University Hospitals Sussex
NHS Foundation Trust

Meeting of the Board of Directors

10:00 to 13:30 on Thursday 09 November 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 03 August 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** To receive and note ICS activities	Verbal	Presenter: George Findlay
		<u>INTEGRATED PERFORMANCE REPORT</u> *To receive and note all items:*		
Item:7	10:25	**Integrated Performance Report** *To receive and note* • ***Chief Executive's Introduction*** • ***Patient*** • ***People*** • ***Sustainability*** • ***Quality*** • ***Systems and Partnerships*** • ***Research and Innovation*** • ***Systems Oversight Framework***	Enclosure	Presenters: George Findlay Maggie Davies David Grantham Karen Geoghegan Katie Urch and Maggie Davies Andy Heeps Katie Urch Darren Grayson

Item:8	11:05	*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:9	11:25	**Board Assurance Framework and Corporate Risk Register highlight report** To approve	Enclosure	Presenter: Darren Grayson Glen Palethorpe
	11:35	***5 Minute Break***		
		ASSURANCE REPORTS FROM COMMITTEES ***Escalated Items Only:***		
Item:10	11:40	**Report from the Research & Innovation Committee *including Research and Innovation*** To note assurance from Committee and recommendations from the Committee - **from the meeting held on the 31 October 2023**	Enclosure	Presenter: Claire Keatinge

Item:11	11:45	**Report from Quality Committee**
		To note assurance from Committee and recommendations from the Committee
		- **from the meetings held on the 29 August, 26 September, and 31 October 2023 including:**
		  - ***Annual Infection Prevention and Control 2022-2023***
		  - ***Learning from Deaths report***
		  - ***Surgery Corporate Project Update***
		  - ***Annual Report - Organ Donation*** *(Presented by Alex Harrison)*
		To approve for submission
			Enclosure	Presenter:
				Lucy Bloem

Item:12	12.05	**Report from People Committee** To note assurance from Committee and recommendations from the Committee - **from the meeting held on the meetings held on the 1 November**	Enclosure	Presenter: Paul Layzell
Item:13	12:10	**Report from Sustainability Committee** To note assurance from Committee and recommendations from the Committee - **from the meetings held on the 22 August, 28 September, and 2 November**	Enclosure	Presenter: Lizzie Peers
Item:14	12:15	**Report from Systems and Partnerships Committee** To note assurance from Committee and recommendations from the Committee - **from the meeting held on the 2 November 2023**	Enclosure	Presenter: Bindesh Shah
Item:15	12:20	**Report from Audit Committee** To note assurance from Committee and recommendations from the Committee	Enclosure	Presenter: David Curley

		- **from the meeting held on the 17 October 2023**		
Item:16	12:30	**Report from Charitable Funds Committee** To note assurance from Committee and recommendations from the Committee - **from the meeting held on the 17 October 2023**	Enclosure	Presenter: Lizzie Peers
		WELL LED & COMPLIANCE		
Item:17	12.40	**Quality and Safety Improvement Plan** To note	Enclosure	Presenter: Darren Grayson
Item:18	13.00	**Nursing and Midwifery Establishment Review** To note	Enclosure	Presenter: Maggie Davies
Item:19	13:10	**Company Secretary Report** To note	Verbal	Presenter: Glen Palethorpe
		OTHER		
Item:20	13:15	**Any Other Business** To receive any notified business and action	Verbal	Presenter: Alan McCarthy
Item:21	13:20	**Questions from the public** To receive and respond to questions submitted by the public at least 48 hours in advance of the meeting.	Verbal	Presenter: Alan McCarthy
Item:22	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 08 February 2024.** **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 03 August 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
Jackie Cassell	Non-Executive Director
Claire Keatinge	Non-Executive Director
Lucy Bloem	Non-Executive Director
Professor Paul Layzell CBE	Non-Executive Director
Lizzie Peers	Non-Executive Director
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 Catherine (Katie) Urch	Chief Medical Officer
Darren Grayson*	Chief Governance Officer

*Non-voting member of the Board

In Attendance:

Glen Palethorpe	Company Secretary
Tamsin James	Board and Committees Manager

TB/08/23/1 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 acknowledge Paul Layzell attending in the capacity of Deputy Chairman for the first time.

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

TB/08/23/2 DECLARATIONS OF INTERESTS

2.1 There were no other interests declared.

TB/08/23/3 MINUTES OF THE MEETING HELD ON 04 MAY 2023

3.1 The Board received the minutes of the meeting held on 04 May 2023.

3.2 The minutes of the meeting held on 04 May 2023 were **APPROVED** as a correct record.

TB/08/23/4 MATTERS ARISING FROM THE MINUTES OF THE PREVIOUS MEETING

4.1 There were no Matters Arising from the previous Board meetings requiring action.

TB/08/23/5 CHIEF EXECUTIVE REPORT

5.1 George Findlay began by taking the opportunity to say thank you to staff highlighting that June, July and August had continued to be challenging months for staff and services due to the continued industrial action, and high demand for urgent care and extended waiting lists which have all contributed to the persisting difficulties the Trust faces. George highlighted that staff had continued to go above and beyond by cancelling holidays and being redeployed to other areas to meet these challenges.

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 to cancel many thousands of patients' appointments over the past months, 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 the celebration of the second Patient First STAR Awards where winners were chosen from more than 1,100 nominations made by colleagues, patients and the public for individuals and teams to recognise the extraordinary achievements of our staff and the difference they make to patient care. Also, recognition was shared of the innovative new knee replacement technology available from our Trust with the Sussex region to offer robot technology for knee replacements. It was also reported that earlier diagnoses and treatment of women with severe endometriosis, thanks to a dedicated service at Princess Royal Hospital, this has maintained its accredited status for the third year running. Also, a cause for celebration was the second National Healthcare Estates and Facilities Day in June, which allowed the Trust to recognise the invaluable contribution of the some 2,000 E&F colleagues who work across the Trust. It was also noted that the research and innovation team had introduced a new toolkit called the Antibiotic Review Kit which was introduced across 39 hospitals.

5.4 George explained that the Trust was continuing to invest in service developments which include the newly renovated fracture clinic at St Richard's Hospital which would allow patients to be seen more quickly as well as reduce the length of time from referral to first appointment. The development of a Community Diagnostic Centre at Southlands Hospital had passed significant milestones with the installation of new CT and MRI scanners; and a new children's audiology unit had 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.

5.5 George highlighted that the Louisa Martindale Building had successfully opened in June-2023, through the month of June, and 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 other patients, as more and more services moved into the modern, spacious new estate, culminating with Critical Care moving across from the Thomas Kemp Tower. The Board shared its thanks to the thousands of people who had worked on the building programme over the past 15-years bringing the advancement of the Trust's estate to fruition.

5.6 George explained that the Trust's workforce is valued, and work is undertaken to support them by a broad support programme which acknowledges and recognises everything they do for our patients, each other, and the Trust. George highlighted the appointment of the Guardian Service (TGS) to the Trust, which is an external, specialist provider to help support the Trust's workforce to have improved confidence should they wish to speak up or raise concerns. This appointment supported the work to build a system and 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 it was anticipated that TGS would strengthen that provision further. The Board went on to share its thanks to Trust colleague Dr Varadarajan Kalidasan, who had been our interim Freedom To Speak Up Guardian.

5.7 Alan McCarthy took the opportunity to echo George's thanks to staff during this operationally pressured time.

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

TB/08/23/6 ICS – SUSSEX SHARED DELIVERY PLAN

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 Sussex Shared Delivery Plan (SDP).

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 the SDP would be delivered as 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 which would provide a much wider collaborative way of working to deal with increased demand.

6.3 The Board agreed it was an important collaboration that required integrated oversight in terms of delivery assurance and achievement of outcomes.

6.4 The Board **ENDORSED** the final draft SDP agreed by the System Oversight Board (SOB) on 8 June 2023, and **NOTED** the proposed governance and assurance mechanisms for overseeing NHS Sussex's contribution to the delivery of the SDP.

6.5 The Board thanked George and **NOTED** the update on the Trust work within the ICS to develop this plan.

TB/08/23/7 INTEGRATED PERFORMANCE REPORT

7.1 The Chair introduced the new performance report for University Sussex Hospitals. Informing the Board that this report shows the Trust's performance to June 2023 and sets out the progress being made to deliver the Trust's Patient First Strategy, the NHS National Oversight Framework and the NHS Operating Plan.

7.2 Alan explained that it had been a challenging period for the Trust and for the NHS as a whole, reflecting that there had 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 had also experienced industrial action across a range of professional groups which has had an adverse impact on our planned care activity which had unfortunately continued into July. Whilst this had impacted operational capacity and the Trust's finances, reflect that the Trust and its staff have concentrated

on maintaining the continuity of good quality patient care. There had been progress made in reducing very longest waits (104 weeks and 78 weeks) for the Trust's patients and the Trust is ahead of its planned recovery trajectory for reducing the number of 62-day cancer patients waiting.

TB/08/23/8 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 have 90% or more of patients rating Friends and Family Testing (FFT) surveys as Very Good or Good.

8.2 The Board was advised that during Q1 over 42k patients responded to the Trust's FFT returning a 91% positivity rating for the experience they received. Leanne explained that the Trust had received 321 complaints during Q1, it was noted that themes from the negative patient feedback continue to relate to waiting (on site and for treatment), clinical treatment, and communication, 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 securing and reporting patient feedback the Trust's FFT system is being evolved to better reflect the Clinical Operating Model (COM) and to be widely utilised to inform divisional priorities using patient feedback.

TB/08/23/9 PEOPLE

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

9.2 The Board was advised of 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 Trust's IRIS training system. The True North engagement score had consecutively remained at 7 or above, divisional plans are in place to aid improvements to staff engagement this year which are progressing well. It was noted that the Trust continues to carry out Pulse Surveys which continues to improve consecutively with the metric now moving from a driver to a watch.

9.3 David explained that the Trust was working on providing staff with feedback if a concern has been raised to ensure that they understand how their concerns have been listened to. The Trust had also engaged a service called the guardian service and advised the Board that this was an approved provider and was supported by the national guardian's office, David explained that it was hoped that this new service would be reassuring to staff.

9.4 David advised the Board that the Trust was supporting an improvement in appraisals compliance following a deterioration in compliance for non-medical appraisals during the quarter.

9.5 David highlighted the key statistics noting an increase in the in-month staff sickness rates. In addition, it was noted that there had been a slight deterioration in Statutory and Mandatory training performance, however positively there had been some innovative recruitment with and increase in Registered Nursing (RN) recruitment, and retention levels were stabilising.

9.6 David emphasised that improvements were in place to oversee the attention to processes to ensure staff are paid on time which was reflected recently at the Junior Doctors Induction week.

TB/08/23/10 SUSTAINABILITY

10.1 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.

10.2 Karen advised the Board that it had been highlighted previously that achieving a breakeven position for 2023/2024 would be extremely challenging and reported that the Trust had submitted a breakeven financial plan for 2023/24; however, the year to date planned deficit at M3 was £4.8m. The actual deficit is £10.5m, which was £5.7m above plan. The key drivers of this included:

- Costs of Industrial Action,
- Mental Health Specialling and;
- Inflation and expenditure related to junior doctor deployment.

Karen added that the detailed forecast for 2023/24 continues to be developed and the forecast is maintained at breakeven. It was noted that cash position was £9.35 above plan predominantly due to the impact of the IT incident which impeded BACs payments.

10.3 Karen provided the Board with an update on Capital expenditure which is £12.93m against a plan of £12.08m. Karen drew out the key drivers to the plan variance and expressed in aggregate, capital expenditure is forecast to be on plan by year end. Karen went on to explain that efficiency schemes are continuing to be matured with mitigations being developed and deployed for higher risk schemes, and the plan is forecast to be delivered in full.

10.4 In relation to Productivity, Karen advised the Board that overall the Trust was performing well in respect of elective recovery and the programme was on track, it was noted that the ongoing industrial action was affecting performance with a reduction from 107% to 104%. Karen highlighted that there was ongoing work in relation to ensuring the newly implemented PAS system was fully embedded with the 'outcoming' of patients on the system having a positive benefit.

10.5 Karen informed the Board of the risk that divisional performance will not be in line with allocated budgets and if the current run-rate continues without sufficient mitigations to bring expenditure in line with plan, then the year end position will be extremely difficult to achieve. Karen added that tiered support meetings continue with the divisions and good progress is being made in a number of Divisions addressing their financial challenges. Forecasts and recovery actions are being incorporated into a Trust roadmap to review year end delivery options.

TB/08/23/11 QUALITY

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

11.2 Katie advised the Board that the UHSussex crude 12-month rolling mortality rate for non-elective admissions is at 109.3. The UHSussex rolling 12-month HSMR is 93.8. Katie outlined the Trust's actions when the SHMI is above 100 for a diagnostic group or specific hospital site and the developments that are in place to support the framework for triangulating high standardised mortality rates with other intelligence, such as the Learning from Deaths programme, National audit programme, Model Health System data. The first is reviewing COPD which is one of 7 SHMI diagnostic groups which fall outside an over

dispersed 95% data funnel plot, and the second pilot is reviewing high mortality rates at RSCH.

11.3 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.

11.4 The Board was advised the highest percentage of reported patient safety incidents are graded as low or no harm which for June 2023 was 92%, this indicates a positive reporting culture at UHSussex. In addition, there had been a 35% reduction in incidents indicating the potential for severe harm or death since April 2022.

11.5 Leanne explained to the Board that the Trust had seen a reduction in the number of patient falls, which was being supported by a number of workstreams underway to meet the reduction targets from additional risk assessments and ensuring bay-watch is in place to try and prevent unwitnessed falls.

11.6 Leanne explained there was a slight rise in reporting of category 2 and above pressure ulcers in June 2023, however, this demonstrated an overall reduction of 44% when compared to the peak in December 2022.

11.7 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. 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, whilst reporting on the associated workforce efficiencies including effective rostering, recruitment, retention strategies and sickness reduction plans.

TB/08/23/12 SYSTEMS & PARTNERSHIPS

12.1 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 True North components of A&E, RTT, Cancer and Diagnostics.

12.2 **A&E**

Andy advised the Board that the Trust treated 71.4% of patients within 4 hours of attending all A&E departments during June 2023 against 73.3% national performance, the Trust' capacity constraints continued to be exacerbated due to Industrial Action.

12.3 Andy explained that whilst the Trust's performance for the number of patients waiting over 12-hours in the emergency department (ED) was improving, it remained off target. The median hour of discharge was also improving and was now at 15.00 however it was noted that industrial action continued to have a negative impact on the median hour of discharge performance. Regarding the patient Length of Stay (LOS), Andy explained that whilst there had been a marked improvement only in Worthing, he was confident that the improvement methodology was beginning to embed with further reductions expected across the Trust.

12.4 **RTT**

The Trust had 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 in May 23. It was noted that there were 3673 65-week waits in June 23 against a plan of 2600, and the Trust continues to focus on the elimination of those patients experiencing the longest waits.

12.5 **Cancer**

It was noted that 53.4% of patients were treated within 62 days during May, against National performance was 58.7%. The Board was advised that there had been a marginal increase in over 62-day and 104-day prospective waits in the period up to June 2023, with an increase from 446 in May 2023 to 484 in June 2023 for patients waiting over 62-day, and from 88 patients in May 2023 to 103 patients in June 2023 for patients waiting over 104-days. Andy explained that the Faster Diagnosis Standard (FDS) performance was 69.5% during May, which was a reduction from 71.8% in May.

12.6 **Diagnostics**

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

TB/08/23/13 RESEARCH AND INNOVATION

13.1 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.

13.2 Katie advised that Board that the True North Metric for the R&I domain was within 3 years to be in the top 20 Acute Trusts nationally for patients recruited into portfolio studies and explained that the Trust's rank in terms of study participation compared to other acute Trusts on a quarterly basis from national statistics from the NIHCR website, the data for Q4 2022/23 shows the Trust as being ranked 33rd, an improvement relative to Quarter 3.

13.3 Katie explained 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.

At this point the Chair invited Board members to ask questions and discuss any pertinent areas of the Integrated Performance Report and agree any necessary actions.

13.4 The Board reflected on the Integrated Performance Report update and recognised the importance of excellent care, every time, and its delivery against the True North metrics. From a Quality perspective it was important to note the metrics that remain important factors to patient safety and to note the gaps in assurance relating to Clinical Outcomes and Effectiveness. The IPR shares with our patients the importance of progress whilst highlighting the operational challenges the Trust is facing.

13.5 Alan McCarthy expressed that it remained an essential factor for the Trust to retain its staff during this period of challenge, and that whilst recruitment metrics were positive to note it would be beneficial to understand the challenges to retaining our staff and understand more from an equalities perspective to identify talent across diversity. David Grantham outlined to the Board the improvements to the Trust's recruitment and retention plan which provides additional support to the ward areas using the Patient First system to drive the organisation forward and improve processes. The Chair of the People Committee, Paul Layzell, went on to explain that Health and Wellbeing for our workforce remains paramount and support was being sought from the Trust's Charity to further enhance the HWB offerings currently available.

13.6 The Board went on to discuss the Patient First approach and the opportunities available to the Trust around productivity and where this is linked to standard approaches to embedding and reinvigorating the approaches to the Clinical Operating Model. Andy Heeps explained that the Patient First Steering Group oversees the training and engagement commitment to the model however it was noted that industrial action has impacted the delivery of clinical care and whilst this remains a key risk for the Trust the importance remains to the recovery and efficiency workstreams in place to mitigate these increased risks.

TB/08/23/14 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.

TB/08/23/15 BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK REGISTER HIGHLIGHT REPORT

15.1 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.

15.2 Darren explained that that the Quality Committee and the Systems and Partnerships Committee in their review of their allocated risks agreed that risk 4.1 would be increased and 5.3 would not be reduced from its quarter 1 score, therefore the first had been adjusted.

15.3 The Board discussed the risk 4.1 which had received Quality Committee oversight who were assured by the scale of the Clinical Outcomes and Effectiveness remedial work underway which would see the risk move towards its target score by the end of the year.

15.4 The Board discussed the increased oversight of the effect of industrial action has on the operational risk 5.3 which Systems and Partnerships Committee has oversight for, it was recognised that given the continuation of industrial action then there is a low level of confidence that this risk would achieve its target score by the end of 2023/24. The Board agreed that this would remain under consideration through the winter planning mechanisms.

15.5 Paul Layzell commented as Chair of the People Committee, that the Committee in their review of risk 3.3 confirmed that the current score was inconsistent against the workforce update provided within the IPR due to a lag in assurance to the Committee. The Board were content with the evidenced progress of the strategic workforce plan which is supporting the 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.

15.6 Alan McCarthy questioned the level of confidence that could be taken in reducing risk 4.2 relating to the delivery of service improvements to improve the safety and outcomes for our patients or to demonstrate that our services are clinically effective and comply with regulatory requirements or clinical standards. The Board discussed the strengthened divisional reporting mechanisms underway which support the Clinical Operating Model which are starting to provide a higher level of assurance against the compliance improvements underway.

15.7 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 can be satisfied with the scores detailed within the BAF.

15.8 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.

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

TB/08/23/16 REPORT FROM PATIENT COMMITTEE CHAIR *INCLUDING RESEARCH AND INNOVATION* FROM THE MEETING ON 25 JULY 2023

16.1 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.

16.2 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.

16.3 The Board received the proposed terms of reference which following a previous discussion for the Research and Innovation workstream to have a dedicated Committee. The Committee 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 Board **APPROVED** the Research and Innovation Terms of Reference noting that the decision on health inequalities was yet to be resolved

16.4 The Board received the Patient Experience Annual report for 2022-2023 which reflected on the previous year described in previous reports, and incorporated 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 Board **APPROVED** the Patient Experience Annual Report 2022-23.

16.5 Claire added that the Committee had 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 R&I domain.

16.6 The Board **NOTED** the Report from the Patient Committee Chair.

TB/08/23/17 REPORT FROM QUALITY COMMITTEE CHAIR FROM THE MEETING ON 23 MAY, 27 JUNE AND 25 JULY 2023

17.1 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.

17.2 Lucy advised the Board that the Committee had met 3 times since the last Board meeting and during those meetings had received updates 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. The impact of industrial action on requirements for CNST year 5 and its ability to deliver training and medical attendance was noted and subsequently raised with NHS Resolution.

17.3 Lucy presented to the Board the Learning from Deaths Annual Report for 2022/23; the Safeguarding Adults Annual Report 2022/23 and the Safeguarding Children & Looked After Children Annual Report 2022/23; and the Medical Appraisal and Revalidation Annual Report 2022/23.

17.4 Lucy explained that the Clinical Strategy was brought to the Committee before its presentation to the Board and had acknowledged the significant work and assurance of its alignment with the ICB strategy, future prioritisation and engagement with the workforce on the strategy.

17.5 Lucy advised the Board that the Committee had undertaken a review of its effectiveness and recommended the revised Terms of Reference to the Board which was incorporating matters previously received by the Patient Committee leaving an opportunity to repurpose that committee time to a dedicated Research and Innovation committee.

17.6 The Trust Board **APPROVED**:

- 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
- The revised Terms of Reference for the Quality Committee (to include Patient Experience)

17.7 The Board **NOTED** the Report from the Quality Committee Chair.

TB/08/23/18 REPORT FROM PEOPLE COMMITTEE CHAIR FROM THE MEETING ON 24 MAY, AND THE 26 JULY 2023

18.1 The Chairman invited the Chair of the People Committee, Paul Layzell, to update the Board on their recent meeting and the assurances received in relation to People.

18.2 Paul advised the Board that the operation of this Committee had progressed 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 Medicine Division on their people processes.

18.3 Paul added that the Medical Workforce report provided a progress update on the procurement and validation testing of Appraisal system, the rostering system and communications mechanisms.

18.4 Paul 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 the positive news regarding the procurement of a Freedom to Speak Up (FTSU) Guardian function supported by the National guardian's office.

18.5 The Board **RECEIVED** and **APPROVED** the Annual Equality report, for publication on the Trust website, which included:

- Gender Pay Gap
- Workforce Race Equality Standard
- (WRES) Annual Report
- Workforce Disability Equality Standard (WDES) Annual Report

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

TB/08/23/19 REPORT FROM SUSTAINABILITY COMMITTEE CHAIR FROM THE MEETING ON 25 MAY, 29 JUNE, 27 JULY 2023

19.1 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.

19.2 Lizzie advised the Board that both the May and June meetings had focused on the delivery of the Trust's financial position, the efficiency programme and the productivity breakthrough objective. Lizzie added that the quarterly July meeting had an increased focus on all areas within the Committees remit including the work to develop the Medium-Term Financial Plan which would form part of a system-wide financial plan, and be brought to a future Board meeting for review.

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

19.4 Lizzie advised that there continues to be a well-tested and robust system for delivery of efficiencies and that the Trust had modelled and evidenced length of stay reductions through standard work that enables bed closures and that the impact of Winter pressures on escalation beds remained a risk.

19.5 Lizzie advised that the Committee had received the Q1 update against the 2023/2024 Capital Plan and discussed the significant overprogramming within the plan and the costs associated with the critical incident which could add further pressure to the capital plan.

19.6 Lizzie explained that the Committee had approved significant capital Investments which included the Same Day Emergency Care Unit at SRH; the Urgent Treatment Centre at Worthing, and the Hot Water Phase 1 Works at RSCH. the Trust's response to the National Cost Collection Pre-Submission Report had also been approved which confirmed 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.

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

TB/08/23/20 REPORT FROM SYSTEMS & PARTNERSHIPS COMMITTEE CHAIR FROM THE MEETING ON 27 JULY 2023

20.1 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.

20.2 Bindesh explained that 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.

20.3 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.

20.4 The Board **NOTED** the Report from the Systems & Partnerships Committee Chair.

TB/08/23/21 REPORT FROM AUDIT COMMITTEE CHAIR FROM THE MEETING ON 20 APRIL 2023

21.1 David Curley, Chair of the Audit Committee, presented the Chair's report from the meeting held on 18 July and drew out the following key points.

21.2 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.

21.3 It was noted that the Committee had received updates from the Local Counter Fraud Services, the External Auditors who provided 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, and the Internal Auditors and progress against the plan for the year from which to the Committee took assurance.

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

21.5 The Board **APPROVED** the Audit Committees Annual Report, which was included as an appendix to the Chair's report.

TB/08/23/22 CARE QUALITY COMMISSION (CQC)

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

22.2 The Board was advised that the action plan is continuously reviewed and scrutinised by the Quality Governance Steering Group and Quality Committee at their monthly meetings, and Leanne explained that the report summarised the 'Must do' and 'Should do' actions from the published CQC inspection reports in conjunction with the current divisional compliance status. The report provides clear indications of where the trust is improving against actions with clear distinction between those actions completed, or on track.

22.3 Leanne recognised that a review is being undertaken against the evidence of the 'completed' actions, whilst highlighting to the Board that there are a number of actions for which previously agreed 'close by dates' would not be achieved as they are by the nature of the action 'ongoing'. Leanne added that further discussions regarding these actions are progressing to see how these are included with the business as usual (BAU) monitoring through divisional governance which would be reflected in future updates of this report.

22.4 The Board acknowledged the assurance that could be taken from the report and George Findlay explained that there was an unannounced CQC inspection currently happening across the Trust and that the findings report would be shared at a future meeting.

22.5 In relation to Well-Led inspection action plan, Darren Grayson explained that each action, which is rag-rated within the report has an assurance plan in place to deliver consistent changes in core governance processes and engagement.

22.6 The Board held an in-depth discussion relating to the assurances which could be taken from the report, from a business as usual lens, which would support the engagement and review with the CQC.

22.7 The Board **NOTED** the update on the CQC Action Plan.

Andy Heeps left the Board meeting at this point; the meeting remained quorate in his absence.

TB/08/23/23 COMPANY SECRETARY REPORT

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

23.2 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 mid-Sussex and the Princess Royal Hospital site, and there remained

vacancies within two public constituencies, these being Brighton and Hove and Out of Area / East Sussex.

23.3 The Board was advised that the Annual General Meeting took place on the 25 July, the event was broadcast live, and it was noted that the recording would be loaded to the web page in due course along with the presentations from the evenings event. The annual report, including the Trust's financial statements and the Trust's quality account for the Trust can also be found on the Trust website with the following link: https://www.uhsussex.nhs.uk/about/trust/statutory-documents/#annual-reports-and-accounts

23.4 The Board were advised that 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/

23.5 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.

23.6 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.

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

TB/08/23/24 OTHER BUSINESS

24.1 There was no other business to discuss.

TB/08/23/25 QUESTIONS FROM MEMBERS OF THE PUBLIC

25.1 The Board received one question from the public in advance of the meeting which was in respect of the Board's current understanding of the CPD funding commitment from the Government and how will a potential stop to rolling funding over to Yr2 and Yr3 impact planning for the 3-year CPD renewal cycles.

25.2 David Grantham explained that having had input from Martyn Clark, Director of Education, the background to this question is that In 2019 the government set aside £150million of funding for CPD for registered nurses and allied health professionals.

25.3 The funding equated to £1000 per eligible registered health professional over the subsequent three years (so for 20/21, 21/22 and 22/23). This offer was then extended to cover the 2023/2024 financial year meaning that registered healthcare professionals have been entitled to an additional £333 of CPD monies this financial year.

25.4 At this stage there is no plan to continue the funding beyond 2023/24. However we await to see how the new Long Term Workforce Plan and merger of HEE into NHS England impacts upon training and development funding. To manage the risk of funding not continuing as a Trust we have used the monies to support CPD development of staff by developing and delivering a number of new

sustainable programmes and these should be able to remain in place even if further funding is not provided. We are also seeking to maximise our opportunities to deliver CPD for staff through the use of apprenticeships, supported by the apprenticeships levy funding that is available to us. So we expect to be able to continue to support staff with CPD, which should continue to be an important part of regular staff appraisal and career conversations, and supporting re-validation and registration renewal etc.

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

TB/08/23/26 RESOLUTION INTO BOARD COMMITTEE

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

TB/08/23/27 The Chair formally closed the meeting.

TB/08/23/28 DATE OF NEXT MEETING

28.1 It was noted that the next meeting of the Board of Directors was scheduled to take place at **10.00** on **Thursday 09 November 2023**.

Tamsin James
Board & Committees Manager
August 2023

Signed as a correct record of the meeting

…….. Chair

..…… Date

Agenda Item:	5	**Meeting:**	Trust Board	**Meeting Date:**	5 November 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: November 2023**

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

1. THANK YOU

1.1 The previous three months proved extremely challenging for our staff and services, with continued spates of industrial action, high demand for urgent care and large waiting lists (caused by the pandemic) all contributing to the persisting difficulties we face. Once again, I wish to take this opportunity to thank colleagues for all their hard work in very difficult circumstances.

1.2 Without their dedication, 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 During this period, we experienced both the longest strike and first combined junior doctor and consultant strike in NHS history. This ongoing industrial action led to more appointments and elective procedures being rescheduled to ensure we could prioritise patient safety and life-preserving care amidst the disruption.

1.4 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 risks of strike action. I want 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 and reduce waiting lists as swiftly as we can.

1.5 Despite 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 August. Well done to all colleagues involved.

2. ACHIEVEMENTS, AWARDS AND RECOGNITION

2.1 Congratulations to *occupational therapist Amanda Cornish* who won our Star of the Month award for July for organising a voluntary community day that saw students improve the garden for the St Richard's neuro-rehabilitation service at Donald Wilson House. Amanda was nominated for her commitment to creating a tranquil space time and time again for patients, having previously welcomed students in 2019 and 2022 to fill the garden with beautiful flowers and plants for patients to enjoy.

2.2 Congratulation to *consultant obstetrician and gynaecologist Dr Praneil Patel* who was our Star of the Month for August after being recognised for his kind and supportive attitude to helping those around him at work. Praneil was nominated by midwifery matron Julie Carr for being the "epitome of team working" for the countless occasions he has stepped up to

support his team and colleagues in their time of need, as well as for his exemplary patient care and communications skills.

2.3 Congratulations to the *Sussex Orthopaedic Treatment Centre (SOTC) team at Princess Royal Hospital* who were the winners of Star of the Month for September for their "exceptional demonstration of the Trust's values and unwavering commitment to patient care." The team was nominated for their dedication and resilience during the pandemic, and more recent embodiment of Trust values such as inclusivity, compassion, communication, and professionalism.

2.4 Thanks to our physiotherapy team's drive for improvement, a new therapy garden at Worthing Hospital will offer a dedicated outdoor space to support the mental and physical rehabilitation of patients, particularly those who have brain injuries, dementia, have had a stroke or are in the Intensive Care Unit (ICU). Physiotherapy technician, Julie Harris, was instrumental in the garden's creation after recognising patients with these types of conditions could benefit from other forms of therapy away from the busy hospital environment.

2.5 A pilot to create a digital pathway for orthopaedic surgery patients at Royal Sussex County Hospital has delivered impressive results that help to reduce the Trust's carbon footprint. Led by trauma and orthopaedic surgeon Sandeep Chauhan, the goal was to reduce the need for face-to-face visits from referrals to discharge and go paper-free wherever possible. After six months, impressive results included reducing face-to-face appointments and pre-assessment visits by 80% and more than 7.5 tonnes CO_2 was saved.

2.6 During Sexual Health Week (11-17 September), we celebrated our HIV and sexual health and contraception 'green team' who were awarded the Cathy Harman Award at the British Association of Sexual Health and HIV national conference. The team, made up of doctors, nurses, health advisors, pharmacists, administrators, and patients, meet regularly to promote environmental sustainability. During the Trust's last Environment Week, they all made green pledges, such as cutting down on printing, introducing re-usable cups and eating no meat on Mondays, and now 90% of staff in department feel they have made a permanent lifestyle change as a result.

3. INVESTING IN OUR HOSPITALS

3.1 A newly renovated antenatal clinic at Princess Royal Hospital now provides a dedicated space for antenatal care and offers more services to pregnant women and people. As well as providing a lighter and brighter space, this busy clinic which can see up to 120 people a day, has additional consultation rooms, more areas for them to be seen privately and is wheelchair and pushchair accessible. With extra space, the clinic can offer more services, including a vaccination hub and additional community midwifery clinics.

3.2 We have had significant investments approved to transform three of our emergency departments. This includes Worthing Hospital with a new Urgent Treatment Centre, including a Same Day Emergency Care unit (£4.5m); and a reconfiguration of the Acute Floor (including A&E) at Royal Sussex County Hospital (£48m). Unfortunately, the presence of RAAC at St Richard's Hospital has led to a delay of an approved scheme to develop a new Same Day Emergency Care (SDEC) unit (£4.5m) in Chichester. We are currently awaiting national guidance on this scheme. Separately, at Princess Royal Hospital we are piloting a GP-led Urgent Treatment Centre model of care which is already reducing waiting times and enabling our medics to focus on those most in need of their specialist skills.

3.3 The opening of our new Southlands Community Diagnostic Centre in Shoreham is supporting our elective care waiting times recovery programme. It provides patients with access to diagnostic and testing services in a purpose-built facility, away from our busy acute hospitals. The centre has opened with brand-new CT and MRI scanners, which will see 45,000 patients per year. There are also three new x-ray rooms, all in one dedicated space. The project is being managed in two phases, with the next phase expanding the facilities to include ultrasound, gynaecological investigations, lung function and echo services.

4. NEW SUSSEX CANCER CENTRE

4.1 Stage 2 of the 3Ts development at the Royal Sussex County Hospital is now underway, following the completion of stage 1 – the Louisa Martindale Building. Stage 2 is a new Sussex Cancer Centre to be built on the south-west corner of the site where the Barry Building is currently situated. Hundreds of people have been sharing their thoughts over the past few weeks during a public consultation on the design of the centre that will help inform a planning application amendment to the council early next year.

4.2 The building has been meticulously designed with our patients, their outcomes and wellbeing at the heart of every decision. It will bring state of the art purpose-built facilities, employing novel treatments and technologies, expertise, and research together in an environment that supports improved patient and staff experience. Stage 1 has completely transformed the clinical environment for more than 30 wards and departments since it opened for patients a few months ago. Stage 2 will do the same for our radiotherapy, oncology, and haematology departments too and provide state-of-the-art facilities for patients receiving treatment for cancer when it opens in 2027.

5. NEW RESEARCH AND INNOVATION STRATEGY 2023-28

5.1 Our new Research and Innovation Strategy, published in October, sets out our five-year ambitions for healthcare research and innovation within the Trust and for the people of Sussex. The strategy supports our overarching Patient First vision of providing excellent care, every time for all our patients, and broader improvement strategy.

5.2 From expanding access to research to offering new treatments, our research and innovation strategy is informed by what our patients, public and staff have told us, what our clinical and academic leaders think, and the health and wellbeing needs of our local population.

5.3 Through the strategy, we aim to:

- Engage with patients and staff to ensure our research is driven by their needs
- Embed research and innovation in the organisation and in the daily lives of our patients and staff
- Offer research and innovation career opportunities for our staff
- Develop high-quality research and innovation support services and facilities
- Develop partnerships across Sussex with other NHS organisations, our medical school, other academic partners, charities, and commercial partners
- Improve care for our patients, the NHS and beyond

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 example:

6.2 The Staff Psychological Support Service has supported more 430 colleagues so far in 2023/24. The Trust's counselling rooms are currently being refurbished, with Princess Royal and Worthing Hospital rooms the first to receive a face-lift. Additionally, Jane and Kelly from the service facilitated Breakout Rooms at our staff conference, focusing on personal resilience and mental wellbeing techniques for more than 150 staff.

6.3 Nearly 400 members of staff are now trained in Mental Health First Aid. The first peer support continuous professional development session was held on 11 October, providing trained staff with an opportunity to check-in, receive a knowledge and skills update, and share resources. Five more sessions have been organised during the next 12 months.

6.4 Nearly 100 colleagues from across the Trust have become the first to sign up for our refreshed Trust Ambassador scheme. Our ambassadors are members of staff who want to go above and beyond to help promote our Patient First improvement programme and our values, as well as provide support to other colleagues and for Trust initiatives. New ambassador badges will be provided to staff in-person during 'meet and greet' sessions with our hospital directors.

6.5 A virtual Menopause Café was held on World Menopause Day (18 October), focusing on hormone replacement therapy. With guest speaker Dr Rhianydd McGlone, a practicing GP with an Advanced Certificate in Menopause Care, the welcomed 65 staff attendees. The menopause group has nearly 200 members receiving information and providing peer support. The Trust is signed up to the Menopause Pledge.

6.6 The Heritage Space in the Louisa Martindale Building opened to staff in September, with a new timetable of classes including yoga, Pilates, and meditation. Massage, discounted activities and other classes are also available to staff at Princess Royal, Worthing, St Richard's and Southlands with offers being added to the intranet every month.

6.7 Our *Cost of Living* support service, launched in January, has continued to help colleagues. To date, the panel has allocated more than £84,000 to support around 450 staff with cost-of-living rises, a sudden drop in income or help with an unexpected expense which has caused hardship. Additionally, Tracy Cox-Horton, our dedicated Financial Wellbeing Support Officer from Wave Community Bank started July 2023, offering 1:1 appointments to help staff with money management, budgeting, debt advice and saving and loan advice. So far, she has supported 241 staff with their finances. Both initiatives are being supported by *My University Hospitals Sussex Charity.*

6.8 The Guardian Service launched in August with Trish Marks appointed as the Trust's first independent Freedom to Speak Up Guardian. 52 staff have reported a concern the service launched with 24 cases already resolved. Highest reported issues were around systems and processes, followed by management issues and other relationship breakdowns or behaviour. October was 'Speak Up Month'. New 'Speak Up' banners are now displayed across the Trust outside Wellbeing Hubs and Education Centres.

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

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

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	7	**Meeting:**	Trust Board	**Meeting Date:**	09 November 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 Integrated performance report for University Sussex Hospitals. It shows our performance to September 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 another challenging period for UHSussex and for the NHS as a whole. The period has been focused on the drive to deal 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.

Key Recommendation(s):

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

NHS
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Integrated Performance Report

September 2023

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Chief Executive Summary

Please see enclosed the performance report for University Sussex Hospitals. It shows our performance to September 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 with more detail provided in the body of the report.

During Q2 the Trust saw an increased level of performance challenge across some key delivery areas which has been recognised nationally. The Trust has been included in the national Tier 1 process for RTT and Cancer performance. The Tiering process allows for access to greater support but also brings increased oversight which informs National Oversight Framework meetings.

The Trust has seen deterioration across the cancer standards in the reported month, more recently this has stabilised and improved following intervention for the most challenged specialties and the creation of recovery action plans.

Elective pathways have also remained challenged up to September with a worsening of the position across several headline measures. Despite this position and in more recent weeks improvement actions have started to bear fruit with the waiting list reducing for the first time since the pandemic.

Diagnostics performance has been consistent with the previously reported period. Plans are being developed in the coming quarter to work towards recovery of this standard.

For our Emergency Care pathway, we have experienced another challenging quarter treating 70.3% of patients within 4 hours of attending. Despite this the Trust has improved by 7.7% since the same period last year.

Financially, the Trust saw a further increase in the deficit to £24m. The financial impact of industrial action is significant, both in terms of staffing costs, productivity and lost income. The cost of inflation is adding to our financial challenge, alongside additional nursing and medical costs to support our patients requiring urgent care in our emergency departments.

From a quality perspective, there has been gradual improvement in the SHMI mortality rate, and continued achievement of reductions in falls. Staffing indicators show improved appraisal and STAM rates, reduced vacancy rates and sickness levels in Q2.

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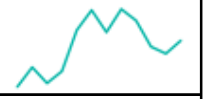
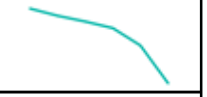
True North Metrics

	Patient First Domain	Metric	Value	Target	Trend
Pt	Patient	Patient experience - To have 90% or more of patients rating FFT surveys as Very Good or Good	88.9%	95.0%	
P	People	Staff Engagement - To be within the top quartile of acute Trusts for the National staff engagement score	6.97	7.06	
S	Sustainability	Financial Stability - Variance from breakeven plan YTD	-18,619k	0k	
Q	Quality	Clinical outcomes/effectiveness - SHMI equal to or less than 100	108.4	100.0	
Q	Quality	Safety - Reduction of 5% in preventable harm - UHSx approved	482		
SP	Systems & Partnerships	A&E and Emergency flow - % treated and admitted/discharged within 4 hours	69.3%	76.0%	
SP	Systems & Partnerships	Cancer - To achieve the 62 day standard	57.60%	85.00%	
SP	Systems & Partnerships	RTT Elective care - >=65 Weeks	5664	2800	
SP	Systems & Partnerships	Planned care - By March 2023, no patient is waiting more than 78 weeks for treatment.	669	0	
RI	Research & Innovation	Within 3 years to be in the top 20 Acute Trusts nationally for patients recruited into portfolio studies	26	35	

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Patient

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

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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).

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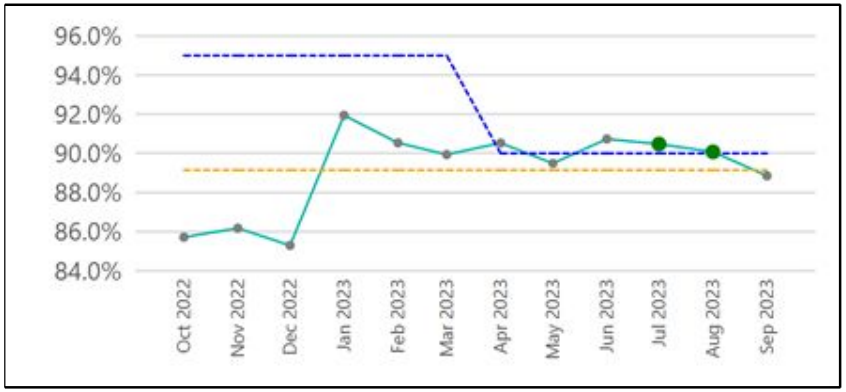
True North

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

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
85.7%	86.2%	85.3%	91.9%	90.5%	89.9%	90.5%	89.5%	90.7%	90.5%	90.1%	88.9%

Overview

Based on available FFT data, the significant majority of patients (90.7%) are satisfied that they have a good or very good experience. This is comparable to Q1 2023/24. All divisions (when EDs are excluded from the results) have patient reported positive reviews of 90% or greater.



What the chart tells us

In September a decline in patient reported experience in FFT was evident, and positivity in EDs (with the exception of PRH, RACH, SEH) has fallen below the national average and is on a downward trajectory. Inpatient reported experience is also below the national average and is declining (with national average at 95% good or very good and 92.5% for UHSx).
For UHS, 40,898 patients provided a review in Q2 with an average response rate of 21%.

Intervention and Planned Impact

Emergency department improvements are overseen through the S&P breakthrough objectives with ED performance correlating with patient reported experience. Patient experience rounds and audits are being implemented on the wards to identify concerns early for resolution.

Risks/Mitigations

Themes in negative patient feedback continue to relate to waiting (on site and for treatment), clinical treatment, communication and staff behaviours with the Trust Strategy work streams focussed on delivering improvements in waiting times, performance and staff wellbeing, which will impact on patient experience as detailed in the Patient Experience Strategy.

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Watch Metrics for Patient

Metric	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
Patient experience - Number of complaints	97	81	76	77	92	89	88	75	117	100	120	125
Patient experience - Total open formal complaints	329	315	317	322	267	255	286	305	310			436

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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%

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Patient First Domain
The Trust relies on it's 17,000 staff to deliver safe high quality care. We monitor a range of staff based metrics which give a high level insight into how they are feeling about the Trust, their health and wellbeing, vacancy rates, which can constrain particular services, their adherence to statutory and mandatory training requirements, and 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 in 2023. This is monitored via an equivalent Pulse Survey tracked on a monthly basis. We have also been encouraging 'staff voice that counts'. Both have shown significant improvement since December-22. Other data is stable or improving but the Band 5 nursing vacancy rate has increased, and although mitigated by increased HCA recruitment and increased bank coverage represents a potential risk to safe staffing. Work is ongoing to improve the position.

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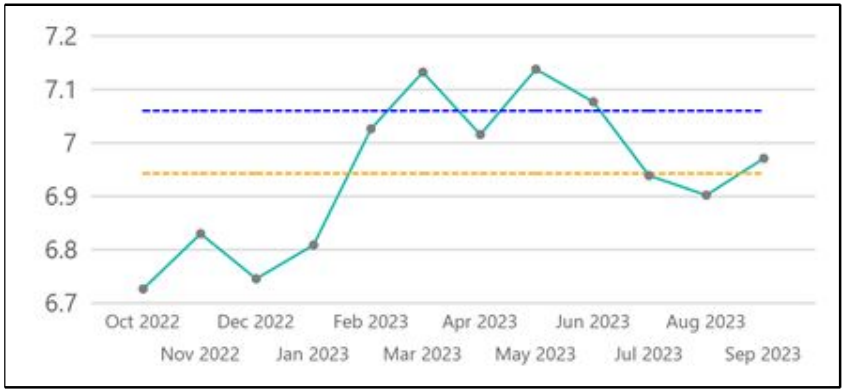
True North

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

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
6.73	6.83	6.75	6.81	7.03	7.13	7.02	7.14	7.08	6.94	6.90	6.97

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 per month, on an index to 10, from monthly surveys.
The engagement score stands at 6.9 which represents an increase from Sep-22 when the score was 6.6. Admin & Clerical and Estates & Ancillary have the highest scores with 7.3.
640 staff responded to the Pulse Survey in September which is the highest completion rate since Feb-23. The NHS National Staff Survey has seen a 36% completion rate after Week 5 with 6044 colleagues having completed the survey so far which is 6% above the response rate at the same time last year and 6% better than other acute trusts.
The Efficiency and HRBP/ER Teams have reached 100%; F&E has reached 49% (4% above their final response rate in 2022); 5 clinical divisions are at or above 30%.

Intervention and Planned Impact

All the Divisions have staff survey action plans based on the results of 2022 National Staff Survey. The divisions for whom True North is a driver metric continue to work on their staff engagement plans which this month include actions to encourage completion of the survey and finding ways to provide staff with time and space to do so.
Continuous Improvement Project manager supporting divisions and HRBPs by visiting wards and departments with historically low response rates to support an increase in returns. This is having a positive impact on the completion rate in these areas.

Risks/Mitigations

Operational demands, workforce capacity and industrial 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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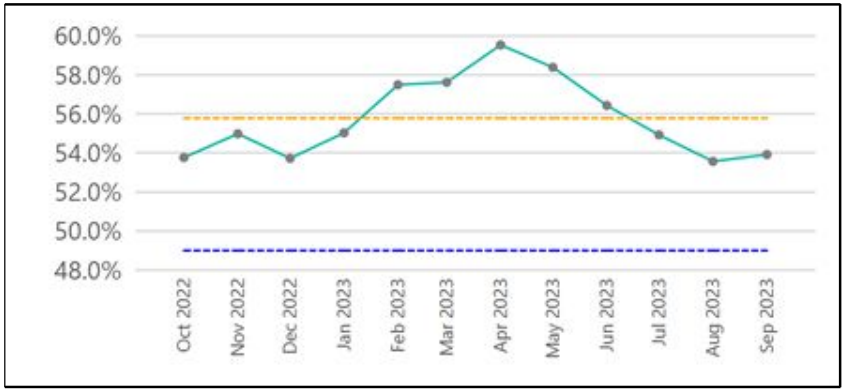
Breakthrough

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	Jul 23	Aug 23	Sep 23
53.8%	55.0%	53.7%	55.0%	57.5%	57.6%	59.5%	58.4%	56.4%	54.9%	53.6%	53.9%

Overview

No Data



What the chart tells us

This measure stands at 54.5% Sep-23, a slight increase from August (53.79%) but a decrease from 59.7% April 2023.
By Staff Group the highest rates are Estates & Ancillary (73.3%) and lowest is AHPs (48.8%).
The Trust is above the People BTO target for the 13th consecutive month. RSCH/PRH achieved 49.2% (2 months below target) ; WGH/SRH achieved 64.4% (highest since Dec-22 and 2nd month above 60%)

Intervention and Planned Impact

The Toolkit Q&A session for staff (which provides help and support with responding to staff concerns and difficult scenarios in the workplace) continues to be promoted.
Successful use of the manager's toolkit Q&A sessions: 19 completed and 10 booked for october.
Further session dates to be added for October for both line managers and staff and being promoted by HRBPs with their divisions.
Breakthrough Objective Plans continue to be worked on and monitored as part of divisional SMT and driver meetings and Trust SDR. All BO plans due to be completed by end of December 2023.
The new Guardian service is in month 2. The communication plan to promote the new service has been implemented and there is a good awareness of the new service.

Risks/Mitigations

The most significant risk has been the impact of operational pressures and industrial action on being able to deliver the BO action plans. This has been mitigated by HRBPs proactively in-reaching in to the Divisions to help deliver the actions.
SRO holds a weekly meeting with Team to ensure delivery of key action and to monitor progress.
Regular updates are provided to Trust SDR and People Committee.

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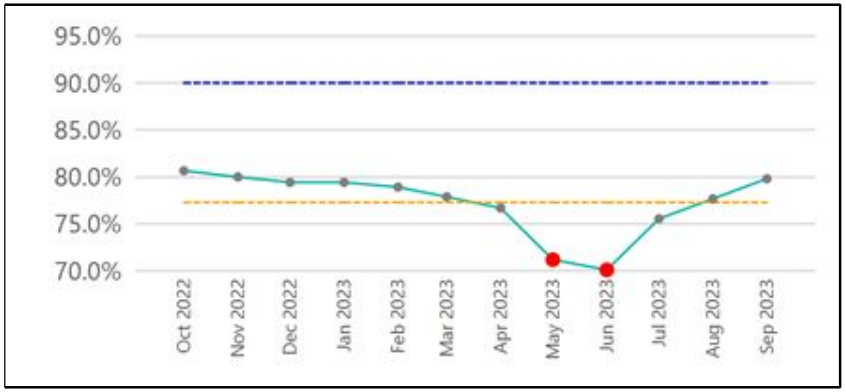
Driver

Metric: Training & development - Appraisals completed

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
80.7%	80.0%	79.4%	79.4%	78.9%	77.9%	76.7%	71.2%	70.1%	75.5%	77.7%	79.8%

Overview

- Non-Medical Appraisal rate, also excluding (i) Junior Doctors in Training, (ii) all Medical & Dental staff.
- Compliance target: 90%.



What the chart tells us

The Trust Appraisal rate (non-medical staff) has seen an increase over the previous 4 month period and currently stands at 80.5%, up from 69.45% seen in June 2023. This is the first time since October 2022 that the rate has sat above 80%.

There are three main staff groups with rates below 80%, these are Admin & Clerical (77.2%), ST&T (72.83%) and Healthcare Scientists (70.34%).

Intervention and Planned Impact

The notable improvement (11.0% points) since June 2023 reflects sustained effort to improve compliance – including data accuracy (i.e.. completed appraisals that had not been reported).

In addition to ongoing Trust SDR process and HR Business Partner support to Divisions, this has involved a series of targeted emails directly to staff with significantly overdue appraisals, and individual follow-up/support where required.

Risks/Mitigations

- Operational pressures remain challenging – however all Clinical/Operational Divisions have higher reported compliance than most Corporate Divisions.
- Appraisal continues to be flagged at Divisional and Trust SDRs (Watch/Driver Metric).
- Further improvement expected next month in response to continuing focus and data cleansing.

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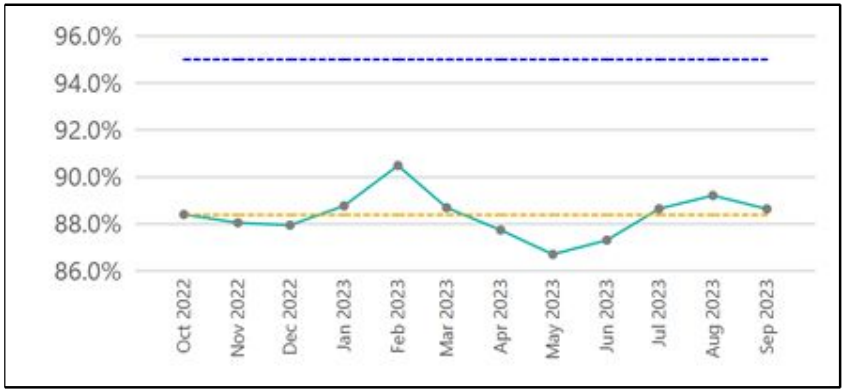
Driver

Metric: Training & development - STAM Weighted Average

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
88.4%	88.0%	87.9%	88.8%	90.5%	88.7%	87.7%	86.7%	87.3%	88.6%	89.2%	88.6%

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

The UHSussex STAM compliance is at 88.64% September.
Resuscitation training still reflects the lowest compliance but has seen an increase in uptake over the past month rising form 78.0% to 79.2% September.

Intervention and Planned Impact

Resuscitation services and Moving and Handling now have a permanent home at the RSCH with dedicated training space. This has aided increases in compliance as attendance at training has improved.
STAM subjects can now be passported in and out of the organisation through the IRIS/ESR interface.
Compliance has dipped slightly in some areas and across people division due to major junior doctor changeover - 500+ junior doctors move on a single day at the beginning of the month.

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.

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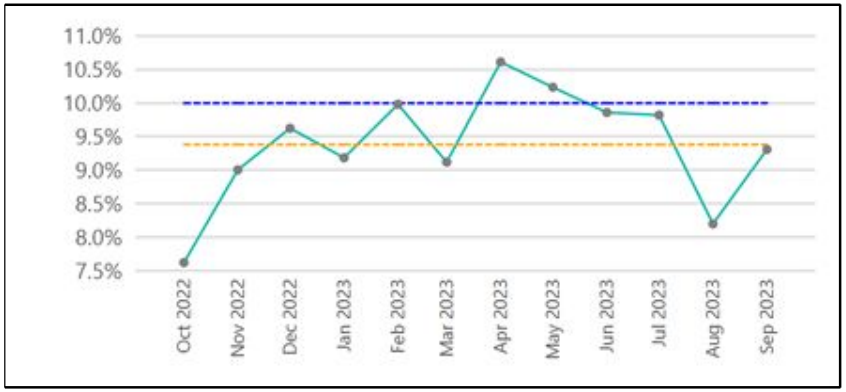
Driver

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

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
7.6%	9.0%	9.6%	9.2%	10.0%	9.1%	10.6%	10.2%	9.9%	9.8%	8.2%	9.3%

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 vacant substantive FTE divided by budgeted establishment FTE.
The September vacancy rate was 9.31% down from 10.61% April 2023. The Trust Budgeted Establishment has increased by 44.1 FTE since August, to 17,035.4 FTE, whilst substantive staff in post decreased by 148.5 FTE to 15,449.6 FTE. Substantive headcount is 17,371.
By staff group, highest rates are Estates and Ancillary (15.1%) and ST&T (14.6%). Band 5 RN vacancy rates remain high at 17.6% , an ongoing risk in deploying sufficient substantive nurses and impacts negatively on agency spend.
HCA vacancy rates improved to 8.23% Sep, with a plan to reach 1-3% by Jan-23 with a healthy candidate pipeline.
Time to recruit is 42 days on average from approval to pre-employment checks, below 45 day target.

Intervention and Planned Impact
IEN recruitment for 75 nurses is progressing well with a targeted approach to deployment to high-cost agency areas to ensure good ROI There is a focus on attracting and recruiting newly qualified nurses from partner universities and the wider HEI population. This includes guaranteed jobs subject to practice mentor sign off. There is an always open approach to registered nurse recruitment and plans are being developed to confirm a calendar of open days for the next 12 months. There has been a small restructure of the team to free up an experienced resourcing manager to focus on candidate attraction and talent acquisition strategies. A detailed plan is being developed to address registered nurse recruitment that will be monitored via the N&M Nursing Steering Group and directly by the Director of Workforce Planning & Deployment. Work continues to ensure that the Trust is recruiting from a diverse candidate pool including strong links with the Princes Trust and Job Centre. A diverse recruitment action plan has been developed and is due to be signed off at the EDI recruitment working group shortly. Work is underway to understand the Estates and Ancillary vacancy factor and provide resourcing support in this area – particularly in Estates
Risks/Mitigations
Planned review of models of nursing care when new deputy chief nurse - workforce starts in November. Redoubling our efforts on newly qualified recruitment/promoting bank work internally and building the employer brand for nursing.

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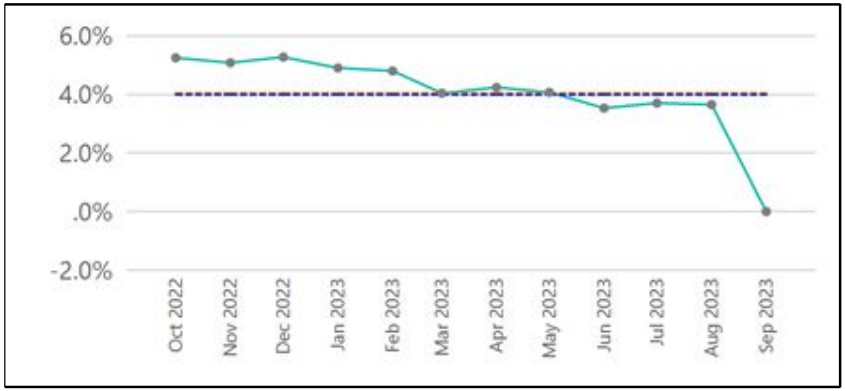
Driver

Metric: Workforce efficiency - Absence Sickness in month

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
5.3%	5.1%	5.3%	4.9%	4.8%	4.0%	4.2%	4.1%	3.5%	3.7%	3.7%	0.0%

Overview

No Data



What the chart tells us

This chart shows sickness in month. It runs a month in arrears to allow for a time lag for information to flow from managers into ESR.

In August the UHSussex one month Sickness Absence rate was 3.65%, the second lowest monthly rate in the past year. The 12-month sickness absence rate stands at 4.82%, down from the high of 5.2% seen in May 2023 and sees a rise from rates at this point last year, which were 4.57%.

When looking at 12 month rate by staff group there is a marginal increase in scientific and technical professionals (6.3% to 7.4%), Additional clinical services, mainly unregistered nursing (up from 8.7% to 9.7%), and registered nursing (up from 4.,65% to 5.17%)

Intervention and Planned Impact

Sickness rates have improved during the last four months which is positive, but it is recognised that we are moving into the more challenging Autumn and Winter period when absence is likely to increase due to seasonal flu and Covid.

Work continues to focus on Divisional hotspots and A3 Action plans, monitored via the SDR process and on the Trust-wide work streams into HCA absence (highest group for absence) and mental health (highest reason for absence).

Sickness Absence Training continues. To the end of July over 300 supervisors/managers attended the half day sickness training course with very positive feedback.

During the Aug/Sept period bespoke sessions on absence management have been provided for specific teams/departments including a module on the first three cohorts of the F&E Supervisors Academy running at RSCH/WTG and SRH, and for Medical Records.

The sickness training course has been reduced to a shorter session (75 mins) to encourage further participation and separate sessions are being devised: one for beginners and one for managers more experienced in sickness absence management. These are available to book via IRIS and the first beginners' course is scheduled for the end of October.

Risks/Mitigations
•Potential risks are the continued industrial action 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.

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Watch Metrics for People

Metric	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
Workforce capacity - FTE Budgeted	16127	16342	16446	16431	16645	16578	16846	16862	16861	16869	16991	17035
Workforce capacity - FTE Substantive contracted	14897	14870	14863	14922	14983	15066	15058	15136	15199	15212	15598	15450
Workforce capacity - FTE Substantive contracted variance from Budget	1229	1472	1583	1509	1661	1512	1788	1726	1662	1657	1393	1586
Workforce capacity - Number of leavers	172	115	119	253	88	145	119	93	108	125	187	143
Workforce capacity - Number of Starters	369	200	112	491	237	209	226	226	175	188	550	295
Workforce efficiency - Absence 12 month sickness rate	4.7%	5.4%	5.2%	5.1%	5.4%	5.2%	5.3%	5.2%	5.1%	4.9%	4.8%	0.0%
Workforce efficiency - Absence Total in month.	14.6%	14.7%	14.6%	17.3%	14.4%	13.8%	14.1%	13.8%	13.8%	14.3%	13.7%	0.0%
Workforce efficiency - Turnover (12 month)	9.44%	9.54%	9.49%	9.87%	9.68%	9.65%	9.52%	9.33%	8.97%	8.95%	8.85%	8.64%

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Sustainability

	Metric	Target
True North	Financial Stability - Variance from breakeven plan YTD	0k
Breakthrough	Productivity Metric - Elective Recovery Fund Performance Actual	107.0%

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

Integrated Care Boards (ICBs) have a statutory duty to contain expenditure within the limits directed by NHS England, with a requirement to deliver system financial balance. Each constituent Organisation within the Sussex ICB submitted breakeven financial plans for 2023/24.

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True North
Metric: Financial stability - Variance from breakeven plan YTD

Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
5,756	9,605	10,527	12,771	16,900	24,579
2,763	4,919	4,834	5,700	6,184	5,960

Overview

The Trust submitted a breakeven financial plan for 2023/24; the ytd planned deficit at M6 is £5.96m. The actual deficit is £24.58m, which is £18.62m above plan.
The drivers of the deficit have been categorised as either outwith **(£13.4m)** or within the Trust and/or System's direct control **(£5.2m)**.

Elective restoration performance has decreased to 102.2% as at M6, from 102.7% reported in M5. The impact of industrial action is 3.1% ytd.

The cash position is £20.73m, £39.28m below the plan. This variance is:
- £18.60m ytd in support of the deficit to plan;
- £15.00m costs incurred for LMB (3Ts), with no income received to date from NHSE; and
- £ 5.70m timing differences on contractual payments due.

Capital expenditure is on plan, with expenditure of £29.56m against a plan of £29.40m.

Efficiency performance is cumulatively £1.14m below plan. Predominantly related to procurement schemes and Patient Transport Services (PTS) opportunities.

Agency expenditure is 3.2% of the pay expenditure. This is on an upward trajectory but below the 3.7% target.

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M6 YTD	Annual Plan	Plan	Actual	Variance
	£m	£m	£m	£m
I&E	0.00	5.96	24.58	18.62
Cash	60.01	60.01	20.73	(39.28)
Capital	99.63	29.40	29.56	(0.16)
Efficiency	62.00	24.72	23.58	(1.14)
Agency Ceiling	34.33	17.43	15.12	(2.31)

What the chart tells us

The actual deficit is **£24.58m**, which is **£18.62m** above plan.

Key drivers outwith the Trust's direct control **(£13.4m)** are the cost of industrial action (both direct and indirect impacts), excess cost of inflation and the impact of pay award costs in excess of funding.

In addition, and based on the change in guidance, Elective Recovery Fund (ERF) 'clawback' has been included in the ytd position; and contributes to the reported deficit by **£3.7m**.

The key drivers of the deficit which are defined as being within the Trust and/or System's direct control **(£5.2m)** continue to include excess costs, above budget, of mental health specialling, medical premium and junior doctor deployment and activity related clinical supplies and drugs, including high cost drugs.

Intervention and Planned Impact

Executive level dialogue continues with the ICS and NHSE to communicate the financial impact, in excess of funding allocated, of industrial action, inflation and the 2023/24 pay awards.

Executive led deep-dive meetings are being undertaken with each of the operational divisions to assess current financial position, planned interventions, forecast and governance arrangements. Divisions will be set realistic, but stretching, financial targets for the second half of 2023/24.

Divisional forecasts and roadmaps will be combined into a Trust level financial outturn. Included within this is the efficiency programme performance and cash forecasting to understand future requirements based on an updated forecast outturn.

The Trust will complete the actions required for the forecast change protocol, which will enable to the Trust to revise the financial forecast outturn for 2023/24 in the month 9 reporting to NHSE.

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Risks/Mitigations

There are a number of key risks to the delivery of the 2023/24 financial plan.

The key risks, which are **outwith the Trust and/or System's direct control**, include the excess cost of inflation, the impact of industrial action and unfunded costs associated with the 2023/24 pay awards. There is a further risk that agreed funding for the Louisa Martindale Building (LMB/3T's) development will not be allocated by NHSE and / or will be insufficient to cover the costs incurred in 2023/24.

Mitigations: The Trust is working alongside the Sussex ICS to monitor and report, to NHSE, inflationary pressures; whilst also ensuring collaborative solutions are developed and economies of scale realised where possible. The Trust contributes to information submissions with respect to the financial impact of industrial action; both direct costs and lost activity/income. Relief for the financial impact of industrial action has been received for April only. Further discussions are taking place between NHSE and the Treasury with respect to relief for the impact of IA for June to September; decision pending.

Mitigations: Ongoing dialogue with Sussex ICB and NHSE in regards to the funding allocation shortfall associated with the nationally agreed 2023/24 pay awards and agreed funding support for the LMB development.

The key risks to the financial position, which are **within the Trust and/or System's direct control**, relate to the excess costs of mental health specialling, medical premium, junior doctor deployment, activity related clinical supplies and drugs, the impact of the 65 week wait delivery plan and efficiency performance.

Mitigations: For mental health specialling, a combination of internal and external measures have been introduced including new protocols for confirming requirements and pilot models of care; coupled with mental health crisis pathway management, implemented as a joint ICB solution to provide care in the most appropriate setting.

Mitigations: The monitoring and reporting of activity targets to deliver the reduction of 65 week waits trajectory is continuing, with cost estimates being further refined and income assessments being completed. Further NHSE guidance regarding ERF target amendments is expected, with further discussions taking place between NHSE and the ICB. Note, there is a risk that ongoing industrial action will further impact the achievement of activity plans

Mitigations: Executive led deep dive meetings have taken place with operational divisions post month 6 reporting. Tiered support meetings will continue, with agreed financial targets, updated forecasts and recovery actions being incorporated into the Trust forecast outturn roadmap.

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Breakthrough

Metric: Productivity measured by the income value of activity delivered in 23/24, compared to the 19/20 baseline

Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	YTD
104.0%	108.9%	102.1%	98.1%	101.4%	99.2%	**102.2%**
107.0%	107.0%	107.0%	107.0%	107.0%	107.0%	

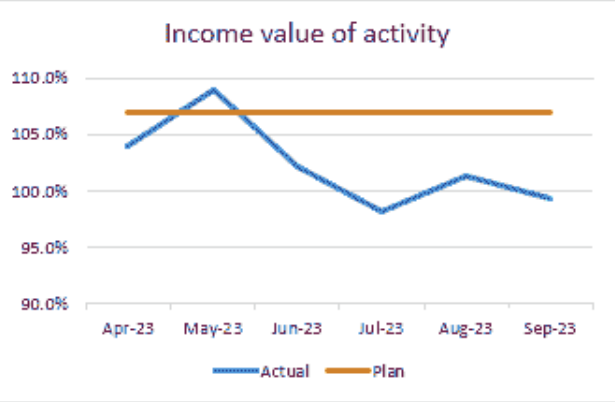
Overview

Initially NHS England (NHSE) set the Sussex Integrated Care Board (ICB) an elective recovery target of 109%; 9% above 2019/20 published activity levels. The final plan submission for the ICB included a delivery target of 107%. The Trust's contribution to this ICB target was also agreed as 107% and Elective Recovery Funding (ERF) allocations, to fund the cost of delivering activity between 100% and 107%, have been set at this level.

In July NHSE published new elective recovery targets targets for each ICB; reducing targets by 2% to compensate for the value of lost activity due to the impact of Industrial Action (IA). This relief related to April IA only. The target for the ICB has been confirmed as 107%; whereas a reduction to 105% was expected based on the ICB and Trust's final plan submissions. This issue is being queried by the ICB with regional NHSE teams.

Elimination of 65-week waits would require performance of c110%. Additional funding is available performance in excess of the agreed target.

The value of activity performance is evaluated at both Trust and ICB levels and payment is adjusted based on distance from the agreed target. If there is under-performance against the target, income is recovered from the Trust at 100% of the tariff price.



What the chart tells us

Performance as at Month 6 equates **102.2%** in comparison to the 2019/20 baseline target (100%). This means that the income value of activity is between **2.8%** and **4.8%** lower than the plan; pending confirmation of the final target (105% v107%).

Industrial action has had a significant impact on the achievement of activity targets. The impact equates to **3.1%** as at Month 6. Without industrial action, performance levels would have been at c**105.3%** for the year-to-date.

There was no industrial action in May and performance achieved was **108.9%**.

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Intervention and Planned Impact

Operational plans to deliver the additional activity necessary to support the elimination of 65 week waits by 31/03/2023 have been developed. These plans are being to tested to ensure deliverability; with a focus on monitoring, reporting and timely intervention. Cost and income assessments will be updated as appropriate.

There is further line of enuiry in realtion to the recording and coding of activity to ensure full capture and depth of coding is maintained.

Independent Sector capacity has been secured to support activity in quarters 3 and 4 of this financial year. In addition to internal capacity which has been flexed to accommodate the increase in activity expected.

If 65 week waits are eliminated, the activity performance achieved would be c110%; securing additional investment over and above current financial allocations.

Risks/Mitigations

Performance as at Month 6 is lower than the target by 2.8% to 4.8%. This means that the Trust is at risk of returning income of between £3.7m and£6.1m; depending on the activity target (105% v 107%). Required repayment of income is termed 'clawback'.

Estimated 'clawback' of £3.7m has been included in the Trust's reported financial position; based on the target of 105% which is in line with the Trust/ICB's plan submission post adjustment for IA relief (2%). The financial forecast for year-end assumes that there will be no 'clawback' given the plans to eliminate 65 week waits and achieve performance of c110%.

Dialogue between Trust, ICB and NHSE teams are ongoing in relation to the agreed activity target. Further discussions are taking place between NHSE and the Treasury with respect to relief for the impact of IA for June to September. Continued industrial action will impact both the delivery of activity and financial targets.

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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

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

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

For actual harms (approved) graded as low, moderate, severe and death the numbers reported for September = 482 (an increase from August and marginally in line with reporting in October 2022= 495). Overall reporting was positively up from August to 2652.

The highest percentage of reported patient safety incidents are graded as no harm.

Falls, pressure damage/medication and staffing are the most common themes within the low harm categories.

Moderate harm and reported deaths rising. Moderate harm increased by 54%- (34-62)

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.

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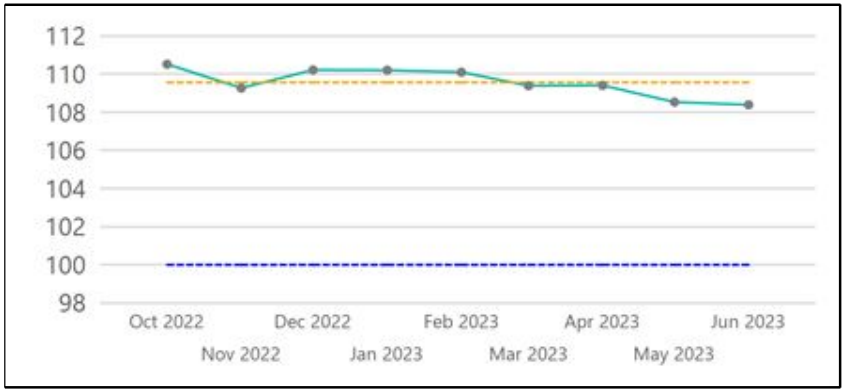
True North

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

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
110.5	109.3	110.2	110.2	110.1	109.4	109.4	108.5	108.4

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

SHMI is 108 June with 4732 observed against 4377 expected. This has reduced since 110.5 Oct-22. This is not an outlier using a 95% over-dispersed funnel plot but is an outlier on the stricter 95% Poisson limits. PRH is the only site below 100; however, out-of-Hospital SHMI at PRH remains high at 124 compared to trust rate 113.

The top two contributors in deaths (pneumonia and septicemia) both have SHMI's below 100. However, the next 5 conditions are above 100 - Acute cerebrovasc disease (SHMI 119); Congestive heart failure – nonhypertensive (SHMI 129), Aspiration pneumonitis (SHMI 103); COPD (SHMI 128) and Acute and unspecified renal failure (SHMI 128).

The two specialities with highest deaths (n=2783) general medicine (SHMI 114) and elderly care (SHMI 129) have SHMI of 118 combined.

Intervention and Planned Impact

The Clinical Effectiveness Team is working to a standardised response when the SHMI LCL is above 100 for a diagnostic group or specific hospital site.
Current reviews include:

- 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.
- SHMI review for fluid and electrolyte disorders. This review has been initiated because the SHMI is currently 152 (LCL 122; UCL 188) for the 12 months to June 2023. The current focus involves discussions with the coders about how primary diagnosis is assigned.
- SHMI high for Worthing #NOF which is possibly an outlier due to delayed time to surgery & post-operative mobilisation.

The reports into these reviews we be shared later in the year.

Risks/Mitigations

No Data

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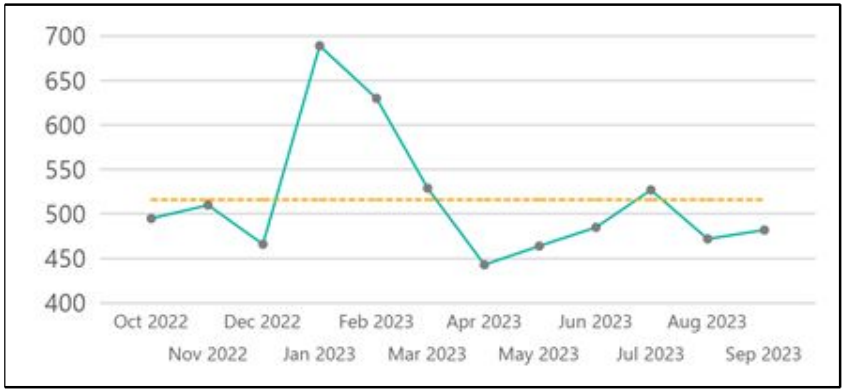
True North

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

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
495	510	466	689	630	529	443	464	485	527	472	482

Overview

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



What the chart tells us

There were 482 actual harms reported (approved) graded as low, moderate, severe and death (an increase from August and in line with reporting in October 2022 of 495). Overall reporting was positively up from August to 2652. The highest percentage of incidents are graded as no harm.
Falls, pressure damage/medication and staffing are the most common themes within low harm categories.
Moderate harm increased by 54%. A revised harm category of psychological harm has recently been updated, and is highlighted when patients have delayed surgery or mental health patients awaiting specialist treatment and placement in acute hospitals. This harm level may be downgraded when incidents have been fully investigated or via the mortality and morbidity (M&M) divisional review process.

Intervention and Planned Impact

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.

Thematic Review: In line with the new Patient Safety Incident Response Framework, thematic reviews have commenced in Q2 2022/23.

Divisional thematic reviews focusing on: Harm reviews from cancelled surgery: vascular, ortho, trauma, surgery, cancer. RTT follow up ophthalmology.

Under-reporting of incidents due to capacity and industrial action. SJR to be reviewed at mortality panels and any evidence of omissions in care pathways to be presented at PSIRG.

Reporting culture to be addressed with the implementation of DCIQ and ongoing training and education. Targeting medical workforce.

Risks/Mitigations
Rise in incidents presenting to the Patient Safety Incident Response Group (PSIRG) regarding patient harm from patient deterioration and lost to follow up, mental health management and RTT ophthalmology. Under-reporting of incidents remains a risk due to capacity and industrial action. Reporting of all incidents is encouraged via the Datix incident reporting system Mental Health: High risk remains in both emergency departments and paediatric areas with Tier 4, LA and specialist placement.

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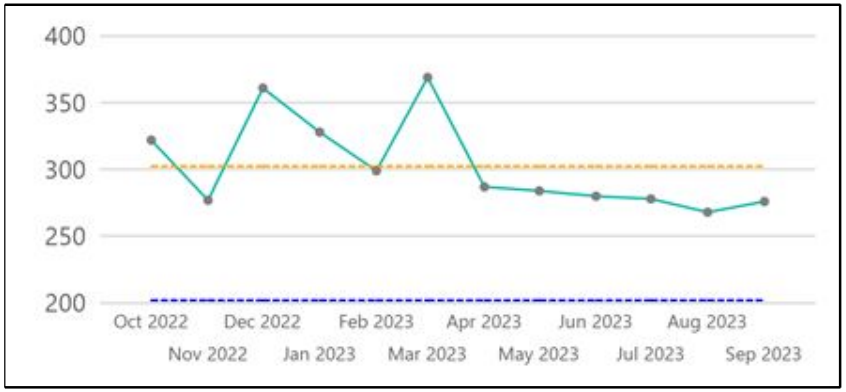
Breakthrough

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

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
322	277	361	328	299	369	287	284	280	278	268	276

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 September there were 276 falls reported which is 5.05 per 1,000 beddays (5.16 average rolling year). When compared to the baseline data in March 2023 (369 falls; 6.04 per 1,000 bed days), this demonstrates a consistent reduction of 25% in line with the previous report.

Intervention and Planned Impact

The project improvement plan currently has 20 countermeasures. Key updates for October:
1. New Trust-wide Rapid Review trialled and being rolled out Trust-wide
2. The "Baywatch" operational procedure has been revised, with the harm free care team finalising the SOP before roll-out in November.
3. A "Falls Prevention Audit" for use in the Tendable auditing system now created and installed. Go-live 1st October 2023 - Weekly reports of compliance being circulated.
4. Trial of Intentional Rounding commenced in the Lousia Martindale Building in September due to increase in falls since ward moves. Due for review end of October
5. Falls dashboard created on Compass BI to provide detail into potential causes and risks of falls.

Risks/Mitigations

The provision of Falls leaflets have a funding source as mitigation. The development of the Falls risk assessment on patient track has also been funded and underway.

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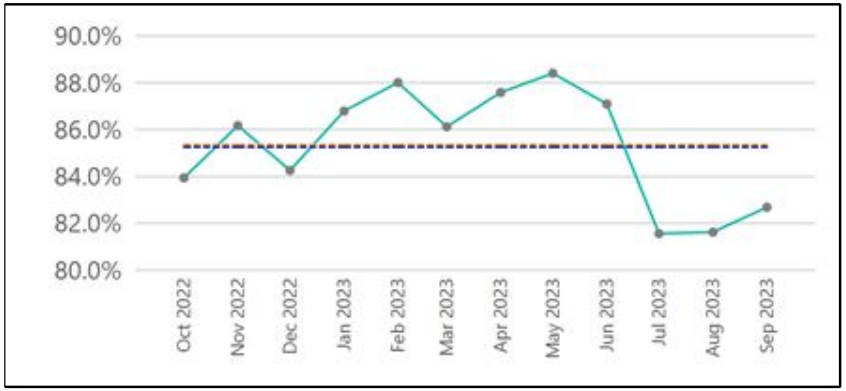
Driver

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

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
83.9%	86.2%	84.3%	86.8%	88.0%	86.1%	87.6%	88.4%	87.1%	81.6%	81.6%	82.7%

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 difference in patient outcomes, patient experience, quality of care, and the efficiency of care delivery. (RCN, 2011; Griffiths and Ball, 2021). Trusts must ensure 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 and care staff for day and night each month. Registered Nurses / Midwives for days and nights had a reduced fill rate over the period of July, August and September 2023. Care staff fill rate for day and night increased over the period of July, August and September 2023. Please note that the months of July, August and September are peak holiday seasons. Reference RN fill: there has been the opening of the Louisa Martindale Building, which has increased the bed base; there has also been a gradual increase in band five vacancies across all sites. In reference to the care staff fill rate, there has been an increase across all sites and a reduction in vacancies from 19% to 8%.

Intervention and Planned Impact

The Trust Nursing and Midwifery Steering Group meet monthly to support the Trust in recruiting, deploying, and retaining a nursing and midwifery workforce that is appropriately experienced and qualified to deliver high-quality standards of care. The group is also responsible for monitoring and reporting the associated workforce.

Risks/Mitigations

There are currently 17% Band 5 Registered Nurse vacancies and turnover of 7.3% across UHSussex. The impact of this is that there may be an inability to fill absence and escalation shifts. There is also a high demand for registrants of HCAs with specialist skills to care for patients with mental ill health.
There is a planned review of models of Nursing Care in Nov-23 when the Deputy Chief Nurse for Workforce and Professional Standards commences. In January 2-24 there should be thirty enhanced mental health care workers commence into post to care for patients with mental ill health. There are also new recruitment and retention initiatives for student nurses, permanent and temporary band 5 registrants. A monthly steering group oversees the governance of the nursing and midwifery workforce.

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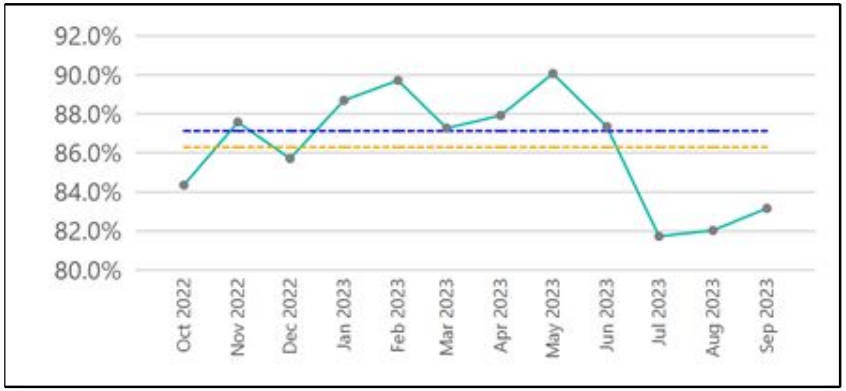
Driver

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

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
84.4%	87.6%	85.7%	88.7%	89.7%	87.3%	87.9%	90.1%	87.4%	81.7%	82.0%	83.2%

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 difference in patient outcomes, patient experience, quality of care, and the efficiency of care delivery. (RCN, 2011; Griffiths and Ball, 2021). Trusts must ensure 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 and care staff for night shifts each month. Registered Nurses / Midwives for days and nights had a reduced fill rate over the period of July, August and September 2023. Care staff fill rate for day and night increased over the period of July, August and September 2023. Please note that the months of July, August and September are peak holiday seasons. Reference RN fill: there has been the opening of the Louisa Martindale Building, which has increased the bed base; there has also been a gradual increase in band five vacancies across all sites. In reference to the care staff fill rate, there has been an increase across all sites and a reduction in vacancies from 19% to 8%.

Intervention and Planned Impact

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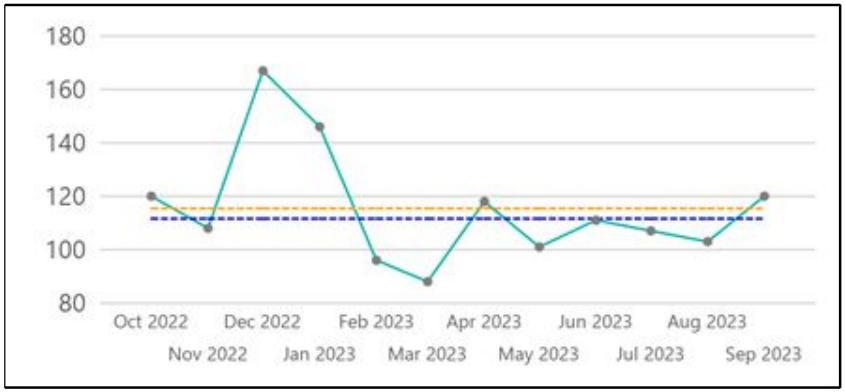
Driver

Metric: Safety - Grade 2+ pressure ulcers

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
120	108	167	146	96	88	118	101	111	107	103	120

Overview

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



What the chart tells us

September saw a rise to 120 (2.1 per 1000 beddays) grade 2 pressure ulcers reported from 103 August, with 60 of these reported in Medicine WGH/SRH. Medicine RSCH/SRH had 21 reported grade 2 pressure ulcers. Surgery WGH/SRH saw an increase to 22 compared to 13 in August.
The Specialist division saw a surge in reporting in June and July but this has significantly reduced in August (2 cases) and September (5).

Intervention and Planned Impact

- On-going training both on wards and during induction into Pressure Damage Prevention
- Roll out of Purpose-T training and development on PAtientrack at RSCH and PRH to improve complinace with PD assessment and planning
- Formulary Review completed to ensure best product availibility
- Wound Care Champion group being convened to promote local ownership and influence best practice
- Continence care plan being developed by TVNs and product supplier to reduce incidence of moisture associated skin damage which could lead to further pressure damage
- Pressure Damage Prevention Audit now live on Tendable for assurance
- TVNs at WGH and SRH trialling WABA image software to review wounds virtually and increase Triage accurancy

Risks/Mitigations

We are awaiting a release date for the Purpose - T risk assessment on patient track (a funded development), with education continuing regarding this significant change.
Pressure damage CQUIN delivery risk - especially related to completion of risk assessment within 6 hours. This has been escalated to divisional teams via the Deputy Chief Nurse and monitored via weekly 'Tendable' audit. It will also form part of the Ward Assurance Dashboard currently in development.

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Watch Metrics for Quality

Metric	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
Clinical outcomes/effectiveness - Timeliness of observations against targets (NEWS2)	66.1%	67.7%	65.5%	67.3%	68.1%	67.9%	68.7%	69.3%	68.7%	67.2%	64.4%	64.6%
HCAI - Number of hospital attributable C.diff cases (HOHA/COHA)	14	7	3	5	11	10	5	7	8	10	10	14
HCAI - Number of hospital attributable E.coli cases (HOHA/COHA)	23	17	11	18	15	23	18	17	20	25	23	15
HCAI - Number of hospital attributable Klebsiella species cases (HOHA/COHA)	7	6	6	6	4	3	6	8	8	11	8	12
HCAI - Number of hospital attributable MRSA cases (HOHA/COHA)				1				2	1	1	1	
HCAI - Number of hospital attributable MSSA bacteraemia cases (HOHA/COHA)	14	6	5	15	5	3	3	11	6	9	9	5
HCAI - Number of hospital attributable Pseudomonas cases (HOHA/COHA)	4	5	3	4	4		1	1	2	5	4	7
Safety - % of Deaths with Comfort Obs in Place	28.5%	37.1%	56.7%	65.7%	71.9%	69.1%	73.4%	71.8%	72.8%	70.5%	70.0%	73.4%
Safety - Total moderate, severe or death incidents	3	5	1	5	2	5	4	6	2	3	4	4

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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	

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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 deteriorated at the end of September 2023. While A&E performance deteriorated in Q2 it remains materially better than Q2 2022/23. There has been deterioration in RTT long waits in Q2, leading to rapid implementation of recovery plans to tackle this. 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 has been place in Tier 1 as part of the NHSE oversight framework for RTT and Cancer in September.

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True North

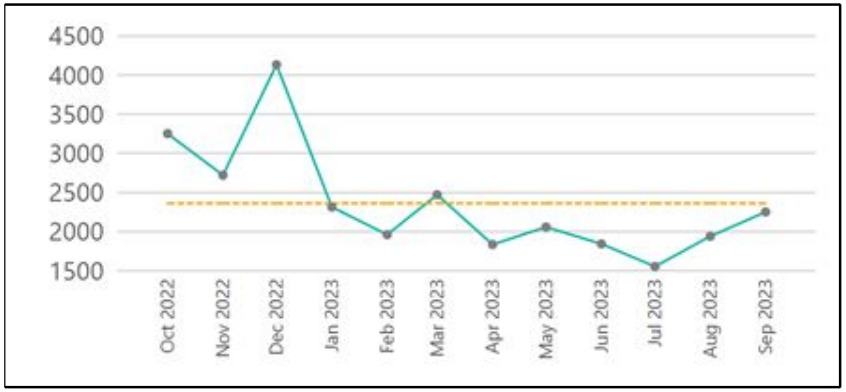
Metric: A&E and Emergency flow - No patients to exceed a 12 hour wait in our emergency departments

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
3253	2722	4133	2315	1962	2472	1836	2059	1843	1555	1941	2252

Overview

The measure of wait time above 12 in ED is an important one due to the increase in morbidity associated with long stays in departments.

The Trust has had significant issues with 12 hr waits and this is a cause of concern for the organisation and althopugh there has been imporvement over the year we are not where we would want to be.



What the chart tells us

The metric worsened in September and is variable by site: 14.2% of patients breaching 12 hrs at RSCH. The position at RSCH is improved compared to a year ago: Last September there was 1233 x 12 hr breaches and this September it was 1032. Within the RSCH ED site there is a programme of work in place to ensure patients are well cared for despite being in ED for long periods of time e.g. rounding, nutrition and hydration needs addressed

The other sites are considerably lower with 9.2% SRH, 7.6% PRH, 3.5% Worthing. The remit of EPIG and the ED recovery plans includes all divisions in actions to improve flow across the site. This aim is to improve outflow through the hospitals and improve flow from ED and reduce the long stays.

Intervention and Planned Impact

Revised UEC performance monitoring is being introduced to provide both internal and external assurance re KPIs of which ambulance handover times is one
Weekly meetings lead by MD Unscheduled Care and Director for Performance Information with the Divisions and Hospital Directors will go through reasons for performance, immediate action and the medium/long term action plans. Immediate corrective action will be discussed with the expected impact.
Long waits in the department are a symptom of lack of flow within the hospital due to reduced timely discharges. The UEC system wide work on admission avoidance, discharge improvement schemes and virtual wards will all help impact positively on flow. Internally the LoS and MHD work will also impact on flow by improving LoS metrics and the time which people are discharged. The UEC recovery plans which involve site specific work across the hospitals and divisions will target the areas which need to improve processes to maximise earlier movement of patients from ED

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Risks/Mitigations
Risk 1. The demand for beds during the winter months is greater than the capacity 2. The system wide programmes of work do not have the expected impact **Mitigations** 1. Revised OPEL actions developed at each site. Planned escalation capacity with risk assessments completed. Triggers in place for use of the escalation capacity 2. System wide mentoring of the admission avoidance and discharge plans. 3. Internal discharge place focus group to be implemented

University Hospitals Sussex
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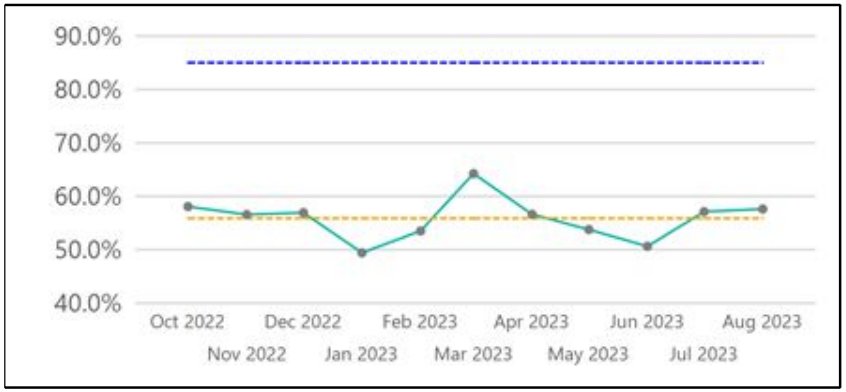
True North

Metric: Cancer - To achieve the 62 day standard

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
58.05%	56.56%	56.91%	49.40%	53.50%	64.23%	56.60%	53.76%	50.61%	57.10%	57.60%

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.
August-23 performance was 57.5%, compared to 57.1% July, and national performance of 71.6% Aug-23

Intervention and Planned Impact

The Trust has developed recovery plans for the 5 most challenged anatomical sites with fortnightly COO led deep dive meetings, and enhanced governance with the weekly oversight group.
Key actions being taken include:-
Insourcing for breast anatomical sites, to increase capacity for one-stop clinics.
Work is also being rapidly developed to extend and improve the skin telederm model plus increase insourcing to increase capacity.
Work to increase outpatient capacity and pace for the gynaecological pathways, will improve both FDS performance, but also reduce prospective 62 day waits.
The Trust has submitted a bid for additional financial support from the cancer alliance to help contribute to recovery of the cancer performance position.

Risks/Mitigations

Diagnostic capacity is a potential vulnerability, particularly as patients advance through their cancer care pathways. This concern is further exacerbated by comparable challenges emerging from the elective RTT recovery programme and emergency pathways.
Divisions have diligently prioritised and sought measures to alleviate the effects of Industrial Action on cancer patients over the preceding six months, the risk persists, especially in the context of Industrial Action related to diagnostic testing.

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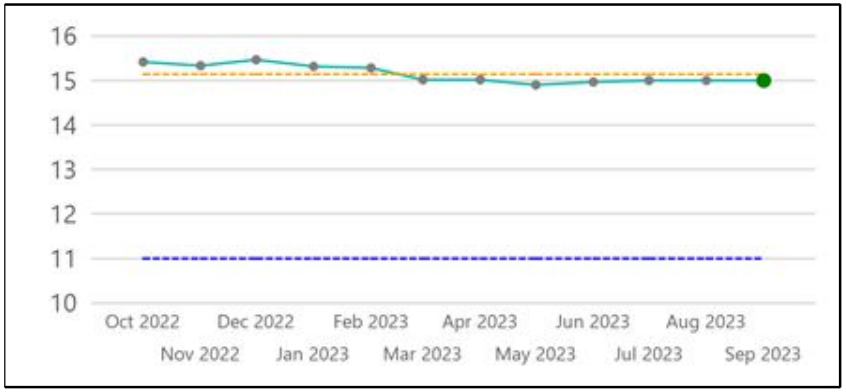
Breakthrough

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

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
15:25	15:20	15:28	15:19	15:17	15:01	15:01	14:54	14:58	15:00	15:00	15:00

Overview

The Median hour of discharge has shown significant improvement from a year ago. However in the last few months this improvement has not continued and a slight deterioration in position has been observed and this has not been recovered.



What the chart tells us

The chart tracks the success of the project during the first months of the work.
This success has stalled and in some cases reversed slightly and the this has meant that progression towards the 11am target is some way off. Further action is required to move the dial on this metric to enable our patients to be discharged in a more timely way

Intervention and Planned Impact

The work being done across the Trust as part of the BO of improving the MHD has moved to being division owned due to the differences seen between the median hour of discharge across the divisions.
There is renewed focus at a divisional level with feedback on a monthly basis to the divisional teams.
Work is being launched across the Trust with a standard discharge resource pack and this includes standard work for board rounds to help facilitate earlier discharges.
There is also a separate piece of work being done on discharge summaries which should result in more timely completion of discharge summaries and the earlier discharge of patients.

Risks/Mitigations
Risk 1. Lack of divisional ownership and clinical engagement to ensure all processes have been followed to facilitate earlier in the day discharge. 2. Discharge lounge not being used as business as usual for those patients suitable to move there. **Mitigations** 1. Ownership of the MHD has moved from hospital leadership teams to the divisions. Work to be started with the improvement team support on improving the quality, consistency and timeliness of the discharge summaries by the clinical teams. 2. Daily numbers of patients to be moved to the discharge lounge, based on the discharge list, are owned by the site leadership team to ensure that the suitable patients are moved to the discharge lounge to free up space on the ward.

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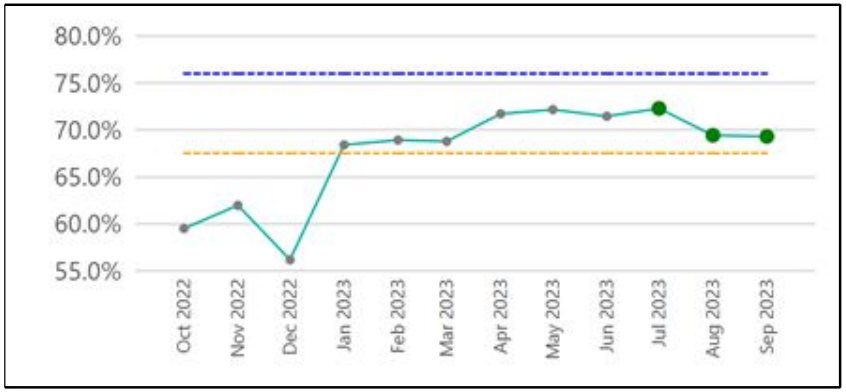
Driver

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

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
59.5%	62.0%	56.2%	68.4%	68.9%	68.8%	71.7%	72.2%	71.5%	72.3%	69.4%	69.3%

Overview

The agreed Trust True North Goal for emergency care is to achieve the 4 hour access target.
Nationally the emergency care 4 hour target has been changed to achieving 76% of patients being treated within 4 hours in Emergency Care services.



What the chart tells us

The Trust treated **69.3%** of patients within 4 hours of attending all A&E departments in September 2023. National performance was 71.6%
Performance across the group was consistent to August, with improvement RSCH (to 55.5% from 51.9% August) but a fall in performance at other sites (74.8% PRH compared to 76%; SRH 55.3% compared to 56%; Worthing 62.2% compared to 63.4%, and a drop at RACH 85.8% from 94%)
4 hour performance has been impacted by Industrial action as flow through the hospitals has decreased with reduced discharges due to a lack of numbers of doctors ion the wards and this can be seen by the dip in performance when compared to earlier on in the year. This deterioration is mainly driven by performance at SRH

Intervention and Planned Impact

A revised trajectory for UHSx and its associated EDs has been developed.
Improvement plans are being revised to ensure the expected impact from the action plans can achieve the trajectories on a monthly basis.

A revised structure for monitoring of UEC performance is being implemented along with a standardised report pack which will be presented weekly to the ICB at oversight meetings.

The imporvement plans involve a whole hospital repsinse and not just ED internal imporvemnt plans

Risks/Mitigations
Risks 1. Continued volumes of mental health patients who require admission to mental health units stay in our EDs for extended periods of time whilst waiting for a bed. 2. Demand at the front door exceeds capacity within the hospital. **Mitigations** 1. Ongoing system wide solutions being discussed to the increase requirement for mental health services. The Trust working with SPFT to establish improved ways of working to keep patients and staff safe whilst the patients wait in our EDs 2. A UHSx winter plan developed which includes OPEL escalation actions, risk assessed escalation areas identified. Continued work on the LoS and MHD projects to maximise flow.

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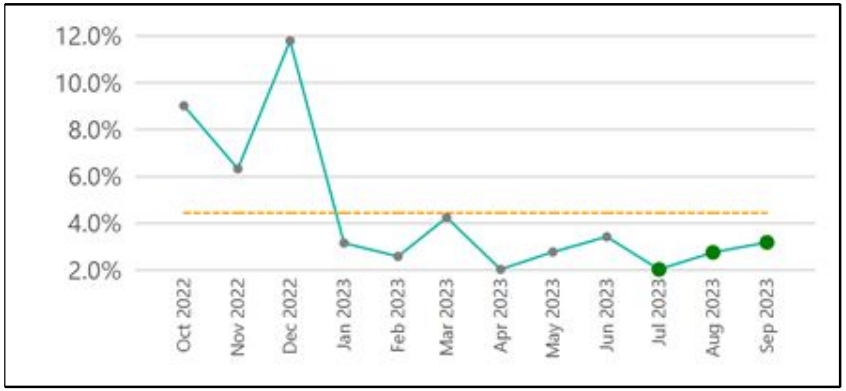
Driver

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

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

Overview

The incidence of ambulance handover breaches exceeding 60 minutes has notably declined compared to the previous year. However, this improvement appears to have reached a plateau, with a subsequent uptick observed in recent months.
The protracted delay of ambulances not only compromises patient experience but also prevents ambulance crews from being promptly redeployed for other emergency situations. It remains a key performance indicator monitored through the Emergency Performance Improvement Group.



What the chart tells us

Ambulances taking over 60 minutes to handover increased in September to 216 (3.2%) compared to 193 (2.8%) in Aug-23. This is an improvement on the same period last year when there were 367 breaches in Sep-22 (5.7%).

The numbers of breaches is driven by the handovers at RSCH with 140 of the 216 were at the County Site. Ambulance handover performance is predicated on space to offload ambulances and thus related to discharge challenges at the County site.

Intervention and Planned Impact

Revised UEC performance monitoring is being introduced to provide both internal and external assurance re KPIs of which ambulance handover times is one
Weekly meetings lead by MD Unscheduled Care and Director for Performance Information with the Divisions and Hospital Directors will go through reasons for performance, immediate action and the medium/long term action plans. Immediate corrective action will be discussed with the expected impact. Ambualnce habndiover times are dependent on deopartment oprociesses as wekll as flow through teh department and this metric requires joint wokring across the divisons and with teh hsiopital teams

Risks/Mitigations

Risks
1. The numbers of patients in the corridor at RSCH means that no further off loads can be achieved due to physical constraints.
Mitigations
1. Work happening at the RSCH with the site leadership team and the divisions to release flow earlier in the day to reduce the number of patients being held in the corridor

University Hospitals Sussex
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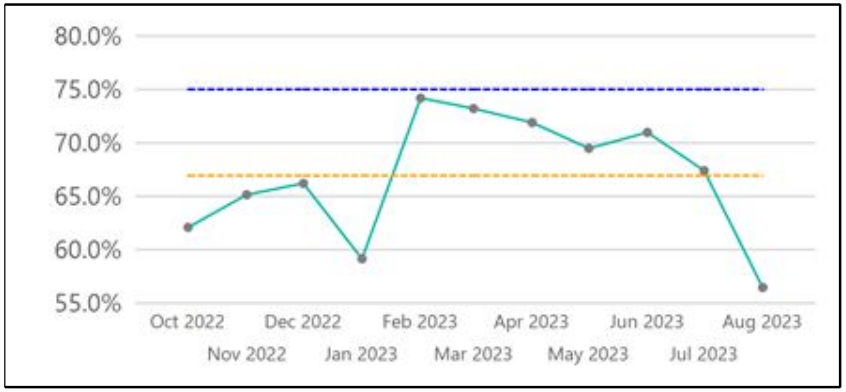
Driver

Metric: Cancer - 28 day faster diagnosis standard

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
62.08%	65.14%	66.20%	59.14%	74.19%	73.21%	71.90%	69.48%	70.97%	67.39%	56.45%

Overview

The 28 day faster diagnosis standard (introduced Jul-19) is an important target for patient experience and as part of expedient cancer pathways. The national standard 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 materially in Aug-23 to 56.5% against the 75% target (from 72.4% July-23)

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Intervention and Planned Impact

FDS performance deterioration in Aug-23 (566 extra breaches) was primarily driven by Breast (191 extra breaches), skin (177 extra breaches), Lower GI (78 extra breaches) and Gynae (44 extra breaches). The Trust has developed recovery plans for each of these tumour sites, with enhanced deep dives at tumour level on a fortnightly basis led by COO, MD and Director of Performance and weekly recovery oversight group.

Summary of improvement actions and expected percentage point impact:

- Breast (WH/SRH) – Increased breast one-stop capacity (now in place) **[expected to improve performance by 6.4%]**
- Skin (WH/SRH) – New skin teledermatology pathway (now live), increased 2WW capacity (now in place, cross site support **[expected to improve performance by 5.9%]**
- LGI (pan-Trust) – Actions to improve colonoscopy turnaround time to 10 days: additional endoscopy capacity (starting Nov-23)); standardising FDS model across sites **[expected to improve performance by 3.4%]**
- Gynae (pan-Trust) – additional capacity via WLI in place; post-menopausal bleeding pathway now live (reducing demand on cancer pathway) **[expected to improve performance by 3.9%]**

The collective impact of these actions are expected to achieve compliance with the 75% target by Dec-24.

Risks/Mitigations

Risks to deliver of the 28 day FDS include:
Increased demand - mitigated by working with primary care colleagues to clarify referral pathways in high demand areas - for example, established a post menopausal bleeding on HRT pathway.
Diagnostic capacity challenge - mitigated by securing funding from the cancer alliance for extra capacity
Navigator roles to ensure pathways are closely observed - alliance funding for high-risk pathways now secured so that detailed navigator overview is in place.

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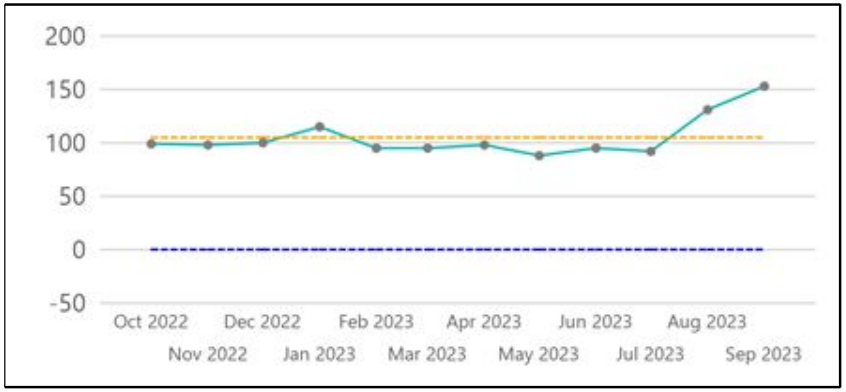
Driver

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

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
99	98	100	115	95	95	98	88	95	92	131	153

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

There has been an increase in over 104 day prospective waits to September, from 131 patients August-23 to 153 September-23.

Intervention and Planned Impact

For the FDS improvement plan, the Trust is undertaking insourcing for breast, to increase capacity for one-stop clinics – with the added advantage of more streamlined pathways. Work is also being rapidly developed to extend and improve the skin telederm model plus increase insourcing to increase capacity. Work on increasing outpatient capacity and pace for the gynae pathways, and improved reporting turnaround times for colorectal will all contribute to an improvement in FDS performance, which will impact positively at the front end of pathways (and into 62 and 104 day performance).
The Trust has submitted a bid for additional financial support from the cancer alliance to help contribute to recovery of the cancer performance position.

Risks/Mitigations

Diagnostic capacity is a risk for the Trust as patients progress through their cancer pathways, and with similar pressure at this stage of treatment from the RTT recovery programme and emergency pathways. Whilst the Trust has prioritised and looked to mitigate the impact of Industrial Action over the past 6 months for cancer patients, this continues to be a risk going forward including for IA relating to diagnostic testing.

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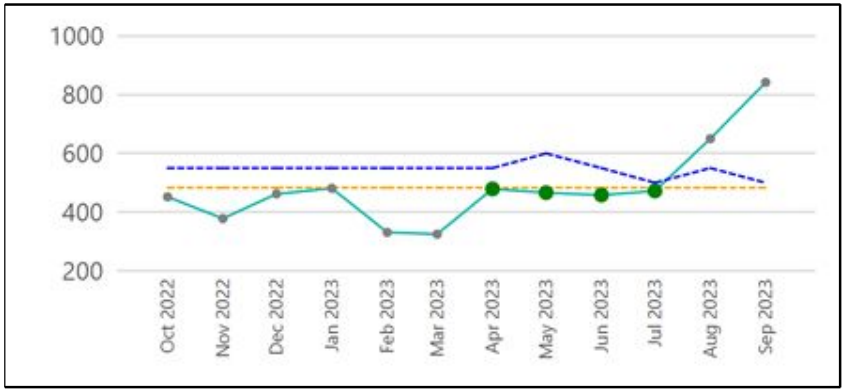
Driver

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

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
452	378	462	481	331	325	479	466	458	472	650	842

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 is required to reduce the 62-day backlog to 438 patients by Dec-24 as a result of being placed in Tier 1 by NHS England.



What the chart tells us

There has been an increase in over 62 day and 104 day prospective waits to September, to 842 from 650 August. This is above the original operating framework plan of 500 for September.

Intervention and Planned Impact

Increase in the 62-day backlog has been driven by increases in Skin, Colorectal, Gynae, Breast and Head & Neck. The Trust has developed recovery plans for the each of these tumour sites with fortnightly COO-led deep dive meetings, and put in place enhanced governance (including weekly oversight group).
Key actions being taken include:

- Skin (WH/SRH) – additional 2WW capacity ; new medical photography pathway; Cross-site support from Brighton
- Breast (WH/SRH) – additional One-Stop capacity; cross-site support for operating on diagnosed patients.
- LGI (pan-Trust) – additional endoscopy capacity (including for enhanced sedation); cross-site support for operating on diagnosed patients; standardising FDS model across sites
- Head and Neck (WH/SRH) – improvements to diagnostic pathway, move to single cancer PTL and service for ENT
- Gynae (pan-Trust) – additional 2WW capacity and improvements in waits at start of pathway; post-menopausal bleeding pathway (now live)
- Diagnostics – planning underway to improve radiology and pathology turnaround times. Cancer Alliance to provide support at reviewing process for cancer imaging bookings and reporting; new access policy for imaging bookings to be established; D&C for pathology underway

The Trust has submitted a bid for additional financial support from the cancer alliance to help contribute to recovery of the cancer performance position.

Risks/Mitigations
Diagnostic capacity is a risk for the Trust as patients progress through their cancer pathways, and with similar pressure at this stage of treatment from the RTT recovery programme and emergency pathways. Whilst the Trust has prioritised and looked to mitigate the impact of Industrial Action over the past 6 months for cancer patients, this continues to be a risk going forward including for IA relating to diagnostic testing.

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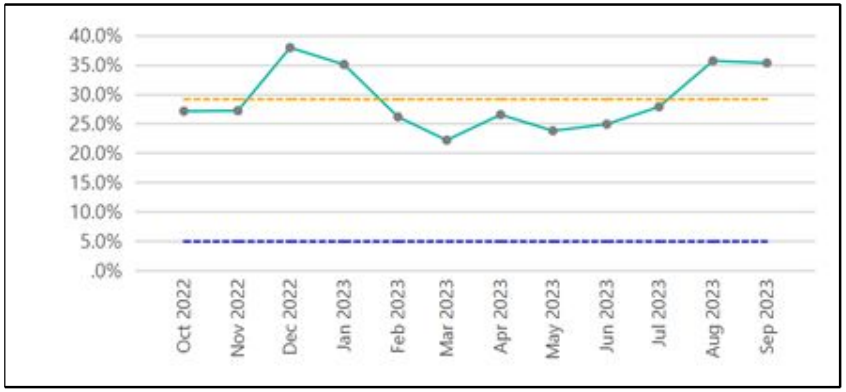
Driver

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

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
27.2%	27.3%	38.0%	35.2%	26.2%	22.3%	26.6%	23.9%	25.0%	27.9%	35.8%	35.4%

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

UHS Sussex achieved 35.4% in September-23 against the diagnostic patients over 6 week target March-24 of <5%.
This was a marginally improved position from August, by 0.4%. This is worse than 27.5% National performance.
The number of patients waiting over 6 weeks for their diagnostic increased by 113 to 8,566 whilst the waiting list size increased by 554 to 24,191.
The most challenged modality is echocardiography with 3,359 over 6 week waits as of September 23.

Intervention and Planned Impact

The Trust is undertaking a range of actions to tackle the diagnostic backlog.

For imaging:-

1. A list of proposed bids to increase capacity were submitted to both the cancer alliance and BCSP.
2. Additionally, an initial cohort of 300 routine scans outsourced, followed by 150 each week until the end of the financial year
3. Review of the workplans of patient navigators to enhance the reporting Turnaround Time (TAT).
4. Trajectories for TAT and unreported scans to be developed

For cardiac MR:

1. The Trust are revising the cancer alliance bid for cardiac MR. with finance undertaking costing work, to help finalise the bid in October.
2. Trajectories for TAT and unreported scans to be developed

For histo-pathology:

1. Cancer alliance funding has been provided to Cellular Pathology at RSCH from Sep-23 to Mar-24 to help improve cancer performance.
2. A proposal has been developed for staffing to extend operational hours for the Brighton lab.
3. Trajectories being developed for reporting turnaround times and unreported histology.

For Echos:

1. Recruitment of 2 substantive echo technicians and 2 Locum cover for 16 weeks and extended weekend working to extend capacity
2. Rental of additional echo machine, to provide additional resilience to existing equipment
3. Comprehensive Validation review of Echo waiters and ongoing maintenance
4. Plans to increase activity by 85 echos per respective week underway as result of the above.
5. This recovery programme is being refreshed as part of enhanced governance and demand and capacity recovery work.

Risks/Mitigations

There remain risks around the amount of additional diagnostic capacity required to support emergency, cancer and RTT recovery. This is exacerbated by continued industrial action which constrains capacity. Significant increases and/or spikes in demand for diagnostics can also compromise the Trust's ability to meet the performance target.

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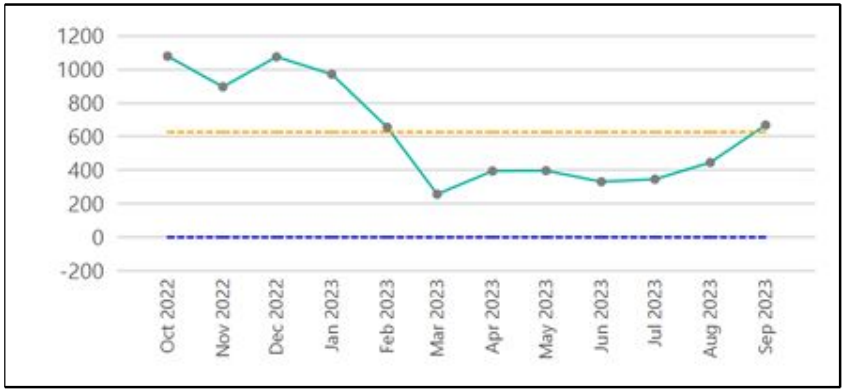
Driver

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

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
1080	897	1076	972	656	257	395	397	331	346	446	669

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. Due to challenges in the achievement of these targets, the Trust has been placed in Tier 1 by NHSE in September, with enhanced CEO review with NHSE Executive on a fortnightly basis to oversee recovery.



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 Sep-23 there were 669 patients waiting over 78 weeks. This is 223 more than Aug-23.

Intervention and Planned Impact

The Trust has developed recovery plans by specialty to target reduction of the 78 week waits by December-23. These are tracked closely on a weekly cycle to ensure adherence to plan, with additional actions if the recovery is off track.
The Trust has enhanced governance arrangements led by Director of Performance and COO for Elective care on weekly basis. The Trust also has fortnightly meetings with CEO and NHS executive to oversee progress.
The Trust has reinvigorated the productivity programme to target increased outpatient clinics and theatre utilisation to increase activity levels.
The Trust has increased WLIs to support recovery with extended weekend and evening clinics./list and support from NHS Sussex system and Digital Mutual Aid System (DMAS).
The Trust has also created a small virtual team to man-mark the 78 week cohort to add further grip in tackling this patient list.
The Trust is undertaking a clerical validation exercise to target approximately 60,000 patients on the waiting list.

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.

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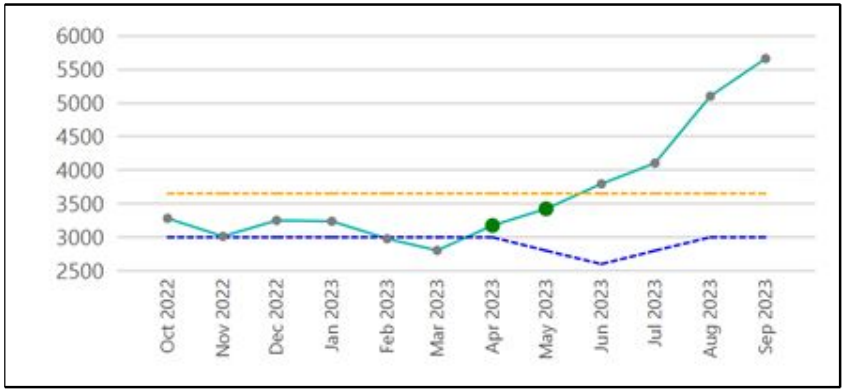
Driver

Metric: RTT Elective care - >=65 Weeks

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
3282	3013	3251	3238	2978	2804	3175	3424	3796	4105	5103	5664

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. Due to challenges with 65 week performance, the Trust has been placed in Tier 1 level support by NHSE.



What the chart tells us

There has been an increase in the number of patients waiting over 65 weeks at the end of September, to 5,664.
The Trust tracks this plus the cohort of patients who unless seen will breach 65 weeks by the end of March. There were 31,094 patients on this cohort as of the 23rd October, compared to 38,969 as of the 24th September. With just over 5 months to the end of March, this requires circa 6000 patients completing their pathways per month to achieve the operating framework aim of zero by March.

Intervention and Planned Impact

The Trust has developed recovery plans by specialty to target reduction of the 65 week waits by March-23. These are tracked closely on a weekly cycle to ensure adherence to plan, with additional actions if the recovery is off track.
The Trust has enhanced governance arrangements led by Director of Performance and COO for Elective care on weekly basis. The Trust also has fortnightly meetings with CEO and NHS executive to oversee progress.
The Trust has reinvigorated the productivity programme to target increased outpatient clinics and theatre utilisation to increase activity levels.
The Trust has increased WLIs to support recovery with extended weekend and evening clinics/lists and support from NHS Sussex system and Digital Mutual Aid System (DMAS).
The Trust is undertaking a clerical validation exercise to target approximately 60,000 patients on the waiting list.

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.

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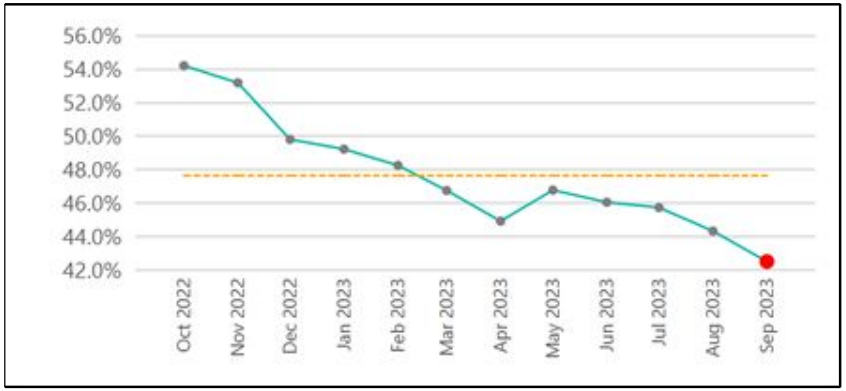
Driver

Metric: RTT Elective care - 18 Week Performance

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
54.22%	53.20%	49.81%	49.23%	48.26%	46.76%	44.93%	46.78%	46.06%	45.74%	44.33%	42.51%

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 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 productivity 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
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
A virtual team established to focus on the 78 week cohort.
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

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Risks/Mitigations
Industrial action and emergency pressures have exacerbated risk associated with 18 week performance. There are also some highly complex pathways, and specialist capacity constraints particularly in neurosurgery/spinal care for example, which have created risk in minimising longest waits. Increases in urgent or 2WR demand which take precedence in terms of clinical priority order can also constrain residual routine waiters capacity.

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Watch Metrics for Systems & Partnerships

Metric	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
A&E and Emergency flow - % Patients with a 21+ day length of stay	8.3%	8.4%	9.0%	10.4%	8.8%	9.0%	8.8%	8.8%	8.1%	8.2%	7.6%	8.0%
A&E and Emergency flow - A&E 4 Hour Breaches	14209	12997	15370	9545	9280	10607	9087	10012	10122	9799	10536	10752
A&E and Emergency flow - A&E Attendances	35082	34172	35070	30212	29859	33981	32125	35961	35460	35358	34460	35026
A&E and Emergency flow - Ambulance Handovers	7219	7087	6952	6910	6541	7329	7068	7644	7328	7386	7405	7200
A&E and Emergency flow - Ambulance Handovers - % Under 15 mins	40.9%	40.8%	31.2%	50.3%	51.9%	46.7%	55.1%	55.8%	60.5%	67.6%	63.8%	59.5%
A&E and Emergency flow - Average LOS (Excl LOS 0)	7.7	7.9	8.1	8.6	8.1	7.6	7.4	7.8	7.4	7.5	7.3	7.2
A&E and Emergency flow - Bed Occupancy	1659	1657	1670	1674	1672	1671	1651	1668	1617	1573	1630	1652
A&E and Emergency flow - Emergency Admissions > 1 LOS	5285	5399	5389	5318	4930	5762	5396	5619	5506	5628	5625	5581
A&E and Emergency flow - Mean Waiting Time	358	344	417	325	300	314	288	290	293	281	299	314
A&E and Emergency flow - Time to treatment in ED (Median time to treatment mins)	69	83	89	54	74	77	70	77	77	72	78	79
A&E and Emergency flow - Time to Triage in ED - % seen within 15 mins	46.0%	44.9%	42.5%	62.6%	55.9%	52.3%	64.5%	64.5%	59.7%	74.7%	70.5%	64.8%
Cancer - Two week rule performance	73.9%	74.9%	69.2%	72.4%	86.6%	87.5%	76.6%	79.6%	64.9%	66.1%	51.2%	
Diagnostics - 6 week backlog	5342	5327	6739	6211	4995	4591	5126	4946	5268	6272	8453	8566
Diagnostics - Activity	34229	39170	29902	32845	31646	35348	34345	36425	34682	32370	32809	34481
Diagnostics - Waiting List size	18413	18350	16599	16675	18102	19634	18293	19768	20081	21039	22280	22601
Elective care - Activity compared to 2019/20							106.6%	114.2%	105.3%	98.2%	98.2%	94.0%
RTT Elective care - >= 52 Weeks	16502	17182	18352	19260	19542	20994	23078	25540	27874	30264	32530	33844
RTT Elective care - >104 Weeks (NHSi Criteria)	20	15	15	20	25	18	19	13	5	3	0	0
RTT Elective care - Clock Starts	23856	24920	17961	20465	18788	20858	16381	19690	21668	21975	21872	20956
RTT Elective care - Clock Stops	20873	22269	14775	17117	18865	20325	15321	17754	19396	17906	19361	20542
RTT Elective care - Waiting list size	119522	121200	125572	128990	128034	128872	131872	138874	145332	152145	154136	155086

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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	

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Patient First Domain

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.

Data shows the relative Trust rank in terms of study participation compared to other acute Trusts on a quarterly basis from national statistics from the NIHR website. Data for Q1 2023/24 shows 26th highest ranked trust, and improvement relative to Quarter 4 2022/23. 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.

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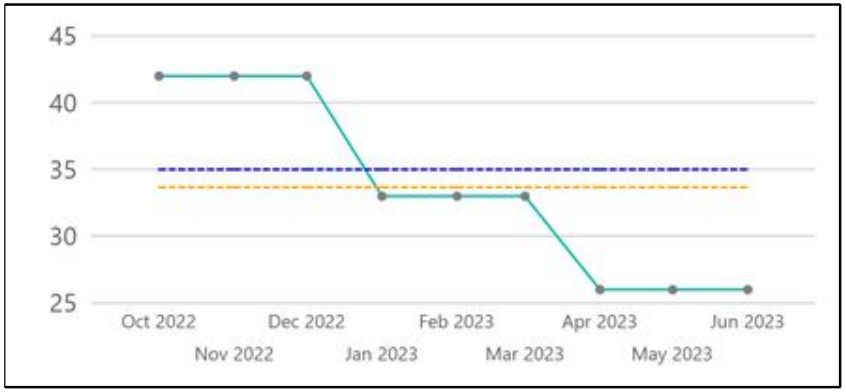
True North

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

Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
42	42	42	33	33	33	26	26	26

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 NIHR website. Data for Q1 2023/24 shows 26th highest ranked trust, and improvement relative to Quarter 4 2022/23. 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 has a new Research and Innovation Strategy.
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 establishing a shared research infrastructure across Sussex through the Brighton and Sussex Health Research Partnership.
The Trust is raising awareness and understanding of research and innovation amongst staff and patients, through a R&I communications plan, additional PCIE leadership support identified with HRP, and via a Research Champions Group.
The Trust is developing a clinical academic career development offer in partnership with the HRP and My UHSussex Charity.
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.

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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. 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

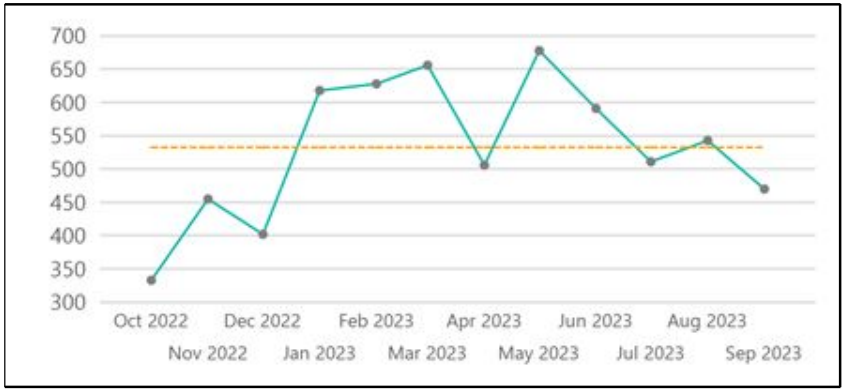
Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
333	455	402	618	628	656	506	678	591	511	543	470

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.

Key headlines

- **Total recruitment above target 3500 (Current 5823, 151%)**
- **Increase driven by high performance on GBS3 study (W&C)**
- To note divisional and specialty recruitment data will fluctuate from month-to-month due various reasons such as; opening and closure of studies; staff leave or absence; sponsor issues; regulatory issues; patient availability; patients not meeting inclusion criteria.



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
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 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.

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. 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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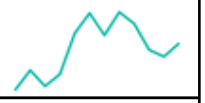
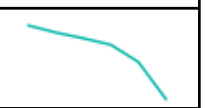
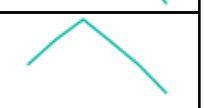
Watch Metrics for

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	6.97	7.06	
Sustainability	Agency Spending - Agency Costs as a % of staff costs (3.7% target YTD)	3.2%	3.7%	
Sustainability	Financial Stability - Variance from breakeven plan YTD	-18,619k	0k	
Sustainability	Financial efficiency - Variance from efficiency plan YTD	-1,141k	0k	
Quality	Clinical outcomes/effectiveness - SHMI equal to or less than 100	108.4	100.0	
Quality	HCAI - Number of hospital attributable C.diff cases (HOHA/COHA)	14	4	
Quality	HCAI - Number of hospital attributable E.coli cases (HOHA/COHA)	15	3	
Quality	HCAI - Number of hospital attributable MRSA cases (HOHA/COHA)	1	0	
Quality	Safety - Reduction of 5% in preventable harm - UHSx approved	482		
Systems & Partnerships	Cancer - 28 day faster diagnosis standard	56.45%	75.00%	
Systems & Partnerships	RTT Elective care - >=65 Weeks	5664	2800	

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Systems & Partnerships	RTT Elective care - >= 52 Weeks	33844	11058	
Systems & Partnerships	Planned care - By March 2023, no patient is waiting more than 78 weeks for treatment.	669	0	
Systems & Partnerships	RTT Elective care - >104 Weeks (NHSi Criteria)	0	0	
Systems & Partnerships	Cancer - Number of patients waiting over 62 days for treatment	842	550	
Systems & Partnerships	A&E and Emergency flow - No patients to exceed a 12 hour wait in our emergency departments	2252		

Current segmentation
The Trust's remains in Segment 3 of the National Oversight Framework. and continues to engage with NHSE and the ICB through the oversight processes.
The lead for the oversight of the Trust's performance remains with the ICB and through the oversight meetings the Trust provides assurance on its delivery of its annual plan covering all of the Trust's strategic domains.
Drivers of the segmentation
During Q2 the Trust has seen an increased performance challenge which has been recognised nationally with the Trust being categorised as in Tier 1 for RTT and Cancer performance. Tiering allows for access to greater support but also brings increased scrutiny which informs the NOF meetings.
The Trust has also seen an increase in its variance from its financial plan and whilst a number of drivers of that adverse variance are outside the direct control of the Trust, such as inflation costs, there are also significant elements where the Trust has direct control including the delivery of the efficiency programme, the management of the workforce within agreed budgets and the care of patients with mental health needs (where engagement with SPFT continues to focus on delivering a sustainable solution).
The Quality and Safety Improvement Programme (QSIP) will enable the delivery of of the undertakings which the Trust has entered into with NHSE. Progress on this will be reported to the Board and also through the oversight process allowing the Trust's segmentation to be aligned to evidence of improvement.
The Board Assurance Framework shows an increase in risk aligned to performance, quality and finance.
Implications of this segmentation
Segment 3 allows the Trust to have access to external advice and support including consultancy support to improve UEC performance and funding for increased capacity and capability to address cultural improvement.
Actions being taken to move from segment 3
The Trust has consolidated its quality improvement plans into QSIP and this programme captures the specific concerns highlighted by the CQC as reflected in the undertakings with NHSE.. In order to exit segment 3 the Trust will need to deliver its operating and financial plan along with demonstration that all the improvements have been sustainably addressed.
Noting the increase in assessed risk the Trust does not anticipate exiting segment 3 over the next quarter.

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Agenda Item:	9.	**Meeting:**	Board	**Meeting Date:**	9 November 2023
Report Title:	Quarter 3 BAF				
Sponsoring Executive Director:	Chief Governance Officer				
Author(s):	Company Secretary				
Report previously considered by and date:	Reported to the Audit Committee 17 October 2023 Reported to the respective oversight Committees in the week of the 30 October to 3 November 2023				

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:

The purpose of this report is to provide assurance to the Board that the Trust's Board Assurance Processes have been applied across the quarter and based on the respective Committee review of the Q3 Risk Scores agree these fairly represent the risk profile of the Trust.

The Board Assurance processes see the respective executive leads for each strategic risk their review of the assurances received and their consideration as to what they say in respect of the controls in place to reduce the specific strategic risk. In considering this information along with the progress against the key actions the Executive then determine the current risk score and if further actions are needed to address identified control or assurance gaps. The outcome of this revies is reporting firstly to the Audit Committee and then to each of the allocated oversight Committees where the executive proposed scores are tested.

Quarter 3 Overview

For each of the 14 strategic risks the expected assurances have been received over the period of quarter 2 enabling a determination to be made as to the opening quarter 3 score.

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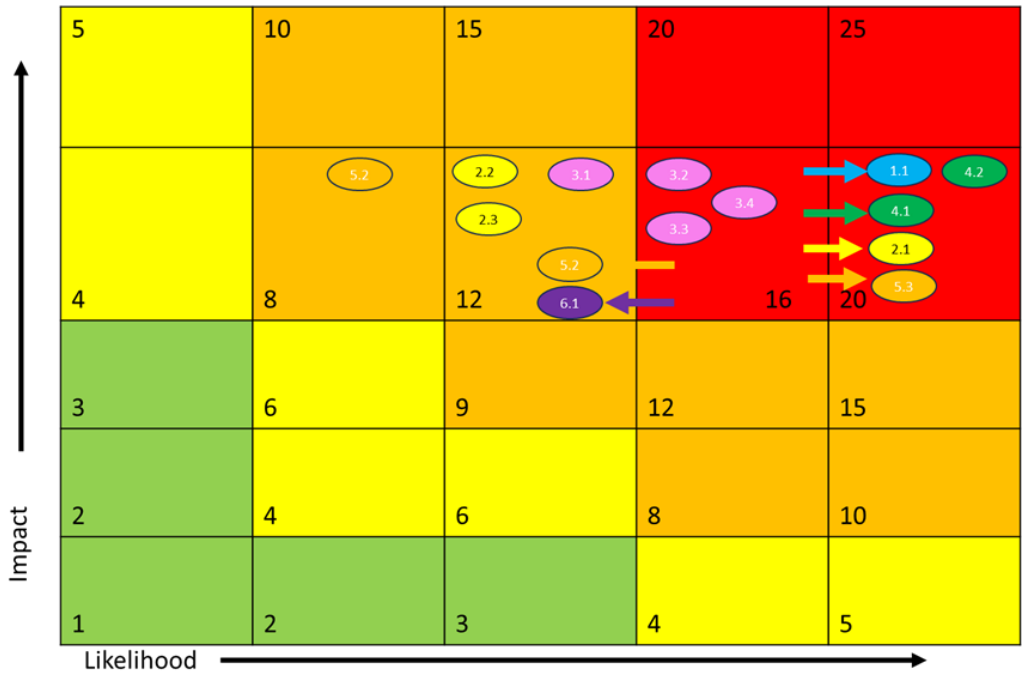
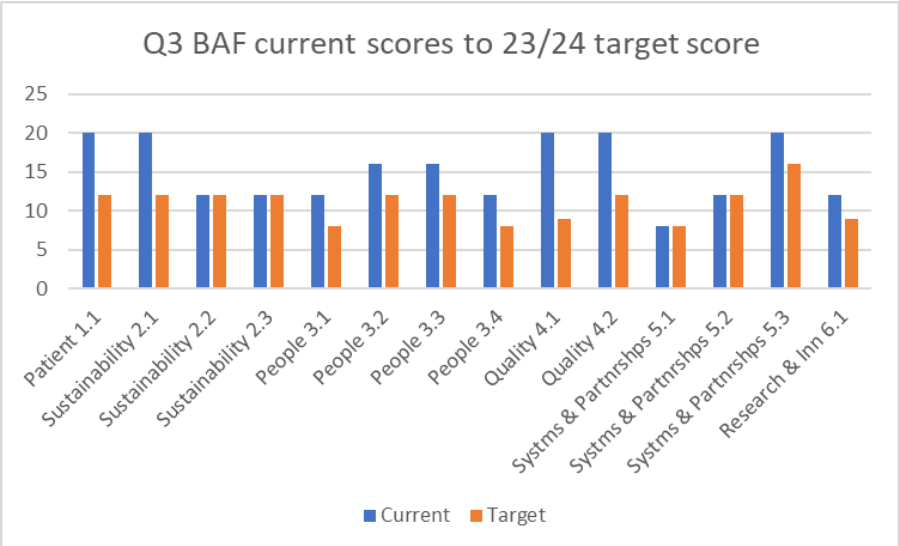
The review of the 14 risks has seen the quarter 3 scores increase for 4 risks and reduction for 2 risks. This sees 4 of Trust's strategic risks achieving their 2023/24 target scores, leaving 10 risks exceeding their target scores.

For quarter 3 there are five risks scoring 20, noting that these include 4 risks that have increased to 20 for this quarter.



Quarter 3 summary

Below is a summary chart showing for the 14 Strategic Risks their quarter 3 scores and the distance from their respective target score.



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Quarter 3 BAF risks

Overview

The review of the BAF has shown for the start of quarter 3 the following:

Four risks achieving their 2023/24 target score; these being risks
Sustainability risk 2.2 (met since the start of the year),
Sustainability risk 2.3 (met since the start of the year),
Systems and Partnerships risk 5.1 (met since the start of the year), and
Systems and Partnerships risk 5.2 (reduced this quarter to target).

Ten risks are exceeding their 2023/24 target score, with five of these scoring 20.

There are TWO quality risks assessed as NOT being able to meet their 2023/24 target scores.

There are FOUR risks where there is a low level of confidence the risk will achieve its target score.

For the following risks there is a low level of confidence that they will achieve their 2023/24 target score noting that this is mainly due to external factors influencing that risk. These are Patient risk 1.1, Sustainability risk 2.1, People risk 3.1 and People risk 3.3.

Recommendations

The Board is asked to **AGREE** the BAF risk scores for the start of Quarter 3 based on the review undertaken by their respective Board Committees and the Board's receipt and discussion of the Trust's Integrated Performance Report.

University Hospitals Sussex NHS Foundation Trust

2023/24 Quarter 3 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.

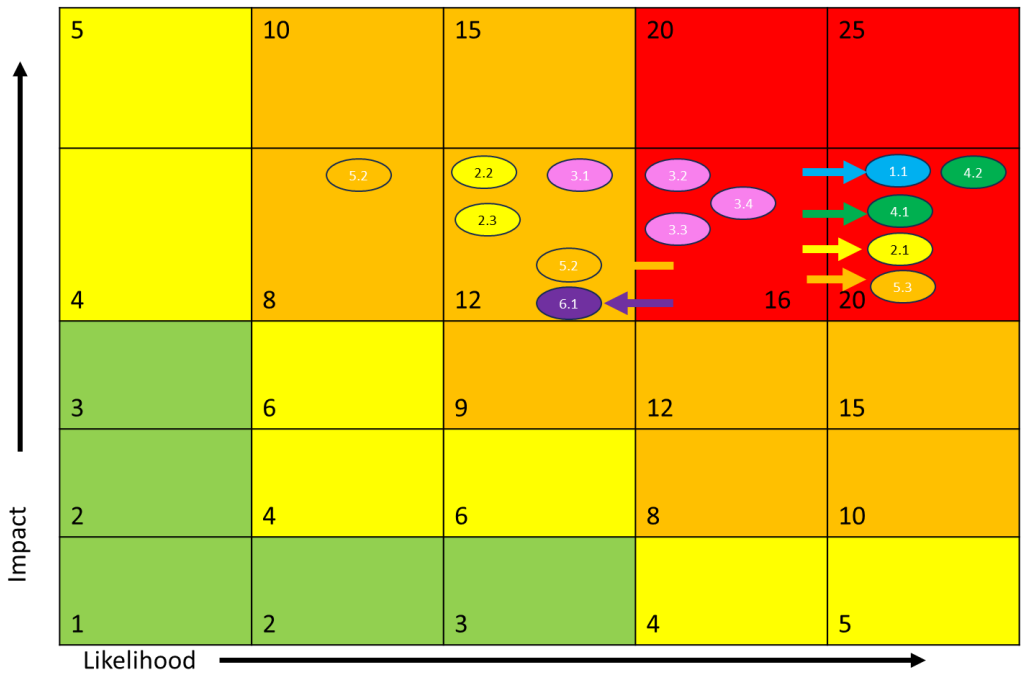
1.2 As in prior years each Strategic Risk has an Executive lead and is grouped within one of the Trust's six strategic domains with each domain being aligned to their respective allocated oversight Committee.

1.3 The Board Assurance Framework process sees the respective executive leads for each risk review the assurances received and consider what they say in respect of the controls in place to reduce the specific strategic risk. In considering this information along with the progress against the key actions the Executive determine the current risk score and if further actions are needed to address identified control or assurance gaps. The respective oversight Committees have through their meetings considered the proposed Quarter 3 risk scores against the assurances received to enable them to provide a recommendation to the Board.

2 Quarter 3 BAF Overview and Context

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 3 score, which have then been scrutinised by the respective oversight committee.

2.2 For each of the 14 strategic risks the expected assurances have been received over the period of quarter 2 enabling a determination to be made as to the opening quarter 3 score.



Appendix 1 shows the summary of changes in the BAF risks over 2023/24 to date

2.3 There are FOUR risks for which the quarter 3 score has increased from that at quarter 2, these being.

- **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. The Quarter 3 score is increased to 20 and despite planned actions the delivery of the 2023/24 target score of 12 is at risk.

- **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. The Quarter 3 score is increased to 20. As had been reported at the last quarter there is low level of confidence that this risk will achieve its target score by the end of 2023/24 given the continuing significant number of external factors impacting this risk.

- **Quality – Risk 4.1** We are unable to deliver safe and harm free care to reduce mortality and morbidity. This risk also increased in Quarter 2 and with the latest increase is now scoring 20. Despite planned actions the risk is not going to meet its 2023/24 target score, this is the same for the other quality risk 4.2 which will not meet its 2023/24 target score.

- **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. Whilst the risk has increased with the planned enhanced oversight and detailed ED improvement plans then the risk is expected to reduce to its 23/24 target score by the end of the quarter 4. ED improvement has been sustained at Worthing, Princess Royal and Royal Alex Children's Hospital sites but remains challenges at the Royal Sussex County and St Richard's Hospitals.

2.4 There are TWO risks for which the quarter 3 score has reduced from that at quarter 2, these being.

- **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. Following the approval of the Clinical Strategy the development of the implementation plan is progressing to prioritise the delivery of the strategic intentions as laid out in the Strategy and therefore the risk is reduced to 12 which sees the risk at its target score for 23/24.

- **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. The risk has reduced to 12 but remains above the 2023/24 target score of 9.

2.5 There are FOUR risks achieving their 2023/24 target score but it should be noted that all of these are above their longer term goal score, these being

- **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 3 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 3 remains at its target score of 12.

- **Systems and Partnerships – 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.

- **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. Following the approval of the Clinical Strategy the development of the implementation plan is progressing to prioritise the delivery of the strategic intentions as laid out in the Strategy and therefore the risk is reduced to 12 which sees the risk at its target score for 23/24.

3. Committee Review

3.1 Each of the Board Committees have during their last meetings have 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.

3.2 The Patient and Quality Committee agreed that risk 1.1 and risk 4.1 should both increase and that for both risks 4.1 and 4.2 that the target score would not be achieved by the year end. The Quality and Safety Programme established which will report to the Board will provide enhanced oversight of these elevated quality risks.

3.3 People Committee reflected on the proposed reduction of risk 3.4 and whilst they recognised the work that had been delivered to improve the wellbeing and environment for staff they reflected that they wished to see the staff survey results before any reduction should be actioned. Therefore post the Committee review this risk remained at its quarter 2 score.

3.4 Sustainability Committee agreed based on the reports received and the discussions held that risk 2.1 should increase and that given the degree of external drivers for this increase there is a low level of confidence the target score will be achieved by the year end.

3.5 Systems and Partnerships Committee agreed based on the reports received and the discussions held that risk 5.3 should increase and took the decision to increase the frequency of its meetings to provide enhanced oversight of the delivery of the performance recover plans. The Committee also agreed based on the information received that risk 5.2 should reduce to ots target score.

3.6 Research and Innovation Committee agreed with the reduction in strategic risk 6.1 noting this was expected given the approval of the Trust's R&I Strategy at Board in August.

4 Quarter 3 Summary

Below is a summary of the strategic risk review:

Risk	Score	Assurance	Supporting highly scored risks	Actions	Target Score (risk)
1.1	20	All expected assurance has been provided to the Patient Committee and has moved to the Patient and Quality Committee from August. These included; FFT recommendation rates; Number of formal complaints & PALS concerns; CQC National Surveys; Patient Experience reporting to Quality Committee and Patient Experience and Engagement Committee and QGSG report on divisional learning and complaints response levels The BAF risk reflects the challenges in responding to complaints in a timely way and difficulties with reporting on complaints whilst the new reporting system beds down and the friends and family test indicates a small but steady increase in negative experiences for inpatients and these have driven the increase in the score to 20 (one of the five highest scored risks). This has been a mix of operational, executive and through FFT external assurance.	There are a number of highly scored supporting risks covering Management of young people requiring inpatient care for mental health problems, levels of nursing vacancies and an inability to provide consistent nursing & medical cover for escalation/outliers if bed capacity full, the risk of harm to staff and patients by violent and aggressive patients in ED. Operational demands leading to a failure to meet the ED, RTT and Cancer performance targets along with patient demand on ophthalmology especially within the glaucoma pathway. Also there is a risk relating to access to CTs within ED at RSCH. Assurance over the actions being taken to reduce the impact of these risks on patient experience has been reported through the Patient Committee and latterly to the Patient and Quality Committee.	Actions have been established to further support learning from patient feedback, through an improvement and action tracker in response to national surveys along with the inclusion of improvement priorities in response to patient feedback within the divisional quality governance reporting templates. Longer term actions have commenced with the Hospital Nurse Directors and Divisional Directors of Nursing to implement 'patient experience rounds' to address any concerns patients/families have with care whilst in our care.	Given the impact of industrial action, the negative media and reduced public confidence but increased public expectations on the NHS these bring an elevated risk that the 2023/24 target score of 12 can be achieved by the 31 March 2024
2.1	20	All expected assurance has been provided to the Sustainability Committee. These included; CFO reporting including financial scorecard and risks, Productivity	There are a number of highly scored supporting risks covering operational pressures and workforce constraints which are impacting on operational costs	A series of actions are being taken to both enhance the control environment aswell as improving the level of assurances, these include the	Given the range of external factors impacting this risk their remains a low level of confidence that this

Risk	Score	Assurance	Supporting highly scored risks	Actions	Target Score (risk)
		Reporting, Tender waivers, losses and comps reporting, Capital Programme report, Efficiency Programme report and Workforce deployment reports to People Committee. This has been a mix of operational and executive assurance. The risk score has increased to 20 as this recognises that at M5 the Trust's financial performance and the 2023/24 forecast outturn is not consistent with the submitted plan. Key drivers of the forecast deficit include the level of unfunded financial support for LMB, the impact of Industrial Action and associated impact on efficiency programme delivery, the excess costs of inflation, the MH specialling, pay awards, delivery of 65 weeks and abortive costs linked to the Endoscopy HVLC scheme.	and productivity. These, alongside organisational capacity and a new financial framework are adding further risk to delivery of financial targets, a required step-up in elective capacity and delivery of a challenging efficiency programme. Assurance over the actions being taken to reduce the impact of these risks has been reported through the Sustainability Committee especially through the reporting of the financial plan, efficiency programme, and the corporate project on productivity and those reporting to the Systems and Partnerships Committee including the median hour of discharge and patient access transformation.	enhancing of support to divisions, the maturing of the 2023/24 efficiency programme and improvements with workforce control compliance reporting.	risk will achieve its target score by the end of 2023.
2.2	12	All expected assurance has been provided to both Audit Committee and Sustainability Committee over Q1 and Q2. These included; Tender waivers, losses and comps reporting, IA review of internal control environment, Commercial activity reporting and LCFS reporting on control environment. This has been a mix of operational, executive and through Internal Audit / LCFS external assurance.	There are a number of highly scored supporting risks covering operational pressures and workforce constraints which are impacting on the consistent delivery of the Trust's established control. Work is oversee at the Sustainability Committee and the People Committee for enhanced workforce development controls.	Actions planned have been delivered to maintain the risk at it target score. Improvement to the control environment continue including the enhanced support to the divisions through the tiered support meetings along with the continuing with the completion of the actions resulting from the HFMA sustainability audit, most specifically those linked to financial education and literacy.	Meeting target score, low risk of this changing

Risk	Score	Assurance	Supporting highly scored risks	Actions	Target Score (risk)
2.3	12	Assurance has been provided to the Sustainability Committee over Q1 and Q2. These included Environmental Sustainability SI report. This has been a mix of operational and executive assurance.	Supporting risks cover the ability to devote resources to deliver the respective CO2 reduction targets.	For risk 2.3 work is ongoing to determine the methodology for measuring CO2 reduction against each of the respective green plan workstreams, to refine trajectories to achieve the 2025 and 2040 goals along with the introduction of monthly reporting on the actual energy CO2 usage against these trajectories and the previous year.	Meeting target score, low risk of this changing
3.1	12	Assurance has been provided to the People Committee over Q1 and Q2. These included, the People scorecard, the LCD reporting, the FTSU and guardian of safe working reports and HEE reports. The Trust has recruited to its senior leadership roles and reporting has been provided to the People Committee attention has turned to the delivery of training and development the senior leadership team. This has been a mix of operational and executive assurance.	There are a number of highly scored supporting risks covering the ability to secure and protect leadership capacity in the divisions especially as they deal with the impact of operational pressures and workforce constraints in their teams. Assurance over the actions being taken to reduce the impact of these risks has been reported through the People Committee.	Actions continue as improvements in capability and capacity take time and therefore the risk score has not yet reduced. The Chief People Officer provides reports through the reporting of the delivery of the People True North and Breakeven Objectives along with the Leadership Development work through the Corporate Project enhancing leadership capacity and developing leaders' capabilities.	Whilst industrial action and the inevitable winter pressures impact upon those leaders. The lead executive remains optimistic that despite these challenges the 2023/24 target risk score of 8 can be achieved.
3.2	16	Assurance has been received through the People Committee relating to the reporting of the monthly measurement of engagement which has shown positive improvement albeit declining to the Trust staff voice counts target score (acute average) for 23/24 in August.	There are a number of highly scored supporting risks covering the stretch on staffing and their engagement. Assurance over the actions being taken to reduce the impact	The work on initiatives to support the '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	The benefits of stable leadership, the improvement actions being delivered at Corporate and Divisional level should yield further improvements in staff

Risk	Score	Assurance	Supporting highly scored risks	Actions	Target Score (risk)
		This has been a mix of operational and executive assurance and included Equalities and Inclusion reports, Gender Pay Gap Report, WRES and WDES report and the People Scorecard.	of these risks has been reported through the People Committee.	which were shared with the People Committee in June 2023. The actions to reduce this risk remain aligned with the leaderships and culture strategic initiative.	having confidence that the when speaking up will be listened too to allow the current score to reduce in quarter 4 to the 2023/24 target score of 12 albeit there is risk that industrial relations difficulties nationally with the industrial action and ongoing dispute about pay affecting nurses, radiographers and medical staff may impact on this risk.
3.3	16	Assurance has been received through the People Committee. The Trust has strengthened the controls and visibility on the use of staffing using HeathRoster for the Agenda for Change workforce. There has been a mix of operational and executive assurance, inclu, ding Equalities and Inclusion reports, National Staff Survey data, Gender Pay Gap Report, WRES and WDES report and the People Scorecard	There are a number of highly scored supporting risks reflecting the divisional challenges in recruiting staff, aligning staff to increasing service demands and the general pressure on staffing of being able to sustain the levels of workforce needed, particularly at times of stretch (escalation beds, extra RTT activity etc). Assurance over the actions being taken to reduce the impact of these risks has been reported through the People Committee.	There are plans to deploy systems to allow similar central oversight of the medical workforce, improvements are being delivered under the respective corporate project during 2023-34 which is already yielding benefits in key areas such as Medicine (WH & SRH, where there is an increased focus withing these Divisional teams on recruitment needs and activities with some successes in reducing vacancy levels, particularly within the Healthcare Assistant cohort. The Trust is also seeking to tackle retention with its activities to improve staff experience.	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 any extra capacity needed that is not planned for could further stretch staff. As the Winter Plan develops and delivery is evidenced then this should support the reduction in

Risk	Score	Assurance	Supporting highly scored risks	Actions	Target Score (risk)
				Further international recruitment is underway.	this risk to its target score of 12 in quarter 4
3.4	16	Assurance has been received through the People Committee over the H&W activities including staff support for the cost of living crisis (supported by the Trust charity), EDI reporting and FTSU report. These have been a mix of operational and executive assurance. The Committee in its meeting agreed it wished to see the staff survey results to corroborate the assurances it had received over the year before the risk score should be reduced.	There are highly scored supporting risks covering the stretch on staffing and their morale and wellbeing coupled by operational pressures and workforce constraints.	Reviews of staff support options have been conducted by the H&W team which demonstrate that the level of support offered (EAP, counselling, MH support, rest spaces) are comparable to other NHS organisations. Improvements in basic systems for rostering and supporting accurate payment to staff should reduce the incidence and stress of queries within our staff. New arrangements for retire and return will be made in October, supporting more flexible options for staff, along with the audit of the staff facilities to develop these further.	Acton has been taken to improve health and wellbeing activities for staff and there is confidence from the reports received and the improvements made to the established systems of internal control that this will reduce during the quarter. The Committee agreed that action had been taken but wished to see further assurance before the risk score is reduced.
4.1	20	Assurances are provided to the Quality Committee. These included, Safe Staffing report (nursing), Incident reports, DoC compliance reporting, QIA reporting, Quality Scorecard, Quality risk reporting, Clinical Coding review and Harm reviews. The reporting through to the Quality Committee show an increase in patients harm due to delay to operative intervention, delay in diagnostics, delay in cancer pathways (> 62 days and 104d cancer waits). The Committee also received information in assurance due to gaps in	There are a number of highly scored supporting risks covering the operational demands leading to a failure to meet the ED, RTT and Cancer performance targets along with the gaps in the Trust's clinical outcomes and effectiveness processes. There has also been an increase in patient demand on ophthalmology especially within the glaucoma pathway. Also the risk in being able to resource the learning from deaths processes.	Along with the Trust's own reporting gaps in quality governance processes have also been identified during the most recent CQC inspection and the Trust's own response to the CQC Provider Information Requests. The required improvement which will drive the reduction in the score of this and the other quality strategic risks with come through the delivery of the developing Single Improvement Plan.	It is recognised that the delivery of the improvements through the Single Improvement Plan will take some 12 months and therefore neither quality risks will achieve their 2023/24 target score by 31 March 2024.

Risk	Score	Assurance	Supporting highly scored risks	Actions	Target Score (risk)
		clinical policies, guidelines and protocols and the continuing gaps in quality assurance, with over 30% NICE guidelines having no clinical lead. There remain continued challenges in Mental Health, both in respect of Children and Young People and Adult, attending via ED or through admitted patients with primary mental health care requirements. These have been a mix of operational, executive and via the CQC external assurance.	Assurance over the actions being taken to reduce the impact of these risks has been reported through the Quality Governance Steering Group and Quality Committee, latterly the Patient and Quality Committee.		
4.2	20	Assurances are provided to the Quality Committee. These included, Serious Incident and Incident (no/low/moderate harm) report, DoC compliance reporting, QIA reporting, Quality Scorecard, Maternity Scorecard, Quality risk reporting, Learning from deaths report, Clinical Effectiveness reporting, MSSP report, Birth Rate+ report, Maternity Survey and Mental Health reports and CQC action tracker reports These have been a mix of operational, executive and via the CQC external assurance. The reporting to the Committee has confirmed control environment gaps to deliver the service improvements as has been demonstrated through gaps in clinical policies, guidelines and protocols and the continuing gaps in quality assurance, with	There are a number of highly scored supporting risks covering the management of young people requiring inpatient care for mental health problems, levels of nursing vacancies and an inability to provide consistent nursing & medical cover for escalation/outliers if bed capacity full, the risk of harm to staff and patients by violent and aggressive patients in ED and operational demands leading to a failure to meet the ED, RTT and Cancer performance targets along with the gaps in the Trust's clinical outcomes and effectiveness processes. There has also been an increase in patient demand on ophthalmology especially within the glaucoma pathway. Also	Actions are already commencing the Trust's processes in respect of improving clinical outcome and effectiveness processes, including enhancing harm reviews, SJR, central oversight of NICE assessments, Clinical Audit programmes. The required improvement which will drive the reduction in the score of this and the other quality strategic risks with come through the delivery of the developing Single Improvement Plan.	It is recognised that the delivery of the improvements through the Single Improvement Plan will take some 12 months and therefore neither quality risks will achieve their 2023/24 target score by 31 March 2024.

Risk	Score	Assurance	Supporting highly scored risks	Actions	Target Score (risk)
		over 30% NICE guidelines having no clinical lead.	there is a risk relating to access to CTs within ED at RSCH. Assurance over the actions being taken to reduce the impact of these risks has been reported through the Quality Committee and latterly the Patient and Quality Committee.		
5.1	8	Assurance has been primarily received at the Systems and Partnerships Committee, but each Board Committee also receives reports on the work of the Trust within the ICS. This assurance was provided by executive reports and included the Clinical Strategy, ICS and Collaborative Networks meeting reporting, and annual operational plan linked to system priorities.	Operational stretch challenges the Trust's ability to support wider system aims. System actions in respect of MH pathways and ED demand management not reducing demands on the Trust.	The Trust has delivered the planned actions regarding increased integrated working with the system on UEC and discharge. Through the strengthened collaborative relationships with system partners along with the UHSussex CEO now being the lead CEO for Urgent and Emergency Care work for the ICB.	Meeting target score, low risk of this changing
5.2	12	Assurance has been provided to the Systems and Partnerships Committee and the Quality Committee on the Trust's clinical strategy development and impact on its delivery on performance. This assurance was provided by executive reports.	The ability to deliver the clinical strategy give operations demands and workforce capacity challenges in certain services.	The planned strategic actions were taken allowing the risk score to reduce to its target score. There are a series of actions being taken to deliver the intentions defined within the Strategy to meet the longer term goal score.	Meeting target score, low risk of this changing
5.3	20	The Sustainability Committee and Systems and Partnerships Committee have received assurance over productivity gains, delivery of the 65 week target which whilst showing a	There are a number of highly scored supporting risks covering operational pressures and workforce constraints impacting	Plans have been developed to enhance the oversight and detailed Emergency Department improvement plans will drive	Whilst there are a number of external factors that could impact on this risk it is

Risk	Score	Assurance	Supporting highly scored risks	Actions	Target Score (risk)
		degree of improvement there remain significant risk due to the impact of industrial action which threatens delivery of the elective plan, especially in Surgery RSCH/PRH and the rising two week wait activity is increasing the cancer backlog above the sustainable backlog target across the Trust, which threaten the delivery of the operational plan. These have been a mix of operational and executive assurance within Operational Performance Reporting, the Integrated Performance Reporting, Patient First Programme reports, ICS and Collaborative Networks meeting reporting and the Annual operational plan linked to system priorities.	on productivity along with demands on the Trust's services along with the impact of industrial action on capacity and increased backlogs for treatment. Assurance over the actions being taken to reduce the impact of these risks has been reported through the Systems and Partnerships Committee.	through the control improvements. The delivery of the 65week improvement plan continues alongside the productivity corporate project.	anticipated that with the planned actions the risk could reduce during quarter 4 to its target score of 16 which was set recognising the degree of challenge in meeting the operational plan targets.
6.1	12	Assurance has been received via the Patient Committee which had oversight of the Research and Innovation breakthrough objective to increase research participation which has reflected that this has been sustained above the Trust's established target There has been a mix of operational and executive assurance, including that through the R&I Programme reporting processes. Future assurance oversight will be provided by the repurposed Research and Innovation Committee.	There are risks to divisional capacity to develop the strategy delivery plan to grow the capacity for research growth, along with the ability to develop the Trust estate to support research.	Through the R&I Committee assurance will be secured over the development of the strategy delivery plan to address the divisional action plans to develop and grow the capacity for research growth along with information on how the Trust is working with the Brighton and Sussex Health Research Partnership.	Whilst this risk has reduced to 12 for quarter 3 it expected to reduce to its target by the year end

5 Conclusion

5.1 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.

5.2 The respective Board Committees and the Executives continue to oversee their allocated strategic (BAF) key risks aligned to their patient first domain.

5.3 Each of the Board Committees have during their last 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.

6 Recommendation to the Board

6.1 The Board is asked to **AGREE** the BAF risk scores for the start of Quarter 3 based on the review undertaken by their respective Board Committees and the Board's receipt and discussion of the Trust's Integrated Performance Report.

6.2 The Board is asked to **NOTE** there are two risks which have been judged to not be able to achieve their target score these being for quality, and those four risks where there is a low level of confidence they will achieve their target score by the end of the next quarter, these being the one patient risk, one risk within sustainability and two of the people risks.

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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 Q3 and Q2
(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 & Quality 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	5	**20** ↑	**Elevated risk of not achieving the 23/24 target score**			4	3	**12**
Assessed strength of control	***Some weaknesses***			***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	5	**20** ↑	**Continuing risk of not achieving the 23/24 target score**			4	3	**12**
Assessed strength of control	***Some weaknesses***			***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** ⟷	**Achieved target score**			4	3	**12**
Assessed strength of control	***Some weaknesses***			***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	3	**12** ⟷	**Achieved target score**			4	2	**12**
Assessed strength of control	***Some weaknesses***			***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	3	**12** ⟷	**Continuing risk of not achieving the 23/24 target score**			4	2	**8**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***								

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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** ↔	4	4	**16** ↔	**Expected to achieve target score by year end**	4	3	**12**
Assessed strength of control	***Some weaknesses***			***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	4	**16** ↔	**There is an increasing risk of not achieving the 23/24 target score**	4	3	**12**
Assessed strength of control	***Some weaknesses***			***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	3	**12** ↔	**Expected to achieve target score by year end**	4	2	**8**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***						
4 Quality ***(Oversight provided by the Patient & 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** ↑	4	5	**20** ↑	**NOT Expected to achieve target score by year end**	3	3	**9**
Assessed strength of control	***Some weaknesses***			***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	5	**20** ↔	**NOT Expected to achieve target score by year end**	4	3	**12**
Assessed strength of control	***Some weaknesses***			***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** ↔	**Achieved target score**	4	2	**8**
Assessed strength of control	***Operating as intended***			***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** ↓	**Achieved target score**	4	3	**12**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***						

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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	4	**16** ↓	4	5	**20** ↑	**Expected to achieve target score by year end**	4	4	**16**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***						
6.Research and Innovation (Oversight provided by the Research & Innovation 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 ↔	4	3	**12** ↓	**Expected to achieve target score by year end**	3	3	**9**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***						

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Agenda Item:	10.	**Meeting:**	Trust Board	**Meeting Date:**	November 2023
Report Title:	Research and Innovation Committee Chair report to Board				
Sponsoring Non Executive:	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	N/A	
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	Yes	Effective	Yes
Caring	Yes	Responsive	Yes
Well-led	Yes	Use of Resources	Yes

Regulatory / Statutory reporting requirement

Communication and Consultation:

Executive Summary:

The Research and Innovation Committee met on the 31 October 2023 and was quorate, as it was attended by two Non-Executive Directors and the Chair and four executives, the Chief Medical Officer, Chief Executive, Chief People Officer and the Chief Nurse. In attendance at the meeting were also the Commercial Director, Associate Commercial Director. Clinical Research Director, the Director of Integrated Education, Managing Director for Planned Care and Cancer and Company Secretary.

This was the first meeting of the dedicated Committee supporting Research and Innovation and as such the Committee **confirmed** its Terms of Reference and its cycle of business. The Committee **noted** that the Research and Innovation Strategy had been widely publicised and a summary and accessible format of the full strategy. The Committee also noted the assurance over the delivery of this Strategy is both framing this meeting agenda and those of future meetings.

The Committee **received** a number of reports. These included:

- a research activity report and dashboard. The Committee whilst noting this was developing document provided feedback on the underpinning metrics and how these may be developed to assist the Committee with its oversight of Research activity. The Clinical Research Director

thanked the Committee members for their feedback and undertook to develop the report for future meetings.

- a report on the work being undertaken in respect of research and innovation training and clinical academic career development. Alongside the update from the Clinical Research Director the Committee heard from the Director of Integrated Education and the Chief People Officer on the wider support being developed within the Trust to assist with this work. The Committee **endorsed** the promotion of wider training support and the access to research activities within the Trust to aid recruitment and retention.

- a report providing information on both the level of commercial research activity, benchmarked to the wider NHS sector and areas of where the Trust has the opportunity to develop this work and the level of innovation activity that is being undertaken across the Trust and the developing infrastructure that supports the innovation studies and the working relationships being with wider innovation partners. Through the discussion with Clinical Research Director, the Commercial Director and the Associate Commercial the committee was **assured** that work on the supporting infrastructure will aid the strategy's delivery within the sustainability domain.

- a report on the Patient and Community Involvement and Engagement activities undertaken so far this year and **endorsed** the value of the activities being undertaken to better understand our patients own understanding of research activity of the Trust, the development of the research champions, and the successful bid that has secured reginal funding to establish community researchers to aid the development of research projects that engage with underrepresented communities. The committee **noted** the work with the Sussex Partnership Trust to join up studies on physical and mental health.

The Committee also **received** a report summarising the most recent activity of the Brighton and Sussex Health Research Partnership. Through the presentation of the report and the subsequent discussion with the Chief Medical Officer and Clinical Research Director both of whom are members of the partnership, the Committee was **assured** over the Trust's engagement with the partnership and the work undertaken to ensure the Trust's Research Strategy is aligned to the Strategy of the wider systems and study collaboration.

The Committee **received** the risk paper covering the key risks to the delivery of the Trust's Research and Innovation Strategy and Breakthrough Objective in relation of study membership growth. The Committee noted that this report would develop for the future meetings to incorporate the oversight of the divisionally held key risks to the delivery of the Trust research and innovation True North.

The Committee reviewed the BAF risk for which it has oversight of, and **agreed**, having regard to both the BAF summary, the Strategy Delivery risks and the reports considered during the meeting, that the quarter 3 2023/24 scores for risk 6.1 was fairly stated as reduced to a score of 12.

Key Recommendation(s):

The Board is asked to **NOTE** this was the first meeting of a dedicated Research and Innovation Committee and that it received its expected reports and to note the assurance these reports provided.

The Board is asked to also **NOTE** that the Committee provided feedback on the developing activity scorecard report along with a recognition that as the Committee meets across the remaining part of the year it intends to keep under review its cycle of business in order that the Committee meetings adapt to the developing assurance processes within the Research and Innovation domain.

The Board is asked to **NOTE** the Committee recommendation that the BAF risk 6.1 for which it has oversight, is fairly represented.

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RESEARCH AND INNOVATION COMMITTEE CHAIRS HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	**31 October 2023**	**Chair**	Claire Keatinge	**Quorate**	Yes
Declarations of Interest	No declarations were raised				

Items received at the Committee meeting			
Introductory matters			
Committee Terms of Reference and Cycle of Business.	**Presenter** Chief Medical Officer / Company Secretary	**Purpose** To approve the cycle of business supporting the agreed ToR.	**Outcome /Action taken** The Committee approved the Cycle of Business and agreed this supported the previously agreed Terms of Reference.
Research and Innovation to Strategy.	**Presenter** Chief Medical Officer / Company Secretary	**Purpose** For information	**Outcome /Action taken** Noted as proving a good source of reference for the Committee members.
Research and Innovation Strategy Delivery			
Research Activity Report including Strategy Deployment Scorecard.	**Presenter** Clinical Research Director	**Purpose** For information and assurance	**Outcome /Action taken** Noted the developing scorecard and engaged on the metric development.
Workforce Workstream report covering R&I training and clinical academic career development.	**Presenter** Clinical Research Director	**Purpose** For information	**Outcome /Action taken** Noted the work being undertaken to develop the Trust R&I workforce.
Sustainability Workstream report, covering income and innovation.	**Presenter** Clinical Research Director / Associate Commercial Director	**Purpose** For information	**Outcome /Action taken** Noted the work being undertaken to develop the innovation infrastructure.
Patent and Community Involvement and Engagement Update.	**Presenter** Clinical Research Director	**Purpose** For information	**Outcome /Action taken** Noted
Brighton and Sussex Health Research Partnership Report	**Presenter** Clinical Research Director	**Purpose** To provide assurance of both the Trust's engagement with and alignment of research activities across the system	**Outcome /Action taken** Noted the Trust's active involvement within Brighton and Sussex Health Research Partnership and how this engagement supports the alignment of the Trust and wider system Research activities.

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Risk			
R&I Highly Scored Risk Register extract	**Presenter** CMO /Company Secretary	**Purpose** For information	**Outcome /Action taken** Noted and discussed the key risks to the delivery of the R&I Strategy and correlated to the information within the reports received at the meeting.
R&I Extract of Board Assurance Framework for Quarter 3	**Presenter** Company Secretary	**Purpose** For agreement	**Outcome /Action taken** Agreed the R&I strategic risk for quarter 3 was risks fairly stated.

Actions taken by the Committee within its Terms of Reference	
The Committee **APPROVED** its cycle of business noting this would be kept under review in order for this to adapt to the developing assurance processes within the Research and Innovation domain. The Committee **AGREED** to recommend the reduced quarter 3 score for BAF risk 6.1 to the Board, noting to achieve the target score there remained actions to be taken and these were tracked within the Strategy Delivery Risk Register.	
Items to come back to Committee / Group (Items Committee / Group keeping an eye on)	
There were no specific identified areas outside the Committee's cycle of business.	
Items referred to the Board or another Committee for decision or action	
Item	**Who / when**
The Committee made no referrals to other Committees. The Committee agreed to recommend to the Board the Q3 score of the Research and Innovation Strategic Risk 6.1	Board on 9 November 2023

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Agenda Item:	11.	**Meeting:**	Trust Board	**Meeting Date:**	November 2023
Report Title:	Patient & 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 was brought together with the Patient Committee from in Quarter 2 2023. The Patient & Quality Committee meets monthly and therefore this report covers three meetings in August, September and October 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, the Trust's Director of Patient Safety and Learning, the Director of Patient Experience, the Director of Midwifery, and the Director of Clinical Outcomes & Effectiveness or their nominated deputies. The Chief Nurse gave apologies for the August meeting, and the interim Chief Nurse was in post for that meeting. In addition, other key personnel attended the meeting as appropriate to present specific papers including Infection Prevention and Control, Safeguarding, Learning from Deaths, Chief Pharmacist, End of Life Care and Organ Donation.

During the quarter the Committee received its planned items including the Safeguarding quarterly reports and the annual and quarterly reports for Infection prevention & control, End of Life care reports, quality scorecard, the perinatal quality surveillance dashboards, Patient Safety and Duty of Candour reports. The Committee also received quality assurance reports, and reports from the Committee's reporting group:

Quality Governance Steering Group (QGSG) as well as the reports on the respective Patient First Trust Norths, Breakthrough Objectives, Strategic Initiatives and Corporate Projects.
The Committee's broader remit incorporating the activities of the former Patient Committee has meant that the Patient Experience Assurance Report was received together with the National Inpatient Survey Report.

Quality Governance Steering Group (QGSG) and Quality Scorecard

The reports from QGSG included divisional summaries, as well as safety and quality domain summaries plus updates against the CQC action plans. This provides the committee with insight and triangulation with the divisions reporting on patient, safety, risk, quality assurance, and patient experience. The committee welcomed the assurance that there was good engagement at the meeting by clinicians and divisional Chiefs. The Committee noted the improved narrative and reporting of the Divisional Reports of the quality and safety standards met and outstanding.

The dashboard continues to evolve but the significant progress that had been made was recognised. A number of challenges remain on data collection. The committee has asked for assurance on data quality to be undertaken once the dashboard is complete and awaits a Quality dashboard that can be used for exception reporting.

It was reported that incident reporting rates are low at 41 per 1000 bed day and there is an ambition to increase this to 100 per 1000 bed days. There is an increase in the number of major and severe harms and a significant increase in falls and pressure damage. It was noted surgical site infection in some areas are increasing and a number of actions are being taken. The key themes of risks are harms due to waits, wait time and overcrowding in ED, safe staffing and the challenge of meeting mental health needs. The Committee asked for additional clarity on Harm Reviews, the process and how that is executed. The update provided with Committee with assurance that QGSG are closely considering the patient and quality domains.

Patient Experience, Safety & Quality Domains

The committee at each meeting discussed the key elements within patient experience and received the Q2 Patient Experience Report. The number of open complaints has increased from quarter one which brings a considerable resource pressure on the patient experience and divisional teams. In Q2 fewer complaints were closed than received leading to an increasing backlog and mitigating actions are being taken. The Committee **NOTED** that based on available Friends and Family Test (FFT) data, the significant majority of patients responding in Q2 were satisfied that they have a good or very good experience, which was comparable to Q1 however, in September, a decline in patient experience was evident particularly associated with the themes of waiting and inpatient experience. Chiefs of Service were now signing complaint letters so were closer to themes around medical teams' coordination and communication.

'Welcome' training undertaken by reception staff for the Louisa Martindale Building continued to be reflected in very positive patient feedback. Joint working around development of the new Cancer centre had been received similarly positively.

The National Inpatient Survey was reported where UHSussex's position was average compared to other Trusts. A review to understand areas with worse feedback than previous years includes who to contact after admission and communication from medical teams. These areas had been aligned to improvement areas and patient experience rounds have been instigated by the Deputy Chief Nurse.

The Committee discussed the key elements relating to Patient Safety themes and learning and received the Q1 Patient Safety Incident Report. The Trust's performance in the associated processes around incidents including the timeliness of incident investigation was reviewed and the Committee received learning from

Prevention of Future Deaths notices. Themes continue include patients lost to follow-up, mental health care and harms following long waits for procedures. The committee received a detailed briefing on Ophthalmology incidents and actions taken as a result of these. At each meeting the Committee received an update on reported Serious Incidents and were assured the learning from the investigations has thorough oversight from the Serious Incident Review Group (SIRG). In August, the Committee were advised of a Never Event. The Committee were updated on the immediate actions taken including an audit of the Local Safety Standards for Invasive Procedures.

The Committee received a briefing on the plan for implementing the new framework for investigating and learning around patient safety themes (PSIRF) using a range of tools and approaches appropriate to the safety risk. The Committee welcomed the improvements offered by this approach and the Trust is on track to implement this by the end of the year.

The Q1 Duty of Candour Report was received by the Committee and audits demonstrated the Trust is non-compliant with Duty of Candour . The audits reported compliance by Divisions which has enabled Divisional recovery plans to be put in place. This is a gap in assurance and an area of scrutiny for the Committee.

In relation to the Trust's clinical effectiveness support processes and the previously noted gap in assurance, there has been considerable work done to further identify the gaps and plans, and actions plans are being developed and are underway to rectify this. 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; and Health Inequalities and an update on the plans and resources solution. While a significant gap in assurance remains across these domains, the Committee is now **assured** that the nature of that gap is understood, supported by Internal Audit, and that suitably prioritised plans are in place or being finalised to rectify this. This is reflected in the Board Assurance Framework recommendation by the Committee.

The committee received an update on Mortality Reviews undertaken into Fractured Neck of Femur, CPD and Fluid and Electrolyte Imbalance as the standardised hospital mortality indicator (SHMI) had been noted as high for these conditions. Using a framework for triangulating outlier mortality rates, reports were presented for each area and recommendations received for next steps and how to disseminate the learning across Trust sites, The committee took assurance from this that outlier mortality indicators were being analysed and causes and learning identified.

The Committee received an update from the first meeting of a Health Inequalities group.
The Committee was pleased to learn, following my last report, that the Integrated Commissioning Board (ICB) has agreed Tobacco Dependency allocation of funding for maternity but there is a remaining risk to consider baseline funding for tobacco dependency for future years as the Committee is not assured this will be forthcoming.

The committee noted the Trust's participation in national audit and those audits where there is partial participation or no participation. There is a gap in assurance on changed practice and quality improvement for patients. Where audits are not taking place, recognise we need more clarity for the rationale and oversight of the clinical ownership, participation level and link to the Trust outcomes. The committee asked for a complete overview of the current status and that a full Audit Plan be put in place for 2024/25.

The Committee considered the Trust's annual organ donation report and agreed that it matched the information provided by the specialist team and commended the team for their work and outcomes

achieved. The Committee agreed this should be presented to the Board for their information (attached as an appendix to this main report).

Learning from Deaths

Following the Annual Report received at the last Board, the Committee received for the Q1 2023/24 Learning from Deaths Report and a progress update on the ongoing review of data and reporting. It was noted the Learning from Deaths framework continues to mature working to full alignment across UHSussex on Structured Judgement Reviews (SJR) and Medical Examiner Officer scrutiny . The Committee heard about appointment to the SJR lead post and training the SJR and reviewers, also chairing the mortality panel. There continues to be a gap in assurance in this area.

A significant SJR backlog has built up over time. The Committee received the action plan on how the backlog will be addressed band sought assurance on associated challenges with other processes including the Trust's Duty of Candour and support for this. The dedicated work expected to be cleared within 4-6 months.

End of Life

Committee received an update on the arrangements for the Trust's Palliative and end of life care through a Q2 report which includes reporting on the Trust's arrangements in conjunction with resuscitation groups and arrangements for do not attempt CPR but also a focus on the use of data with the Medical Emergency Team Call arrangements that is expected to report metrics form Q3. The Committee heard there had been better earlier recognition of the dying patient that enabled individualised care but there was still work to do on symptom control.

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 an 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. The Committee welcomed the comparison across Trust sites as well as with National and South East comparators where the Trust is in line with or better than the benchmarks. Through receipt of reports the Committee was **assured** that the Maternity Directorate continue to report Maternity and Neonatal data and engage with Maternity and Neonatal Safety Investigation team (MNSI, formally 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 and Trust arrangements to maintain funding for the remainder of 2023/24 .

The Director of Midwifery highlighted the risk posed by the impact of industrial action on both the service and requirements for CNST year 5 in respect of the ability to deliver training and medical attendance. It was **noted** and confirmed that this has been recognised by NHS Resolution and further guidance is awaited for consideration at a future meeting of the Committee.

Updates were received from the Maternity Safety Support Programme (MSSP) improvement group and associated recommendations had been agreed. In October there had been a visit to review the impact of the actions and considerable investment while slow progress was acknowledged around medical leadership and theatre capacity, The theatre capacity risk was discussed and an update received from the Chief Nurse on plans being developed to mitigate this at the Royal County Sussex Hospital.

The Committee **NOTED** the Saving Babies Lives v2 Care Bundle had been 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 Sussex LMNS Peer Review was shared which noted Element 1, Reducing Smoking was fully achieved with the remaining 4 elements partially achieved. The Director of Midwifery briefed the Committee on the plans in place to ensure full compliance with all standards before v3 issue issued in 2024/25.

The Committee **NOTED** the contents of the reports and **APPROVED** the latest scorecards.
The Committee received an update on neo-natal workforce which identified a number of risks around both medical and nursing staff and the Committee heard about the work underway to mitigate the impact of this alongside an active recruitment and engagement campaign.

Safeguarding

The Committee **received** the Q2, 2023/24 quarterly reports for Adults' and Children's Safeguarding activity. The Report outlined how the Trust continues to fulfil its safeguarding responsibilities for adults and children and provided an overview of both teams' activity. The Committee was **assured** that the Trust is discharging its statutory duties in partnership working.

The committee noted the focus on data quality and specialised training and that a gap in 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.

Gaps were reported in the Adult learning team, and the committee heard about the interim fill arrangements. Level 3 safeguarding children training is being examined to ensure in conjunction with the education team to restore face to face training.

The committee was pleased to learn that there had been a reduction in violence and aggression incidents involving dementia patients following a 'Communication and Interaction Training programme to help staff acquire greater dementia care literacy.

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 commenced in August to support the discharge of patients to an appropriate setting. While the Committee were briefed initially on the positive impact of the arrangement, at the time of writing this has not had the sustained impact that had been hoped for.

The Committee received an extensive external report into a tragic event and will dedicate a longer meeting session in Q3 (November) to considering the report and its learnings. The Committee heard the recommendations that had been made and that they required a high degree of collaboration between providers. The investigators had also been engaged to assist with providing further support to staff who are distressed by the incident.

The Committee heard about the October Mental Health Quality Summit in the Trust's Children division, including NHS England and Sussex system partners and that shared learning from families with representatives of the national team.

The Committee noted the higher incidence of mental health presentations from children and young people to Worthing Hospital and further updates on the reasons for delayed discharges. A group had been established to further look at pathways. New recruits are being onboarded to the enhanced care team to support of patients with mental health needs and a Senior Mental Health Nurse from Sussex Partnership Foundation Trust is being seconded to UH Sussex. This continues to have significant focus by the Committee.

Care Quality Commission (CQC) action plans

Following the inspections in Medicine and Surgery across the Trust in Summer 2023, an extensive Provider Information Request was received. It has become apparent that there were some essential safety standards that could not be evidenced and that there were evidential or actual gaps in our assurance. 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 asked for assurance on the arrangements for testing assurances of evidence and their sustained impact. This will be bought to a future committee.

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.

General Surgery Corporate Project

The Committee reviewed the one year progress update against the Improving General Surgery corporate project. The update described the overall clinical governance structure developed and coaching of senior leaders but it was acknowledged the service continued to require considerable support and there are significant challenges as evidenced quality indicators. The Royal College of Surgeons Review feedback noted an improvement of standards of governance had been observed but their formal report remained awaited.

A new model of service is in development to address the recognised imbalance of demand and capacity while the Committee heard about the Trust funded work to reduce the backlog of activity.

Neurosurgery

Following recent media coverage, the Committee had requested a quality assurance report from Neurosurgery including evidence of national outcome data and quality governance. The report included outcome data from National Audit Programme from 2017-2022 which demonstrates mortality rate for elective surgery is below the expected number. a Royal College of Surgeon Review 2019, CQC action plan, incident reporting, risk register, updates on Morbidity and Mortality meeting, clinical governance meetings

and Clinical Outcome and Effectiveness meetings. These were all supported by evidence including minutes which showed a focus on learning and evidence of how the RCS recommendations were implemented.

The Committee acknowledged the considerable improvement over several years and credited the staff and leadership to demonstrate the safety of neurosurgery service to patients and as Chair I will personally share this appreciation with the Specialist Chief of Service. The Committee concluded this gave good assurance including strong medical engagement.

Infection Prevention and Control Quarterly Report and 2022/23 Annual Report
The reports were received and noted.

The Committee noted the Trust was above trajectory for eColi, Klebsiella and MRSA and noted the continued need for focus on improved data collection and action to target intervention (e.g. suppression therapy). Covid-19 outbreaks had taken place on one Trust ward that remained closed and there was work to review the guidelines.
The Committee is seeking further assurance to be included in routine Infection, Prevention and Control reports around environment, water and ventilation.

In response to previous referrals from the Audit Committee and new to 2023/24 reporting, Surgical site infection data had been included. The report indicated higher than expected numbers in cardiac, orthopaedic and breast surgery teams. Action plans will come through Divisional Governance via QGSG to future meetings.

The Annual Infection Prevention and Control Report is provided to the Trust Board.

Clinical Strategy
An update on Clinical Strategy was brought to the Committee since being taken to the Board in August. The Committee acknowledged the engagement work with Divisions around future prioritisation and engagement with the workforce on the strategy. In depth pathway reviews are reflected in mission statements for adherence to national guidance. The Director of Strategy introduced the work and confirmed there will be a focus on Dermatology and Ophthalmology as two representative areas where waiting times had been a particular challenge.

Risks and Board Assurance Framework (BAF)
The Committee reviewed the Trust's key risks with the potential to impact on quality and noted those with the highest current score and their alignment to the areas that the Committee had continued to scrutinise for assurance. The Committee noted the commencement of a Risk Oversight Group and improved arrangements to demonstrate to support improved articulation and scoring of risks and the emphasis on effective controls. Updates were reviewed at each meeting and the recognition of the issues experienced by patients and staff. Members recognised a risk scored at 25 reflected the general harm recognised by prolonged crowding in emergency departments even though mitigations had meant there was not an identifiable harm coming to an individual. There was discussion about the connection between estate issues and their potential to give rise to a business continuity incident and the Committee sought an update on the contingencies both from estates and clinical areas.

The Committee had a discussion on the BAF and the respective risks it has assigned oversight, these being risks 1.1, 4.1 and 4.2. The Committee reflected on the information received during the meetings in respect of these risks along with the update provided post the review by the Audit Committee. The Committee supported the continuation of 4.2 at 20 while the challenging circumstances persisted. The Committee

recommended that 4.1 is further increased to 20. The proposed increase in risk score recognises the work to understand the gaps in the areas of clinical outcomes and effectiveness but reflects the scale of the outstanding work (in particular clinical ownership) and some further challenges around Safeguarding.

In relation to risk 1.1, the Committee heard that we are unable to deliver or demonstrate a continuous and sustained improvement in patient experience resulting in adverse reputational impact, and poorer patient experience. The Quarter 3 score is increased to 20 and despite planned actions the delivery of the 2023/24 target score of 12 is at risk.
The Committee does not have confidence that these risk scores can reduce to their target score by year end.

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 Executives for consideration by 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**:

- The Committee's recommendation in respect of BAF risks 1.1, 4.1 and 4.2 for which it has oversight, that the scores for start of quarter 3 are fairly represented.
- The General Surgery Update

The Quality Committee invites the Board to **APPROVE** the following:

- Annual Organ Donation Report 2022-23
- Annual Infection Prevention & Control Report 2022-23

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	**29 August 2023**	**Chair**	Lucy Bloem	**Quorate**	Yes
Meeting Date	**26 September 2023**	**Chair**	Lucy Bloem	**Quorate**	Yes
Meeting Date	**31 October 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	**Aug**	**Sep**	**Oct**	**Presenter** Chief Medical Officer	**Purpose** For information	**Outcome /Action taken** Noted Action to give assurance on suitability of data flow
Quality Dashboard (excluding Maternity) Safety, Effectiveness, Experience, Mortality	**Aug**	**Sep**	**Oct**	**Presenter** Chief Medical Officer / Interim Chief Nurse (Aug only) / Chief Nurse	**Purpose** For information	**Outcome /Action taken** Noted.
Mortality - Counter Measure Summary	**Aug**	**Sep**	**Oct**	**Presenter** CMO / Interim CNO	**Purpose** For information	**Outcome /Action taken** Noted
Mortality - Fractured Neck of Femur Mortality Review	**Aug**			**Presenter** Chief Medical Officer	**Purpose** For information	**Outcome /Action taken** Noted continued lines of enquiry for QGSG
Learning from Deaths Assurance Report		**Sep**		**Presenter** Mortality & Learning from Deaths Manager	**Purpose** For assurance	**Outcome /Action taken** Noted
Structured Judgement Review Update			**Oct**	**Presenter** Chief Medical Officer	**Purpose** For information	**Outcome /Action taken** Noted Action Plan to address back-log of SJRs
Harm Counter Measure Summary Reports (True North and Breakthrough)	**Aug**	**Sep**	**Oct**	**Presenter** Director Patient Safety & Learning	**Purpose** For information	**Outcome /Action taken** Noted
Patient Experience Assurance Report	**Aug**	**Sep**	**Oct**	**Presenter** Director Patient	**Purpose** For information	**Outcome /Action taken** Noted

				Experience & Engagement		
Patient Safety Incidents Q1 & Duty of Candour Q1		**Sep**		**Presenter** Director Patient Safety & Learning	**Purpose** For assurance	**Outcome /Action taken** Assurance Noted
Strategic Initiative – Clinical Strategy Q2			**Oct**	**Presenter** Chief Medical Officer	**Purpose** For information	**Outcome /Action taken** Noted
Corporate Project - General Surgery Q2 (Terms of Reference endorsed at September 2023 meeting)			**Oct**	**Presenter** Chief Medical Officer	**Purpose** For information	**Outcome /Action taken** Noted
Corporate Project – Enhancing Quality Governance Counter Measure Summary	**Aug**			**Presenter** Company Secretary	**Purpose** For information	**Outcome /Action taken** Noted
Perinatal Quality Surveillance Report and Dashboards	**Aug**	**Sep**	**Oct**	**Presenter** Director of Midwifery / Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted
Perinatal Workforce 6-month review		**Sep**		**Presenter** Director of Midwifery	**Purpose** For assurance	**Outcome /Action taken** Noted
Perinatal Single Delivery Plan		**Sep**		**Presenter** Director of Midwifery	**Purpose** For assurance	**Outcome /Action taken** Noted approval by LMNS
Maternity Safety Support Programme (MSSP) Funding		**Sep**		**Presenter** Director of Midwifery / Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted
Saving Babies Lives Peer Review			**Oct**	**Presenter** CNO/ Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted
Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS)	**Aug**	**Sep**	**Oct**	**Presenter** CNO/ Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted
Avoiding Term Admissions Into Neonatal Units (ATAIN) /Transitional Care Report & Action Plan			**Oct**	**Presenter** CNO/ Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted
Safe, Effective, Caring, Well Led and Responsive						
Infection Prevention & Control 2022/23 Annual Report			**Oct**	**Presenter** Director Infection Prevention & Control	**Purpose** To endorse	**Outcome /Action taken** Noted

Infection Prevention & Control Q2 Report			**Oct**	**Presenter** Director Infection Prevention & Control	**Purpose** To endorse	**Outcome /Action taken** Noted
Infection Prevention and Control Assurance on Water Quality			**Oct**	**Presenter** Director Infection Prevention & Control	**Purpose** For assurance	**Outcome /Action taken** Noted
CQC Update / Action Plans	**Aug**	**Sep**	**Oct**	**Presenter** Interim CNO (Aug/Sep), Chief Nurse (Oct)	**Purpose** For information	**Outcome /Action taken** Noted
Mental Health Update – Safeguarding Mental Health Assurance Report including Serious Incident investigation findings to October meeting Resource Gap Analysis to September 2023 meeting	**Aug**	**Sep**	**Oct**	**Presenter** Interim CNO (Aug/Sep), Chief Nurse (Oct)	**Purpose** For information	**Outcome /Action taken** Noted
Safeguarding Adults and Children Report Q2 2022/23			**Oct**	**Presenter** Chief Nurse/ Head of Safeguarding	**Purpose** For assurance	**Outcome /Action taken** Noted
Quality Assurance Report Including Clinical Outcomes & Effectiveness Group Reports Internal Audit Actions to October 2023 meeting	**Aug**	**Sep**	**Oct**	**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
Supportive-End of Life Care & Resuscitation Group Report Quarter 2 2023/24			**Oct**	**Presenter** CMO / CNO	**Purpose** For information	**Outcome /Action taken** Noted
Policies: Managing Concerns and Complaints Policy New Interventional Procedures Policy			**Oct**	**Presenter** CNO Director of Clinical Outcomes & Effectiveness	**Purpose** For information For information	**Outcome /Action taken** Noted.
Risk						
Trust Risk Register relating to Patient & Quality	**Aug**	**Sep**	**Oct**	**Presenter** CMO / Interim CNO/ Chief Nurse (Sep & Oct only)	**Purpose** For information	**Outcome /Action taken** Noted
Board Assurance Framework			**Oct**	**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 3 2023/24. The Committee received Patient Experience Quarterly Reports The Committee received the Adult Safeguarding and Child Safeguarding Quarterly Reports The Committee received the Infection Prevention and Control Annual Report 2022/23 and quarterly reports The Committee received the Learning from Deaths Quarterly Reports
Items to come back to Committee / Group (Items Committee / Group keeping an eye on)
Aspects of Winter Planning that will require oversight Q3 paper on Winter risk management processes at a ward /site level Quality Assurance Clinical Outcomes and Effectiveness Improvement Plan. The Committee asked for a report setting out more clarity on Clinical Harm Reviews, the process and how these are executed

Items referred to the Board or another Committee for decision or action	
Item	**Date**
The Quality Committee invites the Board to **APPROVE** the following: ▪ Annual Organ Donation Report 2022-23 ▪ Annual Infection Prevention & Control Report 2022-23 The Quality Committee invites the Board to **NOTE** the following: - The General Surgery Update	**November 2023**

University Hospitals Sussex
NHS Foundation Trust

INFECTION PREVENTION AND CONTROL ANNUAL REPORT 2022-2023
DIRECTOR IPC

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Executive Summary

This annual report is a summary of the outcomes and work program for infection prevention and control (IPC) and antimicrobial stewardship for the period 1st April 2022- 31st March 2023. The report covers all sites within University Hospitals Sussex (UHSussex), which compromises of Royal Sussex County Hospital (RSCH), Royal Alexandra Childrens' Hospital (RACH), Princess Royal Hospital (PRH, Haywards Heath); Worthing Hospital (WH), Southlands (SH, Shoreham); St Richards Hospital (SRH, Chichester), as well as other services Crawley & Worthing Sexual Health Service, Brighton General Hospital, Hove Polyclinic, Lewes Victoria Hospital, Newhaven Hospital, and Park Centre for Breast Care. There are also IPC service contracts in place with 2 hospices in West Sussex.

As the Trust and the country recover from the COVID (SARS-CoV-2) pandemic, there has been a renewed emphasis on training and education to maintain correct personal protective equipment (PPE) for infectious diseases, appropriate screening and isolation, and laboratory identification. Hospital acquired infections remain a significant area of attention, given the age and compromise of the estates and the persistent pressure on space in clinical areas. Site redevelopment (projected opening of Louisa Martindale Building at RSCH) requires attention to IPC sign off prior to opening.
The Infection prevention and control Board Assurance Framework demonstrated compliance with 82 key lines of enquiry, partial with 11 and non compliant with one. The thematic analysis demonstrated these clustered around, ventilation constraints in current sites, Fit testing, isolation rooms for infectious diseases and antimicrobial stewardship.

In recognition of their work at UHSussex, the IPC team were awarded the Patient First Star Award for Clinical Team of the Year.

University Hospitals Sussex NHS Foundation Trust

Abbreviations

Abbreviation	Full Text		Abbreviation	Full Text
UHSussex	University Hospitals Sussex NHS Foundation Trust		UKHSA	UK Health and Security Agency
RSCH	Royal Sussex County Hospital		HOHA	Hospital onset healthcare associated
RACH	Royal Alexandra County Hospital		COHA	Community onset healthcare associated
PRH	Princess Royal Hospital		COIA	Community onset indeterminate associated
SRH	St Richards Hospital		COCA	Community onset community associated
WH/W&SH	Worthing & Southlands Hospital		IV	Intravenous
CQC	Care Quality Commission		VIP	Visual infusion phlebitis
PPE	Personal protective equipment		MSM	Men who have Sex with Men
IPC (T)	Infection Prevention and Control (Team)		MPV	Monkey Pox virus
NHSE	National Health Service England		CAG	Clinical Advisory Group
HCAI	Healthcare Associated Infection		PLACE	Patient Led Assessment of the Care Environment
C. difficile (CDT)	*Clostridioides difficile* (toxin)		HPV	Hydrogen Peroxide Vapour
MRSA	Meticillin Resistant *Staphylococcus aureus*		MDRO	Multi drug resistant organisms
MSSA	Meticillin Sensitive *Staphylococcus aureus*		3Ts / LMB	Three Ts, Louisa Martindale. Building new hospital building at RSCH
CEO	Chief Executive Officer		WSP	Water Safety Plan
CMO	Chief Medical Officer		SSD	Sterile Service Department
SRO	Senior Responsible Officer		EDU	Endoscopy decontamination units
DIPC	Director of Infection Prevention Control		DDD	Defined Daily Dose

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QGSG	Quality Governance and Safety Group		EUCAST	European Committee on Antimicrobial Susceptibility Testing
TIPC	Trust Infection Prevention Committee		AMP	Anti-microbial pharmacist
ICB	Integrated Care Board		EPRR	Emergency preparedness resilience and response
SCFT	Sussex Community Foundation Trust		LIMS	Laboratory information management system
IPOG	Infection Prevention Operational Group		aDIPC	Associate Director Infection Prevention Control
SSI	Surgical Site Infection		EDU	Endoscopy decontamination unit
IPC -BAF	Infection Prevention & control – Board Assurance Framework		JAG	Joint Advisory Group on Gastrointestinal Endoscopy (quality assurance framework)
DCS	Data Capture System			

University Hospitals Sussex
NHS Foundation Trust

1. Introduction

UHSussex provides secondary and tertiary care to a population of 1.9 million people, employing almost 20,000 staff, and links with neighbouring specialist centres at Southampton, Guildford Cancer Centre, Kings College London and others.

The report offers assurance the UHSussex is compliant with the CQC Health and Social Care Act 2008 (Regulated Activities) regulations 2014, regulations 12 (2)(h), regulation 15 (2), as well as the Code of Practice on prevention and control of infection (ten Criteria see Table 1). The report is supported by the Board Assurance Framework assessment which outlines compliance with specific areas of the Act and the National Infection Prevention and Control Manual (Appendix 1).

Table 1: Health and Social Care Act 2008: Code of Practice on the prevention and control of infection

Criteria	Description
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of the service users and any risks that their environment and other users may pose to them.
2	The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.
5	That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the sike of transmission of infection to other people.
6	Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	The provision or ability to secure adequate isolation facilities.
8	The ability to secure adequate access to laboratory support as appropriate.
9	That they have and adhere to policies designed or the individual's care, and provider organisations that will help prevent and control infections.
10	That they have a system or process in place to manage staff health and wellbeing, and organisation obligation to manage infection, prevention and control.

The IPC service is responsible for ensuring all relevant guidelines, policies and protocols are current, available, and applied, to support the reduction in HCAI, promote appropriate antimicrobial use, ensure correct PPE is advised and available. The IPC is a corporate service which supports Sites and Divisions in managing outbreaks and embedding best practice.

During 2022/23 UHSussex remobilised services following the lessening of the COVID-19 (SARS-CoV-2) pandemic. The NHSE IPC manual (April 2022) was noted and acknowledged in Trust IPC policies. The local Clinical Advisory Group was disbanded in January 2023. The ageing population, increased acuity, and more immunocompromised patients, with limited range of new antimicrobials present a challenge to maintain a safe IPC environment. Dominant HCAIs such as *C. difficile*, MRSA, MSSA, Influenza, were joined by a virulent outbreak of invasive group A *strep* infection in the paediatric population during autumn and winter. The Trust continues to promote a safe and infection free environment through a continued improvement cycle.

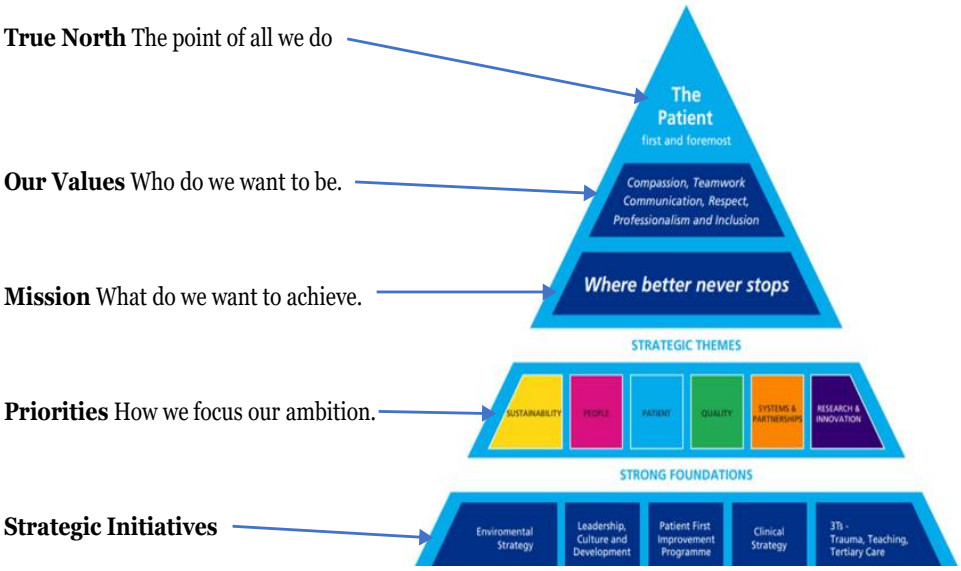
2. Organisation & Governance of IPC Service within UHSussex

The CEO has overall corporate responsibility for IPC within the Trust. The Chief Nursing Officer is the Trust DIPC supported by an Associate Director IPC. A Deputy DIPC has direct operational responsibility for managing the IPC service clinical team.

The IPC team provide the expert advice, training, education, audits and support outbreak response and infection practice within the Trust. The Divisions (Divisional Director of Nursing and Chief of Service) are responsible for effecting the policies, procedures, and reporting to IPC via the Infection Prevention and Control Operational Group (IPOG) and the Trust Infection Prevention and Control Committee (TIPC). Divisional Quality and Safety meetings report to Quality governance and safety group (QGSG). The Trust Infection and Prevention Committee (chaired by the Assoc DIPC) provides monthly and quarterly reports to QGSG on all aspects of IPC service and standards (including audits, updated risk register, summary of ventilation, water and built environment IPC risks). TIPC reports into the Trust Quality Committee.
Currently no report is received from the laboratory or epidemiology services into QGSG or TIPC. These may be raised via the Clinical Support & Service division.

The principle of continuous improvement is delivered via the Patient First' management system (see below Figure 1). IPC is core to ensuring the 'True North' objective of harm free care.

Figure 1: The values and organisation strategy at UHSussex

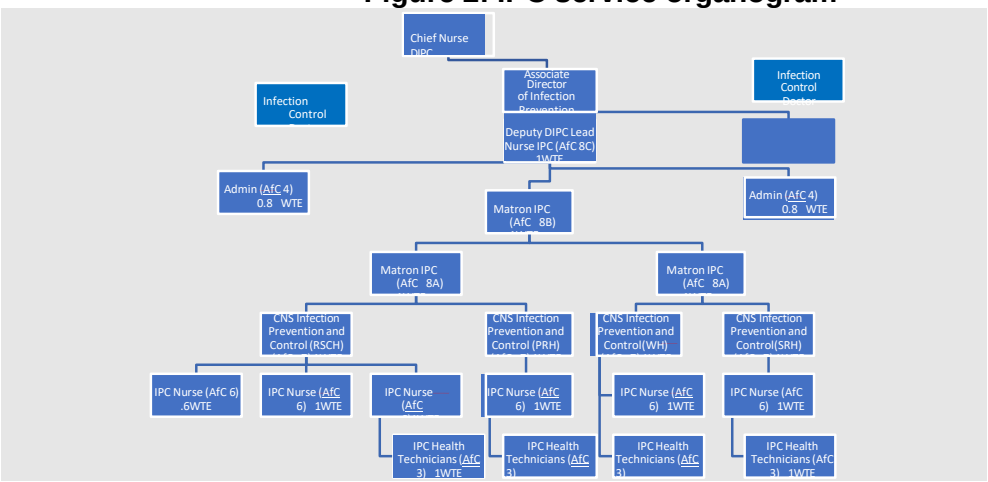


2.1. The Infection Prevention & Control Team

The Chief Nurse (Dr Maggie Davies) is the Executive Director of Infection Prevention and Control (DIPC). Associate Director Infection Prevention and Control (Pat Cattini) provides expert IPC support to the DIPC. Deputy Director Infection Prevention and Control and lead Nurse (Sharon Reed) is responsible for the operational delivery of IPC service.

The IPC service was restructured in 2022 to enhance the service across all sites. See Figure 2. Recruitment to vacant posts (i.e. epidemiologist /data analyst) is ongoing.

Figure 2: IPC service organogram



The IPC team is supported by the trust Consultant Microbiologists and Virologist. In addition there are IPC medical leads, Dr James Price (WH-SRH) and Dr Catherine Sargent (RSCH- RACH-PRH).

2.2. Key Roles & Responsibilities of the IPC Service

The responsibility of the IPC team encompasses all aspects of IPC across all staff groups, including management of outbreaks and incidents, alert organism management, environmental management, antimicrobial stewardship and epidemiology. This includes:

- Providing expert advice and guidance to staff, patients/relatives, and visitors in relation to infection prevention and control.
- Participation in surveillance, investigation, and management of HCAI and infectious diseases.
- Ensuring that current legislation in relation to IPC is implemented and adhered to Trust wide.
- Advising and assuring the Trust board on IPC legislation, its implementation and compliance.
- Planning and implementing strategies to reduce HCAI including mandatory training requirements.
- Ensuring policies and procedures are in place to provide safe and effective care, including measures such as hand hygiene.
- Organising and implementing IPC audits and reports to demonstrate compliance with IPC policy.
- Encouraging responsible antimicrobial use through safe, appropriate, and economic application and current Trust wide policies.
- Recording and follow up of incidents of infection after surgery and using results to review and change practice as necessary.
- Providing advice and support to staff with respect to invasive device management
- Providing surveillance and epidemiology support to monitor and manage HCAI outbreaks.

2.3. Governance Framework

Infection prevention and control activity in the Trust is overseen by the Trust's Infection Prevention and Control Committee (TIPC) which met quarterly in 2022-23.

- Chair – DIPC (Chief Nursing Officer) or delegated to Associate DIPC
- Infection Prevention & Control Doctors
- Consultant Microbiologist
- Deputy DIPC
- Infection Prevention Matron(s)
- Surgical Site Surveillance Lead Nurse/Matron
- Antimicrobial Pharmacist(s)
- Decontamination Lead(s)
- Heads of Nursing – Medicine divisions
- Heads of Nursing – Surgery divisions
- Head of Nursing - Women & Children
- Head of Nursing – CSS divisions
- Associate Director of Facilities
- Associate Director of Estates
- Health and Safety Lead(s)
- Consultant in Communicable Disease Control
- Occupational Health Manager(s)
- NHS Sussex Integrated Care Board (ICB) Infection Prevention Lead Nurse(s)
- Sussex Community Foundation Trust (SCFT) Nurse representative

The TIPC oversees the delivery of the IPC service and takes reports from all subcommittees (IPOG, SSI, Water Safety, Specialist Ventilation, Decontamination, waste management and facilities, laboratory / epidemiological/ surveillance, audits and HCAI). TIPC is chaired by DIPC (may bedelegated to Associate DIPC). TIPC reports to CMO (SRO for all Quality and Safety) via the monthly QGSG, to Trust Management committee and to the Board via Quality Committee.

The monthly IPC Operational Group meeting (IPOG) (other than in months when TIPC is held) is chaired by the Deputy DIPC or Senior Matron. This group includes a range of internal stakeholders and monitors progress on the IPC work plan (appendix 1). The IPOG allows operational issues to be reported, discussed, actioned, and escalated to the TIPC. Monthly summary reports (including risk register, emergent themes, or key actions) are reported to QGSG (Figure 3).

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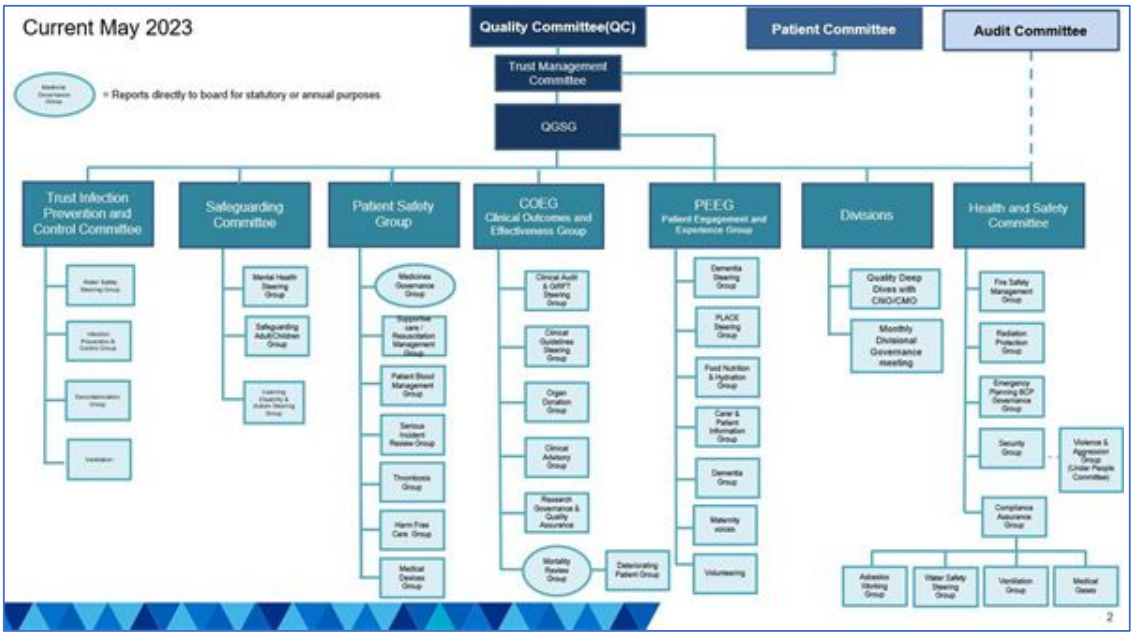
Figure 3: Governance structure for IPC



The DIPC reports directly to CEO and Trust Board presenting the DIPC IPC Annual report (author DIPC) and IPC-Board assurance framework (IPC-BAF). NHSE published an IPC BAF to support the provision of assurance to Trust Boards that the management of COVID (SARS-CoV-2) was in line with National guidance. This was subsequently updated in December 2021 and most recently in October 2022, aligning 94 key lines of enquires over 10 domains. A baseline assurance has been completed (December 2022), demonstrating full compliance in 6 domains. Of the 94 key lines of enquiry, 82 were compliant, 11 partial and 1 non-compliant (see Appendix 1) and a resulting action plan has been compiled.

The below table highlights thematic analysis of the 12 partial or non-compliant key lines of enquiry and associated mitigations.

Ventilation – strategy and delivery	Mitigations – air scrubbers, open windows. Medium- ventilation strategy update plan
Fit-testing for staff	Business case to invest in more Fit testers
Isolation policy and practice for transmissible infections	Increase in side rooms in LMB, balanced risk assessment across all sites
Occupational Health service review	Enhanced availability; vaccination support
Antimicrobial stewardship	Development of specialist pharmacists ward support

3. Significant Reportable Incidents

Healthcare-associated COVID infection was the most common category for significant harm which reflects the national situation with the pandemic (Figures 4 and 5). Other incidents included sharps and needlestick injuries and inability to isolate patients in a timely manner.

The national outbreak of invasive Group A *Streptococcus* (iGAS) in Q3-Q4 resulted in several severe incidents.

Two deaths were reported amongst children who had presented at UHSussex, both are subject to UKHSA incident reports.

- One baby presented to WH emergency department, left before being seen and presented at another Trust and died. Actions include safety netting follow up of all children who leave ED prior to being seen.
- 12 year old presented to RACH ED with cough, fever and septic. Following confirmation as iGAS, a joint follow up with UKHSA with the school was conducted.
- Child death (with multiple comorbidities) secondary to iGAS infection of an IV line. The investigation is ongoing.

Two further cases were reported.

- Elderly patient at WH who presented with a fall with leg blisters, from which iGAS was isolated. The root cause analysis accepted that this may have been a HCAI.

- Female patient at WH who iGAS following a SVD with episiotomy. Mother and baby were both treated successfully with antibiotics and recovered.

SSI incidents:

Patient presented 2 months post coronary artery bypass graft (CABG), with a sternal wound infection. *S. aureus* was isolated and the patient deteriorated on the ward. Subsequently a multidrug-resistant *Pseudomonas aeruginosa* (Carbapenemase-producing organism) was isolated. The infection persisted and the patient died from multi-organ failure.

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Figure 4: Datix incidents linked to IPC at SRH and WH.

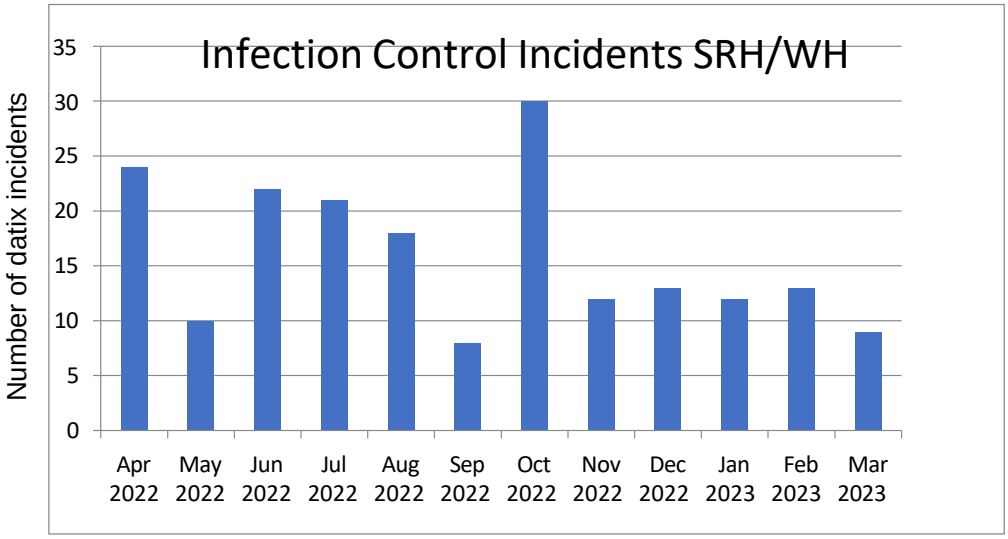
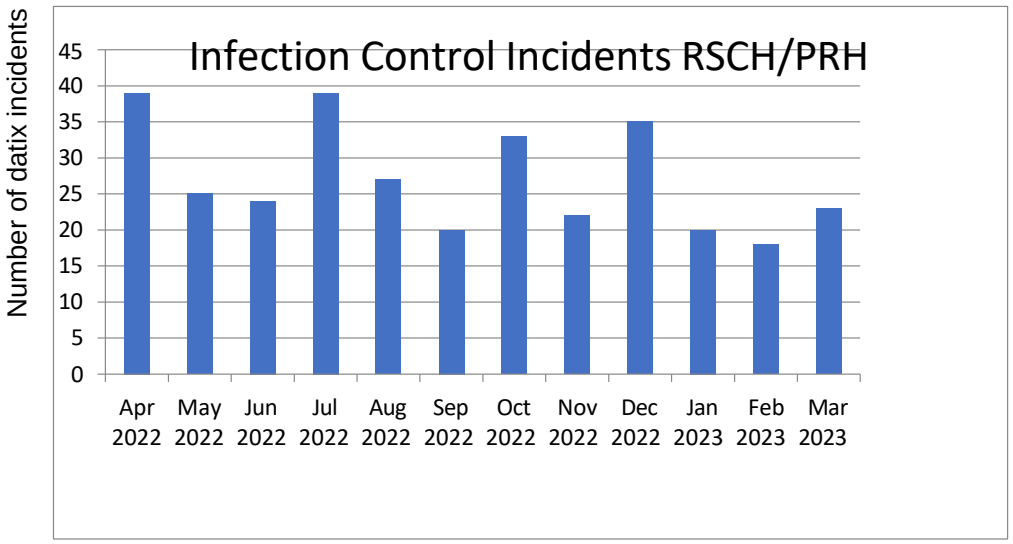


Figure 5: Datix incidents linked to IPC at RSCH and PRH



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3.1. Recovery from COVID (SARS-CoV-2)

The IPC service has supported the Trust (staff, patients and visitors) to understand and adapt to the new guidance on testing and use of PPE. Universal face coverings were discontinued in April 2023. A successful 'Gloves Off' campaign across the Trust has re-emphasised the need for good hand hygiene and appropriate use for single use gloves for specific encounters with bodily fluids. On going education is in place for clinical departments with respect to appropriate PPE, isolation and management of COVID positive patients, cohorting of potentially affected patients and application of testing requirements. Provision of FFP3 respirator fit-testing has been supported.

4. Healthcare-Associated Infection

Mandatory surveillance data for UHSussex 2022-23 is presented in Table 2 below. *MRSA, MSSA, Escherichia coli*, *Pseudomonas aeruginosa, Klebsiella species* bacteraemia's, and *Clostridioides difficile (CDT)* infections are reported to the national Data Capture System (DCS).

Table 2: Trust attributable mandatory surveillance

Key Organisms	Annual Trajectory 2022-23		Q1	Q2	Q3	Q4	YTD	Annual Tajectory 2023-24
CDT	142	Trajectory	35	35	36	36	142	141
		Actual	33	38	30	33	134	
		Variance	-2	3	-6	-3	-8	
E. coli	158	Trajectory	40	40	39	39	158	150
		Actual	39	52	51	56	198	
		Variance	-1	12	12	17	40	
Klebsiella. sp	54	Trajectory	13	13	14	14	54	51
		Actual	13	26	19	13	71	
		Variance	0	13	5	-1	17	
Pseudomonas aeruginosa	38	Trajectory	9	9	10	10	38	36
		Actual	12	11	12	8	43	
		Variance	3	2	2	2	5	
MRSA	0	Trajectory	0	0	0	0	0	0
		Actual	2	3	0	1	6	
		Variance	2	3	0	1	6	
MSSA	n/a	Actual	22	18	25	23	88	n/a

The Trust met the UKHSA mandatory surveillance target for *Clostridioides difficile* infection. 134 attributable cases was a reduction of 15 compared to 2021-2022 and 8 below trajectory.

All other HCAI exceeded the targets, but were similar to other comparable Trusts. Of the 6 attributable MRSA cases there were 4 individual patients (2 were repeats):

at St Richards Hospital, 1 at Royal Sussex County Hospital, 2 at Princess Royal Hospital.

There were 198 cases of *E. coli* bacteraemia which is 40 above trajectory.

4.1. Definitions of Healthcare and Community Associated Infection

Positive microbiology results for key metric infections are reported through the UKHSA DCS. National epidemiological definitions assign cases as follows:

- Hospital onset healthcare associated (HOHA): cases that are detected in the hospital two or more days after admission.
- Community onset healthcare associated (COHA): cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.
- Community onset indeterminate association (COIA) Date of onset is ≤ 2 days after admission and the patient was admitted in the previous 12 weeks, but not the previous 4 weeks prior to the current episode.
- Community onset community associated (COCA) Date of onset is ≤ 2 days after admission and the patient had not been admitted to the trust in the previous 12 weeks prior to the current episode.

HOHA and COHA cases are deemed attributable to the trust (Figure 6)

Figure 6: UH Sussex mandatory surveillance data benchmark data with neighbouring acute trusts*

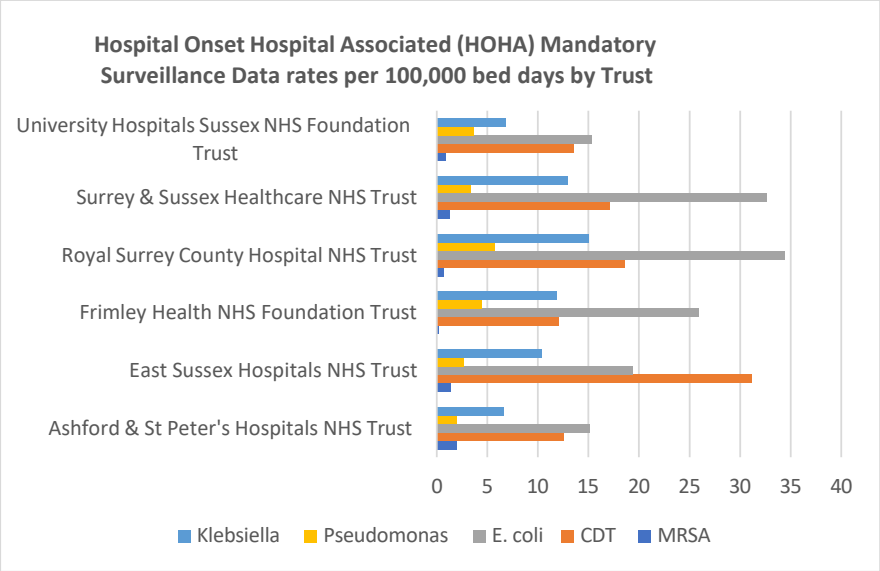


Figure 6 shows UHSussex mandatory surveillance data benchmark data with neighbouring acute trusts, per 100,00 bed days (April 22 to Feb 23). Please note where *C. difficile* and Gram-negative bloodstream infection case counts are presented as rates per 100,000 bed days, for example on Fingertips, bed days data is sourced from the KH03 collection published quarterly by NHS England. There is a greater lag on this data than the monthly case counts of *C. difficile* and Gram-negative bloodstream infections. Prior to the COVID pandemic, bed days could be readily estimated as the seasonal pattern was fairly stable. However, the pandemic has resulted in greater variation in bed days, and as such the lag on bed days data would pose a challenge to timely monitoring of progress towards the reductions set out in the thresholds. For this reason, thresholds are presented as cases.

The Trust was above its set trajectory in 4 of the key mandatory surveillance metrics; however, when bench marked with data against other Surrey and Sussex trusts (Figure 6) using the denominator of 100,000 bed days the Trust is performing comparably well. All NHS trusts have been under considerable pressures in the last year with the ongoing pandemic, the backlog in waiting lists and the pressures on social care which has made discharge into the community challenging. The requirement for extra beds in wards, and the delays in discharge may all contribute to increased infection especially in frail elderly who may become deconditioned after prolonged hospitalisation. It should be noted that nationally the mandated trajectories have not been adjusted to account for the additional pressures on the NHS.

4.2. Meticillin Resistant *Staphylococcus Aureus* (MRSA) Bacteraemia (blood stream infection)

There were 6 attributable MRSA bacteraemia's in 2022-23 shown in Figure 7 below.

There were 2 cases (in one patient) of MRSA bacteraemia, both deemed as HOHA at PRH, reported in April. This was an elderly patient who came in after a fall and soft tissue injury. The patient had a history of MRSA but was not screened on admission, despite a request from IPCT; and did not get any suppression therapy. The patient was deemed end of life and was palliated.

There were 3 cases of MRSA bacteraemia in Q2.
A COHA MRSA bacteraemia was identified in a patient on Pyecombe ward (PRH) in August. The likely source was a diabetic foot ulcer. This was community onset (identified in Emergency Department (ED)). The patient was identified as MRSA positive in May 22 as an outpatient. Notes were flagged and alerted. The patient was in and out of ED and had several day case admissions. They also had 2 further short admissions. The positive blood culture was taken in ED on 23rd August.

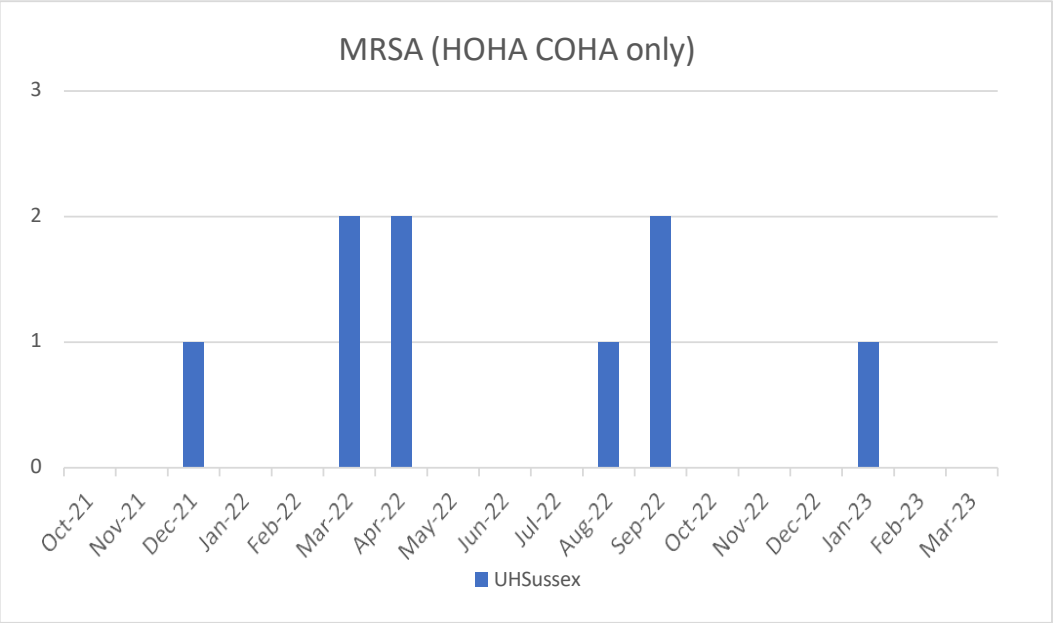
A HOHA case was identified on Pyecombe ward (PRH) in September. The patient was admitted in June. They had been cared for on a variety of wards including Ardingly and Balcombe (PRH). The patient had been known MRSA positive prior to admission (since 2018). The admission screen was taken late, and only the nose was screened. They were initially negative (Ardingly). A rescreen taken 10 days later was positive and the patient was prescribed suppression therapy. They

developed bacteraemia 5 days after moving to Pyecombe ward. The Intravenous (IV) team were asked to review IV device access management as the patient required multiple cannulas during their admission. Other actions taken included:

- IV team review of IV device insertion/ongoing management on Pyecombe.
- Review of Visual Infusion Phlebitis (VIP) Score management
- MRSA policy fully redrafted and republished.
- Environmental and clinical cleaning checked and satisfactory.
- Discussion on need for multiple patient transfers with Site Nurse Director

A HOHA MRSA bacteraemia was identified on Albion Ward (Cardiac) at RSCH in September. The likely source was an existing soft tissue injury. The patient had been screened on admission however results were not reported by microbiology until 29th (possibly due to the ongoing issue with ICT track). Blood culture was collected on 13/9 and reported on 16/9. Suppression therapy was commenced immediately. If the result had not been reported late, he could have started suppression therapy earlier which may have prevented the bacteraemia. This patient had a repeat MRSA positive blood culture in January. Despite treatment with appropriate antibiotics, he deteriorated in early January and passed away in late January.

Figure 7: MRSA Bacteraemia 2021-23



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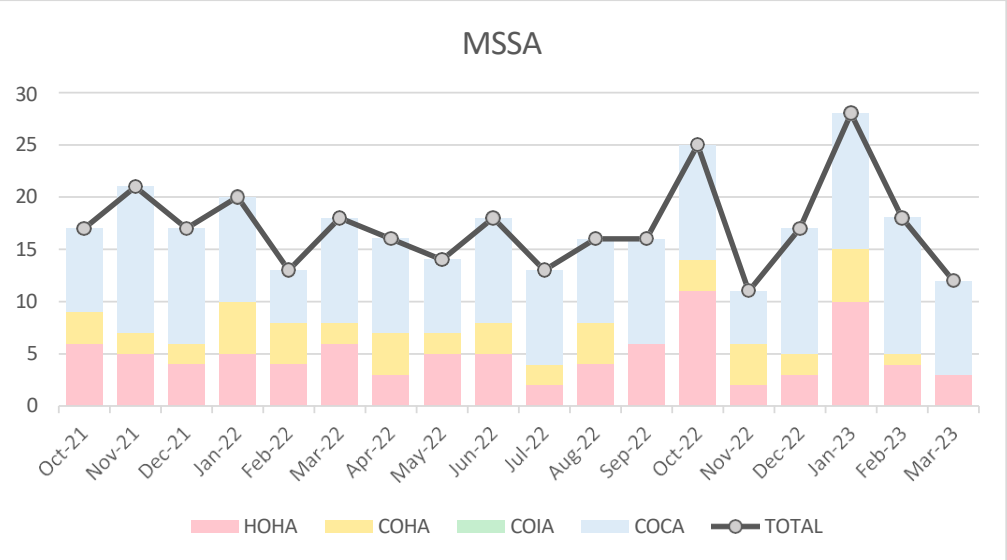
4.3. Meticillin-sensitive *Staphylococcus aureus* (MSSA) Bacteraemia

MSSA, like MRSA, causes a variety of infections, of which bacteraemia is one of the most serious. However, unlike MRSA, the majority of these infections occur in the community and are unrelated to healthcare. In 2022-23 there were 204 MSSA bacteraemia's identified of which 88 were attributed to UH Sussex (Figure 8). Due to increased workload a selection of attributed MSSA bacteraemia were reviewed and root cause analysis carried out to look for preventable causes. The cases of bacteraemia were associated with the following sources of infection: skin and soft tissue infections, biliary stents, discitis, pyelonephritis. We do not have a formal target for reduction of MSSA bacteraemia cases.

Figure 8: MSSA Bacteraemia cases 2021-23



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4.4. *Clostridioides difficile*

All stool samples found to be *C. difficile* toxin (CDT) positive must be reported.
C. difficile cases identified as HOHA and COHA are deemed attributable to the trust.

There was a total for the year of 134 attributable cases, which is 8 below the trajectory of 142 set for the year Figure 9.

Figure 9: *C. difficile* cases by attribution Oct 21 – March 23

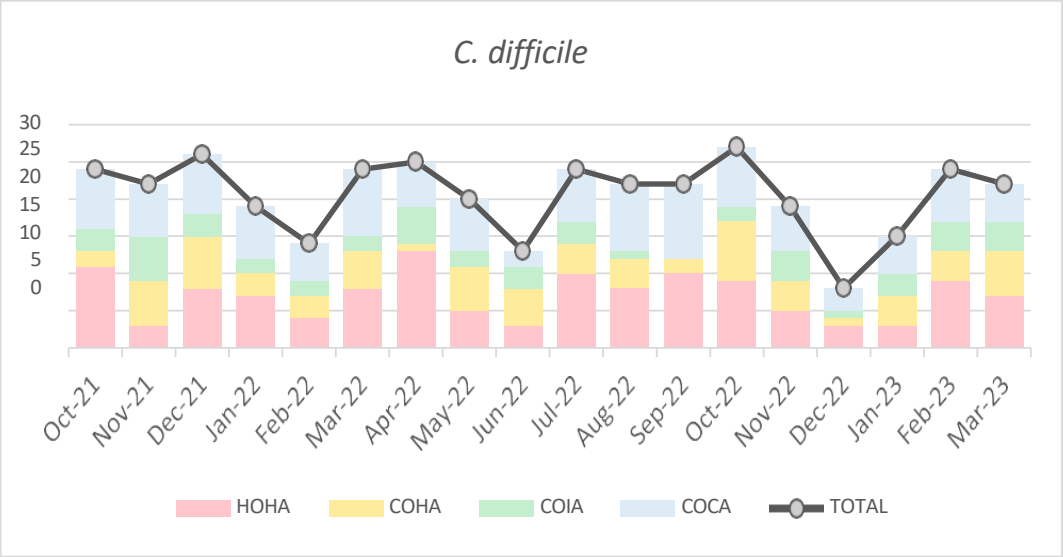
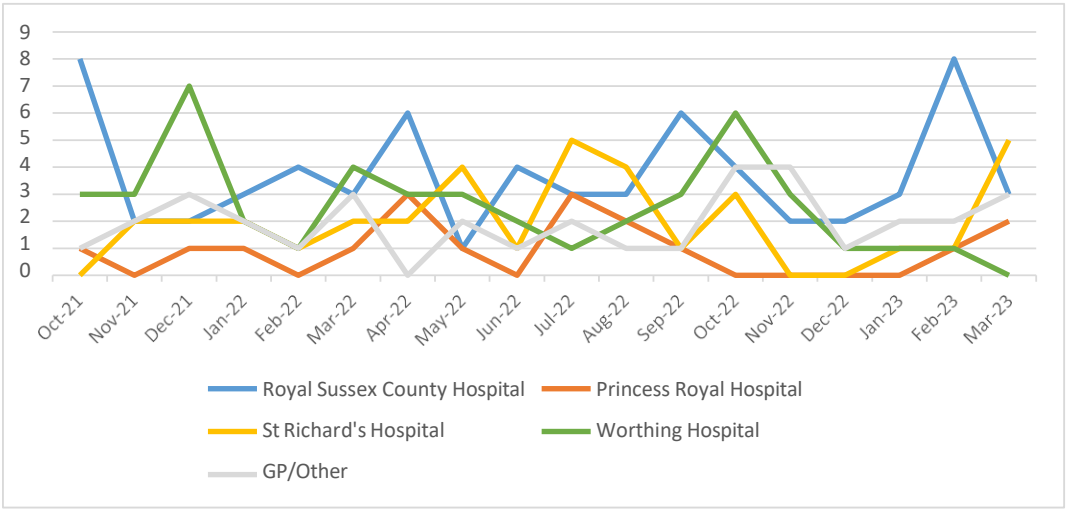


Figure 10: *C. difficile* HOHA/ COHA cases by hospital site Oct 21 – March 23



Attributed *C. difficile* cases undergo a clinical review to identify learning points. Causes for *C. difficile* transmission are varied and may include environmental contamination, antimicrobial use, chemotherapeutics, and use of hand gels as opposed to hand washing (Figure 10).

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4.5. *Escherichia coli* (*E. coli*) Bacteraemia

E. coli are Gram-negative bacteria which is considered normal human gut flora. However, it has been increasingly implicated as a source of blood stream infection (bacteraemia) often associated with the urinary tract, and commonly seen in patients in the community (80% of cases occur outside of hospitals). In 2018 NHSI/E set an objective for the UK to halve healthcare associated *E. coli* bacteraemia rates by 2024.

Reporting of *E. coli* bacteraemia is mandatory through the UKHSA DCS along with *Klebsiella sp* and *Pseudomonas aeruginosa bacteraemia*.

Collection of the enhanced data set to include risk factors has been limited due to difficulties with access to data. A project underway with the Business Intelligence team will make this process easier for the next year.

The burden of *E. coli* comes from the community. Among those with Healthcare associated *E. coli*, sources included hepatobiliary, IV device and respiratory samples. Hydration is increasingly reported as an important factor in gram negative bacteraemia, and the Trust is involved with a Sussex wide project led by the ICB, to look at how hydration may be promoted to reduce bacteraemia.

The trust had a total of 198 cases which is 40 over trajectory of 158. It should be noted though that the rate per 100,000 bed days is the lowest of all the acute providers in Sussex and Surrey as per figure 6.

Figure 11: *E. coli* by attribution Oct 21 – March 23

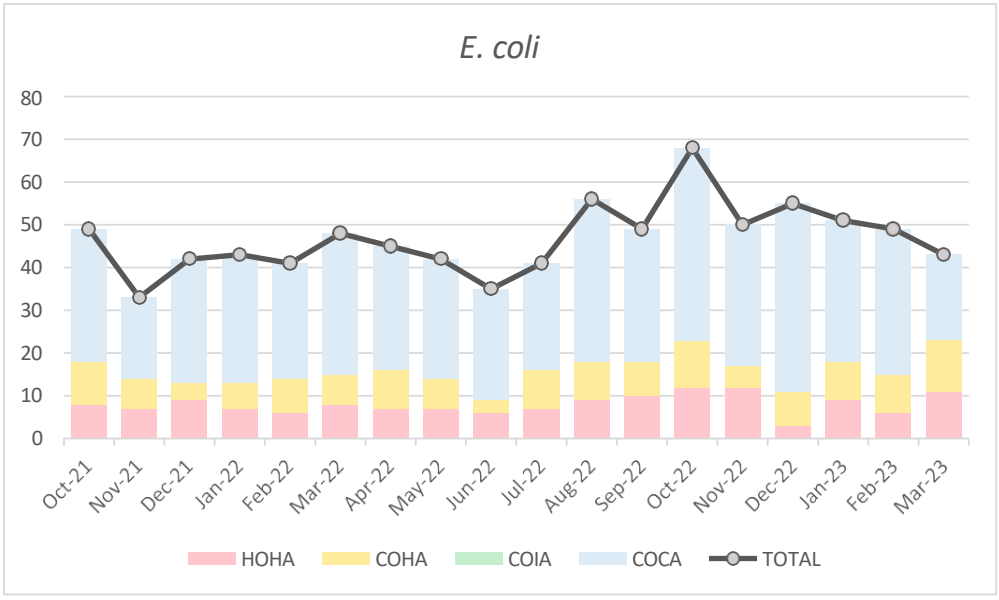
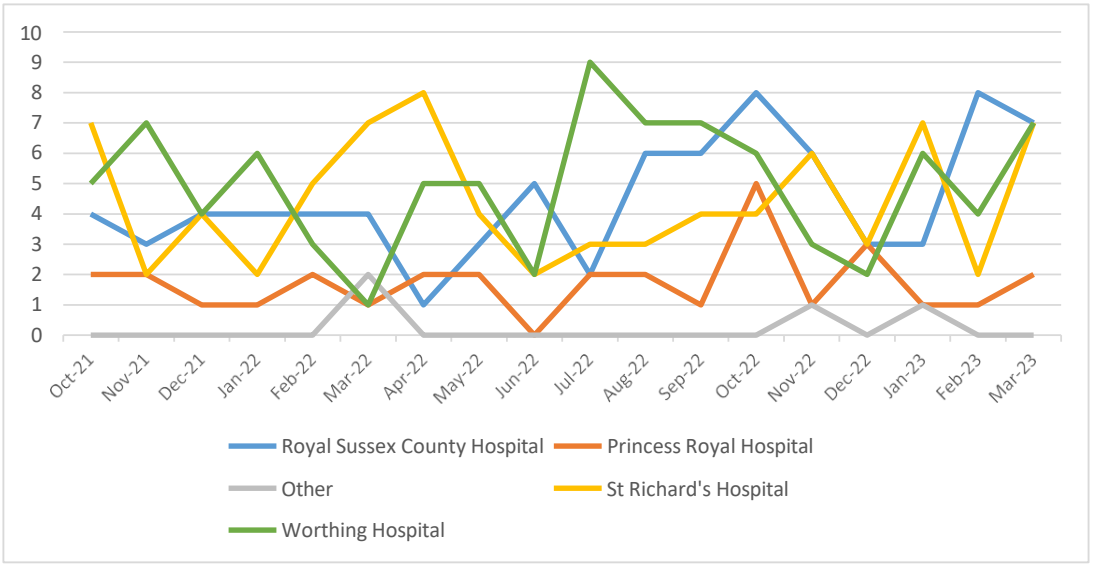


Figure 12: *E. coli* HOHA/COHA cases by hospital site Oct 21 – March 23



4.6. Pseudomonas aeruginosa

P. aeruginosa are Gram-negative organisms primarily found in water. It is associated with a range of infections including serious wound and blood stream infection. There have been several high-profile health care associated outbreaks which have resulted in public enquiry and corporate manslaughter litigations (Belfast, Glasgow). Trusts are obliged to sample water outlets in augmented care areas (including Intensive care, neonatal units, renal or haematology units) to check for the presence of *P. aeruginosa* and take appropriate action to prevent transmission to patients.

The trust reported a total of 43 (HOHA/COHA) *P. aeruginosa* which is 5 over the trajectory for the year (Figure 13,14)

Figure 13: *Pseudomonas aeruginosa*; by attribution Oct 21 – March 23

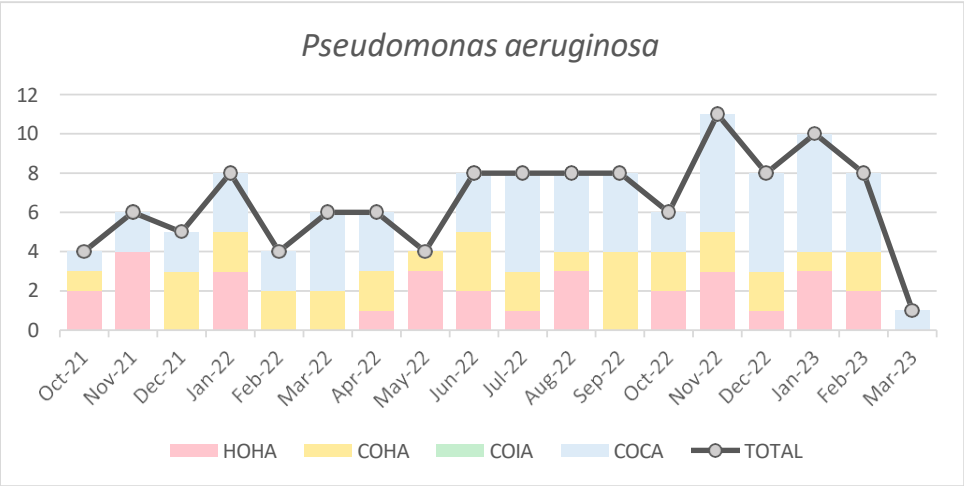
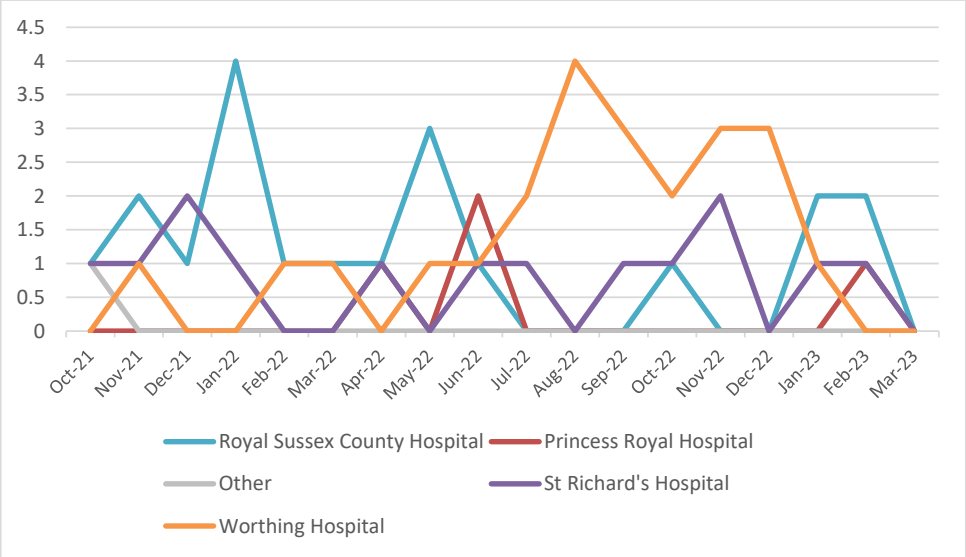


Figure 14: *Pseudomonas aeruginosa*; by hospital site Oct 21 – March 23



Where there have been occasional isolates of *P. aeruginosa*, following routine water sampling, point of use filters were put in place on the water outlets as a precaution. *P. aeruginosa* is thought to contaminate the taps due to transfer of the organism from the drain. This is more likely to occur if a sink has excess splashing, if it is slow draining; if the taps jet straight into the waste, or if cleaning staff move their cloth from the drain/waste area to the tap.

The Trust Water Safety Group continue to identify and drive improvements in the provision of sanitary ware, water monitoring, and appropriate remedial work.
There were two significant incidents with *P. aeruginosa* during the year as detailed below.

Amberley Ward Refurbishment: This ward was repurposed as a medical day unit for chemotherapy and acute oncology provision. *P. aeruginosa* was detected within the ward's water system. Expert advice on decontamination was provided, with risk assessment with respect to clinical opening. A full RCA was undertaken.

Recommended actions included:

- Install new taps or send contaminated taps to SSD.
- Chlorination of inner cartridges within tap casing
- New pipe work as now have post positive counts (based on replacing 70cms-1M from outlet).
- Peracetic acid decontamination of new sinks or drains
- Disinfection of whole water system with chlorine dioxide or Sanosil.
- Thermo-disinfection of local Amberley system
- Clarify flushing duration and force of water as splashing will transfer pathogen within the environment.
- Obtain external UKHSA support or independent Consultant for Consultancy fee for further advice.

The unit was opened after the remedial work and clear samples in mid-December, a delay from November.

Learning from this event was captured in an RCA and will be applied to the building of phase 2 of 3Ts, the new Cancer Centre at RSCH.

Cardiac Surgery Ward: Following a post CABG sternal wound infection, a very resistant form of *P. aeruginosa* was isolated. This was the same hospital strain seen in an outbreak in 2010 and again in 2022. These previous isolates were in different buildings and do not have connected water supplies. There was also a significant time lag between the isolates (12 years and 18 months). Supplementary water sampling was undertaken and samples in January 2023 showed *P. aeruginosa* in the water from 3 points on the ward; a shower room, sluice, and bay 4. The resistant isolate has not been found. Further samples in February had no growth.

Inspection of the ward showed several concerns regarding water hygiene which were rectified, including over-crowding with risk of splash, and a new macerator was required. Level 7 is a very crowded area and there is a lot of stored equipment which may inhibit cleaning. There was also potential for splashing onto stored equipment, relocation of patient care items away from the macerator and sluice hopper, steam cleaning of the shower doors, refurbishment of the shower in the single room with new tiles and shower chair on wheels.

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4.7. Klebsiella species Bacteraemia

There was a total of 71 (HOHA/COHA Klebsiella species bacteraemia's for the year of 71, which is 17 over for the trajectory.

The Trust Water Safety Group continue to identify and drive improvements in the provision of sanitary ware, water monitoring, and appropriate remedial work, however unlike *P. aeruginosa* there is no requirement for regular sampling for Klebsiella species. Klebsiella species are organisms of concern to the IPCT and, with access to whole genome sequencing through a wider programme of IPC research, we intend to carry out some further investigation to identify any environmental links with patient cases. There appear to be peaks at both Princess Royal and Worthing hospitals, both of which have a large number of non HTM compliant hand wash basins (Figure 15,16).

Figure 15: Klebsiella Species bacteraemia by attribution Oct 21 – March 23

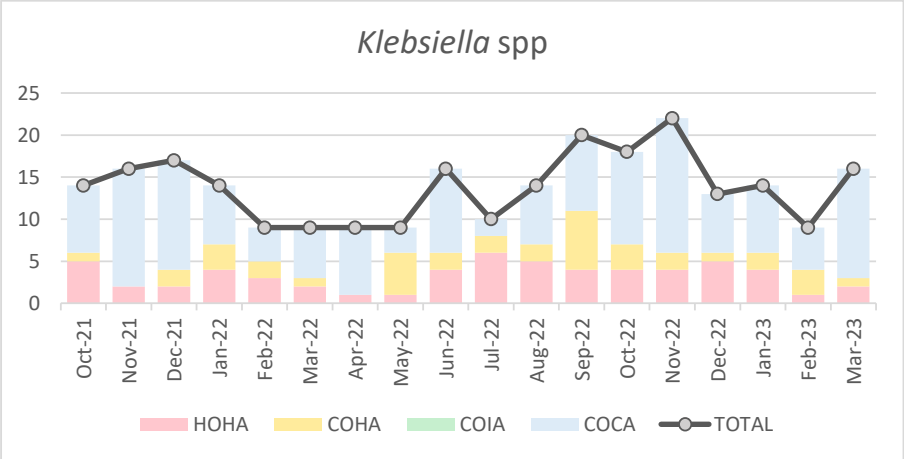
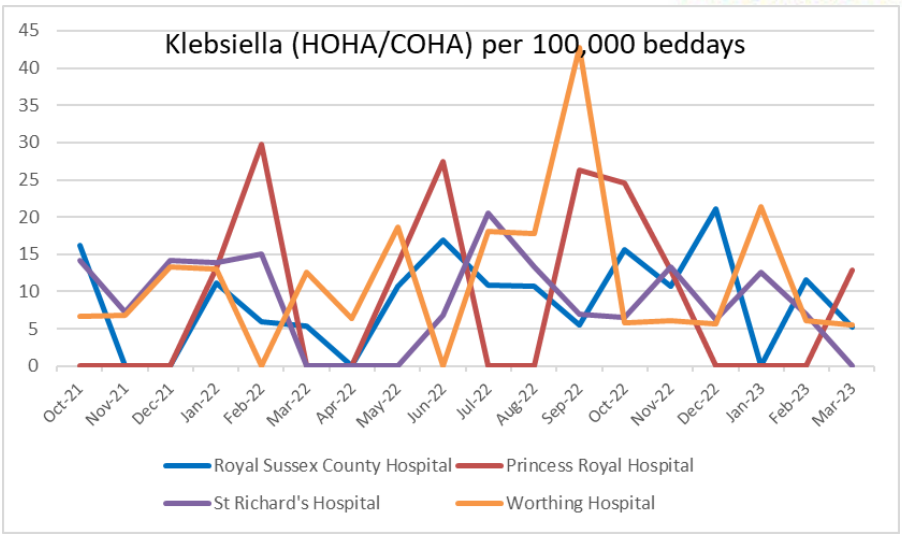


Figure 16: *Klebsiella sp*; HOHA/ COHA by hospital site cases Oct 21 to March 23



4.8. COVID

COVID has presented the biggest health challenge across the globe in living memory. The pandemic which started in early 2020, has posed an ongoing logistical challenge to keep our patients and staff safe whilst working towards providing efficient services for patients and catch up with backlogs.

COVID has continued to affect patients and staff across our Trust with pop up cases and outbreaks. Outbreaks often resulted in the closure of bays, though full ward closures were averted where possible. The use of surgical masks was maintained in clinical areas to reduce transmission of respiratory viruses to our staff and patients. The universal mask mandate was lifted at the end of March as COVID cases were seen to reduce.

There were frequent changes of guidance from NHSE throughout the year as the UK hospitals attempted to get back to pre-COVID activity. NHSE reduced testing capacity significantly with only symptomatic COVID testing remaining. The Trust initially maintained some asymptomatic testing, predominantly for patents being admitted through ED and those who were deemed significant contacts; but with the severe winter pressures, this was stopped.

Most COVID testing is carried out using Lateral flow tests (LFT) on the wards. As these tests are not performed in microbiology and records are not held by the lab, it has become very difficult to collate accurate figures of cases or determine when the patient acquired the infection. Known cases have been managed through the daily outbreak meetings and policy.

Staff did not have any shortages of essential PPE, and they were supported by the Infection Prevention Team, senior nurses, managers, and the leadership team who endeavoured to ensure safe operational running of services across the Trust.

The trust reviewed all guidance coming in from NHSE/I UKHSA at a Clinical Review Group meeting (CAG). This was chaired by the medical directors and included a wide range of clinicians who interpreted guidance in the light of local service knowledge. Whilst the Trust acknowledged national guidance, and in particular the national ambition to start 'living beyond COVID', decision making was driven by the local situation as it affected Trust sites, and local prevalence. Thus, at times, the Trust continued with mitigations including patient testing and use of masks beyond that recommended. This was decided in the best interests of our patients and staff and kept under review in light of changing local prevalence.

The Trust has not carried out its own research with regard to areas such as the effectiveness of mask wearing to decrease the spread of COVID. Those looking for the science behind aspects of care such as mask wearing, have been directed to the many resources available online or to contact NHS England and/or the UK Health Security Agency.

The Trust vaccinated 83.2% of eligible Healthcare workers for COVID. This was the highest uptake in the region (average 58.9%). This includes those vaccinated by the trust and in community settings. Further breakdown shows the trust achieved 81.8% for frontline workers and 93.8% for non-frontline workers.
There was a reduction in uptake of COVID vaccination from the previous year which was 88.4%. The same reductions from last year are reflected in numbers for other trusts and aligns with anecdotal vaccine apathy.

4.9. Flu

46.7% of eligible healthcare workers were vaccinated for Flu, the regional average was 53.4. This was a reduction 58.4% the previous year. A CQUIN for 2024 is requiring an 80% uptake of Flu vaccination.

There was very little flu seen across the Trust during the winter which may in part be due to the ongoing awareness of respiratory etiquette and use of masks.

Infection Control Doctor James Price getting his COVID & Flu Boosters from Associate DIPC Pat Cattini.

4.10. RSV

It had been predicted that there would be a surge in RSV during the winter of 2022-23, however this did not occur, again probably due to the ongoing pandemic precautions in place. There were no recorded outbreaks.

4.11. Carbapenemase-Producing Enterobacterales (CPE)

There is growing concern worldwide about the threat of antimicrobial resistance especially in multi-drug resistant Gram-negative bacteria. Some of these organisms including *Escherichia coli* and *Klebsiella pneumoniae* are showing resistance to the

antibiotics of last resort, including the Carbapenems and Colistin. These organisms which are usually found in the gut and are associated with a high mortality rate in vulnerable patients. The majority tend to be found most in overseas patients from countries where these organisms are prevalent. Recognition of carriers of these highly resistant gut organisms is considered vital in limiting their spread. Robust infection prevention and control is essential for preventing spread and limiting the exposure of other patients.

The IPCT have worked with the clinical site teams to enable safe intra hospital transfer arrangements for patients to reduce risk of CPE transmission.

An area for development in 2023-24 is the implementation of routine screening for CPE in key areas such as the ITUs. This has been challenging due to microbiology laboratory capacity.

4.12. Diarrhoea & Vomiting/Norovirus

There were several outbreaks of norovirus on all sites during the winter months.

The Barry building (RSCH) was particularly badly hit in February 2023, with most wards affected. The Barry building was known to be a challenging area due to bed spacing, open plan layouts and poor ventilation and it is anticipated that the move into the new LMB with 60% side rooms, will have a positive impact on future management of Norovirus.

Worthing had Norovirus outbreaks in 2 specialist clinical areas that were challenging to manage. Courtlands (Cardiac), because the layout of the ward is designed as such that both patients (wandering) and staff traffic is unrestricted (horseshoe shape for observation of monitored patients). Balcombe (Haematology-oncology) was a challenge because initial IPC measures needed to be strengthened due to the additional risk to severely immunosuppressed patients as well as the layout of the ward and demand for side rooms.

All incidents were managed as per policy. Daily outbreak meetings were held to contain spread and the IPCT attended operational meetings to ensure beds were managed as effectively as possible. Mitigations were initiated including use of air scrubbers to reduce airborne contamination.

4.13. Mpox

On 7th May 2022, UKHSA confirmed an individual case of monkeypox in England, who had recent travel history from Nigeria, where the infection was likely contracted. Mpox is a rare disease caused by infection with the monkeypox virus (MPV) and most cases occur in central and western African countries. Transmission usually occurs when in close contact with infected animals. The incubation period is between 5 and 21 days. The illness begins with fever, headache, muscle aches, backache,

swollen lymph nodes, chills and exhaustion. Within 1 to 5 days after the appearance, a rash develops, often on the face then spreading to other parts of the body including palms. Others can become infected if in close contact with the rash.

On the 14th May two further cases were identified in London with no obvious links with the index case. Four more cases were identified on 16th May with known contact with the index case and other cases. It soon became apparent that the infections were occurring mainly in men who had sex with men (MSM). By the 15th of July 2022, 1178 cases had been identified in England, again predominantly in MSM.

The Claude Nichol (sexual health) unit and Infectious Diseases unit at RSCH were named as sites where suspected cases could be assessed and treated. Post exposure vaccine was also offered to contacts referred by UKHSA on the Infectious Diseases Unit. By the 14th of July 2022, RSCH had assessed 99 suspected cases and 50 were positive for MPV. Most cases had a milder prodrome and minimal rash occurring mainly on the genitals and rectum. There were no severe cases or deaths in Brighton. A vaccination programme was rolled out in August to cover the most susceptible populations. Cases continued over the summer but began to be managed in the community. The outbreak had significantly waned by the end of the year.

4.14. *Staphylococcus capitis*

On the 22nd February 2021, 22nd June 2021 and 15th November 2021, the PHE/ UKHSA (2021) released briefing notes about increased detection of invasive *Staphylococcus capitis* in samples from hospitalised infants. Whole genome sequencing (WGS) of the isolates identified a common worldwide clone known as NRCS-A strains. A national incident, requiring a UKHSA response was declared on 4th June 2021.

S. capitis are coagulase-negative species (CoNS) of *Staphylococcus*. It is part of the normal flora of the skin of the human scalp, face, neck, scrotum, and ears and has been associated with prosthetic valve endocarditis but is rarely associated with native valve infection.

UKHSA advised an infection prevention review of practices in neonatal units including decontamination of incubators, enhanced cleaning of the environment, hand hygiene compliance and correct use of personal protective equipment (PPE).

The Trevor Mann baby unit has had five cases since 14th January 2022. The first three cases were closely linked by WGS. None of the babies have come to harm. Actions include a Trust-wide SOP for cleaning incubators, review of decontamination and audits of hand hygiene and PPE.

Between August 2022 and September 2022, there were four neonates found to have the same strain of *Staphylococcus haemolyticus*. In November and December 2022, four neonates were found to have invasive *Enterobacter cloacae* where two of them

(twins) came back as the same strain. Typing is awaited on the other two cases. There were also two neonates found to have invasive *Serratia marcescens*.

Further actions were taken in relation to all organisms and covered by a DATIX. These included, review of gestational age and birth weight, review of intravenous lines (all neonates had multiple lines), review of staffing, review of patient placement (the area has no isolation facilities and conditions are quite cramped), review of incubator cleaning, hand hygiene and PPE, use of thermometers, review of expressing breast milk area and parents' areas, and use and storage of sterilising equipment.

A deep clean of the unit has been completed. An isolation room has been created. Cleaning frequencies have been increased to include the breast pump machines and fridges. There is a shower that is not in use and works are underway to remove the shower tray and drain to create more storage space.

There was discussion at the Southeast Regional IPC about neonatal outbreaks and this resulted in a regional neonatal meeting about outbreaks. This was shared with our neonatal leads. Great Ormond Street are currently surveying how incubators are cleaned across the region and this will result in recommendations for cleaning. There have been no further blood stream infections on the unit.

4.15. Invasive Group A *Streptococcus* (iGAS)

On the 2nd of September, the UKHSA released briefing note 2022/073, that advised on persistently high incidence of scarlet fever and invasive Group A *Streptococcus* above seasonally expected levels, mainly affecting children.

Group A Strep (also known as *Streptococcus pyogenes*) is a common organism which causes a range of clinical illness from mild to severe. These infections include skin, soft tissue and respiratory tract infections including tonsillitis, pharyngitis, scarlet fever, impetigo, erysipelas, cellulitis, and pneumonia. Before the advent of antibiotics, they were the commonest cause of infection in hospital, and it is still the commonest cause of bacterial sore throat. Most Group A Strep remains sensitive to treatment with Penicillin. It is thought that the rise in cases may be related to the lack of social mixing during the pandemic. It is said to be invasive when it causes a systemic illness.

During November and December all of UH Sussex paediatric emergency departments saw an increase in children attending with parents 'worried' about iGAS and Scarlet Fever infections. All cases had throat swabs and were treated with antimicrobials.

5. Surgical Site Infection (SSI) Surveillance

SSI are a significant cause of HCAI. Rates of SSI vary depending on type of surgery the majority being confined to the point of incision.

SSIs are associated with an increased risk of morbidity and mortality, with patients developing SSI likely to have longer hospital admissions leading to additional costs related to patient care. Evidence-based SSI prevention recommendations are available from National Institute of Clinical Excellence.

The IPCT provide support to the divisions to undertake surveillance according to the UKHSA protocols. High quality, benchmarkable data is essential to enable monitoring of trends, investigation of underlying causes, and institute appropriate prevention and control measures.

The UKHSA mandates reporting of SSIs associated with orthopaedic surgery for at least 3 months every year and encourages reporting of other surgeries.

UH Sussex undertakes the mandated SSI surveillance (orthopaedics) and voluntary surveillance of breast surgery (SRH/WH) and Cardiac surgery (RSCH) (Table 3).

Table 3: Summary of surgical site infection rates in key operations and their comparison to national rates.

Operation	Site	2022/23 Q1 SSI rates	2022/23 Q2 SSI rates	2022/23 Q3 SSI rates	2022/23 Q4 SSI rates	National 5-year average
Total hip replacement	SRH	1.3%	2.7%	1.1%	2.2%	0.8%
Total hip replacement	RSCH/PRH	NA	NA	1%	2.6%	0.8%
Total knee replacement	SRH	0%	0%	5.3%	0%	1%
Total knee replacement	RSCH/PRH	NA	NA	0%	0%	1%
Breast surgery	SRH	7.7%	5.9%	7.4%	4%	2.6%
Breast surgery	Worthing	7.2%	6.5%	12.9%	7%	2.6%
CABG (Cardiac)	RSCH	NA	NA	10.7%	2%	5.2%

Rates of SSI related to orthopaedics and breast surgery remain above the national average. As such UHSussex has received and responded to outlier letters from UKHSA.

The IPC and surgical teams are working together to examine potential factors which may have caused a rise in infection rates. This includes examining processes at both theatre and ward level to ensure best practice as per guidelines. A multi-disciplinary 'One Together' meeting was held in May 2022 by SRH and WH surgical teams, to examine compliance and a follow up meeting was held in June 2023. Work is ongoing to ensure antimicrobial prophylaxis guidelines are followed. Work is ongoing with the Surgery team at RSCH and PRH to examine practice within orthopaedics. Improvements include introduction of pre-operative suppression therapy for patients undergoing joint replacement, improved patient information pre-operatively and introduction of Chloraprep for surgical skin disinfection.

Additional resource for surgical site surveillance has been put in place for RSCH and PRH Surgery and Specialist services.

Actions for 2023/24 include reporting to QGSG by both IPCT and Divisions.

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5.1. SSI at PRH & RSCH

The Cardiac Team at RSCH have begun SSI data collection for Coronary Artery Bypass Grafts from October 2022. This has been enabled by interim appointment of a part time Surveillance Nurse (Gina Keeley).

Q3 surveillance for Orthopaedics (total hip and knee replacements) was undertaken by the IPCT. One infection was found in the hip replacement surgeries and no infections among the knee surgeries.The Surgery division (RSCH/PRH) have appointed an SSI surveillance nurse (due to start April 2023).

Work has been undertaken by the surgical division, facilitated by the Associate DIPC, to identify areas for improvement in line with NICE guidance, and implement changes to reduce orthopaedic infection rates.

A cross trust meeting is planned for September 2023 to review practice and develop a cross site strategy for SSI surveillance so that it can be undertaken in a robust manner with appropriate learning.

5.2. SSI at WH & SRH

The SSI work is led by the surgical division at WH and SRH, with dedicated nursing staff to undertake data collection.

The service reviews data from orthopaedics (total hip, knee) and breast surgeries.

An internal audit reviewed the data collection process and made recommendations to reduce transcription and duplication of information. This included engagement with business intelligence to streamline data collection and improving data entry at theatre level to ensure fields are available for collection.

A multidisciplinary workshop was held in June to review care against NICE guidelines and make recommendations for improving practice. This will be followed up at the Trust cross site meeting in September (Figure 17).

5.3. Surgical Site Infection Surveillance Results

Figure 17: One Together resource for best practice in surgery, based on NICE guidance.

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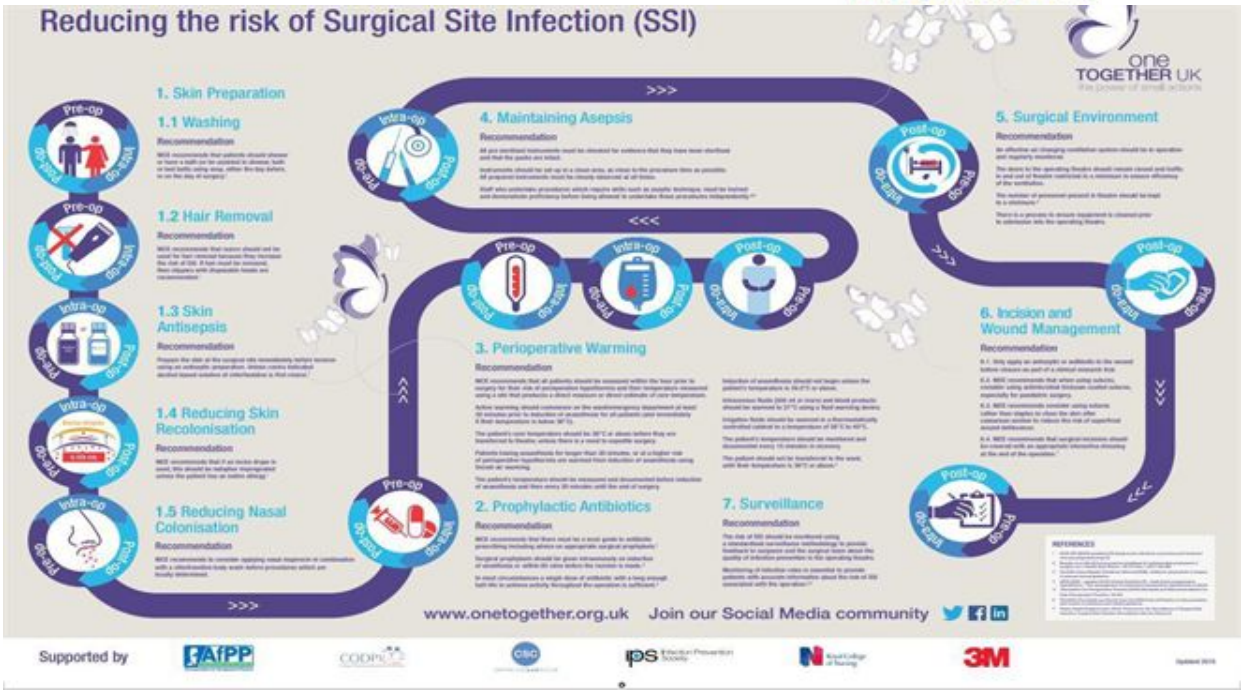


6. Risk Assessment

The IPCT works closely with the risk management team to ensure risks are identified correctly on the Trust IPC risk registers with appropriate mitigation put in place. These risks are regularly reviewed with oversight from TIPC for any risks graded above 12 (see table 4)

Table 4

Risk	Rating	Progress
Insufficient progress with Trust planned annual deep cleaning programme	12	Working with Facilities team to progress.
Patient harm through delay in diagnosis/mismanagement of infection due to lack of timely notification of laboratory results	16	No progress in upgrading the laboratory reporting system due to other IT priorities. This risk was upgraded as there were 2 MRSA Bacteraemia's that may have been prevented if screening results had not been delayed.

Provision of Fit testing of staff to ensure FFP3 resilience	12	Business case approved in principle. Awaiting outcome of funding agreement
Flooring within many clinical areas is uncleanable and beyond repair	12	Planning in place with Estates team to progress repairs.
Other notable risks		
Ventilation to many wards and departments falls far short of HTM standards.	9	Ongoing liaison with Estates to provide air scrubbers
Micro lab clinical and IT support at RSCH and Micro support across the Trust	9	Ongoing issue
Non-compliant Handwash basins in many clinical areas	9	Ongoing issue. Replacement as able.

Risks are also highlighted by the RAG rating in the BAF (Appendix 1). This document provides a gap analysis and identifies areas for improvement.

The IPCT work with the Water Safety and Ventilation Groups for water safety and ventilation risk assessments.

Specific work has been undertaken regarding COVID include the 'Hierarchy of Controls' assessments of clinical areas. National COVID guidance changed during the year to focus more on a respiratory virus approach and move many areas to a lower risk approach based on symptoms. COVID 'dynamic' risk assessment have continued with decisions on patient placement, isolation requirements and treatment options, based on evolving guidance. Where needed, risk assessment for difficult or contentious decisions were taken through the Trust Clinical Advisory Group (CAG); a multi-disciplinary group of senior clinical staff who can review available evidence and make an appropriate decision, for endorsement by Gold command. The CAG was stood down in January 2023.

6.1. Provision & Maintenance of a Clean Environment

Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

6.2. Environmental Cleanliness

The Trust manages its facilities contract 'in-house' rather than using a contractor. Checks of clinical areas against The Hygiene Code are carried out weekly by the ward sisters with a validation check monthly by the matrons. The results are recorded on the Tendable system (previously known as 'Perfect Ward').

There is a requirement for all NHS Trusts to have an annual Patient Led Assessment of the Care Environment (PLACE). PLACE assessments were reintroduced in 2022-

23 across the Trust following a pause due to the pandemic. PLACE assessments provide a snapshot of how an organisation is performing against a range of non-clinical activities which impact on the patient's experience of care. This includes cleanliness; the condition, appearance, and maintenance of healthcare premises; the extent to which the environment supports the delivery of care with privacy and dignity; the quality and availability of food and drink; and whether the facilities meet the needs of patients with dementia.

SRH, and WH have embedded PLACE as standard weekly work (monthly at SH). The inspections are conducted weekly by patient assessors assisted by teams of staff, inclusive of facilities, estates and infection prevention and control.

The annual PLACE schedule ensures that all clinical departments are covered, in addition to a small number of non-clinical areas (main receptions, gardens). Outcomes of weekly inspections have led to reactive environmental solutions as well as identifying proactive future improvements within the patient environments. The outcomes are discussed at a bi-monthly PLACE review meeting and a quarterly report and supportive action plan is provided to the Patient engagement and experience committee. The ambition is to replicate this approach at RSCH, PRH and RACH following the move to Louisa Martindale Building.

The Facilities and Estates Division are responsible for providing a safe clean environment for patients, staff and visitors at all Trust sites.

The Housekeeping department provides a variety of cleaning methods that include both manual and automated methods of cleaning.
As part of the Trusts compliance there is the requirement to monitor and carry out Technical Audits of all areas within the hospital. These are split in to four risk categories, 1 - 4 with category 1 being very high-risk areas. Table 5 below details the outcome of audits carried out in each quarter for the period April – March 2022/23.

Table 5: Outcome of cleaning audits.

Quarter 1

Risk Level	RSCH	PRH	WH	SRH	Southlands
Very High	98%	98%	98%	98%	98%
High	96%	97%	96%	98%	95%
Significant	91%	97%	91%	96%	87%
Low	86%	97%	86%	97%	85%

Quarter 2

Risk Level	RSCH	PRH	WH	SRH	Southlands
Very High	98%	98%	98%	98%	98%
High	97%	97%	96%	97%	97%
Significant	91%	95%	89%	95%	81%

Low	N/A	96%	78%	90%	75%

Quarter 3

Risk Level	RSCH	PRH	WH	SRH	Southlands
Very High	98%	99%	98%	99%	98%
High	97%	98%	97%	99%	96%
Significant	93%	99%	92%	98%	85%
Low	N/A	N/A	90%	96%	78%

Quarter 4

Risk Level	RSCH	PRH	WH	SRH	Southlands
Very High	98%	99%	98%	98%	98%
High	97%	99%	97%	99%	95%
Significant	92%	99%	92%	98%	91%
Low	87%	99%	78%	98%	87%

New national Standards of Cleanliness were implemented in 2022. The Estates and Facilities team use Synbiotix to record scores against the 50 key elements of the cleaning standards.

The Synbiotix reports are spilt down in to Housekeeping, Nursing and Catering. Daily reports are distributed to all departments detailing scores. Table 6 shows these scores with areas of failure detailed in red and rectifications at source.

Table 6: Synbiotix national cleaning standard scores.

Completed Audits Report

01/02/2023 - 01/02/2023

Zone	Hospital	Ward	Audit Date	Overall	Housekeeping	Nursing	Catering	Functional Risk	Target Score	Star Rating
Royal Sussex County Hospital	B Block (Pathology/A&E/UCC)	Short Stay Ward	01/02/2023 12:15	98.30%	99.47%	96.39%	95.24%	FR1	98.00%	★★★★★
Royal Sussex County Hospital	B Block (Pathology/A&E/UCC)	Urgent Treatment Centre-UTC GF	01/02/2023 12:38	96.83%	96.67%	97.30%	N/A	FR1	98.00%	★★★★☆
Royal Sussex County Hospital	B Block (Pathology/A&E/UCC)	A&E Majors 2B	01/02/2023 11:56	97.68%	97.58%	97.89%	N/A	FR1	98.00%	★★★★☆
Princess Royal Hospital	SOTC PRH	Theatres SOTC GF	01/02/2023 07:43	100.00%	100.00%	100.00%	N/A	FR1	98.00%	★★★★★
Princess Royal Hospital	SOTC PRH	PACU-SOTC-GF	01/02/2023 08:04	99.81%	99.76%	100.00%	N/A	FR1	98.00%	★★★★★
Royal Sussex County Hospital	Main Building (Barry)	IR-Suite-Barry-GF	01/02/2023 09:06	98.79%	98.86%	98.61%	N/A	FR1	98.00%	★★★★★
Royal Sussex County Hospital	Main Building (Barry)	Discharge lounge	01/02/2023 11:47	97.37%	96.61%	100.00%	N/A	FR2	95.00%	★★★★★
Royal Sussex County Hospital	Sussex Eye Hospital	Theatres SEH L2	01/02/2023 09:06	98.79%	98.41%	100.00%	N/A	FR1	98.00%	★★★★★
Royal Sussex County Hospital	Sussex Eye Hospital	A&E SEH BF	01/02/2023 08:15	97.07%	96.36%	99.29%	N/A	FR1	98.00%	★★★★☆
Royal Sussex County Hospital	Millennium (A Block)	High Dependency Unit	01/02/2023 12:14	99.23%	99.32%	100.00%	0.00%	FR1	98.00%	★★★★★
Royal Sussex County Hospital	Millennium (A Block)	7A CARDIAC CATHETER LABS	01/02/2023 08:41	98.36%	99.14%	95.83%	N/A	FR1	98.00%	★★★★★
Royal Sussex County Hospital	Millennium (A Block)	7A CARDIAC THEATRE	01/02/2023 07:50	99.63%	99.52%	100.00%	N/A	FR1	98.00%	★★★★★
Royal Sussex County Hospital	Millennium (A Block)	7A WARD - CICU	01/02/2023 11:27	99.00%	99.07%	98.44%	100.00%	FR1	98.00%	★★★★★

The Division also carries out various Deep Cleans and Infectious Cleans within the Hospitals. Table 7 below details these showing a total of 22,848.

Table 7: Deep clean numbers

Apr -22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Total	
550	343	517	732	314	41	0	85	497	337	292	325	4033	RSCH
200	144	143	239	120	88	154	73	136	96	133	124	1650	PRH
896	666	792	931	710	573	803	652	1155	907	671	797	9553	WH
977	569	691	803	473	363	660	461	798	583	447	787	7612	SRH

The Division has recently gone through a restructure process that provides a robust management structure supporting the needs of the organisation.

6.3. Automated Room Disinfection

Effective room decontamination is essential to prevent cross infection of pathogenic organisms between patients. This is particularly so with *Clostridioides difficile* Toxin (CDT) and for control of multi-drug resistant organisms (MDRO's) including Carbapenem-resistant Enterobacterales (CRE). (Table 8)
Research confirms that enhanced disinfection with automated systems such as high strength of Hydrogen Peroxide Vapour (HPV) is very effective and enables the Trust to make effective and safe use of beds and reduce length of stay by reducing risk of infection.

There is availability of a HPV system called 'Bioquell' at SRH and WH, however there is no provision at RSCH and PRH.

Table 8: Number of HPV disinfections 2022-23

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Total	
32	22	40	37	24	35	31	15	21	12	16	24	309	WOR
60	31	24	14	17	10	27	39	14	23	19	21	299	SRH

The Estates team have planned to purchase some Ultra-Violet (UV) Lights. These are portable machines that can be used easily for room disinfection. While they are not quite as effective as the HPV (this is because HPV is a gas and can permeate everywhere, whereas UV light only travels in straight lines) this is balanced by the fact that use is much quicker and less complicated and so can increase turnaround times for the room.

6.4. National Standards of Cleanliness

The organisation has implemented the new National Standards of Cleaning 2021 which has replaced the older percentage score system with a Star grading system.

There are some identified issues with wards in St Richards which have floors that are so badly damaged they are effectively uncleanable. The IPC team have requested that the star rating on these wards is lowered to a maximum of 4, until such time as the essential repairs is actioned. Planned preventative maintenance has been made more difficult due to the pandemic and also high bed pressures which make closure of wards for repair difficult.

Funding has been identified to make all the necessary repairs and arrangements are being agreed with the relevant areas in order to facilitate the repairs.

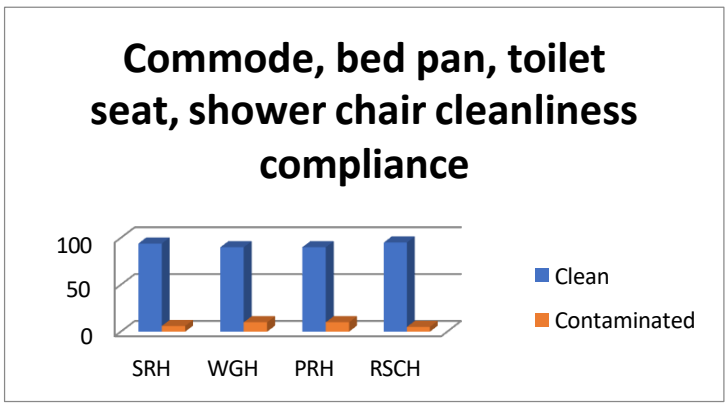
Additional flooring repairs have been completed to corridors in public areas at Worthing hospital.

6.5. Commode Audit

Cleanliness of toilets, commodes and additional toilet aids is a fundamental standard anywhere but is essential in hospitals to reduce transmission of *C. difficile*.

To ensure all commodes are consistently cleaned to an acceptable standard to render them safe for use for each patient, commodes are checked by ward staff at least 3 times per day. The IPCT aim to complete monthly commode cleaning validation audits across all sites. (Figure 17). These include shower chairs, raised toilet seats and bed pans. The results are included within monthly IPC IPOG reports and the data outcomes facilitate learning opportunities for post infection *C. difficile* reviews.

Figure 17: Commode, bed pan, toilet seat, shower chair cleaning compliance 2022-23



7. Infection Prevention in the Built Environment, Estates & Capital Projects

The IPCT continues to work with the Estates and Facilities and Capital Projects to

ensure that buildings and facilities meet the appropriate standards to enable good infection prevention practices.

The key project for the Trust is the building and commissioning of the 3Ts project at RSCH. The project was commissioned several years ago but has been subject to delays for various reasons including the pandemic. The build opens in June 2023. The IPCT will continue to monitor progress as staff settle into their fantastic new surroundings. From an infection prevention perspective, the new facility brings many benefits, including a large number of single rooms and 10 isolation suites, improved ventilation system, compliant handwash basins, spacious treatment rooms and an improved fabric which will be easier to clean and maintain. The new building will help our staff to meet the highest standards for patient safety.

Martin Still signing off a clean utility with Barbara Kavanagh-Day

One of the new operating theatres

Ward corridor

New ITU with a view!

This year the IPCT has also contributed to the following projects:

- Project planning for updates to ED at RSCH
- Project planning for updates to ED at SRH
- Project planning for phase 2 of 3Ts, the new cancer centre facilities
- Purchase and use of additional HEPA filtration units to improve air quality during the pandemic.
- Project planning for external modular buildings within SRH, WH and RSCH.
- Project planning for capital refurbishment of Amberley Medical Day Case Unit at WH.
- Project planning for a capital refurbishment of Laundry site at SRH.
- Project planning for new Urology Investigation Unit at PRH
- Project planning for new Audiology services in RACH

7.1. Water Hygiene Risk Management

The Trust Water Safety Committee met quarterly during 2022-23. There were also 3 local meetings for WH and SRH and a further 3 for RSCH and PRH. In addition, there were 4 extraordinary water group meetings to discuss issues associated with the Amberley Unit at WH and The Louisa Martindale Building at RSCH.

The Water Safety Committee undertakes to review results of water sampling, manage the Trust 'Water Safety Plan' (WSP), and bring together an aligned approach for water safety management across the Trust.

The water safety plan has been reviewed. Routine water testing for Legionella and Pseudomonas contamination has been carried out as part of the Trust's planned preventative maintenance strategy and according to governmental advice both from Department of Health (DH), Health and Safety Executive (HSE) and Health Technical Memoranda (HTM) guidance. Water testing is carried out by different providers in each legacy trust, but work is underway, led by the chief engineer, to look at how this may be streamlined. Results are reviewed, and appropriate remedial actions initiated by the Estates Team.

The IPCT continue to monitor sink usage across the Trust. The estate has many older style basins and outlets which are no longer compliant with current standards. A full audit is being planned with estates to catalogue the compliance of all outlets and devise an appropriate replacement programme going forward, prioritising the most important. Hand wash basins may be a significant source of gram-negative infection including *Pseudomonas aeruginosa* and Klebsiella Species which may lead to patient infection. Basins which do not drain effectively, those that splash significantly and those where the water directly hits the drain hole, can significantly increase risk of contamination with such organisms.

Further work is needed in 2023-24 to better understand if there is any correlation between positive water outlets and the rates of blood stream infection caused by *Pseudomonas aeruginosa* and Klebsiella Species. The trust was over expected trajectory for these organisms in 2022-23. There was one case of significant patient infection in a cardiac wound which may link with contamination of the water on the ward with *Pseudomonas*. There is no testing for Klebsiella species so this is more

difficult to detect. A project being led by our Infection control Doctor, Dr James Price, through Brighton and Sussex Medical School, may give us more information through the ability to do some whole genome sequencing of both a patient isolate and a linked water sample. This will allow us to identify ways to further improve water management.

The Water Safety Committee played an important role in ensuring water safety of the new Louisa Martindale Building (LMB). The IPCT actively discouraged the early filling of the water tanks which could have allowed significant growth of organisms in the water supply. Eradication of these is more challenging than prevention. Avoiding filling the tanks until as late as possible, combined with water sanitisation, frequent flushing, temperature monitoring and careful cleaning has meant that the frequent testing has not grown any unwanted pathogens. IPCT will continue to work with the Estates and Facilities teams to ensure best practice in maintaining the water system.

7.2. Decontamination

The Trust has established a Trust wide Decontamination Committee which meets quarterly to address any issues with decontamination of medical devices throughout the Trust, and to monitor the performance of the Trust's four sterile service departments (SSD's). A user group meeting is held quarterly for each site to review local issues associated with each SSD. There has been an ongoing issue with attendance which has been escalated through the divisions.

The Sterile Services Departments at RSCH & PRH are fully compliant with the UK Medical Devices Regulation 2002, annex V (sterility only) and has an auditable 'ISO 13485 Quality Management System: for Medical Devices'.

Audits of SSD's and EDUs are carried out on a regular basis by an external approved body on behalf of the MHRA. The SSDs are due an unannounced audit by the approved body, which is a requirement to have one at some point within a 3-year period.

All Sterile Services and Endoscope Decontamination units have ventilation concerns due to aged plant. Some plants are only operating <50% below the design specification and achieving inadequate pressure, air flow and air changes etc. There are capital plans in place to upgrade these systems.

7.3. Endoscopes

The endoscopy decontamination units (EDU) at all sites hold Joint Advisory Group (JAG) accreditation and ISO 13485:2016, these are carried out annually by an independent body independently from SSD.

On receipt of water test results the Trust policy for endoscopy is actioned by the Water Safety Committee, this involves endoscopy decontamination team, estates team, IPC, SSD management cascading the information to the rest of the group.

There is an identified risk with the shortage of trained estates team workforce to maintain the EDU's. Breakdowns have a significant impact on service provision. This has been escalated through Estates and Facilities.

8. Antimicrobial Stewardship

Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

Antimicrobial resistance has been identified as one of the biggest challenges to modern healthcare and is a 'One-Health' issue as identified by the WHO as having enormous social and economic impact. The UK Government 20-year vision sets out a number of national objectives to manage antimicrobial resistance including a need to demonstrate appropriate use of antimicrobials. This has been further developed in the 5-year action plan with specific targets to reduce antimicrobial consumption in both primary & secondary care. The current secondary care goal to reduce the proportion of broad-spectrum antimicrobials against narrow spectrum antimicrobials is challenging especially in the post-COVID era which has seen a significant change in infections seen and the burden of patients being treated in the NHS. The plan also includes targets for reducing unintentional exposure to antibiotics by effective infection control policies to prevent the need for using antimicrobials in the first place.

The trust employs 3 Antimicrobial Pharmacists (and 1 additional rotational post at RSCH) to oversee stewardship and guide the ward and departmental Pharmacists in appropriate prescribing practice to reduce overall use of antimicrobials. They support our Consultant Microbiologists who interpret and manage infection in patients presenting to the Trust and those who may acquire infection whilst under our care or potentially as an adverse effect of other treatments. This may include cancer patients who require antibiotics to prevent their own normal flora from causing infection when they have immunosuppressant therapies or manage the competing organisms of a patient in intensive care with many invasive devices.

There have been national workforce challenges including insufficient trained Pharmacists available in the marketplace which has continued over the last 12 months. This has both reduced the number of general ward Pharmacists reviewing charts, and also the pull of the Antimicrobial specialist Pharmacists away from stewardship work into core pharmacy service provision. There has also been a shortage of Consultant Microbiologists which has impacted on stewardship activities.

8.1. Antibiotic Consumption

Antibiotic consumption is reported using data from 'RxInfo'.

Standard contract target for 2022/23 was changed from a total antibiotic reduction to a reduction on the 'watch' & 'reserve' antibiotics as denoted by the WHO. The target was 4.5% reduction in use from the 2018 baseline (Defined Daily Dose (DDD) per 1000 admissions), a significantly more challenging target compared to last year:

- Whole Trust 2266 DDDs per 1000 admissions*: +15%. The target was to use less than 1877 DDDs per 1000 admissions (* this is not a finalized figure as the admissions data will not be confirmed until September 2023)

The ASG are still in the process of reviewing the data to establish the reasons for the increase in use. However confounding factors are expected to include:

- Ongoing COVID impacts both waves of infection leading to admissions for chest infections, particularly in the winter.
- Changes in the types of patients being admitted to hospital including the reduced number of elective (low antibiotic using) admissions and high levels of medical (higher antibiotic using) admissions. Also the extended stay of patients due to social care constraints leading to more hospital acquired infections.

- EUCAST recommendations to use increased dosages of antibiotics for some organisms will have contributed to increased usage of broad-spectrum agents in particular e.g. ciprofloxacin, ceftazidime and piperacillin-tazobactam for *P. aeruginosa* and ceftriaxone for *S. aureus*.

- Group A Strep outbreak – the Group A Strep outbreak in Dec22/Jan 23 put significant pressures on the antimicrobial supply chain and subsequent use of 2nd & 3rd line agents, some of which are 'watch' antibiotics due to unavailability of the 1st line 'access' antibiotics.

8.2. CQUINS

No antimicrobial CQUINS were undertaken in 2022-23. The Antimicrobial Pharmacists did complete data collection and evidence review for an IV to Oral CQUIN in development for 23-24. This CQUIN has been chosen as a national CQUIN and the Trust has adopted for 23-24.

8.3. Group A *Streptococcus* & COVID

Work to support the COVID medicines delivery unit at RSCH continued in 22-23 with a significant requirement for specialist Pharmacist advice from the antimicrobial Pharmacist at Brighton. There was significant input from pharmacy in the organisation and delivery of the COVID staff vaccination campaign.

All the AMPs were involved in supporting the local ICB EPRR response to the Group A Streptococcus outbreak in December 22-February 23.

8.4. ASG Meetings & Guidelines

Cross-site ASG meetings have continued and joint priorities and action plans have been agreed. Work to unify the empiric antimicrobial guidelines across the organisation has continued this year and an ongoing work plan of outstanding guidelines to unify has been put in place. ASG work has been impacted by the staffing challenges in both pharmacy and microbiology which has impeded progress this year.

Along with the IPCT, the antimicrobial stewardship team, plan to take part in the next national point prevalence survey of hospital acquired infection and antimicrobial usage in October 2023.

9. Provide Suitable Information on Infections

Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.

9.1. Results

The IPC Nursing team ensure all key results are communicated both internally and to external agencies as appropriate maintaining patient confidentiality.

The IT system (ICTrack) linking to the pathology laboratory at RSCH has been noted as a cyber risk on the Trust Risk Register. The system runs on an old unsupported Windows platform. It is beyond repair, poses a cyber risk, and there is a significant risk that all data will be lost. The ICTrack system has at times failed to give timely results for IPCT action. In one case a patient with MRSA was not notified and thus no suppression therapy was given. This patient later developed a bacteraemia which may have been preventable if the earlier result had been delivered.

Efforts were being made to improve the situation, however other priorities such as the procurement of a new Laboratory Information Management System (LIMS) has meant that no progress has been made. While the new LIMS will improve the situation, it will not be completed in the next year.

IPC reporting would benefit from a bespoke IPC software solution which could be used across the Trust. The employment of a skilled epidemiologist to the team will enable improvements to be made so that systems may be used proactively to identify risks and direct actions.

9.2. Information Leaflets & Posters

Information leaflets are available for staff to discuss with patients and the IPCT provides further support as requested.

During the COVID pandemic, the IPCT have made significant effort to ensure that the team are visible in clinical environments providing staff with training and education and giving the support they need throughout this challenging time.

The IPCT have continued to work with the communications team to ensure effective communication of important information to staff and patients to enable safe care and compliance with national guidance.

10. Systems to ensure care workers are aware of their responsibilities

Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

10.1. Link Practitioners

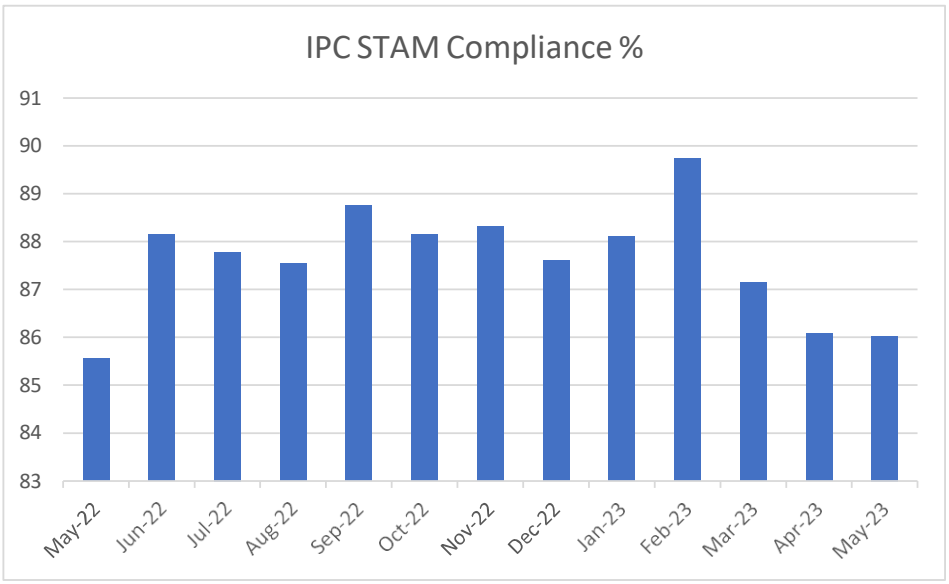
There are some identified Link Practitioners for Infection Prevention across the Trust, but this is an area for development. The link practitioners are local staff who can take a lead in embedding infection prevention into their clinical area.

This scheme has not been consistently supported and will become a priority for the team going forward with the new structure, so that we can help embed good practice across our clinical areas. We aspire to improve local understanding and interest in IPC which benefits the Trust as a whole by setting up a series of training sessions and improving the communications through increased ward presence.

10.2. Education & Training

All clinical and non-clinical staff members are given Infection prevention training on induction. Clinical staff members (including doctors) are trained annually in Infection Prevention and Control. Overall compliance is 87.6% (Figure 18).

Figure 18: IPC Statutory Mandatory Training compliance figures.



10.3. Hand Hygiene Audit & Observational Data

Monitoring of compliance to the WHO My 5 Moments of Hand Hygiene has been enabled across the Trust using the 'Tendable' audit application. Audits are carried out by named staff in each department. The average score recorded across UH Sussex was 95% from a total of 1279 inspections. The Tendable software is still in its infancy at SRH and WH. IPC staff are fully trained in its use and the Tendable team are supporting the ward staff (Figure 19).

Figure 19: Hand hygiene overall compliance April 22 to March 23

Hand hygiene validation audits have been carried out by the IPCT. Hand hygiene refresher training is carried out by team members to ensure theory and practice is embedded.

IPC technician Laura Servante-Holmes giving hand hygiene support on the Emergency Floor Ward at Worthing

10.4. Gloves Off

The inappropriate use of gloves has been identified as an area of concern. Observations have shown gloves worn for multiple tasks, gloves not being changed in between tasks and little hand hygiene in between glove use. Gloves also contribute significantly to plastic waste and thus have a negative environmental impact.

Staff have been reminded that gloves should be worn as a standard precaution as per pre pandemic guidance. The IPC team is supporting the 'Gloves Off' campaign supporting the Trust wide message to use gloves only when they are really needed (Figure. 20).

Figure 20: Trust 'Gloves Off' infographic

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11. Adequate Isolation Facilities

Provide or secure adequate isolation facilities.

11.1. Provision of Isolation Facilities

The Trust maintains a reasonable proportion of single rooms for source isolation of patients with infection across all sites. The new Louisa Martindale Building at RSCH is equipped with 60% single rooms including 10 isolation rooms in the new infectious diseases' unit and the Intensive Therapy Unit.

Appropriate signage is used throughout the Trust depending on the type of isolation required. Signage has been reviewed several times due to the COVID pandemic.

Nurses and other clinical staff are regularly updated through mandatory and other training on key aspects of isolation.

Where there are difficulties in locating a single room, risk assessments are used to determine priority.

11.2. Ventilation

Specialist Ventilation has always been a high priority at University Hospital Sussex and the IPCT work in conjunction with the Estates Team, to ensure that systems are monitored correctly. There are frequent planned maintenance and annual external verification required for all operating theatres, sterile services department, pharmacy and endoscopy units.

Since the emergence of the COVID pandemic, ventilation has been recognised as one of the most important contributing factors to ongoing transmission of infection. A key part of the national approach has been focused on the fact that transmission is less likely outdoors and in well-ventilated and uncrowded spaces, than in crowded, poorly ventilated, and indoor spaces.

The role of ventilation is recognised as an important element in the hierarchy of controls and the ventilation, and the quality of air supplied to all hospital areas has come under scrutiny 'Ventilation should be integral to the COVID risk mitigation strategy for all multi-occupant buildings and workplaces. This should include identification of how a space is ventilated and articulation of the strategy that is adopted to ensure the ventilation is adequate'.

University Hospital Sussex has 7 main geographical sites, all built in different years with building additions and reconfigurations over many decades. Not all areas are compliant to the 'Health Technical Memorandum 03-01 Heating and ventilation of health sector buildings' guidance, for which most clinical areas are required to have 6 air changes every hour. Some parts of the trust including wards at Princess Royal, and Worthing fall well below this standard. This situation will be found in many if not

most UK hospitals. Rectification work to meet desired standards would require millions of pounds of capital investment and cause significant disruption. The new LMB has compliant ventilation throughout.

To mitigate and improve air quality, additional 'air scrubber' machines have been purchased. These are machines with a HEPA filter which removes particles in the air, so while not suppling fresh air, they very effectively clean the air in a room and have been felt to be very beneficial in helping prevent or control COVID outbreaks.

Air Scrubber in place at St Richards Hospital

12. Laboratory Support

Secure adequate access to laboratory support as appropriate.

Clinical Pathology Accreditation (CPA) accredited microbiology services are provided on site at both RSCH and SRH.

The IPCT act upon email alerts from the microbiology lab for key organisms and conditions to ensure information is appropriately communicated.

Microbiology results are also available to IPC staff via different methodologies. On SRH and WH sites microbiology communicate to IPC via an excel database (manual process), email or telephone call. On RSCH/PRH sites microbiology communicate to IPC via a system called ICTrack.

As noted in 4.1 above check, there remains an urgent need to update the IC Track IT systems used by the IPCT at RSCH and PRH as these are dependent on an old computer which is a cyber risk. There is also a shortage of Microbiology consultant cover across the Trust, particularly at RSCH/PRH, which has impacted on timely sign off of results.

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13. Policies to Prevent & Control Infections

Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.

13.1. Policy Provision

The IPCT has merged all policies from the legacy trusts. All policies are maintained on the Trust intranet. They are subject to three yearly review or sooner if there is change to national guidance (Table 9). Policy information including new changes is communicated to staff via mandatory training, via the senior nurse meetings and via the comms team.

A new national IPC manual was being issued from NHSE/I. There is a link to the manual on the trust intranet. All our IPC policies are in line with or exceed the national policy.

Table 9: Policies approved in 2022-23

Code	Policy Title	Review Date	Code	Policy Title	Review Date
UHSC049	Viral haemorrhagic fever policy	01/06/2025	UHSIC010	Blood Borne Virus Policy (Management of Sharps Exposure Incidents & HIV Post Exposure Prophylaxis)	01/11/2025
UHSC059	Blood Culture Collection Technique Policy	01/06/2025	UHSIC011	Management of Tuberculosis	01/03/2025
UHSIC001	Organisational and assurance framework for infection prevention and control	01/06/2025	UHSIC012	Aseptic Technique	01/06/2025
UHSIC002	Standard Infection Control Precautions	01/03/2024	UHSIC013	Respiratory Viruses	01/12/2025
UHSIC004	Isolation of Patients Policy	01/03/2025	UHSIC014	Creutzfield Jacob Disease (CJD) and variant CJD	01/09/2025
UHSIC006	Decontamination Policy	01/10/2025	UHSIC017	Prevention of Apergillosis and infection from other fungi during demolition/construction and renovation activities	01/06/2025
UHSIC007	MRSA Policy	01/10/2025	UHSIC018	Infestation Policy	01/06/2025

UHSIC008	Clostridium Difficile Policy	01/10/2025	UHSIC020	Control of multi drug resistant (MDR) organisms (including glycopeptide-resistant enterococci (GRE))	01/06/2025
UHSIC009	Norovirus Policy	01/01/2025	UHSIC026	Management of a Patient's Body Following Death with an Infection Policy	01/06/2025
UHSTW015	Outbreak Management of Healthcare Associated Infection (HCAI) Policy	01/09/2026	UHSIC027	Surgical Instrument Loan Policy	01/06/2025
UHSTW014	Animals and Pets in Hospital	01/06/2025			

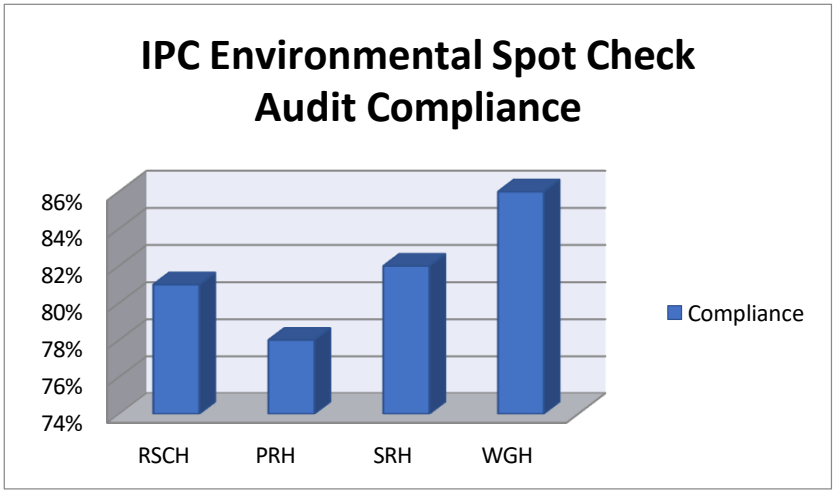
13.2. Audit Reporting

IPCT audit feedback is given directly to clinical/department staff at the time of the audit. This timely feedback allows praise to be issued in addition to taking immediate rectification actions. Audit data and outcomes, including hand hygiene validation compliance, is shared in the monthly IPOG report and quarterly TIPC report. The full audit plan for 2023-24 is in appendix 3.

Over the course of 2022 to 2023 audits have migrated to the Tendable electronic platform. This has enabled audit tools to be embedded for use at ward level by the clinical staff as well as by IPCT members. Use of Tendable ensures consistency and accuracy for feeding back to the clinical teams, monitoring actions taken and taking learning opportunities forwards.

The IPCT aim to undertake a monthly Environmental spot check audit, in conjunction with the facilities and lead nurse, for all inpatient areas. This audit enables the IPCT to monitor compliance with IPC policies and benchmark the status of each area audited (Figure 21)

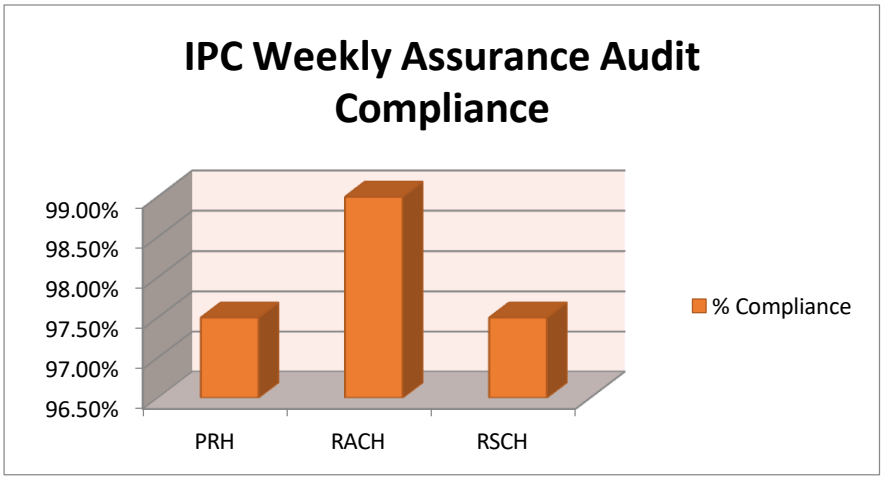
Figure 21: Monthly IPC spot checks completed at RSCH, PRH, SRH and WH



During 2022 to 2023 RSCH, RACH and PRH hospitals completed IPC weekly assurance audits (Figure 22). These audits were performed by the Ward manager/Matron/Nurse in charge of the area enabling them to regularly review aspects of Infection Prevention and Control in their area and facilitate senior staff to act on any issues identified.

This audit has been widened to include the whole Trust for 2023 -2024.

Figure 22: IPC Weekly assurance audit compliance



Planned audits for 2023-24 can be found in appendix 3.

14. Occupational Health

Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

14.1. Occupational Health Service

The Occupational Health (OH) service is an in-house service for RSCH and PRH, while a contractor called 'Team Prevent'; provide services for SRH and WH.

OH work alongside the IPCT to ensure that any staff concerns with regard to infection are appropriately addressed so that the staff are safe and feel supported in their work. This is particularly notable with issues such as sharps injury prevention, risk assessments, hand skin integrity and vaccination for infection.

14.2. Seasonal & Pandemic Influenza Planning

The Occupational Health Department and IPCT also work closely in planning the seasonal flu prevention campaign.

14.3. Face Mask Fit Testing

Fit testing of a filtering face piece 3 (FFP3) respirator mask is a mandated service to be provided every 2 years in line with NHSE resilience principles.

The trust needs to provide fit testing of FFP3 respirators to its clinical staff including nurses, doctors, physiotherapists, speech and language therapists, ward-based cleaning staff and other ad hoc staff. Priority areas are emergency departments which may see untriaged patients with respiratory conditions including COVID, Flu or TB. ITU staff, respiratory ward, and medical ward staff, and those undertaking chest physiotherapy or undertaking speech and language assessments. Cleaning staff may be expected to clean rooms housing isolated patients.

Failure to provide fit testing service may put Trust staff at risk of infection from respiratory pathogens, and there is also risk of prosecution of the Trust by the Health and Safety Executive (HSE)

A government funded programme of fit testing was in place across UH Sussex up till the end of March 2023. From April 2023 the Trust must provide its own service in line with 'NHS resilience principles'. A business case has been agreed in principle pending identification of funding.. Pending finance, there are 3 bank fit testers in place.

Despite best efforts the overall fit testing compliance remains low. In areas where staff are likely to care for COVID infected patients such as ITU, the compliance is much higher.

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Figure 24: NHS resilience Principles

FFP3 Resilience Principles in acute settings

1. All FFP3 users should be fit tested and using at least two different masks (ideally three)
   - UK Make masks will be used for all new Fit Tests (high supply resiliency and excellent fit test performance) when appropriate for the individual
   - Fit testing will be repeated at least every two years
2. FFP3 users should interchangeably wear the masks they are fit tested.
   - Mask rotation reduces the risk of skin damage and other conditions linked to extended PPE use and allows users to build familiarity with several FFP3
3. Trusts should ensure that a range of FFP3 masks are available to users on the frontline and overall should not exceed 25% usage on any one type of FFP3
   - This supports user ability to rotate masks and wear the mask that is right for them
4. Frontline stocks will be managed at no more than 7-10 days per SKU
   - This ensures that stock rooms have enough space to hold a wide range of FFP3 and more UK Make is available
   - High local stockpiles of FFP3 that have been stored due to previous ordering/delivery arrangements will be considered for uplift or redistribution
5. Trusts will register FFP3 users and fit test results in ESR and review individual usage every quarter
   - This ensures all users and their fit testing evidence is freely available and action is taken to support individual resilience

Staff member being fit tested, using a PortaCount machine.

15. Priorities for 2023-24

The following are highlighted as the key priorities for 2023-24. The full work plan can be found in Appendix 2. and Audit Plan.

- Mature the new IPC staffing structure enabling a proactive approach to further embed effective IPC into clinical practice.
- Further develop SSI surveillance program to enhance safe surgery.
- Improve the clinical review process for reportable infections, to enhance learning and future initiatives.
- Roll out of a trust wide ‘mouth care matters’ initiative, to improve patient

comfort, dignity and reduce pneumonia infection.

- Work with sustainability team to reduce glove usage and look at how effective IPC can help deliver our Trust green plan.
- Work with Estates and Facilities in the delivery of phases 2 & 3 of the RSCH development

16. Conclusion

The Trust can demonstrate compliance with requirements of the Hygiene Code across all its sites. This is demonstrated in the Board Assurance Framework (appendix 1).

The IPCT continues to work with staff across UH Sussex in a collaborative way to ensure Infection Prevention is fully embedded in everything we do so that our patients and staff are protected from avoidable infection. The success and importance of the team was recognised in winning the Patient First Star Award for Clinical Team of the Year (May 2022, see below).

University Hospitals Sussex NHS Foundation Trust

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1) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/928720/S0789_EMG_Role_of_Ventilation_in_Controlling_SARS-CoV-2_Transmission.pdf

2) https://www.gov.uk/government/publications/guidance-on-specialised-ventilation-for-healthcare-premises-parts-a-and-b

3) Jones, B. et al. (2020)'Modelling uncertainty in the relative risk of exposure to the SARS-CoV-2 virus by airborne aerosol transmission in Buildings', Preprint at Research Gate. Doi: 10.13140/RG.2.2.25874.89283

4) NHS England » National infection prevention and control manual (NIPCM) for England

5) Coronavirus » FFP3 resilience principles in acute settings (england.nhs.uk)

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Appendix 1: IPC Board Assurance Framework – May 2023

Infection Prevention and Control board assurance framework v0.1						
	Key Lines of Enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Comments**	**Compliance rating**
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them						
Organisational or board systems and process should be in place to ensure that:						
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	The Executive DIPC is the chief Nurse. There is a board level Associate DIPC to manage day to day DIPC responsibilities of a big Trust. IPC Team Structure refreshed and expanded in 2022. There is a Trust Infection Prevention and Control Committee (TIPC) with terms of reference, annual programme of work and an annual report. There is a monthly operational group (IPOG). TIPC feeds into the Quality Governance Steering Group (QGSG), Trust Management Committee (TMC) and The Quality Committee(QC). All meetings above are minuted.				3. Compliant

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1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	IPOG, TIPC, TMC and QC minutes. Trust DIPC Annual Report. A monthly dashboard is compiled from DCS data by BI and a Power BI report is in development. A risk register is held and reviewed regularly with risks escalated through TIPC and QGSG.				3. Compliant
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	IPOG, TIPC, minutes. Risk register, SIRG and DATIX reports. PowerBI reporting will further improve focus to provide assurance and direct action for improvement.		Working to improve PIR process, better capture learning and monitor outputs		3. Compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	IPOG, TIPC, minutes. All IPC policies for the Trust are available on the intranet. Policies from Legacy trusts now merged. None contradict national policy and they all enhance going over and above the basic national policy. link to the NIPCM on the Trust intranet. Hyperlink within specific policies.			NIPCM is referenced in Trust policies which are more comprehensive. Work ongoing to ensure standardisation of audit practice among IPC team and others undertaking audits and validation audits of other auditors.	3. Compliant

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1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	SSI surveillance in place. Mandatory data surveillance in place and reported via UKHSA Data capture System (DCS). Results reported in TIPC reports. IPOG, TIPC, Trust Board and Quality Committee minutes show review and discussion of results with action planning as appropriate.	Comprehensive Surveillance of alert organisms or alert conditions not achievable due to current lack of surveillance data captures systems. Limited surveillance of mandatory alert organisms only due to current manual data collation and data entry with excel spreadsheet in place which is at risk from transcription error or missed data input. Paper based system for surveillance may lead to errors in reporting therefore lengthy triangulation of data to ensure accuracy, which impacts significantly on IPN time resources and therefore limiting ward based clinically focused work. Shortage of Microbiology staff to support early identification of infection.	Working with business intelligence Team (BI)to improve capture of data. Plan to employ a data analyst as part of IPC team. The role will include looking at systems to improve productivity and give strategic direction.	Improve summation of data with detailing of relevant actions to be taken. Risk register notes cyber risk from micro lab reporting system which is unreliable. Micro lab staffing at RSCH and the LIMS often cause delay to specimen results.	2. Partially compliant

1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	IPC Team Structure. SSI Data. DCS data. Quarterly IPC reports. Annual Report. TIPC Terms of reference. IPOG, TIPC, Trust Board and Quality Committee minutes. Audits carried out on 'Tendable' system. Results collated for reporting through TIPC. Regular senior IPC walkabouts with Hospital directors of Nursing, DDoNs, heads of Nursing to identify issues and initiate actions.				3. Compliant
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	STAM records. Face to face induction reinstated post pandemic. Other STAM on-line. Training programme currently covers mandatory infection control and complies with new national guidance . Planning in place to start a Link Practitioner forum in Autumn 2023 with Study day on 27/9.	Don't currently have an annual refresh for ANTT/IV care which might help improve care. No Link Practitioner Forum.	IV policy in place	Implement a programme of mandatory training and assessment for ANTT for relevant healthcare professionals	3. Compliant
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	HoC assessments were completed in 2021/2. Risk register, IPOG and TIPC Minutes demonstrate review of risks. Previous BAFs. Notes from Clinical Advisory Group (CAG) show risk assessments regarding PPE during pandemic. MRSA screening in place for high risk patients including orthopaedic and cardiac implant surgery to enable patient placement and management.				3. Compliant

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2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
System and process are in place to ensure that:						
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	Cleanliness audits. Score on doors. PLACE results. IPC environmental spot check audits undertaken regularly in key clinical areas. Facilities team supervisors undertake weekly audits.	Issues with the fabric of the estate. These may impact on the effectiveness of cleaning processes. Significant maintenance needed in clinical areas to repair damage to floors and walls. Some reconfiguration to improve storage in clinical areas also required.	Discussion with Estates and operational teams to initiate repairs as soon as possible	Slow to progress	3. Compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	Records of PLACE visits. PLACE results. E&F SDR meeting minutes. IPC have a weekly facilities meeting. Regular IPC /F&E correspondence. Spot check audit feedback.				3. Compliant
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	IPC and F&E policies detail necessary steps and responsibilities. Regular team meetings. IPOG and TIPC minutes.				3. Compliant

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2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	Monitoring in place as per recommendations. Minutes of water, ventilation and decontamination committees. IPOG and TIPC minutes. Water Safety Plan. External AE Water contracted.	Ventilation in some parts of the trust is below HTM standards. There are issues with provision of hand wash basins. Many of them are non-compliant with HTM standards, many are also aged and damaged.	Priority areas identified by IPC have been reviewed. Non-compliant ventilated areas are mitigated with air scrubbers with HEPA filter, opening windows and where possible not using for respiratory positive patients. It is not possible to 'not use' these areas as they are required for clinical capacity Estates team prioritising assessment of existing ventilation with plans for upgrades as appropriate. Purchase of further air scrubbing units is planned. Estates are commissioning work to do a detailed review of ventilation across the sites. This is a major cost.	New LMB greatly improves situation at County as Barry building demolished. Princess Royal has little ventilation. Requests have been made for detailed assessment but this has not been actioned by capital due to cost. Necessary remedial work will be in the millions. Hence use of airscruber devices. Worthing Hospital and St Richards also need a fuller assessment in clinical areas. Need to improve the attendance at Decontamination User Committee level to ensure relevant feedback can be actioned.	2. Partially compliant

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2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	Minutes of water, ventilation and decontamination committees. IPOG and TIPC minutes. Notes from capital building projects including stage 1 and 2 of 3Ts.	Areas which need PPM have been identified but there have been delays in actioning due to operational pressures These issues impact on the effectiveness of cleaning process. There is a significant backlog of works on all site. Floors on wards at St Richards are particularly poor. Fabric of wards at Worthing needs work, and fabric in the TKT at RSCH needs attention. Some reconfiguration to improve storage in clinical areas also required.	Estates working with IPC to devise plan	Difficult to progress	1. Non-compliant
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	New state of the art laundry opened at SRH in 2022. Linen from RSCH and PRH to going to SRH from May 2023.	Some issues with laundry cupboards including non-compliant shelving.	Plan to replace non-compliant shelving with proper trollies.		3. Compliant

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2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non- NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	IPOG minutes. Waste officers in place. Regular F&E meetings including SDR. Duty of care visit records (undertaken by waste officers). Sustainability group look at recycling and waste reduction.				3. Compliant
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	Minutes of Decomtamination user group meeting and Trust wide decontamination committee. Endoscopy user group meetings. Validation standards verification documents for the 4 CSSDs. IPOG and TIPC minutes.	Poor attendance at user group meetings. Lack of planning for scope decontamination in the new urology centre at PRH			3. Compliant
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.	F&E records. PLACE assessment				3. Compliant

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3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
Systems and process are in place to ensure that:						
3.1	If antimicrobial prescribing is indicated, arrangements for antimicrobial stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated.	AM Stewardship Committee Minutes. AMS leads across Trust				3. Compliant
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	AMS leads across Trust prepare reports on progress. EPMA in place across site. AMS activity is reported at TIPC and through to QC.				3. Compliant
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan.	DIPC				3. Compliant

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3.4	NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' or Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET) are implemented and adherence to the use of antimicrobials is managed and monitored: • to optimise patient outcomes. • to minimise inappropriate prescribing. • to ensure the principles of Start Smart, Then Focus are followed.	AMS reports and minutes	Not all wards have a pharmacist. Auditing could be more frequent if staffing allowed. More education could be provided to staff especially prescribers.	Business plans for more pharmacy staff	Aim to have at least one pharmacist for every ward	2. Partially compliant
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: • total antimicrobial prescribing. • broad-spectrum prescribing. • intravenous route prescribing. • treatment course length.	AMS reports and minutes. Audit reports from AM pharmacists.				3. Compliant

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3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)	Pharmacy structure	Some wards do not have their own pharmacist and thus may be missing out on AMS advice.	Pharmacy business case re staffing		2. Partially compliant
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion						
Systems and processes are in place to ensure that:						
4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	Work with patient engagement team. Information leaflets. Posters	Need to review GP letters			3. Compliant
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (eg digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	Information leaflets. Posters				3. Compliant

4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	Information leaflets. Posters. Website				3. Compliant

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4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: • hand hygiene, respiratory hygiene, PPE (mask use if applicable) • Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (eg cleanliness) • Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. • Provide published materials from national/local public health campaigns (eg AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.	Information leaflets. Posters. Website. Trust policies. IPC team presence on wards to support patients and staff. Trust's communications team have been posting updates to the UHSussex media pages inclusive of keeping the internet up to date. Within trust sites information is clearly displayed, surgical face masks and alcohol gel dispensers are readily available at all entrances.				3. Compliant

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4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	Catheter passport introduced. Discharge information.	Need to audit discharge information			3. Compliant
5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.						
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:						
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	IPC policy. Swabbing protocols in place. ED staff aware to look out for signs of infection. MRSA screening in place for high-risk patients including orthopaedic and cardiac implant surgery to enable patient placement and management. CPE screening carried out for high risk patients as per policy. SSI surveillance established.	Issue with timely lab reporting at RSCH on occasion due to LIMS and staffing. Could benefit from a wider CPE screening protocol but hindered by lab capacity Would benefit from MSSA screening of orthopaedic and cardiac surgery patients as this is more likely pathogen for SSI. This is prevented by lab capacity.	Instigation of pre-operative skin prep and nasal suppression for selected Pre-op e.g orthopaedics or cardiac with implant. SSI review panel. OneTogether SSI group meeting to review practice in multidisciplinary forum.		2. Partially compliant

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5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes.	Daily operational bed meetings with IPC attendance, IPC outbreak meetings. MRSA screening for high risk patients e.g implant surgery	Shortage of side rooms and significant operational pressures can make prompt isolation difficult to maintain at all times.	IPC work closely with site teams to manage patient moves. New LMB brings a big improvement to side room and isolation provision at RSCH site.		3. Compliant
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	Patient discharge records				3. Compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	ED entrances. Trust policy				3. Compliant
5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	Investigation reports and action plans. DCS data. Typing results. IPOG and TIPC minutes. Datix records. SSI surveillance established across the Trust.				3. Compliant

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6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection						
Systems and processes are in place to ensure:						
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	Induction and STAM programme in place. STAM records				3. Compliant
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	Training records. Policy audit of practice e.g hand hygiene, sharps disposal and commode cleaning.				3. Compliant
6.3	Monitoring compliance and update IPC training programs as required.	STAM records				3. Compliant
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	Fit testing recorded on health roster. Business case for fit testing service.	Despite effort, not all staff are fit tested	Effort to prioritise high risk staff for fit testing. Testers on each site.		2. Partially compliant
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	Fit testing recorded on health roster.	Despite best efforts it is difficult to get all staff through testing and compliance is not as high overall as required.	Priority given to higher risk staff e.g ED, respiratory medicine, anaesthetics.		2. Partially compliant

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6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	Competency assessment records. Practice development team records.	Oversight and audit of records is unclear. Don't currently have an annual refresh for ANTT/IV care which might help improve care. Need to implement a programme of mandatory training and assessment for ANTT for relevant healthcare professionals		Area for development in conjunction with Practice Development Team	2. Partially compliant
7. Provide or secure adequate isolation precautions and facilities						
Systems and processes are in place in line with the NIPCM to ensure that:						
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	Swabbing protocols in place. ED staff aware to look out for signs of infection (e.g rash or PUO) and isolate as per policy		Regular review of poster information e.g Measles identification.		3. Compliant

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7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: • single rooms are in short supply and if there are two or more patients with the same confirmed infection. • there are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	IPC work with site teams to prioritise beds. Daily IPC attendance at operational bed meetings. Patients cohorted where required. IPC involvement in 'boarding' or escalation bed plans to ensure safety. New LMB has 60% side rooms which will increase capacity significantly. LMB also provides 10 rooms with positive pressure ventilated lobbies.		Risk of crowding in ED has to be balanced with risk of boarding extra patients in wards.		3. Compliant
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	IPC policies. IPC audits of care. Isolation posters.				3. Compliant
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	Patient discharge records				3. Compliant

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8. Provide secure and adequate access to laboratory/diagnostic support as appropriate						
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	Accredited microbiology labs on site at Worthing, St Richards and RSCH	Short staffing of microbiologists, particularly significant at RSCH.	Mitigated at SRH and WH with locums		3. Compliant
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	Labs on site. IPC policies. Records of IPC team reporting and actioning key results	Outdated LIMS which is due for upgrade	Sussex wide LIMS due for roll out later in year		2. Partially compliant
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	Pathology system in place.	There are some issues with reporting from the lab at RSCH to IPC. These have been flagged on risk register. This may occasionally lead to delay in resulting and therefore impact on timely treatment of the patient.		This has been escalated on the risk register with no progress.	2. Partially compliant

8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	Trust and lab policy. MRSA screening of high risk patients including orthopaedic and cardiac surgery, ITU, Haem-onc and renal.	Need to screen implant surgery patients for MSSA but no capacity in lab	Use suppression regime to reduce risk at time of surgery		3. Compliant
8.5	Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	Relevant testing undertaken. Checks by internal audit team.				3. Compliant
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high- risk pathogens.	Weekly formal clinical meeting with IPC and micro colleagues to discuss pathways and approaches to current and evolving situations.				3. Compliant
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	Trust and lab policy. Clinical Advisory Group (CAG) of relevant multi-disciplinary clinicians established during COVID pandemic.				3. Compliant

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9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						
9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA, A to Z pathogen resource, and the NIPCM). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider.	Policies all updated since merger and available on intranet.				3. Compliant

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10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:						
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	Assessments carried out by managers and Occupational Health Team OH provision at SRH Worthing by TP Health and in house at RSCH/PRH. FFP3 Fit testing available to book on all sites.			Plans in place for HR to look at a single trust wide service.	3. Compliant
10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	IPC work with OH and HR to ensure staff confidentiality while giving relevant advice.				3. Compliant
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	OH records.	OH relies on paper records for RSCH/PRH, awaiting an electronic system			3. Compliant

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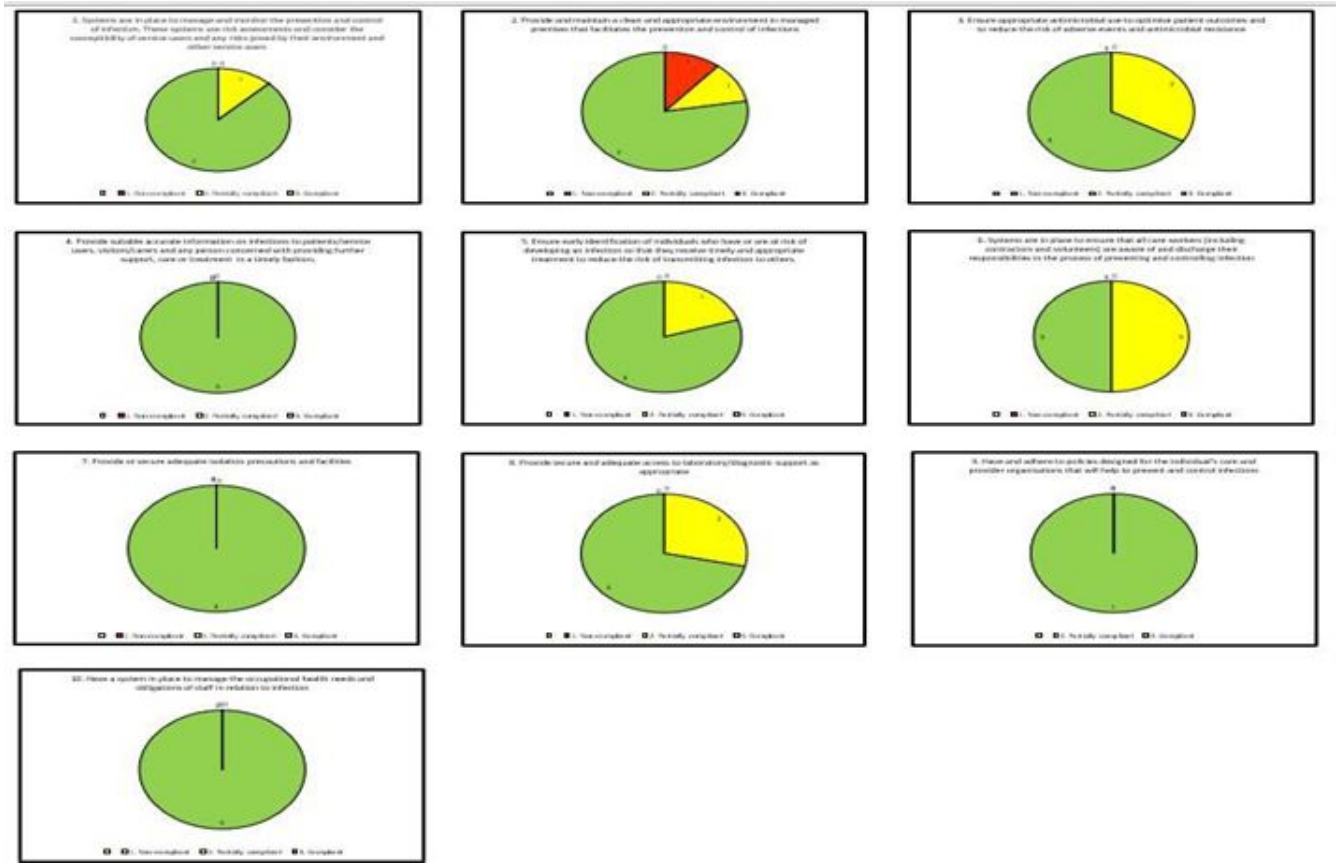
Figure 3 BAF Summary Plots



Appendix 2: IPC Work Programme Summary 2023-24

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Objective	What we need to do	How we recognise success
Establish a Link Practitioners scheme	Set up a link practitioner programme with training programme and dedicated clinical time	Active 'Link practitioner' programme with training in place and good attendance at sessions.
Establish 'Mouthcare Matters' programme	Launch 'Mouthcare Matters' initiative with SALT Introduce hydration initiatives.	'Mouthcare Matters' rolled out across Trust with MDT and cross site engagement, improved hydration and reduced E.coli bacteraemia.
Support sustainability initiatives including 'GlovesOff'	Support Gloves off campaign Work with sustainability team on other initiatives to reduce waste	Reduced glove usage across Trust
Reduction of Key Infections	Invest in PowerApps solution for data capture Participate in national point prevalence survey 2023 Use analyst to look for trends and identify areas for improvement. Work with lab to improve arrangement for CPE screening Review the clinical review process and learning	Meet and improve on national IPC Targets with improved learning from clinical review process
SSI reduction strategy	SSI prevention review using OneTogether Framework Strengthen SSI reporting process	Robust and efficient SSI Surveillance programme in place. SSI results within expected range or lower
Continue to strengthen and develop the IPC Team	IPC attendance at conferences and study days to develop learning Improved cross site working	Fully resourced team with low sickness and attrition
Education of Trust clinical staff	Ward based education, support and learning	Audits show good adherence to policy Low rates of infection
Continue to work with Estates to effect improvements across the trust	Audit of air flows in clinical areas Review options for enhanced ventilation Work with Capital projects and estates to ensure highest standards of ventilation, water safety and environmental decontamination for new builds	Improvements in ventilation Improvements in infrastructure including sinks. Planned preventative maintenance in place. Water testing in place with appropriate actions.
Quality Improvement Initiatives	Use new structure to embed a robust audit process for key metrics	Full audit programme completed with action planning and quality improvement initiatives driven forward
Driving antimicrobial stewardship	Work proactively with AMPs to increase awareness of AMR	Audits to demonstrate improvements in prescribing practice.

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Appendix 3: Infection Prevention & Control Planned Audit Programme 22-23

AUDIT	INTERVAL	COMPLETED BY	RESPONSIBLE
IPC Weekly Assurance Audit	Weekly	Ward Sister/Charge Nurse	Ward Sister/Charge Nurse/ Matron
PLACE	Weekly	NIC/IPC/Facilities/Estates/ Volunteer (Patient rep)	Facilities site lead
Hand Hygiene	Monthly	Ward staff/Link practitioner	Ward Sister/Charge Nurse
IPC Environmental Spot check audits	Monthly	Ward NIC/IPC/Facilities	Ward/area and IPC site Matron
Commodes	Monthly	IPC Team	IPC site Matron
SSI surveillance	Monthly	SSI Team	Surgical Divisional Site Lead
Ventilator associated pneumonia	Monthly	Ward Sister/Charge Nurse	Ward Sister/Charge Nurse
MRSA Screening	Monthly	IPC Team	IPC site Matron
Hand Hygiene Validation audits	Quarterly	IPC Team	IPC site Matron
Antimicrobial Prescribing	6 monthly	Pharmacist	Lead Antimicrobial Pharmacist
Full IPC environmental audit	Annual	IPC Team	IPC site Matron
Sharps	Annual	Sharps bin provider	IPC site Matron
Decontamination- Endoscopy	Annual	Endoscopy Team leads	Decontamination site Leads
Operating Theatre	Annual	IPC Team	IPC site Matron

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Mortality & Learning from Deaths Report

Quarter 1

1st April – 30th June 2023

Contents

Learning from Death

Introduction

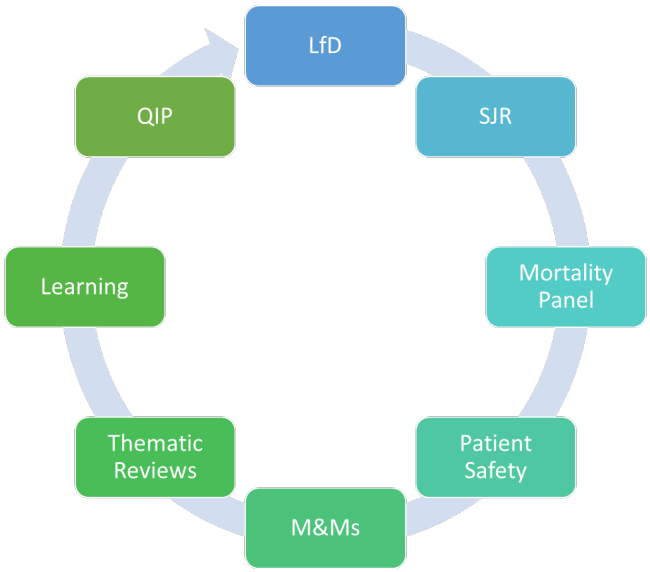
Dying is a natural event for everyone and not every death requires a review or investigation. However, when things do go wrong or the care provided does not meet the standards expected, University Hospitals Sussex NHS Foundation Trust (UHSussex) have processes in place to review and/or investigate what went wrong; be open with families and loved ones and learn from what went wrong. Similarly, identifying good practice and excellence in care that can also be shared, celebrated and learned from.

Quarterly Reports – Quarter 1

In 2019 Brighton & Sussex University Hospitals merged with Western Sussex Hospitals to create a new University 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 June 2023. As the first report for the new aligned Learning from Deaths Programs, it also provides details of the new processes along with our aims and objectives for the remainder of the year (April 2023 – March 2024). Appendices

Mortality Processes



Aligning the Mortality & Learning from Deaths Programs

Aligning the Mortality & Learning from Deaths Programs continues to develop. Phase one completed 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 enables 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 is then 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 Patient Safety through uploading to 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 excluded from the 90 day target.

Structured Judgement Reviews – The Aligned Process

Completion of phase one of aligning the Learning from Deaths programs introduced a new pathway for processing Structured Judgement Reviews (Diagram 1).

The process was piloted (excluding patients with a learning Disability) at all UHSussex hospitals in June 2023 and was successfully embedded.

During quarter two (July – Sept 23) it is anticipated that three SJR reviewers will be appointed and trained in SJR methodology at RSCH and PRH. Once the new dedicated reviewers are successfully trained, administration staff will be required to process a weekly Mortality Panel and SJRs using the new pathways. Once administration staff have been appointed, RSCH/PRH and WGH/SRH will become fully aligned in their LfD processes.

Phase two will commence with recruitment of administration and Project Management staff to facilitate the planned projects.

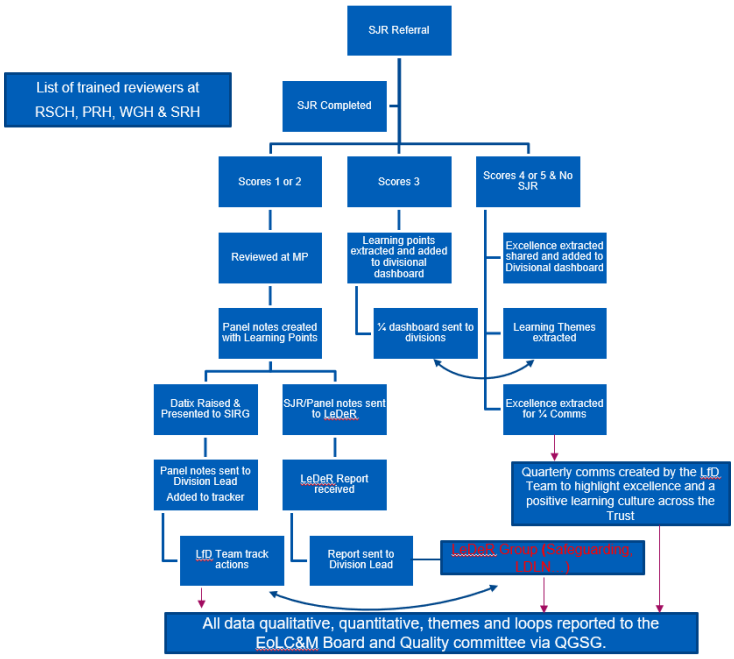
- Engagement with Mortality and Morbidity Meeting leads to develop a standardised module on the Panda IT platform that feeds into the LfD module to provide a closed loop feedback system. This system will enable M&M leads

to access SJRs, Mortality Panel outputs, LeDeR Reviews and recommendations for learning.

- Development of a monthly Learning Disabilities (LD) Mortality Panel to review all SJRs carried for patients with a LD.
- Quarterly thematic reviews will be conducted to support Trust wide learning and increase engagement with divisions.

To commence and achieve successful implementation of phase two, further recruitment of administrative and Project Management staff is required.

Diagram 1



The Aligned Process - Summary of Activity during Quarter 1

Progress continues towards full alignment of the Mortality & Learning from Deaths programs across all UHSussex hospitals and roll out of the statutory Medical Examiner service for all community and acute hospital deaths.

Community Roll Out of the Medical Examiner (ME) Service continues to progress at pace in preparation of the statutory mandate in April 2024.

Recruitment of a further 8 PAs of ME activity were in progress at the end of June 2023. Further Medical Examiner Officer (MEO) recruitment has been achieved with three new MEOs successfully appointed in June 2023.

In preparation of the statutory scrutiny of all community deaths, GP Medical Examiners have been recruited at each Medical Examiner Office at UHSussex. GP MEs continue with reaching out to onboard two GP Practices per week.

All UHSussex Medical Examiner Services are making good progress and are on target to achieve the statutory deadline of 1st April 2024.

Phase one of alignment has achieved a single point of access and collation of Mortality data between the Medical Examiner Service and the Learning from Deaths Service producing information that is starting to deliver robust meaningful outputs to support the Trust to embed learning from deaths.

SJR Reviewer Recruitment commenced in June 2023 and development of a Mortality Panel at RSCH and PRH to review all SJRs that identify poor or very poor care is aimed to commence at the start of quarter 3 (October/November 2023).

Recruiting dedicated reviewers at RSCH and PRH aims to increase the number of SJRs that are completed in a timely manner, at RSCH and PRH as well as support thematic reviews and wider Quality Improvement plans.

SJR backlogs occurred during to a period on inactivity in 2022 when a significant vacancy rate existed within the Clinical Outcomes and Effectiveness team. A plan of action to reduce the backlog of 281 SJRs and prevent future backlogs is currently being explored.

Risks and bottlenecks have been identified with plans and actions being taken.

The Medical Examiner Service and teams continue to increase in size and workload resulting in a requirement to increase the office space. This has been identified as risk.

- **WGH** – Larger office space to accommodate the team is being explored. This is an outstanding risk.
- **SRH** – Adequate office space has been allocated and office equipment has been sourced.
- **RSCH** – Adequate office space has been identified. The team are awaiting confirmation of a date to move offices. Office equipment will need to be sourced once the move is complete. This is an outstanding risk with mitigation that an office has been identified.
- **PRH** - Adequate office space has been allocated and office equipment has been sourced.

Industrial Action (Strikes) resulted in three patients' death not receiving ME scrutiny at WGH during the first strike week in April 2023. Business continuity plans were followed and all three patients were subjected to MEO pre-scrutiny and MEO call to the Next of Kin (NOK). No concerns were identified for these patients.

Scrutiny at RSCH and PRH was lower than previous quarters due to industrial action. Business continuity plans are currently being developed to ensure ME cover at both Medical Examiner Offices during periods of reduced medical staffing such as industrial action, sickness, or annual leave.

Alignment of the Learning from Deaths Programs included Gap Analysis and review of the processes across all of UHSussex.

Delivery of a UHSussex fully aligned Learning from Deaths service requires resource. Resource has been identified for the Learning from Deaths portfolio in the new structure of the Clinical Outcomes and Effectiveness workstream. Due to the lengthy process of consultation, recruitment and selection this remains a significant risk to the delivery of a Learning from deaths service.

There are no dedicated SJR Reviewers at RSCH and PRH which has resulted in three SJRs being completed out of 43 that were referred during quarter 1. There were four historical SJRs completed during quarter 1. There were 189 SJRs outstanding at the end of quarter 1. Recruitment of up to five dedicated SJR Reviewers at RSCH/PRH totalling 2.5 Planned Activities (PAs) was in progress at the end of quarter 1.

Due to the lengthy process of recruitment and selection this remains a significant risk.

It is also recognised that 2.5 PAs may not be adequate resource to address the backlog. A review of other models to deliver SJRs is currently being explored to identify whether an alternative model may be able to support addressing the backlog.

Industrial Action (Strikes) resulted in a reduced number of SJRs being carried out during the strike period. This was due to SJR reviewers providing cover during the strike periods. Additional SJRs are being completed by reviewers at WGH and SRH to ensure delays to SJRs are kept to a minimum

Summary of Notable Achievements during Quarter 1

- Completion of Panda IT module aligning the ME service and LfD service.

- Redesigned SJR forms and governance process

- Recruitment of SJR Reviewers at RSCH and PRH

- Recruitment of ME’s and MEO’s

UHSussex Mortality Data & Metrics

All Deaths

1. Mortality Reviews

Table 1: Number of hospital deaths by setting and site

Total Adult Deaths				
	Apr-23	May-23	Jun-23	Total for Quarter
WGH	120	116	97	**333**
SRH	92	95	79	**266**
RSCH	114	109	107	**330**
PRH	32	31	25	**88**
Total	**358**	**351**	**308**	**1017**

Table 2: Number of inpatient deaths

Total Adult Inpatient Deaths				
	Apr-23	May-23	Jun-23	Total for Quarter
WGH	115	112	93	**320**
SRH	89	93	78	**260**
RSCH	101	101	99	**301**
PRH	31	29	23	**83**
Total	**336**	**335**	**293**	**964**

Table 3: Number of ED deaths

Total Adult ED Deaths				
	Apr-23	May-23	Jun-23	Total for Quarter
WGH	5	4	4	**13**
SRH	3	2	1	**6**
RSCH	13	8	8	**29**
PRH	1	2	2	**5**
Total	**22**	**16**	**15**	**53**

1.1 The following data source for tables 2 – 4 is HEDS and is the latest data available. Data Source SHMI Module HEDS and includes out of hospital deaths

Table 4: Number of adult inpatients who died within 30 days of being discharged* by site of discharge during quarter 1.

Table 4	WGH	SRH	RSCH	PRH	UHXs
April	28	29	32	11	100
May	42	24	21	14	101
June	Available in October				
Total	**70**	**53**	**53**	**25**	**201**

Table 5: SHMI (12 Month Rolling)

Table 5	WGH	SRH	RSCH	PRH	UHXs
April	108.26	103.59	119.47	103.38	109.19
May	108.25	103.43	117.21	99.78	108.12
June	Available in October				

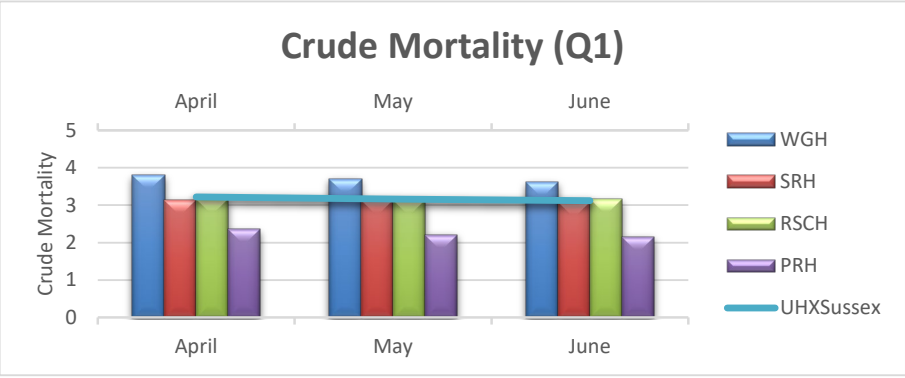
1.2 **Table 6:** HSMR (12 Month Rolling)

Table 6	WGH	SRH	RSCH	PRH	UHXs
April	102.77	101.01	98.63	86.96	99.17
May	102.68	102.47	98.86	86.06	99.49
June	102.83	101.55	100.24	83.93	99.49

1.3 **Table 7:** Crude Mortality (12 Month Rolling) for Q1 2023

Table 7	WGH	SRH	RSCH	PRH	UHXs
April	3.81	3.13	3.17	2.36	3.22
May	3.7	3.12	3.12	2.21	3.16
June	3.61	3.09	3.15	2.15	3.12

Graph 1: Q1 Crude Mortality displaying a Trust-wide downward trajectory during quarter 1.



2. Medical Examiner's Office

2.1 Medical Examiner scrutiny

Table 8: Percentage of deaths scrutinised by ME

Table 8	WGH	SRH	RSCH	PRH	UHXs
April	97.5%	100%	98.25%	93.75%	97.38%
May	100%	100%	100%	96.77%	99.19%
June	100%	100%	97.20%	100%	99.30%
Total	**99.17%**	**100%**	**98.48%**	**96.84%**	**98.62%**

Three patients did not receive ME scrutiny in April 23 due to industrial action at WGH. Business continuity plans were followed and all three were subjected to MEO pre-scrutiny and MEO call to NOK – which identified no concerns.

Five patients at RSCH did not receive scrutiny due to industrial action (two in April and three in June).

Three patients at PRH did not receive scrutiny due to industrial action (two in April and one in May). All cases were subjected to MEO pre-scrutiny and MEO call to NOK – which identified no concerns.

2.2 Referral to Coroner

Table 9: Number of deaths referred to the coroner.

Table 9	WGH	SRH	RSCH	PRH	UHXs	Percentage
April	16	21	42	6	85	**23.74%**
May	21	18	38	9	86	**24.50%**
June	11	18	44	7	80	**25.97%**
Total	**48**	**57**	**124**	**22**	**251**	**24.68%**
Percentage Referred to Coroner	**14.41%**	**21.43%**	**37.58%**	**25.00%**	**24.68%**	

2.3 Investigated by Coroner

Table 10: Number of deaths investigated by the coroner's office

Table 10	WGH	SRH	RSCH	PRH	UHXs	Percentage
April	12	7	20	5	44	**51.76%**
May	10	9	11	4	34	**39.53%**
June	6	9	25	4	44	**55.00%**
Total	**28**	**25**	**56**	**13**	**122**	**48.61%**
% investigated by Coroner	**58.33%**	**43.86%**	**45.16%**	**59.09%**	**48.61%**	

2.4 Deaths referred for structured Judgement review (SJR)

Table 11: Number of deaths referred for SJR

Table 11	WGH	SRH	RSCH	PRH	UHXs	% of all Deaths referred for SJR
April	17	7	10	3	37	**10.34%**
May	15	12	16	4	47	**13.39%**
June	16	10	10	0	36	**11.69%**
Total	**48**	**29**	**36**	**7**	**120**	**11.80%**
% of all Deaths referred for SJR	**14.41%**	**10.90%**	**10.91%**	**7.95%**	**11.80%**	

3. Learning from deaths

Table 12: Number of SJRs reviewed by the Mortality Panel.
WGH and SRH SJR process includes a panel of reviewers and the Mortality & Learning from Deaths Manager. The panel reviews all completed SJR's with a score of 1 or 2. RSCH/PRH Mortality Panel is currently being developed.

Table 12	SRH	WGH	Total
Apr	3	4	7
May	3	10	13
Jun	3	6	9
Total	**9**	**20**	**29**

3.1 SJR outcome scores

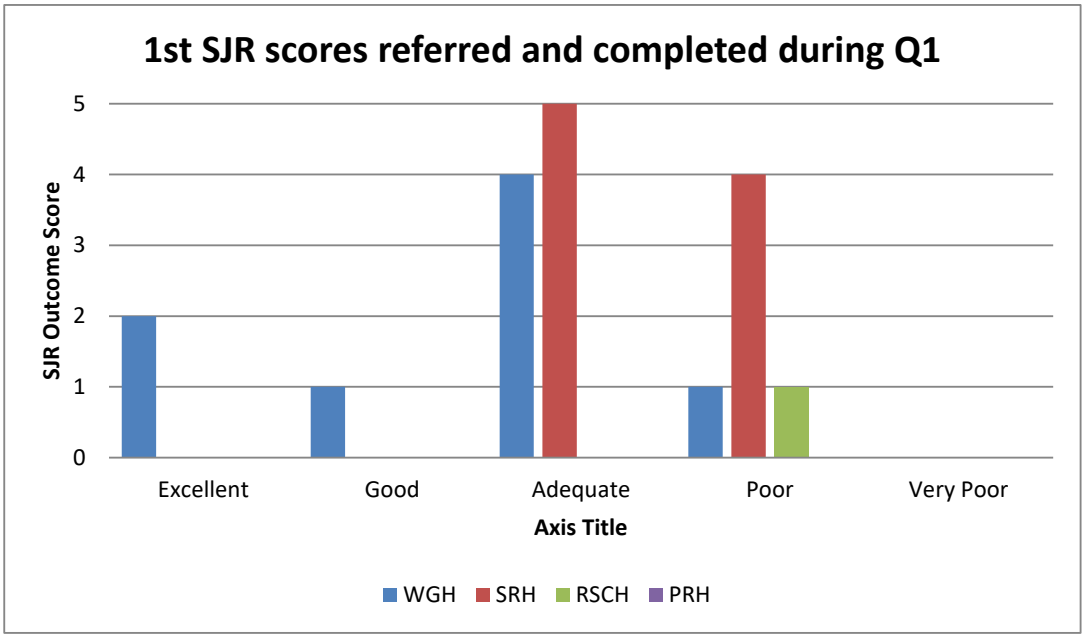
Table 13: Details the overall outcome score of 1st SJR per site completed during Quarter 1 for patients who died during the reporting period (Excludes five 2nd SJRs).

Outcome Score	WGH	SRH	RSCH	PRH
5 - Excellent	2			
4 - Good	2	2		
3 - Adequate				
2 - Poor	9		1	
1 - Very Poor		1		
Total	**13**	**3**	**1**	

Table 14: Details the overall outcome score of 1st SJR per site completed during Quarter 1 for patients who died outside the reporting period (Excludes 5 2nd SJRs).

Outcome Score	WGH	SRH	RSCH	PRH	Total
5 - Excellent	2				2
4 - Good	1		4		5
3 - Adequate	4	5		1	10
2 - Poor	2	4		1	7
1 - Very Poor	1				1
Total	**10**	**9**	**4**	**2**	**25**

Graph 2: SJR Outcome scores of SJRs referred and completed during quarter 1



SJR Activity and Outcomes

Aligning the Mortality & LfD Programs aims to use SJR Methodology to support clinical teams by providing opportunities to learn from constructive feedback and excellent care.

During quarter 1 of 2023/24 there were 120 deaths referred for an SJR. 22 of those referrals were in progress or completed at the end of Q1. A further 25 SJRs were completed that were referred in previous quarters.

Table 15: Quarter 1 activity of SJRs referred and completed or in progress

Number of SJRs Referred and Completed or in progress during Q1 by Hospital Site				
	Number of SJRs Referred during Q1	Number of SJRs referred in Q1 that were completed or in progress at the end of Q1	Number of SJRs referred in previous quarters that were completed or in progress at the end of Q1	Total number of SJRs completed or in progress at the end of Q1
WGH	48	16 (32.7%)	11	27
SRH	29	3 (10.3%)	10	13
RSCH	36	2 (5.9%)	4	6
PRH	7	1 (11.1%)	0	1
Total	**120**	**22 (18.3%)**	**25**	**47**

Graph 3: SJRs completed or in progress

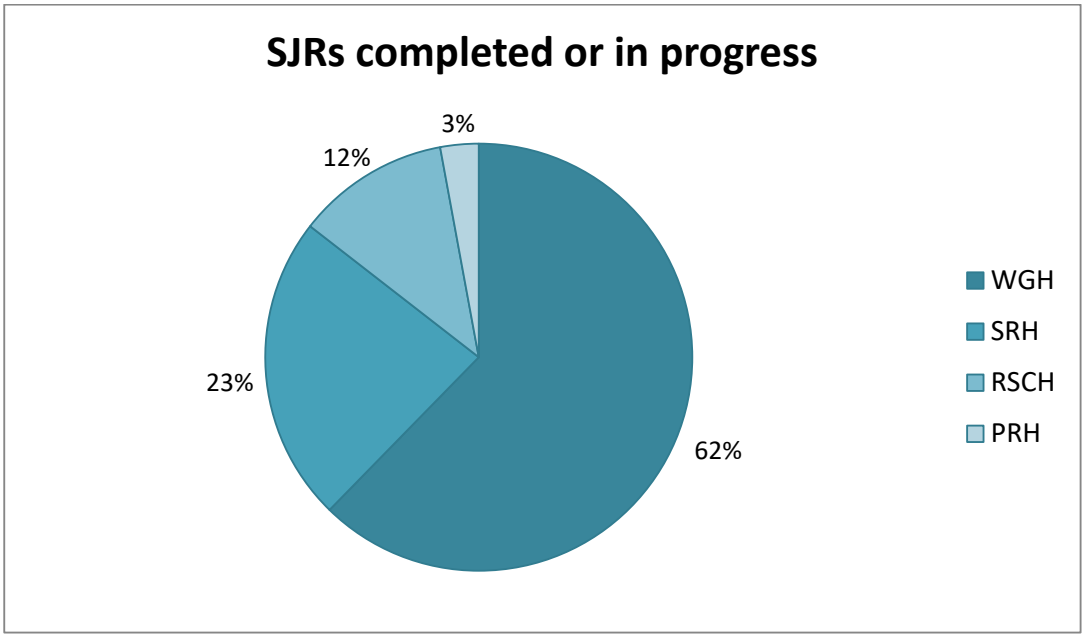


Table 16: Outstanding SJRs

Outstanding SJRs by Hospital Site as of end of Quarter 1 (30th June 2023)					
	Patient died during Q1 (90 days)	Patient died 3 – 6 months previous	Patient died 6 – 12 months previous	Patient died greater than 12 months previous	Total
WGH	33	16	3	0	52
SRH	26	13	1	0	40
RSCH	32	59	25	33	149
PRH	5	15	7	13	40
Total	**96**	**103**	**36**	**46**	**281**

Table 17: SJRs were completed during Q1

SJRs Completed during Q1 by Hospital Site as of end of Quarter 1 (30th June 2023)					
	Patient died during Q1 (90 days)	Patient died 3 – 6 months previous	Patient died 6 – 12 months previous	Patient died greater than 12 months previous	Total
WGH	12	8	1	0	21
SRH	3	9	0	0	12
RSCH	1	4	0	0	5
PRH	1	0	0	0	1
Total	**17**	**21**	**1**	**0**	**39**

Table 18: SJRs in progress at the end of Q1

SJRs in Progress by Hospital Site as of end of Quarter 1 (30th June 2023)					
	Patient died during Q1 (90 days)	Patient died 3 – 6 months previous	Patient died 6 – 12 months previous	Patient died greater than 12 months previous	Total
WGH	4	2	0	0	6
SRH	1	1	0	0	2
RSCH	1	2	0	0	1
PRH	0	0	0	0	0
Total	**6**	**5**	**0**	**0**	**11**

Learning Disabilities and LeDeR

The Learning from Life and Death Reviews (LeDeR) was established in 2017 to review deaths to identify opportunities for learning and improvements as well as excellent care. Working in collaboration with other local services, information is used to improve services for people living with a learning disability and autistic people.

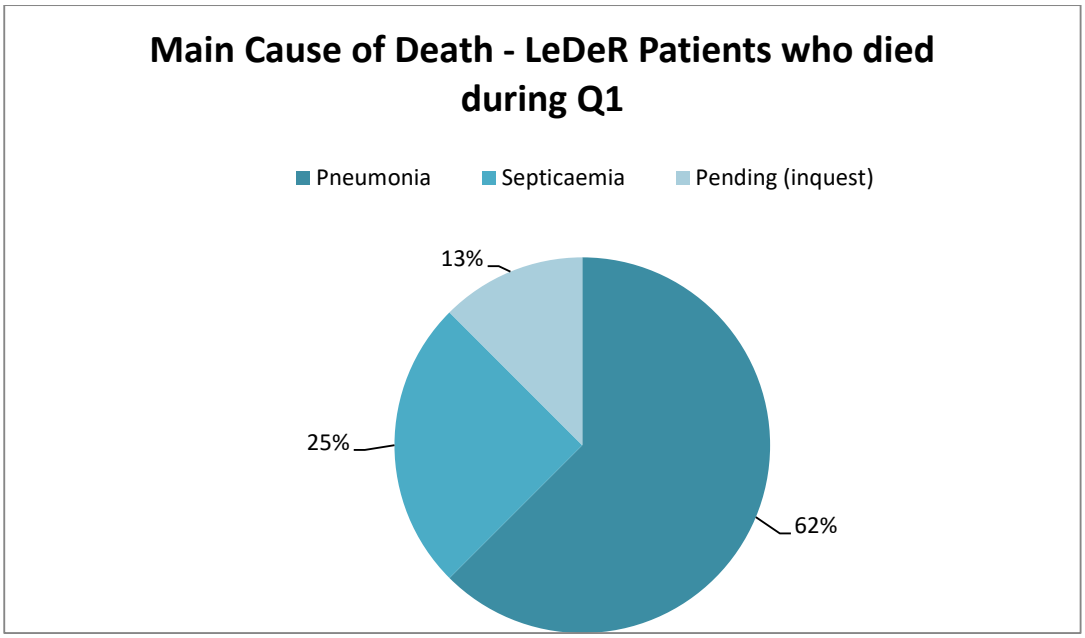
6.8% of the total SJR referrals in Q1 were patients with Learning Disabilities. Three SJRs were completed during the quarter for patients that had died in quarter 1. One scored 4 (Good Care) at SRH and two scored 2 (Poor Care) at Worthing. All eight SJRs that were referred in quarter 1 were in progress at the end of June 2023.

SJRs Referred in Q1 for patients with a learning disability and/or autistic people:

Table 10	WGH	SRH	RSCH	PRH	UHXs
April	0	1	1	0	2
May	1	1	1	0	3
June	0	2	1	0	3
Total	**1**	**4**	**3**	**0**	**8**

All patients were over 65 years old at the time of death. 87.5% had a DNACPR in place. The main cause of death of patients with a learning disability was pneumonia (62.5%), or septicaemia (25%). Long-term conditions included diabetes, dementia and cancer.

Graph 4: Main cause of death of LeDeR patients who died during Q1



See appendix B for more infographics.

Serious Incidents

Three patients who died during quarter 1 generated a patient alert response at the time of ME scrutiny. The 3 cases were escalated to the Patient Safety team prior to SJR. All three cases underwent SJRs and were subsequently declared serious incidents.

A further case involving a patient who died in the previous quarter was declared a serious Incident following a SJR that was completed during this quarter (SJR completed in June 2023).

A further patient did not undergo a SJR and proceeded straight to Serious Incident investigation.

A total of 5 deaths were declared Serious Incidents. All cases are being considered under the Patient Safety Framework.

Table 19: Serious incidents during quarter 1

Month of Death	Site	Division	Potentially Avoidable	Status at 31/6
February	WGH	ITU	Y	Serious Incident Undergoing Root Cause Analysis with division
April	WGH	Surgery	Y	With Patient Safety Team/CMO
April	WGH	Surgery	Y	With Patient Safety Team/CMO
April	WGH	Surgery	N	With Patient Safety Team/CMO
April	RSCH	Surgery	Y	Serious Incident Undergoing Root Cause Analysis with division

SJR Learning Themes

Extracting learning themes from SJRs supports clinical teams by providing opportunities to learn from constructive feedback and where excellent care is identified.

RSCH / PRH Learning Themes

Very Poor or Poor Care

- ✖ Poor communication, both verbally and documented ('NBM' at bedside)
- ✖ Delay in recognising dying patient
- ✖ Patient underwent unnecessary CPR due to no TEP or DNACPR

Adequate Care

- ✖ The patient could have benefited from a SALT referral

Good / Excellent Care

- ✓ Good care of a complex patient
- ✓ Early and regular consultant input
- ✓ Good communication with family

WGH / SRH Learning Themes (a break-down of themes by division can be found in the appendices)

Very Poor or Poor Care

A recurring theme of most SJRs that scored a 1 or 2 were due to a combination of factors. Ceilings of Care not being identified or agreed, Treatment Escalation Plans (TEP) not in place and DNACPR not in place or available. Other factors included:

- ✖ Delay in recognising End of Life
- ✖ Recognition / escalation of deteriorating patient
- ✖ Lack of Senior input
- ✖ Lack of Mental Health Assessment / input
- ✖ Lack of Mental Capacity / DoLS / Best Interest Assessment

9 SJRs identified patients with severe Mental Health. Quality Improvement Plans will be considered following successful implementation of the aligned LfD Programs.

Adequate Care

Inappropriate admission was the main recurring theme when an SJR reviewer concluded that the care provided was adequate. Other themes included:

- ✖ Delayed discharge planning
- ✖ Fluid balance recording
- ✖ Ceilings of Care (TEP) / DNACPR

There is currently a piece of working being undertaken jointly with the EoLC team and the LfD team to explore opportunities to reduce inappropriate admissions for patients on EoLC pathways.

Good / Excellent Care

Early recognition of the dying patient is identified throughout SJRs scoring Good or Excellent care. The themes identify that early recognition can support good decision making, good pain management and enable families to support their loved ones. Other themes that were identified by SJR reviewers included:

- ✓ Good management plans
- ✓ Good clerking / clear documentation
- ✓ Best interest decision making / Recording
- ✓ Timely responses
- ✓ Senior Clinical input
- ✓ Good discussions with family

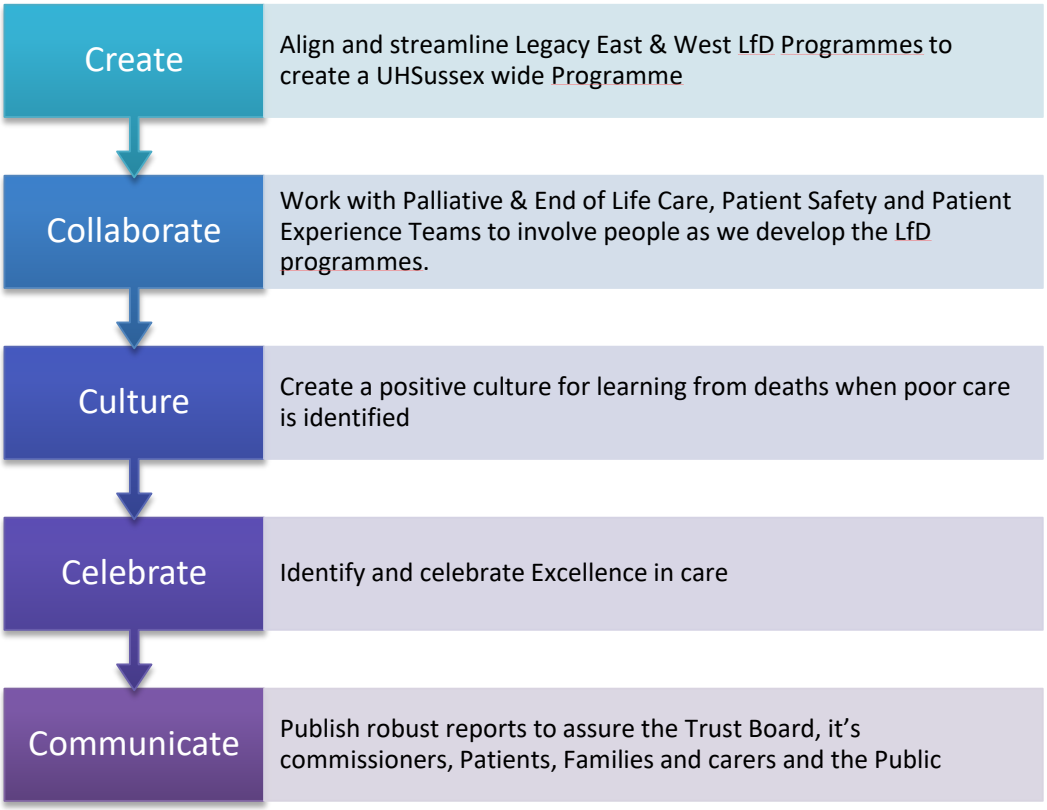
Medical Examiner Feedback - Learning Themes

Key concerns raised by families/ Next of Kin calls

- ✖ Issues around End of Life Care
- ✖ Poor communication
- ✖ Lack of communication
- ✖ Queries over cause of death / MCCD

Positive feedback from families/Next of Kin calls

OBJECTIVES 2023/24 – 2025/26



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

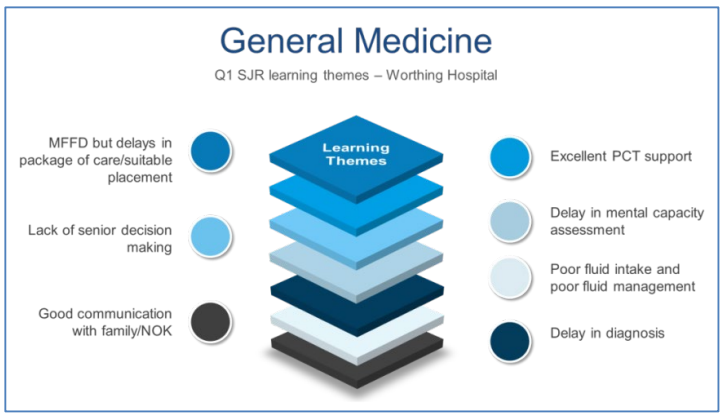
Year 2 2024-25

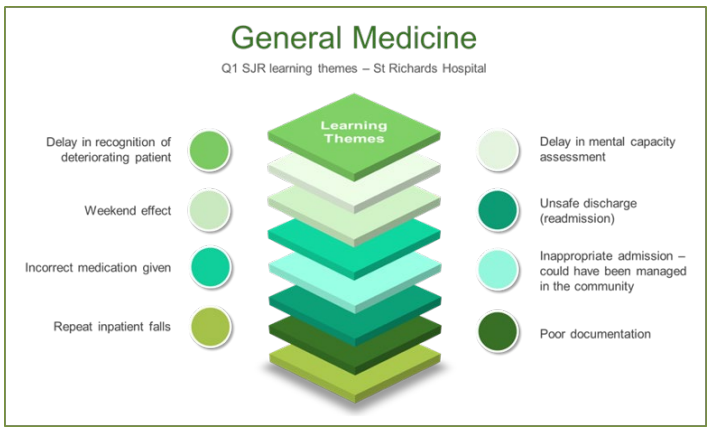
Objective	Purpose	By when
Support identifying and implementing two Quality Improvement plans from Mortality Panel outputs	Demonstrate how Mortality Panels can support improving patient Safety, Patient Care and Patient Experience.	April 2024
Deliver first annual report on the new Mortality & Learning 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

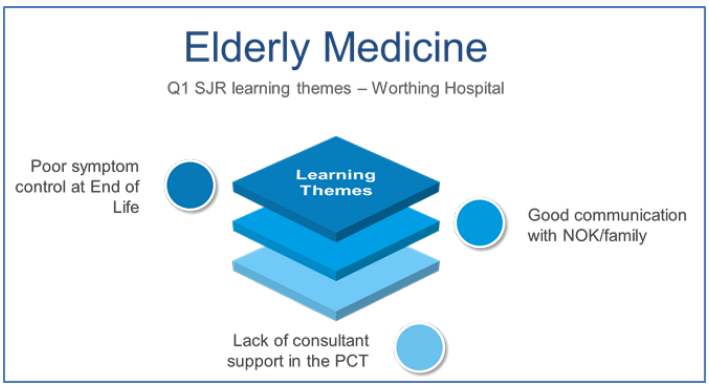
Appendices

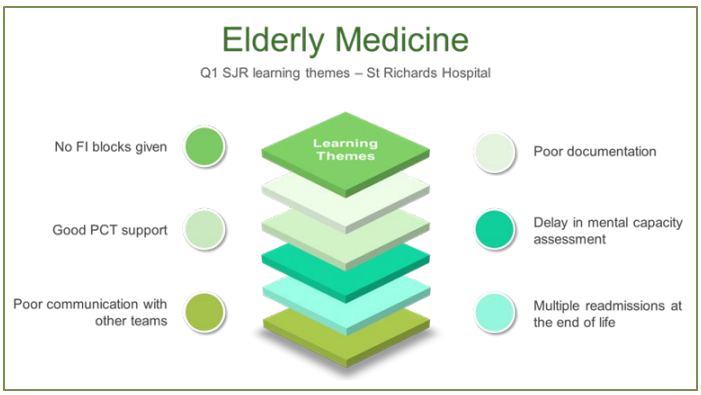
Appendix A

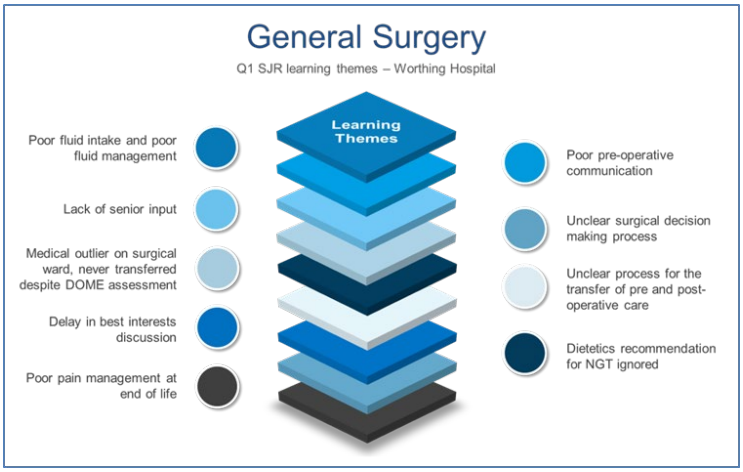
SJR learning themes for divisions at Worthing and SRH.

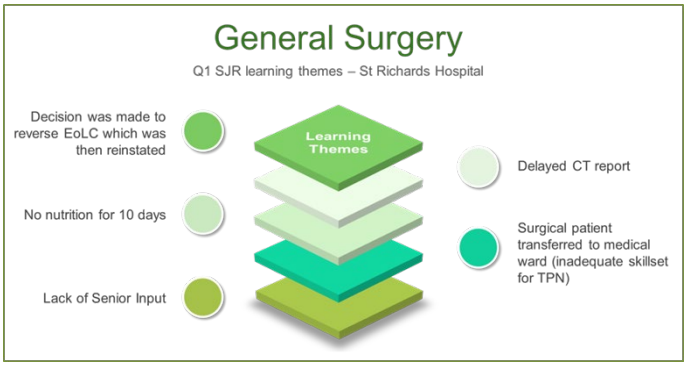






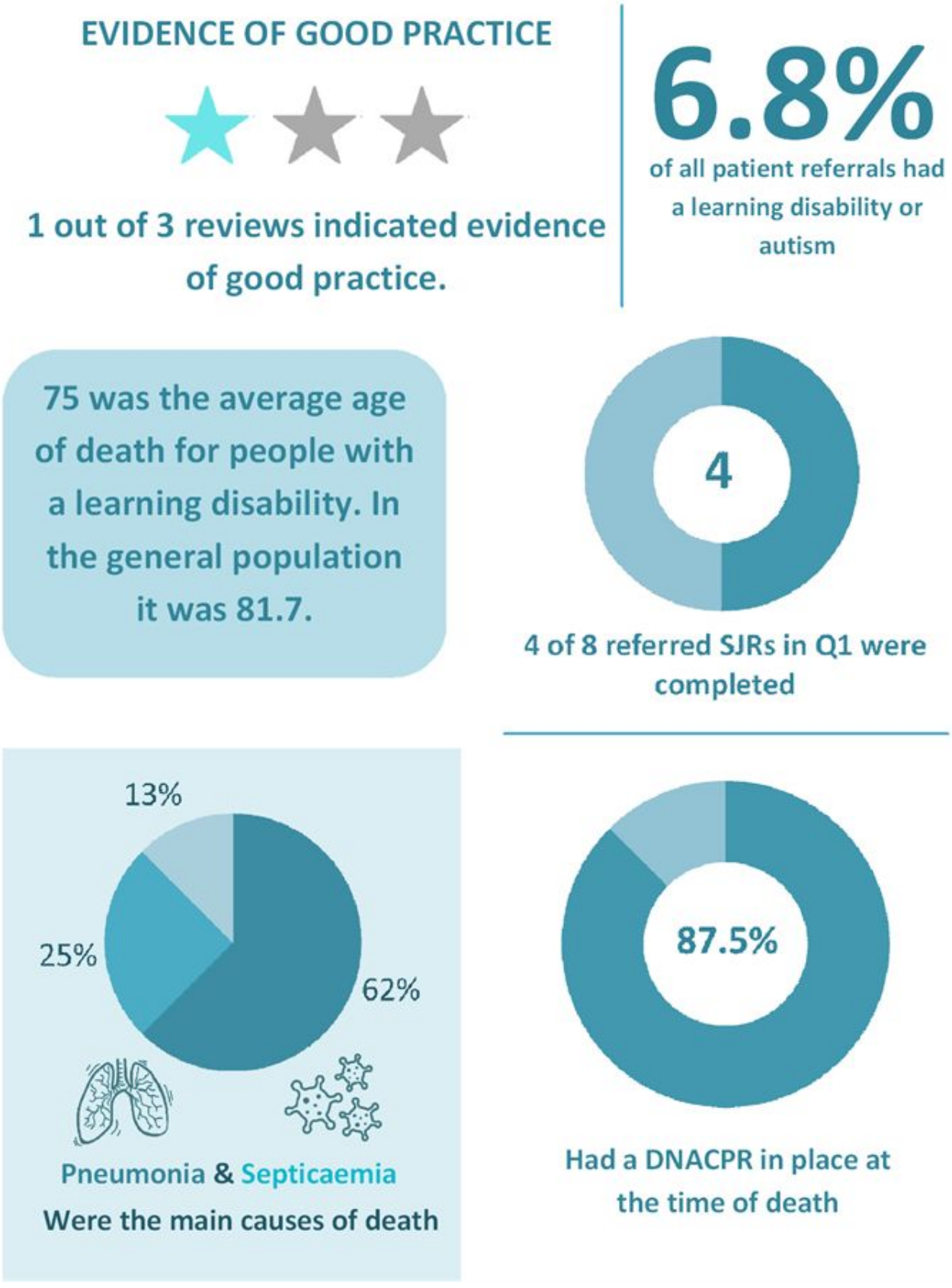






Appendix B

Learning Disabilities Infographics for Q1



University Hospitals Sussex
NHS Foundation Trust

Royal Sussex County Hospital (RSCH)

General Surgery Department

An insight into how the Trust is addressing long-standing issues within the General Surgery Service at Royal Sussex County Hospital & Princess Royal Hospital.

1

Contents

General Surgery Service at RSCH UHSussex

Introduction

The University Hospitals Sussex Foundation Trust (UHSx) consists of four main hospital sites namely, Royal Sussex County Hospital (RSCH), Princess Royal Hospital (PRH), Worthing Hospital (WTH) and St Richards Hospital (SRH).

The General Surgery Department, which operates across the Royal Sussex County Hospital, and Princess Royal Hospital, has a catchment population of circa 478k people. Between January 2022 and December 2022, saw over 55k outpatients, over 5k Non-Elective Admissions, and over 11k Elective Admissions. The RSCH is a designated tertiary major trauma and cancer centre and has provided an oesophago-gastric cancer resection service for Sussex over the last 20 years.

The service has had long-standing problems linked to insufficient staffing levels, cultural and behavioural issues within the department. These issues have led to unfair treatment and inequitable workload amongst colleagues leaving some staff feeling demotivated, demoralised, and disengaged. Over the last two to three years, the senior leadership team have commissioned two reviews into the culture and functioning of the department. The reviews raised concerns about quality and safety governance, service structure, and inadequate teaching and training capacity. These also indicated that there were difficulties with relationships at every level, and staff experiences were largely negative.

Regulators including the Care Quality Commission (CQC) and Health Education England (HEE) have also raised concerns about the delivery of general surgical services and training at RSCH/PRH.

In response to these reviews, the Trust leaders and the department identified improvement opportunities for the department. These included leadership, culture, and better new ways of working including Morbidity and Mortality(M&M), and Multidisciplinary Team (MDT) meetings, clinical governance, complaint management, and provision of emergency care. These improvements are being undertaken through the Trust' General Surgery Improvement Corporate Project.

Challenges being addressed.

In October 2022, HEE removed four higher trainees in General Surgery due to issues around the quality of training which had an impact on the surgical junior training recognition. For surgical trainee placement to be reinstated, sustainable improvements across all aspects of the department need to be achieved.

An unannounced CQC inspection in the summer of 2022, (report published 1st December 2022) identified significant concerns around the quality of surgical services at the RSCH and the upper gastrointestinal service (UGI). These concerns resulted in an enforcement action restricting elective oesophagus-gastric resections at RSCH and a move of the service to Guildford.

Quality and safety governance processes were poor with evidence of expired clinical guidelines, incident reporting was under-utilised, limited clinical outcomes data were available, poor-quality Morbidity and Mortality, and Multidisciplinary Team meetings, and overall concern about patient safety were raised.

The service structure and delivery model were not fit for purpose, which led to teams being under-resourced and overwhelmed with patients. There was evidence of imbalance between capacity and demand for beds and heavy reliance on locum appointments.

There were significant challenges linked to culture and behaviour which led to poor staff morale and reputation of the Trust amongst trainees. Staff within the service felt there were communication gaps in the department especially from the senior leaders.

Since the implementation of the project, the police have commenced an investigation into several post operative deaths at the RSCH site. This investigation is ongoing; the Trust and the department are cooperating fully with the police.

“Patient First” is the Trust’s long-term approach to transforming hospital services for the better. It is a process which includes clear strategic deployment and continuous improvement. One component of this, is a set of Executive-led corporate projects within the organisation.

The General Surgery Improvement Corporate Project was agreed by the Trust Executive to support the improvement of the identified issues with a focus on the areas specified above split across five workstreams. The project has since continued to progress across all workstreams and is on track with intended deliverables. Improvements have commenced to support the Lower and Upper GI Multidisciplinary Teams (MDT) processes and structures, the department's quality governance standards, leadership and culture, and the clinical and operational model.

Quality Governance

There has been improvement in clinical governance since the improvement programme began. A Royal College of Surgeons (RCS) review was commissioned in May 2023 to assess the progress of the improvements made through the corporate project. The initial findings of this review reported no immediate patient safety concerns and no major concerns regarding outcomes. The review also found the quality of national audits data submission including NELA and NBOCA to be in line with best practice.

There have been increase in the number clinical audits activities, some of which included junior doctors as part of their ongoing developments. An example is the "audit on overuse of CT in patients with clinical appendicitis." Output of these audits were presented back at clinical audit meetings. Clinical audits and research are being embedded as 'business as usual' within the department.

Attendances at M&M and Lower GI MDT meetings with consultant engagement have improved taking in to account best practices and feedback from a recently completed Surrey and Sussex Cancer Alliance (SSCA) audit recommendations. These meetings now have regular consultant participation and chairs that are rotated. There has been CMO and Chief of Service oversight of meeting functionality, behaviours, and process.

A strengthened process for managing and responding to patient complaints is now in place, with a consultant governance lead and specific governance administrator.

A good governance maturity review is underway which will assess the department's maturity level in relation to key governance elements. The review will highlight areas

requiring further improvement and ensure action plans are in place to support robust governance.

Clinical and Operational

The development of a new service model is a key deliverable of the corporate project. This will support the management of elective and emergency care demands, compliance with major trauma and cancer centre standards and the standardisation of departmental operational management processes.

A comprehensive demand and capacity analysis has been completed to assess how the workforce capacity should be right-sized. This has identified medical workforce shortfalls. A comprehensive service and workforce business case is being developed to deliver the best care possible for patients. The new model will ensure timely emergency intervention and enhanced consultant delivered care and decision-making resulting in better patient outcomes and experience.

Lower GI and Upper GI

These workstreams aim to ensure the department's MDT processes consistently meet national best practise and have developed action plans to achieve these.

An audit of the Upper and Lower GI Multidisciplinary Team (MDT) was undertaken by the Surrey and Sussex Cancer Alliance (SSCA) to review existing MDT practices with a view to streamlining processes in line with national recommendations.

The key recommendation from these audits is the need to standardise MDT processes across both services and a Standard of Care document and Standard Operating Policies were drafted by clinical leads to address the requirements. The policy outlines best practice, structures, and processes for improving the quality of MDTs.

Whilst resectional Upper-GI cancer surgery will remain centralised at Guildford, the Upper-GI workstream aims to ensure the process and pathways remain effective for patients in Sussex.

Leadership and Culture

Through this workstream, a "three-team" leadership structure was put in place, with the recruitment of a clinical director and three clinical leads (Upper GI, Lower GI, and

Emergency). All clinical leaders in the department are undergoing coaching to develop and strengthen their leadership capability.

The department now has a stable clinical leadership team driving improvements in culture, inclusion, diversity, and equality. The clinical leaders will create an environment of collaboration at all levels. The RCS review (see below) highlighted the new divisional leadership arrangements as a positive development.

External Review

In May 2023, a Royal College of Surgeon invited service review of the department took place. This focused on three specific themes:

1. The effectiveness of current clinical governance practices and clinical leadership within the department to ensure safe outcomes for patients.
2. The quality and safety of surgical care provided at individual and departmental level.
3. Multi-disciplinary Team (MDR) working, communication, and behaviours and culture within the department.

Initial written feedback highlighted areas of good practice including significant improvement in clinical governance, new divisional leadership arrangements, Mortality and Morbidity (M&M), Multi-Disciplinary Team (MDT), and Quality Safety and Patient Experience (QSPE) meetings. The review also identified clear areas requiring improvement including the imbalance in demand and capacity, lower than required staffing levels and over reliance on certain clinical roles, as well as the need to improve culture and behaviours amongst some consultant surgeons.

A staff briefing was held by the Chief Medical Officer, Chief Operating Officer and Chief of Surgery and Critical Care to share the initial findings with the department.

Conclusion

Whilst the Trust and department have made some significant progress, there is a recognition that these improvements must be sustained, and that further action is required. Increased leadership presence at governance and consultant meetings have ensured continuous challenge of unhelpful behaviours and an encouragement of collaboration within the department.

To ease pressure on emergency cases and backlog, recruitment within consultant workforce has commenced to address immediate shortfalls and a detailed business case to right-size the “three-team” model will be presented at the Trust board soon.

The department and HEE are aiming for the return of trainees in October 2024. The department will ensure the proposed workforce changes and service model provides the right training needs for both trainees and trainers.

Actual and Potential Deceased Organ Donation 1 April 2022 - 31 March 2023

NHS Blood and Transplant

University Hospitals Sussex NHS Foundation Trust

Organ Donation and Transplantation 2030: Meeting the Need

In 2022/23, from 42 consented donors the Trust facilitated 31 actual solid organ donors resulting in 72 patients receiving a life-saving or life-changing transplant. Data obtained from the UK Transplant Registry.

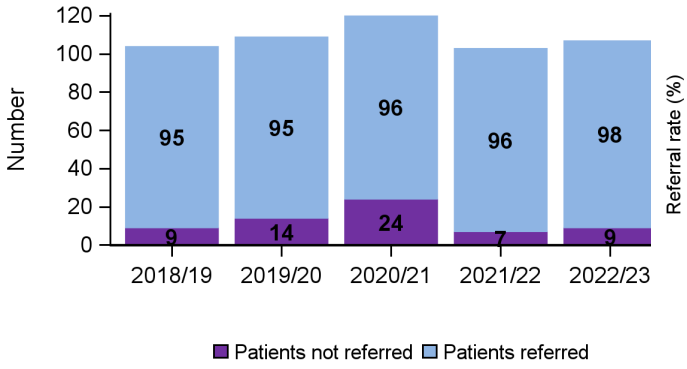
In addition to the 31 proceeding donors there were 11 consented donors that did not proceed.

Best quality of care in organ donation

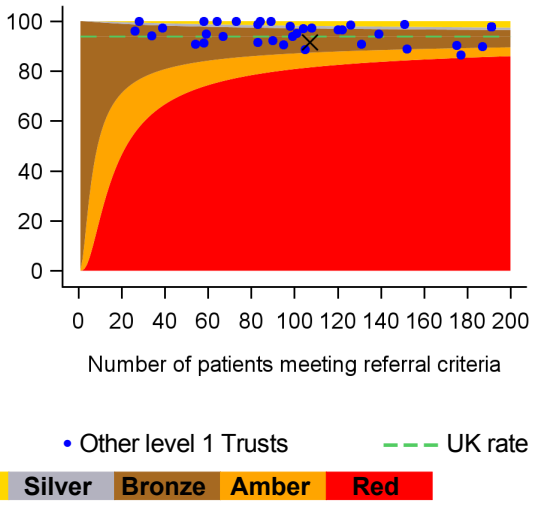
Referral of potential deceased organ donors

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

Aim: There should be no purple on the chart



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



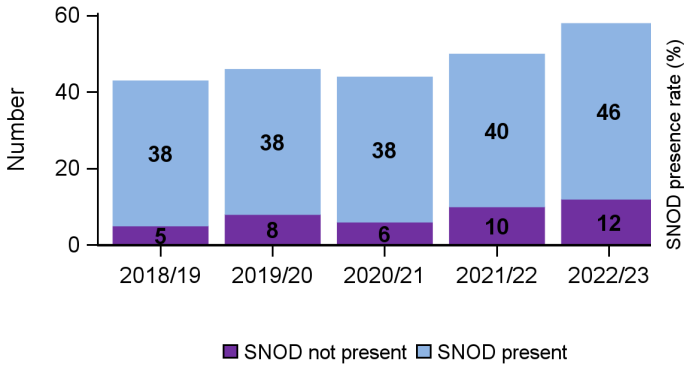
The Trust referred 98 potential organ donors during 2022/23. There were 9 occasions where potential organ donors were not referred.

When compared with UK performance, the Trust was average (bronze) for referral of potential organ donors to NHS Blood and Transplant.

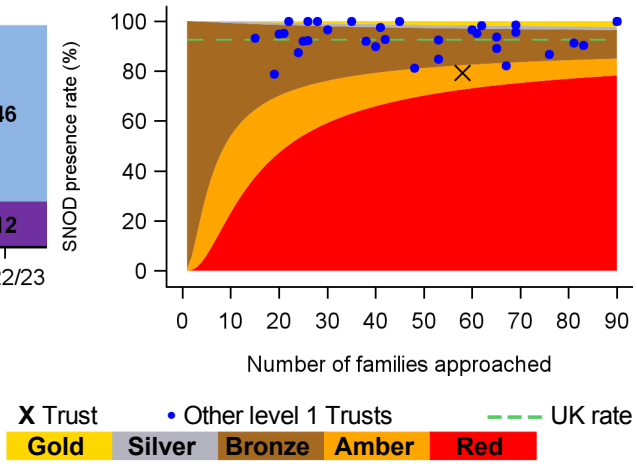
Presence of Specialist Nurse for Organ Donation

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

Aim: There should be no purple on the chart



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



A SNOD was present for 46 organ donation discussions with families during 2022/23. There were 12 occasions where a SNOD was not present.

When compared with UK performance, the Trust was below average (amber) for SNOD presence when approaching families to discuss organ donation.

Why it matters

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

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

	South East Coast*	UK
1 April 2022 - 31 March 2023		
Deceased donors	100	1,429
Transplants from deceased donors	194	3,589
Deaths on the transplant list	23	441
As at 31 March 2023		
Active transplant list	379	6,959
Number of NHS ODR opt-in registrations (% registered)**	2,261,428 (49%)	28,567,574 (44%)

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

Further information

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

Key numbers, rates and comparison with UK data, 1 April 2022 - 31 March 2023

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	32	1980	79	5307	107	6910
Referred to Organ Donation Service	31	1965	70	4886	98	6482
Referral rate %	B *97%*	*99%*	B *89%*	*92%*	B *92%*	*94%*
Neurological death tested	28	1556				
Testing rate %	B *88%*	*79%*				
Eligible donors[2]	25	1439	50	3467	75	4906
Family approached	23	1244	35	1691	58	2935
Family approached and SNOD present	19	1190	27	1526	46	2716
% of approaches where SNOD present	B *83%*	*96%*	B *77%*	*90%*	A *79%*	*93%*
Consent ascertained	16	846	22	959	38	1805
Consent rate %	B *70%*	*68%*	B *63%*	*57%*	B *66%*	*61%*
- Expressed opt in	10	476	11	578	21	1054
- Expressed opt in %	*100%*	*95%*	*69%*	*84%*	*81%*	*89%*
- Deemed Consent	3	284	10	306	13	590
- Deemed Consent %	*50%*	*63%*	*83%*	*52%*	*72%*	*57%*
- Other*	3	86	1	74	4	160
- Other %*	*100%*	*60%*	*25%*	*38%*	*57%*	*47%*
Actual donors (PDA data)	15	783	15	636	30	1419
% of consented donors that became actual donors	*94%*	*93%*	*68%*	*66%*	*79%*	*79%*

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

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

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

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

Gold | Silver | Bronze | Amber | Red

For further information, including definitions, see the latest Potential Donor Audit report and up to date metrics via our Power BI reports at:
https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.

NHS
Blood and Transplant

Detailed Report

Actual and Potential Deceased Organ Donation

1 April 2022 - 31 March 2023

University Hospitals Sussex NHS Foundation Trust

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Further Information

- Appendix A.1 contains definitions of terms and abbreviations used throughout this report and summarises the main changes made to the PDA over time.
- The latest Organ Donation and Transplantation Activity Report is available at https://www.organdonation.nhs.uk/supporting-my-decision/statistics-about-organ-donation/transplant-activity-report/
- The latest PDA Annual Report and our Power BI reports with up to date Trust metrics are available at https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.
- Please refer any queries or requests for further information to your local Specialist Nurse - Organ Donation (SNOD)

Source

NHS Blood and Transplant: UK Transplant Registry (UKTR), Potential Donor Audit (PDA) and Referral Record.
Issued May 2023 based on data meeting PDA criteria reported at 9 May 2023.

1. Donor Outcomes

A summary of the number of donors, patients transplanted, average number of organs donated per donor and organs donated.

Data in this section is obtained from the UK Transplant Registry

Between 1 April 2022 and 31 March 2023, University Hospitals Sussex NHS Foundation Trust had 31 deceased solid organ donors, resulting in 72 patients receiving a transplant. Additional information is shown in Tables 1.1 and 1.2, along with comparison data for 2021/22. Figure 1.1 shows the number of donors and patients transplanted for the previous ten periods for comparison.

Table 1.1 Donors, patients transplanted and organs per donor, 1 April 2022 - 31 March 2023 (1 April 2021 - 31 March 2022 for comparison)

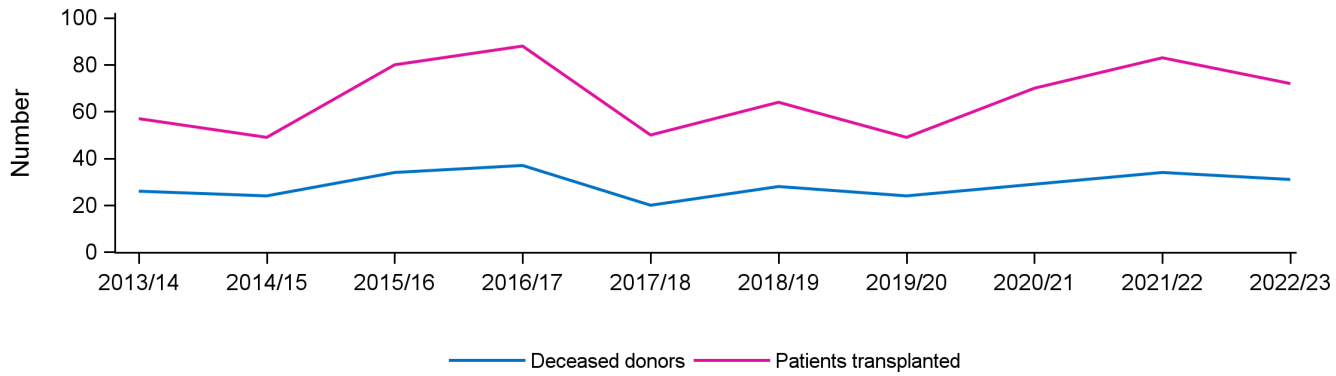
Donor type	Number of donors	Number of patients transplanted	Average number of organs donated per donor	
			Trust	UK
DBD	15 (15)	42 (44)	3.1 (3.7)	3.5 (3.4)
DCD	16 (19)	30 (39)	3.1 (2.9)	2.9 (2.7)
DBD and DCD	31 (34)	72 (83)	3.1 (3.3)	3.2 (3.1)

In addition to the 31 proceeding donors there were 11 additional consented donors that did not proceed, 2 where DBD organ donation was being facilitated and 9 where DCD organ donation was being facilitated.

Table 1.2 Organs transplanted by type, 1 April 2022 - 31 March 2023 (1 April 2021 - 31 March 2022 for comparison)

Donor type	Number of organs transplanted by type											
	Kidney		Pancreas		Liver		Heart		Lung		Small bowel	
DBD	25	(26)	2	(1)	12	(10)	2	(5)	5	(4)	0	(0)
DCD	22	(35)	1	(1)	7	(3)	2	(2)	0	(2)	0	(0)
DBD and DCD	47	(61)	3	(2)	19	(13)	4	(7)	5	(6)	0	(0)

Figure 1.1 Number of donors and patients transplanted, 1 April 2013 - 31 March 2023



2. Key Rates in Potential for Organ Donation

A summary of the key rates on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section presents specific percentage measures of potential donation activity for University Hospitals Sussex NHS Foundation Trust.

Performance in your Trust has been compared with UK performance in both Figure 2.1 and Table 2.1 using funnel plot boundaries and the Gold, Silver, Bronze, Amber, and Red (GoSBAR) colour scheme. When compared with UK performance, gold represents exceptional, silver represents good, bronze represents average, amber represents below average, and red represents poor performance. See Appendix A.3 for funnel plot ranges used.

It is acknowledged that the PDA does not capture all activity. There may be some patients referred in 2022/23 who are not included in this section onwards because they were either over 80 years of age or did not die in a unit participating in the PDA.

Note that caution should be applied when interpreting percentages based on small numbers.

Figure 2.1 Key rates on the potential for organ donation including UK comparison, 1 April 2022 - 31 March 2023

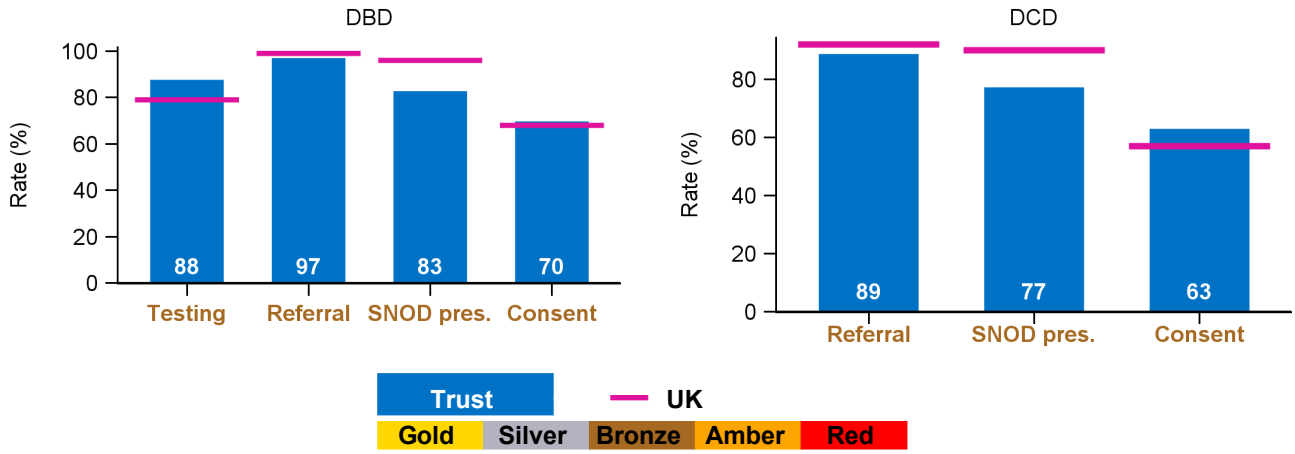


Figure 2.2 Trends in key rates on the potential for organ donation, 1 April 2018 - 31 March 2023

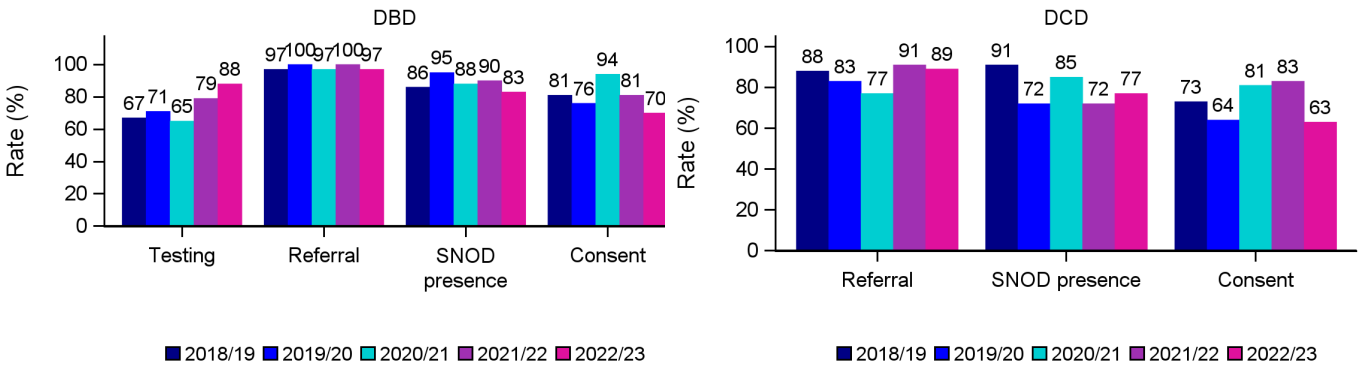


Table 2.1 Key numbers, rates and comparison with national rates, 1 April 2022 - 31 March 2023

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	32	1980	79	5307	107	6910
Referred to Organ Donation Service	31	1965	70	4886	98	6482
Referral rate %	B *97%*	*99%*	B *89%*	*92%*	B *92%*	*94%*
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Family approached and SNOD present	19	1190	27	1526	46	2716
% of approaches where SNOD present	B *83%*	*96%*	B *77%*	*90%*	A *79%*	*93%*
Consent ascertained	16	846	22	959	38	1805
Consent rate %	B *70%*	*68%*	B *63%*	*57%*	B *66%*	*61%*
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- Deemed Consent	3	284	10	306	13	590
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[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

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

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

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

Gold | Silver | Bronze | Amber | Red

3. Best quality of care in organ donation

Key stages in best quality of care in organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section provides information on the quality of care in your Trust at the key stages of organ donation. The ambition is that your Trust misses no opportunity to make a transplant happen and that opportunities are maximised at every stage.

3.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 3.1 Number of patients with suspected neurological death, 1 April 2018 - 31 March 2023

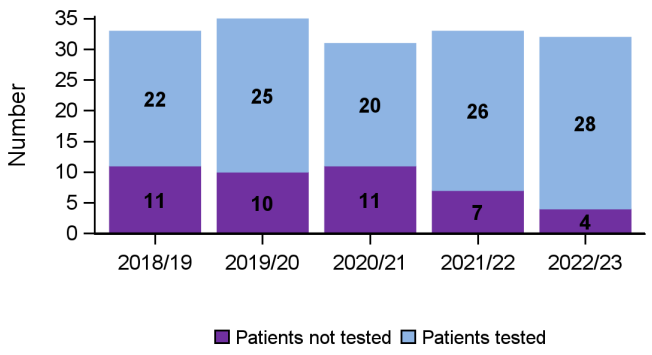


Table 3.1 Reasons given for neurological death tests not being performed, 1 April 2022 - 31 March 2023

	Trust	UK
Biochemical/endocrine abnormality	-	29
Clinical reason/Clinician's decision	-	62
Continuing effects of sedatives	-	6
Family declined donation	-	28
Family pressure not to test	-	48
Inability to test all reflexes	1	20
Medical contraindication to donation	-	5
Other	1	43
Patient had previously expressed a wish not to donate	-	2
Patient haemodynamically unstable	1	151
Pressure of ICU beds	-	1
SN-OD advised that donor not suitable	-	8
Treatment withdrawn	1	18
Unknown	-	3
Total	**4**	**424**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.2 Referral to Organ Donation Service

Goal: Every patient who meets the referral criteria should be identified and referred to the Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Aim: There should be no purple on the following charts.

Note that patients who met the referral criteria for both DBD and DCD donation will appear in both bar charts and both columns of the reasons table.

Figure 3.2 Number of patients meeting referral criteria, 1 April 2018 - 31 March 2023

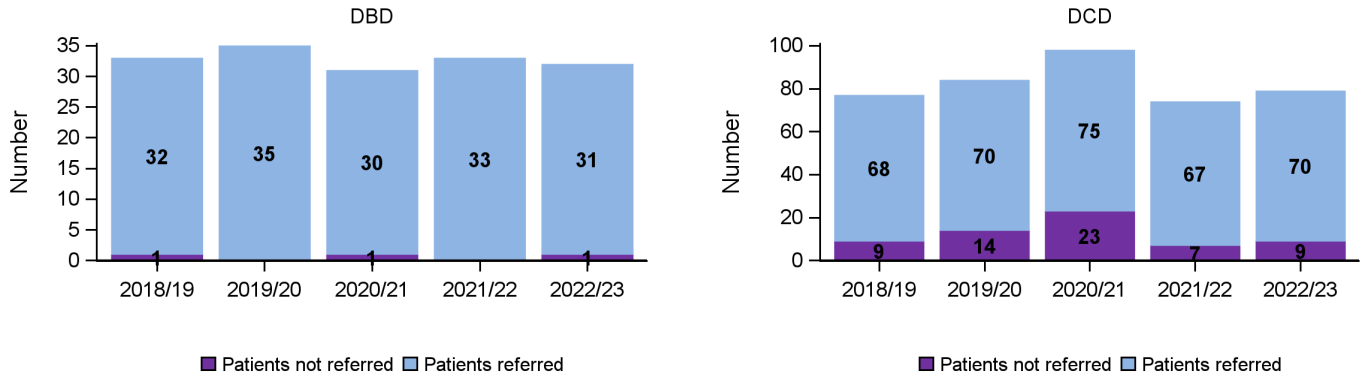


Table 3.2 Reasons given why patient not referred to SNOD, 1 April 2022 - 31 March 2023

	DBD		DCD	
	Trust	UK	Trust	UK
Clinician assessed that patient was unlikely to become asystolic within 4 hours	-	-	-	2
Family declined donation following decision to remove treatment	-	1	1	15
Family declined donation prior to neurological testing	-	1	-	1
Medical contraindications	-	-	-	28
Not identified as potential donor/organ donation not considered	1	6	7	271
Other	-	-	-	27
Patient had previously expressed a wish not to donate	-	-	-	3
Pressure on ICU beds	-	-	-	3
Reluctance to approach family	-	1	-	2
Thought to be medically unsuitable	-	1	1	53
Uncontrolled death pre referral trigger	-	5	-	16
Total	**1**	**15**	**9**	**421**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.3 Contraindications

In 2022/23 there were 14 potential donors in your Trust with an ACI reported, 1 DBD and 13 DCD donors. Please note, the number of potential DBD and DCD donors with an ACI reported may not equal the total stated as a patient can meet potential donor criteria for both DBD and DCD donation.

3.4 SNOD presence

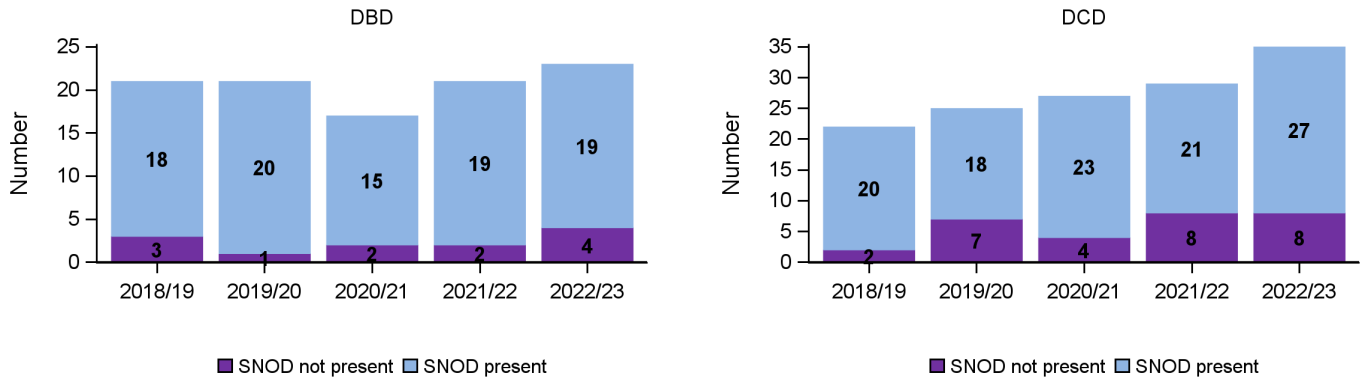
Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

Aim: There should be no purple on the following charts.

In the UK, in 2022/23, when a SNOD was not present for the approach to the family to discuss organ donation, DBD and DCD consent/authorisation rates were 31% and 19%, respectively, compared with DBD and DCD consent/authorisation rates of 70% and 61%, respectively, when a SNOD was present.

Every approach to those close to the patient should be planned with the multidisciplinary team (MDT), should involve the SNOD and should be clearly planned taking into account the known decision of the patient. The NHS Organ Donor Register (ODR) should be checked in all cases of potential donation and this information must be discussed with the family as it represents the eligible donor's legal consent to donation.

Figure 3.3 Number of families approached by SNOD presence, 1 April 2018 - 31 March 2023



[1] NICE, 2011.
NICE Clinical Guidelines - CG135
[accessed 9 May 2023]

[2] NHS Blood and Transplant, 2012.
Timely Identification and Referral of Potential Organ Donors - A Strategy for Implementation of Best Practice
[accessed 9 May 2023]

[3] NHS Blood and Transplant, 2013.
Approaching the Families of Potential Organ Donors – Best Practice Guidance
[accessed 9 May 2023]

3.5 Consent

In 2022/23 the DBD and DCD consent rates in your Trust were 70% and 63%, respectively.

Figure 3.4 Number of families approached, 1 April 2018 - 31 March 2023

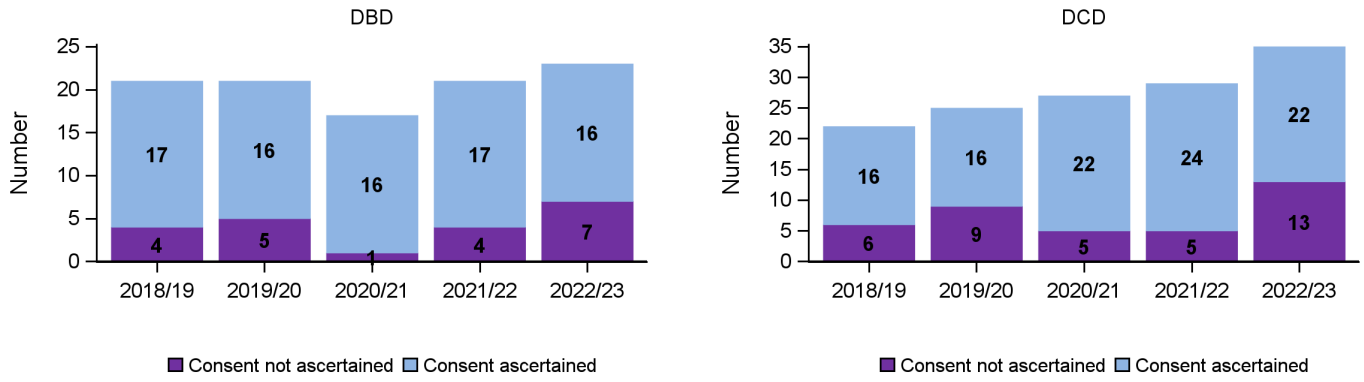


Table 3.3 Reasons given why consent was not ascertained, 1 April 2022 - 31 March 2023

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Family believe patient's treatment may have been limited to facilitate organ donation	-	1	-	-
Family concerned donation may delay the funeral	-	2	-	1
Family concerned other people may disapprove/be offended	-	1	-	2
Family concerned that organs may not be transplantable	-	1	-	7
Family did not believe in donation	-	4	-	12
Family did not want surgery to the body	-	38	-	51
Family divided over the decision	-	21	-	18
Family felt it was against their religious/cultural beliefs	1	40	1	24
Family felt patient had suffered enough	-	22	2	62
Family felt that the body should be buried whole (unrelated to religious/cultural reasons)	-	20	-	13
Family felt the length of time for the donation process was too long	1	17	2	126
Family had difficulty understanding/accepting neurological testing	-	3	-	-
Family wanted to stay with the patient after death	-	2	-	16
Family were not sure whether the patient would have agreed to donation	-	44	2	90
Other	1	22	2	73
Patient had previously expressed a wish not to donate	4	121	4	175
Patient had registered a decision to Opt Out	-	22	-	31
Strong refusal - probing not appropriate	-	17	-	31
Total	**7**	**398**	**13**	**732**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.6 Solid organ donation

Goal: NHSBT is committed to supporting transplant units to ensure as many organs as possible are safely transplanted.

Table 3.4 Reasons why solid organ donation did not occur, 1 April 2022 - 31 March 2023

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Clinical - Absolute contraindication to organ donation	1	10	-	8
Clinical - Cardiac arrest during referral	-	2	-	-
Clinical - Considered high risk donor	-	7	-	8
Clinical - DCD clinical exclusion	-	-	1	1
Clinical - No transplantable organ	-	6	1	12
Clinical - Organs deemed medically unsuitable by recipient centres	-	10	1	51
Clinical - Organs deemed medically unsuitable on surgical inspection	-	7	-	3
Clinical - Other	-	3	-	10
Clinical - PTA post WLST	-	-	3	165
Clinical - Patient actively dying	-	4	-	19
Clinical - Patient asystolic	-	1	-	-
Clinical - Patient's general medical condition	-	2	-	3
Clinical - Positive virology	-	1	-	3
Clinical - Predicted PTA therefore not attended	-	-	-	3
Consent / Auth - Coroner/Procurator fiscal refusal	-	5	-	10
Consent / Auth - NOK withdraw consent / authorisation	-	5	1	24
Logistical - Other	-	-	-	3
Total	**1**	**63**	**7**	**323**

If 'other', please contact your local SNOD or CLOD for more information, if required.

4. Comparative Data

A comparison of performance in your Trust/Board with national data

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section compares the quality of care in the key areas of organ donation in your Trust with the UK rate using funnel plots. The UK rate is shown as a green dashed line and the funnel shape is formed by the 95% and 99.8% confidence limits around the UK rate. The confidence limits reflect the level of precision of the UK rate relative to the number of observations. Performance in your Trust is indicated by a black cross. The Gold, Silver, Bronze, Amber, and Red colour scheme is used to indicate whether performance in your Trust, when compared to UK performance, is exceptional (gold), good (silver), average (bronze), below average (amber) or poor (red).

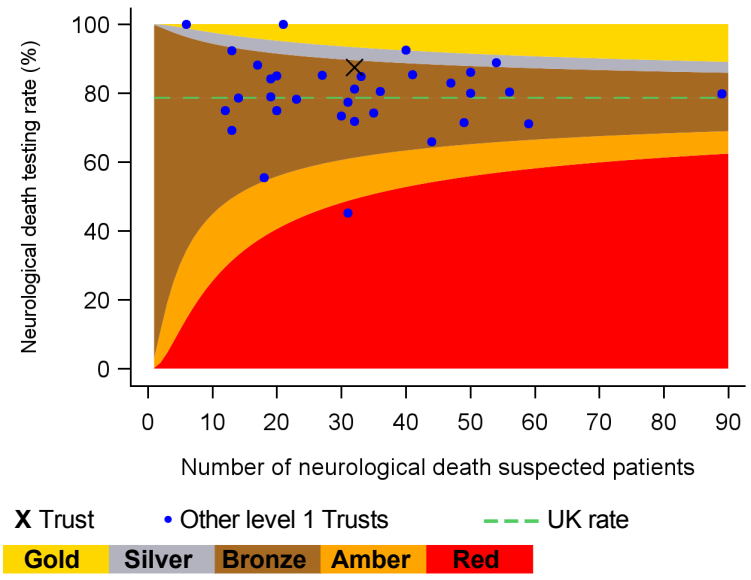
It is important to note that the differences in patient mix have not been accounted for in these plots. Further to these, separate funnel plots for DBD and DCD rates are presented in Section 7.

Note that caution should be applied when interpreting percentages calculated with numbers less than 10.

4.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 4.1 Funnel plot of neurological death testing rate, 1 April 2022 - 31 March 2023

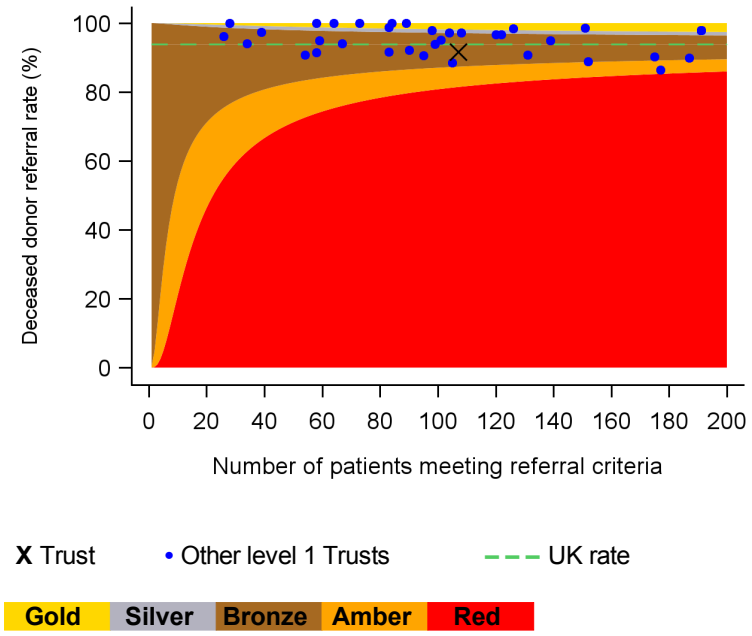


When compared with UK performance the neurological death testing rate in University Hospitals Sussex NHS Foundation Trust was average (bronze).

4.2 Referral to Organ Donation Service

Goal: Every patient who meets the referral criteria should be identified and referred to NHSBT's Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Figure 4.2 Funnel plot of deceased donor referral rate, 1 April 2022 - 31 March 2023

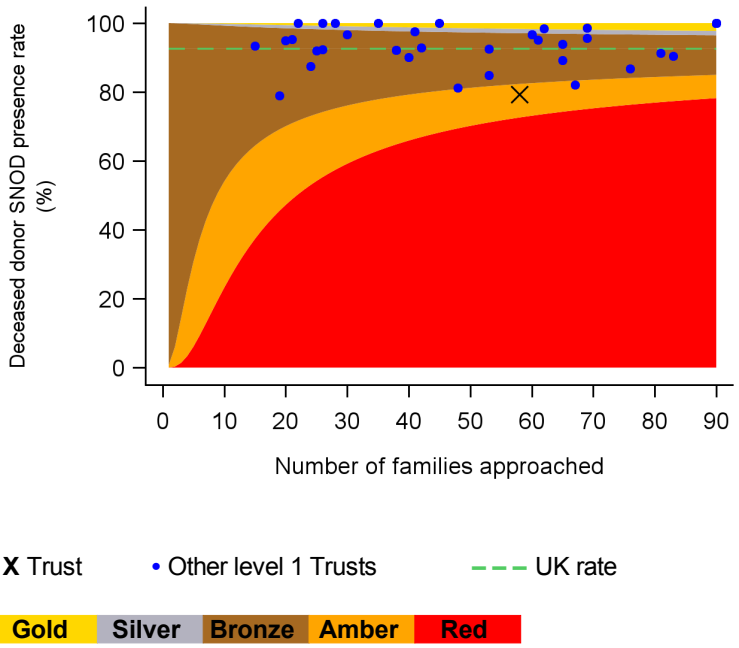


When compared with UK performance University Hospitals Sussex NHS Foundation Trust was average (bronze) for referral of potential organ donors to NHS Blood and Transplant's Organ Donation Service.

4.3 SNOD presence

Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

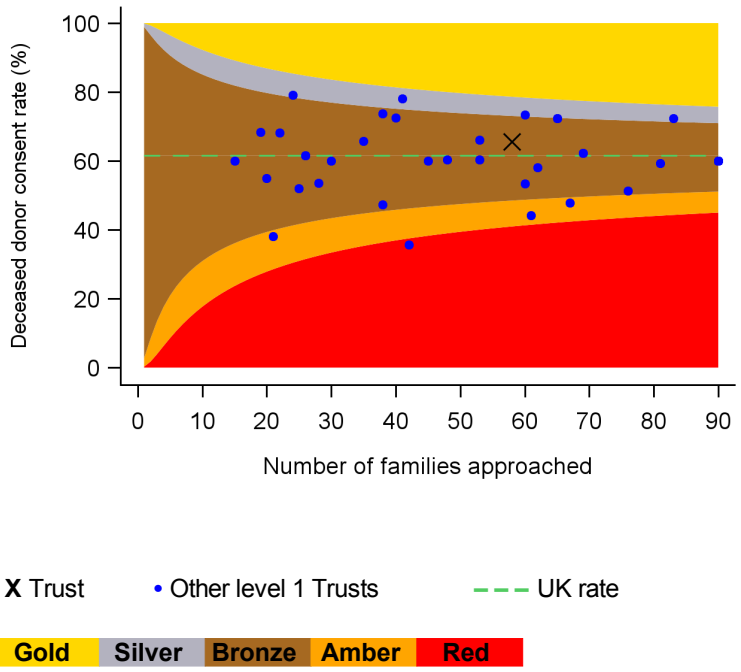
Figure 4.3 Funnel plot of SNOD presence rate, 1 April 2022 - 31 March 2023



When compared with UK performance University Hospitals Sussex NHS Foundation Trust was below average (amber) for Specialist Nurse presence when approaching families to discuss organ donation.

4.4 Consent

Figure 4.4 Funnel plot of consent rate, 1 April 2022 - 31 March 2023



When compared with UK performance the consent rate in University Hospitals Sussex NHS Foundation Trust was average (bronze).

5. PDA data by hospital and unit

A summary of key numbers and rates from the PDA by hospital and unit where patient died

Data in this section is obtained from the National Potential Donor Audit (PDA)

Tables 5.1 and 5.2 show the key numbers and rates for patients who met the DBD and/or DCD referral criteria, respectively. Percentages have been excluded where numbers are less than 10.

Table 5.1 Patients who met the DBD referral criteria - key numbers and rates, 1 April 2022 - 31 March 2023

Unit where patient died	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Brighton, Royal Sussex County Hospital													
A & E	1	0	-	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	20	19	95	20	100	18	17	16	13	81	11	69	10
ICU - cardiothoracic	1	1	-	1	-	1	1	1	0	-	0	-	0
Chichester, St Richard's Hospital													
A & E	0	0	-	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	6	4	-	6	-	4	4	3	3	-	2	-	2
Haywards Heath, Princess Royal Hospital													
A & E	0	0	-	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	1	1	-	1	-	1	1	1	1	-	1	-	1
Worthing, Worthing Hospital													
A & E	0	0	-	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	3	3	-	3	-	3	2	2	2	-	2	-	2

Table 5.2 Patients who met the DCD referral criteria - key numbers and rates, 1 April 2022 - 31 March 2023

Unit where patient died	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DCD donors
Brighton, Royal Sussex County Hospital											
A & E	1	0	-	1	1	0	0	-	0	-	0
General ICU/HDU	50	44	88	50	34	23	17	74	16	70	11
ICU - cardiothoracic	1	0	-	1	1	1	0	-	0	-	0
Chichester, St Richard's Hospital											
A & E	0	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	8	8	-	8	6	5	5	-	2	-	2
Haywards Heath, Princess Royal Hospital											
A & E	0	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	4	3	-	4	3	2	1	-	1	-	0
Worthing, Worthing Hospital											
A & E	0	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	15	15	100	14	5	4	4	-	3	-	2

Tables 5.1 and 5.2 show the unit where the patient died. However, it is acknowledged that there are some occasions where a patient is referred in an Emergency Department but moves to a critical care unit. In total for University Hospitals Sussex NHS Foundation Trust in 2022/23 there were 0 such patients. For more information regarding the Emergency Department please see Section 6.

6. Emergency Department data

A summary of key numbers for Emergency Departments

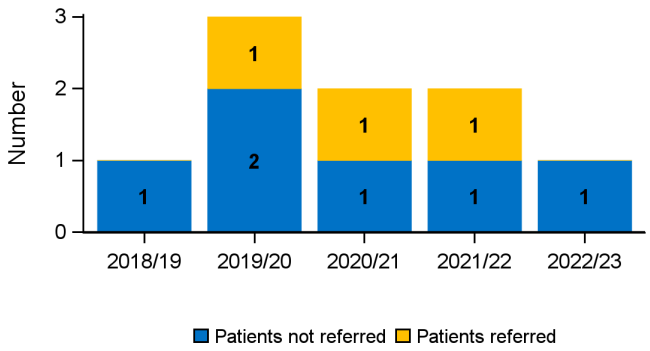
Data in this section is obtained from the National Potential Donor Audit (PDA)

Most patients who go on to become organ donors start their journey in the emergency department (ED). Deceased donation is important, not just for those people waiting on the transplant list, but also because many people in the UK have expressed a decision in life to become organ donors after their death. The overarching principle of the NHSBT Organ donation and Emergency Department strategy [4] is that best quality of care in organ donation should be followed irrespective of the location of the patient within the hospital at the time of death.

6.1 Referral to Organ Donation Service

Goal: No one dies in your ED meeting referral criteria and is not referred to NHSBT's Organ Donation Service.
Aim: There should be no blue on the following chart.

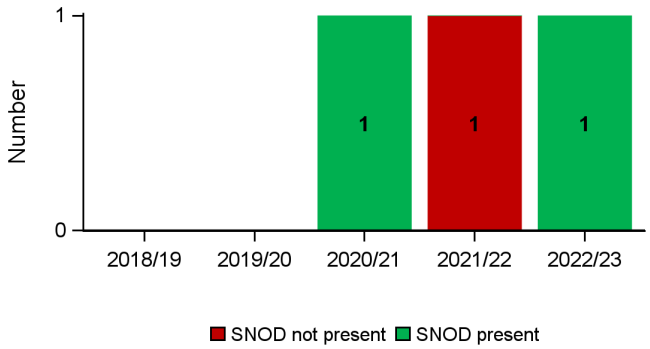
Figure 6.1 Number of patients meeting referral criteria that died in the ED, 1 April 2018 - 31 March 2023



6.2 Organ donation discussions

Goal: No family is approached in ED regarding organ donation without a SNOD present.
Aim: There should be no red on the following chart.

Figure 6.2 Number of families approached in ED by SNOD presence, 1 April 2018 - 31 March 2023



[4] NHS Blood and Transplant, 2016.
Organ Donation and the Emergency Department
[accessed 9 May 2023]

7. Additional data and figures

Regional donor, transplant, and transplant list numbers

Data in this section is obtained from the UK Transplant Registry

7.1 Supplementary Regional data

Table 7.1 Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	South East Coast*	UK
1 April 2022 - 31 March 2023		
Deceased donors	100	1,429
Transplants from deceased donors	194	3,589
Deaths on the transplant list	23	441
As at 31 March 2023		
Active transplant list	379	6,959
Number of NHS ODR opt-in registrations (% registered)**	2,261,428 (49%)	28,567,574 (44%)

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

Key numbers and rates on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

7.2 Trust/Board Level Benchmarking

University Hospitals Sussex NHS Foundation Trust has been categorised as a level 1 Trust. Levels were reallocated in July 2018 using the average number of donors in 2016/17 and 2017/18, Table 7.2 shows the criteria used and how many Trusts/Boards belong to each level.

Table 7.2 Trust/Board level categories

		Number of Trusts Boards in each level
Level 1	12 or more (≥ 12) proceeding donors per year	35
Level 2	6 or more but less than 12 (≥ 6 to <12) proceeding donors per year	45
Level 3	More than 3 but less than 6 (>3 to <6) proceeding donors per year	47
Level 4	3 or less (≤ 3) proceeding donors per year	41

Tables 7.3 and 7.4 show the national DBD and DCD key numbers and rates for the UK by Trust/Board level, to aid in comparison with equivalent Trusts/Boards. Note that percentages have been excluded where numbers are less than 10.

Table 7.3 National DBD key numbers and rate by Trust/Board level, 1 April 2022 - 31 March 2023

	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Your Trust	32	28	88	31	97	27	25	23	19	83	16	70	15
Level 1	1133	896	79	1124	99	879	831	714	677	95	474	66	438
Level 2	441	340	77	439	100	331	307	267	259	97	182	68	171
Level 3	287	229	80	283	99	224	216	188	184	98	135	72	124
Level 4	119	91	76	119	100	90	85	75	70	93	55	73	50

Table 7.4 National DCD key numbers and rate by Trust/Board level, 1 April 2022 - 31 March 2023

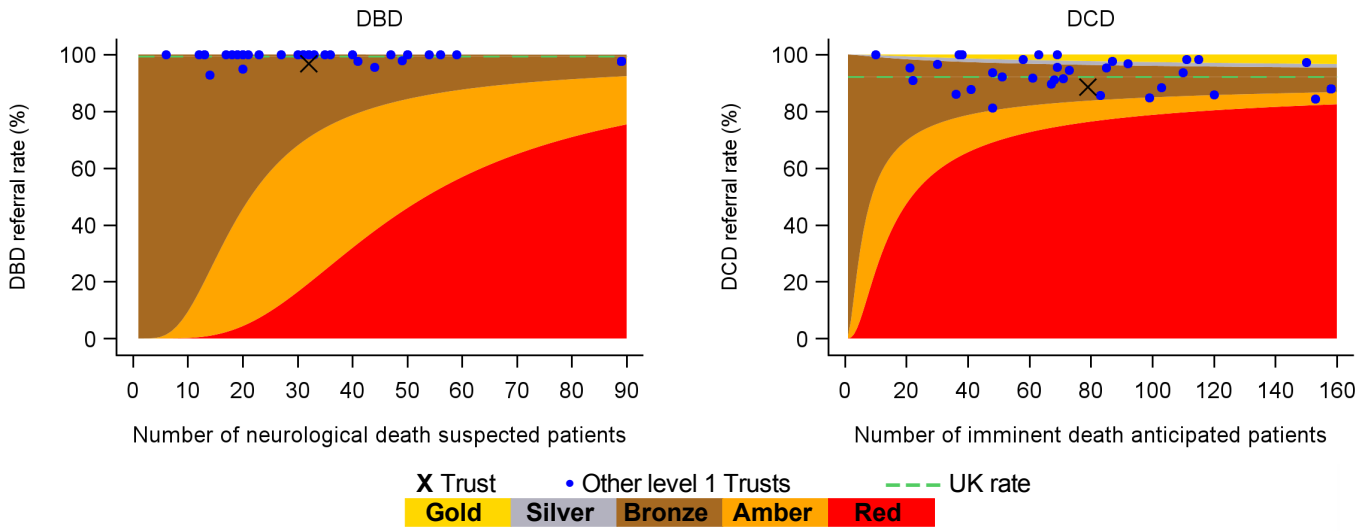
	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DCD donors
Your Trust	79	70	89	78	50	35	27	77	22	63	15
Level 1	2564	2370	92	2464	1772	941	856	91	537	57	369
Level 2	1346	1239	92	1313	841	373	333	89	209	56	132
Level 3	979	910	93	944	571	269	241	90	155	58	97
Level 4	418	367	88	408	283	108	96	89	58	54	38

7.3 Comparative data for DBD and DCD deceased donors

Funnel plots are presented in Section 4 showing performance in your Trust against the UK rate for deceased organ donation. The following funnel plots present data for DBD and DCD donors separately.

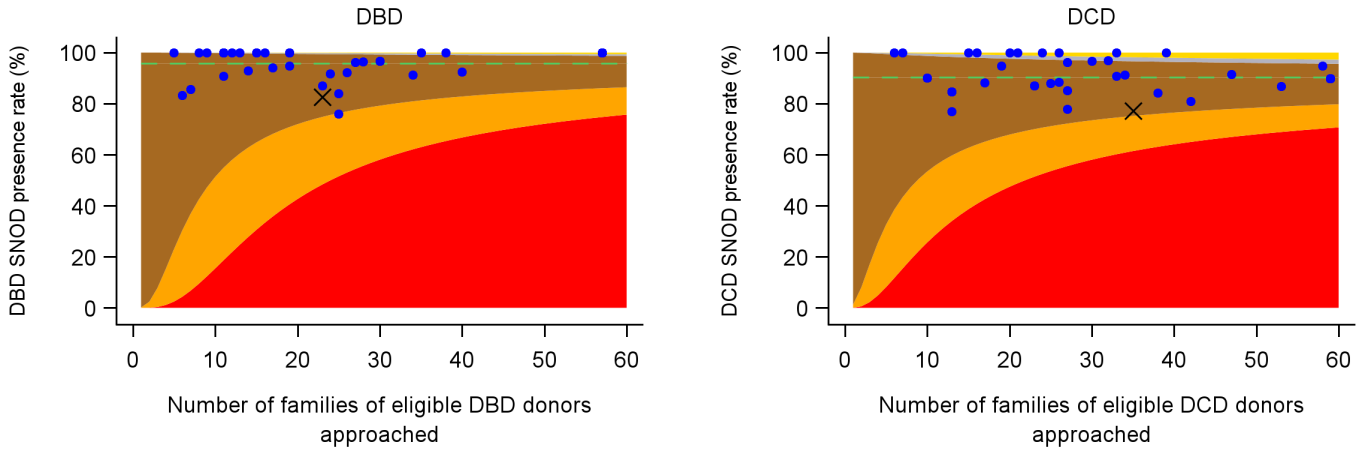
Note that caution should be applied when interpreting percentages calculated with numbers less than 10.

Figure 7.1 Funnel plots of referral rates, 1 April 2022 - 31 March 2023



When compared with UK performance University Hospitals Sussex NHS Foundation Trust was average (bronze) for referral of potential DBD organ donors and average (bronze) for referral of potential DCD organ donors to NHS Blood and Transplant's Organ Donation Service.

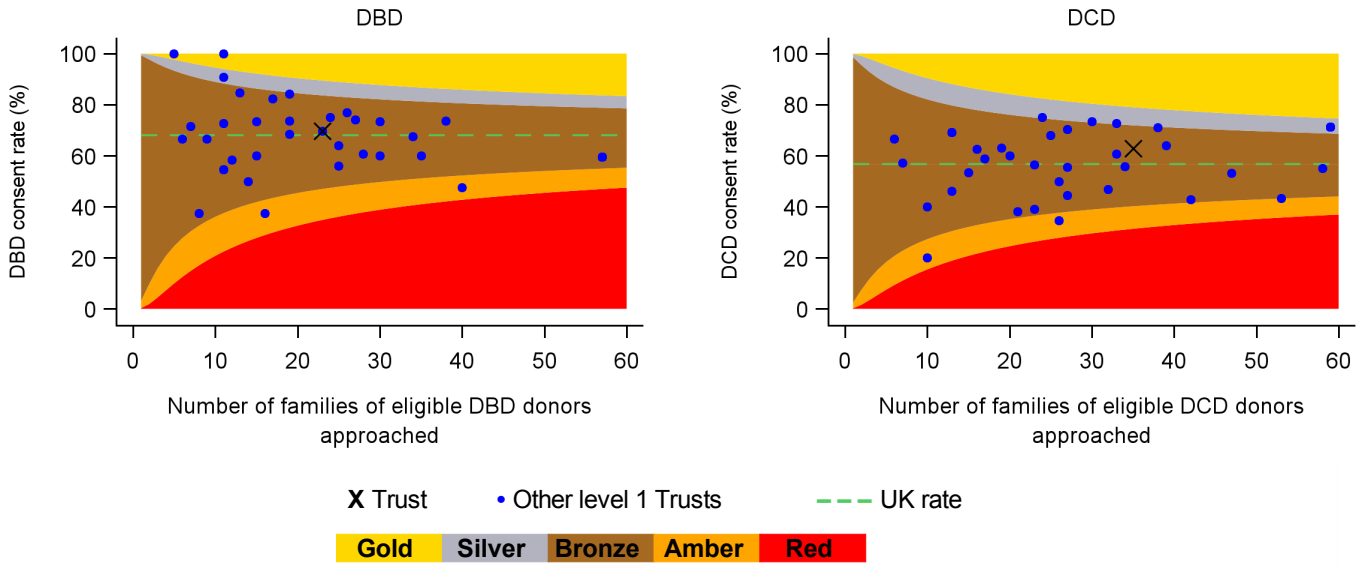
Figure 7.2 Funnel plots of SNOD presence rates, 1 April 2022 - 31 March 2023



DCD

When compared with UK performance University Hospitals Sussex NHS Foundation Trust was average (bronze) and average (bronze) for Specialist Nurse presence in approaches to families of eligible DBD and DCD donors, respectively.

Figure 7.3 Funnel plots of consent rates, 1 April 2022 - 31 March 2023



When compared with UK performance the consent rate in University Hospitals Sussex NHS Foundation Trust was average (bronze) and average (bronze) for DBD and DCD donors, respectively.

Appendices

Appendix A.1 Definitions

Potential Donor Audit Definitions

Potential Donor Audit inclusion criteria	1 October 2009 – 31 March 2010 All deaths in critical care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2010 – 31 March 2013 All deaths in critical and emergency care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2013 onwards All deaths in critical and emergency care in patients aged 80 and under (prior to 81st birthday)

Donors after brain death (DBD) definitions

Suspected Neurological Death	A patient who meets all of the following criteria: invasive ventilation, Glasgow Coma Scale 3 not explained by sedation, no respiratory effort, fixed pupils, no cough or gag reflex. Excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – below 37 weeks corrected gestational age'. Previously referred to as brain death
Neurological death tested	Neurological death tests performed to confirm and diagnose death
DBD referral criteria	A patient with suspected neurological death
Specialist Nurse Organ Donation or Organ Donation Services Team Member (SNOD)	A member of Organ Donation Services Team including: Team Manager, Specialist Nurse Organ Donation, Specialist Requester, Donor Family Care Nurse
Referred to Specialist Nurse – Organ Donation	A patient with suspected neurological death referred to a SNOD. A referral is the provision of information to determine organ donation suitability. NICE CG135 (England) : Triggers for clinicians to refer a potential donor are a plan to withdraw life sustaining treatment or a plan to perform neurological death tests
Potential DBD donor	A patient with suspected neurological death
Absolute contraindications	Absolute medical contraindications identified in assessment which clinically preclude organ donation as per NHSBT criteria (POL188) Absolute medical contraindications to donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/17160/clinical-contraindications-to-approaching-families-for-possible-organ-donation-pol188.pdf
Eligible DBD donor	A patient confirmed dead by neurological death tests, with no absolute medical contraindications to solid organ donation
Donation decision conversation	Family of eligible DBD asked to make or support patient's organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation ascertained	Family supported opt in decision, deemed consent/authorisation, or where applicable the family or nominated/appointed representative gave consent/authorisation for organ donation
Actual donors: DBD	Patients who became actual DBD donors following confirmation of neurological death, as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Actual donors: DCD	Patients who became actual DCD donors following confirmation of neurological death, as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Neurological death testing rate	Percentage of patients for whom neurological death was suspected who were tested

Referral rate	Percentage of patients for whom neurological death was suspected who were referred to the SNOD
Donation decision conversation rate	Percentage of eligible DBD families or nominated/appointed representatives who were asked to make or support an organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation rate	Percentage of donation decision conversations where consent/authorisation was ascertained
SNOD presence rate	Percentage of donation decision conversations where a SNOD was present (includes telephone and video call conversations)
Consent/Authorisation rate where SNOD was present	Percentage of donation decision conversations where a SNOD was present and consent/authorisation for organ donation was ascertained (as above)

Donors after circulatory death (DCD) definitions

Imminent death anticipated	A patient, not confirmed dead using neurological criteria, receiving invasive ventilation, in whom a clinical decision to withdraw treatment has been made and a controlled death is anticipated within a time frame to allow donation to occur (as determined at time of assessment)
DCD referral criteria	A patient for whom imminent (controlled) death is anticipated following withdrawal of life sustaining treatment (as defined above)
Specialist Nurse Organ Donation or Organ Donation Services Team Member (SNOD)	A member of Organ Donation Services Team including: Team Manager, Specialist Nurse Organ Donation, Specialist Requester, Donor Family Care Nurse
Referred to SNOD	A patient for whom imminent death is anticipated who was referred to a SNOD. A referral is the provision of information to determine organ donation suitability NICE CG135 (England) : Triggers for clinicians to refer a potential donor are a plan to withdraw life sustaining treatment or a plan to perform neurological death tests
Potential DCD donor	A patient who had treatment withdrawn and imminent death was anticipated within a time frame to allow donation to occur.
Absolute contraindications	Absolute medical contraindications identified in assessment which clinically preclude organ donation as per NHSBT criteria (POL188). Absolute medical contraindications to donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/17160/clinical-contraindications-to-approaching-families-for-possible-organ-donation-pol188.pdf
Eligible DCD donor to be assessed	A patient who had treatment withdrawn and imminent (controlled) death was anticipated, with no absolute medical contraindications to solid organ donation.
DCD exclusion criteria	DCD specific criteria determine a patient's suitability to donation when there are no absolute medical contraindications (see absolute contraindications documentation above)
DCD screening process	Process by which an organ may be screened with a local and national transplant centre to determine suitability of organs for transplantation
Medically suitable eligible DCD donor	An eligible DCD donor to be assessed considered to be medically suitable for donation (i.e. no DCD exclusions and not deemed unsuitable by the screening process)
Donation decision conversation	Family of medically suitable eligible DCD donor who were asked to make or support patient's organ donation decision - This includes clarifying an opt out decision.
Consent/Authorisation ascertained	Family supported opt in decision, deemed consent/authorisation, or where applicable the family or nominated/appointed representative gave consent/authorisation for organ donation
Actual DCD	DCD patients who became actual DCD as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Referral rate	Percentage of patients for whom imminent (controlled) death was anticipated who were referred to the SNOD

Donation decision conversation rate	Percentage of medically suitable eligible DCD families or nominated/appointed representatives who were asked to make or support an organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation rate	Percentage of donation decision conversations where consent/authorisation was ascertained.
SNOD presence rate	Percentage of donation decision conversations where a SNOD was present (includes telephone and video call conversations).
Consent/Authorisation rate where SNOD was present	Percentage of donation decision conversations where a SNOD was present and consent/authorisation for organ donation was ascertained (as above).

Deemed Consent/Authorisation

Deemed consent applies if a person who died in Wales, Jersey or England has not expressed an organ donation decision either to opt in or opt out or nominate/appoint a representative, is aged 18 or over, has lived in the country in which they died for longer than 12 months and is ordinarily resident there, and had the capacity to understand the notion of deemed consent for a significant period before their death.

Deemed authorisation applies if a person who died in Scotland has not expressed, in writing, an organ donation decision either to opt in or opt out, is aged 16 or over, has lived in Scotland for longer than 12 months and is ordinarily resident there, and had the capacity to understand the notion of deemed authorisation for a significant period before their death. Note that, in Scotland, a patient who has verbally expressed an opt in decision is included as a deemed authorisation, whereas a patient who has verbally expressed an opt out decision is not included.

Consent/Authorisation groups

Expressed opt in	Patient had expressed an opt in decision. Opt in decisions can be expressed in writing or via the ODR in all nations and verbal opt in decisions are also included in Wales, England and Jersey. Verbally expressed opt in decisions are not included in Scotland
Deemed consent/authorisation	Patient meets deemed criteria specific to each nation as described above. In Scotland, this includes patients who have verbally expressed a decision to opt in
Expressed opt out	Patient had expressed an opt out decision. Opt out decisions can be expressed verbally, in writing or via the ODR in all nations
Other	Patient has expressed no decision or deemed criteria are not met. Paediatric patients are included in this group

UK Transplant Registry (UKTR) definitions

Donor type	Type of donor: Donation after brain death (DBD) or donation after circulatory death (DCD)
Number of actual donors	Total number of donors reported to the UKTR
Number of patients transplanted	Total number of patients transplanted from these donors
Organs per donor	Number of organs donated divided by the number of donors.
Number of organs transplanted	Total number of organs transplanted by organ type

Appendix A.2 Data Description

This report provides a summary of data relating to potential and actual organ donors as recorded by NHS Blood and Transplant via the Potential Donor Audit (PDA), the accompanying Referral Record, and the UK Transplant Registry (UKTR) for the specified Trust, Board, Organ Donation Services Team, or nation.

This report is provided for information and to facilitate case based discussion about organ donation by the Organ Donation Committee at your Trust/Board.

As part of the PDA, patients over 80 years of age and those who did not die on a critical care unit or emergency department are not audited nationally and are therefore excluded from the majority of this report. Data from neonatal intensive care units (ICU) have also been excluded from this report. In addition, some information may be outstanding due to late reporting and difficulties obtaining patient notes. Donations not captured by the PDA will still be included in the data supplied from the accompanying Referral Record or from the UKTR, as appropriate.

Percentages have not been calculated for level 3 or 4 Trust/Boards and where stated when numbers are less than 10.

Appendix A.3 Table and Figure Description

1 Donor outcomes	
Table 1.1	The number of actual donors, the resulting number of patients transplanted and the average number of organs donated per donor have been obtained from the UK Transplant Registry (UKTR) for your Trust/Board. Results have been displayed separately for donors after brain death (DBD) and donors after circulatory death (DCD).
Table 1.2	The number of organs transplanted by type from donors at your Trust/Board has been obtained from the UKTR. Further information can be obtained from your local Specialist Nurse – Organ Donation (SNOD), specifically regarding organs that were not transplanted. Results have been displayed separately for DBD and DCD.
Figure 1.1	The number of actual donors and the resulting number of patients transplanted obtained from the UKTR for your Trust/Board for the past 10 equivalent time periods are presented on a line chart.

2 Key rates in potential for organ donation	
Figure 2.1	Key percentage measures of DBD and DCD potential donation activity for your Trust/Board are presented in a bar chart, using data from the Potential Donor Audit (PDA). The comparative UK rate, for the same time period, is illustrated by the pink line. The key rates labels are coloured using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme to show the performance of your Trust/Board, relative to the UK rate, as reflected in the funnel plots (see description for Figure 4.1 below.
Figure 2.2	Trends in the key percentage measures of DBD and DCD potential donation activity for your Trust/Board are presented for the past five equivalent time periods, using data from the PDA.
Table 2.1	A summary of DBD, DCD and deceased donor data and key numbers have been obtained from the PDA. A UK comparison is also provided. Note that caution should be applied when interpreting percentages based on small numbers. Appendix A.1 gives a fuller explanation of terms used. The key rates are highlighted using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme to show the performance of your Trust/Board, relative to the UK rate, as reflected in the funnel plots (see description for Figure 4.1 below).

3 Best quality of care in organ donation	
Figure 3.1	A stacked bar chart displays the number of patients with suspected neurological death who were tested and the number who were not tested in your Trust/Board for the past five equivalent time periods.
Table 3.1	The reasons given for neurological death tests not being performed in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.2	Stacked bar charts display the number of DBD and DCD patients meeting referral criteria who were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Table 3.2	The reasons given for not referring patients to the Organ Donation Service in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.3	The primary absolute medical contraindications to solid organ donation for DBD and DCD patients have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.3	Stacked bar charts display the number of families of DBD and DCD patients approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.
Figure 3.4	Stacked bar charts display the number of families of DBD and DCD patients approached where consent/authorisation for organ donation was ascertained and the number approached where consent/authorisation was not ascertained in your Trust/Board for the past five equivalent time periods.

Table 3.4	The reasons why consent/authorisation was not ascertained for solid organ donation in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.5	The reasons why solid organ donation did not occur in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.

4 Comparative data

Figure 4.1	A funnel plot of the neurological death testing rate is displayed using data obtained from the PDA. Each Trust/Board, of the same level, is represented on the plot as a blue dot, although one dot may represent more than one Trust/Board. The UK rate is shown on the plot as a green horizontal dashed line, together with 95% and 99.8% confidence limits for this rate. These limits form a 'funnel', which is shaded using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme. Graphs obtained in this way are known as funnel plots. If a Trust/Board lies within the 95% limits, shaded bronze, then that Trust/Board has a rate that is statistically consistent with the UK rate (average performance). If a Trust/Board lies outside the 95% confidence limits, shaded silver (good performance) or amber (below average performance), this serves as an alert that the Trust/Board may have a rate that is significantly different from the UK rate. When a Trust/Board lies above the upper 99.8% limit, shaded gold, this indicates a rate that is significantly higher than the UK rate (exceptional performance), while a Trust/Board that lies below the lower limit, shaded red, has a rate that is significantly lower than the UK rate (poor performance). It is important to note that differences in patient mix have not been accounted for in these plots. Your Trust/Board is shown on the plot as the large black cross. If there is no large black cross on the plot, your Trust/Board did not report any patients of the type presented. The funnel plots can also be used to identify the maximum rates currently being achieved by Trusts/Boards with similar donor potential.
Figure 4.2	A funnel plot of the deceased donor referral rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 4.3	A funnel plot of the deceased donor SNOD presence rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 4.4	A funnel plot of the deceased donor consent/authorisation rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.

5 PDA data by hospital and unit

Table 5.1	DBD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.
Table 5.2	DCD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.

6 Emergency department data

Figure 6.1	Stacked bar charts display the number of patients that died in the emergency department (ED) who met the referral criteria and were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Figure 6.2	Stacked bar charts display the number of families of patients in ED approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.

7 Additional data and figures

Table 7.1	A summary of deceased donor, transplant, transplant list and ODR opt-in registration data for your region have been obtained from the UKTR. Your region has been defined as per former Strategic Health Authority. A UK comparison is also provided.
Table 7.2	Trust/board level categories and the relevant expected number of proceeding donors per year are provided for information.
Table 7.3	National DBD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Table 7.4	National DCD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Figure 7.1	A funnel plot of the DBD and DCD referral rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 7.2	A funnel plot of the DBD and DCD SNOD presence rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 7.3	A funnel plot of the DBD and DCD consent/authorisation rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	12	**Meeting:**	Trust Board	**Meeting Date:**	9 November 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 1st November 2023 (October meeting) and was quorate as it was attended by two Non-Executive Directors and Executives including the Chief People Officer and the Chief Operating Officer. The Chief Nurse, Chief Executive and Trust Chairman were also present. In attendance were the Director of Human Resource Management; Director of Integrated Education; the Associate Director of Leadership, Culture and Development and the Company Secretary.
Apologies were received from the Director of Medical Education and the Guardian of Safe Working Hours.

The Committee received its planned items including the reports on the respective Patient First Trust North, Breakthrough Objective, Strategic Initiatives and Corporate Project; a presentation on the Patient First Strategic initiative, updates on health and wellbeing, leadership, culture and development; the Medical Workforce Systems review; workforce scorecard (KPIs), updates on performance around equality & diversity and violence prevention & reduction; an update on the activity of the Freedom to Speak up Guardian as well as a report 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.

A Referral had been received from Quality Committee to examine whether more service specific learning could be gleaned from staff responses to the 2022 National Staff Survey. The Committee received advice from the Chief People Officer that the Trust was not able to further break down the results because of the way data is collated and heard other ways leadership and managers could gain staff opinions. The Committee noted that the question was referred to the Executive for further consideration.
The Committee heard that the 2023 Staff Survey had been issued and asked for initial findings to be brought to the January 2024 meeting.

People Performance Overview Report.

The Committee received its first Overview report in the new format. The Committee acknowledged the previous quarter had been a particularly pressured time for staff with challenges on services but also the increased cost of living. The Committee heard that the Trust had made headway in recruitment, staff engagements and building confidence in speaking up. The Chief People Officer described benchmarking taking place to confirm the Trust is aware of the actions other trusts had also explored to tackle similar challenges.

The Committee welcomed the report of the work underway and the positive progress being made, as reported through the metrics in the overview report and committee papers. While the Committee expects these improvements to translate into a more positive experience for staff over time, it felt that this cannot be confirmed until the findings of the next Staff Survey showed an improvement.

Culture work update

The Director of Human Resources and Director of Communications shared findings of a diagnostic exercise on culture within the Trust, alongside a set of prioritised actions to help develop and improve the culture. The Committee took assurance from the large sample of staff surveyed, along with Board members. The Committee welcomed the initial programme around leadership values and behaviours, building on recognition and analysis based on detailed staff survey responses. The Committee was pleased to hear about the enthusiasm of the co-creation group and consideration of how the Trust will engage seldom heard staff groups.

The Committee looks forward to the action plan, based on the identified priorities, coming to the Committee and particularly welcomed the focus on what the support to be given to middle managers and how the Trust will disseminate and restating our values. It was noted that a number of areas of work had overlap with activities already underway such as inclusive recruitment that looks to ensure our values are reflected.

The Committee welcomed the plans to share the findings with the Board and Governors at a future session.

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. The Survey had been open for 7 weeks and the Committee welcomed the completion rates so far that were considerably above the national average.

The Committee **NOTED** the challenging context of recent months that had led to some slippage on engagement plans. The Committee were **ASSURED** Staff have routes for speaking up and that there have

been additional tools and resources for managers including listening events that some Divisions have continued to use.

The Committee welcomed the presentation from the new Freedom to Speak Up Guardian service and their feedback that the Trust had promoted the service well. The service advised they had received a higher number of reports from trust staff than was typical and advised the Committee that this was positive and meant staff felt confident in using the service . The Committee was **ASSURED** that the arrangements offer strong availability of the service to staff and that their reporting processes with give assurance to staff that issues are recorded and resolved. The Committee **NOTED** that the significant majority of calls represented management system and process issues and the very few that concerned quality and safety matters had been swiftly escalated and addressed. The Committee will continue to monitor the service and look forward to the annual report from the Freedom to Speak Up Service.

The Committee received updates and continued to be **ASSURED** of the continued focus on appraisals and mandatory training that 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.

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.

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.

Strategic Initiative, Patient First Improvement Programme

Following Changes to Trust Committees from August, the Committee commenced oversight of the Patient First Programme and heard about a wide variety of initiatives enabling staff and making changes that they can see the measurable benefits from.
The Committee was **ASSURED** there are a multitude of areas where the Patient First methodology was used appropriately to deliver tangible improvements.

Distinct from leader standard work, the Committee heard about the success of a daily management system pilot on a ward in Worthing that connects daily management and visual arrangements on ward issues through to Hospital and Operational leadership around bed management and staffing for the week ahead. The Committee look forward to an update on the pilot and the plans to advance these arrangements.

Strategic Initiative, Leadership, Culture and Development

The Committee received an update on the delivery of Leadership Culture and Development (LCD) Corporate Project and **NOTED** the progress on Actions received from the LCD Steering Group to provide assurance that progress is being made.
The Equality, Diversity and Inclusion (EDI) update included updates on the progress towards assurance through Internal Audit to come back to Committee, the work of the Inclusive Recruitment Working Group, and the six high impact actions of the NHS England EDI Improvement Plan.

The Committee look forward to a more detailed report on the progress of the Trust's violence prevention and reduction programme at the next meeting and noted the consideration this work has from the Health and Safety Committee. The Committee **NOTED** the associated governance for the workstream and were ASSURED that each group was established and reporting. It was noted that the EDI reporting line includes the Integrated Care System.

Sexual Safety Charter

The Committee was invited to consider endorsing the Trust signing up to a Sexual Safety Charter addressing work to tackle sexual harassment in the workplace. The Committee RECEIVED a report from the Chief People Officer and **APPROVED** the Trust becoming a signatory to the national Sexual Safety in Healthcare Organisational Charter.

The Committee was sensitive to the need to ensure that the zero tolerance commitment is felt to be truly experienced by Trust Staff and look forward to detail on practical arrangements supporting this for which Staff side input would be sought.

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. There had been an increase in the number of reports and the report highlighted hotspots The Committee **NOTED** that these are triangulated with other reports.
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 Guardian had helped to ensure the performance measure around use of funds had improved during the reporting period and were used for positive benefits.

Medical Workforce
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 had progressed well with a majority of medics now on an e-rostering platform and all appraisals on a single system. There was an update that Job plans had been transferred onto healthrota. The Committee welcomed further updates on how this was embedded and sustained noting its significance to the Trust.

The Committee **NOTED** that a Nursing & Midwifery Workforce Workstream Highlight Report is to be provided to the Board for Noting.

NHS Long term workforce plan
The Committee noted that the People team had considered the NHS long term workforce plan and a future update would consider the implications for the Trust. The Committee were hopeful that the plan will help to progress the Trust's objectives as a catalyst driving change including integrating use of education resource, shape of nursing workforce and pathways.

The Committee received Education Reporting Groups that bring together corporate and clinical multi-disciplinary leadership with site and divisional representation to oversee aspects of the workforce plans and delivery of education. The Committee **APPROVED** the establishment and terms of reference of the Workforce Education Groups.

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.

Nature of risks not changed. Flagged reports from divisions. Still work to do on descriptor of risks to get to the cause of the issue e.g. if the establishment is not right. Some risks around security and noted some recent incidents from risk of assault. Central People risks acknowledged the information governance considerations of data held.

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 2 going into Quarter 3 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 remain fragile and pending confirmation of a change in staff experience through the staff survey.

Referrals to other Committees

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

Key Recommendation(s):

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

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

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	**1 November 2023 (October Meeting)**	**Chair**	Paul Layzell	**Quorate**	Yes
Declarations of Interest	No declarations were raised				

Items received at the Committee meeting				
True North – Staff Survey update on 2023 Survey	**Oct**	**Presenter** Director of Human Resources Mgt	**Purpose** For information	**Outcome /Action taken** Noted
Reward & Recognition Core Plan	**Oct**	**Presenter** Chief People Officer	**Purpose** For approval	**Outcome /Action taken** Supported in principle
Breakthrough Objective – Staff Voice that Counts	**Oct**	**Presenter** Director of Human Resources Mgt	**Purpose** For information	**Outcome /Action taken** Noted
Freedom to Speak Up Update	**Oct**	**Presenter** Chief People Officer	**Purpose** For information	**Outcome /Action taken** Noted
Strategic Initiative – Patient First Programme	**Oct**	**Presenter** Chief Operating Officer	**Purpose** For information	**Outcome /Action taken** Noted
Strategic Initiative – Leadership Culture and Development update and KPIs	**Oct**	**Presenter** Chief People Officer / AD Leadership, OD & Engagement	**Purpose** For approval	**Outcome /Action taken** Noted
Integrated Education Update	**Oct**	**Presenter** Director of Integrated Education	**Purpose** For information	**Outcome /Action taken** Noted
Violence Prevention & Reduction Update;	**Oct**	**Presenter** Chief People Officer	**Purpose** For information	**Outcome /Action taken** Noted
Equalities Diversity & Inclusion Update	**Oct**	**Presenter** Chief People Officer	**Purpose** For information	**Outcome /Action taken** Noted
Medical Workforce Systems, Update	**Oct**	**Presenter** Director of Workforce Planning	**Purpose** For information	**Outcome /Action taken** Noted
People Scorecard and KPI Report	**Oct**	**Presenter** Director of Workforce Planning Director of Human Resources Mgt	**Purpose** For information	**Outcome /Action taken** Noted
NHS Long Term Workforce Plan impact on UHSussex	**Oct**	**Presenter** Chief People Officer / Director of Workforce Planning	**Purpose** For information	**Outcome /Action taken** Noted

Guardian for Safe Working Q2 Reports	**Oct**	**Presenter** Chief People Officer (on behalf of Guardian of Safe Working)	**Purpose** For assurance & approval	**Outcome /Action taken** Noted & Approved
Nursing & Midwifery Workforce Workstream Highlight Report	**Oct**	**Presenter** Deputy Chief Nurse (Workforce)	**Purpose** For information	**Outcome /Action taken** Noted
Update on Workforce Culture	**Oct**	**Presenter** Chief People Officer and Director of Communications	**Purpose** For information	**Outcome /Action taken** Noted
Updates from Reporting Groups - Education & Workforce Group - Diversity Matters Steering Group - Health & Wellbeing Steering Group - Joint Negotiation & Consultation Committee	**Oct**	**Presenter** AD Leadership, OD & Engagement, Chief People Officer	**Purpose** For information	**Outcome /Action taken** Education & Workforce Group Terms of Reference Approved Updates Noted
Patient First Programme Update	**Oct**	**Presenter** Chief Operating Officer	**Purpose** For information	**Outcome /Action taken** Noted
Sexual Safety Charter	**Oct**	**Presenter** AD Leadership, OD & Engagement	**Purpose** For approval	**Outcome /Action taken** Noted the NHS England charter & endorsed sign-up by UHSussex
Updates on Integrated Care System	**Oct**	**Presenter** Chief People Officer	**Purpose** For information	**Outcome /Action taken** Noted
Risk Report	**Oct**	**Presenter** Chief People Officer	**Purpose** For information	**Outcome /Action taken** Noted
Board Assurance Framework	**Oct**	**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 **APPROVED** the Trust becoming a signatory to the national Sexual Safety in Healthcare Organisational Charter. The Committee **AGREED** to recommend the risk score for BAF risks 3.1 to 3.4 to the Board for the start of quarter 3 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

The Committee noted that initial Staff Survey 2023 findings will be brought to the Committee in January 2024. On the Culture Work the Committee will receive a report of what has been done (and areas of overlap) with a summary of the associated action plan at its meeting in January 2024

Items referred to the Board or another Committee for decision or action	
Item	**Date**
Nursing & Midwifery Workforce Workstream Highlight Report is provided to the Board for Noting	**November 2023**

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	13.	**Meeting:**	Trust Board	**Meeting Date:**	09 November 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 has focused monthly meetings as well as quarterly meetings. This report therefore covers three meetings in August, September, and October 2023 (the latter held on 2 November and being the full quarterly Committee).

The meetings were quorate, attended by at least two Non-Executive Directors and two executives including the Chief Finance Officer, Chief People Officer and were attended by the Finance Director, the Commercial Director, the Director for Improvement and Delivery and the Managing Director, Planned Care & Cancer. The Director of Improvement and Delivery was present for the September meeting but was represented by their deputy at the October meeting. The Chief Governance Officer gave apologies to the October meeting.

The August meeting focused on the outline business case for an Electronic Patient Record and September meeting focused on the financial position, the efficiency programme, and the productivity breakthrough objective. The October meeting was a full quarterly Committee and covered all areas within the Committee's remit.

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.

The October Sustainability Committee of 2 November 2023 was quorate as it was attended by two Non-Executive Directors, the Chair, the Chief Financial Officer, the Chief People 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 and Managing Director Planned Care and Cancer. The interim Chief Information Officer was in attendance and apologies were received from the Chief Governance Officer and the Director of Improvement and Delivery.

The October 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 2 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.

Investment decisions were also considered and approved (subject to the Committee's delegated limits) at the August and September meetings. These concerned:

- Electronic Patient Record Outline Business Case
- Radiology Remote Reporting Services Contract Award

<u>True North Financial Performance Report</u>
Quarter 2 2023/24 Financial position

The Committee received finance updates at the September and October meetings and were advised by the Finance Director that the Trust had adverse year to date variance against the income and expenditure measures. 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 2023/24 year.

The Committee **NOTED** there has been a change in guidance and reporting around any underperformance against plan. There remains some ambiguity on the treatment of performance in relation to any adjustment for industrial action impact. Due to delivery of elective performance below target, the Committee **NOTED** the expectation that that there will be clawback of Elective Recovery Fund income.

The Committee **NOTED** the Trust has not had confirmation from NHS England on 3Ts funding and that this could be material to the upcoming month 9 position statement.

The Committee **NOTED** the Financial Forecast Roadmap report and NOTED the risks to delivery of the Financial Plan 2023/24. The Committee **NOTED** that actions in relation to the forecast change protocol had commenced.

The Committee noted the risk that inflation impact is higher than allowed for drugs and clinical supplies and that further work is needed to explore the financial impact of 65 weeks and stress test plans.

The Committee noted that while the bed base had reduced as planned with substantive staff redeployed to other areas the Trust has not achieved a reduction on its bank and agency and had increased fill rate. The Committee sought assurances regarding the control environment to ensure that increased fill rates were

needed from a safety and quality perspective. The controls were described but it was acknowledged there is further work to do to ensure consistency of approach.

Winter planning was noted as a key financial risk which is not reflected in the roadmap. Further work is needed to understand the cost implications of this.

ICS Finance Update

The October Committee received an update on the Integrated Commissioning System 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 development of the Integrated Commissioning Board Medium Term financial Plan and the level of efficiencies required to achieve recurrent system breakeven by 2025/26.
The Committee also **NOTED** the ICB led work to evaluate efficiency opportunities and the expectation of provider collaboration being key to understanding and delivering these. The Committee heard how the finance team had applied this understanding to the Trust's medium term financial plan and plans for 2024/25.

The Committee discussed the extent to which opportunities need to be reviewed and the transformational change that will be required to make sustainable cash releasing savings. The Committee is seeking a clearer line of sight on options that are within the Trust's control, particularly opportunities to accelerate any opportunities arising from merger.

Productivity Breakthrough Objective

The Committee discussed the productivity breakthrough objective. In the October meeting the Committee **RECEIVED** an update from Managing Director for Planned Care and Cancer for the position at Month 6.
The Committee **NOTED** that but for industrial action, would have continued to make improvements on work towards 2019/20 activity and productivity with particular progress around day case activity and addressing previous challenges to theatre session availability. The Committee welcomed positive updates on Outpatient productivity, work to avoid short notice cancellations, reducing the inefficiency of re-booking and patient impact and imminent work advancing digital communications driving down clinic non-attendance.
The Committee **NOTED** some slippage on key actions and **NOTED** that key risks to the programme would be operational management capacity during Winter pressures while delivering the 65-week activity.

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, trajectories having been reported and agreed.
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

The 2022/23 Environmental Sustainability Annual Report was received at the October meeting. Current year progress was noted and updates were provided for each of the workstreams. The interim target for 2025 was recognised to be challenging and required a step change to deliver a 12,000 tonne reduction in direct emissions. The Committee **NOTED** the Carbon efficiency plan has a focus towards direct emissions within the Trust's control and that closer tracking was needed against projections for seasonal changes. Waste

segregation and reducing the streams for clinical waste had been a successful scheme for CO2 reduction at RSCH and was being extended to other sites.

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 and was still due to come back. The Committee reflected on learning from other areas and would continue to examine national benchmarks when data is published.

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 following the launch of the corporate project and were **ASSURED** by the approach to ensure divisional work is aligned to the Trust's key priorities i.e. those encapsulated within the clinical strategy, supporting the green plan through carbon reduction and the corporate and clinical activity expectations. It was noted that without demand and capacity modelling against the clinical strategy and prioritised changes at division and service level, estates master plans may not be able to accurately identify future accommodation and instead would need to be high level.

Non-clinical space and occupation would examine new ways of working for better utilisation across the site. The Committee were assured that the Strategic Principles behind the Estates Master planning had been clearly outlined and formed an objective means of prioritising. The Committee acknowledged the plan and strategy will need to be seen as a dynamic document as the organisation and system needs changed.

The Committee **NOTED** that the Chief Strategy Officer would soon commence their role with the Trust and would lead on the implementation and operationalisation of the clinical strategy which would feed into the Estates master Planning work

The Committee **NOTED** the update and strong engagement being undertaken with the Divisions through the launch of the project.
The Committee **NOTED** that the established Focus group model used for master planning would be used to test the Estates Strategy.

Efficiency and Transformation Programme Quarter 2

The Committee **NOTED** the current level of delivery of the year's efficiency programme. Through the update provided by the Deputy Director the Committee **NOTED** continued positive engagement with the divisional leaders with the efficiency steering groups being well attended and having sustained ownership of escalated issues. However, the delivery assessment had worsened with considerable increase in underperformance between the September and October reports. In relation to the drivers of under-performance, the Committee **NOTED** the need to make an assessment on the shortfall arising from prolonged periods of industrial action. The Committee **NOTED** the report of slippage in efficiency delivery and the drivers of the under-performance. The Committee **NOTED** the risks to delivery of the Efficiency Programme 2023/24.

The Committee **NOTED** that reduction in the bed base had not translated to reduced use of bank and agency staff. The Committee asked for the next meeting to provide assurance on the Governance arrangements for Oversight and consistency through the Trust about the approach to fill rate.

The Committee **confirmed its support of increase in the** Sustainability Risk 2.1 of the Board Assurance Framework (BAF) to 20 as there was low confidence that the risk will achieve its target risk score by the end of 2023/24.

Capital Investment Progress Report Quarter 2

The Committee **RECEIVED** the Q2 update against the Trust's 2023/24 capital plan delivering benefits for our patients and our staff across all hospital sites, and the forecast outturn.
The Committee **NOTED** the forecast outturn is in line with the overall capital plan and the external factors outside the Trust control.
The Committee **NOTED** the work to mitigate the overprogramming of the agreed Capital Plan and that the level of over programming had more than halved since Quarter 1 through rephasing of some schemes.

The Committee were advised that IT costs associated with the critical incident could add further pressure to the capital plan.

The Committee was **ASSURED** that although the plan remains over-programmed, rigorous prioritisation process was being applied to reduce this further.

The Committee **NOTED** a risk associated with resource in the Capital Development team to delivery of the plans and discussed the available approaches to address vacancies.

IM&T Programme update

The Committee **RECEIVED** the Quarter 2 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.
Following a Data Centre incident leading to a business continuity challenge in June 2023, a full Incident Report and learning was underway. The Committee were advised that choices over the future approach represented an opportunity. A report would come to the next Committee.

The Committee discussed an increase in reported data protection incidents to the ICO and asked whether this reflected enhanced data protection awareness or a deterioration in DP compliance. Trends, themes, learning, and actions were requested on ICO DP incidents and also penetration testing work.

The Committee heard about the improvement plan for the Data Security and Protection Toolkit to be delivered by December 2023.

The Committee NOTED that digitising activity within the Trust was beginning to show benefits for care and in clinical communications and the Committee requested a future report showing the time released for care.

The Committee welcomed improved visibility of Cyber risks and discussion of these at the Committee.

Electronic Patient Record

The Committee **NOTED** that there had been a change to the profile of funding for the Electronic Patient Record (EPR) investment and the Committee heard the mitigating arrangements that had some impact on the cost envelope and capital and revenue expenditure.

The Committee **NOTED** the amendments to the 2023/24 Investment Agreement and Outline Business Case for this project.

The Committee **NOTED** discussion in the national and regional context of the EPR guidance and were supportive of the Chief Information Officer's view that the interests of the Trust are best served by an emphasis on interoperability and open standards rather than supplier convergence and **NOTED** that regionally the Trust and its Sussex neighbours have been supported in a modular approach.

Commercial Activities Update

The Committee **NOTED** the update on the activities of the Commercial Directorate over the last quarter that included how Pharm@Sea, the Trust's wholly owned subsidiary has further supported delivery of the Trust's strategy through their spoke at Princess Royal Hospital. The Committee **NOTED** the wide ranging Q2 activities against the areas of priority that included innovating with Partners. A procurement update was also including setting out activities and achievements in Quarter 2. More detailed metrics and key risks relating to commercial and procurement work would be provided at future meetings. The Committee was **ASSURED** that the procurement activity was closely aligned with the Trust's Research & Innovation strategy and Patient First principles. The Committee heard about the procurement team's support to entrepreneurial work and how shared benefits of these were supporting the Trust's environmental sustainability agenda.

The Committee received an update on the programme to reprocure Pathology services on a network wide basis consistent with national requirements and this work has reached an external sign-off stage around the business case. The Committee discussed the benefits of the new model and examined the approach to liabilities from the shared network pathology model.

The Committee welcomed reported progress on the articulation of procurement risks and will review these at an upcoming meeting.

Risks and Board Assurance Framework (BAF)

The Committee **NOTED** the quarter 2 Sustainability Risks 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.

It was noted there were elevated Estates risks around the Sustainability CO2 reduction Strategic Initiative. The Committee also noted a change in the Trust's increased risk profile in a number of areas with emergent themes of competing priorities, management capacity and challenge to deliver the capital programme as well as other business priorities including cyber security.

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 2 2023/24 scores for risks 2.2 and 2.3. remained fairly stated. The Sustainability risk at 2.3 will be reconsidered when the multi-year plan is received.

At the October meeting the Committee **AGREED** to elevate risk 2.1 to 20 based on the matters discussed and a reducing level of confidence in bringing this BAF risk score to its target score by the year end.

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 with 2.1 now scored at 20.

SUSTAINABILITY COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	**22 August 2023**	**Chair**	Lizzie Peers	**Quorate**	Yes
Meeting Date	**28 September 2023**	**Chair**	Lizzie Peers	**Quorate**	Yes
Meeting Date	**2 November 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 2 2023/24 Updates Provided in September on Month 5 respectively		**Sep**	**Oct**	**Presenter** Director of Finance	**Purpose** For assurance	**Outcome /Action taken** Noted position and significant key risks. Assured by governance ,Division engagement and responses to tiered support arrangements
Financial Forecast		**Sep**	**Oct**	**Presenter** Director of Finance	**Purpose** For information	**Outcome /Action taken** Noted. Reviewed mitigated forecast outturn and key risks
Medium-Term financial plan		**Sep**	**Oct**	**Presenter** Director of Finance	**Purpose** For information	**Outcome /Action taken** Noted. Further iterations to return to future Committees. Further work to explore possible acceleration of benefits from merger
ICS Financial Report			**Oct**	**Presenter** Chief Finance Officer	**Purpose** For information	**Outcome /Action taken** Noted system work on financial gap, and national context and the implications for the Trust.
Sustainability Breakthrough Objective Productivity Updates provided in September on Month 5		**Sep**	**Oct**	**Presenter** Chief Finance Officer / Managing Director- Planned Care	**Purpose** To inform the Committee of the productivity against 2019/20 activity at 2019/20 cost	**Outcome /Action taken** Noted risks to delivery and the impact of industrial action.
Sustainability Strategic Initiative			**Oct**	**Presenter**	**Purpose** To inform the Committee on	**Outcome / Action taken**

Environmental Sustainability				Director of Estates and Facilities	the progress being made to reduce the Trust's environmental impact	Noted considerable progress. However, energy usage increased compared to 2022/23 so means CO2 target will require a significant step change to deliver in year Assurance noted on 2022/23 delivery on targets and against the Green Plan. Multi-year roadmap with resourcing required to deliver still awaited.
Corporate Project Estates Strategy & Master Planning			**Oct**	**Presenter** 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 Q2 on foundations to identify priorities, opportunities and constraints	**Outcome /Action taken** Noted the update and endorsed the work undertaken toward a Trust Estates Strategy 2024/25-30 Capital plan. Noted limitations to detail pending operationalisation of Clinical Strategy, demand and capacity planning and risk associated with finding of RAAC in premises
Use of Resources						
Efficiency & Transformation Programme. Updates provided in September on Month 5		**Sep**	**Oct**	**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 slippage to the plan and further risks as delivery is weighted toward year end.
Capital Investment Progress Report Q2 2023/24			**Oct**	**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 Q2 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 Q2 2023/24			**Oct**	**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 Q2 and how these align to our Trust strategy.
Protecting and expanding elective capacity Board Self Certification		**Sep**		**Presenter** Chief Finance Officer / Managing Director-Planned Care	**Purpose** To endorse	**Outcome /Action taken** **Approved at Board for submission**
IM&T Programme Progress Report Q2 2023/24			**Oct**	**Presenter** Chief Information Officer	**Purpose** For information	**Outcome /Action taken** Noted the programme update Network Critical Incident full report and learning still to be brought back. Trends, learning from DP incidences, and penetration testing to come to future Committee. Strategy refresh, delivery against this and benefits realisation to come to future meetings.
Investment Decisions						
Electronic Patient Record Outline Business Case	**Aug**			**Presenter**	**Purpose** To endorse	**Outcome /Action taken** (above delegated limit) Recommended to Board for approval, subject to adjustments
Radiology Remote Reporting Services Contract Award		**Sep**		**Presenter**	**Purpose** To Approve	**Outcome /Action taken** Approved (within Committee delegated limit)
Risk						
Trust Risk Register relating to Sustainability			**Oct**	**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			**Oct**	**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 3 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: ▪ **Radiology Remote Reporting Services Contract Award**
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 In relation to the medium-term financial plan the Committee is seeking a clearer line of sight on options that are within the Trust's control to come back to NEXT MEETING, particularly opportunities to accelerate any opportunities arising from merger.

Items referred to the Board or another Committee for decision or action	
Item	**Date**
None	

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Agenda Item:	14.	**Meeting:**	Trust Board	**Meeting Date:**	November 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 2 November and was quorate as it was attended by three Non-Executive Directors and the Trust Chair, as well as the Chief Finance Officer, the Chief Operating Officer and Chief Executive. In attendance was the Managing Director for Urgent and Emergency Care, Managing Director for Planned Care and Cancer, the Director of Strategy and Planning, the Director of Performance and Information, the Chief of Medicine and the 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, patient access transformation update on the ICS 5 year strategy and the Trust's developing winter plan. The Committee also received the standing items of the Systems and Partnerships key risks and the Board Assurance Framework.

The activity of the Committee is summarised below noting the full breath of the meeting's activity is included as an appendix to the paper.

Constitutional Standards Performance

The Chief Operating Officer, the Managing Director for Unscheduled Care and the Managing Director for Planned Care and Cancer updated the Committee on the Trust's performance against each of the key performance metrics to end of September (quarter 2) including a reflection on the challenges impacting on the Trust's operational performance.

The Committee **discussed** the deteriorating position across quarter 2 in respect of the A&E performance indicators of waiting times and ambulance handovers, although these are better than the same period last year. The Committee discussed the work being undertaken not only within the established improvement projects but also in respect of the internal cultural challenges to allow a greater focus on flow against the competing demands of elective care. The Committee **noted** the developed oversight over A&E performance recovery and **noted** the joint working with system partners to improve performance. The Chief Operating Officer updated the Committee on the scale of work to be undertaken to address the performance challenges especially across winter and recognised the elevated risk this patient demand on the service and how this is recognised with the elevated strategic risk on performance.

The Committee **received** a report from the Managing Director for Planned Care and Cancer on the Trust's developed 65wk RTT and Cancer delivery plan. The Committee noted the recovery plans and the actions being taken noting the challenges within the recovery of the 65wk position. Within the Cancer delivery plan the Committee noted the reduction in performance for August had deteriorated, and discussed the drivers for this and the developed recovery plans supported by enhanced management oversight of operational delivery which has seen the increasing cancer backlog position arrested with a significant reduction trajectory over the forthcoming weeks in December. The Managing Director reflected he had confidence over the recovery of the cancer position. The Committee through the report and presentation was **assured** over the programme of work and oversight being applied to the delivery of these plans, **noting** the level of risk from operational pressures and should there be any further industrial action.

The Committee welcomed the inclusion of improvement trajectories within these reports.

Median Hour of discharge

The Chief of Service as the project Senior Responsible Officer (SRO) 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 continued to be **assured** over the delivery of the project improvement actions through the improving position at a site level and noted the realigned focus on improvement given a plateauing of improvement during August and noted that stronger medical leadership to support this project.

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 linkage of the improvements within this project and the work of the median hour of discharge. The Committee noted the work being done through this project with our system partners in respect of discharges including the work within the ICB discharge frontrunner programme. The Committee was **assured** over the delivery of the project improvement actions through the Trust's improving position but **noted** how this was in odds to the Trust's 4-hour performance deterioration.

Patient Access Transformation

The Committee **received** the first report from the Managing Director for Planned Care and Cancer, as the project Senior Responsible Officer (SRO), on this newly commenced corporate project. The Committee

noted the breadth of the project and the developed improvement workstreams and noted the quick wins delivered in quarter 2. The Committee was **assured** over the governance arrangements are aligned to provide effective oversight and support for the project deliverables, covering appointment bookings and patient communications.

The Committee reflected that having a sound baseline will aid the tracking of the expected project benefits.

The ICS 5 Year Strategy Update

The Committee **received** an update from the Director of Strategy and Planning informing the Committee on the Trust is working collaboratively with the system to support the seven strategic aims. The Committee **noted** the summary of the Trust's contribution to these aims and through the update and discussion was **assured** the Trust is engaging with this strategy. The Committee **noted** that the ICB is developing a strategy delivery plan and that this would be shared with the Trust as it develops.

Winter Plan Update

The Managing Director for Unscheduled Care presented to the Committee the developing winter plan. The Committee **noted** the modelling of activity and bed requirements. The Committee **noted** the development of the delivery plan and the planned oversight arrangements for this plan including the tiered approvals required for the use of any extra capacity areas.

The Committee **noted** there are some final refinements to be made before the plan presented to the Board.

Risk and Board Assurance Framework oversight

The Committee reviewed the quarter 2 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 **agreed** that the scores relating to BAF risks 5.1, 5.2 and 5.3 for the start of quarter 3 were fairly represented endorsing the reduction of risk 5.2 and the increase in risk 5.3 to 20.

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, which is at its target score, risk 5.2 being reduced to its target score and 5.3 increasing back to a score of 20.

The Board is asked to **NOTE** that the winter plan will be presented to Board for discussion and agreement.

The Biard is asked to **NOTE** that the Committee has decided to increase the frequency of its meetings to monthly which will allow for timely oversight of the delivery of the Trust's performance improvement plans.

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COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	**2 November 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 / Managing Director of Planned Care and Cancer / Chief Operating Officer	**Purpose** For information.	**Outcome /Action taken** Noted and recognised the performance challenges linked to an increase in BAF risk 5.3.
True North – RTT 65 Week Wait and Cancer Delivery Plan	**Presenter** Managing Director of Planned Care / Chief Operating Officer	**Purpose** For information and assurance	**Outcome /Action taken** Noted and took assurance over the delivery plan development
Breakthrough Objective – Median Hour of Discharge	**Presenter** Chief of Medicine and SRO for this project	**Purpose** For information and assurance	**Outcome /Action taken** Noted and took assurance through the positive impact this project is having on patients going home earlier
Corporate Project – Reducing Length of Stay	**Presenter** Managing Director of Unscheduled Care	**Purpose** For information and assurance	**Outcome /Action taken** Noted and took assurance through the positive impact this project is having on reducing the patients' length of stay
Corporate Project – Patient Access Transformation	**Presenter** Managing Director of Planned Care	**Purpose** For information and assurance	**Outcome /Action taken** Noted the commencement of this project
Strategic Initiatives – 3Ts Hospital Development Report	**Presenter** Chief Finance Officer	**Purpose** For information and assurance	**Outcome /Action taken** Noted the sharing of lessons from the move

Corporate Project – Community Diagnostic Centres	**Presenter** Managing Director of Unscheduled Care	**Purpose** For information and assurance	**Outcome /Action taken** Noted the opening of phase 1 at Southlands
ICS 5 Year Strategy Update	**Presenter** Director of Strategy and Planning	**Purpose** For information	**Outcome /Action taken** Noted the Trust active engagement in supporting the delivery of the ICS strategic themes
Winter Plan update	**Presenter** Managing Director of Unscheduled Care / Chief Operating Officer	**Purpose** For information	**Outcome /Action taken** Noted that once finalised this will be presented to the Board
Risk Report	**Presenter** Chief Operating Officer	**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 to the Board the risk scores for BAF risks 5.1, which is at its target score, risk 5.2 being reduced to its target score and 5.3 increasing back to a score of 20. The Committee **AGREED** to increase the frequency of its meetings to monthly which will allow timely oversight of the delivery of the Trust's performance improvement plans.
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.

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Agenda Item:	15.	**Meeting:**	Board	**Meeting Date:**	9 November 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 17 October 2023 and was quorate as it was attended by five Non-Executive Directors, with a sixth attending for the Board Assurance Framework item. In attendance was the Chief People Officer, the Chief Governance Officer and the Trust's Director of Finance, the Chief Information Officer, and the Company Secretary along with the Trust's Internal and External Auditors and Local Counter Fraud team members. The Trust's Commercial Director attended to present the respective report on tender waivers and the Chief Nursing Officer attended for the Board Assurance Framework item.

Risk Register and BAF reports

The Committee considered, reviewed and discussed the Trust's BAF report and risk management policy compliance report. The Committee recognised the enhancements made to the report structure allowing it to focus its attention on the strength of assurances.

The Committee recognised that the proposed quarter 3 scores had yet to be scrutinised and approved by the respective oversight committees and therefore asked that for those risks where their score is being assessed as reduced in the quarter that the supporting assurances are tested at the Committee.

The Committee recognised that work remains to align the reporting periods of the key supporting risks to the BAF and that through the established Risk Oversight Group meetings the draft BAF would be adjusted to better reflect these as it is presented to the respective oversight committees.

The Committee noted the continued process for updating the BAF and recognised through discussion the drivers of the respective elevated risks.

The Committee noted that there had been a reduction in divisional compliance with their timely review of risks along with a reduced level of completed fields but recognised that the development of the Executive Led Risk Oversight Group would provide a process to explore the reasons for this and lend support for improving levels of divisional compliance with the Trust's Risk Management Policy with its first meeting to be held on the 19 October.

The Committee asked at the next meeting an update on the Risk Oversight Group and the outcome of its first round of meetings be provided to complement the Risk Management Policy Compliance Report.

Internal Audit activity

The Committee noted the positive opinion on the Trust's cyber security arrangements and the advisory recommendations made in respect of the Trust's environmental sustainability programme.

The Committee noted the Internal Auditors follow up report continued to show good levels of engagement with Internal Audit to provide evidence of action delivery or a sound rationale for any date changes.

The Committee noted that for the next meeting there is a significant volume of planned work and asked that the Executives continue to support their teams to engage with the auditors to ensure delivery of the planned reviews to the January Committee meeting.

Local Counter Fraud

The Committee considered the Local Counter Fraud progress report for Quarter 2 2023/24 in relation to their work undertaken in respect of reported concerns. Through this reporting the the Committee noted there were no elevated fraud risks.

The Committee noted the single tender waiver benchmarking report showed the Trust was in the lower quartile for the use of these by volume and value, noting this supported the detailed reports the Committee receive from the Commercial Director in respect of the way the Trust engages with managers to undertaken competitive procurement processes.

Key Recommendation(s):

The Board is asked to **NOTE** the assurances received especially those from Internal Audit and the Local Counter Fraud Specialist.

The Board is asked to **NOTE** that the Audit Committee endorsed the review of the assurances being relied upon by the Executives in proposing a reduction in BAF risks 3.4, 5.2 and 6.1 by the respective People, Systems & Partnerships and the Research & Innovation Committees.

University Hospitals Sussex NHS Foundation Trust

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate
Audit Committee	17 October 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 allowing it to focus its attention on the strength of assurances. The Committee recognised that the proposed quarter 3 scores had yet to be scrutinised and approved by the respective oversight committees and therefore asked that for those risks where their score is being assessed as reduced in the quarter that the supporting assurances are tested at the Committee. The Committee recognised that work remains to align the reporting periods of key supporting risks to the BAF and that through the established Risk Oversight Group meetings the draft BAF would be adjusted to better reflect these as it is presented to the respective oversight committees. The Committee noted the continued process for updating the BAF and recognised through discussion the drivers of the respective elevated risks.
Risk Management Policy Compliance Report	Chief Governance Officer / Deputy Company Secretary	For assurance over Trust's process.	The Committee noted that there had been a reduction in divisional compliance with their timely review of risks along with a reduced level of completed fields. The Committee noted the development of the Executive Led Risk Oversight Group would provide a process to explore

			the reasons for this and lend support for improving the levels of divisional compliance with the Trust's Risk Management Policy with its first meeting to be held on the 19 October. The Committee asked at the next meeting an update on the Risk Oversight Group and the outcome of its first round of meetings be provided to complement the Risk Management Policy Compliance Report.
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 positive opinion on the Trust's cyber security arrangements and the advisory recommendations made in respect of the Trust's environmental sustainability programme. The Committee noted the Internal Auditors follow up report continued to show good levels of engagement with Internal Audit to provide evidence of action delivery or a sound rationale for any date changes. The Committee noted that for the next meeting there is a significant volume of planned work and asked that the Executives continue to support their teams to engage with the auditors to ensure delivery of the planned reviews to the January Committee meeting.
Counter Fraud Reports - Activity Progress Report - Single tender waiver benchmarking report	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 noted the work undertaken by the counter fraud team, that there were no elevated fraud risks. The Committee noted the single tender waiver benchmarking report showed the Trust was in the lower quartile for the use of these by volume and value, noting this supported the detailed reports the Committee receive from the Commercial Director in respect of the way the Trust engages with

			managers to undertaken competitive procurement processes.
External Audit Update	GT (External Audit)	To note status of the External Audit work	The Committee noted that the audit update on the preliminary planning work for the 2023/24 audit.
2022/23 Annual Accounts Lessons Learnt Report	Director of Finance	To review and recommend to the Council of Governors	The Committee noted the key lessons identified and agreed the positive work of the Trust and Auditors this information would in future be folded into the routine reporting on the annual report and accounts updates.
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 generally 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 albeit as in prior years there was an uptick in the use of these in quarter 2. Through the report and the discussion over the processes applied the Committee was assured over the work undertaken by the procurement team working with manager to ensure competitive procurement processes are pursued wherever possible and these were used in exceptional circumstances which aligned to the benchmarking undertaken by RSM (Counter Fraud).
Information Governance (Data Protection Toolkit) Progress Report	Interim Chief Information Officer	To note the progress and consider	The Committee noted the Trust's delivery of outs action plan following its assessment of compliance being "approaching standards". The Committee noted that whilst there were only a relatively small number of standards requiring action to move the Trust's overall compliance rating there were for few of these a degree of risk to their achievement by the date of December due to the volume of work to be undertaken. The Committee was informed that in these areas then the work was weaved into business-as-usual processes and those processes owners were indicating a high level

			of confidence that the actions will be achieved. The Committee noted this update and the positive Internal Audit report on cyber security about preventative measures but asked for further assurance about the Trust's recovery measures from any IT unavailability.
Health and Safety Committee Chairs Report	Company Secretary	Provision of information on the activity of this Committee and review of the Committee's view of the Trust's Health and Safety risks.	The Committee noted the assurance provided over the management of the respective H&S risks.

Actions taken by the Committee within its Terms of Reference

There were no specific actions taken by the Committee other than to note the assurances provided and through the discussion on the BAF support the respective Committees focus within their meetings at the end of the month to test out the assurances being relied on by management to support a reduction in a number of the strategic risks.

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

The Committee **AGREED** for an update on the Executive Risk Oversight Group operation across its first quarters meetings be incorporated into the Risk Management Compliance Report at the next meeting and that an update on Trust's IT system recovery processes be brought to the next meeting to complement the IG and data Security update.

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

Item	Referred to
The Committee endorsed the review of the assurances being relied upon by the Executives in proposing a reduction in BAF risks 3.4, 5.2 and 6.1.	People, Systems & Partnerships and Research & Innovation Committees
The Committee asked the Executives to continue to provide support to ensure the planned Internal Audit reviews are able to be reported at the next meeting in January 2024.	The Executives

University Hospitals Sussex
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Agenda Item:	16.	**Meeting:**	Board meeting in Public	**Meeting Date:**	9 November 2023
Report Title:	Report from Charitable Funds Committee				
Committee Chair:	Lizzie Peers – Non-Executive Director and CFC Chair				
Author(s):	Glen Palethorpe - Company Secretary				
Report previously considered by and date:					

Purpose of the report:			
Information	Yes	Assurance	N/A
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	N/A	Link to Trust Annual Plan	Yes

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	Yes	Bids enhance patient experience
Sustainability	Yes	Bids complement funding from the Trust's resources
People	Yes	Bids support staff wellbeing
Quality	Yes	Bids enhance the quality of care
Systems and Partnerships	Yes	Bids support timely treatment and care
Research and Innovation	Yes	Bids support local improvements

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 Board as Corporate Trustee of the Charity have a legal duty to ensure the funds donated are used in accordance with the Charities objects and comply with the requirements of supporting public benefit.

Communication and Consultation:

Report:

The Committee met on the 10 October and was quorate as it was attended by 3 non-executives and 3 executives. This meeting was attended by the Charity Director and members of the Finance Teams. The meeting considered the business of the Committee had a separate Bids Meeting on 19 September 2023 for which the proposed bids were reported to Board (the Charity's Trustees on 5 October 2023).

At each meeting the Committee has been quorate.

The meeting received one bid for support and a request to adjust an existing funded programme previously approved. The Committee was also invited to consider proposals for the drawdown of the Charity's investment assets in order to fund bids.

Each bid was considered against the charities funding plan and the level of available resources and were assessed against the public benefit test. In considering the funding requests the Committee also received assurance that the required engagement and support had been obtained where appropriate from the capital investment group, medical devices group and procurement team.

University Hospitals Sussex
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The Committee **approved two** bids within the Committee's delegated authority around:

- A Trans Oral Robot – extending the capabilities of the Trust's robot allowing for less invasive surgery and thus enhancing patient experience; and
- Worthing Hospital Courtyard – jointly funded by the League of Friends,

Also within the Committees' delegated authority, the Committee **approved** adjustments to the existing Patient Experience Welcome Standards Programme funded by the Charity.

One bid was agreed to be recommend to the Board (as corporate Trustee) as it was above the Committee's delegated authority this was:

- For additional equipment in the Simulation Centre suite within the Louisa Martindale building that would allow greater use of these facilities. This proposal was subsequently approved by the Trustees on the 5 October 2023.

One further bid has been recommended to the Board (as corporate Trustee) as it was above the Committee's delegated authority this was:

- Submission of the 5 year Research & Innovation charitable funding investment plan

Two other items were referred for decision by the Board (as corporate Trustee) as they are matters above the Committee's delegated authority, these are:

- A request for a drawdown of some of the investment portfolio to allow the Charity to fund proposed bids

- Submission of a form that supports the Trust Charity holding investments in US held stocks, by the Corporate Trustees.

Recommendations

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

The Board is also asked to **NOTE** the decisions taken by the Committee within its delegated authority and to support the funding proposals that exceeded the Committee's delegated authority.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	17.	**Meeting:**	Trust Board in Public	**Meeting Date:**	9 November 2023
Report Title:	Quality and Safety Improvement Programme				
Sponsoring Executive Director:	Darren Grayson, Chief Governance Officer				
Author(s):	Darren Grayson, Chief Governance Officer				
Report previously considered by and date:					

Purpose of the report:			
Information	N/A	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	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

This report relates to undertakings on its FT licence entered into by the Trust

Communication and Consultation:

QSIP will be enabled by wide engagement and communications within the Trust and with system partners and regulators.

Executive Summary:

The undertakings recently entered into require the Trust to develop and deliver a comprehensive improvement plan that gives assurance to the Board, system partners and regulators that the improvements identified by the CQC as 'must and should dos' are being delivered in a timely way. This includes those identified in the CQC Well-Led inspection report February 2023. The undertakings also require the Trust have an open and transparent reporting framework and ensure effective Board oversight.

The slides attached summarise the approach being taken by the Trust.

- A draft charter for the programme has been developed that sets out the problem statement, the scope of the programme, the goals it is aiming to achieve, the key performance indicators, exit criteria etc.
- Governance has been established including the creation of a new Board committee for QSIP and a Chief Executive Chaired Steering Group both to meet each month.
- The Terms of reference for the committee have been drafted and will be presented to a future Board meeting for approval.
- External oversight is provided through established processes with the ICB and NHSE.

- Four delivery workstreams have been established: improving quality governance and risk management, improving RSCH and PRH surgery, improving safety culture and improving quality assurance.
- Two enabling workstreams have been identified: internal and external staff engagement and communications.
- All the workstreams have Executive leads and director lever Senior Responsible Officers.
- Project charters for each delivery workstream have been developed enabling work on charters for the enabling workstreams to progress.
- A high-level timeline is in place that envisages that the programme will be fully articulated by the end of November.
- A summary of progress across all the CQC 'should and must dos' including Well-Led is attached in the appendices.
- Work continues to address areas for improvement whilst the plan is being developed. These include improving training and appraisal compliance.
- The Steering Group is reviewing the consequences of QSIP on the delivery of the plan for this year with a view to identifying aspects that might be managed differently to create capacity across the Trust.

Key Recommendation(s):

The Board is asked to **NOTE** the progress on the creation of the QSIP.

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Quality & Safety Improvement Programme (QSIP)

Public Board

November 2023

Background – NHS Undertakings

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NHS England and the ICB are supportive of University Hospitals Sussex remaining in the National Oversight Framework segment 3 if undertakings focussing on actions to reduce the risk of breaching elements of its Licence were agreed with UHSx. The Board considered this, and undertakings were agreed with NHS England that cover two key areas - quality and governance.

QUALITY

- Development of a comprehensive improvement plan with Board level accountabilities, incorporating feedback from NHSE and any external reviews commissioned as part of its improvement work
- The improvement plan will include:-
  - Priorities and actions in relation to all previous CQC inspection reports
  - Delivery improvement to four-hour performance and planned care
  - Engage and support staff in the improvement plan
  - Transparent internal processes and reporting is available to provide staff with confidence to raise concerns
  - Ensure effective mechanisms for all staff to provide feedback and respond effectively to this feedback including staff survey, complaints, grievances and whistleblowing concerns
  - Ongoing triangulation of the impact of improvement actions with wider quality metrics including patient and staff feedback, incidents and complaints
- Demonstrate ongoing delivery of the comprehensive improvement plan through an open and transparent reporting framework

GOVERNANCE

- Ensure sufficient capacity and capability to lead and oversee successful delivery of the plan and ensure Board oversight and accountability for incidents, clinical harm, complaints and patient feedback
- Ensure effective Board-level governance arrangement to oversee planned delivery, including response to whistleblowing cases, complaints, staff feedback and serious incidents

Project Charter	DRAFT Quality & Safety Improvement Programme (QSIP) – PARENT CHARTER	Date Agreed	October 2023 v3 DRAFT

Problem Statement

The Trust has entered into undertakings with NHSE that address a series of performance, quality and safety metrics and processes that have been identified by regulators as requiring improvement. Whilst there exists a number of improvement projects currently underway in the Trust – including corporate projects, strategic initiatives and business-as-usual management of safety, quality and risk – these are not providing the speed of improvement required. The Trust requires a coherent single improvement plan that delivers improvements quickly and provides assurance to the Board and regulators.

Scope

In scope

- Priorities and actions in relation to all previous CQC inspection reports, and anticipated new reports due end 2023
- Delivery of NHS Undertakings
- Improvement of safety culture in the Trust

Out of scope

- Patient First Improvement Programme (although there will be formal links between PF tools/capability to deliver elements of this programme)
- BAU activities to deliver ongoing Quality and Safety in the Trust
- Deliver improvement to four-hour performance and planned care

Project Goal

- Deliver sustainable improvement to the quality and safety of our services
- Engage and support staff in the improvement plan
- Transparent internal processes and reporting is available to provide staff with confidence to raise concerns
- Ensure effective mechanisms for all staff to provide feedback and respond effectively to this feedback including staff survey, complaints, grievances and whistleblowing concerns
- Ongoing triangulation of the impact of improvement actions with wider quality metrics including patient and staff feedback, incidents and complaints

Exit Criteria

- Key quality and safety metrics achieving Trust standard
- Clear and robust processes embedded into BAU resources
- Achieve minimum GGI Maturity level 3 (out of 6) across all clinical divisions
- External stakeholders (NHSE and ICB) are comfortable that sufficient progress has been made
- The Trust's reporting of incidents has reached sufficient maturity to ensure improved awareness of risk and safety in the organisation
- Staff are comfortable raising concerns related to safety and quality

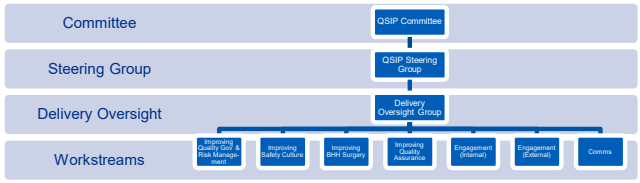
Sponsor & Project Team

Executive Programme Sponsor – Darren Grayson
SRO – tbc

Programme Management Office – Jo Smith / 2 x project managers
All Executives
Identified SROs for workstreams
Additional resources as identified to support workstream completion, to be agreed with relevant Exec leads as programme progresses

BAU processes that remain under existing resource structures

Governance Structure)



Project Roadmap & Timescales

- Phase 1 – Scoping and design of programme. Project charter/s signed off with programme resources identified and in place, alongside agreed programme governance. Plan articulated (end Nov 23)
- Phase 2 – Understanding the as-is and getting started. Baseline assessment of current state. Set KPIs and trajectories. Implement quick wins (end Dec 23)
- Phase 3 – Make improvements (to end Sep 24 – 9 months)
- Phase 4 – Sustain Improvements (to end March 25 – 6 months)

Critical Success Factors & Key Risks

Critical Success Factors

- Review of Trust strategic priorities - both BO/SI/CP as well as Patient First priority projects – to create capacity in organisation to deliver speed of improvements
- Maintaining relationship with external parties to ensure expectations are managed and delivered against
- Quality of data produced and reported (links to BI)

Risks

- Continued and changing priorities from external authorities, including upcoming CQC reports and potential future inspections
- Identified improvement may require business cases and source of funding
- Limited internal SME resources to deliver programme

Project KPIs (Target)

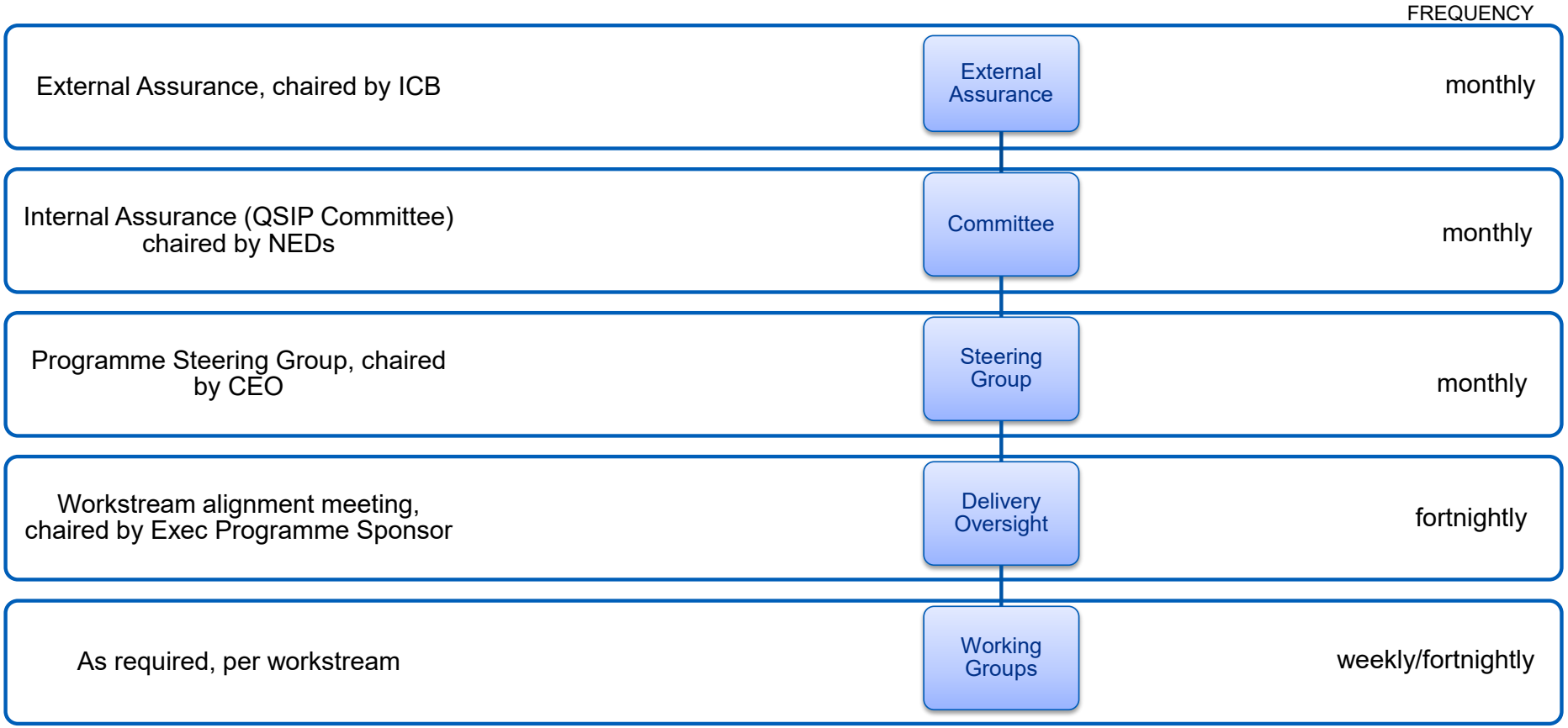
- Key safety and quality metric delivery (to be defined through workstreams)
- Delivery of all Must do/should do actions within agreed timelines
- GGI Maturity of Level 3 (minimum) across all clinical divisions
- 100 Datix reports per 1000 bed days

Benefits Realisation

- tbc

Governance of Quality & Safety Improvement Programme

University Hospitals Sussex NHS Foundation Trust



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Project Goal

- Deliver sustainable improvement to the quality and safety of our services
- Engage and support staff in the improvement plan
- Transparent internal processes and reporting is available to provide staff with confidence to raise concerns
- Ensure effective mechanisms for all staff to provide feedback and respond effectively to this feedback including staff survey, complaints, grievances and whistleblowing concerns
- Ongoing triangulation of the impact of improvement actions with wider quality metrics including patient and staff feedback, incidents and complaints

Exit Criteria

- Key quality and safety metrics achieving Trust standard
- Clear and robust processes embedded into BAU resources
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- External stakeholders (NHSE and ICB) are comfortable that sufficient progress has been made
- The Trust's reporting of incidents has reached sufficient maturity to ensure improved awareness of risk and safety in the organisation
- Staff are comfortable raising concerns related to safety and quality

Project Roadmap & Timescales

PHASE 1 – Oct to Nov 23

Scoping and design of programme

- Resource Planning
- Project charter/s signed off with programme resources identified and in place, alongside agreed programme governance
- Interviews with key internal and external stakeholders to confirm expectations

PHASE 2 - Dec 23

Understanding the As-Is and getting started

- Baseline assessment of current state
- Mobilise programme governance
- Implement quick wins where rapid improvement can be achieved
- Set KPIs and trajectories

PHASE 3 – Jan to Sep 24

Make Improvements

- As per improvement programme

PHASE 4 - Oct 24 to Mar 25

Sustain Improvements

- As per improvement programme

Improvement Workstreams

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Alongside 3 enabling workstreams (Internal Engagement, External Engagement and Communications), there are four key improvement workstreams:-

Improving Quality Governance & Risk Management

- Achievement of Trust quality standards
- Standardised speciality & divisional processes
- Improved maturity of divisional quality governance
- Standardised roles and responsibilities
- Systems used to manage quality and risk are fully operational
- Effective quality governance and risk management processes to enable timely response to risk and safety issues

Improving RSCH & PRH Surgery

- Development and operationalisation of new model of care and workforce model for general surgery in Brighton & Haywards Heath
- A sustained improvement in leadership, where effective leaders are nurtured and supported to deliver improvements in departmental culture and staff engagement
- Increased confidence in provision of high quality surgical training
- Improvement performance against key quality and safety KPI

Improving Safety Culture

- Improved safety culture in the Trust
- Delivery of a framework tool to help assess and measure safety culture
- Develop roles, responsibilities and processes to enhance the effectiveness of reporting and feedback, and embed an open, learning culture
- Ensure that safety culture training is embedded into organisation and considered core to staff

Improving Quality Assurance

- Design the system that provides assurance of completion of must do/should do
- Assure delivery against must do / should do action plans
- Ensure standard work is in place to embed future requests into streamlined ways of working that deliver required assurance to internal and external parties

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Well-Led Action Plan - Update

Appendix A

Well-Led Action Plans

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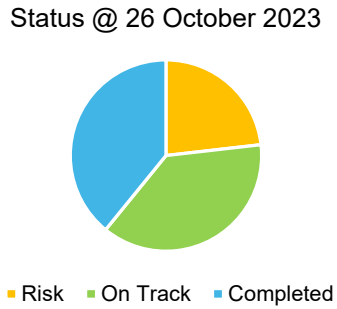
Action plans related to our previous Well-Led inspection continue to be progressed, with the current status shown below of the 8 Must Do and 5 Should Do recommendations:-

	RED	AMBER	GREEN	BLUE
	Significant Risk	Progressing with risk	In Progress / On Track	Completed
Must Do	-	3	4	1
Should Do	-	1	1	3



Of the four items showing at amber risk:-

Recommendation	Status	Next steps
Reporting via Trust systems	Behind schedule due to delays with launch of Datix IQ Incident module launch.	System anomalies currently being addressed with Provider. Oversight of incidents currently remains through Quality Governance Steering Group
Ensure staff of black and minority ethnic backgrounds are not disproportionately disadvantaged	Work is scheduled to take place throughout the year	Work is underway to cascade the delivery of the EDI plan into the clinical and corporate operating divisions
Review medical staffing in RSCH Surgery to ensure service can deliver safe and responsive care	Business case prepared	Due to be presented to Business Case Scrutiny Panel November 2023
Ensure staff with long-term health conditions are protected in line with Equality Act 2010 *(should do)*	Work in progress, including 'Lived experience' videos and workshops launched to help raise awareness.	Need to conclude on central budget to fund support with reasonable adjustments; cascade EDI plan into clinical and corporate divisions

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Divisional Action Plan - Update

Appendix B

Divisional Action Plans

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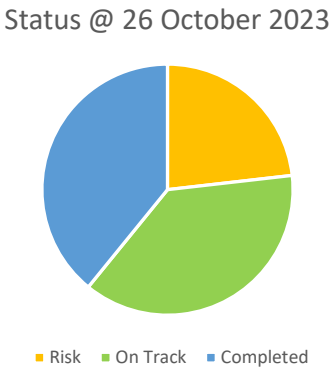
The Trust has received action plans relating to eight different inspection visits, taking place between September 2021 and October 2022. There were 69 must do/should do improvements identified, and the Trust has been managing these through action trackers owned and maintained by the relevant clinical divisions, reporting up through divisional quality meetings, through Quality & Governance Steering Group and into Quality Committee.

Of the 69 improvements identified, 27 have been completed:-

	RED	AMBER	GREEN	BLUE
	Significant Risk	Progressing with risk	In Progress / On Track	Completed
Must Do	-	10	17	11
Should Do	-	6	9	16



Among the 27 items complete, this includes a variety of improvements including:-

- Significant improvements in STAM compliance
- 100% compliance to WHO ‘5 steps to safer surgery’ checklist
- Increased use of Tendable (software) to enable daily oversight on key equipment checks
- Improved physical environment for patients with Dementia in the emergency department at Brighton

Divisional Action Plans

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Of the 16 items shown at risk, all have action plans in place with many due to complete by end Q3:-

Division	Must Do	Should Do	Comments
Surgery (2022)	3	0	• Cancellations: Project underway to right-size theatre capacity at across the whole of UHSx, to create emergency and elective capacity where it is required • Staffing: Business case due to be presented November 2023 to increase funding for medics • Delays: Corporate Project underway to deliver RTT performance. Progress has been impacted by operational pressures and doctor/nurse strikes
Maternity RSCH	1	0	• Triage RAG: an audit tool is now in usage to ensure compliance across all four sites and is being monitored regularly
Maternity WTG	0	3	• Telephone Triage delivered by midwives: Working group in place across 4 sites • Meds Mgmt annual training: new starters receive training, with annual refresher being discussed through Medicines Optimising committee • Triage area: physical environment identified with minor works being completed
ED RSCH	3	3	• Lifesaving Training: being delivered through study days, education days and B7 PBLS/ABLS • Safeguarding Training: being delivered through study days • Mental Health skills: multiple actions in progress • STAM/Appraisals: in progress, with improved visibility and oversight
Upper GI	3	0	• OOO Staffing: Business case due to be presented November 2023 • MDT: moving to regional MDT hosted by Guildford Hospital, with job plans being updated to support

Agenda Item:	18.	**Meeting:**	Trust Board	**Meeting Date:**	09 November 2023
Report Title:	Nursing and Midwifery Staffing Return October 2023				
Sponsoring Executive Director:	Dr Maggie Davies Chief Nursing Officer				
Author(s):	Jane Woollard Deputy Chief Nurse				
Report previously considered by and date:	Exec 11 October TMC 19 October				

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	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

CQC, NMC

Communication and Consultation:

Executive Board, Interim Chief Nurse, HDON's, DDON's

Executive Summary:

The baseline ward establishments are currently in line with national best practice except for the wards identified in section 7. Section 5 and appendix c outline how safer staffing is assessed, maintained and mitigated daily.

Key Recommendation(s):

- Acknowledge the variation from national benching in key acute areas.
- Acknowledge that mitigations are in place to ensure patient safety remain paramount.
- Support the on-going recruitment and retention workforce initiatives (with a focus on international recruitment, domestic and international retention)
- Acknowledge the variation across UHSussex regarding budgeted uplift, ward managers supervisory time and practice educator roles.

University Hospitals Sussex
NHS Foundation Trust

To: **Trust Board** Date: November 2023

From: Maggie Davies Chief Nurse
Leanne Mclean Interim Chief Nurse

Nursing and Midwifery Staffing Return September 2023

1. PURPOSE

The purpose of this report is to provide the Trust Board with a review of ward staffing levels across University Hospitals Sussex, as directed by the National Quality Board (NQB). The NQB has stipulated that; "*Boards must take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability*". This requirement is in response to the Mid Staffordshire NHS Foundation NHS Trust public enquiry and the NHS England *Hard Truths 'the journey to putting the patient first'.* Within their recommendations it states that every six months, as required by the NHS England *Hard Truths* report (2013), the Board of Directors should receive and discuss at a public board meeting a report on staffing capacity and capability.

The report should include (as recommended by the National Inquiry):

- Methodology used to determine staffing levels.
- The allowance within the staffing model annually to provide time for annual leave, statutory and mandatory training (uplift).
- The skill mix review.
- The details of first supernumerary/supervisory allowances for ward sisters.
- The evidence triangulation of professional judgement and scrutiny.
- Details of workforce metrics.
- Information related to the quality and outcome measures.
- Environmental constraint i.e., large number of single rooms, visibility, size of wards and consideration for age of buildings, increased equipment needs of their speciality.

Please note the purpose of this paper is to provide assurance that ward staffing levels remain safe and that robust mechanisms for mitigation and escalation are in place for times of reduced optimal staffing levels.

Headline

- The baseline ward establishments are currently in line with national best practice except for the wards identified in section 7. Section 5 and appendix c outline how safer staffing is assessed and mitigated daily.

Key recommendations the Board is asked to note:

- Acknowledge the variation from national benching in key acute areas.
- Acknowledge that mitigations are in place to ensure patient safety remain paramount.
- Support the on-going recruitment and retention workforce initiatives (with a focus on international recruitment, domestic and international retention)
- Acknowledge the variation across UHSussex regarding budgeted uplift, ward managers supervisory time and practice educator roles.

2. INTRODUCTION

The purpose of this report is to provide the Trust Board with a review of ward staffing levels across University Hospitals Sussex (UHSussex) as directed by the National Quality Board (NQB). This is the second review of ward staffing levels across the newly formed UHSussex since the implementation of the Clinical Operating Model (COM). The review has assessed the funded bed base, impact of escalation beds across all UHSussex sites as well the planned relocation of services into the Louisa Martindale Building (LMB, formally referred to as the 3T project).

3. NATIONAL CONTEXT

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 difference 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 2013).

NICE guidelines (2014) provide recommendations on safe staffing for nursing in adult inpatient wards in acute hospitals, based on the best available evidence. It does not cover intensive care, high dependency; maternity, mental health, acute admission or assessment units or wards, or inpatient wards in community hospitals safe staffing ratios cannot be simply defined in numbers it requires the support of professional judgement.

NICE guidance (2014) advises that there is no single nursing staff-to-patient ratio that can be applied across the whole range of wards to safely meet patients' nursing needs. However, there is much research to show that there is increased risk associated with a registered nurse caring for more than 8 patients during the day shifts.

The Board and the Trust must demonstrate safe staffing to comply with Care Quality Commission's (CQC) regulatory framework and standards. The CQC considers staffing levels in its current inspection regime and CQC well-led framework (2018).

The NMC Code (2018) makes it clear that all Registered Nurses and Midwives are professionally accountable for safe practice in their sphere of responsibility, ensuring that risk is managed, and concerns are escalated without delay.

The Royal College of Nursing has recently released (May 2021) Nursing Workforce Standards comprising of 14 standards.

4. REVIEW OF SCOPE

The scope of the review covered all 4 major sites (Worthing/St Richards/Brighton/Hayward's Heath). In addition, the peripheral unit at Newhaven was also reviewed. In total 35 wards/clinical areas on the Worthing and St Richards hospital sites and 47 wards/clinical areas on the Brighton and Princess Royal hospital sites. The review took place during quarter one 2023. Appendix A - Identifies all clinical areas which participated with the reviews.

5. METHODOLOGY OF THE REVIEW

Nursing establishment reviews entail face to face meetings with ward / department leaders reconciling the current establishment against national recognised benchmarks and previously identified methodology indicators.

The information was then triangulated against the patient experience and safety outcomes (the metrics including Serious Incidents (SI), Never Events (NE), Tissue Viability (TV), outcomes falls and complaints and acknowledge national red flag data. Appendix B – Red flag

Care Hours per Patient Day (CHPPD)

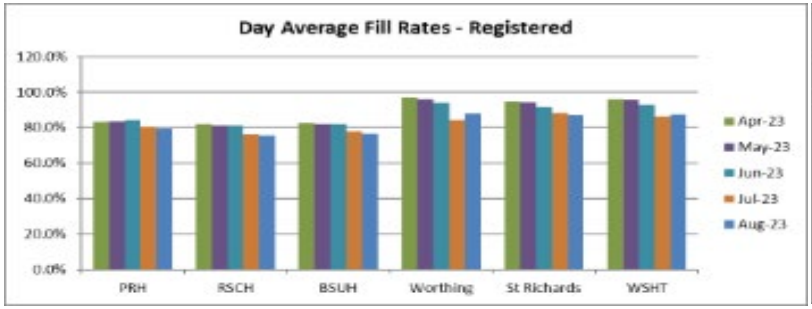
In the Lord Carters' final report: '*Operational Productivity and Performance in English Acute Hospitals: Unwarranted Variations'*, better planning of staff resources is crucial to improving quality of care, staff productivity and financial control. The report recommended that all Trusts start recording Care Hours per Patient Day (CHPPD) – a single, consistent metric of nursing and health care support workers deployment on inpatient wards and units.

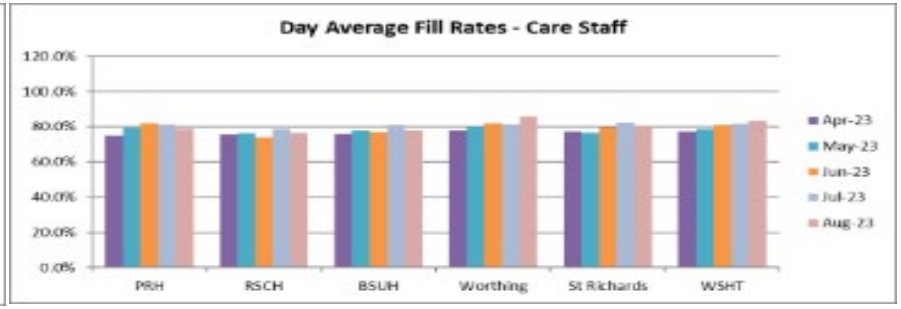
This metric enables trusts to have the correct staff mixes in the right place at the right time, delivering the right care for patients. From 1st May 2016, all trusts were requested to submit monthly CHPPD data to NHSi in order that they can build a national picture of how nursing staff are deployed. From October 2019 the planned and actual hours by ward for Allied Health Professionals and Nursing Associates will also be reported.

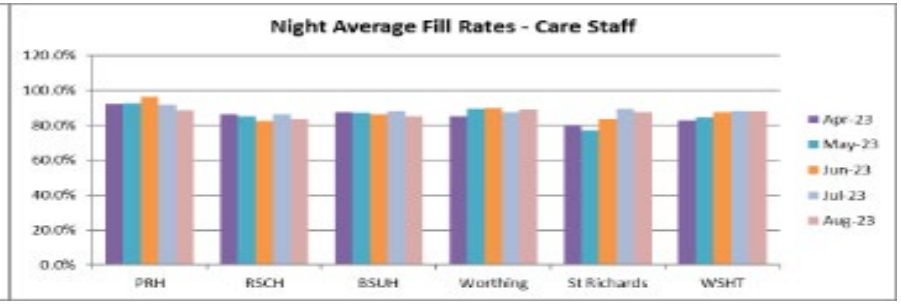
In September 2021 Shelford Systems developed an Emergency Department and Emergency Admissions Area Module and this is about to be implemented across the organisation.

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

NHS University Hospitals Sussex NHS Foundation Trust







	Overall															
	May-22	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	Jul-23	Aug-23
PRH	8.31	7.83	7.22	7.08	7.06	7.03	7.13	6.94	7.78	8.12	7.41	7.53	7.82	7.93	7.93	7.89
RSCH	8.75	8.75	8.68	8.33	8.39	8.02	8.15	7.87	7.89	7.91	8.66	8.11	8.14	10.34	7.61	7.46
BSUH	**8.86**	**8.70**	**8.48**	**8.17**	**8.23**	**7.93**	**8.03**	**7.80**	**8.13**	**8.17**	**8.46**	**8.19**	**8.29**	**9.82**	**7.97**	**7.87**
Worthing	7.25	7.21	6.93	6.92	7.09	7.09	7.02	7.50	6.62	6.95	6.79	6.77	6.63	6.34	5.94	6.42
St Richard	6.64	6.68	6.76	6.67	6.84	6.73	6.63	6.90	6.67	6.95	6.20	6.11	6.27	6.02	5.88	6.17
WSHT	**6.97**	**6.97**	**6.86**	**6.81**	**6.97**	**6.92**	**6.83**	**7.20**	**6.64**	**6.95**	**6.49**	**6.44**	**6.47**	**6.19**	**5.91**	**6.31**
UH Susse	**7.92**	**7.84**	**7.68**	**7.51**	**7.64**	**7.46**	**7.46**	**7.53**	**7.42**	**7.58**	**7.53**	**7.39**	**7.31**	**7.66**	**6.86**	**7.04**

Points to consider for fill rates / CHPPD for Registered and Care Staff

- In response to fluctuations in staffing levels, staffing huddles are held at least twice a day to ensure that areas with challenged staffing levels are supported. Unmitigated staffing shortfalls are escalated as per the safer staffing policy. (Appendix c)

- There has been a slight increase in the overall fill rate for both Registered Nurses and Unregistered staff during quarter one 2023 in comparison to the fourth quarter of 2022/2023, The Care Hours Per Patient Day (CHPPD) remain similar 6.39 - 7.80. This CHPPD remains below the peer median score of 8.1 (Model Hospital data, January 2023).

- "Safer Care" has been rolled out at the Royal Sussex County, Princess Royal Hospital, Worthing, and St Richard's Hospital within all in patient adult and paediatric areas. It is a tool that triangulates actual (live) staffing levels, patient acuity, and professional judgement on a shift-by-shift basis. The impact of this is that the staffing levels and acuity of the patient population for each site can be visualised and where necessary staff redeployed to ensure safe staffing levels.

- A detailed recruitment plan is provided in section 6

6 Vacancies and Recruitment

The NHS Five Year Forward View identified the importance of recruitment and retention (Department of Health 2017), and the NHS Long Term Plan incorporates a focus on workforce including plans for training and recruitment making the NHS a better place to work. This is also a focus of the People Plan Programme for the NHS.

It stated in the plan that there should be no more than 5% RN vacancies by October 2021, this aspiration has been compromised by the COVID-19 pandemic. At the time of writing the report the UHSussex % vacancy rate for Nursing and Midwifery is listed below:

Overview of Nursing and Midwifery WTE vacancies across UHSussex

Data Source - Workforce Transformation Summary August 2023

Total WTE vacancies across Unregistered and Registered Nurses

- Band 2 Unregistered vacancies have decreased from 19% - 8% (283 WTE - 129 WTE)
- RSCH and PRH = 6.0 %
- WRH and SRH = 13.9 %
- Turnover Average = 0.5%

- Band 5 Registered Nurse vacancies have increase from 4.77% to 16.8% (107 WTE - 385 WTE)
- RSCH and PRH = 15.7%
- WRH and SRH = 17.7 %
- Turnover Average = 7.3%

UHSussex - Registered Midwives - Band 6 Vacancies

- RSCH and PRH = 11%
- WRH and SRH = 5 %
- Turnover Average = 5 %

- Please note - at UHSussex, the rolling 12-month turnover for registered Nurses is 7.3% against a national average of 10.67%.

- HCA turnover has reduced significantly to 0.5% and is credited to the newly implemented HCA career conversations and support groups.

- A detailed organisational workforce plan is listed below to address the current vacancy rates underway to address the vacancy rates which is detailed below.

Recruitment

At UHSussex Registered Nurse (RN) vacancies remain high in line with the national position of 11.8%. Whilst there is a continued effort for both local, national, and international recruitment, the Trust is concentrating on retention of staff and *'growing our own' workforce of the future.*

Recruitment Initiatives projects include:

- 12 month rolling recruitment program for RN and HCA's
- Bespoke recruitment campaigns for areas with high vacancies
- Open days at all local universities to promote roles within UHSussex.
- 12-month preceptorship program for newly qualified nurses
- Recruitment of 75 overseas Nurses, who should be in post by Dec 2023. All these Nurses will receive Objective Structured Clinical Examination (OSCE) training.
- OSCE training is also offered to internationally educated nurses working in Band 2 - 4 roles to support the transition to Band 5 RN roles
- Improved pre-registration (pre-reg) student experience that includes in-house simulation and training dates, increased pastoral care to support health and wellbeing and seamless transition into an RN post on qualification.
- UHSussex is working closely with HEIs and the ICS to increase placements. A new placement capacity tool and placement allocation process has been embedded at UHSussex. UHSussex now receives nursing students from 9 universities.
- Internal transfer for Nursing staff to facilitate the transfer of staff within the Trust.
- Introduction of new routes into nursing including Nursing Associates.
- Further practice development roles to support in house education and mentoring.

7.OVERALL FINDINGS

Across the general acute bed base most of the ward establishments were in line with national expectation when measured against previously mentioned criteria.

Exception Adult in Patient Areas

In the adult areas the nurse-to-patient ratio across a 24-hour period was less or equal to 1 RN to 8 patients, in all but the following ward areas listed below.

Please note:

- The wards listed above are based within the Medicine Division at Worthing and St Richards Hospitals. The bed base for each ward can range from 20- 27.
- The wards are care of the elderly wards where the patients require high levels of support with activities of daily living. Therefore, all areas have 3 HCAs rostered on at night.

Ward	Night-Time Ratio
1. Becket	1:10
2. Durrington	1:12
3. ◊Burlington	1:9
4. Buckingham	1:11
5. Boxgrove	1:14
6. Ford	1:13
7. ◊Chilgrove	1:11
8. Ashling	1:14

- If a patient needs more enhanced observations for example due to delirium/ dementia, the support offered will range from bay watch within the nursing numbers or by an additional HCA 1:1 or RMN if the patient has mental ill health needs.
- Quality metrics are monitored and triangulated on a regular basis and if there are any actual or potential concerns appropriate escalation is enacted.

◊ *Burlington and Chilgrove wards care only for patients who are medically, and therapy fit for discharge.*

8 Clinical Areas Reviewed Outside the Remit of Ward Establishment Review

Maternity Services

- Birth-Rate reported in April and was approved by Board in May 2023. The wider staffing review was under the Maternity Safety Support Programme, recommendations approved in June 2023 (£1m uplift to governance, leadership and specialist midwifery and obstetric roles).

- A plan to recruit registered nurses to support the post-natal wards and release midwives to the labour ward has been established to maintain a safe effective service. One nurse per shift has been recruited on all sites. This innovation has been extremely successful.

- Further workforce requirements are envisaged to comply with the Continuity of Carer service provision, which is no longer mandated, but is a recommendation. An implementation plan has been shared with the Board, for actioning once sustained staffing improvements are in place, if it is still the right course of action for the service and service users.

- The workforce challenges related to maternity services form part of the regular Board reporting cycle.

Neonatal Unit

- Annual cot and establishment reviews of all the neonatal units in our organisation are coordinated by the Neonatal networks. St Richard's Hospital in Chichester is part of Thames Valley and Wessex ODN. Our 3 other neonatal units are part of Kent Surrey and Sussex ODN.

- The overview of current establishment that was undertaken in all three special care baby units highlighted no cause for concerns.

- The TMBU at Brighton, which is a Level 3 Surgical Intensive care unit (providing care for highly complex neonates), was highlighted in the bottom quartile for staffing and in the top quartile for occupancy of its cot. It remains the busiest level 3 unit in Kent, Surrey, and Sussex ODN.

- A deficit in staffing was identified of 35 WTE nurses across bands 5 – 7.

- Recruitment and training of QIS nurses is ongoing, failure to provide staffing level in line with National recommendations may have a financial impact upon the organisation CNST contribution. CNST requires a recruitment plan to be in place. We do have a 3-year workforce plan with this reported through quality governance.

Paediatric wards Worthing and St Richards hospitals

- The paediatric wards on the west currently provide a nurse-to-patient ratio across 24 hours of 1: RN to 5 patients which is less than the national benchmark for paediatric wards of 1:4. This is also triangulated by an increase in activity and acuity (the national shortage of CAMHS services impact directly on the children's wards).

- Senior ward leaders have delegated authority to request additional temporary staff if there is an increase in acuity at any time within clinical ward areas to ensure that patient safety remains paramount when observed in the context of the national benchmark. All incidences are reviewed by the divisional team to ensure any themes are identified with appropriate escalations in place.

- Theoretically to align the national staffing with the national requirement each ward will require additional 5.5wte registrant support. This shortfall could be provided either by band 4 or 5 registrants. Total WTE shortfall = 11.

- Significant work has been completed to adjust the templates of these wards to provide the teams with an additional Nurse Associate (band 4) per shift to support the registered workforce. Recruitment to these posts is beginning.

Children's Emergency Department Royal Alex Children's Hospital

- There has been a sustained increase in the activity within the Children's emergency department the department currently covers 3 distinct areas, and the current establishment does not support the ongoing activity. A business case is currently being developed by the division in response to the sustained increased activity. The additional activity could potentially equate to 13 WTE.

Emergency Departments

- The Worthing and St Richards has recently undergone a full workforce review. The consequence has been a significant uplift in the ED staffing supported by additional funding (2.7 million). These vacant posts are now undergoing active recruitment.

- The organisation has invested significantly in the current emergency departments. Like many other trusts, UHSussex does not meet RCEM standards, and this is an area for future workforce discussion.

Theatres

- An overview was undertaken against - The Association for Perioperative Practitioners (AfPP) standards for nursing and theatre staff. Whilst the established templates were in line with the AfPP standards issues relating to vacancies and sickness levels leading to service shortfalls have been highlighted.

Critical Care Units

- The Clinical Operating Model (COM) and the move into the 3Ts environment over the next few years may provide opportunities for both reconciliation and expansion for the organization (a future business will be presented following the transfer of services into the 3Ts environment).

- Currently the units are staffed in line with national benchmarks however the impact of COVID requirements regarding separate units for infective and non-infective patients has impacted directly on staffing requirements and therefore may require further review as the outcome of the pandemic evolves.

9 Key Themes identified regarding differences across UHSussex

Uplift

- A 20.5% uplift is included in ward staffing budgets at the Royal Sussex County and Princess Royal sites and 23.16 % on the Worthing and St Richards sites.
  National best Uplift recommendations vary from 25%-27%. Further analysis of impact will be provided in future reports.

Supervisory Time

- Allocated to the ward leaders, this varied across the two legacy organisations: Royal Sussex County and Princess Royal sites - 33% Clinical 67% supervisory, Worthing and St Richards site is -67% clinical 33% Supervisory.

Practice Education

- It is acknowledged that there is a variance with regard to practise development provision across UHSussex, this discrepancy will be worked through by the education and divisional teams.

10.Conclusion and Key recommendations

Conclusion

- The baseline ward establishments are currently in line with national best practice except for the wards identified in section 6. Section 5 and appendix c outline how safer staffing is assessed and maintained daily.

Key recommendations the Board is asked to note:

- Acknowledge the variation from national benching in key acute areas.
- Acknowledge that mitigations are in place to ensure patient safety remain paramount.
- Support the on-going recruitment and retention workforce initiatives (with a focus on international recruitment, domestic and international retention)
- Acknowledge the variation across UHSussex regarding budgeted uplift, ward managers supervisory time and practice educator roles.

Appendix A - List of Inpatient Areas and Staffing ratios across UHSussex

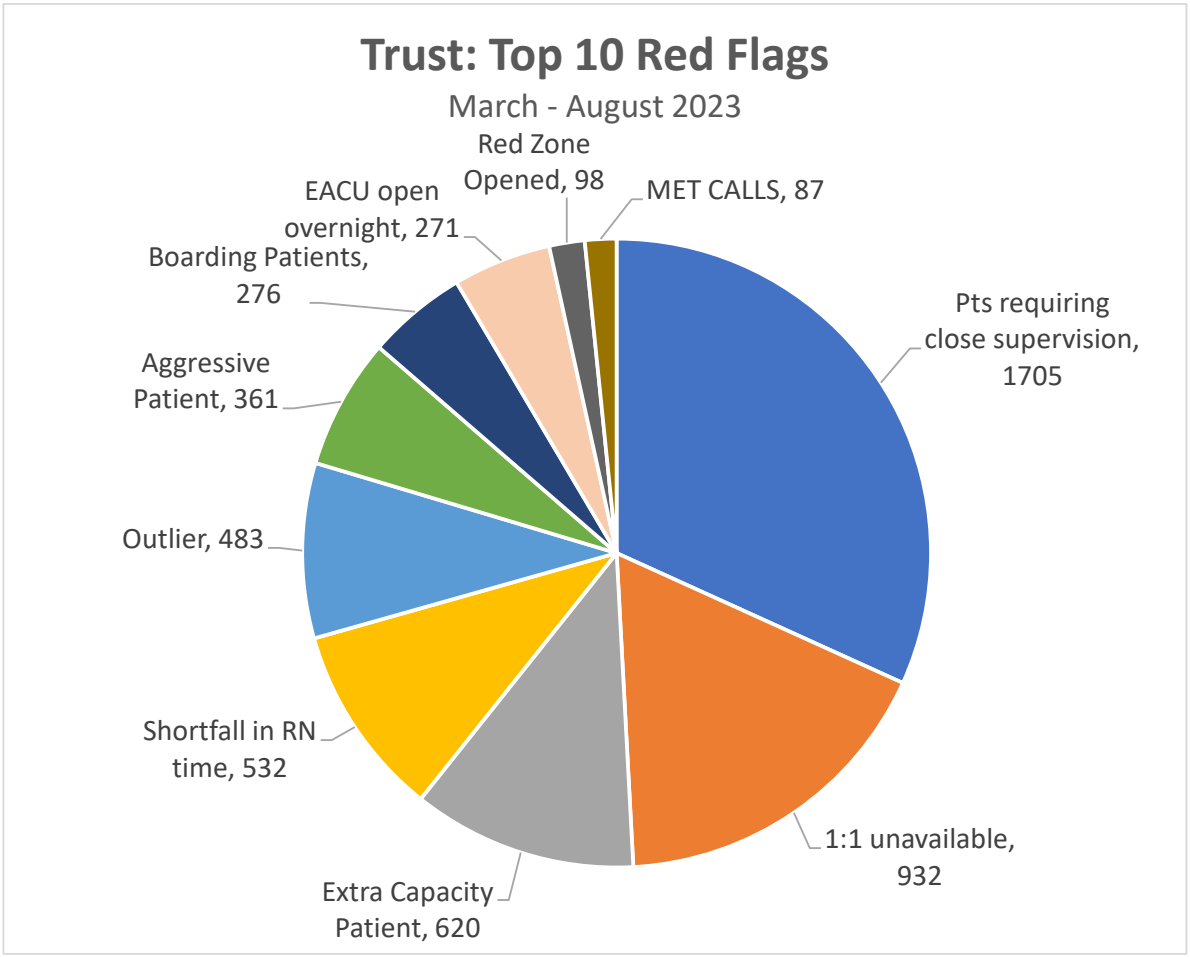
Ward/Area	Site	Beds	Day Ratio	Night Ratio
Middleton	SRH	27	1:6	1:9
Apuldrum	SRH	16	1:0	1:8
Lavant	SRH	26	1:5	1:9
Birdham	SRH	19	1:6	1:9
Fishbourne	SRH	26	1:7	1:9
Petworth	SRH	20	1:5	1:7
ACU	SRH	27 (7CCU)	1:7	1:9
Beacon	WGH	38	1:5	1:7
Broadwater	WGH	33	1:5	1:8
Buckingham	WGH	33	1:5	1:8
Beckett	WGH	21	1:5	1:7
Botolphs	WGH	28	1:6	1:7
Balcombe	WGH	12	1:5	1:9
Erringham	WGH	23	1:6	1:7
Byworth	WGH	20	1:4	1:5
Burlington	WGH	16	1:4	1:8
Ditchling	WGH	24	1:6	1:8
EF SRH	SRH	55	1:6	1:6
EF WGH	WGH	67	1:4	1:5
DWH	SRH	12	1:6	1:6
Chilterton +ESCW	WGH	21	1:5	1:10
Coombes	WGH	27	1:5	1:9
Chilgrove	SRH	27	1:5	1:11
Chi Suite	SRH	16	1:4	1:8
ITU -SRH	SRH	10	9	8
ITU - WGH	WGH	12	10	10

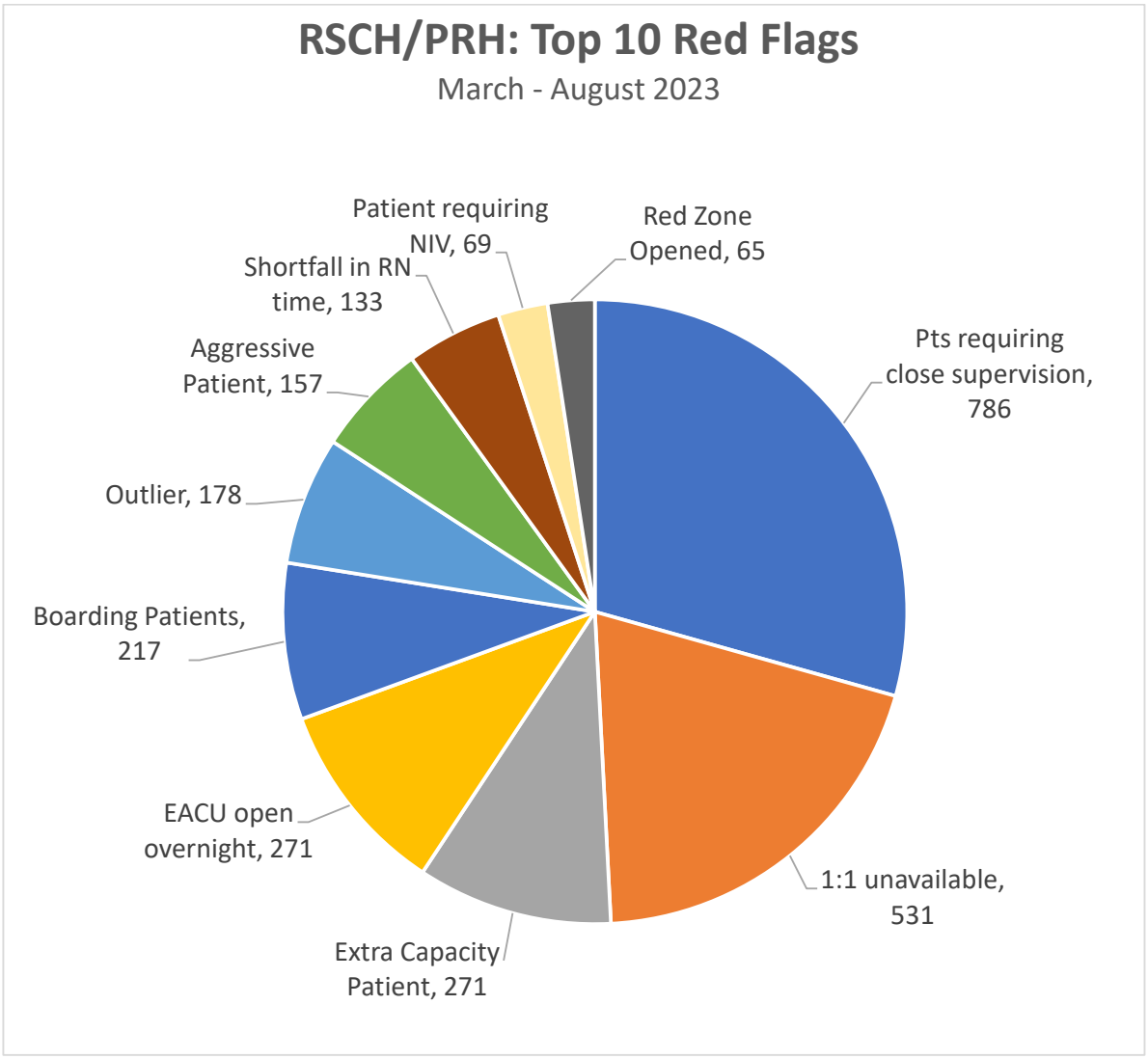
Ward/Area	Site	Beds	Day Ratio	Night Ratio
AAU / EACU RSCH	RSCH	36	1 to 6 & 1 to 3	1 to 6 & 1 to 3
Level 8A East (now MTC)	RSCH	24	1 to 8	1 to 8
Level 6A	RSCH	14	1 to 2 & 1 to 4	1 to 2 & 1 to 4
Level 9A	RSCH	58	1 to 5	1 to 6
Level 11 West	RSCH	18	1 to 6	1 to 6
Level 6/7 Courtyard	RSCH	22	1 to 5.25	1 to 5.25
Emerald Ward	RSCH	16	1 to 5.3	1 to 5.3
Newick (SOTC)	PRH	31	1 to 6	1 to 6
Pyecombe Ward	PRH	27	1 to 5.4	1 to 6.7
Jowers ward	RSCH	11	1 to 5.5.	1 to 5.5
Level 8A West	RSCH	32	1 to 4	1 to 4.5
Balcome	PRH	27 (21 open Oct 19)	1 to 7	1 to 7
L11 Gynae	RSCH	9	1 to 4.5	1 to 4.5
Ardingly	PRH	22 (28 open Oct 19)	1 to 7	1 to 5.6
Horsted Keynes	PRH	12	1 to 6	1 to 6
Plumpton Ward	PRH	18	1 to 6	1 to 6
HPP	PRH	23	1 to 5.8	1 to 6
Acute Respiratory Unit	RSCH	31	1 to 4.5	1 to 6
Albourne	PRH	15	1 to 5	1 to 7.5
Twineham	PRH	37	1 to 6	1 to 8
Courtyard level 8 Oncology (Howard 1)	RSCH	9	1 to 3	1 to 4.5
Ansty	PRH	26	1 to 5	1 to 6
Lindfield	PRH	21	1 to 4.2	1 to 7
Vallance ward	RSCH	17	1 to 5.6	1 to 8.5
Newhaven	NEWHAVEN	23	1 to 7.6	1 to 7.6
Baily	RSCH	14	1 to 4.6	1 to 7
Clayton	PRH	15	1 to 5	1 to 5
L7a Cardiac Surgical Stepdown Unit	RSCH	10	1 to 4	1 to 5.5
Albion and Lewes Ward (Level 10 Cardiac)	RSCH	31	1 to 5	1 to 7
Renal ward (Trafford)	RSCH	26	1 to 5.2	1 to 6.5
Bristol	RSCH	17	1 to 5.66	1 to 5.66
HASU	RSCH	23	1 to 4.6	1 to 4.6
Chichester	RSCH	20	1 to 5	1 to 7
Newtimber	PRH	18	1 to 4.5 (early)	1 to 6
Level 8 Tower	RSCH	37	1 to 5.3	1 to 7.4
Cardiac intensive care unit	RSCH	8	1 to3.3	1 to 5
Haematology	RSCH	10	3 to 3.1	1 to 5
RSCH Critical Care	RSCH	31	NA	NA
PRH Critical Care	PRH	8	NA	NA
ED RSCH	RSCH	NA	NA	NA
ED PRH	PRH	NA	NA	NA
Childrens ED	RSCH	NA (4 Short Stay Beds)	NA	NA
RACH Surgical Ward	RSCH	12	1 to 4	1 to 4
RACH Medical Ward	RSCH	22 / 26	1 to 4	1 to 4
RACH HDU	RSCH	10	1 to 2	1 to 2
RACH Day Case Unit	RSCH	NA	1 to 4	NA
Trevor Mann Baby Unit	RSCH	27	1 to 1; 1 to 2; 1 to 4	1 to 1; 1 to 2; 1 to 4

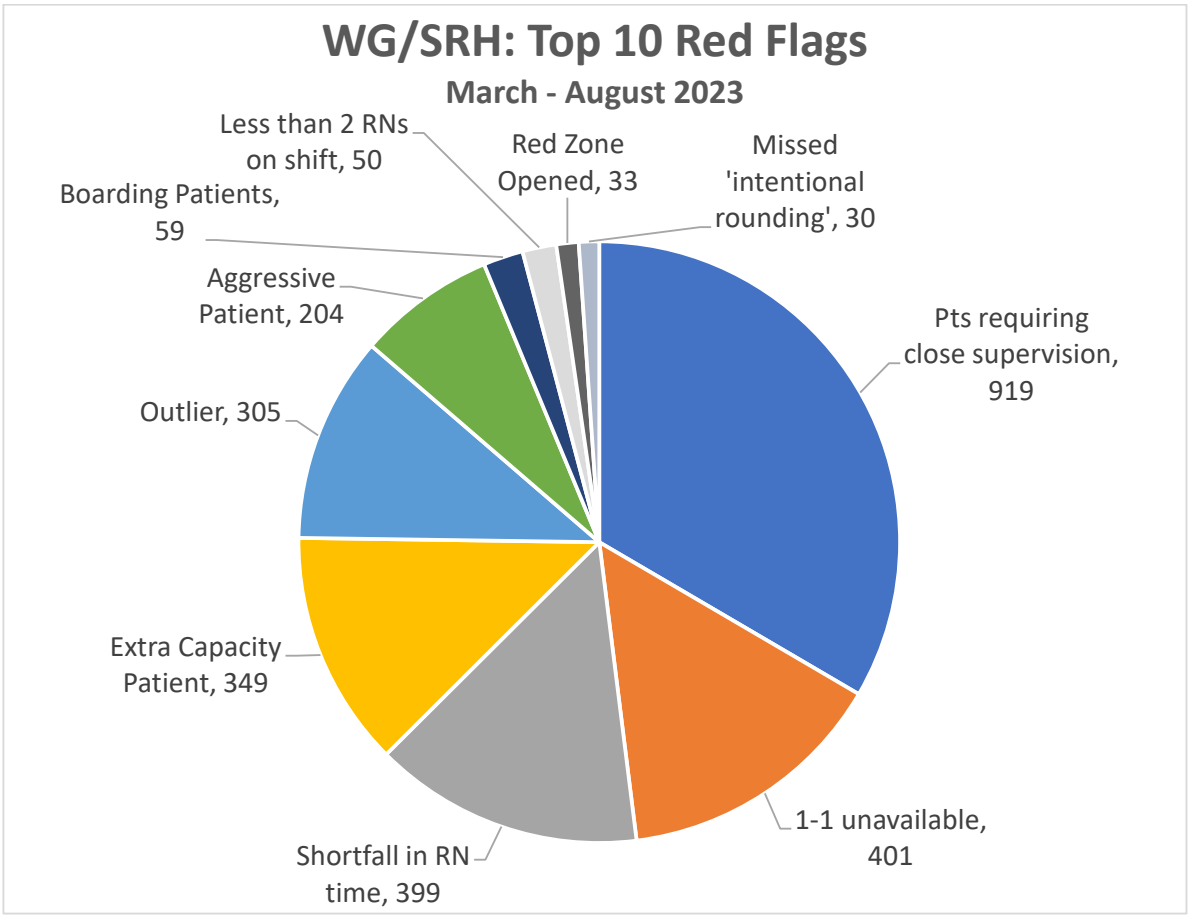
Appendix B - Red Flags

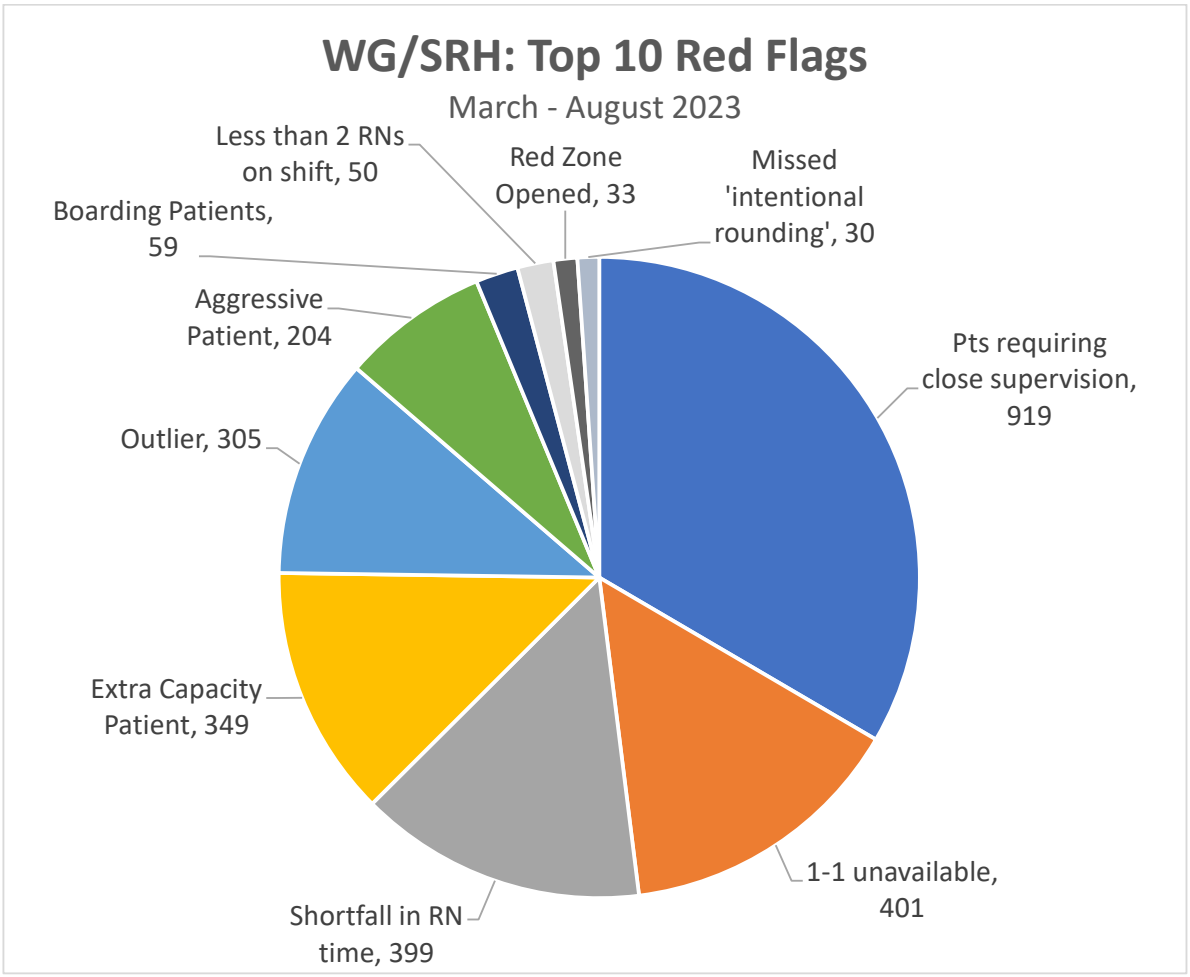
The Safer Staffing Alliance states there is evidence that care is compromised when there are more than 8 patients (beds) to 1 registered nurse. To be compliant with NHS Improvement's Workforce Safeguards, WSHFT have a Red Flag procedure for nursing within the Trust. The purpose of a Red Flag being raised is to identify those times where either essential nursing care has not been delivered, or where there is a risk that the quality of patient care may be impacted. If departments do not have enough nurses on duty with the right skills to safely meet the needs of the unit, they raise a Red Flag via the Datix risk management system.

UHSussex Red Flag Data across all sites




RSCH/PRH: Top 10 Red Flags
March - August 2023
Patient requiring NIV, 69
Red Zone Opened, 65
Shortfall in RN time, 133
Aggressive Patient, 157
Pts requiring close supervision, 786
Outlier, 178
Boarding Patients, 217
EACU open overnight, 271
1:1 unavailable, 531
Extra Capacity Patient, 271


WG/SRH: Top 10 Red Flags
March - August 2023
Less than 2 RNs on shift, 50
Red Zone Opened, 33
Missed 'intentional rounding', 30
Boarding Patients, 59
Aggressive Patient, 204
Pts requiring close supervision, 919
Outlier, 305
Extra Capacity Patient, 349
1-1 unavailable, 401
Shortfall in RN time, 399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