH.

2.2 Maternity RSCH action plan – update July 2023 (submitted to CQC on 21/07/2023)

'Must do' action – RSCH Maternity	Date raised	RAG Status	Due date for completion / completion date	Gaps in assurance / ongoing actions
The trust must ensure the maternity triage RAG ratings recorded in the electronic patient record. (Regulation 12 (1) (2)	July 2022	**Actions partially complete or plan in place with date for completion**	Implemented 17/07/2023	July 2023 - Audit tool to ensure compliance across all four sites. Will be reviewed at monthly four site meeting.
The trust must ensure regular checks on lifesaving equipment are undertaken. (Regulation 12: (2) (b, e).	July 2022	**Actions completed**	Completed 28/02/2023	Fully compliant. BAU.

'Should do' action – RSCH Maternity	Date raised	RAG Status	Due date for completion / completion date	Gaps in assurance / ongoing actions
The trust should ensure the temperature of clinical rooms where medicines and intravenous are stored is monitored daily and remains under 25 degrees centigrade (Regulation 12)	July 2022	**Actions completed**	Completed July 2023	N/A

Identified risks in implementing actions:

- Datix ID 1331: Staffing – dependent on successful international recruitment.

2.3 Maternity PRH action plan – update July 2023 (submitted to CQC on 21/07/2023)

'Must do' action – PRH Maternity	Date raised	RAG Status	Due date for completion / completion date	Gaps in assurance / ongoing actions
The trust must improve staffing levels to maintain safe staffing levels. (Regulation 18 (1))	July 2022	**Action completed**	Completed July 2023	N/A

'Should do' action – PRH Maternity	Date raised	RAG Status	Due date for completion / completion date	Gaps in assurance / ongoing actions
The trust should ensure the implementation of a systematic approach for risk assessing women in triage is continued to be embedded.	July 2022	**Actions partially complete or plan in place with date for completion**	Review August 2023	July 2023 – Ongoing work to review BSOTS with planning review for clinical area.
The trust should ensure that regular checks on lifesaving equipment are undertaken.	July 2022	**Action completed**	Completed 28/02/2023	All staff have log in access and training has been provided.
The trust should ensure that carbon monoxide screening is undertaken.	July 2022	**Actions on track or completed**	Review August 2023	Current status - All staff are equipped with monitors. SBL this information is collated; training figures will be reported in the monthly for each quarter. VBA is incorporated into the yearly mandatory training as BAU.

Identified risks in implementing actions:

- Datix ID 1331: Staffing – dependent on successful international recruitment
- Datix ID 1207: BSOTS full implementation – dependent on business case approval

2.4 Maternity WTG action plan – update July 2023 (submitted to CQC on 21/07/2023)

'Must do' action – WTG Maternity	Date raised	RAG Status	Due date for completion / completion date	Gaps in assurance / ongoing actions
The service must ensure it continues to monitor regular checks on resuscitaires to limit the risk of any gaps in the daily checks. (Regulation 12 (2) (b, e)	July 2022	**Action Completed * CQC Enforcement action**	Completed 28/02/2023	Compliance review BAU.

'Should do' action – WTG Maternity	Date raised	RAG Status	Due date for completion / completion date	Gaps in assurance / ongoing actions
The Trust should ensure the maternity telephone triage services are delivered by experienced midwives. (Regulation 12 (1) (2) (a, b)	July 2022	**Actions partially complete or plan in place with date for completion**	Review August 2023	07/07/2023 - Plan B for location of maternity assessment area at Worthing currently in place (Initial area was suspended as felt to be too far away from Labour ward). Estates work being completed (sinks, call bells etc) BSOTS continues but currently within the ward footprint.

				MAU plan being presented at Q&S meeting in July has been agreed by estates and infection control teams. Monthly four sites BSOTS meeting, meeting 31st July will discuss telephone calls and recording across the sites. Badgernet available since 13th June so a move towards just reporting calls on Badgernet will be discussed at next meeting.
The service should ensure that it continues to monitor cardiotocographs (CTG) documentation to embed accurate documentation of CTG readings and accurately categorise their findings. (Regulation 12 (a)	July 2022	**Action completed**	Completed December 2022	July 2023 - BAU - Audits continue undertaken by FWB midwives monthly and reported as per SBLCB, business case approved, and extra hours will be advertised to increase the hours to 1 WTE for each site once cross site job descriptions are approved, and budgets are amended by the finance team. One midwife has already had her hours increased from 7th August 2023. this will allow more time on the delivery suite performing fresh eyes and live audits.
The trust should ensure that simulated pool evacuation training is completed as a priority for all staff caring for women in labour. (Regulation 12 (1) (2) (a, b)	July 2022	**Action completed**	Completed 31/03/2023	July 2023 - Video developed for all staff across all 4 sites due to difficulties with the number of pools we have and using pools for training impacting a patient's choice to have a pool birth. The video is now on IRIS and as of 7th July 2023 71% of staff have seen the video, the register of attendance is now kept by the PD admin team.
The service should ensure it maintains securely an accurate, complete, and contemporaneous record in respect of each service user (Regulation 17(C)	July 2022	**Actions completed**	Completed July 2023	07/07/2023 - Worthing and Chichester have successfully implemented Badgernet from 13th June, monthly notes audits continue to be completed and audit of compliance with Badgernet also being undertaken.
The service should ensure that the divisional risk register continues to be update on a regular basis and that it includes clear time frames for completion. (Regulation 17(C)).	July 2022	**Actions completed**	Completed December 2022	07/07/2023 - Worthing and Chichester have successfully implemented Badgernet from 13th June. Monthly notes audits continue to be completed and audit of compliance with Badgernet also being undertaken.
The trust should consider updating the job description for the band 5 nurses working on the maternity ward to reflect their remit and ensure clear boundaries between midwifery and nursing care.	September 2022	**Action completed**	Completed July 2023	07/07/2023 - Job description was completed by staff at PRH & RSCH, SOP for the role of the nurse has been ratified in June JOGG meeting and shared with staff.

The trust should consider increasing the working hours of the fetal wellbeing midwife to make sure outcomes of audits can be followed up and improved.	September 2022	**Action completed**	Completed 31/05/2023	07/07/2023 - Business case approved, now Job descriptions being written and approved, and roles will go out to advert.
The trust should consider implementing annual medicines management competency training. So that they are confident all staff administering medication to mothers and babies are doing so safely.	September 2022	**Actions partially complete or plan in place with date for completion**	Ongoing Trust-Wide action	10/07/2023 - Currently all new staff have to undertake EPMA training which is accessed through IRIS and an E learning module. Currently there is no Trust wide yearly update on medicines management. This has been discussed at the Medicines Optimising committee and is currently being reviewed.
The trust should consider using MEOWS observations charts as soon as a woman arrives for care.	July 2022	**Actions completed**	Completed June 2023	07/07/2023 - Since the introduction of Badgernet on 13th June all observations are now recorded onto Badgernet. The digital team undertake weekly compliance checks that data is being correctly reported, this has become business as usual.
The trust should consider identifying a designated area to safely and appropriately triage women who call the unit unexpectedly.	August 2022	**Actions partially complete or plan in place with date for completion**	October 2023	07/07/2023 - Plan B for location of maternity assessment area at Worthing currently in place (Initial area was suspended as felt to be too far away from Labour ward). Estates work being completed (sinks, call bells etc). MAU plan being presented at Q&S meeting in July has been agreed by estates and infection control teams. BSOTS undertaken currently from inpatient area. Monthly 4 sites BSOTS meeting, meeting 31st July will discuss telephone calls and recording across the four sites. Badgernet available since 13th June so a move towards just reporting calls on Badgernet will be discussed at next meeting.

Identified risks in implementing actions:

- Datix ID 1206: BSOTS full implementation – Assessment area now fully functional on the Chichester site, plans stil underway at Worthing.
- Datix ID: 1480: Implementation of yearly Medicines management competency training - Currently the trust does not offer a yearly medicines management competency training update for staff, all new staff have to undertake EPMA training which is accessed through IRIS and an

E-learning module. Currently there is no Trust wide yearly update on medicines management. This has been discussed at the Medicines Optimising committee and is currently being reviewed. This is a risk for the Trust as a whole not just maternity. Initial Grading: 10.

2.5 Maternity SRH action plan – update July 2023 (submitted to CQC on 21/07/2023)

'Must do' action – SRH Maternity	Date raised	RAG Status	Due date for completion / completion date	Gaps in assurance / ongoing actions
The trust must ensure regular checks on lifesaving equipment are undertaken. (Regulation 12: (2) (b, e).	June 2022	**Actions completed** * CQC Enforcement action	Completed January 2023	07/07/2023 - Now fully compliant with TENDABLE. Greater than 95% compliance, reported daily on Maternity Daily Standard spreadsheet, reviewed daily by senior midwifery leadership team - reporting has become business as usual.

'Should do' action – SRH Maternity	Date raised	RAG Status	Due date for completion (if applicable)	Gasps in assurance / ongoing actions
The trust should ensure that training for emergency evacuation from birthing pools is booked for staff to ensure they are up to date a soon as possible. (Regulation 12)	July 2022	**Action complete**	Completed July 2023	07/07/2023 - Video developed for all staff across all 4 sites due to difficulties with the number of pools we have and using pools for training impacting a patient's choice to have a pool birth. The video is now on IRIS and as of 7th July 2023 71% of staff have seen the video, the register of attendance is now kept by the PD admin team.
The trust should ensure consistency with the use of the birth-rate plus tool and escalation policies to ensure safe staffing numbers. (Regulation 17)	July 2022	**Action complete**	Completed February 2023	07/07/2023 - All shift leads trained in use of acuity tool, expectation for 85% compliance as recommended by BR+ team. Acuity is reported monthly in safer staffing report which is discussed at Q&S meeting monthly. Has become business as usual.

The trust should continue to embed the new triage tool and ensure all records are updated when women contact the service.	June 2022	**Actions complete**	Review August 2023	07/07/2023 - Maternity assessment unit and day assessment unit now relocated from the ground floor to 3rd floor adjacent to labour ward since June 2023. Audit tool for paperwork has been reviewed and will be discussed at the monthly BSOTS meetings across the 4 sites. Audit of number of women attending MAU will be completed monthly by Labour Ward Manager and reported in staff newsletters.

Identified risks in implementing actions:

- Datix ID 1206: BSOTS full implementation – new area identified.

2.6 Emergency Department RSCH action plan – updated July 2023 (submitted to CQC on 21/07/2023)

'Must do' action – ED RSCH	Date raised	RAG Status	Due date for completion / completion date	Gaps in assurance / ongoing actions
The trust must ensure that action is taken to improve the environment of the emergency department to ensure it is suitable for its use and protects patients' privacy and dignity. (Regulation 15)	August 2022	**Actions on track or completed**	Due 30/09/2023	Ongoing actions: Acute Floor Rebuild planning - Mitigated by Weekly clinical update meeting. Regular stakeholder sessions. Phasing planning meetings ongoing. Three-year project plan. Protected assessment - Mitigated by regular huddles during shift to make dynamic reviews. Flexible use of departmental footprint - Space flexibly/dynamically i.e., Fit2Sit, CDU Chairs. Reviewed weekly through Emergency Performance Improvement Group (EPIG).

The trust must ensure that all areas of the department can be cleaned effectively. (Regulation 12)	August 2022	**Actions partially complete or plan in place with date for completion**	Due 30/09/2023	Ongoing action: IPC walkabouts - Outputs managed through SQP monthly meeting.
The trust must ensure that staff complete appropriate lifesaving training. (Regulation 12)	August 2022	**Actions partially complete or plan in place with date for completion**	Due 30/09/2023	Ongoing actions: Nursing team away study days - ongoing five-week programme includes STAM and ED specific education. Commenced May 2023. Internal ABLS Education days for Medical/Nursing workforce. Risks mitigated through ensuring all Band 7 nurses remain updated with PBLS and ABLS to ensure at least one person is on duty at all times.
The trust must ensure that staff complete required safeguarding training. (Regulation 12)	August 2022	**Actions partially complete or plan in place with date for completion**	Due 30/09/2023	Ongoing action: Nursing team away study days Not complete/ongoing five-week programme includes STAM and ED specific education. Commenced May 2023.
The trust must ensure all patients are cared for in designated patient areas. (Regulation 12)	August 2022	**Actions on track or completed**	Due 30/09/2023	Ongoing actions: Acute Floor Rebuild planning - Mitigated by Weekly clinical update meeting. Regular stakeholder sessions. Phasing planning meetings ongoing. Three-year project plan. Protected assessment/care giving cubicle - Mitigated by regular huddles during shift to make dynamic reviews. Flexible use of departmental footprint - Space flexibly/dynamically i.e., Fit2Sit, CDU Chairs. Reviewed weekly through Emergency Performance Improvement Group (EPIG).

The trust must make sure patients with mental health illnesses accommodated in the emergency department receive care and treatment from staff who have the relevant skills and experience. (Regulation 12)	August 2022	**Actions partially complete or plan in place with date for completion**	Due 31/12/2023	Ongoing actions: Department specific Mental Health training CAIT, Conflict resolution. Assured by all HCA booked for September/October. Trust development and recruitment into Enhanced Care Team. Dedicated Mental Health Space - Mitigated through use of trust risk assessments and utilisation of RMNs and HCAs. Trust development and recruitment into of Enhanced Care team commencing Aug 2023. Enhanced Care team - Recruitment underway July 2023. Current mitigation through trust risk assessments and utilisation of RMNs and HCAs. Commencing Monday 24 July 2023 - Collaboration between SPFT, ICB and UHSx developing pathways to ensure that the care of patients with primary mental health needs is delivered outside of the ED environment.

'Should do' action – ED RSCH	**Date raised**	**RAG Status**	**Due date for completion / completion date**	**Gaps in assurance / ongoing actions**
The trust should ensure that staff compliance with mandatory training meets the trust target. (Regulation 12(2)	August 2022	**Actions partially complete or plan in place with date for completion**	Due 30/09/2023	Ongoing action: Nursing team away study days - Five-week programme includes STAM and ED specific education. Commenced May 2023.

The trust should ensure that completion of staff appraisals meets the trust target. (Regulation 18(2)	August 2022	**Actions partially complete or plan in place with date for completion**	Due 30/09/2023	As above
The trust should ensure the practice of open notes trolleys in the department does not pose a risk to patient confidentiality.	August 2022	**Actions on Track**	Completed 31/05/2023	Ongoing action: Low risk on risk register - HoN to undertake risk assessment Aug 2023.
The trust should consider improving the environment to meet the needs of people living with dementia.	August 2022	**Actions on Track**	Completed 30/06/2023	Ongoing actions: Acute Floor Rebuild planning - Mitigated by Weekly clinical update meeting. Regular stakeholder sessions. Phasing planning meetings ongoing. Three-year project plan. Department specific Mental Health training, CAIT, Conflict resolution - Assured by all HCA booked for September/October. Trust development and recruitment into enhanced Care Team. Frailty pathway to Frailty wards - Recruitment of dedicated Frailty team within medicine division to lead and maximise pathways.
The trust should consider introducing a structured approach to share learning form incidents.	August 2022	**Actions partially complete or plan in place with date for completion**	Commenced 31/05/2023	Ongoing – BAU.
The trust should consider improving the facilities for relatives.	August 2022	**Actions on Track**	Ongoing works until Spring 2026	Ongoing re-build.

Identified risks in implementing actions:

- Datix ID 44: 1527: There is a risk of compromised unsafe and inadequate care when patients are in the ED corridor. Risk rating 25
- Datix ID 47: 2427: Risk of harm to staff and patients by violent and aggressive patients n ED. Risk rating 15
- Datix ID 61: 1614: Impact of South East Coast Ambulance service delayed handover policy. Risk Register 16
- Datix ID 67: 2068: Risk of configuration of ED delay. Risk register 12
- Datix ID 251: 2088: Risk of reduced staffing and wellbeing and stress due to high numbers of patients and environmental factors. Risk register 20
- Datix ID 252: 2089: Lack of mental health inpatient bed capacity local and nationally impacting on patients and staff safety. Risk register 15
- Datix ID 256: 2367: Infection control risk due to lack of single side rooms on the acute floor. Risk register 12
- Datix ID 259: 2424: Risk of cross infection due to lack of ability to socially distance in ED RSCH. Risk register 12
- Datix ID 262: 2618: Overdue staff STAM which could result in patient harm. Risk register 12
- Datix ID 297: 2475: Inability to provide the appropriate management and care of patients with mental health and eating disorders. Risk register 10.

2.7 RSCH Surgery, Upper Gastro-Intestinal action plan – Update July 2023

NB: CQC have been advised that as RSCH GI service is not undertaking this surgery and things have moved on, the Trust would not be submitting the original action plan.

'Must do' action – RSCH, Surgery Upper GI	Date raised	RAG Status	Due date for completion / completion date	Gaps in assurance / ongoing actions
The Trust must ensure that there is a robust governance and risk arrangements to provide assurance that the upper gastrointestinal service is safe, effective and well led. (Regulation 17)	November 2022	**Actions on track**	Phase 2 – Due 31/12/2023	**Current status**: 06/06/2023 - M&M, QSPE and governance process ongoing. The GSIP will continue to oversee all governance activity and risk mitigation, for a minimum of 12 months to deliver consistent changes in core governance processes and engagement. The specialist external support will be in place for the initial six months of the programme, to deliver the momentum that this work requires. Additional resource and support are being provided via the Trust Project Management Office (PMO). **Surgery Improvement Plan:** Other phases will be confirmed based on completion on Phases 1&2. Expected to set improvement trajectories and milestones for first 90 days, six months and one year.
The Trust must ensure there are enough numbers of appropriately trained and competent upper gastrointestinal consultants working in the service in line with the "NHS standard contract for cancer: oesophageal and gastric (adult) section B Part 1 service specifications." (Regulation 18)	November 2022	**N/A**	N/A	**Status:** Action no longer relevant as UHSx will not be carrying out OG resections.

The Trust must ensure there is enough Cancer Nurse Specialist resources to support the upper gastrointestinal service. (Regulation 18)	November 2022	**Action on track**	Completed 31/12/2022	**Current Status:** Advert out for recruitment of 1WTE UGI CNS to support return of service.
The Trust must ensure that there are enough numbers of competent staff to provide out of hours emergency cover. (Regulation 18)	November 2022	**Actions partially complete or plan in place with date for completion**	Completed 31/12/2022	**Current Status:** 26/07/2023 Complex UGI and general emergency surgical rota's remain on place and populated. 4 surgeons appointed on fixed term contracts, with recruitment for substantive posts in development - pending finalisation of business case for consultant workforce expansion and reconfiguration into 3 teams (lower GI, upper GI and emergency surgery). Business case review target date Q3.
The Trust must ensure that all upper gastrointestinal multidisciplinary team (MDT) meetings are held in line with "NHS England and Improvement Streamlining Multi-Disciplinary Team Meetings" guidance. (Regulation 12)	November 2022	**Actions partially complete or plan in place with date for completion**	Review August 2023	**Ongoing actions:** MDT moving to a regional MDT hosted by Guildford Hospital. The service is in the process of moving all job plans to support regional MDT.
The Trust must ensure that patient records are legible and easily available to all staff providing care and treatment. (Regulation 17)	November 2022	**Action complete** *** CQC Enforcement action**	Completed January 2023	Assurance - Current systems have mandatory training sessions for all relevant staff members using the online training portal (IRIS).

The Trust must ensure that patient records and details are not accessible to unauthorised persons. (Regulation 17)	November 2022	**Action complete**	Complete January 2023	Assurance – Ongoing intermittent monitoring.
The Trust must ensure morbidity and mortality meetings are carried out in accordance with national guidance. (Regulation 17)	November 2022	**Action on track** * **CQC Enforcement action**	Completed June 2023	06/06/2023 – M&M meetings continue in accordance with guidance.
The Trust must ensure they consistently use audits to measure quality and improve services. (Regulation 17)	November 2022	**Action on track**	Completed June 2023	06/06/2023 – Local audits being developed and presented to QSPE meetings. 07/07/2023 - No further update.
The Trust must ensure leaders and managers have protected time to effectively carry out their role. (Regulation 18)	November 2022	**Action on track**	Completed July 2023	24/03/2023: Clinical leads appointed in addition to Clinical Director for Abdominal Surgery and Medicine. 1PA for clinical leads. 3PAs for CD. 07/07/2023 - No further update.

Identified risks in implementing actions:

- Datix ID 2146 / 839 - Oesophageal Cancer Surgery - Lack of Capacity
- Datix ID 2335 / 856 - Deanery withdrawal of Foundation Year 1s from General Surgery
- Datix ID 1872 / 842 - Patient & Staff harm treating Trauma patients outside speciality and lack of support for general surgeons (1872)
- Datix ID 2463/ 890 - General Surgery Consultant Workforce vacancies (2463)

2.9 RSCH Neurosurgery services CQC action plan – update July 2023 (submitted to CQC on 21/07/2023)

'Must do' action – Neurosurgery, RSCH	Date raised	RAG Status	Due date for completion / completion date	Gaps in assurance / ongoing actions
The trust must ensure that all staff complete training about how to interact with people with a learning disability and with autistic people. (Regulation 18)	May 2023	**Actions partially complete or plan in place with date for completion.**	Due October 2023	July 23 Oliver McGowan training now available. Action plan agreed, Consultants to complete training by end Sept 2023. 63 Ward staff to complete the training, aim for 10 per month with a Trajectory of all completed by Dec 2023. Liaise with L&D to access completion records. Monitor at monthly Divisional Board meeting with non-compliance raised directly with the manager. Current mitigation- sign post staff to information for LD on the Infonet and provide staff with the contact details of the LD liaison service so support can be sought. Any patients with LD/Autism will have a care passport, with oversight form the Matron and HoN. Highlight who in the team has completed the training so everyone who to go to for advice is aware if there is any patients in neurosurgery who have LD or autism.
The trust must ensure that staff compliance with mandatory training meets the trust target. (Regulation 12)	May 2023	**Actions on track or completed**	Due September 2023	July 2023: STAM 91% A&B9 (post move) - now to be monitored as BAU at Directorate and divisional board with early action taken to address dips in compliance, plus oversight at Divisional SDR. The division will undertake a validation of the data in July 2023 to understand any variants from the reports to the local data and take action to update these.

The trust must ensure completion of staff appraisals meets the trust target. (Regulation 18)	May 2023	**Actions on track or completed**	Due September 2023	July 2023: Medical appraisal trajectory to be >90% by Sept 2023. Monitor at directorate board with escalation at Divisional board. Nursing appraisal-monitored as BAU at Divisional monthly Meetings, and oversight at Divisional SDR. If six staff complete the training each month this will keep compliance at >90%.
The trust must ensure there are enough neurosurgery theatres to meet the needs of the local population, including availability of theatres for emergency cases. (Regulation 15)	May 2023	**Actions partially complete or plan in place with a date for completion**	Due December 2023	July 2023 - Neurosurgery service has moved into the Louisa Martindale Building at RSCH with a project plan agreed; with relevant stakeholders meeting weekly. The initial plan is to open the theatres and sustain the Tuesday all day weekly list by August 2023, with the next step to add lists with slowly increasing activity in LMB and reduce in SOTC. Autumn 2023: When the elective spinal service opens in the LMB it will significantly increase capacity as the fit for purpose spinal theatre will significantly increase efficiency and consequently throughput.
The trust must ensure leaders and managers have protected time to effectively carry out their role. (Regulation 18)	May 2023	**Actions partially complete or plan in place with a date for completion**	Due December 2023	Staff shortages remain on the risk register - Directorate team will add therapy staff and link with CCS radiographer shortages with regard to the weekend service and therapy time for ITU. Vacancies are monitored at a directorate level and escalated to the Division; this is monitored at board. Working group looking at recruitment for expansion of neurosurgery as part of the move to LMB and the 100-day plan. July 2023 - Advert out for Junior doctors, as well as nursing staff. International nurses identified for placements in this service from October 2023 - Divisional Director of Nursing working pan trust with senior

				nurse leadership team on recruitment and retention workstreams. Working with workforce, Surgery, and the comms team to create a bespoke advert for all areas in neurosurgery show casing the new facilities and the planned expansion. This will include a film of the new facilities. Risks are monitored and any harms reported via Datix and go through the patient safety process.
The trust must ensure there is enough equipment to manage patient care in a safe and effective manner. (Regulation 15)	May 2023	**Actions on track or completed**	Due September 2023	July 2023: Business case agreed to equip 3rd theatre LMB for spinal cases alongside a capital replacement programme. Autumn 2024: Expansion of capacity to meet demand business case will include further equipping emergency theatre and encompass equipment and staff to operate.
The trust must ensure the culture of the service means that staff are treated with respect by all staff. (Regulation 17)	May 2023	**Actions partially complete or plan in place with date for completion**	Due December 2023	July: Plan agreed for delivery of feedback and Listening events (in august on the ward and via team with support from HR) as part of the staff survey action plan, Divisional focus on neurosurgical ward. Provide a score card for the ward with metric for staff, quality and performance. to have weekly monitoring meetings to support heh Matron and Ward manager to improve the staff experience. The progress of this will be shared at divisional board.
The trust must make sure that all staff work together in a manner that promotes the safe and effective care of patients. (Regulation 12)	May 2023	**Actions partially complete or plan in place with date for completion**	Due October 2023	July 2023 - Hold joint anaesthetics and neuro governance session. Listening events planned for Aug 2023 to encompass feedback on move and development of service business case.

The trust must ensure that multidisciplinary meetings are attended by the required number and mix of healthcare professionals. (Regulation 12)	May 2023	**Actions on track or completed**	Due September 2023	Robust MDT meeting are now in place with attendance recorded. There will be a department wide review of MDT membership undertaken in Sept 23 following up on work undertaken through the neurosurgery steering group. Risk is time to attend MDT, job plans to support attendance. Review at directorate governance.

'Should do' action – Neurosurgery, RSCH	**Date raised**	**RAG Status**	**Due date for completion / completion date**	**Gaps in assurance / ongoing actions**
The trust should consider reviewing current staff engagement processes to ensure they are effective. (Regulation 17)	May 2023	**Actions on track or completed**	TBC	Summer 2023 - detailed plan in response to staff survey to include communication strategy. Focus on New neurosurgical ward in LMB, developing a ward scorecard. Autumn 2023 -neurosurgery listening events.
The trust should review how incidents are being graded to ensure the severity levels are graded appropriately. (Regulation 17)	May 2023	**Actions on track or completed**	Ongoing BAU	Spring 2023 – Datix incidents are reviewed in weekly directorate driver meeting, Monthly Clinical Governance Meetings feeding into Divisional Quality and Safety meeting. New Divisional safety lead links with Directorate team to feedback from Trust serious incident review group. BAU- monitor and escalation at Monthly divisional Quality and safety board.
The trust should ensure staff with long-term health conditions are protected in line with the Disabilities Discrimination Act 1995 and have meaningful personal adaptation plans to ensure they are treated fairly; with dignity and respect they deserve. (Regulation 17)	May 2023	**Actions on track or completed**	TBC	Summer 2023 - Focus on Medical Appraisal and staff survey action plan - underway - Dr Chris Carey & Jo Simpson. Autumn 2023 - Listening events as part of staff survey action plan.

The trust should ensure it recruits to the Guardian of safe working hours post to oversees the Royal Sussex County Hospital and Princess Royal. (Regulation 12)	May 2023	**Actions on track or completed**	Due October 2023	Awaiting update from the Executive chief of people for when these roles will be in place.
The trust should ensure the Freedom to Speak up Guardian and the Freedom to Speak up champions have sufficient resources to support staff to raise concerns.	May 2023	**Actions on track or completed**	Due October 2023	As above.

Identified risks in implementing actions:

- Datix ID 1073: There is a risk to patient outcomes due to lack of capacity for elective complex spines. Service delivery. – Risk rating 12
- Datix ID 889: Lack of nursing staff for the neuro angiography suite - Risk rating 6
- Datix ID 1075: Risk that an absence of weekend radiography in Neuro theatres leads to delays in surgical treatment, resulting in poor patient outcomes and extended length of stay. – Risk rating 4
- Datix ID: 853: Lack of neuro surgery and spinal beds – ENT have 5 beds. Risk rating 8
- Datix ID: 851 – Relationship with neuro and spinal surgery – due to working relationships with the neurosurgery departments there is a risk to patient's safety and trust which could result in not learning from mistakes. Risk that the department has become insufficient due to a clear workable strategy – Risk rating 6
- Datix ID: 862 – Lack of nurse specialists particularly in the skull base team, spinal and pituitary. – Risk rating 8
- Datix ID: 1074 – Risk of patients coming to harm as there is insufficient emergency theatre sessions resulting in urgent spinal and neurosurgery elective cancellations – Risk rating 12
- Datix ID: 898 – Financial risk to division due to increase in demand services and increased costs – Risk rating 4
- Datix ID: 63 – Risk of patient harm due to an increase in waiting times for RTT and non-RTT patients (along with delays in diagnostics) – Risk rating 15
- Datix ID: 798 – Pharmacy staff levels to support the specialist services division – Risk rating 9
- Datix ID: 849 – Junior medical staffing shortages across the division. – Risk rating 4
- Datix ID:10 – Nursing staff shortages across the division – Risk rating 4
- Datix ID 966 – Insufficient capacity to meet the demand for urgent patients and to address the RTT backlog – Risk rating 9

3.0 Recommendations

The CQC compliance team will provide a monthly CQC divisional action plan compliance report to the Quality governance Steering Group which will include the fully populated divisional action plans, current compliancy status and associated divisional risks registered on Datix IQ.

It is to be noted that the Trust's Well-Led action plan is being managed by the Trusts Company Secretary.

4.0 Actions

- The Board are asked to note the current position and plans going forward.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	23.2	**Meeting:**	Board	**Meeting Date:**	3 August 2023
Report Title:	Well Led Improvements – Action Tracker				
Sponsoring Executive Director:		Chief Governance Officer			
Author(s):		Company Secretary			
Report previously considered by and date:					

Purpose of the report:			
Information	N/A	Assurance	Yes
Review and Discussion	Yes	Approval / Agreement	Yes

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

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	N/A	Link to Trust Annual Plan	Yes

Implications for Trust Strategic Themes and any link to BAF risks		
Patient	Yes	Improvements are centred to improve services for our patients
Sustainability	Yes	Improvements are balanced to ensure the Trust is sustainable
People	Yes	Improvements are linked to improvements of our process for our staff
Quality	Yes	Improvements are centred to ensure our services are safe for our patients
Systems and Partnerships	Yes	Improvements will support the Trust's deliver of its business plan and that of the system plan
Research and Innovation	N/A	

Link to CQC Domains:			
Safe	Yes	Effective	Yes
Caring	N/A	Responsive	Yes
Well-led	Yes	Use of Resources	N/A

Regulatory / Statutory reporting requirement

The Trust is required to develop and deliver an action plan to address the CQC recommendations as part of having an effective system of governance, risks management and internal control.

Communication and Consultation:

Executive Summary:

The CQC undertook a Well Led review of the Trust in October 2022 and based on the feedback the Trust developed a series of actions to address their findings. The Trust received the final report and the action tracker developed and reported to the Board remains aligned to the 8 must do and 5 should do CQC recommendations.

Each action has an allocated executive lead who monitor the progress being made. Each executive has provided an update in July in respect of each action, this progress has been shared with the Executive Team. The detailed action tracker, based on feedback, has been designed to reflect a summary of the evidence of improvement (ie the outcome of the actions is delivering the intended and sustained improvement) along with information on the established assurance processes of these actions.

Summary of action tracker

The action tracker shows two actions have been delivered.

There are four actions (three must do and one should do) where there is some risk to the delivery of their original dates these being :-

- Must do action 3 - The trust must ensure all staff report incidents via the trust reporting systems. (Regulation 17). There is a delay to the implementation date for the harmonised incident reporting module within Datix IQ. It should be noted that whilst there is a delay to the Datix IQ incident module implementation the divisions through reporting to QGSG report on incidents and the level of reporting is tracked at QGSG and Quality Committee aligned to the Quality True North in relation to Harm reduction which includes the monitoring of the reporting of incidents. The original date was revised to July 2023 but the incident module implementation date will be after this date.

- Must do action 7 - The trust must ensure it takes account of the Race Equality and NHS staff survey to ensure staff from black and minority ethnic backgrounds are not disproportionately disadvantaged by working in the organisation. (Regulation 17). Whilst the Trust has developed its Equality Diversity Inclusion (EDI) plan there remains work to be undertaken to cascade the delivery of the EDI plan into the clinical and corporate operating divisions.

- Must do action 8 - The trust must ensure it reviews the current medical staffing levels in the surgery division at the Royal Sussex County Hospital to ensure the service can deliver safe and responsive care. (Regulation 12). The latest review undertaken suggested the re-instating of a three tier consultant rota. Work is being undertaken to review respective job plans to assess impact for any expansion of consultant numbers.

- Should do action 3 - The trust should ensure staff with long-term health conditions are protected in line with the Disabilities Discrimination Act 1995 and have meaningful personal adaptation plans to ensure they are treated fairly, with dignity and respect they deserve. (Regulation 17). The delivery of this action is linked to the delivery of Must Do action 7 and the need work to be undertaken to cascade the delivery of the EDI plan into the clinical and corporate operating divisions.

The remaining seven areas of improvement have actions in progress but will not see their closure until later in the year.

Key Recommendation(s):

The Board is asked to **REVIEW** the Trust's position against the 13 actions from the well led overall Trust report from the CQC and **AGREE** that this represents a fair reflection of the progress based on information seen at either the Board itself or from updates provided by the respective Committees.

2022/23 Well Led Improvement Action Tracker

Action Tracker Summary

Ref	Action	Exec Oversight	Expected completion date	Current Status	Rating (R/A/G/B)	Comments / Escalations
Must Do						
WLM1	The trust must ensure it publicises the Freedom to Speak up function so staff can raise safety concerns safely. (Regulation 17)	Chief People Officer	Revised date to 1 August 2023 for launch of GS FTSU service (initial date was 30 June 2023)	**Delivered** publicity of FTSU function **On track** for the delivery of the outsourced GS FTSU service, but with a revised date of August 2023.	**GREEN**	External provider appointed, in pre commencement phase. Launch date w/c 1/08/2023
WLM2	The trust must ensure good quality FTSUG records are kept identifying trend and themes and used for to improve services for patients and staff. (Regulation 17)	Chief People Officer	By Sept 2023	**On track** enhancements will be made as the new service provider commences in Q1. Guidance on reporting incident or concerns via datix has been included in the FTSU pathway advice.	**GREEN**	FTSU annual report to PC 26/07/2023
WLM3	The trust must ensure all staff report incidents via the trust reporting systems. (Regulation 17)	Chief Nurse	July 2023	**Behind schedule due to delay within the Datix IA project** (note the initial delivery date was 31 May 2023)	**AMBER**	Note that whilst there is a delay to the Datix IQ incident module implementation the divisions through reporting to QGSG report on incidents and the level of reporting is tracked at QGSG and Quality Committee aligned to the Quality True North in relation to harms
WLM4	The trust must ensure the risks associated with reported safety	Chief Nurse / Chief Governance Officer	Better risk reporting by 30 June 2023	**On track** through the reporting via QGSG the divisions are able to	**GREEN**	

Ref	Action	Exec Oversight	Expected completion date	Current Status	Rating (R/A/G/B)	Comments / Escalations
	concerns are mitigated promptly. (Regulation 17)			demonstrate the triangulation of incidents and risk		
WLM5	The trust must ensure it seeks and acts quickly on feedback from staff for the purposes of continually evaluating and improving services. (Regulation 17)	Chief People Officer	Development will be across 2023/24	**In progress** however work continues to support staff to engage in listening to feedback	**GREEN**	
WLM6	The trust must ensure it collates staff feedback and this is used for trend and theme monitoring and used to improve governance and risk oversight. (Regulation 17)	Chief People Officer / Chief Governance Officer	Pulse feedback supporting Staff Survey action plans	**In progress** culture workshops now in place undertaken across June across 5 sites	**GREEN**	
WLM7	The trust must ensure it takes account of the Race Equality and NHS staff survey to ensure staff from black and minority ethnic backgrounds are not disproportionately disadvantaged by working in the organisation. (Regulation 17)	Chief People Officer	Work is scheduled across the year	**In progress** through the delivery of the EDI plan. A further Board & Governor workshop took place on EDI in July. Plan mapped to NHSE '6 key actions' on EDI.	**AMBER**	Work is needed to cascade the delivery of the EDI plan into the clinical and corporate operating divisions
WLM8	The trust must ensure it reviews the current medical staffing levels in the surgery division at the Royal Sussex County hospital to ensure the service can deliver safe and responsive care. (Regulation 12)	Chief Medical Officer / Deputy Chief Medical Officer	During 2023/24	**In progress** the Surgery Corporate Project has yet to deliver all its outcome enhancements	**AMBER**	The latest review undertaken suggested re-instating of three tier consultant rota. Work is being undertaken to review future workforce requirements.
Should do						
WLS1	The trust should consider reviewing current staff engagement processes to ensure they are effective. (Regulation 17)	Chief People Officer / Chief Governance Officer	During later quarter Q3 of 2023/24	**In progress** staff recognition discussion at Exec meeting on 21 June as well as within culture workshops	**GREEN**	
WLS2	The trust should review how incidents are being graded to ensure the severity levels are	Chief Nurse		**Delivered**	**BLUE**	Patient Safety Group monitors the reporting

Ref	Action	Exec Oversight	Expected completion date	Current Status	Rating (R/A/G/B)	Comments / Escalations
	graded appropriately. (Regulation 17)					of incidents and their grading.
WLS3	The trust should ensure staff with long-term health conditions are protected in line with the Disabilities Discrimination Act 1995 and have meaningful personal adaptation plans to ensure they are treated fairly, with dignity and respect they deserve. (Regulation 17)	Chief People Officer	Across 2023/24	**In progress**. Information is included within the policy guidance. However there is a need to conclude on the formulation of a central budget support to enable support with reasonable adjustments	**AMBER**	Work is needed to cascade the delivery of the EDI plan, inc disabilities, into the clinical and corporate operating divisions
WLS4	The trust should ensure it recruits to the Guardian of safe working hours post to oversees the Royal Sussex County Hospital and Princess Royal. (Regulation 12)	Chief People Officer / Chief Medical Office / Deputy Chief Medical Officer		**Delivered**	**BLUE**	Single GSWH across Trust. April 2023. Active review of LFG and exception reporting. Linking to new Healthrota program.
WLS5	The trust should ensure the Freedom to Speak up Guardian and the Freedom to Speak up champions have sufficient resources to support staff to raise concerns	Chief People Officer	By 30 June 2023	**On track** for the delivery of the outsourced service for Q1 2023-24 (this is to be provided by the Guardian Service)	**GREEN**	Note that the cost pressure to be absorbed within People Directorate / CEO FTSU budget

Key

RED	**Significant risk to the delivery of the actions, revised dates have been missed. Failed to deliver the actions**
AMBER	**Risk to the delivery of the actions but there is a high degree of confidence that the revised implementation date will be achieved**
GREEN	**In progress and high degree of confidence that the implementation date will be achieved**
BLUE	**Actions delivered and continued assurance process established**

Action Tracker – Detail

Ref	CQC recommended action	Lead Executive	Status
WLM1	The trust must ensure it publicises the Freedom to Speak up function so staff can raise safety concerns safely. (Regulation 17)	Chief People Officer	**Delivered** publicity of FTSU function. **On track** for the delivery of the outsourced service for Q1/Q2 2023-24

Weaknesses drivers for CQC recommendation	Trust Actions (summary)	Evidence of action taken (text in red new from last report)	Actions to be taken (and date)
1 Lack of understanding of ways to raise concerns	FTSU details updated on Trust website. New 'speaking-up pathways' documents published. FTSU policy review completed (July 2023)	Web pages https://nww.uhsussex.nhs.uk/about/freedom-to-speak-up/ Meetings with GS on mobilisation (complete)	Contract signed with GS (July 2023). Prep for launch to progress in w/c 01/08/2023
2 Visibility of Freedom to Speak Up Guardian	Procurement concluded of an 'outsourced 24/7 FTSU support with go live of the service during Q1 2023-24.	Supplier proposal (from Guardian Service) received evaluated and progressed. The Trust will work with the supplier to promote the service provide regular management reports to evidence improvements in recognition from staff and use of the service as well as ensuring all contacts are dealt with appropriately.	Publicise new supplier and update intranet pages for launch. (July & August 2023) New supplier staff awareness sessions (September 2023)

Linkage to Trust Strategy (TN/BO/SI/CP)	Oversight Committee(s)
People breakthrough objective of 'staff voice that counts'	People Committee / People Steering Group / Trust SDR

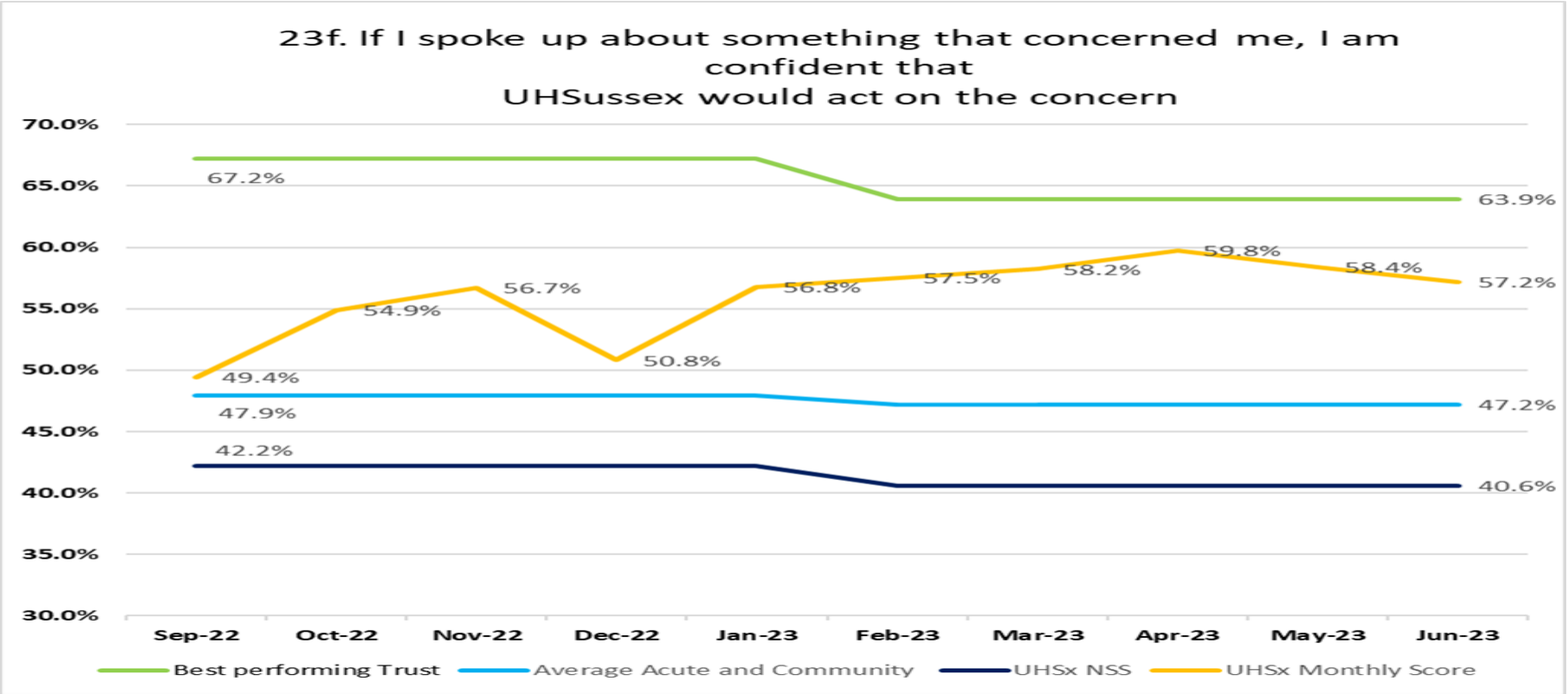
Planned sources of assurance over improvement delivery

Regular surveying and feedback from staff will indicate whether confidence in speaking up and that action will be taken has improved. The new FTSU service will be independent of the Trust and as a supplier to other Trusts able to provide benchmark comparison and independent input and advice.

Summary of current position

Progress has been made commissioning and on-boarding the new GS FTSU provision. Clearance of the contract is required – being chased – but the GS has nevertheless started meetings with relevant stakeholders and delivery of its 'on-boarding' plan. The BO work on 'staff voice that counts' has also continued to progress demonstrating improved confidence that staff will receive feedback on concerns and issues raised (whether through the FTSU route or not). The Trust has made progress publicising the importance of speaking up and clarifying routes to do so. There is regular reference to the importance of raising issues in weekly all staff briefings and other materials. Speaking up has been referenced in 'theme of the week' 17 June 2023. New training and resources have been published

Performance Data supporting outcome of actions being taken (improvement in processes) / evidence of outcome improvement



Escalations (risk to delivery and request being made)	None

Action Tracker – Detail

Ref	CQC recommended action	Lead Executive	Status
WLM2	The trust must ensure good quality FTSUG records are kept identifying trend and themes and used for to improve services for patients and staff. (Regulation 17)	Chief People Officer	**On track** enhancements will be made as the new service provider commences in Q1/Q2

Weaknesses drivers for CQC recommendation	Trust Actions (summary)	Evidence of action taken (text in red new from last report)	Actions to be taken (and date)
1 Reporting from the Freedom to Speak Up Guardian	Procurement commenced of an 'outsourced 24/7 FTSU support with go live of the service during Q1/Q2 2023-24. Employee Relations triangulation reports to People Committee	Supplier proposal (from Guardian Service) received evaluated and progressed. The service will provide regular management reports to evidence improvements in recognition from staff and use of the service as well as ensuring all contacts are dealt with appropriately. ER reporting scheduled to People Committee	Agree reporting structure from Guardian Service (July 2023) Agree process for sharing information on themes (Nov 2023)
2 Establishment of comprehensive data capture database	The new GS will provide tracking and monitoring of all concerns raised through the FTSU with regular reporting.	Trust summary of FTSU case numbers submitted to national FTSU Guardian's office	Launch of new GS support and reporting (July 2023)

Linkage to Trust Strategy (TN/BO/SI/CP)	Oversight Committee(s)
People breakthrough objective of 'staff voice that counts'	People Committee / People Steering Group / Trust SDR

Planned sources of assurance over improvement delivery
Records of FTSU cases will be maintained by the new supplier using their database and reporting standards in use across a number of Trusts.

Summary of current position
The new GS will provide improved tracking and reporting of FTSU concerns which can be more easily monitored and used to inform risk management etc. In the interim there has been closer working between the interim FTSU and ER service.

Performance Data supporting outcome of actions being taken (improvement in processes) / evidence of outcome improvement
See WLM1

Escalations (risk to delivery and request being made)	None

Action Tracker – Detail

Ref	CQC recommended action	Lead Executive	Status
WLM3	The trust must ensure all staff report incidents via the trust reporting systems. (Regulation 17)	Chief Nurse	**Behind original date.** There is delay to the initial launch date of Datix IQ. This system will ensure there is one common system across the Trust that will enhance Divisional confidence in reporting.

Weaknesses drivers for CQC recommendation	Trust Actions (summary)	Evidence of action taken (text in red new from last report)	Actions to be taken (and date)
There was a perception that the Trust is a low reporter of incidents and that this was due to a reluctance to report based on limited feedback being given to staff (based on a feedback from a small sample of staff)	The patient safety team (PST) hold a bi-weekly Serious Incident Meeting (SIM) with the divisions to track all moderate + harm incident investigations. The corporate PST send a snapshot report to all divisions on a weekly basis (Monday) to highlight the divisional overdue incidents- this should be used as the baseline for reviewing all overdue reports. The PST send a more detailed divisional report every Tuesday detailing an incident Sit Rep on all incidents including all overdue no/low harm and moderate + harms (not reported as SI). However, there is a risk that there will be numerous +/- 2500 existing and overdue incidents graded No, Low & Near-Miss on the DatixWeb systems prior to Go-live of the Incident module on DCIQ	Divisions are being encouraged to review and close these incidents as soon as possible, while weekly overdue reports are sent out to all COM divisional triumvirates. The pop-up message on DatixWeb has now been amended to remind all investigating managers to review and close their incidents. Global Comms and Theme of the Week distributed across the Trust. Enterprise Risk Manager /CAS /feedback /Complaints /BI modules have all been implemented	Divisions to ensure all incidents are reviewed, investigated and feedback provided. Learning from themes to be shared both divisionally and Trustwide via the divisional governance meetings, Trust patient safety Group and summary reports for Quality Governance Steering Group Performance with reporting highlighted through Trust SDR process involving Trust leadership teams.

Learning from Patient Safety Events (LFPSE) is replacing the current National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS) the Trust is required to be complaint with these developments.	LFPSE is compatible with the new DCIQ and will be operational from September 2023 LFPSE will provide a live feed to NHSE Training is in line with PSIRF project management and implementation	1) Datix IQ project is being aligned with newly published harm categories to ensure compliance with these new requirements	This will be reflected in the launch of the Incident module within RLDatix CloudIQ (DCIQ) Psychological harm is to become recordable from no harm through to severe harm. There will be added mandatory fields and questions in relation to patient safety events within the new system with amendments being made to existing questions to secure this information.

Linkage to Trust Strategy (TN/BO/SI/CP)	**Oversight Committee(s)**
Quality True North - 5% reduction in harms Quality Corporate Project - Enhancing Quality Governance	Quality Committee / Quality Governance Steering Group / Serious Incident Reporting Group

Planned sources of assurance over improvement delivery

The Trust has developed and circulated a quality governance manual which contains sections on incident reporting, investigation, management and feedback / sharing of learning. This manual supports the reporting made by divisions to QGSG and then to the Quality Committee and codifies the respective roles of the central and divisional teams.

Summary of current position

The Trust reports approximately 2300-2400 incidents per month via RL Datix.

	Total Incidents
Jul-22	2494
Aug-22	2433
Sep-22	2538
Oct-22	2670
Nov-22	2634
Dec-22	2523
Jan-23	2409
Feb-23	2078
Mar-23	2370
Apr-23	2261
May-23	2314
Jun-23	2238
Total	**28962**

Trust wide overdue incidents: No/Low Harm

Divisions (Trust Wide)	Count of Division
Cancer	9
Clinical Support Services	173
Corporate Division	53
Facilities & Estates	24
Medicine & Urgent Care	393
Outside Body / Organisation	4
Specialist Services	87
Surgery Division	245
Women and Child Health Division	241
Grand Total	1229

Current position highlights that currently the Trust have:

1) **13** overdue Serious Incident Investigations (=>60 days)
2) **72** overdue moderate + (concise) investigations (=> 45 days)
3) **1229** overdue incidents no/low harm (=>20 days)- percentage per annum= 4%

This performance has deteriorated significantly since July 2022.
Contributors are in relation to

1) Staffing
2) Industrial action,
3) system pressures
4) critical incident
5) Recruitment to divisional leadership and governance teams (DQSM)

Performance Data supporting outcome of actions being taken (improvement in processes) / evidence of outcome improvement

Serious Incident Divisional Compliance Dashboard (July 2023)

University Hospitals Sussex NHS Foundation Trust

THEME	SIs				
	Previous week		Current week		
	Open (not submitted to CCG)	Overdue	Open (not submitted to CCG)	Overdue	Trajectory
Trust	41	13	37	12	↓
Medicine SRH/Worthing	1	0	1	1	↑
Surgery SRH/Worthing	4	4	3	3	↓
Medicine PRH/RSCH	4	0	4	0	↔
Surgery PRH/RSCH	6	4	5	4	↔
Specialist	4	1	3	1	↔
Clinical Support Services	2	0	2	0	↔
Women & Children	19 (11 HSIB)	3	18 (11 HSIB)	2	↓
Cancer	1	1	1	1	↔
Corporate	0	0	0	0	↔
Estates & Facilities	0	0	0	0	↔

↔ = No change in overdue incident
↓ = Decrease in overdue incidents
↑ = Increase in overdue incidents

PSG exception report for QGSG 4

Escalations (risk to delivery and request being made)	This Trust's incident reporting performance has deteriorated in the year July 2022 to June 2023. Contributors to this relate to • Staffing pressures • Industrial action • demand pressures • a focus on the critical incident • delayed recruitment to divisional leadership and governance teams (DQSM)

Action Tracker – Detail

Ref	CQC recommended action	Lead Executive	Status
WLM4	The trust must ensure the risks associated with reported safety concerns are mitigated promptly. (Regulation 17)	Chief Nurse / Chief Governance Officer	**On track** through the reporting via QGSG the divisions are able to demonstrate the triangulation of incidents and risk

Weaknesses drivers for CQC recommendation	Trust Actions (summary)	Evidence of action taken (text in red new from last report)	Actions to be taken (and date)
The Trust's risk management process within the recently implemented divisional clinical operating model were immature leading to an inconsistent reporting culture.	Patient safety risks are highlighted via the Trust DATIX Enterprise Risk Management system (ERM). SIRG advises divisions to update risks in relation to incident management: (Likelihood/Occurrence X impact). Patient Safety risks are reviewed at PSG. Patient safety risk for the benchmarking for thematic reviews (PSIRF). Trust/divisional risks >12 and new risk are presented at the Quality Governance Steering Group for approval. A central risk governance resource has been established to support divisional risk management processes through the provision of training, coaching and development of Datix IQ enterprise risk reports	Enhanced reporting has been made to QGSG via a standardised reporting on divisional risks The central risk governance team has commenced training and coaching support to the divisional teams.	The role out of the developed risk management training in line with the developed tiered training needs assessment. The development of an Executive Risk Oversight Group

Linkage to Trust Strategy (TN/BO/SI/CP)	Oversight Committee(s)

Quality True North - 5% reduction in harms Quality Corporate Project - Enhancing Quality Governance	Quality Committee / Quality Governance Steering Group / Serious Incident Reporting Group

Planned sources of assurance over improvement delivery

Reporting to each Board Committee complemented by oversight by the Audit Committee on the impact of the Executive Risk Oversight Committee has on the Trust's compliance with the Trust's risk management policy.

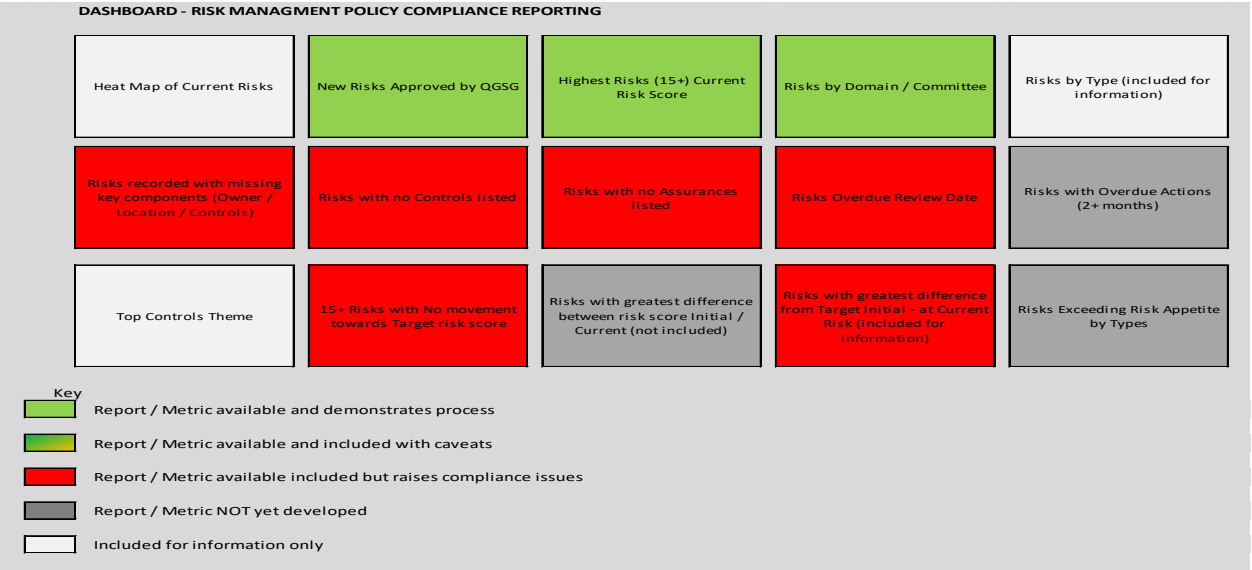
Summary of current position

Risk Management compliance - for risks scored 16+ the Median days overdue their review has reduced to 5.92 (previously 22.5) however there remains work to do to ensure all required fields are being completed.

Performance Data supporting outcome of actions being taken (improvement in processes) / evidence of outcome improvement

Extract from latest report to Audit Committee

The dashboard below outlines the available data against the measures proposed and an indication of those reporting measures that remain in development.



Escalations (risk to delivery and request being made)	There is a risk to the delivery timescale as the Enhancing Quality Governance Corporate Project is behind its original planned schedule however the actions of the respective divisions to improve their risk reporting continue supported by the central risk governance team.

Action Tracker – Detail

Ref	CQC recommended action	Lead Executive	Status
WLM5	The trust must ensure it seeks and acts quickly on feedback from staff for the purposes of continually evaluating and improving services. (Regulation 17)	Chief People Officer	**In progress**

Weaknesses drivers for CQC recommendation	Trust Actions (summary)	Evidence of action taken (text in red new from last report)	Actions to be taken (and date)
1 Improvements needed for structured feedback on action as result of safety concerns raised	Trust BO on staff voice that counts. GS will strengthen reporting of feedback. FTSU issues will be linked to quarterly ER update to People Committee Datix QI being rolled out – should improve reporting and feedback of safety issues	Monthly pulse survey has recorded improvement in Q1 2023-24 Interim guardian following up feedback. GS will introduce tracking of FTSU feedback. Work with Patient Safety team on Datix IQ and feedback on issues through that system.	ER reports to People Committee incorporating triangulation with FTSU once GS established (November 2023)
2 Improving staff opportunities to discuss issues	BO objective work by divisions including listening events etc Divisions have 'staff voice that counts' as a driver metric	Feedback from listening events and hospital forums Listening event 'toolkit' Culture workshops	Culture workshops exploring barriers to engagement / raising issues (June 2023)

Linkage to Trust Strategy (TN/BO/SI/CP)	Oversight Committee(s)
People breakthrough objective of 'staff voice that counts'	People Committee / People Steering Group / Trust SDR

Planned sources of assurance over improvement delivery
Reports to the People Committee and measurement of staff confidence concerns raised will be addressed through people pulse survey questions and national staff survey.

Summary of current position
Work continues to constantly promote feedback as an essential part of speaking up and 'staff voice that counts'. Divisions have all engaged with this work and have local action plans complemented by corporate activities. Pulse survey evidence is of confidence increasing.

Performance Data supporting outcome of actions being taken (improvement in processes) / evidence of outcome improvement

See WLM1	
Escalations (risk to delivery and request being made)	None

Action Tracker – Detail

Ref	CQC recommended action	Lead Executive	Status
WLM6	The trust must ensure it collates staff feedback and this is used for trend and theme monitoring and used to improve governance and risk oversight. (Regulation 17)	Chief People Officer / Chief Governance Officer	**In progress** there is more work that can be done on the triangulation with Datix etc

Weaknesses drivers for CQC recommendation	Trust Actions (summary)	Evidence of action taken (text in red new from last report)	Actions to be taken (and date)
1 Visibility of improvement plans and delivery	Earlier sharing of staff survey and new 'interrogation' tool launched. Divisional engagement and action plans	Presentation of Divisional plans at People Committee (May 2023)	Monitoring of plans through SDR (monthly)
2 Need to strengthen linkage of feedback into risk management processes	Employee Relation reporting scheduled to People Committee	ER reports to PC. Development of IPR and narrative.	New IPR will help triangulate feedback with performance data.

Linkage to Trust Strategy (TN/BO/SI/CP)	Oversight Committee(s)
People breakthrough objective of 'staff voice that counts' Quality Corporate Project – Enhancing Quality Governance	People Committee / People Steering Group / Trust SDR Quality Committee / Quality Governance Steering Group

Planned sources of assurance over improvement delivery
Improved IPR and greater triangulation of data sources on risk, patient feedback and staff opinion reflected in reports to relevant Trust Board subcommittees.
Summary of current position
There remains more to do as risk management processes are strengthened.
Performance Data supporting outcome of actions being taken (improvement in processes) / evidence of outcome improvement
See WLM1

Escalations (risk to delivery and request being made)	Delay in Datix IQ roll-out impacts on triangulation of incident reporting with FTSU and other staff feedback.(See WLM3)

Action Tracker – Detail

Ref	CQC recommended action	Lead Executive	Status
WLM7	The trust must ensure it takes account of the Race Equality and NHS staff survey to ensure staff from black and minority ethnic backgrounds are not disproportionately disadvantaged by working in the organisation. (Regulation 17)	Chief People Officer	**In progress** through the delivery of the EDI plan

Weaknesses drivers for CQC recommendation	Trust Actions (summary)	Evidence of action taken (text in red new from last report)	Actions to be taken (and date)
1) Perceived absence of EDI plans and delivery	EDI element of LCD SI with 3 year action plan. New team, including an analyst. Staff survey report. Charity funded staff relations video and F2F training commission.	EDI plan and Board discussions (two workshops). Resourcing plan (via Charity) for staff networks. Workshop on inclusive recruitment (June 2023)	Board and Governor session planned (July 2023) Annual EDI reports (July 2023) BWRES, MWRES data submissions (July 2023)
2) SOAR network engagement / strengthening	Charity bid for support		Need to support establishing a meeting schedule (July 2023) Preparation for black history month (August 2023)

Linkage to Trust Strategy (TN/BO/SI/CP)	Oversight Committee(s)
People Strategic Initiative – leadership, culture and development	People Committee / People Steering Group / Trust SDR

Planned sources of assurance over improvement delivery
WRES, WDES and other EDI reporting. SDR review of LCD SI. Reports to PC.

Summary of current position
The Trust has established and EDI plan informed by best practice and NHS England expectations etc. Progress is being reviewed at a Board/Governor workshop also addressing the role of Board members and Governors in supporting EDI, inc WRES.

Performance Data supporting outcome of actions being taken (improvement in processes) / evidence of outcome improvement
WRES / WDES 2022

Indicator	Metric	WDES	WRES
1	Staff in AfC Pay Bands	Better	Worse
2	Appointment from shortlisting	Worse	Worse
3	Entering Capability Procedure	Nil	-
3	Entering Disciplinary Process	-	Worse
4	Accessing non-mandatory training & CPD	-	Better
4a	Experiencing harassment & bullying	Worse	-
4b	Reporting last experience of harassment & bullying	Worse	-
5	Experiencing harassment & bullying - by patients/public	-	Worse
6	Experiencing harassment & bullying - by staff	-	Worse
5/7	Believing Trust Equal Opportunities in promotion	Worse	Worse
6	Pressure from manager to come to work unwell	Worse	-
8	Discrimination from manager/colleagues	-	Worse
7	Organisation values their work	Worse	-
8	Employer has made adequate adjustments	Better	-
9a	Staff Engagement	Worse	-
9b	Trust action to facilitate voices to be heard	Narrative	-
10/9i	Board voting membership (LTHC, BME)	Worse	Worse
9ii	Board Exec. voting membership (BME)	-	Worse

Escalations (risk to delivery and request being made)	None

Action Tracker – Detail

Ref	CQC recommended action	Lead Executive	Status
WLM8	The trust must ensure it reviews the current medical staffing levels in the surgery division at the Royal Sussex County hospital to ensure the service can deliver safe and responsive care. (Regulation 12)	Chief Medical Officer / Deputy Chief Medical Officer	**In progress** the Surgery Corporate Project is on track to deliver the intended outcomes

Weaknesses drivers for CQC recommendation	Trust Actions (summary)	Evidence of action taken (text in red new from last report)	Actions to be taken (and date)
Large inpatient and admitting emergency levels.	Successful and ongoing recruitment of theatre staff, improving the resilience of the theatre team(s) Aligned to RCS and Surrey-Sussex cancer Alliance (SSCA) guidance, the UGI and LGI cancer MDT pathways have been reconfigured; x2 new MDT leads have been appointed with job planned time to ensure oversight, full documentation and best practice implementation. X2 new M+M leads appointed - both from recent tertiary training programmes - F2F all day M+M meetings established, externally audited and validated as now meeting best practice guidance National audit processes strengthened and overseen by clinical leads; nationally benchmarked external audit confirms effectiveness of UGI and LGI cancer outcomes at RSCH	Evidence when a pilot three tier rota – faster time to theatre, ward rounds in morning LOS reduced. At the latest review (May 2023) the two tier rota was in place and this was re-escalated. The latest review of surgery acknowledged the improved governance – M&M meeting, Q&S meetings and junior doctor supervision and training.	Upper GI pathway change proposal to come to Board July / August 2023 Assess impact on workforce requirements which may include a business case to expand consultant workforce.

	Corporate Project to improve general surgery established and 7 months into programme- evidence of progress against all 6 workstreams demonstrated. Significant improvements made to training programmes in General Surgery - HEE and GMC have validated these improvements; HEE have committed to restored higher training programme at RSCH		

Linkage to Trust Strategy (TN/BO/SI/CP)	**Oversight Committee(s)**
Quality Corporate Project – improving general surgery	Quality Committee / Quality Governance Steering Group / Trust SDR

Planned sources of assurance over improvement delivery
Action to appoint admin support to enable consistently minuted governance meetings. Expand the substantive consultant base, deliver three tier rota, (metrics, LOS, GIRFT compliance, reduction in ED diagnosed CRC)

Summary of current position
The latest review gives some assurance on continued improvements in the department. The CP will deliver further improvements some of which may require investment. The most recent GMC survey has seen a reduction from 7 red flags (area for action) to just 1 red flag.

Performance Data supporting outcome of actions being taken (improvement in processes) / evidence of outcome improvement

Escalations (risk to delivery and request being made)	Investment in expanded consultant base Difficulty to recruit a substantive consultant base Slow cultural and leadership development in team

Action Tracker – Detail

Ref	CQC recommended action	Lead Executive	Status
WLS1	The trust should consider reviewing current staff engagement processes to ensure they are effective. (Regulation 17)	Chief People Officer	**In progress** with the delivery of the actions within the draft paper to be implemented

Weaknesses drivers for CQC recommendation	Trust Actions (summary)	Evidence of action taken (text in red new from last report)	Actions to be taken (and date)
1) Staff having adequate time and routes for raising issues with leaders	Review of ambassadors and champions. Alignment of recognition activities across comms, people (Health and Wellbeing) and others.	Briefing to Exec team on 'culture' work 26 May 2023 Culture workshops June 2023 Recognition discussion at Execs 24 May 2023 and People Committee 24 May 2023	Finalise approach to and funding ongoing recognition activities (August 2023) Complete culture review (September 2023)
2) Understanding why mechanisms for raising issues may not be working	Engaging with staff on organisational culture to better understand what is working and what isn't working to engage staff	Culture understanding workshops (June 2023) Theme of the week on organisational culture (June 2023) Theme of the Week (uhsussex.nhs.uk)	Review of data gathered in culture investigation (August 2023)
3) Embedding use of daily 'safety huddles' and PFIS improvement board work as staff engagement and voice	Continuing roll-out and re-invigoration of PFIS referencing this as our system for improvement	PFIS steering group updates on PFIS maturity	Monthly review of PFIS maturity at PFIS steering group
4) Improving medical engagement	Developing a plan to tackle medical engagement in light of industrial action, harmonisation of pay/practices across UHSx, change to being clinically led	Discussion and exploration at Executive team and with Chiefs	Development of a strategy and plan (September 2023)

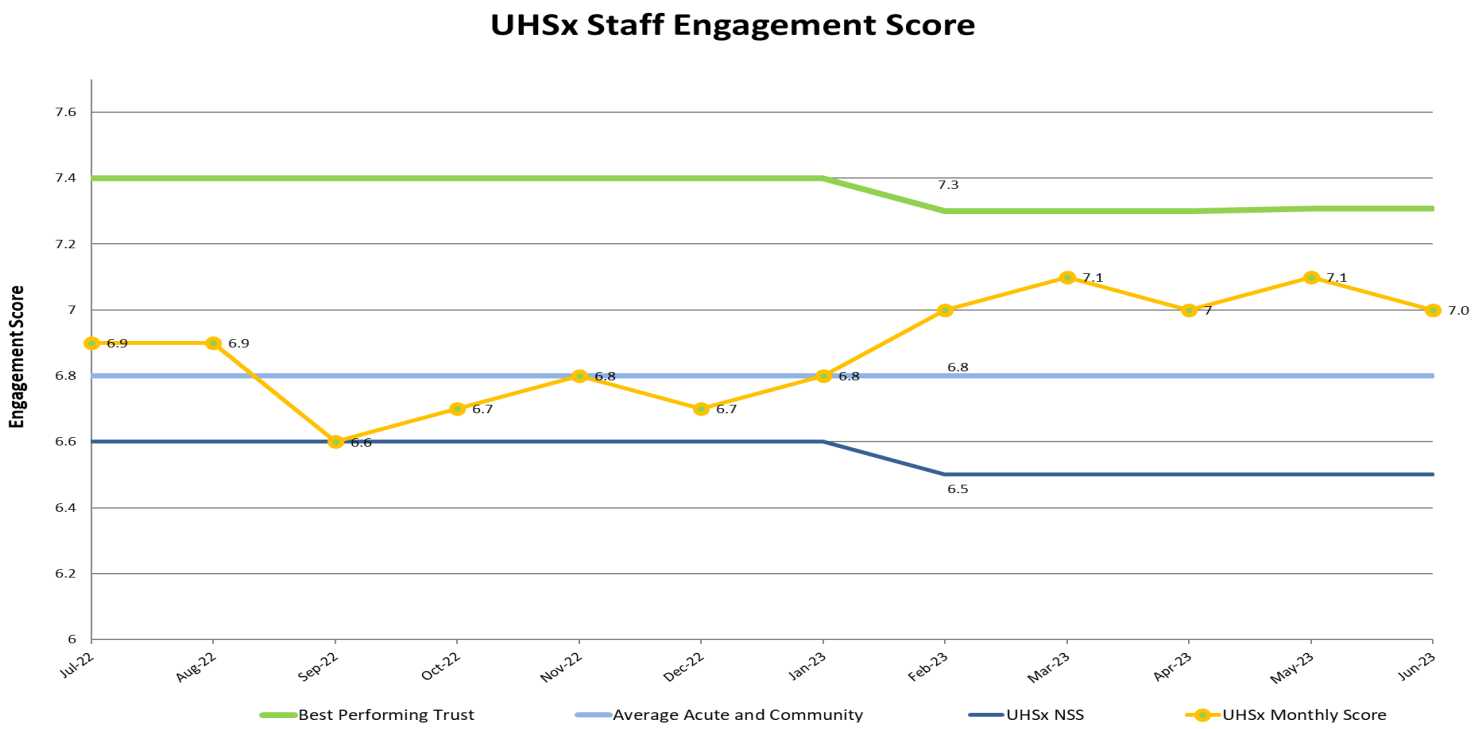
Linkage to Trust Strategy (TN/BO/SI/CP)	Oversight Committee(s)
BO objective of 'staff voice that counts' Staff engagement in improvement and tackling issues at local level via PFIS	People Committee / Trust SDR PFIS steering group

Planned sources of assurance over improvement delivery
People TN is staff engagement and tracked monthly via people pulse survey. Activities reported through TN reporting to Trust SDR and reports to PC.At Divisional level discussion at SDR.

Summary of current position

The Trust has made progress on staff engagement as measured through its monthly pulse survey – using the same questions that make up the national engagement score. All Divisions have engaged in BO work and staff survey action plans. Enquiry into culture is underway that may yield further actions. Use of PFIS as an engagement mechanism has continued – engaging staff on solving problems and supporting Trist priorities - and is monitored through PFIS maturity. There remains a risk that national pay disputes and other factors impact morale and motivation at UHSussex.

Performance Data supporting outcome of actions being taken (improvement in processes) / evidence of outcome improvement



Escalations (risk to delivery and request being made)	None

Action Tracker – Detail

Ref	CQC recommended action	Lead Executive	Status
WLS2	The trust should review how incidents are being graded to ensure the severity levels are graded appropriately. (Regulation 17)	Chief Nurse	**Delivered**

Weaknesses drivers for CQC recommendation	Trust Actions (summary)	Evidence of action taken (text in red new from last report)	Actions to be taken (and date)

Linkage to Trust Strategy (TN/BO/SI/CP)	Oversight Committee(s)
Quality True North on harm reporting	Quality Committee

Planned sources of assurance over improvement delivery

This is provided through Patient Safety Group reporting to QGSG

Summary of current position

The primary role of the weekly Serious Incident Review Group (SIRG) is to review all reported unexpected deaths and new incidents (graded moderate/severe harm and near miss on RL DATIX IQ) on a weekly basis. Using a senior multidisciplinary approach, the panel/group will agree the appropriate level/grading of harm and the appropriate investigation/escalation level. This is a governance and decision-making group. The bi-weekly Serious Incident Meeting (SIM) monitors the assurance, compliance, and progress of; the divisional serious incident (SI) investigations, divisional patient safety incident investigations (moderate/severe harm death not triggering SI) and the compliance with the Health and Social Care Act 2008 Regulations 2015: Regulation 20 Duty of Candour

DCIQ: notifications of all reported incidents graded moderate/severe harm and death are immediately escalated to the divisional triumvirates, medical director, chief nurse, director of patient safety and learning and the patient safety team via email notification for action as required. DCIQ training is being implemented in synergy with the NHSE PSIRF programme on the accurate grading of harm. In addition, drop-down menu explanations are available on the new DCIQ incident module. There is also a new function on DCIQ where staff can report the 'level of concern' alerting both the divisions and patient safety team to no/low harm or near miss that may trigger further patient safety surveillance. The divisions review the reported incidents within the divisional governance forums/groups triangulating with M&M and mortality reviews.

Performance Data supporting outcome of actions being taken (improvement in processes) / evidence of outcome improvement

Escalations (risk to delivery and request being made)	

Action Tracker – Detail

Ref	CQC recommended action	Lead Executive	Status
WLS3	The trust should ensure staff with long-term health conditions are protected in line with the Disabilities Discrimination Act 1995 and have meaningful personal adaptation plans to ensure they are treated fairly, with dignity and respect they deserve. (Regulation 17)	Chief People Officer	**In progress**

Weaknesses drivers for CQC recommendation	Trust Actions (summary)	Evidence of action taken (text in red new from last report)	Actions to be taken (and date)
1) Number of staff saying they are not supported with reasonable adjustment or support for working with a disability 2) Re-invigorate staff ability network	Employee Relations service review of cases to take learning. Improved guidance to managers. Refreshed wellbeing appraisal incorporates opportunity to raise issues. Charity bid for network support time / backfill.	Employee Relations reports at People Committee Lived experience videos developed as a learning resource.	Consideration to establishing a 'central' budget for 'reasonable adjustment' expenditure (Sept 2023) Launch of lived experience resources (Aug 2023) Establishment of schedule of meetings (Aug 2023)

Linkage to Trust Strategy (TN/BO/SI/CP)	Oversight Committee(s)
People Strategic Initiative – leadership, culture and development	People Committee / People Steering Group / Trust SDR

Planned sources of assurance over improvement delivery

Monitoring of reasonable adjustment requests and grievances or complaints related to disability. External accreditations and reviews against NHS standards and Disability Confident employment standards etc reported to PC.

Summary of current position

Like other Trusts staff with disability have a worse experience than others. The Trust has also had a number of ET claims where the impact of disability has not been appropriately considered and supported / addressed. Work is ongoing to raise awareness and promote reasonable adjustment and consideration of disability where performance concerns are raised about staff.

Performance Data supporting outcome of actions being taken (improvement in processes) / evidence of outcome improvement

No new ET cases citing disability discrimination.

Escalations (risk to delivery and request being made)	None.

Action Tracker – Detail

Ref	CQC recommended action	Lead Executive	Status
WLS4	The trust should ensure it recruits to the Guardian of safe working hours post to oversees the Royal Sussex County Hospital and Princess Royal. (Regulation 12)	Chief People Officer / Chief Medical Office / Deputy Chief Medical Officer	**Delivered**

Weaknesses drivers for CQC recommendation	Trust Actions (summary)	Evidence of action taken (text in red new from last report)	Actions to be taken (and date)
The need to establish a substantive Guardian of Safe Working for RSCH and PRH	New cross Trust guardian role established and appointed to. Admin support provided via the Medical HR team.	Reporting to People Committee by Guardian of Safe Working	Complete April 2023

Linkage to Trust Strategy (TN/BO/SI/CP)	Oversight Committee(s)
NOT DIRECTLY LINKED	People Committee

Planned sources of assurance over improvement delivery
Action complete. On going feedback to PC on exception reporting and themes.

Summary of current position
Action completed. Lotte Ford is the Trust-wide GoSW wef 1 April 2023 supported by two admin roles.

Performance Data supporting outcome of actions being taken (improvement in processes) / evidence of outcome improvement
N/A

Escalations (risk to delivery and request being made)	None

Action Tracker – Detail

Ref	CQC recommended action	Lead Executive	Status
WLS5	The trust should ensure the Freedom to Speak up Guardian and the Freedom to Speak up champions have sufficient resources to support staff to raise concerns	Chief People Officer	**On track** for the delivery of the outsourced service from August 2023

Weaknesses drivers for CQC recommendation	Trust Actions (summary)	Evidence of action taken (text in red new from last report)	Actions to be taken (and date)
1 Need to increase the Trust's resources for this role	Procurement commenced of an 'outsourced 24/7 FTSU support with go live of the service during Q1 2023-24.	Supplier proposal (from Guardian Service) received evaluated and progressed. Supplier has assessed level of resource against similar sized organisations and will keep under review with the Trust	Review resources after initial 6 – month contract period (Jan 2024).
2 Develop FTSU champions network / upskill other champions to promote FTSU	Contract includes development of FTSU champions	Work has started on mapping existing champions and networks and those that can be used to help promote FTSU as part of their champion / ambassadorial role	Engagement of new supplier in FTSU champion development (September 2023)

Linkage to Trust Strategy (TN/BO/SI/CP)	Oversight Committee(s)
People breakthrough objective of 'staff voice that counts'	People Committee / People Steering Group / Trust SDR

Planned sources of assurance over improvement delivery
New GS will advise on adequacy of resources and can benchmark. FTSU reports to PC.

Summary of current position
The supplier is providing a level of resource commensurate with that is uses in other organisations of similar size. This will be reviewed periodically.

Performance Data supporting outcome of actions being taken (improvement in processes) / evidence of outcome improvement
N/A

Escalations (risk to delivery and request being made)	Cost pressure to be absorbed within People Directorate / CEO FTSU budget

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	24	**Meeting:**	Board	**Meeting Date:**	3 August 2023
Report Title:	Company Secretary Report				
Sponsoring Executive Director:	Company Secretary				
Author(s):	Company Secretary				
Report previously considered by and date:					

Purpose of the report:			
Information	N/A	Assurance	N/A
Review and Discussion	Yes	Approval / Agreement	N/A

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

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	N/A	Link to Trust Annual Plan	Yes

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	N/A	
Sustainability	N/A	
People	N/A	
Quality	N/A	
Systems and Partnerships	N/A	
Research and Innovation	N/A	

Link to CQC Domains:			
Safe	N/A	Effective	N/A
Caring	N/A	Responsive	N/A
Well-led	Yes	Use of Resources	N/A

Regulatory / Statutory reporting requirement

The Trust is required to provide its Annual Report and Financial Statements to its Annual General Members Meeting. It is expected that after that meeting the document is placed on the Trust's website.

Foundation Trust's are required to establish and maintain an effective council of governors in line with the Trust's constitution which requires the Trust to undertake elections as governor terms of office end.

Communication and Consultation:

Report:

Governor Elections

Elections concluded in June 2023 and these returned the following members as Governors, Colin Holden as the Public Governor for Mid Sussex and Clare Bewick-Holmes as the Staff Governor for Princess Royal Hospital site. The Trust has vacancies within two public constituencies, these being Brighton and Hove and Out of Area / East Sussex. We are considering the best time to seek nominations for these two positions to then commence the election process.

2022/23 Annual Report and Financial Statements

The Annual General Meeting took place on the 25 July and below for information is the link to where the slides used in the meeting can be found can be found on the Trust's website. The annual report, including the Trust's financial statements and the Trust's quality account for the Trust can also be found using the same link. Statutory documentation - University Hospitals Sussex NHS Foundation Trust (uhsussex.nhs.uk)

2022/23 Charitable Funds Annual Report and Financial Statements

The Board are Corporate Trustees for the Trust's charity my UHSussex. In the year 2022/23 the Trust had two legacy charities Brighton and Sussex Hospitals and Love Your Hospital, noting these charities merged on the 1 April 2023. Whilst the requirement to have these accounts audited and submitted to the Charity Commission is not until much later in the year the Trust elected to have these audited concurrently with the Trust's own financial statements. The annual report and financial statements for these two charities can be found at https://www.myuhsussex.org/annual-reports/

Deputy Chair

The Governors Nomination and Remuneration Committee endorsed the decision of the Chair to appoint Paul Layzell to the position of Deputy Chair from the 1 July 2023 given the retirement of Patrick Boyle.

Recommendations

The Board is recommended to

NOTE the outcome of the recent Governor elections that has seen Colin Holden elected as the Public Governor for Mid Sussex and Clare Bewick-Holmes elected as the Staff Governor for Princess Royal Hospital site.

NOTE that the Trust has vacancies within two public constituencies, these being Brighton and Hove and Out of Area / East Sussex and the time to seek nominations for these two positions is being determined.

NOTE the publication of the Trust's and Charities 2022/23 annual reports and financial statements on the Trust's web site.

NOTE that Paul Layzell is the Trust's Deputy Chair.