University Hospitals Sussex
NHS Foundation Trust

Meeting of the Board of Directors

10:00 to 13:30 on Thursday 08 February 2024

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 09 November 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
		<u>INTEGRATED PERFORMANCE REPORT</u> *To receive and note all items:*		
Item:6	10:20	**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:7	10:55	**Quality & Safety Improvement Programme** To note	Enclosure	Presenter: Darren Grayson

Item:8	11:10	*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	11:30	**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 30 January 2024**	Enclosure	Presenter: Claire Keatinge
Item:11	11:45	**Report from Patient & Quality Committee** To note assurance from Committee and recommendations from the Committee - **from the meetings held 28 November 2023, 19 December 2023 and 30 January 2024 including:** - **Learning from Deaths Q2** To note	Enclosure	Presenter: Lucy Bloem
Item 11.1	11:55	**Clinical Negligence Scheme for Trusts Year 5** To note declared position	Enclosure	Presenter: Maggie Davies
Item:12	12:00	**Report from People Committee** To note assurance from Committee and recommendations from the Committee - **from the meeting held on the meetings held on the 31 January 2024**	Enclosure	Presenter: Paul Layzell
Item:13	12:05	**Report from Sustainability Committee** To note assurance from Committee and recommendations from the Committee - **from the meetings held on the 30 November 2023, and 1 February 2024**	Enclosure	Presenter: Lizzie Peers
Item:14	12:10	**Report from Systems and Partnerships Committee** To note assurance from Committee and recommendations from the Committee - **from the meeting held on the 29 November 2023, and 1 February 2024**	Enclosure	Presenter: Bindesh Shah
Item 14.1	12:15	**Emergency Preparedness and Resilience and Response Assurance (EPRR) Annual Report** To approve	Enclosure	Presenter: Andy Heeps Siobhan Murray

Item:15	12:20	**Report from Quality & Safety Improvement Programme Committee** To note assurance from Committee and recommendations from the Committee **from the meeting held on the 31 January 2024**	Enclosure	Presenter: Paul Layzell
Item:16	12:25	**Report from Audit Committee** To note assurance from Committee and recommendations from the Committee - **from the meeting held on the 16 January 2024**	Enclosure	Presenter: David Curley
		WELL LED & COMPLIANCE		
Item:17	12:35	**Royal College of Surgeon's invited service review report** To note	Enclosure *(To Follow)*	Presenter: George Findlay Katie Urch
Item:18	12:55	**Operation Bramber** To note	Verbal	Darren Grayson
Item:19	13:10	**Company Secretary Report** To note	Enclosure	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 09 May 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 09 November 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
Bindesh Shah	Non-Executive Director
Dr Andy Heeps	Chief Operating Officer and Deputy CEO
Karen Geoghegan	Chief Financial Officer
Dr Maggie Davies	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
Dr Alex Harrison	Clinical Lead for Organ Donation

TB/11/23/1 WELCOME AND APOLOGIES FOR ABSENCE **ACTION**

1.1 The Chairman welcomed all those present to the meeting.

1.2 The Chairman advised that this meeting would be Sadie Mason's last as she was retiring from the Trust as Associate Non-Executive Director from the 30 November 2023.

1.3 There were apologies for absence received from Professor Malcolm Reed, and David Curley was unable to join remotely as planned due to a technical issue. The Chairman acknowledged that both Professor Urch and Claire Keatinge would be late attending the meeting due to urgent matters.

TB/11/23/2 DECLARATIONS OF INTERESTS

2.1 There were no other interests declared.

TB/11/23/3 MINUTES OF THE MEETING HELD ON 03 AUGUST 2023

3.1 The Board received the minutes of the meeting held on 03 August 2023.

3.2 The minutes of the meeting held on 03 August 2023 were **APPROVED** as a correct record.

TB/11/23/4 MATTERS ARISING FROM THE MINUTES OF THE PREVIOUS MEETING

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

TB/11/23/5 CHIEF EXECUTIVE REPORT

5.1 George Findlay began by taking the opportunity to say thank you to staff highlighting that September, October and November 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.

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 sharing congratulations to the Star of the Month winners Amanda Cornish, Dr Praneil Patel, and the Sussex Orthopaedic Treatment Centre (SOTC). Thankyous were also shared to the physiotherapy team's drive for improvement. George informed the Board of 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). George went on to highlight that 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. During Sexual Health Week in September 2023, 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.

5.4 George explained that the Trust was continuing to invest in service developments including a newly renovated antenatal clinic at Princess Royal Hospital which now provides a dedicated space for antenatal care and offers more services to pregnant women and people. Along with the transformation of three of our emergency departments, which includes Worthing Hospital with a new Urgent Treatment Centre, including a Same Day Emergency Care unit; and a reconfiguration of the Acute Floor (including A&E) at Royal Sussex County Hospital. Separately, at Princess Royal Hospital a GP-led Urgent Treatment Centre model of care pilot is already reducing waiting times and enabling our medics to focus on those most in need of their specialist skills.

5.5 George highlighted that the opening of the new Southlands Community Diagnostic Centre in Shoreham is supporting the Trust's elective care waiting times recovery programme, by providing 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 would enable seeing up to 45,000 patients per year. There are also three new x-ray rooms, all in one dedicated space.

5.6 George went on to express that work on the 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. 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

5.7 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.

5.8 George explained that the Trust's workforce is valued, and work is undertaken to support them through a broad support programme which acknowledges and recognises everything they do for our patients, each other, and the Trust. George highlighted that the Staff Psychological Support Service has supported more 430 colleagues so far in 2023/24. Nearly 400 members of staff are now trained in Mental Health First Aid. Nearly 100 colleagues from across the Trust have become the first to sign up for our refreshed Trust Ambassador scheme. A virtual Menopause Café was held on World Menopause Day, focusing on hormone replacement therapy. 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

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

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

TB/11/23/6 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 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 as the SDP matures as a single plan it will incorporate the priority areas of the NHS Operating Plan requirements, 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, and further workstream updates would be provided in order to provide the public with assurance.

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

6.4 The Board thanked George and **NOTED** the update.

TB/11/23/7 INTEGRATED PERFORMANCE REPORT

7.1 The Chair introduced the performance report for University Sussex Hospitals. Informing the Board that this report shows the Trust's performance to September 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 George Findlay explained that it had been a challenging period for the Trust 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 the delivery of the Trust's planned care activity. From a quality perspective, there were gradual improvements in the SHMI mortality rate, and continued achievement of reductions in falls both areas aligning to the Trust's quality True Norths.

TB/11/23/8 PATIENT

8.1 Maggie Davies presented the Patient section of the Integrated Performance Report and explained to the Board that the True North metric for the Patient Committee was to 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 Q2 over 40,000 patients responded to the Trust's FFT returning a 88.9% positivity rating for the experience they received. Maggie explained that a decline in patient reported experience in FFT was evident, and positivity within the Emergency Departments, with the exception of PRH, RACH, SRH, had fallen below the national average. Inpatient reported experience had been recorded as 92.5%, below the national average of 95%. 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, the Board noted the Welcome Standards initiative was receiving positive patient feedback.

TB/11/23/9 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, as received via monthly surveys undertaken as part of the Trust's IRIS training system. The True North engagement score had consecutively remained at 7 or above, and divisional plans were in place to aid improvements to staff engagement this year which were progressing well. It was noted that the NHS National Staff Survey has seen a 36% completion rate after week 5 with 6044 colleagues having completed the survey to date which is 6% above the response rate at the same time last year and 6% better than other acute trusts. The Trust also continues to carry out Pulse Surveys which continue to show improvement in staff engagement score consecutively with the metric now moving from that of a driver metric for change to a watch metric.

9.3 David explained that the Trust was working on the processes to provide staff with feedback if a concern has been raised to ensure that they understand how their concerns have been listened to. 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. The new Freedom to Speak Up Guardian service has been implemented and the service provider has reflected they feel there is a good awareness of the new service.

9.4 David advised the Board that there remains a sustained improvement to appraisal rates for non-medical staff during the quarter period and currently stands at 80.5%.

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 increase in Statutory and Mandatory training performance, however positively there had been some innovative recruitment with an 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/11/23/10 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; however, the year-to-date planned deficit at M6 was £5.9m. The actual deficit is £24.5m, which was £18.6m 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 year end road map for 2023/24 continues to be developed and the forecast is maintained at breakeven.

10.3 Karen explained that operational plans remain challenged in order to deliver the additional activity necessary to support the 65-week waits ambition which includes independent sector capacity and waiting list initiatives.

10.4 Karen provided the Board with an update on Capital expenditure which is £29.5m against a plan of £29.4m. Karen went on to explain that efficiency performance is slightly below plan which predominantly relates to procurement schemes and Patient Transformation Services.

10.5 In relation to Productivity, Karen advised the Board the Trust needed to return to 2019/20 productivity levels, which align to delivering 2019/20 activity levels at 2019/20 costs. For 2023/24 the Trust had committed to delivering 107% of activity value against 19/20 levels and would secure additional resources for all activity above 19/20 levels via the ERF framework which would support investment in internal capacity, insourcing and outsourcing. The Trust was delivering 102.9% of activity at 102.2% of the income, including work conducted in the independent sector which was positive to note.

10.6 Karen informed the Board of the identified risks and 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/11/23/11 QUALITY

11.1 Maggie Davies reminded the Board of the Quality True North for the Trust which is 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.

11.2 The Board was advised the highest percentage of reported patient safety incidents are graded as low or no harm which for September 2023 was 482, a slight increase from August 2023 and marginally in line with reporting from October 2022.

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

11.4 In respect of staffing fill rates Maggie explained that there had been a slight decrease 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.

11.5 In relation to pressure damage, Maggie explained there had been a slight increase in the quarter which were due to multi factorial challenges, the mitigations were drawn out to minimise preventable harms.

11.6 Maggie went on to update the Board on the key messages in respect of the mortality True North. Maggie advised the Board that the UHSussex crude 12-month rolling mortality rate for non-elective admissions is at 108.4. Maggie 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.

TB/11/23/12 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 69.3% of patients within 4 hours of attending all A&E departments during September 2023 against 71.6% national performance. The Trust's remit of Emergency Performance Improvement Group (EPIG) and the Emergency Department recovery plans include all divisional actions to improve flow across the hospital sites. There remains the aim to improve outflow through the hospitals and improve flow from ED and reduce the long stays.

12.3 Regarding the patient Length of Stay (LOS), Andy explained that 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 would impact positively on flow. 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.

12.4 Andy advised that the Surgical Assessment Unit would open at RSCH in December 2023 along with the new area in EDs for mental health patients. The Board heard of the process changes that site leadership teams needed to implement to improve patient flow. It was noted that decisions were required in relation to how best to optimise the LMB until impact of system level inefficiencies had been addressed.

12.5 There had been an increase in 60-minute ambulance handovers delays, the majority of which was in RSCH. The 15 min handover position had also worsened to 59.5% but was an improvement on the 40.9% position a year ago.

12.6 **RTT**
The Trust had 42.5% of patients waiting longer than the target 18 weeks at the end of September-23, national performance was 59.5%. The Patient Treatment List (PTL) had continued its long-term pattern of growth, pushing more patients into the 78-week wait cohort, although there were no patients in the 104-week wait cohort currently. The focus this year was to lower the 65 and 78 week wait cohorts and increase the level of activity to reverse the growing PTL trend.

12.7 **Cancer**
The Trust's 62-day performance in September had declined against the national average at 57.5% in August. Recovery plan actions to reduce the backlog of people waiting from referral had focused on five challenged tumour sites, and were progressing well, having succeeded in reducing the total cancer PTL from over 8,000 to 1,000.

12.8 **Diagnostics**
The Trust had 35.4% of patients waiting more than 6 weeks in September for a diagnostic test against a 5% target. The National average for September 23 was 27.5%.

12.9 Andy concluded by stating that the Trust's key winter plan's initiatives were to improve flow through the four main acute hospitals, reduce the demand on hospital services, and ensure the health and well-being of staff included Reducing Length of Stay, optimising same day emergency care optimisation, and reducing deconditioning.

TB/11/23/13 RESEARCH AND INNOVATION
[Katie Urch joined the meeting at this point.]

13.1 Katie Urch provided the Board with an update in respect of the Trust's 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 Q1 2023/24 shows the Trust as being ranked 26th, an improvement relative to Quarter 4 22/23.

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 to support the delivery of the UHSussex R&I ambitions.

TB/11/23/14 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 performance challenges have been recognised nationally which reflects the Trust's overall position and by remaining at segment level 3 this allows the Trust access to additional support which the Trust is utilising and using this opportunity as a virtue.

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

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.

14.4 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. The IPR shares with our patients the importance of progress whilst highlighting the operational challenges the Trust is facing.

14.5 Alan McCarthy expressed that whilst the improvements in the quarter were important to recognise it remained an essential factor for the Trust to use the Patient First system to drive the organisation forward and improve its processes.

14.6 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 work to embed and reinvigorate the benefits of the Clinical Operating Model through the Quality & Safety Improvement Programme. George Findlay explained that the challenges would be remiss not to note, particularly from the recent NHSE communications which the Board were focusing on the full implications of what we were being asked to consider whilst balancing the demand for Quality, Safety and performance, 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.

14.7 Bindesh Shah explained that the Systems & Partnerships Committee had noted the recovery plans and the actions being taken noting the challenges to the financials, the length of stay and the recovery of the 65week position.

[Claire Keatinge joined the meeting at this point.]

14.8 George Findlay explained that the average patient length of stay had reduced by two days, and the medically fit for discharge levels had peaked at 350 were now down to 260, which was all integral to the improvement plans in place throughout the Trust whilst being supported by system partners, 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 Board heard that the System & Partnership Committee development have oversight of the modelling of activity and bed requirements supported by the 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.

14.9 Paul Layzell questioned the efficacy of the NHS Right Care social media campaign and whether the Trust was aware of the effectiveness of that campaign. Andy Heeps explained that the Trust was not aware of a material difference since the campaign, but it was important to take a pragmatic view of the importance of primary care access supported by the Trust's UTC pathway. Darren Grayson added that the achievability of the winter plan commitment was still expected by NHSE.

14.10 Lucy Bloem added that a sustained improvement was positive to note however what could the Trust expect through the winter period in terms of faster diagnoses or treatment escalations for cancer patients. Andy Heeps explained that there are plans in place to reduce diagnostics waits substantially by Christmas 2023, and whilst some sites are more challenged than others there are individual site trajectories in place to support the improvements.

14.11 The Chair mentioned that he had visited RSCH Emergency Department recently on a difficult day however he was assured by what he had witnessed in terms of staff's focus on quality and safety. Katie Urch added that improvements have been undertaken at RSCH ED which include a robust audit of corridor care, risk-based analysis relating to ambulatory handovers, flow and workforce redeployment is being undertaken, and ED performance correlating with patient reported experience concerns are being identified for prompt resolution. The Board agreed that the complexity of risk needs to be supported appropriately given the regulatory challenges being implemented.

TB/11/23/15 BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK REGISTER HIGHLIGHT REPORT

15.1 Glen Palethorpe 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 Glen explained there were four risks achieving their 2023/24 target score; these being Sustainability risk 2.2 (met since the start of the year), and 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).

15.3 The Board noted that ten risks were exceeding their 2023/24 target score, with five of these scoring 20. Two Quality risks assessed as not being able to meet their 2023/24 target scores, and four risks where there was a low level of confidence the risk would achieve its target score relating to Patient 1.1, Sustainability 2.1, People 3.1 and 3.3.

15.4 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/11/23/16 REPORT FROM PATIENT & QUALITY COMMITTEE CHAIR FROM THE MEETING ON 29 AUGUST, 26 SEPTEMBER, AND THE 31 OCTOBER 2023.

ORGAN DONATION ANNUAL REPORT 2022/23

16.1 The Board welcomed Alex Harrison Clinical Lead for Organ Donation to the meeting to present the Organ Donation Annual Report 2022/23.

16.2 Alex highlighted that in the 12 months from April 2022 to March 2023, the Trust facilitated 31 deceased organ donors, which resulted in 72 patients receiving a life-changing organ transplant. The Trust provided around 1/3 of the donors in the southeast region. For the calendar year 2022, the Trust had the best donation after cardiac death (DCD) consent rate of all the large hospital Trusts in the UK.

16.3 The Trust was audited against the UK's Potential Donor Audit and was shown to have had the highest consent rates in the UK (66%-70% in the 3 categories of donors). A joint approach and the involvement of Specialist Nurses for Organ Donation (SNOD) had contributed to the success in this area.

16.4 There were reported to be differing challenges across sites and the Trust's combined unit was reported to have made a positive change. A major challenge for the service across all sites had been timely access to theatre as delays going into theatre can result in organs becoming unavailable for use.

16.5 The Board commended the Organ Donation team for excellent performance and results during the last year.

16.6 The Board **APPROVED** the Organ Donation report.

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

16.8 Lucy advised the Board that the Committee had met three times since the last Board meeting and during those meetings had received updates 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 True 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.

16.9 Lucy advised that it had 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, however following extensive discussion by the Committee they were assured over their identification and that resources were now in place to rectify these assurance gaps.

16.10 The Board noted that the Quality Governance Steering Group was continuing to mature, and that this provided 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, along with the improved narrative and reporting provided by the Divisional Reports over the quality and safety standards met and those outstanding.

16.11 Lucy explained that 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. 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.

16.12 Lucy confirmed that the Committee continues to receive 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. Specialist Neonatal workforce remains a significant risk for the Trust. The impact of industrial action on the requirements for CNST year 5 and its ability to deliver training and medical attendance was noted and subsequently raised with NHS Resolution.

16.13 In relation to the Learning from Deaths Q1 report it was noted that a significant SJR backlog has built up over time. The Committee received the action plan on how the backlog will be addressed and 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.

16.14 Lizzie Peers questioned the levels of harm reviews undertaken and asked what the main concerns were in this delivery. Lucy Bloem explained that evidence and consistency remained key and the Committee had asked for a report setting out more clarity on Clinical Harm Reviews, the process and how these are executed which was expected to be received later in the month.

16.15 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 Committee had also received a quality assurance report relating to Neurosurgery acknowledging 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.

16.16 The Board to **APPROVED**: the following:

- Annual Infection Prevention & Control Report 2022-23

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

TB/11/23/17 REPORT FROM THE RESEARCH & INNOVATION COMMITTEE CHAIR 31 OCTOBER 2023.

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

17.2 Claire advised that 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.

17.3 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

17.4 The Board **NOTED** the Report from the Research & Innovation Committee Chair.

TB/11/23/18 REPORT FROM PEOPLE COMMITTEE CHAIR FROM THE MEETING ON 1 NOVEMBER 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 highlighted to the Board that 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 and 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.

18.3 In relation to the Culture work update the Board was informed that an action plan, based on the identified priorities, would return to the Committee with the initial focus for improvement being on what the support to be given to middle managers and how the Trust will disseminate and restating its values. Several areas of work had overlap with activities already underway such as inclusive recruitment, and sickness absence that looked to ensure the values were reflected on by the Committee.

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

TB/11/23/19 REPORT FROM SUSTAINABILITY COMMITTEE CHAIR FROM THE MEETING ON 22 AUGUST, 28 SEPTEMBER, 2 NOVEMBER

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 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 and flow will support the Trust's productivity trajectories.

19.3 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.

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

TB/11/23/20 REPORT FROM SYSTEMS & PARTNERSHIPS COMMITTEE CHAIR FROM THE MEETING ON 2 NOVEMBER 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 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

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

TB/11/23/21 REPORT FROM AUDIT COMMITTEE CHAIR FROM THE MEETING ON 17 OCTOBER 2023

21.1 In the absence of David Curley as Chair of the Audit Committee, Glen Palethorpe presented the Chair's report from the meeting held on 17 October and drew out the following key points.

21.2 Glen 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, and Internal Audit whereby the Committee had 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

21.4 The Board **NOTED** the Report from the Audit Committee.

TB/11/23/22 REPORT FROM CHARITABLE FUNDS COMMITTEE CHAIR FROM THE MEETING ON 10 OCTOBER 2023

22.1 Lizzie Peers, Chair of the Charitable Funds Committee, presented the Chair's report from the meeting held on 10 October and drew out the following key points.

22.2 The Board expressed their thanks to the Charity team for the delivery of the successful Goodwood Ball.

22.3 The Board **NOTED** the Report from the Charitable Funds Committee Chair.

TB/11/23/23 QUALITY & SAFETY IMPROVEMENT PLAN (QSIP)

23.1 Darren Grayson presented the update on the Quality and Safety Improvement Plan and drew out the following:

23.2 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 the business-as-usual management of safety, quality and risk, these are not providing the speed of improvement required. The Trust required a coherent single improvement plan that delivers improvements quickly and provides assurance to the Board and regulators.

23.3 Darren explained that a draft charter for the programme had been developed setting out the problem statement, the scope of the programme, the goals it is aiming to achieve, the key performance indicators, and exit criteria. The governance established includes the creation of a new Board committee for QSIP and a Chief Executive Chaired Steering Group both to meet each month, of which a Terms of reference had been drafted. This is also supported by the external oversight provided through established processes with the ICB and NHSE.

23.4 Four delivery workstreams have been established which were explained as Improving quality governance and risk management; Improving RSCH and PRH surgery; Improving safety culture and improving quality assurance. Two further enabling workstreams have been identified as Internal and external staff engagement, and Communications. These workstreams all have Executive leads and Director lever Senior Responsible Officers, and each have project charters for the workstream delivery.

23.5 The Chair questioned the correlation between the Quality Committee and QSIP, Darren explained that the two run harmoniously in sync with the Quality Committee and QGSG monitoring and progressing business as usual, and QSIP being the vehicle to enhance the actions and enhance the BAU fundamentals. The two will continue to complement each other and the Chair of Quality Committee, Lucy Bloem, is a member of the QSIP Committee.

23.6 The Board emphasised that the undertakings recently entered into required the Trust to develop a mechanism that provided 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 through an open and transparent reporting framework and ensuring effective Board oversight.

23.7 The Board **NOTED** the update.

TB/11/23/24 NURSING AND MIDWIFERY ESTABLISHMENT REVIEW

24.1 Maggie Davies presented the report to the Board and explained that the purpose of this report is to provide the Trust Board with a review of ward staffing levels across UHSussex as directed by the National Quality Board (NQB). This is the second review of ward staffing levels across the newly formed Trust since the implementation of the Clinical Operating Model (COM). The review has assessed the funded bed base, impact of escalation beds across all the Trust sites as well the planned relocation of services into the Louisa Martindale Building.

24.2 Maggie explained that the scope of the review covered all 4 major sites during quarter one, these being Worthing, St Richard, RSCH, and PRH. 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 RSCH and Princess Royal hospital sites.

24.3 The information was evidenced against the 2023 Maternity Workforce Transformation Programme scorecard, then triangulated against the patient experience and safety outcomes. The report set out registrant ratios for both day and night shifts in 82 wards and clinical areas over all four Trust sites.

24.5 Maggie explained that overall the baseline ward establishments are currently in line with national best practice except for the wards identified within the report which have mitigating actions against to outline how safer staffing is assessed and maintained daily. This would be supported by on-going recruitment and retention workforce initiatives with a focus on international recruitment, domestic and international retention, however it was important to acknowledge the Trust variation in terms of budgeted uplift for Ward managers supervisory time and practice educator roles.

24.6 The Safer Staffing Alliance states there is evidence that care is compromised when there are more than 8 patients (beds) to 1 registered nurse and to be compliant the Trust has a Red Flag procedure for nursing which identifies 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.

24.7 George recognised the significant progress made in relation to HCA vacancies, that had reduced from 19% to 8%, and were expected to reduce further to nearer 1% at year end and noted that the new Deputy Chief Nurse for Workforce and Professional Standards would consider workforce models.

24.8 The Board **NOTED** the update.

TB/11/23/25 COMPANY SECRETARY REPORT

25.1 Glen Palethorpe explained that there were no items for discussion today that had not been covered in the Board's routine reports it had already received at this meeting.

TB/11/23/26 OTHER BUSINESS

26.1 There was no other business to discuss.

TB/11/23/27 QUESTIONS FROM MEMBERS OF THE PUBLIC

27.1 The Board received one question from a member of the public in advance of the meeting relating to the current Police inquiry into some deaths within the Hospital Group.

27.2 Darren Grayson confirmed that a police enquiry is underway that relates to allegations of medical negligence within the General Surgery and Neurosurgery departments between 2015 and 2021.

27.3 Darren confirmed that the Trust continued to cooperate with the police requests to share information to support the investigation and advised that an incident

control group along with a tactical local group to support the investigation in an open and accessible manner.

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

27.5 The Chairman agreed to take two additional questions posed by members of the public within the room.

27.6 There was an enquiry relating to the quantifiable programme of CO2 omissions savings within the outreach clinics in the children's hospital, to which it was explained that this information was available within the Trust's Green Plan for 2023/24 which was available to view on the Trust's website.

27.7 The third question related to the recent announcement of the Chairmans retirement from the Trust and when he would be leaving, to which Alan McCarthy explained that he would not be leaving the Trust until the end of his second term in June 2024.

27.8 The Board **NOTED** the questions received by the members of the public and subsequent responses.

TB/11/23/28 RESOLUTION INTO BOARD COMMITTEE

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

TB/11/23/29 The Chair formally closed the meeting.

TB/11/23/30 DATE OF NEXT MEETING

30.1 It was noted that the next meeting of the Board of Directors was scheduled to take place at **10.00** on **Thursday 08 February 2024**.

Tamsin James
Board & Committees Manager
November 2023

Signed as a correct record of the meeting

…….. Chair

..…… Date

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	5	**Meeting:**	Trust Board in Public	**Meeting Date:**	8 February 2024
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 (Integrated Care Boards) / 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 in Public **Date: 8 February 2024**

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

1. THANK YOU

1.1 The past three months has once more been characterised by extreme pressures, industrial action, staff working exceptionally hard, and our unrelenting focus to reduce waiting times. I wish to take this opportunity to put on record once more my heartfelt thanks to all my colleagues for everything they do for patients, and each other, in such challenging circumstances.

1.2 Prolonged strike took place before and after Christmas, adding yet more pressure and disruption to the challenging festive period. Without the exemplary dedication of our staff, and with many working extra sifts and longer hours, 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.

1.3 Unfortunately, to ensure we could protect life and limb, it was necessary to reschedule many routine appointments and procedures. These decisions are never taken lightly, and we do all we can to continue with as much activity as possible, 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 we are doing our absolute best to reschedule patients and reduce waiting lists as swiftly as we can.

1.4 Addressing the time patients are waiting for our services, both routine and emergency, has been front and centre of all our plans for many months now. Thankfully, the commitment of teams, extra hours worked, innovations and new ways of working that have been introduced have borne fruit.

1.5 For example, in the run up to Christmas we reduced our total patient waiting list by 11,000 patients in 11 weeks. This is the first time such a continued reduction has been achieved since the pandemic and, despite strikes and extraordinary winter pressures, we have sustained this trend throughout January.

1.6 We have seen significant improvements in our A&E performance against the national standard, which challenges emergency departments to see, treat, admit, or discharge patients within four hours. At the time of writing, our average performance in January is 73% - while lower than we want, it is more than ten percentage points higher than this time last year. In fact, our A&E performance was significantly better for every month in 2023, compared to 2022.

1.7 We know this is cold comfort to patients who are still waiting too long to receive emergency care in our hospitals, or to our staff working in overcrowded and highly challenged A&E departments. But the 4-hour standard is a key measure of how the entire hospital is operating, and it is important to acknowledge and thank colleagues for everything they are doing to admit patients onto wards and treat and discharge them in a safe and timely way.

1.8 While we have seen good year on year improvements, the day-to-day reality for our front-line teams, and the patients they care for, remains in stark contrast. The past few weeks in particular have been extraordinarily difficult and the toughest of the winter to date. Each of our main hospitals has been operating at more than 100% capacity with all escalation beds open at times and we have had to declare several business continuity incidents to urgently reprioritise our resources and rally additional support from our Sussex Health and Care partners. I want to thank them for their assistance, both when urgently needed and everyday as we work together as a system to serve people in Sussex.

1.9 Despite the relentless demands upon our staff and hospitals, 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 three months ago. On behalf of the board, I wish to commend and thank all colleagues involved.

2. ACHIEVEMENTS, AWARDS AND RECOGNITION – CONGRATULATIONS!

2.1 Chief Nursing Officer awards were presented to four nursing and midwifery colleagues from in January, recognising outstanding and compassionate care that exceeds everyday expectations. **Pip Hale**, Ward Manager at Chilgrove Ward, St Richard's, and **Terrie Whiteside**, Ward Manager, Burlington Ward, Worthing, were both awarded, as were **Claire Harris**, Matron, Midwifery at Worthing and St Richard's and **Shailendrasingh Soobhug**, an Advanced Clinical Practitioner working across the Trust.

2.2 **Jane Cleary**, Consultant Midwife, has been honoured with the prestigious Chief Midwifery Officer award for her significant and outstanding contribution to midwifery practice. The Chief Midwifery Award is one of the highest accolades for maternity staff to receive. It is awarded to healthcare staff for going beyond the expectations of their everyday role, demonstrating excellence in clinical practice, education, research, leadership and focusing on diversity and health inequalities.

2.3 Consultant Vascular & Endovascular Surgeon, **Professor Syed Waqar Yusuf** has received a lifetime achievement award from the Vascular Society for Great Britain and Ireland. Prof Yusuf joined UHSussex more than 20 years ago and specialises in endovascular surgery that treats conditions affecting blood vessels (vascular system) without making large incisions in the vascular system. He has dedicated his career to improving endovascular surgery and educating others in this specialty.

2.4 **Surgeon Gianluca Colucci from Worthing Hospital** and has been teaching surgical procedures in Ukraine to help doctors their treat soldiers injured on the front line in the war with Russia. Since the full-scale invasion of Ukraine began, Gianluca has been working with the *SmartMedicalAid* charity, delivering teaching, training, medical supplies, ambulances, medical evacuations and many more activities in the war-torn country. One of the life-saving projects involved creating 10 medical imaging phantoms, which are objects as stand-ins for human tissues to ensure that systems and methods for imaging the human body are operating correctly. Gianlucca, who is also a senior lecturer at Brighton and Sussex Medical School then took the models with him and trained Ukrainian medics in Kharkiv, so they can use the surgical techniques to save lives of wounded soldiers.

2.5 **Professor Mahmood Bhutta**, consultant ENT (Ear Nose and Throat) surgeon, is setting the national agenda to reduce the environmental impact of surgical care for a greener NHS. He

recently led the national committee for a collaborative project which has resulted in the 'Green Surgery' report being published. The report gives a detailed account of how to reduce the environmental impact of surgical care while maintaining high quality patient care and potentially saving the NHS money. Professor Bhutta is also the Trust's clinical lead for environmental sustainability.

2.6 The **Worthing A&E nursing team won our Star of the Month award** for their outstanding commitment, professionalism and teamwork in getting ambulances back out on the road in a record-breaking time. When an ambulance arrives at a hospital, the national target for clinically handing over patients is within 15 minutes of arrival. However, operational challenges including significant peaks in demand can lengthen handover times and cause delays. In the South-East, the average ambulance handover times are performing at 44% across 18 local hospitals, however, thanks to a series of improvements that the team have made over the last six months, using the Trust's Patient First improvement programme Worthing's emergency department is currently above national performance target at 70%.

2.7 **The Audiology Department at Royal Sussex County Hospital won Star of the Month** for improving patient care whilst navigating a series of immense challenges. The Brighton team, which provides care to both adults and children, were commended for their resilience and hard work by the Head of Audiology, Manuel Loureiro, during a period that saw the team relocate into the new Louisa Martindale Building and open a brand-new Paediatric Audiology Department at the Royal Alex.

2.8 The team at **The Sussex Orthopaedic Treatment Centre (SOTC) at Princess Royal Hospital have been awarded Star of the Month** for their exceptional demonstration of UHSussex values and commitment to providing the best care to patients. The team were nominated by Cindy Cruzado, Theatre Practitioner, for their dedication and resilience, consistently showing empathy towards patients and fostering a culture of inclusion and respect within their team and beyond' – embodying the values of UHSussex. The SOTC provides planned surgery and rehabilitation and has a key role in how the NHS in Sussex is working to reduce the number of people waiting for care and help patients to get the operation or procedure they need as quickly as possible. Last year, the centre was one of just eight elective surgical hubs in the country to receive national recognition for the care provided to patients.

2.9 In December, we held more **Long Service Awards** to celebrate a further 200 colleagues who have achieved 20, 30 and 40+ years' service with the Trust, giving a combined length of service of 4,750 years. Funded by our MyUHSussex charity, colleagues were invited to special events held away from our hospitals, at Fontwell Park Racecourse and The Hilton Brighton Metropole. Attendees included 17 members of staff with more than 40 years of Trust service; 26 had 30 years; and 165 have achieved 20 years.

2.10 In recognition of her work with international nurses, **Netce Sia,** Senior Clinical Practice Educator for the International Recruitment Team, was invited to Buckingham Palace in November to attend a reception hosted by King Charles III to celebrate the contribution of internationally educated nurses and midwives working in the UK's health and social care sector. Netce and her team welcome new nurses at the start of their career within the Trust and ensure colleagues adjust to their new environment by teaching and training them to become qualified UK registered nurses.

2.11 The **International Recruitment Team** at University Hospitals Sussex has been honoured with the Pastoral Care Quality Award for their commitment, compassion and support to the recruitment of nurses and midwives from outside of the UK. The team offer a wide-ranging induction, which includes knowledge of the local areas, airport transfers, accommodation and 24/7 contact time. They make significant efforts to ensure their new colleagues feel welcome, making sure their needs are met, including finding places of worship, and registering at GPs.

The dedication from the team does not stop at recruitment, the team strive for a sense of community where the new recruits feel comfortable and safe.

2.12 One of our clinical research teams has had their emergency airway management study published in a top anaesthesia journal. **Dr Jamie Gibson** and **Dr Todd Leckie**, Anaesthetics and Intensive Care Medicine Trainees, and **Dr James Hayward** and **Dr Luke Hodgson**, Intensive Care Consultants, have explored the current UK practice for emergency airway management that happens outside of operating theatres, including simple airway techniques which are non-invasive and advanced airway techniques which are invasive and require specialised medical equipment including intubation and cardiac arrests. Cases involving children were also included and this work has since been published in the same journal.

2.13 Colleagues from Royal Sussex County Hospital contributed to a global study revealing the benefits of delaying umbilical cord clamping for premature babies. Together with her team, **Professor Heike Rabe**, an Honorary Consultant Neonatologist at University Hospitals Sussex and Professor of Perinatal Medicine at Brighton and Sussex Medical School, provided research data to the study, which was published in The Lancet.

2.14 Three new Deputy Chief Medical Officers (CMO) have been appointed, taking on managing roles within our hospital leadership teams. **Mrs Suzie Venn, Mr Tosin Ajala and Dr Madhava (Bob) Dissanayake** will each join our local hospital directors and hospital directors of nursing to form a leadership triumvirate for our three main sites. The role of the deputy CMO is to focus on patient safety and compliance for their designated hospital sites, supporting the delivery of efficient high quality patient care. Working closely with the Hospital Director of Nursing, they will support all clinical areas to meet Quality and Safety Improvement Programme (QSIP) and Care Quality Commission (CQC) standards and will have a particular focus on junior doctor responsibilities and consultant engagement.

3. INVESTING IN OUR HOSPITALS AND SERVICE IMPROVEMENTS

3.1 A new state-of-the-art **Community Diagnostic Centre** (CDC) was officially opened at Southlands Hospital by guest of honour and radiology patient Christine Heels from Ashington on 25 January. Designed to speed up diagnosis and improve patient experience, the CDC has provided quick access to medical tests for more than 14,000 patients since phase one of the CDC opened in October last year. Served by a team of around 50 colleagues, the CDC houses world-class CT and MRI scanners, alongside three cutting-edge X-ray rooms, all in one dedicated space. Work has now begun on phase two of the CDC development which will provide further diagnostic services, including echocardiography, gynaecological and respiratory procedures, expected to be finished in Autumn 2024. Once complete, the CDC will embody a true ‘one-stop’ model of care, enhancing efficiency and further improving the overall patient experience and reducing diagnosis and time to treatment time for people in Sussex.

3.2 A new **Urology Investigation and Treatment Centre at Princess Royal Hospital**, Haywards Heath, is improving patient outcomes and transforming healthcare. The new £8m building opened in October and features a newly refurbished reception and large waiting rooms with scenic views of the hospital’s natural surroundings. The expert hub is helping to reduce the number of hospital visits that many urology patients experience, and it enables staff to diagnose potentially life-threatening conditions such as cancer more swiftly. Since opening, more than 4,000 patients have been treated at the new facility.

3.3 People in West Sussex will be able to access state of the art hospital-based stroke services at a **new Acute Stroke Centre at St Richard's Hospital** in Chichester, following approval of the stroke improvement programme by the NHS Sussex board on 30 November 2023. if proposals are agreed next week. The decision follows five years of work, led by leading health professionals

at University Hospitals Sussex, to review current services, and develop proposals, based on evidence and clinical best practice, that would further improve outcomes for the local population and ensure our services are meeting national guidelines. The Acute Stroke Centre to be developed at St Richard's will work as part of a network with the Comprehensive Stroke Centre at Royal Sussex County Hospital in Brighton. The Acute Stroke Centre would improve care and outcomes for patients by providing access to specialist stroke services 24 hours a day, seven days a week.

3.4 The **demolition of Barry Building at Royal Sussex County Hospital** is now underway, to prepare the site for our **new Sussex Cancer Centre** which is phase 2 of the hospital's 3Ts redevelopment. Over the next few months, the old hospital estate and surrounding buildings will be carefully dismantled, and a revised planning application submitted for the £155m new centre. 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 for our radiotherapy, oncology, and haematology departments.

3.5 University Hospitals Sussex is the first in the country to use a new economical and environmentally friendly sterilisation machine. The new machine, based at the Royal Sussex County Hospital's Ear, Nose and Throat (ENT) department, sterilises small telescopes that doctors use to look inside a patient's ear, nose, or throat faster and more efficiently than before. This is helping to cut the department's carbon output by more than tonnes a year, which is the same as planting 200 trees.

3.6 The neonatal intensive care unit – also known as the Trevor Mann Baby Unit (TMBU) – at the Royal Sussex County Hospital is now using an innovative genetic test that can help identify newborn babies at risk from hearing loss if treated with a common antibiotic. The test, which involves taking a gentle cheek swab, takes just 26 minutes to determine whether a critically ill baby has a single gene change that could cause permanent hearing loss if they are treated with the first-choice antibiotic, Gentamicin. If the genetic change is detected, babies are given a different antibiotic with life-changing effects for them and their families.

3.7 Parents of babies in the Trevor Mann Baby Unit can now use an app designed by medical professionals that supports families of premature babies receiving care in the neonatal unit, featuring UHSussex tailored content. The free app provides parents with easy access to information that can help them to understand their baby's journey, medical terminology they may hear used, as well as specific information about the Trust and key contact details. Parents can track their baby through their neonatal journey, including what each developmental stage means, a diary section to monitor their baby's weight and suggestions of what they can do to help with each week of development.

3.8 A newly Memorial Garden was opened for staff at Worthing Hospital in November with a ceremony led by lead chaplain Rachel Bennett. At the opening, the hard work, compassion and sensitivity demonstrated by several colleagues, including Tony Leggatt, Stuart Cox, Luc Harvengt, Rachel Bennett and Katrina Hawkes, was commended by Trust leaders. Hospital Director Stephen Mardlin planted a rose to commemorate colleague Bessy James, who was a Staff Nurse in Endoscopy, before dying from cancer in September 2022.

3.9 New food and drink options for visitors and staff are on the horizon as the Trust's retail catering team continues to improve what is available at University Hospitals Sussex. Throughout January, restauranteurs, caterers, and café operators were invited to tender to run the hospital restaurants at St Richard's Hospital and Worthing Hospital and the café facility in the Worthing Health Education Centre. Meanwhile, at the Royal Sussex County Hospital, a new café on Level 6 in the Louisa Martindale Building will be opening this year. With seating both inside and outside offering incredible sea views, the space will be run by the popular Peabodys team that already have a

coffee bar in The Welcome Space. Currently, its opening date is awaiting a decision from a new agency responsible for high-rise structures, the Building Service Regulator.

3.10 Our first Volunteers' Conference took place at the Charmandean Centre in Worthing, kindly funded by the dedicated charity for the Trust, My University Hospitals Sussex. This was the first time volunteers from all our hospitals were able to come together to hear news about the future of our voluntary services and celebrate another incredible year of volunteering in our hospitals – even our brilliant *Pets as Therapy* (PAT) volunteer dogs made an appearance! Steve Crump, Director of Charities and Voluntary Services, opened the conference and gave a presentation on the importance of volunteers to the NHS' vision for the future of health and social care. An update on the progress of modernising the service was also given, along with information on how we are looking to maximise the impact of volunteering across the Trust.

4. SUPPORTING OUR PEOPLE

4.1 Our staff are our most precious resource, and we have a comprehensive, broad-0ranging and growing programme to provide support for them, as well as thank, acknowledge, and recognise everything they do for our patients, each other, and the Trust. Full details are available on our website at www.uhsussex.nh.uk/Wellbeing and below are some recent examples:

4.2 During Race Equality Week (5-11 February), free workshops and virtual sessions are being held for staff to share lived experiences, provide support, improve understanding of discrimination, and help colleagues become more confident in challenging inappropriate behaviour and actions. All staff are being encouraged to take time each day next to participate in five activities posted on the staff intranet, to help everyone better reflect on our own attitudes and behaviours towards race equality – and help us act on what we learn.

4.3 A new Women's Network has been launched to create a safe environment for members to come together, make connections and share experiences, and provide support and opportunities to improve the experiences of women and to promote equity. Applications to chair the network are currently sought, supported by Professor Katie Urch and Karen Geoghegan who are the network's executive sponsors.

4.4 We have welcomed two Health Checks Nurses, Rachel Gardiner and Rafael Lontoc, to provide staff with check-ups where blood pressure, BMI and pulse checks will be offered as standard, along with advice and signposting for lifestyle changes, such as weight loss, stopping smoking, alcohol reduction and mental wellbeing.

4.5 The first meeting of our new Health and Wellbeing Staff Network was attended by 68 members of staff. The next meeting will feature guest speaker Jane Mitchell from the Staff Psychological Support Service.

4.6 New training events for staff called Neurodiversity Talks are taking place with colleagues invited to three sessions of awareness talks around neurodiversity in the workplace. Working in partnership with an organisation called Differing Minds, the aim is to provide enlightening insight around neurodiversity.

4.7 Quit smoking events have taken place in our hospitals, with staff invited to attend free 1:1 sessions with a qualified smoking cessation adviser. A free 12-week programme that includes weekly support and free nicotine replacement therapy is also being promoted to all colleagues who smoke.

4.8 Colleagues have been invited to benefit from The Roffey Park Development Programme's Experience Cube. The training is designed for both non-managers and managers who would benefit from its use to explore a situation and understand what might be going on at a deeper level.

4.9 The Aquatic Activity and Swimming for Health e-learning programme is being promoted to staff. The resource, developed in partnership with Swim England, Aquatic Therapy Association of Chartered Physiotherapists (ATACP) and the University of Nottingham, raises awareness of the benefits of aquatic activity on health and wellbeing and aims to enhance learners' confidence in identifying patients who would benefit most.

4.10 A new 'Walk and Talk' group has been set up at St Richard's Hospital, open to all colleagues, friends, family and dogs who would enjoy a walk in nature, take in the beautiful views, and connect with people from work and local community. The group has been set up by member of staff Jazz Tatem-Harrison to support colleagues.

4.11 For Disability History Month 2023, we focused on how to 'lead the change' to tackle discrimination and support disabled people working across the health and care sector. Disability affects 23 per cent of the NHS workforce, with 83 per cent of disabilities acquired during working life. The month provided an important opportunity to raise awareness, share learning and improve experience for colleagues.

4.12 Our staff Crisis Fund has helped more than 600 staff during its first year. Thanks to funding from *MyUHSussex* charity, we have been able to provide cost of living support to staff who find themselves in financial hardship.

5. INTERESTED TO FIND OUT MORE?

5.1 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.

6. RECOMMENDATIONS

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

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	6.	**Meeting:**	Trust Board	**Meeting Date:**	8 February 2024
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 December 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.

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Integrated Performance Report

December 2023

University Hospitals Sussex
NHS Foundation Trust

Chief Executive Summary

Please see enclosed the performance report for University Sussex Hospitals. It shows our performance to December 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 Q3 the Trust saw an increased level of performance challenge for emergency performance linked with winter pressures. The Trust has remained 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 improvement in the 62 day backlog for cancer in December compared to the position in September.

Elective pathways and RTT performance improved materially in October and November, with reduced capacity impacting December performance relating to industrial action and Christmas. The waiting list continues to fall which means that the Trust capacity has been higher than demand in Q3.

Diagnostics performance has deteriorated in Dec-23. Plans to tackle Imaging and endoscopic modality capacity are being developed in Q4 to tackle pressures.

For our Emergency Care pathways, we have experienced another challenging quarter treating 68.6% of patients within 4 hours of attending. Despite this the Trust has improved by 9.2% since Q3 2022/23.

Financially, the Trust saw a £20.47M adverse variance from plan for income an expenditure to Mth 9. The financial impact of industrial action late December was 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 continued improvement in the SHMI mortality rate. Staffing indicators show improved appraisal and STAM rates, reduced vacancy rates and sickness rates relative to the same time last year. Furthermore, our friends and family test (FFT) data shows a small decline in patient reported experience in recent months- this is in line with national public confidence in the NHS. Our registered nurse staffing fill rates have also declined in the reporting period.

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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	87.7%	90.0%	
P	People	Staff Engagement - To be within the top quartile of acute Trusts for the National staff engagement score	6.66	7.06	
S	Sustainability	Financial Stability - Variance from breakeven plan YTD	-20k	0k	
Q	Quality	Clinical outcomes/effectiveness - SHMI equal to or less than 100	106.7	100.0	
Q	Quality	Safety - Reduction of 5% in preventable harm - UHSx approved	758		
SP	Systems & Partnerships	A&E and Emergency flow - % treated and admitted/discharged within 4 hours	68.1%	76.0%	
SP	Systems & Partnerships	Cancer - To achieve the 62 day standard (All referrals - National standard revised Oct 2023)	51.32%	85.00%	
SP	Systems & Partnerships	RTT Elective care - >=65 Weeks	4566	3000	
SP	Systems & Partnerships	Planned care - By March 2023, no patient is waiting more than 78 weeks for treatment.	672	0	
RI	Research & Innovation	Within 3 years to be in the top 20 Acute Trusts nationally for patients recruited into portfolio studies	27	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 ambition is for patients to have excellent care, every time. Based on available FFT data, the significant majority of patients (89.5% in Q3) are satisfied that they have a good or very good experience. This is comparable to Q1 and Q2 2023/24. All divisions (when EDs are excluded from the results) have patient reported positive reviews of 93.5% or greater for 2023. Number of open complaints at the end of December (c390) is slightly lower than the previous month. Open cases remain above manageable levels and there remain some delays in signing of final responses. % closed in 60WD = 55% however more complaints were closed in Q3 than were received.

University Hospitals Sussex
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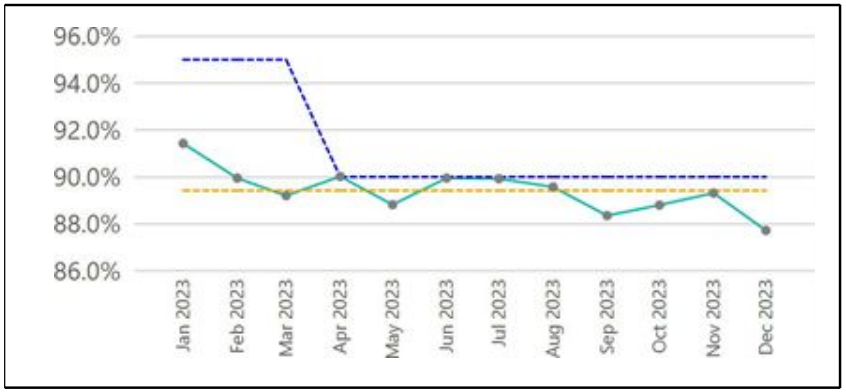
True North

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

Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
91.4%	90.0%	89.2%	90.0%	88.8%	90.0%	89.9%	89.6%	88.4%	88.8%	89.3%	87.7%

Overview

No Data



What the chart tells us

Based on available FFT data, the significant majority of patients (89.5% in Q3) are satisfied that they have a good or very good experience. This is comparable to Q1 and Q2 2023/24. All divisions (when EDs are excluded from the results) have patient reported positive reviews of 93.5% or greater for 2023.
A small but steady decline in patient reported experience in FFT is evident throughout 2023, and this includes positivity in EDs and inpatients. Whilst this is largely connected to public confidence in the NHS, positivity in inpatients is below the national average.

A small but steady decline decline in patient reported experience in FFT is evident through 2023, and this includes positivity in EDs and inpatients. Whilst this is largely connected to national public confidence with the NHS, inpatient positivity is below the national average.
For UHSx, approximately 50,000 patients provided a review in Q3 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, and the Welcome Standards programme is being rolled out to improve experience of receptions and those in greeting roles.

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 focused 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	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
Patient experience - Number of complaints	77	92	89	88	75	117	100	120	125	98	121	74
Patient experience - Total open formal complaints	322	267	255	286	305	310			430	408	380	384

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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 17,553 staff across it's sites to treat 1000s of people per day. We monitor a range of staff based metrics which give a top level insight into how they are feeling about the Trust, vacancy rates which can constrain particular services, their adherence to statutory and mandatory training requirements, their health (in terms of sickness absence) and their demographic characteristics. The Trust True North focuses on staff engagement with the aim to be in the top half of acute Trusts for the National Staff Survey. This is monitored via an equivalent Pulse Survey tracked on a monthly basis . The Trust's engagement score was at or above 7 out of 10 for 6 of the last 12 months. It reduced to 6.7 out of 10 in December 2023. There has been positive improvement for Statutory and Mandatory Training, Appraisal rates, and a reduction in absence rates, and vacancy rates in the latest reporting month.

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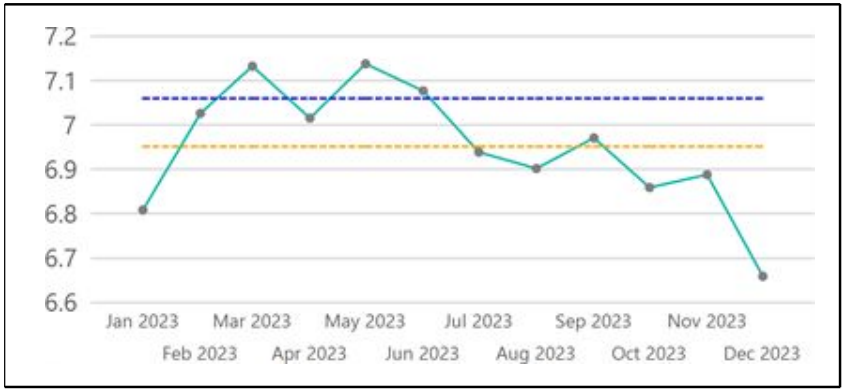
True North

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

Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
6.81	7.03	7.13	7.02	7.14	7.08	6.94	6.90	6.97	6.86	6.89	6.66

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 Trust's engagement score was at or above 7 out of 10 for 6 of the last 12 months. It reduced to 6.7 out of 10 in December 2023.

Intervention and Planned Impact

- All Divisions concluded the actions on last year's Staff Survey Engagement Action Plan by the end of the year.
- The initial high-level Trust and Divisional Staff Survey results have been shared confidentially with the People Committee and with Divisional Triumvirates.
- Department/Cost Centre level reports are being prepared and will be available on Power BI for the senior teams in early to mid-February to allow work to commence on the Staff Survey results by those responsible for taking forward engagement actions ahead of the lifting of the reporting embargo in early March.
- Communications plan devised by HWB team in conjunction with Communications and HRBPs.

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Risks/Mitigations
Risks If Divisions do not maintain a continuous improvement approach to increasing staff engagement, there is a risk that it will be seen only as an annual issue highlighted only via the Staff Survey results and the Trust engagement scores may decrease. Mitigation Managers to maintain open and transparent communication channels to ensure staff issues and feedback are heard and acted on and staff engagement continues to be monitored as a True North metric as part of Trust and Divisional SDR process.

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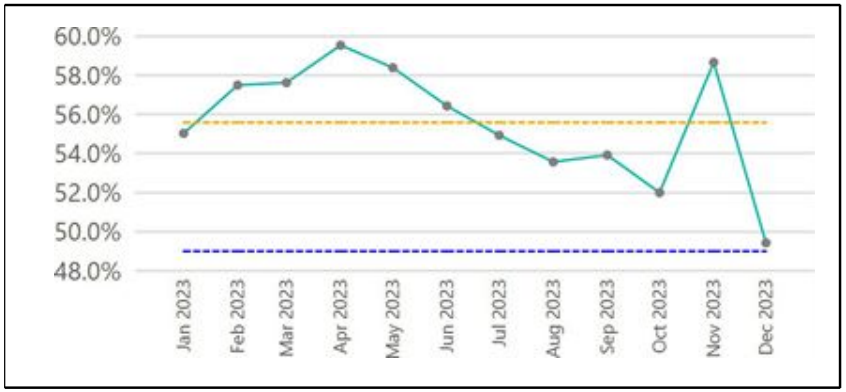
Breakthrough

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

Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
55.0%	57.5%	57.6%	59.5%	58.4%	56.4%	54.9%	53.6%	53.9%	52.0%	58.7%	49.4%

Overview

No Data



What the chart tells us

The score for the Trust's Breakthrough Objective (Staff Voice that Counts) reached a high of 59.8% in April 2023 (above the target of 50%). In November, the results of the Pulse Survey were 58.1% for this question and this reduced to 52.2% in December.

Intervention and Planned Impact

- Discussions underway to close down the People BTO (Voice that Counts) and to pursue further work under the 'Safety Culture' workstream of QSIP
- The Staff Survey Results show an improvement in this metric for the Trust and achievement of the 50% target.

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Risks/Mitigations

Risks

There is a risk that with the BTO being retired, there could be a loss of focus on staff speaking up and utilising the resources and support available (BTO toolkit, Freedom to Speak Up Guardian).

Mitigation

HRBPs to ensure support and tools continue to be promoted and to work with Divisions on their staff survey results to ensure staff voice continues to be heard and to contribute to driving improvements in this area. QSIP 'safety culture' workstream.

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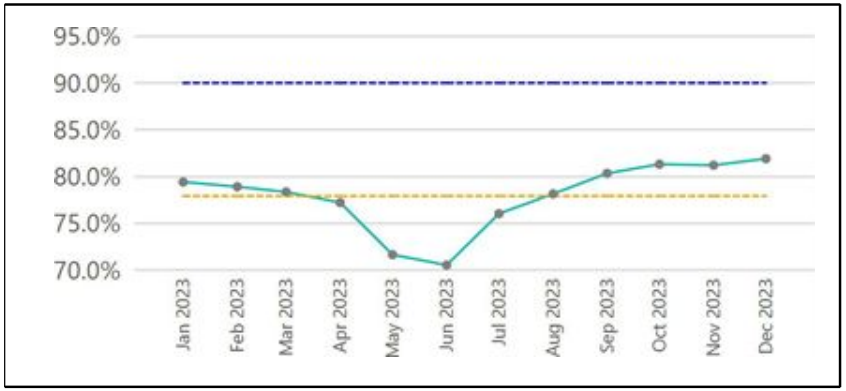
Driver

Metric: Training & development - Appraisals completed

Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
79.4%	78.9%	78.4%	77.2%	71.6%	70.5%	76.0%	78.1%	80.3%	81.3%	81.2%	81.9%

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

In Dec-23, the Trust (Non-Medical) Appraisal rate was 82.52%. This is the highest level achieved in the past 12 months, and sixth successive month of improvement (+13.1% points) since Jun-23. All Divisions are reporting an improvement since November 2023 (by 0.2% to 2.9% points), apart from Medicine (RSCH/PRH) (-1.5% points) and Cancer (-3.7%).

Corporate Divisions are performing relatively poorly, eg. CNO (69.6%), CEO (70.6%), CMO (74.0%), CPO (75.6%), COO (77.1%). Six of the seven poorest performers are Corporate. Corporate Divisions are smaller than Clinical/Operational Divisions; if Corporate Divisions (excl. F&E) achieved 90% compliance (from 75.8% currently), this would increase Trust compliance by +2.3% points (to 84.0%). This is a relatively small increase, but emblematic.

Intervention and Planned Impact

- Appraisal continues to be raised in Divisional SDRs and via engagement with HR Business Partners.
- A further round of targeted individual emails has been undertaken. 45 staff have appraisals overdue by 14-16 months, 21 staff by 17-19 months, 13 staff by 19-20 months, 100 staff by 20 to 30 months, 29 staff by 30-40 months, and 15 staff by 40 to 50 months. Individual follow-ups are identifying staff who have had extended periods without an identified line manager, or whose line managers have not progressed appraisals, and enabling targeted support.
- The Trust continues not to operate provisions in Agenda for Change T&Cs to withhold pay increments (or re-earned increments) if the postholder's own, and team's, appraisals are not fully complete.
- Where appraisals are undertaken, appraisee feedback (via online appraisee feedback survey) remains very positive: 91.2% agree they discussed all the topics they wanted to, 90.0% agree they felt safe to talk about personal issues, 88.0% agree the appraisal was a positive experience overall.

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Risks/Mitigations
Principal risks of continuing under-performance: (i) CQC compliance, (ii) evidence that well conducted appraisals lead to improved staff engagement and range of other team and organisational outcome measures, incl. improved patient mortality.

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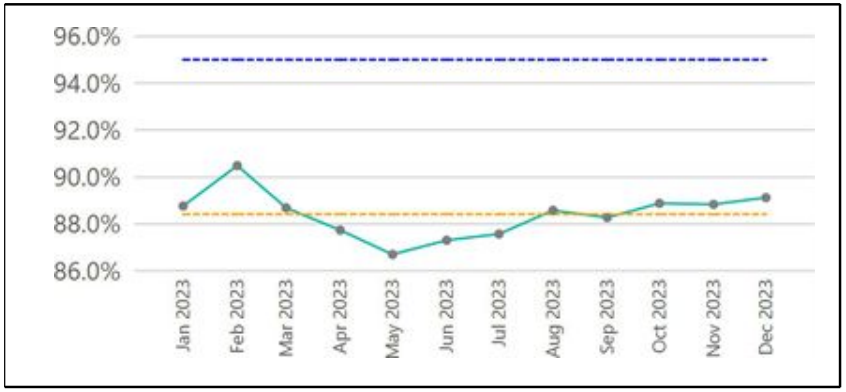
Driver

Metric: Training & development - STAM Weighted Average

Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
88.8%	90.5%	88.7%	87.7%	86.7%	87.3%	87.6%	88.6%	88.3%	88.9%	88.8%	89.1%

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

In December 2023 the Trust STAM rate was 89.12% which is the highest level since February 2023. All Divisions are reporting an improvement since November 2023), apart from Medicine (PRH/RSCH) & Specialist which have seen a drop in compliance, but this is less that 0.5%.

The Trust is performing better against the STAM weight target of 90% and are currently 0.88% under our compliance levels.

Out of the sixteen divisions, seven are performing at above 90% compliance and nine are performing below 90%, with People Directorate and Medicine (PRH/RSCH) the poorest performers. In terms of the modules, three of the ten modules are performing at above 90% (Adult Safeguarding, EDI and Health & Safety), seven modules are performing below 90% with Resus the poorest performer with 81.57%.

Intervention and Planned Impact

- The STAM rate continues to increase and even with the addition of Conflict Management as a new reporting module it has continued to make steady progress.
- The Oliver McGowan training is now reported on the Scorecard due to being mandated training although nationally it is not part of the Core Skills Training Framework and not yet incorporated into overall reporting.
- Work continues to improve attendance at face to face sessions which is always difficult during periods of high pressure such as industrial action and winter.
- STAM subjects can now be 'passported' in and out of the organisation through the IRIS/ESR interface
- An ongoing TNA is underway to ensure that staff have the correct STAM subjects mapped against their profile which will be completed by the end of January 2024.

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Risks/Mitigations
No Data

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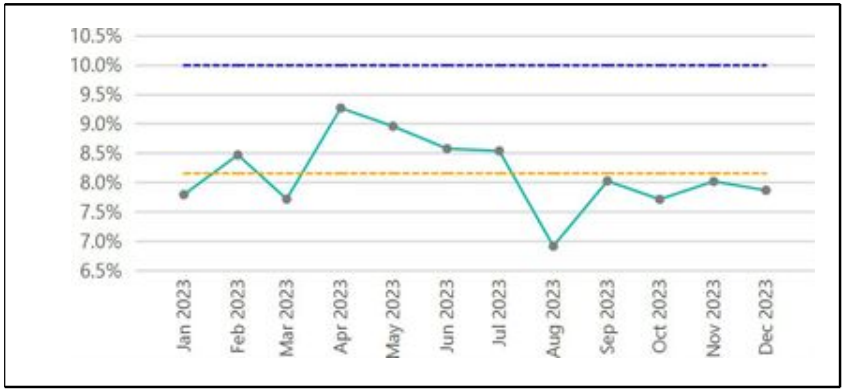
Driver

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

Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
7.8%	8.5%	7.7%	9.3%	9.0%	8.6%	8.5%	6.9%	8.0%	7.7%	8.0%	7.9%

Overview

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



What the chart tells us

The Trust vacancy rate reduced to 7.8% from 8.1% last month (and 8.2% last year). The Trust's budgeted establishment was 17,062 FTE (down 144 FTE), whereas staff in post is now 15,518 FTE (down 73 FTE), meaning vacancies have reduced via establishment reductions rather than increases to staff in post. The Trust currently has 1,544 FTE of vacancies (down 71 FTE on last month).

Looking by staff group shows substantial reductions in vacancy rates within Clinical Support, Admin & Clerical and Estates & Ancillary (although the rate within Estates is 10.8%, down from 15.0%).

Band 5 nurse vacancies reduced from 15.74% Sep-23 to 13.39% in Dec-23 (2.35% improvement)

HCA vacancy factor improved 11.25% since Dec-22 demonstrating ongoing improvements in the Trust's HCA capacity.

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Intervention and Planned Impact
Workforce has increased by 655 wte since December 2023, primarily in clinical roles for example HCA or Ward Clerks directly supporting patient care. Programme of HCA recruitment events planned for 2024 including continuing to work with the Prince's Trust and Job Centre supporting the Trust's work towards become an anchor institution. Series of graduate recruitment events and webinars to attract and recruit newly qualified nurses. Plans for open day for facilities and estates focusing on housekeeping, portering, catering roles and other support roles. Inclusive recruitment action plan being implemented including the aim of increasing representation in managerial roles at band 7/8a, particularly within the nursing profession. Enhanced vacancy controls have been introduced to help strengthen the financial control environment, this includes a requirement for non-clinical and band 8a+ recruitment to be restricted and where essential, approved by the executive leadership team.
Risks/Mitigations
No Data

University Hospitals Sussex
NHS Foundation Trust

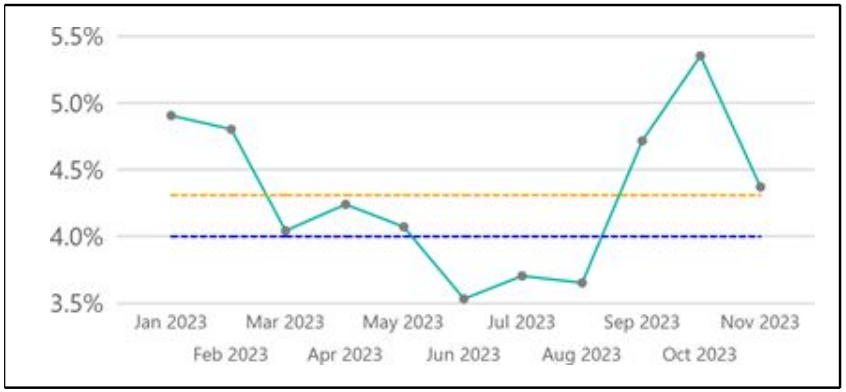
Driver

Metric: Workforce efficiency - Absence Sickness in month

Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23
4.9%	4.8%	4.0%	4.2%	4.1%	3.5%	3.7%	3.7%	4.7%	5.4%	4.4%

Overview

No Data



What the chart tells us

In November the UHSussex in month Sickness Absence rate was 4.36%, a reduction on the previous 2 months. The 12 month Sickness Absence rate stands at 4.83%, which is down from the high of 5.2% seen in May 2023, and a reduction from the rate at this point last year, which was sitting at 5.46%.

In terms of Divisions and portfolios the highest 12 month absent rates are Estates and Facilities at 6.65% and the Chief Operating Officer portfolio at 5.73%.

Looking at the 12 month rate by Staff Group, it can be seen the three highest staff types for absence remain Unregistered Nursing at 9.39%, Estates and Ancillary staff at 7.93%, and Registered Nursing at 4.98%. These 3 staffing groups make up over 56% of the substantive workforce

Intervention and Planned Impact

- Sickness rates have shown an improvement in November but it is recognised that we are moving into a challenging Winter period when absence is likely to increase due to seasonal flu and Covid. A vaccination programme has run throughout this period and into early January available to all staff.
- 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. Over 400 supervisors/managers attended the sickness training course with very positive feedback and bespoke sessions on absence management have been provided for specific teams/departments.
- During Q4 of 2023/24 a further five sessions will be delivered on the F&E Supervisors Academy running at RSCH, PRH WTG and SRH which is a key target audience.

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Risks/Mitigations

Risks

- If sickness increases it has an impact on operational delivery and workforce costs on bank and agency spend.

Mitigation

- Control measures are in place to ensure bank and agency spend is carefully monitored and authorised.
- Multiple measures are in place both as preventation measures and reactive in terms of Health and wellbeing management including direct mental health support on wards, better data monitoring, management training and focus on hotspot areas.

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Watch Metrics for People

Metric	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
Turnover (12 month)	9.8%	9.5%	9.5%	9.4%	9.2%	9.0%	9.0%	8.8%	8.8%	8.7%	8.5%	8.4%
Workforce capacity - FTE Budgeted	16431	16645	16578	16846	16862	16861	16869	16991	17035	17104	17143	17125
Workforce capacity - FTE Substantive contracted	14922	14983	15066	15058	15136	15199	15212	15598	15450	15564	15550	15559
Workforce capacity - FTE Substantive contracted variance from Budget	1509	1661	1512	1788	1726	1662	1657	1393	1586	1540	1593	1565
Workforce capacity - Number of leavers	253	88	145	119	93	108	125	187	153	116	98	90
Workforce capacity - Number of Starters	491	237	209	226	226	175	188	550	297	289	195	139
Workforce efficiency - Absence 12 month sickness rate	5.2%	5.5%	5.3%	5.4%	5.3%	5.1%	5.0%	4.8%	5.1%	5.0%	4.8%	
Workforce efficiency - Absence Total in month.	17.3%	14.4%	13.8%	14.1%	13.8%	13.8%	14.3%	13.7%	15.7%	16.6%	15.5%	

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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	Oct-23	Nov-23	Dec-23
YTD Actual	5,756	9,605	10,527	12,771	16,900	24,579	29,249	18,230	26,060
YTD Plan	2,763	4,919	4,834	5,700	6,184	5,960	5,772	5,220	5,584

Overview

The Trust submitted a breakeven financial plan for 2023/24; the ytd planned deficit at M9 is £5.6m. The actual deficit is £26.1m, which is £20.5m above plan.

Elective restoration performance is 103.2% as at M9 against a target which has been revised to 105%.

The cash position is £13.1m, £46.9m below the plan. This variance is:
- £20.5m ytd in support of the deficit to plan;
- £22.5m costs incurred for LMB (3Ts), (£11.0m has been received in M10, with the balance due in M11); and
- £ 3.9m timing differences on contractual payments due.

Capital expenditure is £4.6m behind plan, with expenditure of £46.9m against a plan of £51.6m.

Efficiency performance is cumulatively £4.7m below plan. Predominantly related to procurement schemes and the additional bed de-escalation requirement.

Agency expenditure is 3.1% of the pay expenditure. This is a 0.1% improvement from M06 and is below the 3.7% target.

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M9 YTD	Annual Plan	Plan	Actual	Variance
	£m	£m	£m	£m
I&E	0.0	5.6	26.1	(20.5)
Cash	60.0	60.0	13.1	(46.9)
Capital	99.6	51.6	46.9	4.6
Efficiency	62.0	41.1	36.4	(4.7)
Agency Ceiling	34.3	17.5	22.4	(4.9)

What the chart tells us

The actual deficit is **£26.1m**, which is **£20.5m** above plan.

The key drivers of the deficit outwith the Trust's direct control are the cost of further industrial action in December 2023, excess cost of inflation and the impact of pay award costs in excess of funding.

There was a further 3 days of industrial action (IA) undertaken in December, expenditure relating to temporary pay costs increased to £6.4m ytd.

The Elective Recovery Fund (ERF) 'clawback' has been included in the ytd position, against the 105% NHSE target; and contributes to the reported deficit by **£3.5m**. Financial performance was 103.2% ytd.

The key drivers of the deficit which are defined as being within the Trust and/or System's direct control continue to include excess costs, above budget, of mental health specialling, medical premium (BMA rate) 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 and discuss the financial trajectory, including the treatment of industrial action from December 2023 and the impact of the revised ERF target, for the Trust in 2023/24.

Executive led control total meetings are continuing with each of the operational divisions to monitor progress against delivery of the targets required to achieve the financial trajectory. The Executive led enhanced control environment actions to year-end will complement these meetings.

Risks/Mitigations

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

The key risks include the excess cost of inflation, the impact of further industrial action and unfunded costs associated with the 2023/24 pay awards; in addition to the key risks identified above.

Mitigations: For mental health specialling, a number of internal measures have been introduced including new protocols for confirming requirements and pilot models of care.

Mitigations: Increased waiting list initatives (WLI) & locum controls have been introduced with all existing and future WLI requests and associated activity plans requiring Executive approval to ensure focus remains on cancer and 78 weeks waits.

Mitigations: Divisonal control totals have been issued and control total meetings have been implemented alongside Executive led meetings to provide oversight and challenge of initiatives to reduce Medical, Nursing premium expenditure and Discretionary non pay spend.

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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	Oct-23	Nov-23	Dec-23	YTD
Actual	103.1%	108.4%	101.6%	98.4%	100.6%	102.3%	102.9%	102.5%	108.9%	**103.2%**
Target	107.0%	107.0%	107.0%	107.0%	107.0%	107.0%	105.0%	103.0%	105.0%	

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 Trust's contribution to this ICB target was 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.

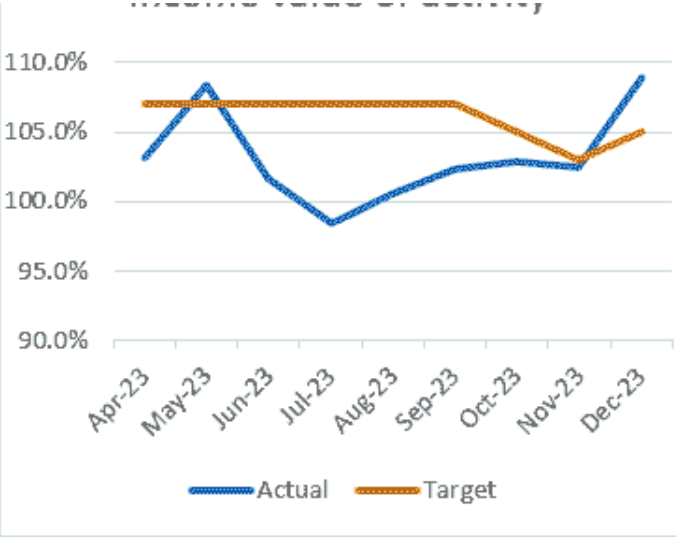
In July NHSE published new elective recovery targets for each ICB; reducing targets by 2% to compensate for the value of lost activity due to the impact of Industrial Action (IA). This relief related to April IA only. The target for the ICB had been confirmed as 107%; whereas a reduction to 105% was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

To cover the costs of industrial action (IA) up to M7 (October) NHSE allocated a total of £800 million to Systems sourced from a combination of reprioritisation of national budgets and new funding and reduced the elective activity target for 2023/24 to a national average of 103%.

The financial arrangements for November 2023 to March 2024 allocated £10m to the Trust for IA, with a requirement to bring the Trust back into financial balance by year end. The breakeven plan submitted was on the understanding the ERF Target for the Trust was 103%.

Income value of activity

What the chart tells us



Performance YTD as at Month 9 equates **103.2%** in comparison to the 2019/20 baseline target (100%). This means that the income value of activity is **1.8%** lower than the 105% target.

Industrial action has had a significant impact on the achievement of activity targets. The impact equates to c.**3.6%** ytd as at Month 9. Without industrial action, performance levels could have been at c**106.8%** for the year-to-date.

There were3 days of industrial action in December and performance achieved was **108.9%**.

Intervention and Planned Impact

Operational plans to deliver the activity necessary to support the elimination of 78 week waits and cancer have been deployed. These plans are to focus on increasing internal productivity (where practical with the risk of further periods of IA); monitoring, reporting and timely intervention.

Independent Sector capacity has been secured to support activity in quarter 4 of this financial year, in addition to internal capacity which has been flexed to accommodate the increase in activity expected whilst ensuring affordability of delivery remains within the Trust roadmap trajectory.

Further opportunities to increase income, improve % performance and reduce the financial impact of ERF clawback are being explored. These opportunities focus on ensuring all activity is captured and coded and have been shared by Divisions during control total review meetings.

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Risks/Mitigations
Performance as at Month 9 is lower than the 105% target by 1.8%. This means that the Trust is at risk of returning income of c £5.3m. Required repayment of income is termed 'clawback'. Estimated 'clawback' of £3.5m has been included in the Trust's reported financial position; based on the target of 105% which is in line with the target confirmed to theTrust/ICB's. Included in the trajectory is expenditure related to the delivery of the Trust ERF performance target of, at least, 103% and the associated clawback from 103% to 105% (c.£5.3m). Work is continuing to ensure that all activity undertaken is captured and recorded. Control total review meetings have taken place with all Divisions with the purpose of monitoring of progress towards delivery of the financial forecast. Control environment has been further enhanced to maximise financial recovery including e.g. executive approval of all additional capacity requests (waiting list initiatives. The impact of the 6 days IA which was undertaken in January has not yet been finalised, this period of IA and any potential further IA, could 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%. We have seen a positive increase in reporting, and increase in percent of low harms as opposed to severe and death, with the aim to increase no harm reporting to provide early warning for actual harm prevention.
The Trust also reports against the Standardised Hospital Mortality Index (SHMI) which compares mortality rates against hospital peers. This has improved over the past quarter, which whilst above the 100 index, is not an outlier when compared statistically. Continued focussed work on learning from deaths, and prevention of harm positively contribute to safer patient care.

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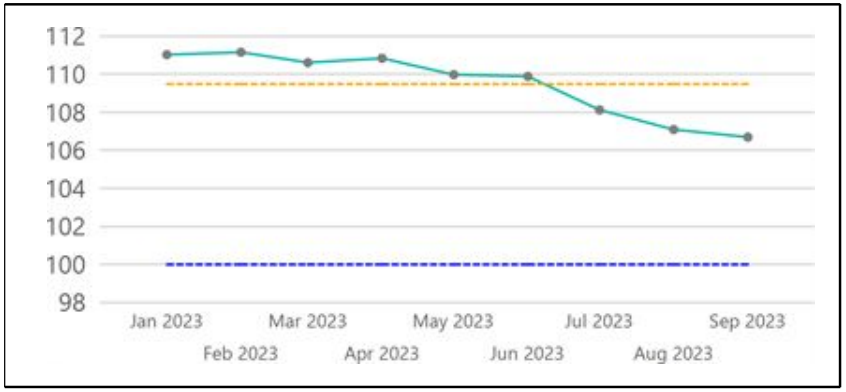
True North

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

Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
111.0	111.2	110.6	110.8	110.0	109.9	108.1	107.1	106.7

Overview

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



What the chart tells us

UHSussex SHMI (which is based on 12 months data up to and including September 2023), is 106.7. This result is not an outlier using a 95% over-dispersed funnel plot but it is an outlier based on the stricter 95% Poisson limits. SRH, WH and RSCH site specific SHMI values are above 100. SHMI is lowest at PRH (94.0) and highest at RSCH (116.0). Out-of-Hospital SHMI at PRH has dropped considerably to 112.98, however SRH now sits at 117.48 and all sites are over 100 and Trust-wide Out-of-Hospital SHMI is 111.17.

Intervention and Planned Impact

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

Risks/Mitigations

No Data

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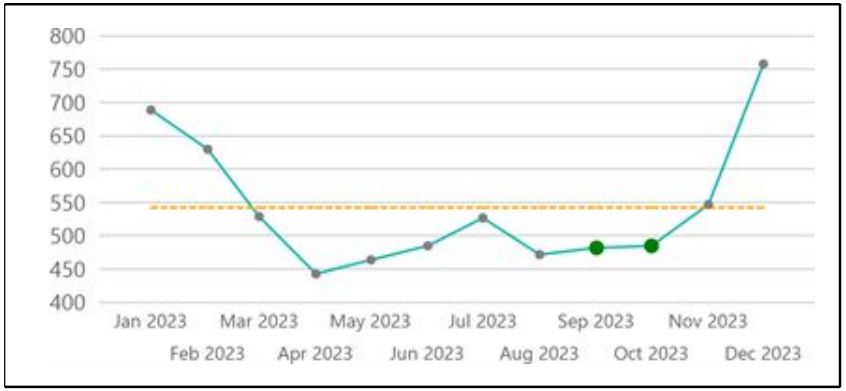
True North

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

Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
689	630	529	443	464	485	527	472	482	485	547	758

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

In 2022 UHSussex were rated in the bottom quartile for the rate of reporting - 43.6 % incidents per 1000 bed days against an average rate of 59.4 per 1000 beddays

For actual harms (approved) graded as low, moderate, severe and death the numbers reported for December = 758 (a significant and positive increase through Q3).

The highest percentage of reported patient safety incidents are graded as no harm (78%) Falls, pressure damage/medication and staffing are the most common themes within the low harm categories.

- Q3 has seen a positive increase on the rate of reporting per 1000 bed days for RSCH/PRH which is now marginally below above the 2022 national average of 54.9.
- 24% of reported incidents caused actual harm - 0.2% = severe/death.

Intervention and Planned Impact

A 3-tier accredited training programme has been designed incorporating human factors and system thinking. This training programme forms part of the foundations of the Trust mandatory Patient Safety Incident Response Plan (PSIRP) ICB confirmed sign off in October- go live December 23.

DCIQ- server transition to new platform will improve standard working, quality of reporting, themes and data and speed and connectivity. Performance Compensation refund agreed with company. Go-Live planned February 24.

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Risks/Mitigations
To be above average the Trust would need an additional 6,713 incidents an increase of 26%, so our target to reach the top quartile would be 12,000 extra incidents per annum averaging 1000 extra per month= *143 extra incidents per month per clinical division.

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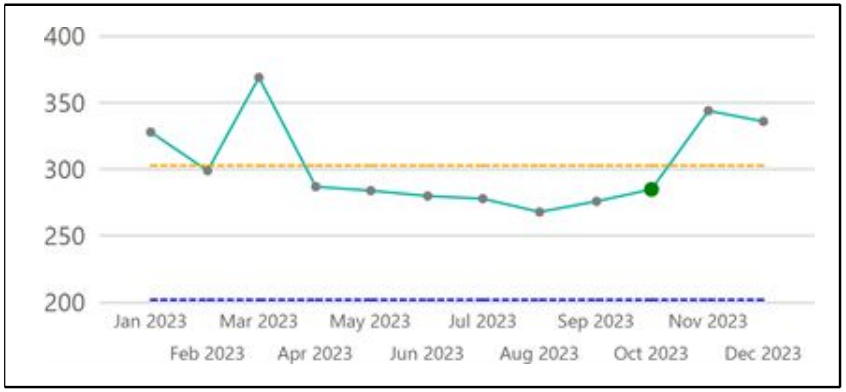
Breakthrough

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

Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
328	299	369	287	284	280	278	268	276	285	344	336

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 December 2023 there were 336 falls reported which is 5.48 per 1,000 bed days (303 falls average /4.92 per 1000 beddays rolling year). When compared to Sep 2023 276 (4.72 per 1,000 bed days), this demonstrates an increase in the rate of falls in November and December

Intervention and Planned Impact

The project improvement plan currently has 20 countermeasures. Key updates for
December 2023:
1. Intentional Rounding and Baywatch launched across UHSussex
2. Safer Care team is collaborating with Divisions to improve the accuracy of staffing levels
3. Falls dashboard created on Compass BI to provide detail into potential causes and risks of falls.
4. Falls assessment bundle being placed onto patent track across UHSussex (go live for RSCH and PRH is February 2024)
5. Yellow blanket and sock" trial in WGH and SRH

Risks/Mitigations

The development of the Falls risk assessment on patient track has also been funded and underway.
A Head of Nursing for harm free care has commenced in post

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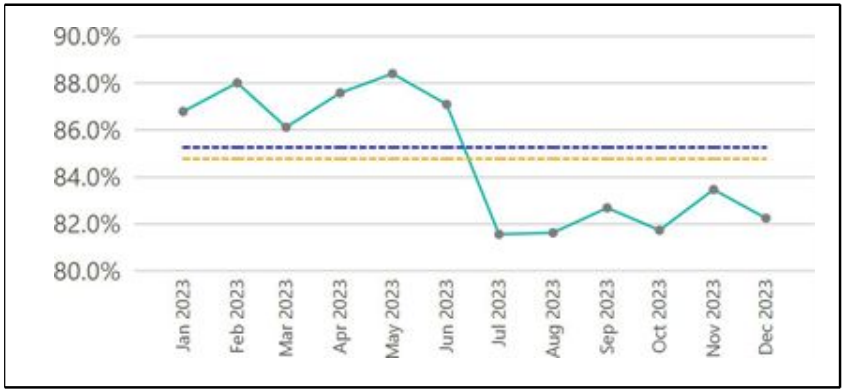
Driver

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

Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
86.8%	88.0%	86.1%	87.6%	88.4%	87.1%	81.6%	81.6%	82.7%	81.7%	83.5%	82.2%

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 day shifts each month. Registered Nurses / Midwives had a reduced fill rate in July and August 2023. There was a gradual increasing trend over the period of August to November 2023. Please note the dip in December reflecting Christmas activity. Reference RN fill: There has also been a gradual increase in band five vacancies across all sites July to October, and reduction in band 5 vacancy in November and December to 13.39%

The Trust merged two legacy rostering systems in early 2023, and has rolled out ward usage in year. Caution is required comparing performance between June and July-23 as a result of these improvements. July onwards is more comparable.

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.

University Hospitals Sussex
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Risks/Mitigations

There are currently 13.39% 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 and HCAs with specialist skills to care for patients with mental ill health.

The Deputy Chief Nurse for Workforce and Professional Standards started in November 23, work has commenced reviewing of models of Nursing Care. 28 enhanced mental health care workers commence into post in January to care for patients with mental ill health.

Rolling recruitment continues for band 5, including targeted campaign for area with high vacancies eg Neuro, frailty and theatres and a focus on targeted recruitment of student nurses. In 2024 we are introducing a guaranteed post to all student nurses and midwives who train at UHSussex and safety join the register. A monthly steering group oversees the governance of the nursing and midwifery workforce.

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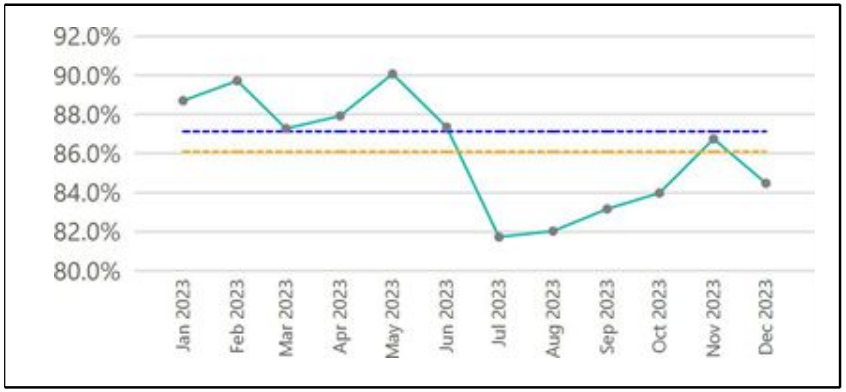
Driver

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

Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
88.7%	89.7%	87.3%	87.9%	90.1%	87.4%	81.7%	82.0%	83.2%	84.0%	86.7%	84.5%

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 fill rate % for Registered Nurses/Midwives and care staff for night shifts each month. The fill rate for nights dipped July and marginally increased Aug to Nov 2023. The fill rate dipped again Dec-23 reflecting Christmas. Reference RN fill: *There has also been a gradual increase in band five vacancies across all sites July to October, and a reduction in band 5 vacancy in November and December*. In reference to care staff fill rate, the nights are marginally better filled than the day coinciding with a better rate of pay overnight.

The Trust merged two legacy rostering systems in early 2023, and has rolled out ward usage in year. Caution is required comparing performance between June and July-23 as a result of these improvements. July onwards is more directly comparable.

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.

University Hospitals Sussex
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Risks/Mitigations

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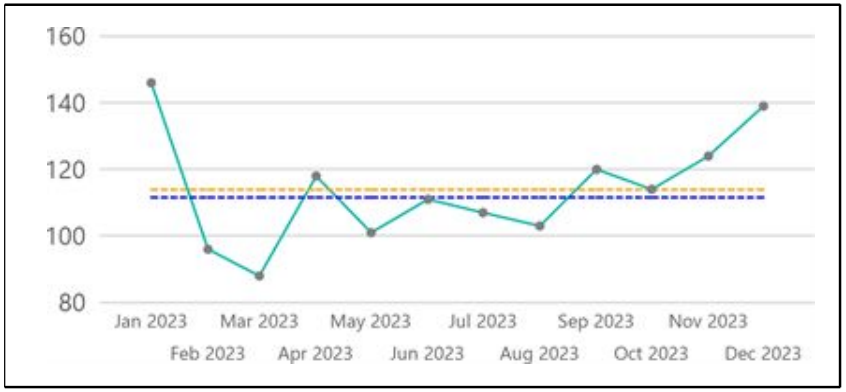
Driver

Metric: Safety - Grade 2+ pressure ulcers

Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
146	96	88	118	101	111	107	103	120	114	124	139

Overview

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



What the chart tells us

December 2023 saw a rise to 139 (2.2 per 1000 bed days) grade 2 and above compared to 120 in Sep 2023 (2.05 per 1000 bed days)
Medicine WGH/SRH reported 66 grade 2 and above Pressure Ulcers this is an increase of 6 cases since September.
Medicine RSCH/SRH reported 23 grade 2 and above pressure ulcers this is an increase of 2 since Sep-23
Surgery WGH/SRH reported 20 grade 2 and above pressure ulcers, this is decrease of 2 since Sep-23
Surgery RSCH/PRH reported 22 grade 2 and above pressure ulcers, this is an increase of 10 since Sep-23
Specialist Division reported . 7 grade 2 and above pressure ulcers, this is an increase of 2 since Sep-23

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 compliance with PD assessment and planning
- 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 accuracy

Risks/Mitigations

- Purpose - T risk assessment on patient track will be implemented on at RSCH and PRH site (February 2023)
- Tendable CQUINN audit now in place
- Head of Nursing for Harm free care has commenced into post

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Watch Metrics for Quality

Metric	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
Clinical outcomes/effectiveness - Timeliness of observations against targets (NEWS2)	67.3%	68.1%	67.9%	68.7%	69.3%	68.7%	67.2%	64.4%	64.6%	64.4%	65.0%	63.7%
HCAI - Number of hospital attributable C.diff cases (HOHA/COHA)	5	11	10	5	7	8	10	9	13	17	13	16
HCAI - Number of hospital attributable E.coli cases (HOHA/COHA)	18	15	23	18	17	20	25	23	15	17	12	25
HCAI - Number of hospital attributable Klebsiella species cases (HOHA/COHA)	6	4	3	6	8	8	11	8	12	11	6	8
HCAI - Number of hospital attributable MRSA cases (HOHA/COHA)	1				2	1	1	1				
HCAI - Number of hospital attributable MSSA bacteraemia cases (HOHA/COHA)	15	5	3	3	11	6	9	9	5	7	7	9
HCAI - Number of hospital attributable Pseudomonas cases (HOHA/COHA)	4	4		1	1	2	5	4	7	6	4	4
Safety - % of Deaths with Comfort Obs in Place	65.7%	71.9%	69.1%	73.4%	71.8%	72.8%	70.5%	70.0%	73.4%	64.8%	69.0%	73.0%
Safety - Total moderate, severe or death incidents	5	2	5	3	6	2	3	5	2	3	2	4

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Systems & Partnerships

	Metric	Target
True North	Cancer - To achieve the 62 day standard (All referrals - National standard revised Oct 2023)	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 There were markers of improvement in operational performance metrics through Q3 2023/24. A&E performance stabilised in Q3 and remains materially better than Q2 2022/23. The Trust has been place in Tier 1 as part of the NHSE oversight framework for RTT and Cancer in September. Since September there has been a reduction in both the actual number of patietns waiting more than 65 weeks for treatment, and the total PTL size for the first time since the pandemic. Industrial action has challenged sustaining performance but long waiting and cancer patients continued to receive treatment through junior doctor and consultant industrial action.

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True North

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

Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
2315	1962	2472	1836	2059	1843	1555	1941	2252	2544	2703	2852

Overview

The number of patients waiting longer than 12 hours in A&E department increased Dec-23 compared to Nov-23 (8.1% compared to 7.7% Nov) but this is a significant improvement on Dec-22 (11.87%).

Performance is most challenged at RSCH with 16.1% on average of RSCH attendances in department more than 12 hours in Dec-23, compared to 16% Nov-23, but is improved compared to 18.9% in Dec-22 .

What the chart tells us

The number of twelve hour breaches has fallen from a peak in December last year to a low in the Summer months in 2023. The position has deterioriated as we have moved through Q3 and is related to an increase in the number of patients who are medically ready for discharge. However, overall Trust position has significantly improved from December 2022.

Intervention and Planned Impact

Initiatives in the community and at our front doors have resulted in increased usage of Virtual Wards (up to 90% mid Jan) and admission avoidance. This results in fewer people being admitted or staying in a hospital bed which supports timely flow through our emergency departments.

Risks/Mitigations

There is evidence at a population level that patients who stay in ED for more than 6 hrs are at greater risk of mortality and morbidity. Improvement work is focused on reducing long stays in the emergency departments, and interventions take place to mitigate where long waits happen.
A further risk is that there are no suitable patients for admission avoidance or virtual wards. Ongoing training and developing of the pathways and communication is in place and the numbers of patients who are either admitted to a virtual ward or their admission is avoided is increasing.

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True North

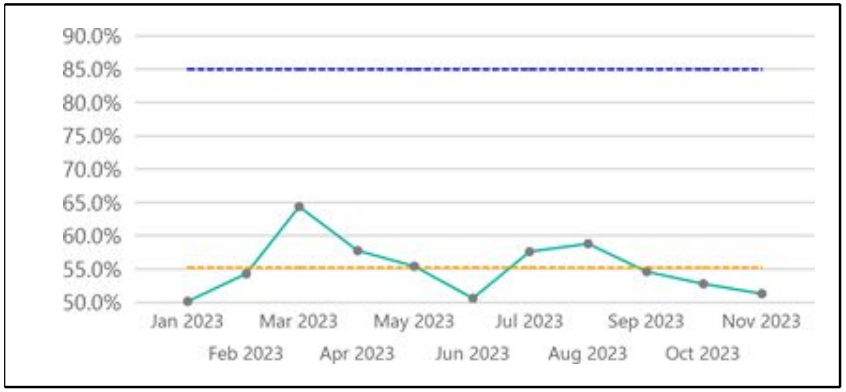
Metric: Cancer - To achieve the 62 day standard
(All referrals - National standard revised Oct 2023)

Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23
50.18%	54.31%	64.38%	57.78%	55.44%	50.64%	57.63%	58.82%	54.63%	52.80%	51.32%

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.

Please not that the constitutional standard changed in Oct-23 to include patients from all referral sources, having previously covered only urgent GP referral only.



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.
Nov-23 performance was 51.3%, compared to 52.8% in Oct-23 and national standard of 85%

Intervention and Planned Impact

The Trust has developed recovery plans for each of its challenged tumour sites. These are being overseen through enhanced governance led by the COO and MD (planned care).

Tumour site plans are focused on improving diagnostic and treatment capacity, shortening the front of the pathway and reducing the backlog. 62-day performance will only materially improve once the backlog has been reduced and sustained at a lower level.
NHS England has placed the Trust into its 'Tier 1' regime due to challenges with cancer waits. This includes fortnightly oversight meetings with CEO to monitor progress.
The Trust was awarded additional financial support by NHS England to recover cancer performance as part of the 'Tier 1' regime.

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Risks/Mitigations
Risks to deliver of the 62-day standard include: 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. Industrial Action - mitigated by careful forward planning when dates are announced, with cancer activities being prrioritised for protection.

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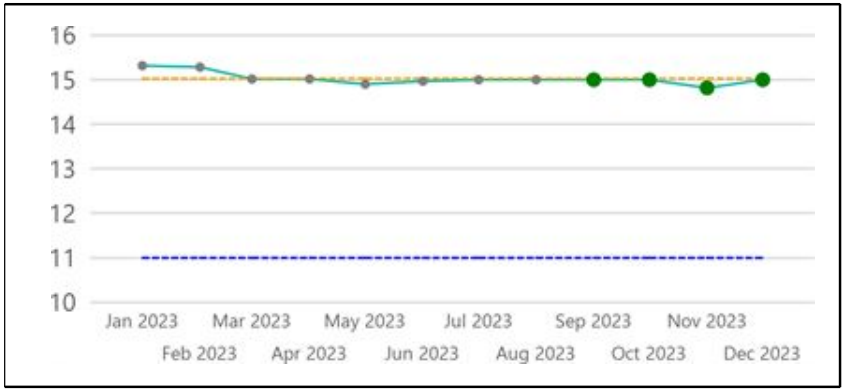
Breakthrough

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

Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
15:19	15:17	15:01	15:01	14:54	14:58	15:00	15:00	15:00	15:00	14:49	15:00

Overview

Median Hour of Discharge is a breakthrough objective for the Trust and wards are concentrating on reducing their MHD to enable earlier flow onto the wards from the emergency floor areas.
The Trust MHD is lower than it was a year ago.



What the chart tells us

The chart shows that MHD has reduced well through the year but in the past 3 months the position has deteriorated and has reverted to the position as of August.

Intervention and Planned Impact

Target wards are part of the Breakthrough objective and the project is divisionally lead. There is also overlap with the CP LoS. The discharge methodology which includes the twice daily board rounds is key to achieving an earlier hour of discharge. The Corporate Project for Length of Stay is working closely with the MHD project to ensure synergy.

Risks/Mitigations

The risk is of mixed messages between the BO MHD and the CP LoS.
The SROs for both projects are working together to ensure the projects are aligned

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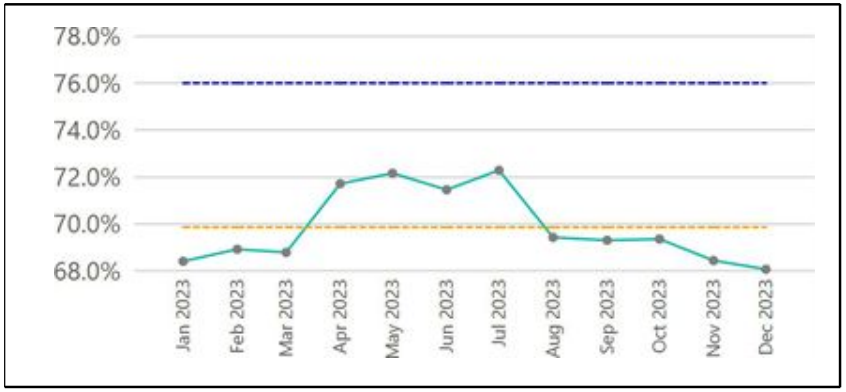
Driver

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

Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
68.4%	68.9%	68.8%	71.7%	72.2%	71.5%	72.3%	69.4%	69.3%	69.4%	68.4%	68.1%

Overview

The Trust treated 68.02% of patients within 4 hours of attending the UHSx A&E departments in December 2023. National performance was 69.4%. The 4 hr position has improved by 11.8% compared to Dec-22 .



What the chart tells us

Performance overall in December has fallen since November by 0.4%. Some sites saw improvements:
SRH with +3.3% performance from last month (57.3%) . PRH with 69.0% (68.7% in Nov).
The other main sites saw a decrease: RSCH 56.1% (58.5% in Nov), RACH 78.3% (78.5% in Nov),, Worthing 59.7% (60.6% In Nov).

Intervention and Planned Impact

Trajectories for 24/25 are being developed for each Emergency Department.
Improvement action plans with specific schemes and projects along with the predicted impact on performance are being reviewed at each hospital with allocated SROs for each scheme.
These plans are reviewed fortnightly at a Trust level.

Risks/Mitigations

Winter pressures are impacting on delivery of the 4 hour standard despite the community interventions to keep people out of hospital. Attendances at the front door have risen with associated seasonal pressures.
A focus on the non admitted performance is where the largest possible gains can be found as these pathways are less likely to be impacted by winter pressures.
Planning guidance is not yet out for 24/25 however we are planning for 80% and will work towards achieving that figure through the action plans.

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Driver

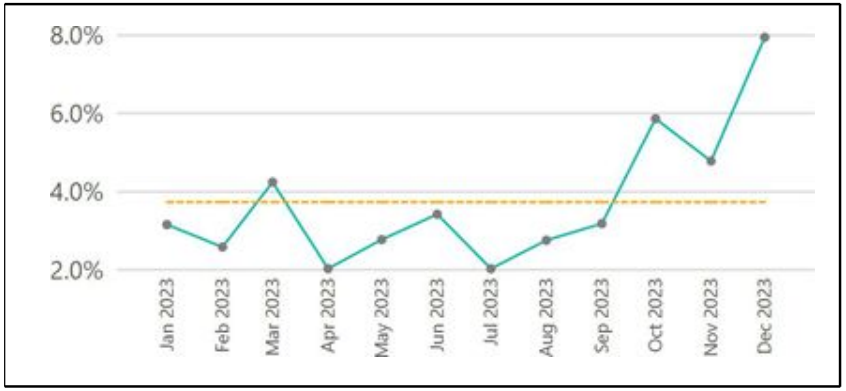
Metric: A&E and Emergency flow - Ambulance Handovers > 60 minutes

Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
3.2%	2.6%	4.2%	2.0%	2.8%	3.4%	2.0%	2.8%	3.2%	5.9%	4.8%	7.9%

Overview

The number of over 60 minute handovers increased in December to 568 (7.9%) from 323 (4.8%) in Nov-23. The majority of delays are at two sites with 338 of these at the Royal Sussex County Site and 117 at Worthing.

This is an improvement on the same time last year (726 Dec-22 (11.8%)).



What the chart tells us

Sixty minute handover delays have improved significantly through the year at all sites, though the place with the worst breaches remains RSCH.
Across Q3 we have seen the number of delays increase and this relates to delayed flow through our hospitals and increased numbers of 12 hr breaches.

Intervention and Planned Impact

Revised UEC improvement plans include focussing on increased flow through the hospitals. Reducing LoS further will impact on improved ED flow and allow for the handover of ambulances to be quicker.
We are also working in partnership with SECAmb and other system partners to develop alternatives to conveyancing from high user areas such as the care home sector.

Risks/Mitigations

A risk is the continued high number of ambulances which we are seeing in January.
We are working with Secamb and community providers to ensure appropriate conveyance to hospital and this aims to reduce the numbers being brought to ED

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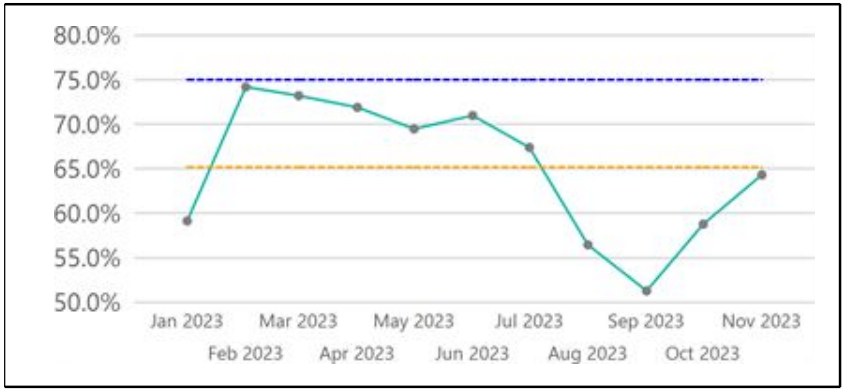
Driver

Metric: Cancer - 28 day faster diagnosis standard

Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23
59.14%	74.19%	73.21%	71.90%	69.48%	70.97%	67.40%	56.46%	51.29%	58.78%	64.31%

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 improved for second consecutive month in Nov-23 to 64.3% against the 75% target (from 58.8% in Oct-23)

Intervention and Planned Impact

FDS performance deteriorated in Aug-23 and Sep-23 due to challenges in high-volume pathways in Breast, skin, Lower GI and Gynae. The Trust has developed recovery plans for each of these tumour sites, with enhanced oversight and governance in place led by COO and MD (planned care & ccancer) to drive improvement.

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 Mar-24.

NHS England has placed the Trust into its 'Tier 1' regime due to challenges with cancer waits. This includes fortnightly oversight meetings with CEO to monitor progress.

The improved Nov-23 position reflects the progress being made against these plans. Industrial action will impact Dec-23 and Jan-24 performance, but careful operational planning has been undertaken to minimise this and confidence remains high in achieving Mar-24 objective.

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.
Industrial Action - mitigated by careful forward planning when dates are announced, with cancer activities being prrioritised for protection.

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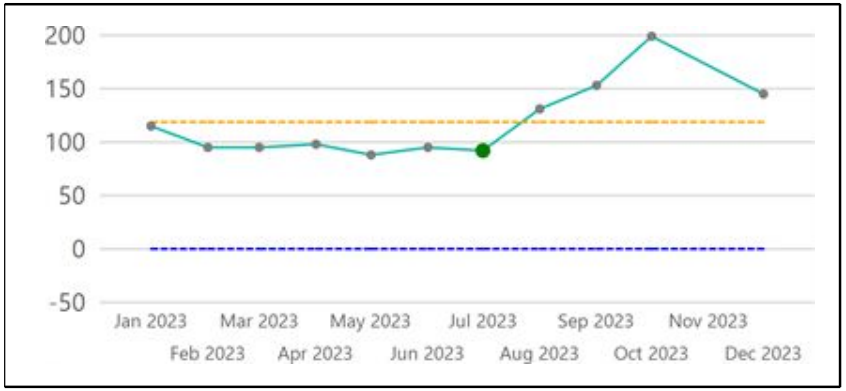
Driver

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

Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Dec 23
115	95	95	98	88	95	92	131	153	199	145

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 to 75 by Mar-24.



What the chart tells us

There has been a decrease in over 104 day prospective waits from 199 in Oct-23 to 145 in Nov-24.

Intervention and Planned Impact

The trust has developed recovery plans for each challenged tumour-site. These are being overseen through enhanced governance led by the COO and MD (planned care).
NHS England has placed the Trust into its 'Tier 1' regime due to challenges with cancer waits. This includes fortnightly oversight meetings with CEO to monitor progress.
The Trust has been awarded additional financial support to help contribute to recovery of the cancer performance position as part of NHS England's 'Tier 1' regime.

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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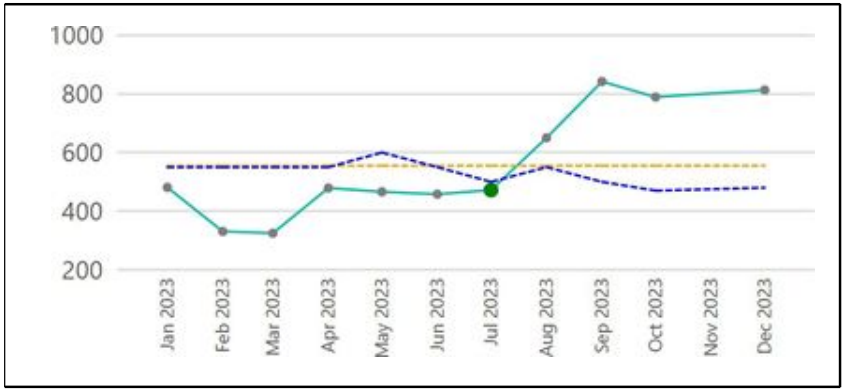
Driver

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

Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Dec 23
481	331	325	479	466	458	472	650	842	789	813

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 351 patients by Mar-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 prospective waits in Dec-23, to 813. This figure includes patients from all referral pathways (reflecting the new national standard) and is not directly comparable to previous months. There were 534 patients waiting from urgent GP referral, compared to trajectory of 480.

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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 NHS England has placed the Trust into its 'Tier 1' regime due to challenges with cancer waits. This includes fortnightly oversight meetings with CEO to monitor progress. The Trust was awarded additional financial support to help recovery cancer performance as part of the 'Tier 1' regime.
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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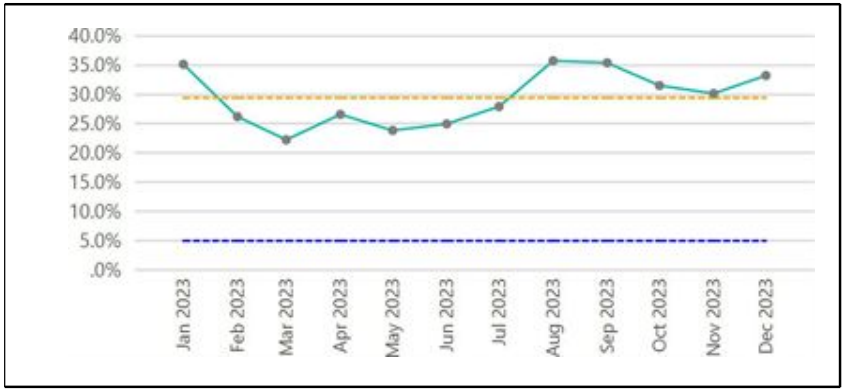
Driver

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

Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
35.2%	26.2%	22.3%	26.6%	23.9%	25.0%	27.9%	35.8%	35.4%	31.5%	30.2%	33.2%

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

UHSX achieved 33.2% in Nov-23 against the diagnostic patients over 6 week Mar-24 target of <5%. This was a 3 percentage point deterioration compared to Oct-23 and is worse than National performance (23.3% Nov-23).
The number of patients waiting over 6 weeks for their diagnostic increased by 497 patients compared to November, whilst the waiting list size decreased by -469. Both of these sides of performance influenced by Christmas period, but also compounded by the knock on impact of Industrial Action.
Largest growth in backlog were observed in MRIs, CT and Gastroscopy, whilst recovery continued for Echos despite the capacity constraints described above.

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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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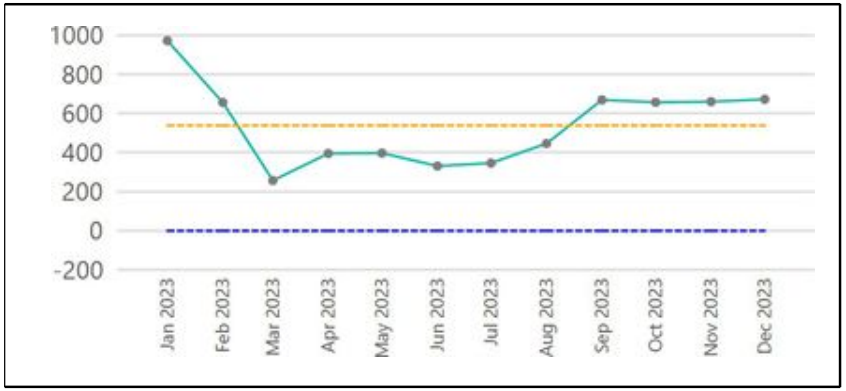
Driver

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

Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
972	656	257	395	397	331	346	446	669	657	660	672

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 was 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 Dec-23 there were 672 patients waiting over 78 weeks. This is in line with past 3 months.

Intervention and Planned Impact

The Trust has developed recovery plans by specialty to target reduction of the 78 week waits by Mar-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 MD (planned care and cancer) and on weekly basis. The Trust also has fortnightly meetings with CEO and NHS executive to oversee progress as part of 'Tier 1' regime..
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 has also created a small virtual team to man-mark the 78 week cohort to add further grip in tackling this patient list.

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Risks/Mitigations
PTL shape and growth: The growth in the PTL since the pandemic means there is an increased number of patients in the Mar-24 78ww risk cohort, and the Trust has to treat an increased number of patients to avoid increasing numbers of 78ww. There are 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 suspected cancer referral demand (which take precedence in terms of clinical priority) also constrain residual routine waiters capacity. There was a 9% growth in cancer referrals in 2023 v 2022.

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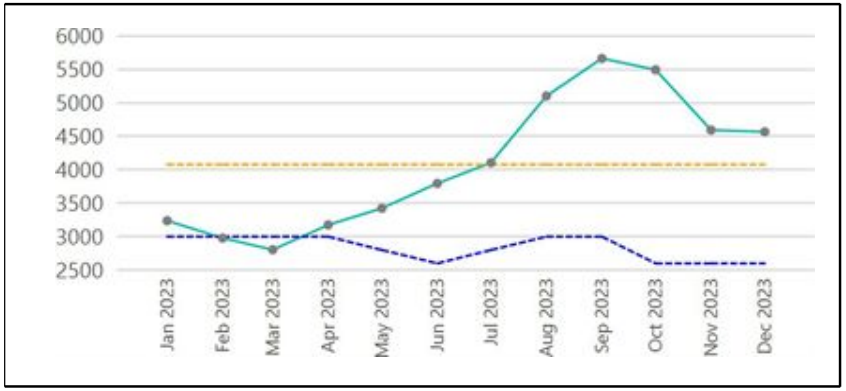
Driver

Metric: RTT Elective care - >=65 Weeks

Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
3238	2978	2804	3175	3424	3796	4105	5103	5664	5495	4594	4566

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 Mar-24. Due to challenges with 65 week performance, the Trust has been placed in Tier 1 level support by NHSE.
NHS England has asked providers to prioritise financial performance ahead of reducing clearing 65-week waits by Mar-24. The trust has therefore agreed to defer achievement of this objective to Sep-24.



What the chart tells us

There has been a decrease in the number of patients waiting over 65 weeks at the end of Dec-23, to 4,566.
The Trust tracks this plus the cohort of patients who unless seen will breach 65 weeks by the end of March. There were 14,465 patients on this cohort as of 31 Dec-23, compared to 21,4205 as of 26 Nov-23. With 3 months to the end of March, this requires circa 4,820 patients completing their pathways per month to achieve the operating framework aim of zero by March.

Intervention and Planned Impact

The Trust had developed recovery plans by specialty to target reduction of the 65 week waits by March-23. These have been scaled back in line with the Trust's financial commitments, with 65-week wait objective being deferred to Sep-24. The position continues to be tracked closely on a weekly cycle, but focus is now on 78-week waits.
The Trust has enhanced governance arrangements led by Director of Performance and MD (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 undertaking a clerical validation exercise of approximately 60,000 patients on the waiting list. There are circa 23,000 non-responders; these patients will be given further opportunities to respond, but will ultimately be returned to primary care in line with our access policy if they do not engage with their care.

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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. Financial constraints mean the Trust cannot undertake the volume of WLI required to deliver the 65-week Mar-24 target; the Trust has agreed with NHS England and Sussex ICB to defer achievement to Sep-24.

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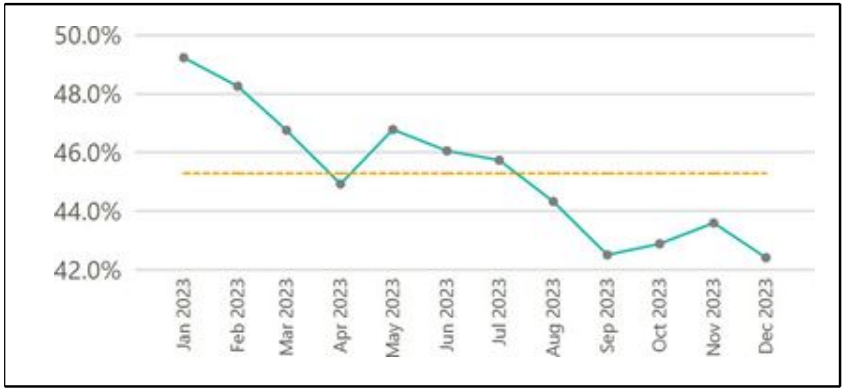
Driver

Metric: RTT Elective care - 18 Week Performance

Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
49.23%	48.26%	46.76%	44.93%	46.78%	46.06%	45.74%	44.33%	42.51%	42.89%	43.60%	42.42%

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).

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Intervention and Planned Impact
Key actions include: 1. Increasing activity delivered, through: • improved productivity and pathway redesign. This is being overseen through the productivity breakthrough objective steering group. For example reducing unnecessary follow ups by increasing use of Straight to Test pathways and PIFU (Patient Initiated Follow Up) • Increased weekend working • 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 2. Improved waiting list management, with 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. 3. Enhanced planned care oversight and governance structure with divisional leadership led by MD (planned care) and Director of Performance, with divisions held accountable for improvement focused on all stages of treatment not just longest waits 4. Central validation of pathways over 12 weeks and continued DQ process re waiting list reporting
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. Financial constraints limit the amount of activity that can be delivered outside of plain time.

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Watch Metrics for Systems & Partnerships

Metric	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
A&E and Emergency flow - % Patients with a 21+ day length of stay	10.4%	8.8%	8.9%	8.8%	8.8%	8.0%	8.2%	7.6%	8.0%	8.2%	7.9%	8.4%
A&E and Emergency flow - A&E 4 Hour Breaches	9545	9280	10607	9087	10012	10122	9799	10536	10752	10889	10981	11239
A&E and Emergency flow - A&E Attendances	30212	29859	33981	32125	35961	35460	35358	34460	35026	30717	30097	30435
A&E and Emergency flow - Ambulance Handovers	6910	6541	7329	7068	7644	7328	7386	7405	7200	7544	7335	7733
A&E and Emergency flow - Ambulance Handovers - % Under 15 mins	50.3%	51.9%	46.7%	55.1%	55.8%	60.5%	67.6%	63.8%	59.5%	56.1%	56.1%	49.8%
A&E and Emergency flow - Average LOS (Excl LOS 0)	8.6	8.0	7.6	7.4	7.7	7.4	7.5	7.3	7.1	7.4	7.2	7.4
A&E and Emergency flow - Bed Occupancy	1649	1646	1645	1627	1643	1596	1573	1630	1647	1678	1733	1760
A&E and Emergency flow - Emergency Admissions > 1 LOS	5274	4892	5705	5348	5583	5473	5628	5625	5581	5789	5712	5802
A&E and Emergency flow - Mean Waiting Time	325	300	314	288	290	293	281	299	314	320	337	338
A&E and Emergency flow - Time to treatment in ED (Median time to treatment mins)	54	74	77	70	77	77	72	78	79	69	70	69
A&E and Emergency flow - Time to Triage in ED - % seen within 15 mins	62.6%	55.9%	52.3%	64.5%	64.5%	59.7%	74.7%	70.5%	64.8%	64.5%	63.1%	58.9%
Cancer - Two week rule performance	72.4%	86.6%	87.5%	76.7%	79.8%	65.3%	66.2%	51.2%	43.5%	58.9%	62.8%	
Diagnostics - 6 week backlog	6211	4995	4591	5126	4946	5268	6272	8393	8541	7226	6336	6829
Diagnostics - Activity	32845	31646	35348	34345	36425	34682	32370	32809	34481	37145	39803	31927
Diagnostics - Waiting List size	16675	18102	19634	18293	19768	20081	21039	22171	22550	21201	19823	19436
Elective care - Activity compared to 2019/20				47.4%	52.7%	57.0%	44.5%	46.6%	44.0%	44.3%	46.2%	46.7%
RTT Elective care - >= 52 Weeks	9630	9771	10497	11539	12770	13937	15132	16265	16922	16379	14441	13673
RTT Elective care - >104 Weeks (NHSi Criteria)	20	25	18	19	13	5	3	0	0	0	3	4
RTT Elective care - Clock Starts	20466	18789	20858	16381	19690	21668	21975	21872	20956	22845	23179	17246
RTT Elective care - Clock Stops	17118	18866	20325	15321	17754	19396	17906	19361	20542	23996	28246	18437
RTT Elective care - Waiting list size	128994	128038	128876	131877	138882	145339	152152	154143	155091	152018	145668	143841

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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	4638

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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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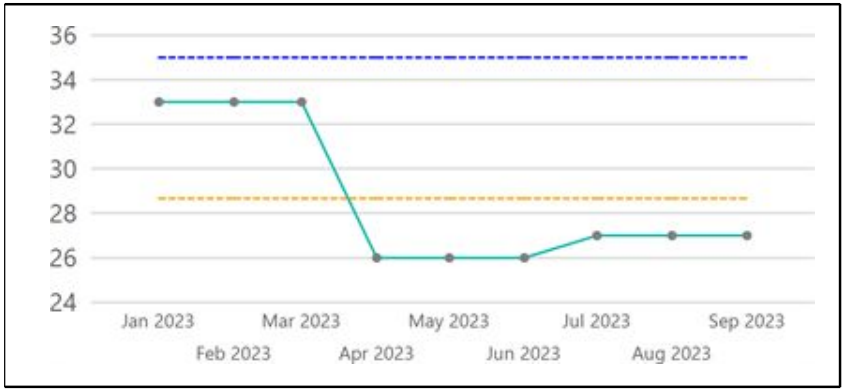
True North

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

Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
33	33	33	26	26	26	27	27	27

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 research engagement. To mitigate, we are introducing divisional research lead roles. These roles will build on the divisional/specialty level mission statements and develop divisional growth plans and targets, supported by the R&I corporate function and Brighton and Sussex Health Research Partnership opportunities. Growth plans will focus on specialty research growth, commercial research growth and workforce research capacity and capability. Fit for purpose clinical research facilities remain a risk to increasing commercial research opportunity, activity and income. Plans for a replacement Clinical Research Facility are included in current estates master planning activities - a firm plan is not yet signed off.

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Breakthrough

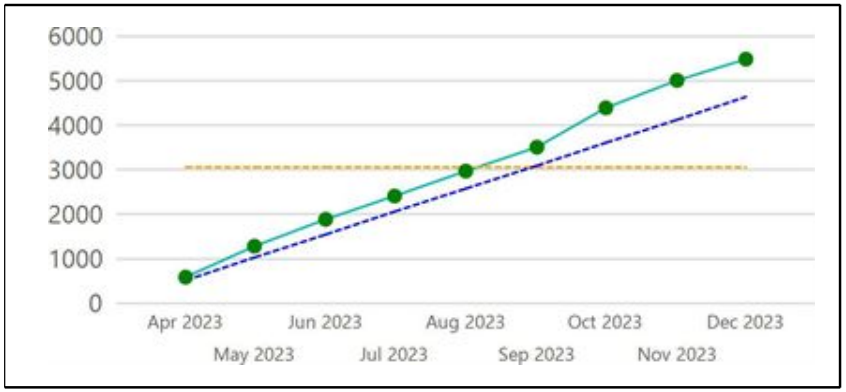
Metric: To recruit additional patients in the next twelve months, with a targeted plan implemented as a result of the R&I Strategy

Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
590	1283	1887	2411	2970	3508	4391	5007	5484

Overview

Key headlines

- **Total recruitment above target 4638 (Current 5484, 118%)**
- 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 (162 recruits December).

Intervention and Planned Impact

- Approval for 'My UHSussex' funded clinical academic fellowship schemes - launch Jan-24
- New Sussex Health & Care Research Training Hub implementation planning - launch planned for Quarter 1 2024/25
- Internal research performance dashboard now live - on track for external release Q1 2024

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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 has been 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 rose 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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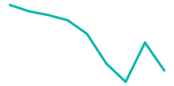
Watch Metrics for

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	6.66	7.06	
Sustainability	Agency Spending - Agency Costs as a % of staff costs (3.7% target YTD)	3.1%	3.7%	
Sustainability	Financial efficiency - Variance from efficiency plan YTD	-5k	0k	
Sustainability	Financial Stability - Variance from breakeven plan YTD	-20k	0k	
Quality	Clinical outcomes/effectiveness - SHMI equal to or less than 100	106.7	100.0	
Quality	HCAI - Number of hospital attributable C.diff cases (HOHA/COHA)	16	3	
Quality	HCAI - Number of hospital attributable E.coli cases (HOHA/COHA)	25	4	
Quality	HCAI - Number of hospital attributable MRSA cases (HOHA/COHA)	1	0	
Quality	Safety - Reduction of 5% in preventable harm - UHSx approved	758		

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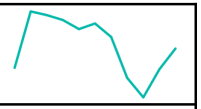
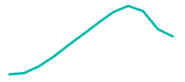
Systems & Partnerships	Cancer - 28 day faster diagnosis standard	64.31%	75.00%	
Systems & Partnerships	RTT Elective care - >= 52 Weeks	13673	11058	
Systems & Partnerships	RTT Elective care - >=65 Weeks	4566	3000	
Systems & Partnerships	Planned care - By March 2023, no patient is waiting more than 78 weeks for treatment.	672	0	
Systems & Partnerships	RTT Elective care - >104 Weeks (NHSi Criteria)	4	0	
Systems & Partnerships	Cancer - Number of patients waiting over 62 days for treatment	813	600	
Systems & Partnerships	A&E and Emergency flow - No patients to exceed a 12 hour wait in our emergency departments	2852		

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Current segmentation

The Trust remains in Segment 3 of the National Oversight Framework (NOF) and continues to engage with NHS England and the ICB through the established oversight processes.
The lead for the oversight of the Trust's performance remains with the ICB and through their 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 Q3 the Trust has continued to see sustained performance challenges which has been recognised nationally with the Trust remaining within Tier 1 for RTT and Cancer performance. Tiering allows for access to greater support but also brings increased scrutiny from NHS England and informs the NOF segmentation meetings. The Trust has made improvements which are recognised nationally but still has significant levels patients waiting for treatment, this performance challenge coupled with the loss of activity through continued industrial actions see the Trust's performance strategic risk remain elevated.
The Trust continues to be at 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 Trust's established Quality and Safety Improvement Programme (QSIP) which was established in response to oversee the delivery of the quality governance undertakings which the Trust has entered into with NHS England is progressing. The programme has established a delivery plan and is reporting its progress to a dedicated QSIP Committee alongside to the oversight direct to the ICB via the Quality Review Meetings.
The Board Assurance Framework shows a continuing level of elevated risk across the delivery of the Trust's strategic objectives, across the domains of quality, people, performance and finance.

Implications of this segmentation

Segment 3 allows the Trust to have access to external advice and support which has included support to improve UEC performance and support 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 with this programme capturing the specific concerns highlighted by the CQC as reflected in the undertakings with NHSE. The undertakings in respect of operational performance are overseen by the Trust's Systems and Partnerships Committee and reported through the national Tiering meetings.
As has been reported previously, in order to exit segment 3 the Trust will need to deliver its operating and financial plan along with demonstrable improvements in quality governance having been sustainably addressed.
Noting the continuation of the elevated levels of strategic risk and changes brought about by the system re-set financial plan the Trust does not anticipate exiting segment 3 over the next quarter and is unlikely this will change for the first part of 2024/25.

Agenda Item:	5.	**Meeting:**	Public Board	**Meeting Date:**	8 February 2024
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:	N/A				

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	N/A	Staff confidentiality	N/A
Patient confidentiality	N/A	Other exceptional circumstances	Yes

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		
Sustainability	Yes	QSIP impacts on all aspects of Trust business
People	Yes	QSIP impacts on all aspects of Trust business
Patient & Quality	Yes	QSIP impacts on all aspects of Trust business
Systems and Partnerships	Yes	QSIP impacts on all aspects of Trust business
Research and Innovation	Yes	QSIP impacts on all aspects of Trust business

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

Regulatory / Statutory reporting requirement

QSIP enables the Trust to discharge its obligations as set out in the undertakings given to NHSE.

Communication and Consultation:

Workstream in QSIP

Executive Summary:

Introduction

1. The Trust has established a Quality and Safety Improvement Programme (QSIP) to discharge its obligations as set out in the undertakings given to NHS England (NHSE). These undertakings require the Trust to develop and implement a comprehensive improvement plan (QSIP) with Board level accountabilities. This report provides assurance on the mobilisation of QSIP.

2. As well as satisfying the undertakings the purpose of QSIP is to make sustained improvements in the quality and safety of our services and to develop improved systems, processes and culture that provide assurance to the Board. In doing so the Trust will also be better placed to provide assurance to the Integrated Care Board (ICB), the Care Quality Commission (CQC), patients families and the communities we serve. An explicit outcome from QSIP

will be to comply with the regulatory requirements of all our regulators including the CQC, and where we are not able to assure compliance, the programme will enable the Trust to identify the risks, to mitigate those risks, to produce a plan to achieve compliance and to deliver that plan.

Context

3. Since establishment through merger in 2021 the Trust has been subject to substantial regulatory intervention from the CQC. The impact of these interventions has seen downgraded ratings for several services and hospitals as well as an 'inadequate' rating for Well-Led. The themes prevalent in these inspections have included some staff reporting feeling that they were afraid to speak up or that when they did speak up nothing changed, a detached Executive and systems of quality governance and a culture that do not assure the safety and quality of services. These themes have informed the development of QSIP.

4. The Trust remains in segment 3 of the National Outcomes Framework and the Trust entered into the undertakings referenced above. The latest inspection by the CQC was in August 2023 and the report is expected imminently.

Programme Mobilisation

5. The programme was conceived and established in October and mobilised in November and December. It should also be noted that action that QSIP builds on work that has been established and delivering results for some time in areas such as quality governance and general surgery and RSCH/PRH both of which were Corporate Projects.

6. **Governance.** A Steering Group to lead the programme has been established, it meets monthly and in addition to the attendance of all Executives it is chaired by the Chief Executive. At its meeting in October, the Steering Group agreed its terms of reference and at its meeting in November it signed-off the draft programme and project charters.

7. There are four delivery workstreams and two enabling workstreams each with and Executive lead and a director level Senior Responsible Officer. The Executive Lead for the programme is the Chief Governance Officer (CGO). The workstreams are:

    a. Improving quality governance, risk management and assurance: Executive leads CMO and CNO.
    b. Well-Led: Executive lead CGO
    c. Improving access to surgery: Executive lead COO/DCEO
    d. Improving safety culture: Executive Lead CEO
    e. Engagement: Executive leads CPO and CGO
    f. Communications: Executive Lead CGO

8. See the appendix for the key deliverables in each workstream. It should be noted that the work on the delivery workstreams enables the workstreams on engagement and communications to be mobilised in January and February.

9. **Assurance.** The Board has established a new committee to assure the delivery of the programme. A report from the Chair of the committee on its January meeting is also provided to the Board.

10. In addition, assurance is provided to the ICB and NHSE through the established quality review process as set out in the appendix.

11. **Programme plan (timeline).** The agreement of the programme and project charters (see appendix) has enabled the production of a detailed programme plan setting out key milestones and timelines.

12. **Programme Resourcing.** Executive and director level leadership has been established and programme management support is being provided by the Programme Management Office. The Executive is working with divisional and corporate leaders to identify aspects of the strategy that may be re-prioritised to create capacity to deliver QSIP.

Summary

13. The mobilisation of a programme of the scale and complexity of QSIP is a major undertaking particularly in the context in which the Trust is working. Nonetheless, the Trust has successfully mobilised the programme in October and November and has moved into the delivery phase from December.

Key Recommendation(s):

14. The Board is asked to note the assurance that programme has been successfully mobilised.

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Quality & Safety Improvement Programme (QSIP)

Trust Board

February 2024

QSIP - Programme Structure

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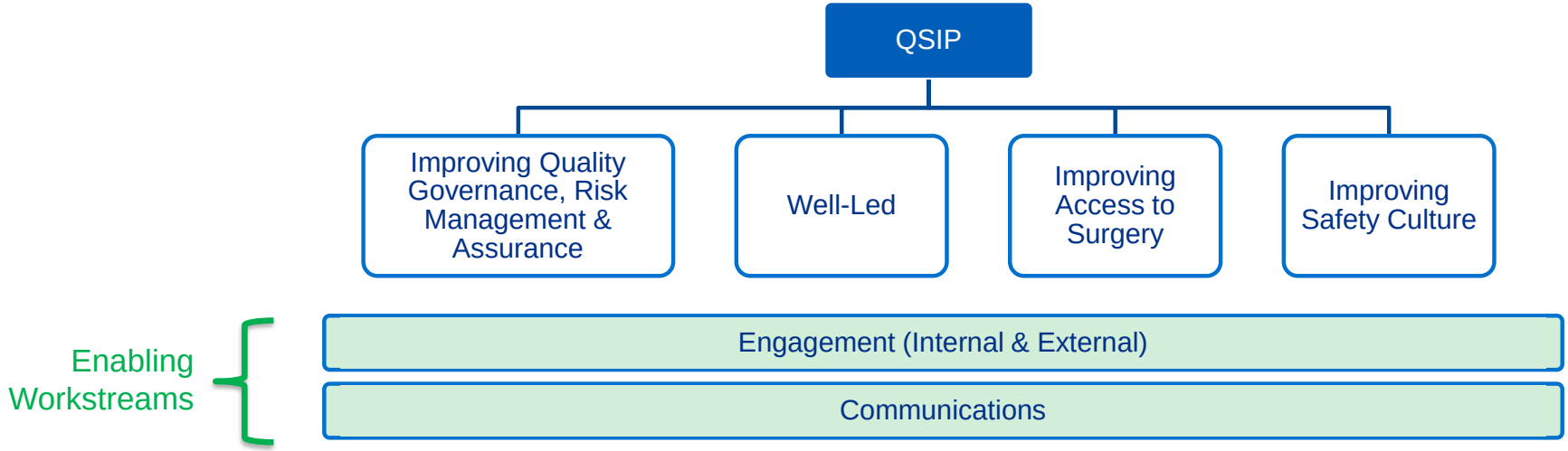

Key deliverables in each workstream:-

Improving Quality Governance, Risk Management & Assurance	Well-Led	Improving Access to Surgery	Improving Safety Culture
• The standards that need to be delivered • The policies that support this • The measurement of how well we are doing • How we need to improve our gaps • The provision of assurance	• Overseeing the delivery of well-led improvements, based on CQC requirements and best-practice	• Focus supporting divisions with onward improvements, many initiated through the Improving General Surgery corporate project • Right-sizing theatre capacity across the Trust • Ensure the provision of surgery is maximised across the Trust	• Improve safety culture in the Trust, ensuring that relevant training is embedded • Delivery of a framework tool to help effectively measure safety culture • Enhance the effectiveness of reporting and feedback, and embed an open, learning culture

QSIP - Programme Resourcing

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QSIP Programme Exec Sponsor – Darren Grayson

	Improving Quality Governance, Risk Management & Assurance	Well-Led	Improving Access to Surgery	Improving Safety Culture
EXEC SPONSOR	Katie Urch / Maggie Davies	Darren Grayson	Andy Heeps	George Findlay
WORKSTREAM SRO	Leanne McLean; Jane Woollard; Glen Palethorpe; Nicole Chavaudra; Su Xavier	Glen Palethorpe	Stephen Drage	Rob Haigh

QSIP Programme Office Support – 1 x 8d, 1 x 8b, 3 x 0.5 8a

QSIP - Programme Governance

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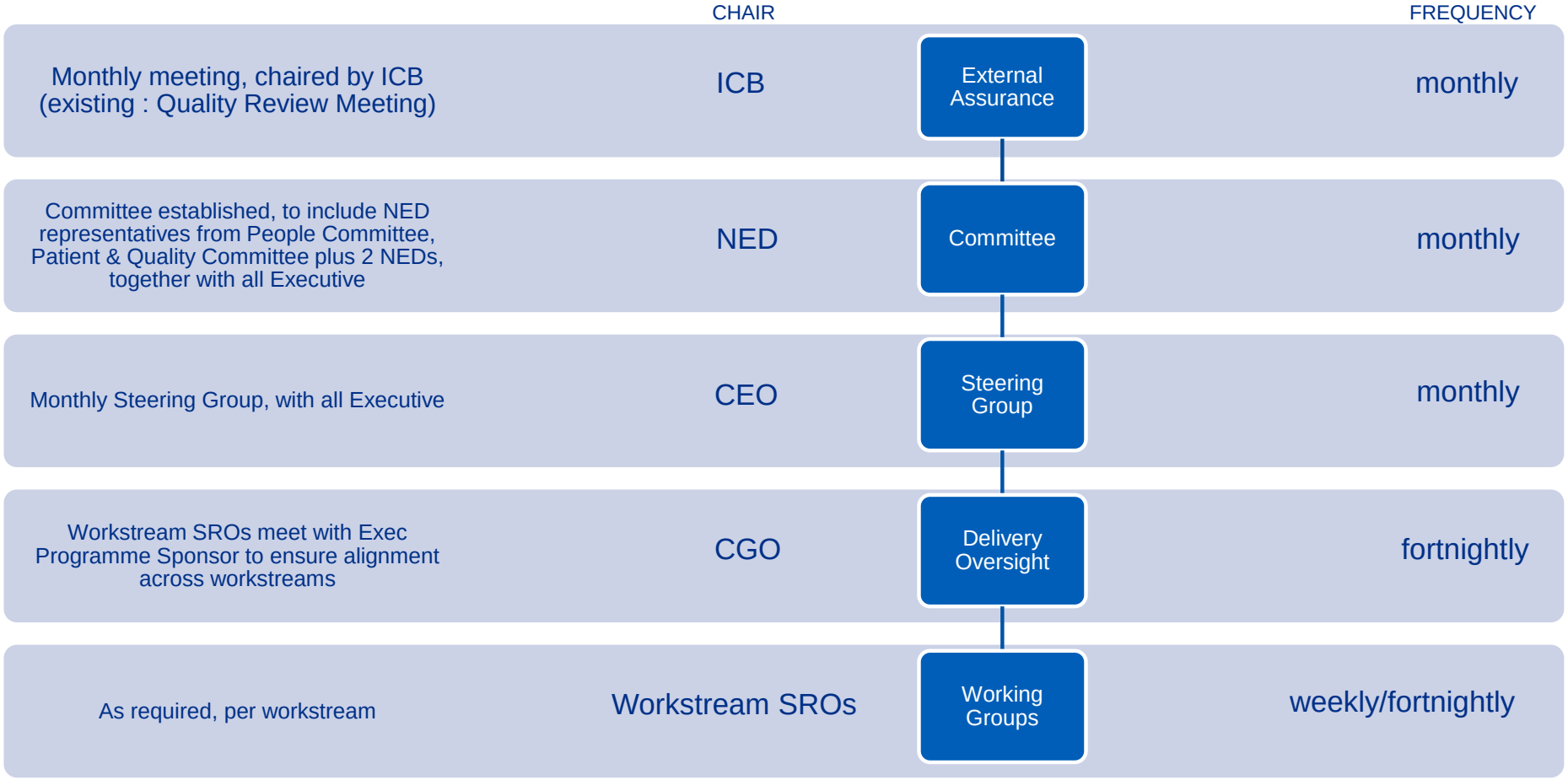

QSIP – how we ensure this becomes our BAU

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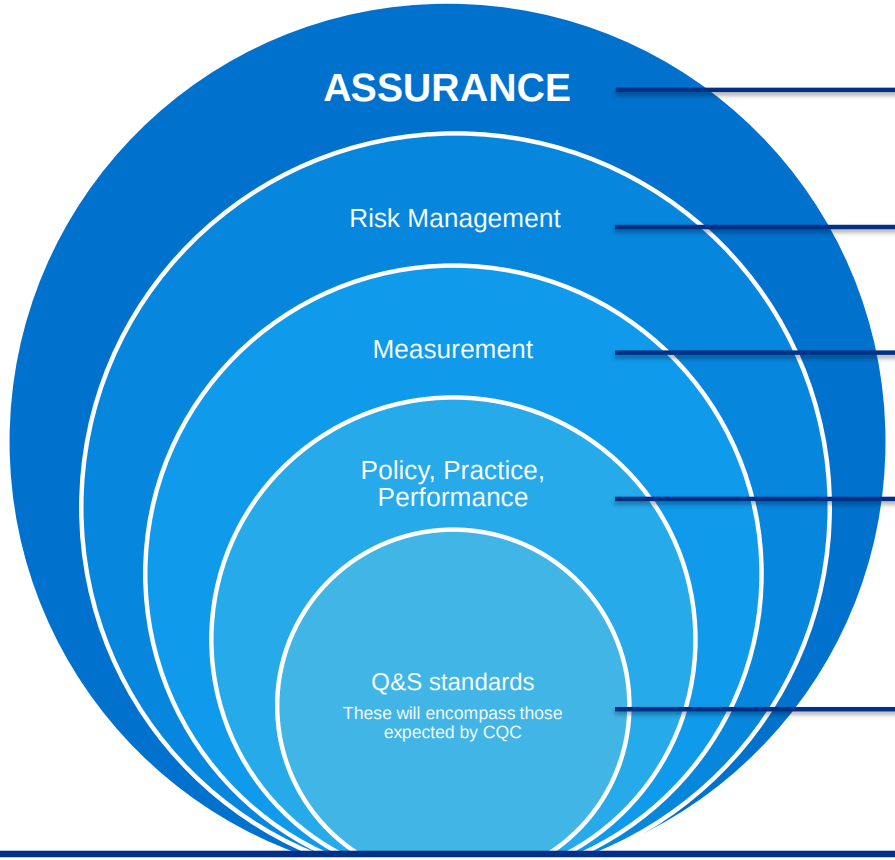


Reporting
Division to QGSG to QC, to QRM to Regulators

Gaps in standards, culture or climate known with plans for QI/mitigate

How well we are doing

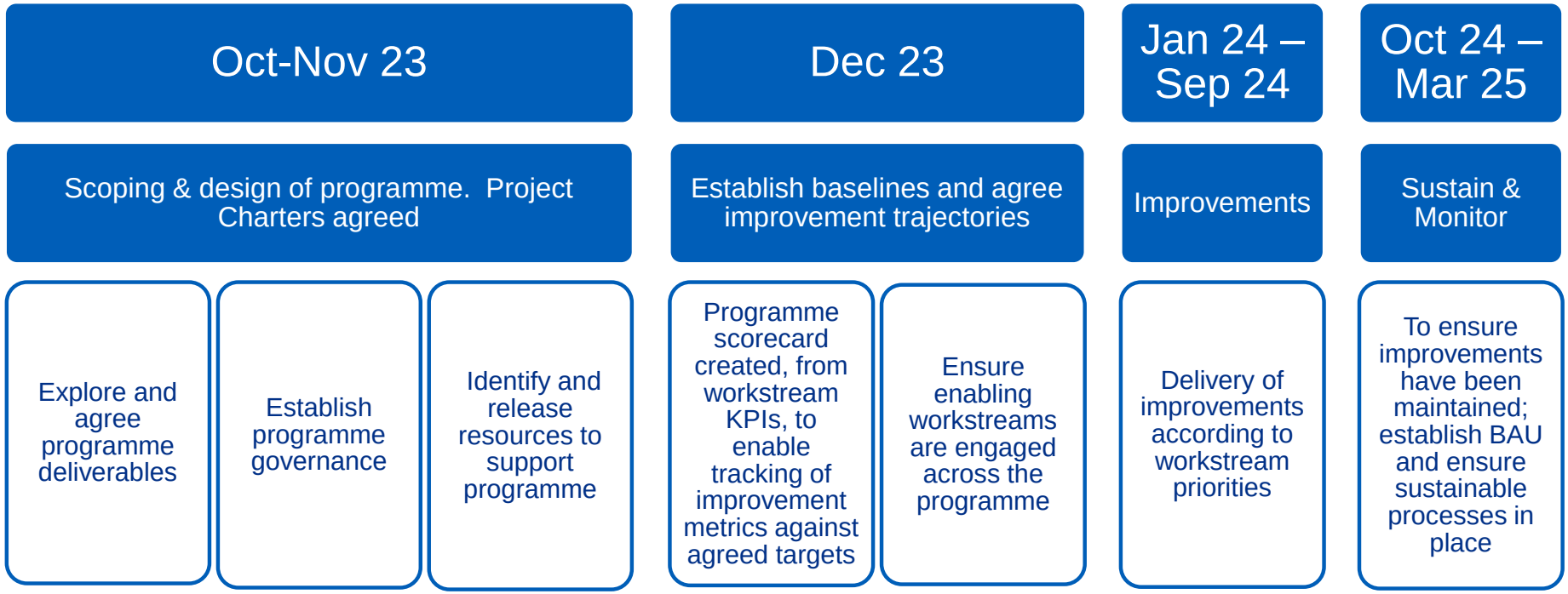
The culture and climate to deliver Q&S standards

The 'what' we should be doing – the minimum standards we and others expect of ourselves

OUTCOME: the creation of ward-to-board evidence bank that provides necessary assurance to all parties at the touch of a button

QSIP – Top-Level Programme Plan

University Hospitals Sussex NHS Foundation Trust



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Agenda Item:	9.	**Meeting:**	Board	**Meeting Date:**	8 February 2024
Report Title:	Quarter 4 BAF				
Sponsoring Executive Director:	Chief Governance Officer				
Author(s):	Company Secretary				
Report previously considered by and date:	Reported to the Audit Committee 16 January 2024 Reported to the respective oversight Committees in the week of the 30 January to 1 February 2024				

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 Q4 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 4 Overview

For each of the 14 strategic risks the expected assurances have been received over the period of quarter 3 enabling a determination to be made as to the opening quarter 4 score.

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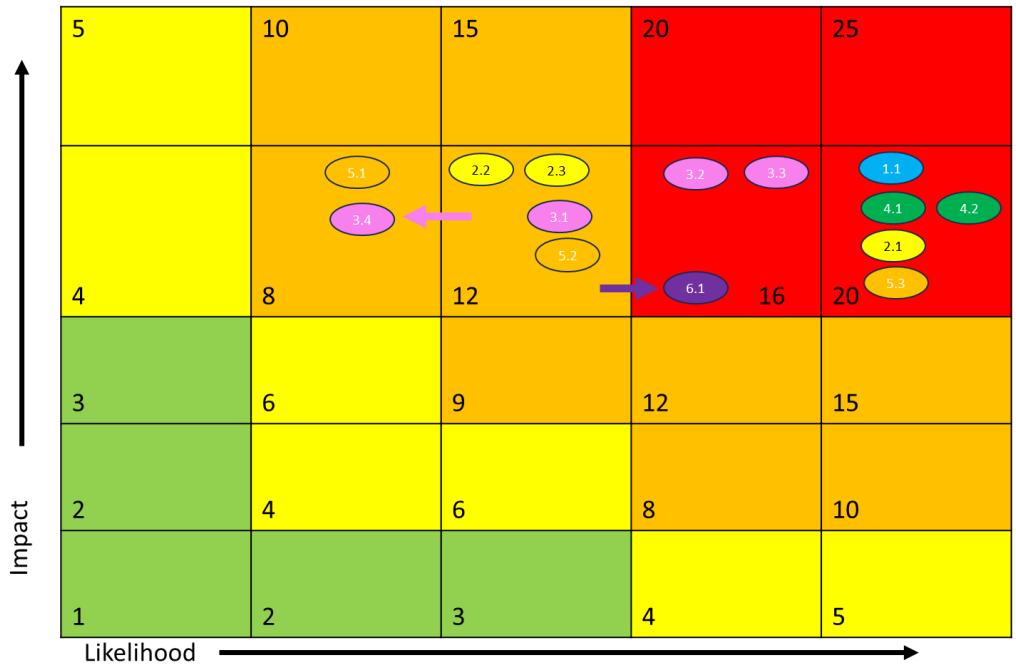
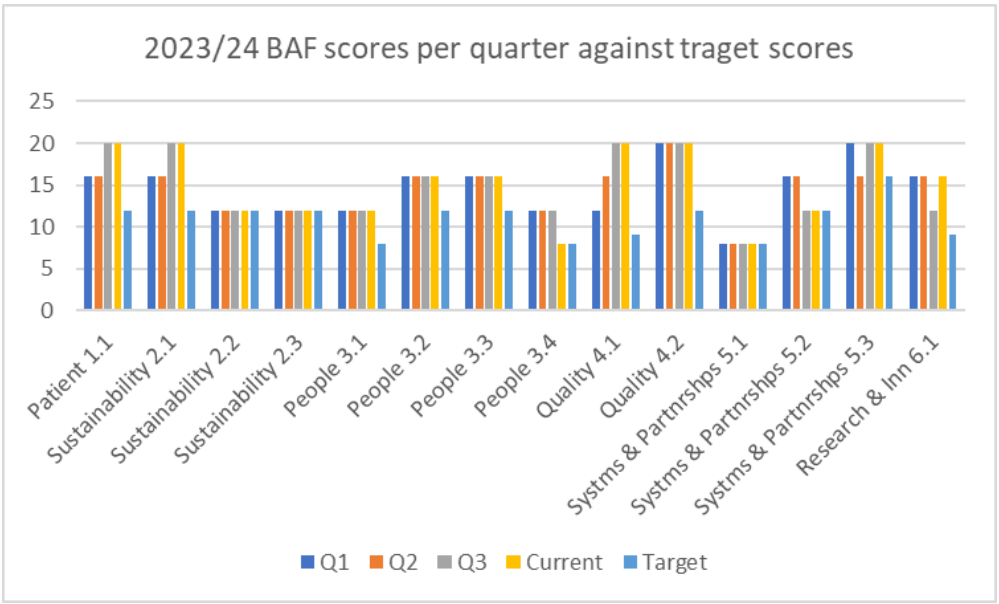
The review of the 14 risks has seen the quarter 4 scores an increase for one risk, this being the research and innovation risk 6.1, and a reduction for one risk, this being the people risk 3.4. This sees 5 of Trust's strategic risks achieving their 2023/24 target scores, leaving 9 risks exceeding their target scores.

For quarter 4 there are five risks scoring 20.



Quarter 4 summary

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



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Quarter 4 BAF risks

Overview

The review of the BAF has shown for the start of quarter 4 the following:

Five risks are 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),
- People risk 3.4 (reduced this quarter to its target score)
- Systems and Partnerships risk 5.1 (met since the start of the year), and
- Systems and Partnerships risk 5.2 (met since its reduction in quarter 3).

Nine risks are exceeding their 2023/24 target score, with five of these scoring 20; these nine are

- Patient risk 1.1 which increased in quarter 3,
- Sustainability risk 2.1 which increased in quarter 3,
- People risks 3.1, 3.2 and 3.3 have not changed during the year,
- Quality risk 4.1 which increased in quarter 3,
- Quality risk 4.2 did not change during the year,
- Systems and Partnerships risk 5.3 this increased from its target score in quarter 3.
- Research and Innovation risk 6.has increased for quarter 4.

It was reported at quarter 3 and agreed by the Board that the two quality risks (risks 4.1 and 4.2) would not achieve their target scores and for a further four risks (Patient risk 1.1, Sustainability risk 2.1, People risk 3.1 and People risk 3.3 risks) where there was a low level of confidence, they would reduce to their target scores by the year end.

For the remaining 3 risks. The People risk 3.1, whilst actions have been taken there have been revised dates for actions into quarter 1 2024/25 and thus the risk is not reduced until these actions are delivered. In respect of the Systems and Partnerships risk 5.3 the ability to achieve the target score has been impacted by the resumption of industrial action and in respect of the Research and Innovation Risk 6.1 the risk score has been recommended by the respective Committee to increase to 16.

As the Trust develops its 2024/25 plan the opportunity will be taken to review the Trust's strategic priorities and the associated strategic risks, the outcome of this work will be reported to the Board along with any recommendation to adjust the Trust's strategic risks for 2024/25.

Committee oversight

Each of the oversight Committee's has met and reviewed their allocated risk within the BAF and on review of the BAF and the reports they received they confirmed the respective scores recommended by the Executive are reasonable, noting that for the R&I strategic risk the score was adjusted upwards at the Committee and where the target score is not being achieved that the action plans are reasonable.

Recommendations

The Board is asked to **AGREE** the BAF risk scores for the start of Quarter 4 based on the review undertaken by their respective Board Committees and the Board's receipt and discussion of the Trust's Integrated Performance Report, noting that this sees nine strategic risks exceeding their target score for the year.

The Board is asked to **NOTE** that as part of the routine planning cycle then a review of the Trust's strategic risks will take place which will inform the 2024/25 BAF.

University Hospitals Sussex NHS Foundation Trust

2023/24 Quarter 4 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.

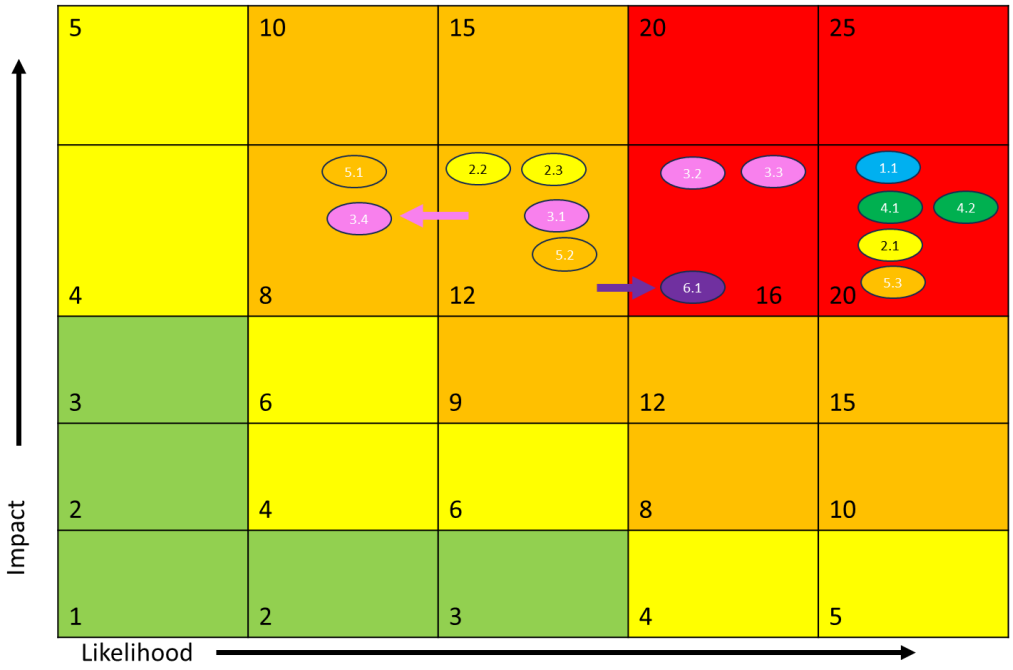
1.2 As in prior years each Strategic Risk has an Executive lead and is grouped within one of the Trust's six strategic domains with each domain being aligned to their respective allocated oversight Committee.

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 4 BAF Overview and Context

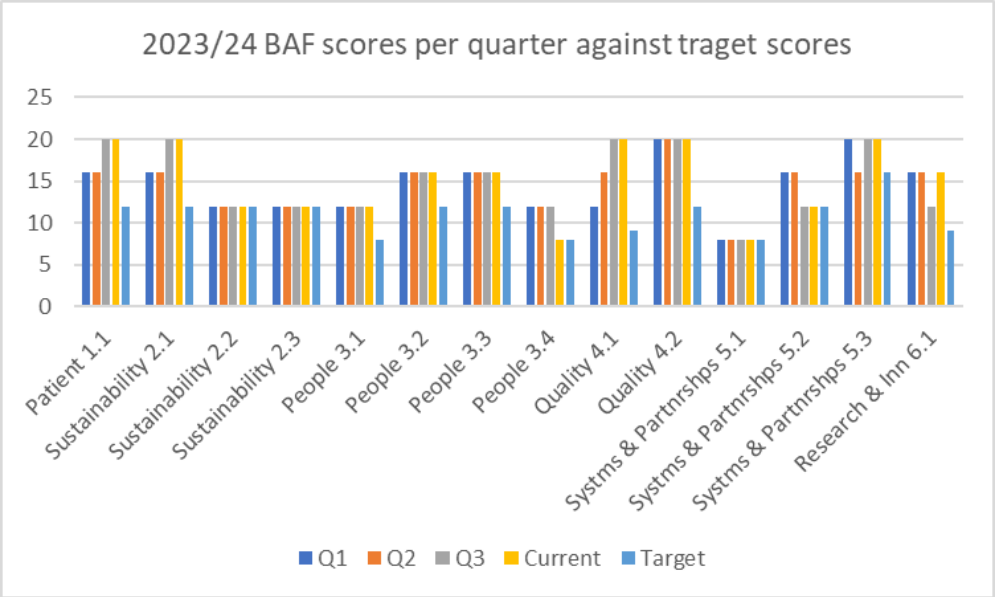
2.1 For each segment of the BAF the respective lead executive has considered their risks along with the supporting highly scored and corporate risks when determining the quarter 4 score, which have then been scrutinised by the respective oversight committee.

2.2 For each of the 14 strategic risks the expected assurances have been received over the period of quarter 3 enabling a determination to be made as to the opening quarter 4 score.



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

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



2.3 Movement in the Quarter

2.3.1 There is **ONE** risk for which the quarter 4 score has increased, this being

- **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 Committee at its meeting considered that the score should increase based on the lack of an identified dedicated research facility and the impact this may have on fulfilling the Trust's R&I strategy.

2.3.2 There is **ONE** risk for which the quarter 4 score has reduced this being

- **People – Risk 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. The initial results from the staff survey support the view that the investment is staff wellbeing is having a positive effect, so the score is reduced in this quarter to 8, but it is noted that there remain areas of the Trust where more work is needed to meet the staff wellbeing needs.

2.4 There are FIVE 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 *(noting this is one more risk than at quarter 3)*

- **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 4 as with 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 4 as with the score for quarter 3 remains at its target score of 12.

- **People – Risk 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. The initial results from the staff survey support the view that the investment is staff wellbeing is having a positive affect, so the score is reduced in this quarter to 8, but it is noted that there remain areas of the Trust where more work is needed to meet the staff wellbeing needs.

- **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 4 as with the score for quarters 2 and 3 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. The score for quarter 4 as with the score for quarter 3 remains at its target score of 12.

2.5 There are NINE risks that are exceeding their 2023/24 target score, with five of these scoring 20.

2.5.1 These nine are

- Patient risk 1.1 actually increased in quarter 3,
- Sustainability risk 2.1 actually increased in quarter 3,
- People risks 3.1, 3.2 and 3.3 have not changed during the year,
- Quality risk 4.1 actually increased in quarter 3,
- Quality risk 4.2 did not change during the year,
- Systems and Partnerships risk 5.3 increased from its target score in quarter 3.
- Research and Innovation risk 6.1 whilst reduced in quarter 3 to 12 is now increased to 16 for quarter 4.

2.5.2 It was reported at quarter 3 and agreed by the Board that the two quality risks would not achieve their target scores and for a further four risks there was a low level of confidence of the reduction to their target scores by the year end.

2.5.3 For the remaining 3 risks,

People risk 3.1, whilst actions have been taken staff experience and engagement may still be overshadowed or put at risk by the industrial relations difficulties nationally and ongoing industrial action against a cost of living challenge for staff. There is also a degree staff anxiety about managing Winter and the difficulties experienced particularly in EDs and Paediatric wards supporting patients who

also present with MH issues which has seen a revised date of quarter 1 2024/25 being given for the reduction to the risks target score.

Systems and Partnerships risk 5.3 the ability to achieve the target score has been impacted by the resumption of industrial action.

Research and Innovation risk 6.1 following the Research & Innovation Committee's review of this risk it was decided that this risk score should increase driven by a lack of a confirmed dedicated research facility.

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 confirmed that for patient risk 1.1 and quality risks 4.1 and 4.2 that they should remain at their elevated score of 20. The Committee also recognised that the improvement plan developed as part of the Quality and Safety Improvement Programme will not conclude before the latter part of 2024/25 and therefore the scores for these risk will remain above their target score for this period.

3.3 The People Committee reflected on the proposed reduction of risk 3.4 and the outcome of the initial staff survey results corroborate the value the work that has been undertaken by the Trust in respect of improving staff health and wellbeing. Whilst the Committee supported the reduction of the strategic risk score it did recognise that for elements of the Trust workforce they face a differential level of pressure and more work was needed to support their wellbeing. The Committee agreed that the other people risks of 3.1 – 3.3 were fairly stated.

3.4 The Sustainability Committee agreed based on the reports received and the discussions held that risk 2.1 should remain for quarter 4 at its elevated score recognising the significant level of external drivers for this increase. This was in line with the quarter 3 review which confirmed there was a low level of confidence the target score would be achieved by the year end. The Committee agreed that risks 2.2 and 2.3 were fairly stated,

3.5 The Systems and Partnerships Committee agreed based on the reports received and the discussions held that risk 5.3 should remain elevated at a score of 20. The Committee continues with the oversight of the delivery of the performance recovery plans through an enhanced monthly frequency to their meetings. For the other strategic risks 5.1 and 5.2 these risks were fairly stated.

3.6 The Research and Innovation Committee as part of their review reflected that the risk for quarter 4 should increase to 16 due to the risk of not having a dedicated research facility is likely to have on the delivery of the agreed research and innovation strategy.

4 Quarter 4 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 and Quality Committee. 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 *(received at the committee in January except for national surveys which were received in October 2023)* 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). The Welcome Standards programme is promoting positive customer care, patient engagement is shaping a number of strategic developments to care pathways and delivery and improvements to the emergency department at RSCH will also support improved experience. This has been a mix of operational,	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 cold temperatures in certain wards leading to a poor experience. 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 continue 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 and work with the divisions on their improvement plans.	As reported at quarter 3 there was an elevated risk that the 2023/24 target score of 12 can be achieved by the 31 March 2024. At quarter 4 this level of risk remains and therefore the risk will not achieve its target score.

Risk	Score	Assurance	Supporting highly scored risks	Actions	Target Score (risk)
		executive and through FFT external assurance.			
2.1	20	All expected assurance has been provided to the Sustainability Committee. These included; CFO reporting including financial scorecard and risks, Productivity Reporting, Tender waivers, losses and comps reporting, Capital Programme report, Efficiency Programme report and Workforce deployment reports to People Committee. *(received at the committee in January* This has been a mix of operational and executive assurance. The risk score was increased in quarter 3 to score 20 and remains at this level recognsing the Trust current position against the revised plan and the additional unplanned industrial action and change in elective recovery targets. As has been reported to the Sustainability Committee there is significant risk in the achievement of the revised breakeven plan with a number of these risks out with the control of the Trust.	There are a number of highly scored supporting risks covering operational pressures and workforce constraints which are impacting on operational costs and productivity. These, alongside organisational capacity and the financial reset framework are adding further risk to delivery of financial targets, a required step-up in elective capacity and delivery of a challenging efficiency programme at a time of continuing industrial action. 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.	A series of actions are being taken to both enhance the control environment aswell as improving the level of assurances, these include the enhancing of support to divisions, and improvements with workforce control compliance reporting.	As reported at quarter 3 there was an elevated risk that the 2023/24 target score of 12 can be achieved by the 31 March 2024. At quarter 4 this level of risk remains and therefore the risk will not achieve its target score.
2.2	12	All expected assurance has been provided to both Audit Committee and Sustainability Committee over Q1, Q2 and Q3. These included; Tender waivers, losses and	There are a number of highly scored supporting risks covering operational pressures which are impacting on the consistent	Actions planned have been delivered to maintain the risk at it target score. Improvement to the control	The risk continues to meet its target score.

Risk	Score	Assurance	Supporting highly scored risks	Actions	Target Score (risk)
		comps reporting, IA review of internal control environment, Commercial activity reporting and LCFS reporting on control environment. *(received at the committee in January* This has been a mix of operational, executive and through Internal Audit / LCFS external assurance.	delivery of the Trust's established control. Work is overseen at the Sustainability Committee and the People Committee for enhanced workforce development controls.	environment continues including 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, and in response to the Trust's financial position a number of control enhancements have been developed with oversight of their delivery being undertaken by the Executive Team.	
2.3	12	Assurance has been provided to the Sustainability Committee over Q1, Q2 and Q3. These included the Environmental Sustainability SI report. *(received at the committee in January* 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 measure the CO2 reduction against each of the respective green plan workstreams, to monitor the delivery of the trajectories to achieve the 2025 and 2040 goals.	The risk continues to meet its target score.
3.1	12	Assurance has been provided to the People Committee over Q1, Q2 and Q3. These included, the People scorecard, the LCD reporting, the FTSU and guardian of safe working reports and HEE reports. *(received at the committee in January except HEE reports received in Nov)* 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	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	Whilst actions have been taken staff experience and engagement may still be overshadowed or put at risk by the industrial relations difficulties nationally and ongoing industrial action against a cost of living challenge for staff. There is also a degree staff anxiety

Risk	Score	Assurance	Supporting highly scored risks	Actions	Target Score (risk)
		development the senior leadership team. This has been a mix of operational and executive assurance.		Project enhancing leadership capacity and developing leaders' capabilities.	about managing Winter and the difficulties experienced particularly in EDs and Peadiatric wards supporting patients who also present with MH issues which has seen a revised date of quarter 1 2024/25 being given for the reduction to the risks target score.
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. 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 and the initial staff survey results. *(received at the committee in January*	There are a number of highly scored supporting risks covering the stretch on staffing and staff capacity impacting of their engagement. Assurance over the actions being taken to reduce the impact of these risks has been reported through the People Committee.	The work on initiatives to support the 'staff voice that counts' has been extended to cover more areas of engagement and culture. All Divisions hade action plans to address staff survey results 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 including the delivery of the Trust's EDI plan. Action continues with the Chief Nurse in developing senior nurse 'standard work' to support their effectiveness.	As reported at quarter 3 there was an elevated risk that the 2023/24 target score of 12 can be achieved by the 31 March 2024. At quarter 4 this level of risk remains and therefore the risk will not achieve its target score.
3.3	16	Assurance has been received through the People Committee. The Trust has strengthened the controls and	There are a number of highly scored supporting risks reflecting the divisional challenges in recruiting staff,	There are plans to deploy systems to allow similar central oversight of the medical workforce, improvements are	As reported at quarter 3 there was an elevated risk that the 2023/24 target score

Risk	Score	Assurance	Supporting highly scored risks	Actions	Target Score (risk)
		visibility on the use of staffing using HeathRoster for the Agenda for Change workforce. There has been a mix of operational and executive assurance, including Equalities and Inclusion reports, National Staff Survey data, Gender Pay Gap Report, WRES and WDES report and the People Scorecard. *(received at the committee in January*	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.	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, but there remain challenges in certain groups of staff particularly registered nursing, radiography, paediatric nursing, pharmacy and some scientific roles. The Trust is also seeking to tackle retention with its activities to improve staff experience. Further international recruitment is underway. Through the electronic workforce deployment project their a number of to enhance the central oversight of the medical workforce.	of 12 can be achieved by the 31 March 2024. At quarter 4 this level of risk remains and therefore the risk will not achieve its target score.
3.4	8	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. The initial staff survey results show improvement in the staff's view of the Trust's support offerings.	There are a number of highly scored supporting risks covering the stretch on staffing within specific areas and the impact on their morale and wellbeing.	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.	Acton has been taken to improve health and wellbeing activities for staff and there is confidence from the reports received and the improvements

Risk	Score	Assurance	Supporting highly scored risks	Actions	Target Score (risk)
		(received at the committee in January These have been a mix of operational and executive assurance.		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.	made to the established systems of internal control that this will reduce during the quarter therefore seeing the risk achieving its target score.
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. *(received at the committee in January except clinical coding review which was in March / April 23)* 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 104day cancer waits). The Committee also received information in assurance due to gaps in clinical policies, guidelines and protocols and the continuing gaps in quality assurance, for example NICE guidelines having no clinical lead and a backlog in SJRs. There remain continued challenges in Mental Health, both in respect of Children and Young People and Adult, attending via ED or through admitted	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. 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.	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 Quality and Safety Improvement Programme.	As reported at quarter 3 there was an elevated risk that the 2023/24 target score can be achieved by the 31 March 2024. At quarter 4 this level of risk remains and therefore the risk will not achieve its target score.

Risk	Score	Assurance	Supporting highly scored risks	Actions	Target Score (risk)
		patients with primary mental health care requirements. These have been a mix of operational, executive and via the CQC external assurance.			
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. *(received at the committee in January, except MSSP which was in April 2023)* 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, covering areas such as NICE guidelines having no clinical lead.	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 there is a risk relating to access to CTs within ED at RSCH and meeting the NHS E standards for dealing with aortic aneurysms. Assurance over the actions being taken to reduce the impact of these risks is reported	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 Quality and Safety Improvement Programme.	As reported at quarter 3 there was an elevated risk that the 2023/24 target score can be achieved by the 31 March 2024. At quarter 4 this level of risk remains and therefore the risk will not achieve its target score.

Risk	Score	Assurance	Supporting highly scored risks	Actions	Target Score (risk)
			through the e Patient and Quality Committee and the Trust's operational Quality and Safety Steering Group.		
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. *(received at the committee in January with clinical strategy via quality committee)*	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 also the relationships between Hospital Directors and Place/Neighbourhood are maturing.	The risk continues to meet its target score.
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. *(received at the committee in January with clinical strategy via quality committee)* This assurance was provided by executive reports.	The ability to deliver the clinical strategy given operational 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.	The risk continues to meet its target score.
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 degree of improvement there remain significant risk due to the impact of industrial	There are a number of highly scored supporting risks covering operational pressures and workforce constraints impacting on productivity along with demands on the Trust's services	The Trust has entered tier 1 (national) oversight for both elective and cancer performance and has developed the corresponding action plans. The delivery of	The ability to achieve the target score has been impacted by the resumption of industrial action and

Risk	Score	Assurance	Supporting highly scored risks	Actions	Target Score (risk)
		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. *(received at the committee in January)*	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.	these actions has seen significant improvements over Q3 in both the number of patients waiting more than 65 weeks for treatment, the total waiting list, and the numbers of patients waiting more than 62 days from referral for cancer treatment.	therefore this is risk this will not achieve its target score by the end of 23/24.
6.1	16	Assurance has been received via the R&I 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. *(received at the committee in January)*	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.	This risk for quarter 4 has increased back to 16.

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.

5.4 As the Trust develops its 2024/25 plan the opportunity will be taken to review the Trust's strategic priorities and the associated strategic risks, the outcome of this work will be reported to the Board along with any recommendation to adjust the Trust's strategic risks for 2024/25.

6 Recommendation to the Board

6.1 The Board is asked to **AGREE** the BAF risk scores for the start of Quarter 4 are reasonably stated 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 nine of the 14 strategic risks which are judged to not be able to achieve their target score for 2023/24.

6.3 The Board is asked to **NOTE** that as part of the routine planning cycle then a review of the Trust's strategic risks will take place which will inform the 2024/25 BAF.

University Hospitals Sussex NHS Foundation Trust

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** ↑	4	5	**20** ⟷	4	3	**12**
Assessed strength of control	***Some weaknesses***			***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** ↑	4	5	**20** ⟷	4	3	**12**
Assessed strength of control	***Some weaknesses***			***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** ⟷	4	3	**12** ⟷	4	3	**12**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			**Achieved target score**		
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** ⟷	4	3	**12** ⟷	4	2	**12**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			**Achieved target score**		
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** ⟷	4	3	**12** ⟷	4	2	**8**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***					
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** ⟷	4	4	**16** ⟷	4	3	**12**

Assessed strength of control	***Some weaknesses***			***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** ↔	4	4	**16** ↔	4	3	**12**				
Assessed strength of control	***Some weaknesses***			***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** ↔	4	2	**8** ↓	4	2	**8**				
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			**Achieved target score**						
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** ↑	4	5	**20** ↔	3	3	**9**				
Assessed strength of control	***Some weaknesses***			***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** ↔	4	5	**20** ↔	4	3	**12**				
Assessed strength of control	***Some weaknesses***			***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** ↔	4	2	**8** ↔	4	2	**8**				
Assessed strength of control	***Operating as intended***			***Operating as intended***			***Operating as intended***			***Operating as intended***			**Achieved target score**						
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** ↓	4	3	**12** ↔	4	3	**12**				
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			**Achieved target score**						
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** ↑	4	5	**20** ↔	4	4	**16**				
Assessed strength of control	***Some weaknesses***			***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** ↓	4	3	**16** ↑	3	3	**9**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***					

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Agenda Item:	10.	**Meeting:**	Trust Board	**Meeting Date:**	February 2024
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 30 January 2024 and was quorate, as it was attended by five Non-Executive Directors and the Chair and three executives, the Chief Medical Officer, the Chief Nurse and the Chief Strategy Officer. In attendance at the meeting were also the Commercial Director, Associate Commercial Director, Clinical Research Director, Programme Lead for Clinical Academic Careers and NMAHP Research, Director of Operations Research and Innovation, the Deputy Chief Nurse, the Managing Director for Planned Care and Cancer and Company Secretary.

The Committee **received** its scheduled reports, these included;

- a research activity report and dashboard. The Committee **noted** the developed KPIs since the last meeting and supported the development of performance targets at a divisional and service level. The Committee received the developed dashboard and **noted** that the dashboard is placed on the Trust's intranet to allow accessibility to data included within it. The Committee reflected the developed dashboard has seen a significant increase in the depth and accessibility of data since the last Committee meeting and that its development had taken on board the Committees feedback.

- a report of delivery against the Research True North of increasing the participation in research. The Committee **noted** the comprehensive nature of this report and shows the move to strategy delivery.

Through the discussion with the Clinical Research Director the Committee was **assured** over the level of interest within the organisation to take part in research but recognised that creating capacity for staff to take part remained a limiting factor as does the ability for the Trust to have a dedicated clinical research facility, both of these matters are impeding the ability of the Trust to meet its research ambition. The Committee reflected that through future reports more information should be added as to the impact of research and information on participation groups especially to understand where the Trust can take action to improve the diversity of patent participation.

- a report from the Programme Lead for Clinical Academic Careers and NMAHP Research on the work being undertaken in respect of developing clinical academic careers. The Committee **noted** the research undertaken to understand the current level of understanding and support for clinical academic positions across the Trust and this was somewhat variable by location and by staff group. The complementary report provided to the Committee then took the meeting through the plans being established to promote clinical academic careers along with new opportunities including the establishment of research fellowships. The Committee **noted** the work undertaken to offer enhanced support to staff to undertaken research activities.

- a report providing information on both the level of commercial research activity. In presenting the report the Clinical Director of Research both provided information on the current level of this activity along with the opportunities to develop this further in line with the approved research strategy. The Committee recognised the link to the other reports and indeed the BAF as to the impact of not having dedicated research facility noting that this links to the Trust's estates master planning work.

- a report on innovation which provided the Committee with information on the development of a an innovation group that is dedicated to supporting staff to progress bids for external innovation funding. The Committee **noted** this report and the value having a dedicated group to support innovation is having.

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 activity is aligned across the Sussex system.

The Committee **received** reports from its subgroups, namely the Research Governance Quality Assurance Group and the Research and Innovation Strategy Steering Group. The Committee **approved** the terms of reference for both these reporting groups recognising that both documents had been subject to appropriate consultation and discussion at their respective groups

The Committee reviewed the BAF risk for which it has oversight of, and **agreed**, having regard to both the BAF summary, the Research and Innovation Strategy Delivery risks and the reports considered during the meeting, that the quarter 4 2023/24 scores for **risk 6.1 should be recommended to the Board to increase to 16**. The Committee reflected that the drivers for the increase namely the need for a dedicated research facility should be referred to the sustainability Committee to ensure that the Committee view of this priority is factored into the estates master planning review.

The Committee also considered its own terms of reference following the Board's review of its Committees where a decision had been agreed to extend the remit of the Research and Innovation Committee to include Digital in recognition of the strong alignment digital has to innovation. The Committee **agreed** a revised terms of reference and supporting cycle of business noting that the movement of digital to this Committee would see a change to the sustainability committee terms of reference who currently oversee the Trust's digital agenda.

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Key Recommendation(s):

The Board is asked to **NOTE** the Committee received its expected reports and the assurance these reports provided.

The Board is asked to **NOTE** the Committee approved the terms of reference for its reporting groups, the Research Governance Quality Assurance and the Research & Innovation Strategy Steering Group.

The Board is asked to **NOTE** the Committee recommendation that the BAF risk 6.1 is increased to a score of 16 primarily because of a need for a dedicated research facility.

The Board is asked to **APPROVE** the Committee revised Terms of Reference which have been expanded to incorporate the digital assurance oversight and will see from the Committee's next meeting this Committee renamed Research, Innovation and Digital (appendix 1).

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RESEARCH AND INNOVATION COMMITTEE CHAIR'S HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	**30 January 2024**	**Chair**	Claire Keatinge	**Quorate**	Yes when decisions were required
Declarations of Interest	No declarations were raised				

Items received at the Committee meeting			
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.
People Workstream reports covering Clinical Academic Careers	**Presenter** Programme Lead for Clinical Academic Careers and NMAHP Research	**Purpose** For information	**Outcome /Action taken** Noted the work being undertaken to develop the Trust R&I workforce.
Sustainability Workstream reports, covering commercial research 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.
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.
Sub Group reporting			
Research Governance Quality Assurance Group which included the group's terms of reference	**Presenter** Clinical Research Director	**Purpose** To provide an update on the work of the group and receive any escalations.	**Outcome /Action taken** Noted the work of the Group and approved their Terms of Reference
Research & Innovation Strategy Steering Group which included the group's terms of reference	**Presenter** Clinical Research Director	**Purpose** To provide an update on the work of the group and receive any escalations.	**Outcome /Action taken** Noted the work of the Group and approved their Terms of Reference

Risk			
R&I Extract of Board Assurance Framework for Quarter 4	**Presenter** Company Secretary	**Purpose** For agreement	**Outcome /Action taken** The Committee recommended an increase in the R&I Strategic Risk to 16 for quarter 4.
Committee activity			
Committee terms of reference	**Presenter** Company Secretary	**Purpose** For agreement	**Outcome /Action taken** Agreed the revised Terms of Reference and supporting cycle of business to reflect the inclusion of digital assurance oversight.

Actions taken by the Committee within its Terms of Reference	
The Committee **APPROVED** the Terms of Reference for its reporting groups of Research Governance Quality Assurance Group and Research & Innovation Strategy Steering Group. The Committee **AGREED** a revised Terms of Reference for agreement by the Board which reflect the inclusion of digital assurance oversight and **APPROVED** a supporting cycle of business to be used for the initial meeting noting it will be kept under review by the Committee Chair and Committee executive lead during 2024/25.	
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 which were asked to return to the next meeting.	
Items referred to the Board or another Committee for decision or action	
Item	**Who / when**
The Committee reflected that the need for a dedicated research facility should be referred to the sustainability Committee to ensure that the Committee's view of this priority is factored into the estates master planning review.	Sustainability Committee April 2024
The Committee agreed to recommend to the Board an increase to a score of 16 for Q4 for the Research and Innovation Strategic Risk 6.1	Board on 8 February 2024
The Committee recommends to the Board for agreement the revised Terms of Reference for the Committee to include digital assurance oversight and the associated committee name change to the Research, Innovation and Digital Committee. (appendix 1)	Board on 8 February 2-24

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Agenda Item:	11	**Meeting:**	Trust Board in Public	**Meeting Date:**	February 2024
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 Quarter 2 2023. The Patient & Quality Committee meets monthly and therefore this report covers three meetings in November and December 2023 and January 2024. 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 December meeting, and the Deputy 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, Pharmacy and End of Life Care.

During the quarter the Committee received its planned items including the Safeguarding quarterly reports and the 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 as well as the Patient Experience Assurance Report

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 and Breakthrough Objectives. The Clinical Strategy updates were not received as the Strategy is brought to Board. Since the November 2023 meeting, the Corporate Projects around Quality (i.e. General Surgery and enhancing quality governance will report to the new Quality & Safety Improvement Programme Committee from which further updates will be received by the Board.

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 Quality Scorecard continues to evolve but the significant progress that had been made was recognised. A few challenges remain on data collection.

Patient Experience, Safety & Quality Domains

Patient Experience: The Committee **NOTED** that based on available Friends and Family Test (FFT) data, the significant majority of patients responding in Q3 were satisfied that they have a good or very good experience, which was comparable to Q2 however continued downward trend in patient experience was evident particularly associated with the themes of waiting and inpatient experience. The Committee were advised that this was consistent with a local and national trend. The committee reflected the complaints reflected the issues the Trust is facing such as waiting times and to reduce complaints we need to reduce the root causes. The Q3 Patient Experience Report was received**.** The number of new complaints had reduced compared to quarter 2 and the more complaints were closed than received. However, the Committee heard there remains a considerable resource pressure on the patient experience and divisional teams.

Patient Safety: The committee was pleased to see an increase in the rate of incident reporting per 1000 bed days but noted this is still below the national average. It reviewed performance and the associated processes around incidents including the timeliness of incident investigation. At each meeting the Committee received an update on reported Serious Incidents and were assured these had thorough oversight from the Serious Incident Review Group (SIRG) with themes of including patients lost to follow-up, mental health care and harms following long waits for procedures. There had been 2 Never Events in the reporting Quarter, the committee discussed Never Events seeking to understand any themes and learning and discussed the context of conditions that can give rise to such incidents and received further update on the implementation of 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 that the Trust remains on track to implement this by the end of the year. The committee also received the Venous Thromboembolism Q2 report and an update on a recent inquest which highlighted important learning and improvements and asked that this be bought back to committee to report on the learning and best model for service. The committee also discussed the increase in the length of inquests and the support required by the Trust including medico-legal support.

The Q2 Duty of Candour Report was received by the Committee and audits demonstrated the Trust is non-compliant with Duty of Candour. While there had been improvement in the timely sharing of investigation

findings, this remained less than 100% and required further progress. The Committee noted that the new DCIQ incident module going live on 6th February 2023 has revised the data collection tools and process to ensure Trust compliance; both ensuring that the patient and families are communicated with at the earliest opportunity when moderate/severe harm or death has occurred with supportive reporting templates.

Quality Assurance: The Director of Clinical Effectiveness provided a Quality Assurance report that indicated the current status of NICE guideline reviews, Technology Appraisals, National audits participation and assurance on changed practice and quality improvement for patients, NCEPOD, Clinical guidelines GIRFT review and action plans, CQUIN delivery, Mortality reporting / Learning from Deaths; and Health Inequalities. While a significant gap in assurance remains across these domains, the Committee is now **assured** that suitably prioritised plans are being developed or are in place to rectify this, progress is being made in some areas, but resource allocation remains a challenge. This is reflected in the Board Assurance Framework recommendation by the Committee. The Committee awaits assurance that confirms completion of Technology Appraisals in a number of cases where the assessment had not been fully recorded.

The committee received an update on Mortality Reviews undertaken where the standardised hospital mortality indicator (SHMI) had been noted as high for particular 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 continued to be assured that outlier mortality indicators were being analysed and causes and learning identified. The committee awaits the complete overview of the current status and that a full Audit Plan be put in place for 2024/25.

The committee received a comprehensive Pharmacy and Medicines Governance Q3 Report where there are gaps in assurance. The committee noted the update on medication incidents and the learnings and themes identified and the low reporting of incidents in some sites which correlates with shortfalls in the clinical pharmacy workforce. The committee discussed medicines storage for fridge medicines and a recent incident related to this and that the review of this incident is brought to committee. The committee was updated on the significant reduction in medicines security after the opening of the Louisa Martindale Building in RSCH and challenges in this area at other sites.

The committee received a report on the suggested approach to harm reviews, which is to focus on areas where harm from waiting is more likely with prospective harm reviews with a view to escalating/intervening in the pathway which covers cancer, P1 and P2 patients. Routine long pathway waits would also be reviewed. This will report through the divisional quality & safety meetings to QGSG.

<u>Learning from Deaths</u>

The Committee received the Q2 2023/24 Learning from Deaths Report and progress updates 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 progress training the SJR and reviewers, and the appointed lead chairing the mortality panel. In response to the significant SJR backlog described in my last report, the Committee received an update report against the action plan to address this, the backlog is reducing and the work remains on course per the timescale previously reported. The Committee sought assurance on the review process at Mortality Panel and the link to the Patient Safety Incident Reporting Group (PSIRG) for discussion and associated governance including Duty of Candour. The quarter 2 Learning from Deaths Report is included behind this report.

End of Life

Committee received an update on the arrangements for the Trust's Palliative and end of life care through a Q3 report which includes reporting on the Trust's arrangements in conjunction with resuscitation groups and arrangements for do not attempt CPR. The Committee heard there had been better earlier recognition of the dying patient that enabled individualised care but there was still room for improvement highlighted in instances raised through the patient experience panel and that had led to adapted care of the dying training.

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 resource challenge associated with an increased use of Court of Protection arrangements, was **noted** along with the additional support being given by the Safeguarding team, in particular for children with mental health needs, looked after children and disadvantaged children and for adults Deprivation of Liberty oversight. The committee also noted the focus on specialised Level 3 training and the gap in compliance and risks with provision of dementia care and delirium. The committee was pleased to receive an update on the two independent domestic violence advocate ,the start-up of a carers café and support group an note the inclusion of a specific update on maternity in the report.

Mental Health

The Committee heard about the re-established governance arrangements applying an ongoing focus on the care of patients with mental health needs in our Emergency Departments and for children and young people with mental health needs. The inaugural UH Sussex Mental Health Strategy and Quality Group was held in. December the aim of which is to review and improve to provision of mental health services through collaboration with partners. Data from hospital sites highlight the extent of the challenge faced and delayed discharges remain a major challenge with delays due to mental health and care needs and particularly from waits for specialist placements. An enhanced care team is being trialled with Head Nurse post for Mental Health secondment for six months started in November with a focus to review our processes with the Mental Health Act and those of our system Mental Health provider with a view to ensuring compliance and standardising arrangements.

In December 2023 I visited Bluefin Ward in Worthing Hospital where there had previously been a noted incidence of mental health presentations from children and young people to Worthing Hospital particular challenges with delayed discharges. I noted the apparent improvement in staff morale in comparison to previous visit. However significant pressure remains in A&E and which has a substantial impact on staff. A visit from the Care Quality Commission Mental Health Team had also visited and had recognised the same considerable challenges but reported favourably on the professionalism and care delivered to patients in the difficult circumstances.

Care Quality Commission (CQC) action plans

In relation to the action plans that have been developed for Maternity, Surgery RSCH and ED RSCH and Neurosurgery resulting from CQC inspections noting. The Committee has begun in depth testing of assurances of evidence of their sustained impact. Considerable improvement was apparent in the evidence provided from neurosurgery.

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 through the establishment of a Quality & Safety Improvement Programme (QSIP) Committee which will report to the Board.

General Surgery Corporate Project

At the November 2023 meeting, the Committee reviewed the General Surgery Assurance Report which was requested by committee in response to CQC reports, the Royal College of Surgeons Review and media interest. An assessment of evidence from a number of sources including a National Emergency Laparotomy Audit (NELA) May-July 2023, Model hospital Data, Quality and Safety meetings and analysis, NBOCA audit oct 2023. While improvement and engagement had been observed in the development of NICE guidance as well as Quality & Safety Governance regular and well attended Mortality & Morbidity meetings, the Committee **noted** Limited Assurance and further improvement was required. The Committee noted that responsibility for the General Surgery Corporate Project would be transferred from the Patient & Quality Committee to the Quality and Safety Improvement Plan Committee since the November 2023 meeting.

Infection Prevention and Control Quarterly Report

The Committee welcomed the Q3 report which also covered SSI's, water and ventilation as requested. The Committee noted the Trust had remained above trajectory for eColi, Klebsiella and MRSA, however, benchmarking hospitals per 100,000 bed days the Trust compared favourably to the national average and local comparators. Ventilation remains a concern for the Committee and updates sought for the February 2024 report. The Committee noted concern that the groups for water and ventilation assurance had not met and asked for confirmation of meetings taking place to be received at the February 2024 Committee.

Surgical site infection (SSI) rates are high in some areas and noted the programme of work to address these, which will come through Divisional Governance via QGSG to future meetings. In relation to infections following cardiac surgery, the Committee noted work looking at the clinical pathway beginning in January 2024. The Committee also noted a ventilation audit tool had been developed.

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. In terms of risks the fragility of staffing in part of the Neonatal service had been escalated to the Committee as a continuing issue though there had been signs of improvement, medical team capacity, sickness levels and ultra-sound capacity. A pilot for additional theatre capacity in RSCH is due to commence in February.

The Committee considered each of the dashboards across each of the domains of; learning from incidents; training which had continued to show good compliance levels; and the voice of the service user for which the information in respect of the Trust's friends and family rates and resultant actions are reported to the Patient Committee. Through receipt of reports the Committee was **assured** that the Maternity Directorate continue to report Maternity and Neonatal data and engage with Maternity and Neonatal Safety Investigation team (MNSI, formally the Healthcare Safety Investigation Branch HSIB) as required. The Committee welcomed the Division's continuing work with the health inequalities group using stratified data and consideration of alternative approaches.

Following each of the Committee meetings this Quarter, I have provided reports to the Board on the Trust's assessed compliance and year 5 declaration against the Maternity Incentive Scheme (MIS) operated by

NHS Resolution. At the January meeting the Committee were advised that the NHS Sussex Integrated Care Board had endorsed the Trust's declaration that reports non-compliance with one of the safety standards however there is confidence that this will be reviewed as a compliant position in light of the limited circumstances and corrective action that had caused that non-compliance against one of the standards. An update on the Trust's declared position follows this report.

The committee noted further reduction in peri-natal mortality rates which are below regional and national rates. The committee received a report on the impact on fetal well-being quality improvement work which has been driven by recommendation from national reports and mandated quality improvement programmes as well as recommendations from Trust reviews. The work has included many areas of improvement including of maternity triage, workforce, smoking cessation provision, central monitoring of CTG's, multi-disciplinary training, fetal wellbeing midwives on all sites amongst others. This report was received alongside the latest Maternal, New-born and Infant Clinical Outcome Review Programme (MMBRACE) report for 2021 that the Trust benchmarks between 5-15% or more lower in perinatal mortality indicators.

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 continue to embed this in clinical practice in all areas, which is attributed to positively impacting on perinatal mortality rates throughout 2023/24.

The Committee **NOTED** the contents of the reports and **APPROVED** the latest scorecards.

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 work of a Risk Oversight Group and improved arrangements to reflect the interlinkage of risks between Divisions. The Committee recognised a risk scored at 25 reflected the general harm and unacceptable patient experience from prolonged crowding in emergency departments even though mitigations had meant there was not an identifiable harm coming to an individual.

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 also recommended that 4.1 remains at 20.

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, in particular due to the challenging situation arising from crowding in the Emergency Departments and waits for treatment resulting in adverse reputational impact, and poorer patient experience. The Quarter 4 score remains at 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.

I made a referral to the People Committee to consider the apparent workforce capacity challenges despite the increase in the staffing establishment.
§
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 4 are fairly represented. - The Q2 2023/24 Learning from Deaths report

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	**28 November 2023**	**Chair**	Lucy Bloem	**Quorate**	Yes
Meeting Date	**19 December 2023**	**Chair**	Lucy Bloem	**Quorate**	Yes
Meeting Date	**30 January 2024**	**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	**Nov**	**Dec**	**Jan**	**Presenter** Chief Medical Officer	**Purpose** For information	**Outcome /Action taken** Noted Action: To review learning from loss of JAG accreditation
Quality Dashboard (excluding Maternity) Safety, Effectiveness, Experience, Mortality	**Nov**	**Dec**	**Jan**	**Presenter** Chief Medical Officer/ Chief Nurse	**Purpose** For information	**Outcome /Action taken** Noted. Action to Review 2023 HED recommendations & seek assurance that they remain implemented.
Mortality - Counter Measure Summary	**Nov**	**Dec**	**Jan**	**Presenter** Chief Medical Officer	**Purpose** For information	**Outcome /Action taken** Noted
Learning from Deaths Assurance Report Q2 2023/24		**Dec**		**Presenter** Director of Clinical Outcomes & Effectiveness	**Purpose** For assurance	**Outcome /Action taken** Noted
Structured Judgement Review Backlog Project – Progress Report			**Jan**	**Presenter** Chief Medical Officer	**Purpose** For information	**Outcome /Action taken** Noted
Patient Experience Assurance Report	**Nov**	**Dec**	**Jan**	**Presenter** Director Patient Experience & Engagement	**Purpose** For information	**Outcome /Action taken** Noted
Strategic Initiative – Clinical Strategy Q3 (Not received)				**Presenter** Chief Medical Officer	**Purpose** For information	**Outcome /Action taken** To receive Q4 Report – Apr 2024
General Surgery Assurance Report	**Nov**			**Presenter** Chief Medical Officer	**Purpose** For information	**Outcome /Action taken** Noted Limited Assurance

Perinatal Quality Surveillance Report and Dashboards	**Nov**	**Dec**	**Jan**	**Presenter** Director of Midwifery / Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted
Maternity Education Strategy / Training Needs Analysis	**Nov**			**Presenter** Director of Midwifery	**Purpose** For information	**Outcome /Action taken** Noted
Perinatal Mortality Review Tool Q2	**Nov**			**Presenter** Director of Midwifery	**Purpose** For assurance	**Outcome /Action taken** Noted approval by LMNS
Medical and Neonatal Workforce Action Plans		**Dec**		**Presenter** Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted
Maternity Serious Incidents Q3 2023/24			**Jan**	**Presenter** Director of Midwifery / Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted
MBRRACE Report Gap Analysis			**Jan**	**Presenter** Director of Midwifery / Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted
Saving Babies Lives Review Quarterly Report			**Jan**	**Presenter** CNO/ Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted
Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS)	**Nov**	**Dec**	**Jan**	**Presenter** CNO/ Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Dec Report to Board
Avoiding Term Admissions Into Neonatal Units (ATAIN) /Transitional Care Report & Action Plan		**Dec**		**Presenter** Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted
Safe, Effective, Caring, Well Led and Responsive						
Patient Safety Assurance Report - Harm free care Report Counter Measure Summary - Harm Reduction Report - Inquest Monthly Report (Jan)	**Nov**	**Dec**	**Jan**	**Presenter** Chief Nurse / Deputy Director Patient Safety & Learning	**Purpose** For information	**Outcome /Action taken** Noted
Infection Prevention & Control Q3 Report			**Jan**	**Presenter** Director Infection, Prevention & Control	**Purpose** For assurance	**Outcome /Action taken** Noted
Infection Prevention and Control Assurance on Water Quality				**Presenter** Director Infection, Prevention & Control	**Purpose** For assurance	**Outcome /Action taken** Noted

CQC Update / Action Plans	**Nov**	**Dec**	**Jan**	**Presenter** Chief Medical Officer/ Chief Nurse	**Purpose** For information	**Outcome /Action taken** Noted
Safeguarding Adults and Children Quarterly Reports			**Jan**	**Presenter** Chief Nurse/ Head of Safeguarding	**Purpose** For assurance	**Outcome /Action taken** Noted
Quality Assurance Report Including Clinical Outcomes & Effectiveness Group Reports	**Nov**	**Dec**	**Jan**	**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 3 2023/24			**Jan**	**Presenter** Chief Medical Officer / Lead Nurse EOLC	**Purpose** For information	**Outcome /Action taken** Noted
Risk						
Trust Risk Register relating to Patient & Quality Summary changes between Quarterly meetings	**Nov**	**Dec**	**Jan**	**Presenter** Chief Medical Officer / Chief Nurse	**Purpose** For information	**Outcome /Action taken** Noted
Board Assurance Framework			**Jan**	**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 4 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 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)

- An update on training compliance with Safeguarding Adults Level 3 Training and Safeguarding Children Level 3 Training.
- Benchmarking of Safeguarding Resourcing
- Assurances around Technology Appraisals
- Water and Ventilation Reports in relation to Infection Prevention & Control
- A report on the management of Fridges

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

Item	Date
Referral to the People Committee to consider workforce capacity challenges despite the increase in the staffing establishment.	**January 2024**
The Quality Committee invites the Board to **NOTE** the following: - the Learning from Deaths Quarterly Reports - the MIS year 5 declared submission - 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 4 are fairly represented.	**February 2024**

NHS
University Hospitals Sussex
NHS Foundation Trust

Mortality & Learning from Deaths Report

Quarter 2

1st July – 30th September 2023

Contents

Learning from Death

Introduction

This report provides details of the activity across the Learning from Deaths workstream during quarter 2 of 2023/24. It covers the period of 1st July to 30th September 2023.

Quarter 1 report provided details of the new aligned LfD programs along with aims and objectives for the year ahead.

Quarter 2 report provides details of activity across the Learning from Deaths workstream and progress towards the aims and objectives for the reporting period (1st July – 30th September 2023).

Recap from Quarter 1 (1st April – 30th June 2023)

Quarter 1 report was the first report for the new aligned Learning from Deaths Programs, it provided details of the new processes along with the aims and objectives for the year (April 2023 – March 2024).

Phase one of aligning the LfD programs completed in June 2023 with the implementation of a single IT platform that streamlined the Medical Examiner Service with the coroner and Learning from Deaths service on all sites. This enabled capturing outputs from SJRs and Mortality Panels ready for sharing with Divisions, M&Ms and Patient Safety through uploading to Datix.

Completion of phase one also introduced a new pathway for referring and processing Structured Judgement Reviews.

Highlights from Quarter 2

Recruitment to the LfD Workstream

New posts were created to support the future LfD programs

- One full time (1 wte) Band 8b Portfolio Lead (LfD & Health Inequalities)
- One full time (1 wte) Band 8a – Mortality & LfD Manager
- One part time (0.6 wte) Band 6 – LfD Project Manager
- Two part time (1.4 wte) Band 4 – LfD Coordinators

Successful appointments were made to the Mortality & LfD Manager and the LfD Project Manager through the Clinical Outcomes and Effectiveness consultation process in September. Posts that were not filled through the consultation process will be advertised in October 2023.

The Aligned Process - Summary of Activity during Quarter 2

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
All UHSussex Medical Examiner Services are making good progress and are on target to achieve the statutory deadline of 1st April 2024.

All Medical Examiner posts are now filled and progress towards full alignment continues to onboard GPs in preparation of the statutory mandate in April 2024.

The newly appointed GP Medical Examiners at each Medical Examiner Office continue with reaching out to onboard two GP Practices per week.

The Medical Examiner Service continued to grow in preparation for the new statutory service in April 2024. Recruitment for MEs and MEOs completed in September with all posts successfully filled. The new MEs are due to commence in post in October and November 2023.

This will be sufficient for weekday working pattern for acute and community deaths.

Larger office space for the Medical Examiner services has been identified to accommodate the larger teams and allow out of hours work per weekend planning. This will be worked up as part of out of hours proposal.

Additional IT equipment will be required on all sites once the new MEs commence in post.

- **WGH** – Larger office space to accommodate the team is being explored. This remains a risk.
- **SRH** – Adequate office space has been allocated and office equipment has been sourced.
- The community hub for WGH/SRH will be based at Stillman House (SRH) with secure, lockable, pincode entry. IT equipment is being sourced for weekday working.

- **RSCH** – Adequate office space has been identified. The team will take occupancy of the new larger space in October 2023. This office space will be shared with the bereavement team. Although this office is larger than the previous, further space is required to accommodate more desks to enable junior doctors to complete referrals. Office equipment has been sourced for the current new space.
- **PRH** - Adequate office space has been allocated and office equipment has been sourced.

SJR Reviewer Recruitment During quarter two (July – Sept 23) it was anticipated that three new SJR reviewers would be appointed and trained in SJR methodology at RSCH and PRH. Following a review of the service, a new methodology was proposed that would support capability to complete greater numbers of SJRs utilising the broad

skills and expertise of senior clinical staff across the organisation. Further details can be found below.

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 374 SJRs and prevent future backlogs is currently being developed.

Proposed model for clearing the SJR backlog and future process

In order to avoid a cumulative continued backlog of SJRs there was a requirement to review the existing service provision. It was agreed to move from the PA payment model to a 'pay per SJR' model alongside the appointment of a Senior SJR reviewer to have oversight of the SJR process for the Trust. This model had been successfully implemented in a number of other large NHS Trusts including Imperial and Southampton.

The benefits of this model include the ability to recruit SJR reviewers from other disciplines such as senior nursing, SAS doctors or allied health professional staff to increase the workforce trained in SJR reviews and mitigate against future backlogs accumulating. Staff will need to be sufficiently senior to ensure the delivery of high quality, holistic reviews.

A minimum number of 10 SJRs conducted each year per reviewer will be set in order to maintain competence with the expectation that many will do more than the minimum requirement.

The appointment of a Senior SJR reviewer will enable a quality assurance process for the SJR service with oversight of the training of reviewers and quality of SJRs with clinical discussion at a Trust wide mortality panel. A job description for the Senior SJR reviewer role is being developed and appointment to the role will be made with the Consultant initiating work by the end of October 2023.

It is proposed that Trust wide mortality meetings will occur weekly to discuss the findings from SJRs and identify any Divisional or wider learning actions that are needed.

A monthly Learning from Deaths/Mortality Board will review SJR feedback, Medical Examiners reports, LeDeR learning and feedback from the Divisional Mortality and Morbidity learning cycle to inform the Trust's wider learning from deaths. Incidents subsequently raised will trigger the patient safety pathways and allow triangulation with end of life care, patient safety and patient/relative experience learning.

The LfD team will work with HR to review existing PA contracts for the SJR reviewers and facilitate the move to pay per SJR model.

Proposed plan to address the backlog of SJRs

- Appointment of a Senior SJR reviewer to commence in October 2023

    - oversee management of the backlog, training and quality assurance of SJRs and reviewers
    - have Trust level oversight of mortality panel and learning from deaths
- Identification and training of a dedicated team of SJR reviewers (internal and external) to tackle the backlog over a concentrated period of time with ready access to notes and senior SJR reviewer support.
    - Training will be given in house for those not previously trained.

Anticipated length of time to conduct each SJR is estimated at 60-90 minutes based on data from RCP and other Trusts. It is anticipated that the backlog could be cleared over a period of 3-4 months depending on dedicated SJR reviewer availability.

- Mortality review meetings to be held daily during the process of backlog management to be led by the Senior SJR reviewer.
- Thematic review will be undertaken daily and weekly and learning shared at the mortality meetings with Divisional leads and the Learning from Deaths team.

The themes will inform the basis of the response to the families involved.

- Any SJRs identified under the Duty of Candour (DofC) in line with current practice will be led by Divisions undertaking the initial contact with families with advice and support from the Patient Safety team.

This will be a significant work load for Divisional leads and will need to be communicated and managed in a timely fashion.

- Incident reporting arising from the process will be conducted as usual policy via PSIRF and the Patient Safety team.

The current backlog has 374 outstanding SJRs.

Hospital Site	**Outstanding SJRs**
RSCH	176
PRH	32
Worthing	94
SRH	58
Not recorded	13
Other*	1
Total	**374**

Alignment of the Learning from Deaths 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.

Delivery of a UHSussex fully aligned Learning from Deaths service continues to progress as a priority. 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 consultation process, vacancies are expected to be filled by early 2024.

Successful recruitment of a Mortality and Learning from Deaths Manager along with a Learning from Deaths Project Manager took place in August. Recruitment to the remaining posts is planned for November 2023.

Continued vacancies within the LfD workstream remains a significant risk to the delivery of a fully aligned Learning from deaths service.

UHSussex Mortality Data & Metrics Quarter 2 (1st July – 30th September 2023)

All Adult Deaths

1. Mortality Reviews

Table 1: Number of hospital deaths by setting and site

Total Adult Deaths				
	Jul-23	Aug-23	Sep-23	Total for Quarter
WGH	83	93	84	**260**
SRH	71	84	87	**242**
RSCH	95	87	104	**286**
PRH	25	24	29	**78**
Total	**274**	**288**	**304**	**866**

Table 2: Number of inpatient deaths

Total Adult Inpatient Deaths				
	Jul-23	Aug-23	Sep-23	Total for Quarter
WGH	81	89	83	**253**
SRH	68	82	85	**235**
RSCH	87	79	93	**259**
PRH	22	23	28	**73**
Total	**258**	**273**	**289**	**820**

Table 3: Number of ED deaths

Total Adult ED Deaths				
	Jul-23	Aug-23	Sep-23	Total for Quarter
WGH	2	4	1	**7**
SRH	3	2	2	**7**
RSCH	8	8	11	**27**
PRH	3	1	1	**5**
Total	**16**	**15**	**15**	**46**

1.1 The following data source for tables 4 – 7 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 1/2 – Data provided is the most up to date available.

Table 4	WGH	SRH	RSCH	PRH	UHXs
June (Q1)	49	45	27	23	144
July (Q2)	35	33	31	17	116
August (Q2)	38	43	33	8	122
September (Q2)	Available January 24				
Total	**122**	**121**	**91**	**48**	**382**

Table 5: SHMI (12 Month Rolling)

Table 5	WGH	SRH	RSCH	PRH	UHXs
June (Q1)	107.83	103.53	118.62	98.13	108.1
July (Q2)	106.88	103.03	118	95.12	106.62
August (Q2)	106.42	102.86	115.44	93.45	106.07
September (Q2)	Available January 24				

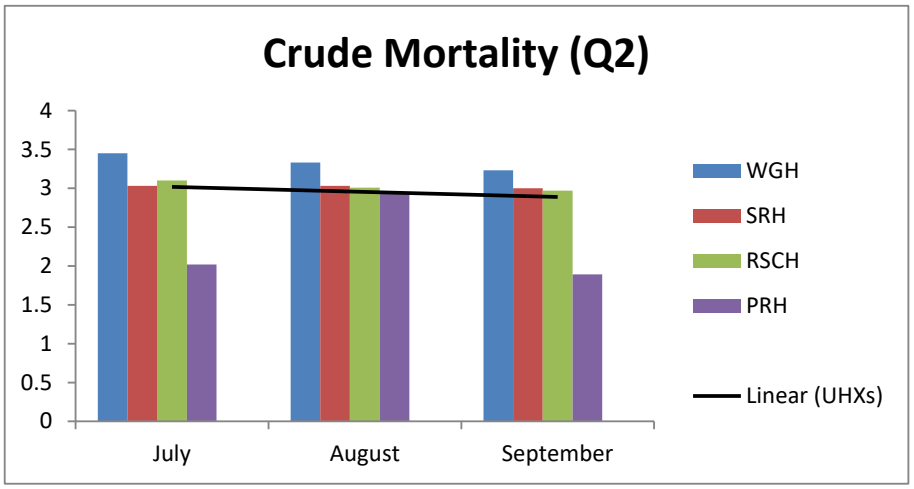
1.2 **Table 6:** HSMR (12 Month Rolling)

Table 6	WGH	SRH	RSCH	PRH	UHXs
July	101.27	100.6	100.59	83.02	98.74
August	101.46	99.96	101.38	84.4	98.73
September	101.81	99.96	100.8	83.93	98.88

1.3 **Table 7:** Crude Mortality (12 Month Rolling) for Q1 2023

Table 7	WGH	SRH	RSCH	PRH	UHXs
July	3.45	3.03	3.1	2.02	3.02
August	3.33	3.03	3.01	2.95	2.95
September	3.23	3	2.97	1.89	2.89

Graph 1: Q2 Crude Mortality displaying a Trust-wide downward trajectory during quarter 2.



Medical Examiner's Office

1.4 Medical Examiner scrutiny

Table 8: Percentage of deaths scrutinised by ME

Table 8	WGH	SRH	RSCH	PRH	UHXs
July	97.59%	100%	91.58%	92%	95.29%
August	100%	100%	97.7%	100%	99.43%
September	98.81%	100%	98.08%	96.55%	98.36%
Total	**98.8%**	**100%**	**95.79%**	**96%**	**97.69%**

1.5 **Table 9:** Percentage of MCCD NOT complete within 3 Days

Table 9	WGH	SRH	RSCH	PRH	UHXs
July	13.25%	23.94%	10.53%	16%	15.33%
August	24.73%	30.95%	22.99%	20.83%	25.69%
September	25%	39.08%	10.58%	17.24%	23.36%
Total	**21.15%**	**31.82%**	**14.34%**	**17.95%**	**21.59%**

1.6 **Referral to Coroner**

Table 10: Number of deaths referred to the coroner.

Table 10	WGH	SRH	RSCH	PRH	UHXs	Percentage
July	18	14	25	5	62	**22.63%**
August	27	24	24	3	78	**27.08%**
September	18	12	31	7	68	**22.37%**
Total	**63**	**50**	**80**	**15**	**208**	**24.02%**

Percentage Referred to Coroner	**24.23%**	**20.66%**	**27.97%**	**19.23%**	**24.02%**	

1.7 **Investigated by Coroner**

Table 11: Number of deaths investigated by the coroner's office

Table 11	WGH	SRH	RSCH	PRH	UHXs	Percentage
July	7	7	10	2	26	**41.94%**
August	12	8	9	2	31	**39.74%**
September	11	8	16	3	38	**55.88%**
Total	**30**	**23**	**35**	**7**	**95**	**45.67%**
% investigated by Coroner	**47.62%**	**46%**	**43.75%**	**46.67%**	**45.67%**	

1.8 **Deaths referred for structured Judgement review (SJR)**

Table 12: Number of deaths referred for SJR

Table 12	WGH	SRH	RSCH	PRH	UHXs	% of all Deaths referred for SJR
July	12	14	11	1	38	**13.87%**
August	25	10	14	1	50	**17.36%**
September	19	9	13	4	45	**14.8%**
Total	**56**	**33**	**38**	**6**	**133**	**15.36%**
% of all Deaths referred for SJR	**21.54%**	**13.64%**	**13.29%**	**7.69%**	**15.36%**	

2. Learning from deaths

Table 13: 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 13	SRH	WGH	Total
July	2	4	6
August	3	12	15
September	4	4	8
Total	**9**	**20**	**29**

3.1 SJR outcome scores

Table 14: Details the overall outcome score of 1st SJR per site completed during Quarter 2 for patients who died during the reporting period

Outcome Score	WGH	SRH	RSCH	PRH
5 - Excellent	0	0	0	0
4 - Good	0	1	0	0
3 - Adequate	1	1	0	0
2 - Poor	1	1	0	0
1 - Very Poor	0	1	0	0
Total	**2**	**4**	**0**	**0**

Graph 2: SJR Outcome scores of SJRs referred and completed during quarter 2

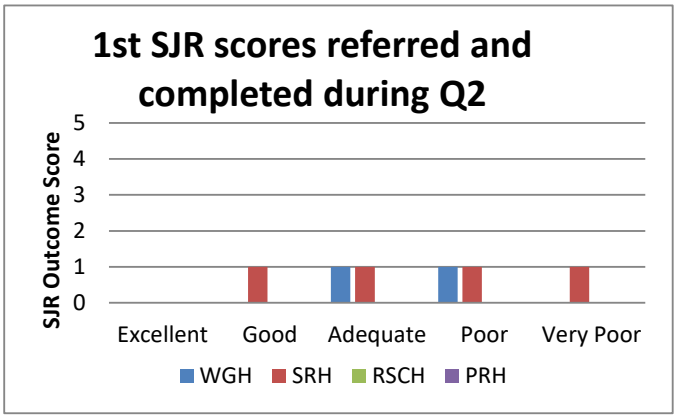


Table 15: Details the overall outcome score of 1st SJR per site completed during Quarter 2 for patients who died outside the reporting period.

Outcome Score	WGH	SRH	RSCH	PRH	Total
5 - Excellent	2	1	0	0	3
4 - Good	6	5	0	1	12
3 - Adequate	7	2	1	0	10
2 - Poor	9	5	2	0	16
1 - Very Poor	2	0	1	0	3
Total	**26**	**13**	**4**	**1**	**44**

SJR Activity and Outcomes

Aligning the Mortality & LfD Programs uses SJR Methodology to support clinical teams by providing opportunities to learn from constructive feedback and excellent care.

During quarter 2 of 2023/24 there were 133 deaths referred for a SJR. 25 of those referrals were in progress or completed at the end of Q2. A further 44 SJRs were completed that were referred in previous quarters.

Table 16: Quarter 2 activity of SJRs referred and completed or in progress

Number of SJRs Referred and Completed or in progress during Q2 by Hospital Site				
	Number of SJRs Referred during Q2	Number of SJRs referred in Q2 that were completed or in progress at the end of Q2	Number of SJRs referred in previous quarters that were completed or in progress at the end of Q2 (exc 2nd SJRs)	Total number of SJRs completed or in progress at the end of Q2
WGH	56	11	25	36
SRH	33	13	15	28
RSCH	38	1	3	4
PRH	6	0	1	1
Total	**133**	**25**	**44**	**69**

Graph 3: SJRs completed or in progress

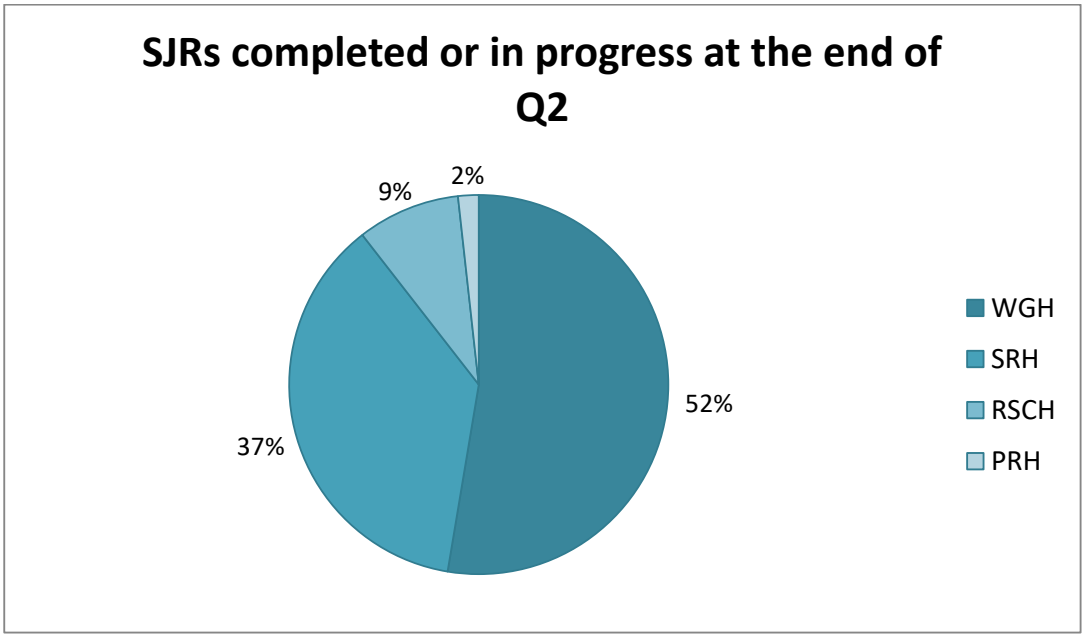


Table 17: SJR referrals - by Hospital Site as of end of Quarter 2 (30th Sept 23)

SJR referrals - by Hospital Site as of end of Quarter 2 (30th Sept 23)					
	Patient died during Q2 (90 days)	Patient died 3 – 6 months previous	Patient died 6 – 12 months previous	Patient died greater than 12 months previous	Total
WGH	55	19	10	19	103
SRH	34	16	12	8	70
RSCH	42	36	55	85	218
PRH	6	5	10	17	38
Total	**137**	**76**	**87**	**129**	**429**

Table 18: SJRs completed during Q2

SJRs Completed during Q2 by Hospital Site (30th Sep 23)					
	Patient died during Q2 (90 days)	Patient died 3 – 6 months previous	Patient died 6 – 12 months previous	Patient died greater than 12 months previous	Total
WGH	2	24	3	0	29
SRH	4	13	1	0	18
RSCH	0	2	5	0	5
PRH	0	1	0	0	1
Total	**6**	**40**	**7**	**0**	**53**

Table 19: SJRs in progress at the end of Q2

SJRs in Progress by Hospital Site as of end of Quarter 2 (30th Sep 23)					
	Patient died during Q2 (90 days)	Patient died 3 – 6 months previous	Patient died 6 – 12 months previous	Patient died greater than 12 months previous	Total
WGH	1	0	0	0	1
SRH	2	1	0	0	3
RSCH	0	0	0	0	0
PRH	0	0	0	0	0
Total	**3**	**1**	**0**	**0**	**4**

Table 20: SJR Status at end of Q2

Total SJRs processed (not completed)	Completed / in progress at end of Q2	Sample completed from Backlog	SJRs being addressed as Backlog project	Outstanding SJRs at end of Q2 (30th Sep 23)
429	53	2	372	0

All outstanding SJRs up to 31st August 2023 are being addressed as part of the backlog project.

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.

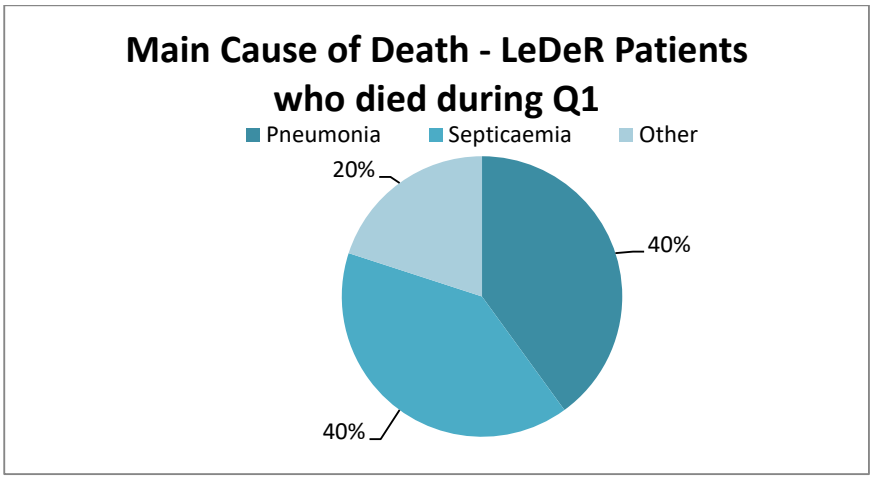
3.65% of the total SJR referrals in Q2 were patients with Learning Disabilities. One SJR was completed during the quarter for patients that had died in quarter 2.

SJRs Referred in Q2 for patients with a learning disability and/or autistic people:

Table 21	WGH	SRH	RSCH	PRH	UHXs
July	1	0	0	0	1
August	0	0	1	0	1
September	2	2	0	0	4
Total	**3**	**2**	**0**	**0**	**5**

4 patients were over 60 years old at the time of death. All patients had a DNACPR in place. The main cause of death of patients with a learning disability was pneumonia (40%), or septicaemia (40%). Long-term conditions included diabetes and pulmonary hypertension.

Graph 4: Main cause of death of LeDeR patients who died during Q2



Serious Incidents

There were no SJRs that resulted in Serious Incidents during the quarter.

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.

PRH Learning Themes

Poor Care

- ✖ Failed discharge, re-admission 4 days later. No package of care was provided.

RSCH Learning Themes

Poor Care

- ✖ IV fluid infusion in a patient with known heart failure and severe aortic stenosis where there seemed to be no good clinical reason why the fluids needed to be administered so rapidly
- ✖ High risk surgery but patient could have benefited from a more conservative approach, focused on the patient's quality of life
- ✖ No Independent Mental Capacity Advocate (IMCA) or Power of Attorney (PoA)
- ✖ Venous thromboembolism (VTE) not completed
- ✖ Discharge Planning
- ✖ Delays with End of Life medication

Good / Excellent Care

- ✓ Good clerking by Consultant during strikes
- ✓ Exemplary care on this ward - daughter died with 'peace and dignity'

WGH Learning Themes

Poor Care

- ✖ No Advance Care Planning discussion
- ✖ No capacity assessment
- ✖ Delayed/no Speech and Language Therapy (SALT) referral
- ✖ No dietician referral
- ✖ Poor pain management at the end of life
- ✖ Treatment continued despite the patient starting a palliative pathway
- ✖ Respect form said not for intervention but staff attempted to treat the infection
- ✖ Fluids not recorded for 10 days, unable to know how much subcut given
- ✖ ReSPECT form was not for hospital admission, however the patient was

admitted and died and there was no advantage of the patient being in hospital.

- ✗ Delay in administering antibiotics in A&E
- ✗ Active treatment given despite poor prognosis
- ✗ Patient transferred to another ward when they were actively dying
- ✗ Primary care (GP) blood result delays led to hospital admission.
- ✗ Decision to palliate could have been made sooner
- ✗ DNAR should have been completed at the time of the Treatment Escalation Plan (TEP)
- ✗ Unnecessary hospital transfer
- ✗ Delay to diagnosis

Good / Excellent Care

- ✓ Good junior reviews
- ✓ Good nursing care in a challenging situation

SRH Learning Themes

Poor Care

- ✗ No nursing record from EF.
- ✗ Lack of senior decision making
- ✗ Poor initial management and fluid resuscitation
- ✗ Lack of fluid balance monitoring
- ✗ Clear records of discussion with family members
- ✗ Delay to commencing antibiotics (3 SJRs mention this).
- ✗ Antibiotics given quickly in A&E but not prescribed post admission despite chest sepsis.
- ✗ Poor documentation
- ✗ Delay to palliative pathway

Good / Excellent Care

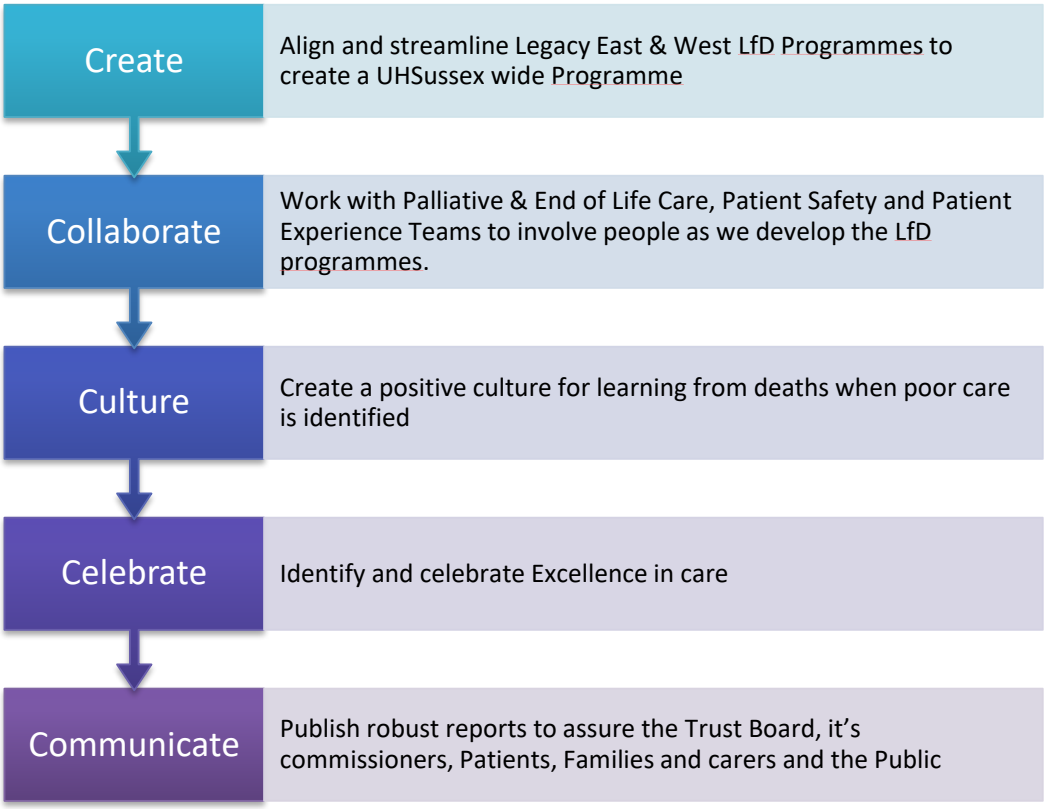
- ✓ Good decision making regarding ceiling of treatment and level of observations prior to EOL pathway.
- ✓ Frequent reviews by senior team
- ✓ Appropriate senior involvement and good conversations regarding risk

Medical Examiner Feedback

Key concerns raised by families/ Next of Kin calls are referred for SJR and learning is identified through the SJR outputs.

Positive feedback from families/Next of Kin calls

OBJECTIVES 2023/24 – 2025/26



Year 1 2023-24

Objective	Purpose	By when	Status
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	**Complete**
Recruit 1 wte Project Manager	To support alignment projects and future LfD Programmes.	May 2023	**Complete**
Recruit 1.4 wte Administrator	To support with general admin, service the Mortality Panels and EoLC&M Board.	June 2023	**In Progress**
Pilot new Mortality Panels and process using new Panda IT Modules	Ensure process is able to achieve desired outcomes using PDSA cycle.	June 2023	**Complete**
Go live with new Mortality & LfD Programmes	Deliver an aligned, streamlined Mortality and LfD platform across all of UHSx	June 2023	**Complete**
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	**In Progress**
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	**In Progress**
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	**In Progress**
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	**In Progress**
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	**In Progress**

Year 2 2024-25

Objective	Purpose	By when	Status
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	**Not Started**
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	**Not Started**
Establish workstreams into GRFT and Health Inequalities Programmes	Utilise LfD and HI Outputs to support GRFT and drive learning.	TBC 2024	**Not Started**
Review LfD Programs	Ensure the aligned programs are achieving the desired outputs	July 2024	**Not Started**

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	11.1	**Meeting:**	Trust Board – Public	**Meeting Date:**	8th February 2024
Report Title:	UHSussex – CNST Year 5 Submission – Board summary				
Sponsoring Executive Director:	Dr Maggie Davies, Chief Nurse				
Author(s):	Emma Chambers, Director of Midwifery Dr Tim Taylor, Chief of Service Hugh Jelley, Director of Operations Claire Hunt, Divisional Director of Nursing Programme Manager – Raili Frost				
Report previously considered by and date:	UHSussex – CNST Year 5 Submission – January 2024				

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	Yes / N/A	Staff confidentiality	Yes / N/A
Patient confidentiality	Yes / N/A	Other exceptional circumstances	Yes / N/A

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

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

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

Regulatory / Statutory reporting requirement

Communication and Consultation:

This paper has been prepared for the Trust Board to provide a summary of the Maternity Incentive Scheme (MIS) Clinical Negligence Scheme for Trusts (CNST) year 5 declaration which has been approved and signed off by both the private Trust Board and the ICB on the 11th and 29th January respectively. The Trust's CNST declaration was submitted by the due date **(**12 noon on Thursday 1st February 2024.)

Executive Summary:

Requirement

The MIS CNST scheme supports the delivery of safer maternity care through an incentive element to Trust contributions to the CNST. The scheme, developed in partnership with the national maternity safety champions, Dr Matthew Jolly and Professor Jacqueline Dunkley-Bent OBE, rewards Trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services.

Whilst the MIS is a self-certified scheme, with all scheme submissions requiring sign-off by Trust Boards following conversations with Trust commissioners, all submissions also undergo an external verification

process. Given the Trust's recent CQC inspection and history with CNST evidence, it is possible that NHSR will review our evidence in full too.

Year 5 CNST UHSussex declaration.

Previous reports to the Quality Committee and Board in December and January outlined that BDO (the Trust internal auditors) completed an assurance audit of UHSussex evidence against year 5 MIS CNST guidance. Their final report provides assurance in support of the Trust's overall declaration. The Trust Board then approved the submission on the 11th January, with the Trust CEO, Dr. George Findlay, signing the declaration. Finally, the LMNS reviewed the Trust's evidence before making a recommendation for the ICB CEO, Adam Doyle, to sign off the Trust's declaration on the 29th January.

NHSR require the Trust to submit the year 5 declaration using a self-assessment template. The summary page of this is embedded below with the full template including each individual Safety Action tab along with action plans as necessary available via the Company Secretary. The responses on this template are based on the Trust's ability to evidence compliance against current MIS requirements. Evidence is catalogued against each Safety Action and reviewed by BDO and the LMNS, with the latest evidence index stored on corporate folders, available via the Company Secretary.

The Board is asked to note that significant progress has been made across all safety actions, with those areas previously reported at risk including training compliance and medical workforce action plans to meet national standards now delivering in line with MIS CNST standards.

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	No
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to fully implement all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?	Yes

Members of the Trust Board will note that the Trust is unable to declare compliance for a sub element of Safety Action 1 – as follows:

Safety Action 1: a) Have all eligible perinatal deaths from 30 May 2023 onwards been notified to MBRRACE-UK within seven working days?
This was not met in 1 case – a missed MBRRACE notification of a 20+2 weeks fetal loss on 1st July (during the transition to BadgerNet), a failsafe process has been commenced, which produces a

daily report from BadgerNet on all sites, to identify any deaths in the preceding 24 hours. This has meant all subsequent deaths have been reported on time.

The Trust has liaised with NHSR and MBRRACE-UK as to the consequences on the declaration given no impact around safety of patients. NHSR have advised to declare non-compliance with an action plan included in the declaration form, and when MBRRACE-UK have completed their verification process, they will rate the Trust as compliant by the end of March 2024.
It was proposed that Trust followed the advice of NHSR, with submission of the above declaration while the Trust awaits MBRRACE-UK's upgrade to compliant in March. Following their review, the Trust will be compliant with all ten safety actions, meeting CNST for the first time since year 1.

Key Recommendation(s):

Members of the Board are asked to note the signed off and submitted declaration against the 10 Safety Action Standards.

Also note the lapse with regards to Safety Action 1 (one sub element only – one case missed) and the declaration of this, the mitigations in place to address future re-occurrence and the confirmation from NHSR and MBRRACE-UK that the Trust will be upgraded to compliant by March 2024.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	12.	**Meeting:**	Trust Board	**Meeting Date:**	8 February 2024
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 29 November 2023 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 Culture and Organisational Development Officer, Chief Executive and Trust Chairman were also present. In attendance were the Director of Human Resource Management; Director of Workforce Planning & Deployment; Director of Integrated Education; the Associate Director of Leadership, Culture and Development, Deputy Chief Nurse – Workforce and Professional Standards and the Company Secretary. Apologies were received from the Director of Medical Education and the Guardian of Safe Working Hours.

At the meeting of the People Committee on 31 January 2024, the meeting was quorate for items requiring a decision as it was attended by two Non-Executive Directors and during those items, at least two executive directors including the Chief People Officer and Chief Operating Officer. The Chief Culture and Organisational Development Officer and Chief Nurse were also present for the majority of the meeting. In attendance were the Director of Workforce Planning & Deployment; Director of Integrated Education; the Associate Director of Leadership, Culture and Development, Deputy Chief Nurse – Workforce and Professional Standards and the Company Secretary. Apologies were received from the Director of Human Resource Management.

At each meeting, the Committee received its planned items including the reports linked to the respective Patient First True North, Breakthrough Objective, Strategic Initiatives and Corporate Projects; 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.

The Committee received sight of the 2023 Staff Survey results that remained embargoed for publication. The initial findings were discussed and would be shared with Divisions 'with staff who are responsible for measuring and improving staff experience at the organisation' per the terms of the embargo.

People Performance Overview Report.

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. If sustained, the Committee expects these improvements to translate into a more positive experience for staff over time.

The Committee discussed a referral from the Patient & Quality Committee in December to consider the risks that suggested pressured staffing leading to treatment challenges, and how this had been recognised with the considerable increase in workforce headcount in the last 12 months. The Committee heard the recognition of factors to consider in workforce planning for 2024/25. In relation to Divisional risks it was recognised that the new Risk Oversight Group can offer clearer identification of the nature of staffing vulnerabilities. Though a partner in the Sussex system, the Trust had seconded support to lead on sickness absence improvement and improving people reporting.

The committee **NOTED** there had been a generally improving position on staff feeling able to speak up.

The Committee received updates and continued to be **ASSURED** of the continued focus on appraisals and mandatory training. Mandatory Training compliance had improved considerably using the data shared at the January meeting. While there had been slow steady improvement in completion of staff appraisals, the Committee **NOTED** a considerable decline in medical appraisals recorded as complete within the period. This is anticipated to be addressed through medical supervision in light of the associated revalidation requirement. At the November Meeting, there was deep dive on Health and Wellbeing arrangements and on arrangements for the management of stress and the Committee **NOTED** the supportive training for staff and managers had been arranged.

The Committee **NOTED** that the Health and Wellbeing Plan is substantially reliant on Charitable Funds support and considered it necessary to **ESCALATE** this risk to the Board while associated bids are presented to the Charity's Trustees.

The Committee was **ASSURED** of the Trust's nursery provision having maintained a GOOD rating following an unannounced inspection. The Committee **NOTED** that a Compliance Assurance Framework was being compiled for People and Workforce matters and would bring employment check standards assurances to the Committee routinely.

Culture work update

At the November meeting the new Chief Culture and Organisation Development (OD) officer was introduced to the Committee. At the January meeting, a detailed report was presented on work to consider optimal targeting opportunities including work around the Trust's values and building OD capability. The

Committee welcomed the robust approach to the diagnostic stage and further stages with recognition of the overlap with the safety culture and well led priorities running concurrently.

The Board will note that a Board Workshop has been identified to consider its role in Trust culture.

True North, Staff Engagement

The Committee noted embargoed National Staff Survey results have been received and considered the early findings.

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 second presentation from the Freedom to Speak Up Guardian service providing their report for Quarter 3 2023/24. 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 looks forward to the annual report from the Freedom to Speak Up Service.

Breakthrough Objective, Staff Voice

The Committee received a deep dive into data that might indicate adverse differential work experience for individuals with a disability. The Committee was **ASSURED** that statutory reporting compliance had been achieved. The Committee **NOTED** a difference between the staff records of disability and disabilities mentioned on staff survey responses. The Committee heard assurance that training was planned to support managers' determination of reasonable adjustments for colleagues and agreed that a focus was required on how to support people with hidden disabilities more effectively, in particular complex issues around mental health and neurodiversity challenges that often requires specialist advice, and that colleagues might feel unable to declare.

The Committee discussed empowering and staff networks particularly the Disability Staff Network to encourage and enable supportive adjustments.

Strategic Initiative, Patient First Improvement Programme

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.

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.

At the November meeting the Committee received detailed report on the progress of the Trust's violence prevention and reduction programme 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.

The Committee considered the recently published EDI maturity report from the Trust's internal auditors. Operational resourcing had delayed the Trust's EDI plans initially, but work is underway and the audit report offered **ASSURANCE** that arrangements were maturing, although the Committee recognised there was more work to do. A **REFERRAL** from the Audit Committee that had received, having seen the report before this Committee. The referral was to ensure follow up to some actions that that not had clearly identified delivery dates or owners and the Committee **AGREED** to monitor delivery.

Violence Prevention and Reduction

In reference to a focus from NHS England and the Health & Safety Executive on violence against staff in the workplace, there had been an update to the self-assessment against published standards. The Committee was **ASSURED** by a report and associated action plan through provision of an outline trajectory to full compliance and refreshed VPR project plan to include the actions identified as required, which would be monitored by the Leadership, Culture and Development (LCD) Steering Group. The Committee discussed in particular the risks of under reporting of incidents and the work to demonstrate organisational support to reporting and taking action.

Gender Pay Gap Reporting

The Committee was alerted to errors in reported data for 2021-22 and 2022-23, identified through a systematic review conducted by the new dedicated analyst in the Equality, Diversity, and Inclusion team in December 2023. The report included a diagnostic for how the errors occurred and details of control measures in place to ensure they do not recur. An internal review diagnosed the data reporting inaccuracies stemmed from raw data being downloaded, manually cleaned and summarised. This was done with incorrect parameters which led to inconsistencies and affected which staff members were included/ excluded in the analysis. In addition, previous bonus pay gap calculations did not include all relevant employees receiving a bonus in the relevant timeframes.

The effect of the correction in almost all respects has been to narrow any gender pay gap in relation to ordinary pay and for bonus pay.

The Committee **ENDORSED** the actions required to publish the corrected data.

There will be a declaration of updated data made to Cabinet Office for 2021-22, and the 2022-23 draft is re-submitted on the Government portal. Updated data will be sent to Model Hospital and an updated Annual Equality Report is to be uploaded on the Trust website.

Talent Management

At the January Meeting the Committee **NOTED** a report and discussed alternative approaches and possible unintended consequences of talent management programmes. The Trust does not yet have a holistic or comprehensive map of its talent management approach. The Committee acknowledged that an important consideration will be how to ensure individual goals align with organisational priorities.

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 a decrease in the number of breaches in the period 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 Committee **AGREED** to request for management assistance to help ensure the timely release of funds to be used for positive benefits.

The Committee **NOTED** a recommendation within the report to confirm a Trust Policy around medical staff 'acting down' that would require discussion with the Joint Negotiating Committee.

GMC National Training Survey Results

The Committee **RECEIVED** the GMC survey results. The data which included safety concerns reported by respondents would be triangulated with that of the main body of the survey and quality interventions were expected. The Committee noted assurance from George Findlay of the improvements being made in surgery at RSCH. This corresponded with a considerable reduction of red flags in the survey data for the RSCH site and PRH sites compared to previous years. It was also noted that the survey response had been lower than in previous years.

At the January meeting, there was a triangulation with other discussions and recognition of the bell-weather opportunity around wider staff satisfaction and organisational culture presented by the GMC National staff survey data.

Medical Workforce Systems

The Medical Workforce report provided a progress update on the phased roll out of the new Medical 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.

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.

The nature of risks has not changed. Flagged reports from divisions. There remains some 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 3 going into Quarter 4 since although there had been progress and six 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.

People Plan

The Committee at the January meeting received an update on ward models of care and recruitment of healthcare assistants and nursing recruitment. The recruitment of registered nurses at Band 5 had been a particular challenge and was in keeping with a national issue, heightened regionally. The Committee was **ASSURED** of some mitigating activity through positive recruitment to nursing associate roles and by the summary on Internationally Educated Nurses and plans to secure Graduate recruitment.

The Committee received the Annual Workforce Plan Submission for 2024/25 and **NOTED** the submission to the Integrated Care Board. The Committee confirmed the Trust is not expecting workforce growth except where this is supported by a business case.

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 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** that the Committee considered, with reflection on continued pressures on staff and time to fully recruit to leadership posts and agreed the risk scores for BAF risks 3.1 to 3.4 are fairly stated for quarter 4.

The Board is asked to **NOTE** There are corrections to be made to the Trust's Gender Pay Gap data and re-submission to the Government GPG reporting service and further actions to be taken: i.e. Declaration of updated data made on Cabinet Office for 2021-22, and the 2022-23

draft is re-submitted on the Government portal. Updated data will be sent to Model Hospital and an updated Annual Equality Report is to be uploaded on the Trust website.

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	**31 January 2024**	**Chair**	Paul Layzell	**Quorate**	During key items
Meeting Date	**29 November 2023**	**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	**Nov**	**Jan**	**Presenter** Director of Human Resources Mgt	**Purpose** For information	**Outcome /Action taken** Noted
Freedom to Speak Up Update Q3		**Jan**	**Presenter** Chief People Officer	**Purpose** For information	**Outcome /Action taken** Noted
Strategic Initiative – Patient First Programme	**Nov**	**Jan**	**Presenter** Chief Operating Officer	**Purpose** For information	**Outcome /Action taken** Noted
Strategic Initiative – Leadership Culture and Development update and KPIs	**Nov**	**Jan**	**Presenter** Chief People Officer / AD Leadership, OD & Engagement	**Purpose** For approval	**Outcome /Action taken** Noted
Integrated Education Update	**Nov**	**Jan**	**Presenter** Director of Integrated Education	**Purpose** For information	**Outcome /Action taken** Noted
Violence Prevention & Reduction Update;	**Nov**	**Jan**	**Presenter** Chief People Officer	**Purpose** For information	**Outcome /Action taken** Noted
Equalities Diversity & Inclusion Update Including Internal Audit Report & Annual Reporting Timeable (Nov) Gender Pay Gap Data (Jan)	**Nov**	**Jan**	**Presenter** Chief People Officer	**Purpose** For information	**Outcome /Action taken** Noted
Medical Workforce Systems, Update		**Jan**	**Presenter** Director of Workforce Planning	**Purpose** For information	**Outcome /Action taken** Noted
People Performance Overview Report	**Nov**	**Jan**	**Presenter** Director of Workforce Planning (Nov/Jan) Director of Human Resources Mgt (Nov)	**Purpose** For information	**Outcome /Action taken** Noted
Guardian for Safe Working Report Q3		**Jan**	**Presenter** Guardian of Safe Working)	**Purpose** For assurance	**Outcome /Action taken** Noted & approved
Exception Reporting: locally employed doctors		**Jan**	**Presenter** Chief People Officer for the Director of Integrated Education	**Purpose** For information	**Outcome /Action taken** Noted
Nursing & Midwifery Workforce Workstream Highlight Report	**Nov**	**Jan**	**Presenter** Deputy Chief Nurse (Workforce)	**Purpose** For information	**Outcome /Action taken** Noted

Update on Workforce Culture	**Nov**	**Jan**	**Presenter** Chief Culture and OD Officer	**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	**Nov**	**Jan**	**Presenter** AD Leadership, OD & Engagement, Chief People Officer	**Purpose** For information	**Outcome /Action taken** Updates Noted
Patient First Improvement Programme Update		**Jan**	**Presenter** Chief Operating Officer	**Purpose** For information	**Outcome /Action taken** Noted
Talent Management Approach Update - outline of ICB approach and Trust considerations		**Jan**	**Presenter** AD Leadership, OD & Engagement, Chief People Officer	**Purpose** For information	**Outcome /Action taken** Noted
Quarterly Education and Training Opportunities, including: - Education development activity scorecard - AHP Preceptorship programme evaluation	**Nov**		**Presenter** Chief People Officer Chief People Officer / AHP Preceptorship programme deliverers	**Purpose** For information	**Outcome /Action taken** Noted Noted
Update on Management of Stress	**Nov**		**Presenter** AD Leadership, OD & Engagement,	**Purpose** For information	**Outcome /Action taken** Noted
Health & Wellbeing Deep-Dive & Year 2 Priorities	**Nov**		**Presenter** AD Leadership, OD & Engagement, Chief People Officer	**Purpose** For information	**Outcome /Action taken** Noted
Disability Deep Dive	**Nov**		**Presenter** AD Leadership, OD & Engagement, Chief People Officer	**Purpose** For information	**Outcome /Action taken** Noted
Leadership Deep Dive		**Jan**	**Presenter** AD Leadership, OD & Engagement, Chief People Officer	**Purpose** For information	**Outcome /Action taken** Noted
Inclusive Recruitment Action Plan		**Jan**	**Presenter** AD Leadership, OD & Engagement, Director of Workforce Planning	**Purpose** For information	**Outcome /Action taken** Noted
Gender Pay Gap: Reported Data Changes		**Jan**	**Presenter** AD Leadership, OD & Engagement, Chief People Officer	**Purpose** For information & to agree action	**Outcome /Action taken** Noted & Agreed actions to publish revised data.
Ward Models of care and HCA & nursing recruitment update		**Jan**	**Presenter** Director of Workforce Planning Deputy Chief Nurse (Workforce)	**Purpose** For information	**Outcome /Action taken** Noted
Annual Workforce Plan - progress against delivery, changes in substantive/ bank/ agency staffing		**Jan**	**Presenter** Chief People Officer	**Purpose** For information	**Outcome /Action taken** Noted

GMC National Training Survey Results - Survey results in relation to supervision - extended educational roles	**Nov**		**Presenter** Chief People Officer (on behalf of Director of Medical Education)	**Purpose** For information	**Outcome /Action taken** Noted
International Recruitment of Registered Nurses and Radiographers, 2022/2023	**Nov**		**Presenter** Chief People Officer / Director of Workforce Planning	**Purpose** For information	**Outcome /Action taken** Noted
Updates on Integrated Care System - ICB People Plan (Jan)	**Nov**	**Jan**	**Presenter** Chief People Officer	**Purpose** For information	**Outcome /Action taken** Noted
Risk Report		**Jan**	**Presenter** Chief People Officer	**Purpose** For information	**Outcome /Action taken** Noted
Board Assurance Framework		**Jan**	**Presenter** Company Secretary	**Purpose** For agreement	**Outcome /Action taken** Agreed risks fairly stated

Actions taken by the Committee within its Terms of Reference	
The Committee **AGREED** to recommend the risk score for BAF risks 3.1 to 3.4 to the Board for the start of quarter 4 2023/24.	
Items to come back to Committee / Group (Items Committee / Group keeping an eye on)	
There are no identified items to come back to committee outside the scheduled cycle of business	
Items referred to the Board or another Committee for decision or action	
Item	**Date**
The Board is invited to **NOTE**: The BAF risks 3.1 to 3.4 are considered fairly stated for the start of quarter 4 2023/24. There are corrections to be made to the Trust's Gender Pay Gap data and re-submission to the Government GPG reporting service and further actions to be taken: i.e. Declaration of updated data made on Cabinet Office for 2021-22, and the 2022-23 draft is re-submitted on the Government portal. Updated data will be sent to Model Hospital and an updated Annual Equality Report is to be uploaded on the Trust website. That the Health and Wellbeing Plan is substantially reliant on Charitable Funds support.	**February 2024**

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	13.	**Meeting:**	Trust Board	**Meeting Date:**	8 February 2024
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 two meetings in November 2023 and January 2024 (the latter held on 1 February 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 represented by the Chief Operating Officer.

The November meeting focused on the funding rephasing for an Electronic Patient Record, a report on a Data Centre Incident and updates on the financial position, the efficiency programme, and the productivity breakthrough objective.

The January 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 January Sustainability Committee of 1 February 2024 was attended by two Non-Executive Directors, the Chair, the Chief Financial Officer, the Chief Operating Officer and the Chief People Officer.

Also in attendance were the Finance Director, the Director of Estates and Facilities, the Commercial Director, the 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 Executive, Chief Governance Officer and the Director of Improvement and Delivery.

The January 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), a Quarter 3 finance report 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 November and January meetings. These concerned:

- The Worthing Heat Network
- Electronic Patient Records (EPR) Programme –to approve a revision to NHSE funding phasing of the case approved previously by the Board

True North Financial Performance Report
Quarter 3 2023/24 Financial position

The Committee received finance updates at the November and January 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. It was noted that there had been some improvements in Registered Mental Health Nursing spend following the mental health workstream initiatives. The Consultant rate card had represented a particular cost pressure and continues to do so alongside other forms of premia workforce spend, relating to both non-elective and elective care.

The Trust had submitted a break-even plan that was predicated on a system agreed Elective Recovery Fund (ERF) target against the 19/20 baseline and in accordance with guidance for the re-forecast of no further industrial action. The Committee **NOTED** drivers of the current deficit position included the cost of further strikes, and clawback against a subsequently amended ERF target as well as other operational factors. The Committee heard that the enhanced control environment arrangements described previously had shown some cost avoidance impact, however, reduction in a run-rate reduction was urgently needed and this was not yet being achieved.

The Committee **NOTED** that work on efficiencies had made some positive impact on the position but was not yet delivering at the necessary pace and was adverse to plan.

The Committee **NOTED** the Financial Forecast Roadmap report and **NOTED** the risks to delivery of the Financial Plan 2023/24 as well as the impacts this would have on the 24/25 financial year.

The Committee **NOTED** that 3Ts Funding had been received for the year which significantly addressed a previously recorded risk to the Trust's position.

There remain significant risks to the delivery of the Trust's financial plan. The Committee received information on those risks, the actions planned and assurance these have been shared and are understood by the Integrated Care System.

24/25 Core gap

The Committee noted the work on identifying the 24/25 core gap which would continue in the coming months.

National Cost Collection Submission Report

The Trust submitted its national cost collection return on time. The financial quantum and accounts were fully reconciled. This showed that costs have proportionally increased ahead of the activity they have delivered in many areas and that the majority of the Trust's cost quantum increase was driven by workforce costs. Divisional teams are being supported to understand where there is unwarranted variation and opportunities using this information and other comparative data from the Model Hospital.

ICS Finance Update

The January meeting of the Committee **RECEIVED** an update on the Integrated Care System (ICS) Finance Leadership Group system.

Productivity Breakthrough Objective

The Committee discussed the productivity breakthrough objective. In the January meeting the Committee **RECEIVED** an update from Managing Director for Planned Care and Cancer for the position at Month 9. The Committee **NOTED** that the Trust significantly outperformed the baseline year at Month 9. The internal delivery excluding use of the independent sector exceeded the baseline year and reflected the success of ringfencing elective beds and was despite the industrial action in December and the impact of festive leave.

The Committee welcomed the positive updates on Outpatient productivity noting significant opportunities remain. The Committee heard about the particular benefits shown through theatres from high volume list work e.g. cataracts and initiatives to advance this approach further.

The Committee discussed the potential benefits of aligned discussion between performance and financial reporting and agreed that deep dives on productivity would come to the future combined Committee.

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 closely 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

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. Considerable progress had been made with the clinical workstream and the reduction of nitrous oxide gases. The work of clinical fellows for environmental sustainability had generated significant benefits.

The Committee **NOTED** 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 with a focus on the activities for the Trust ambassadors. The Committee heard about the other work to decarbonise the RSCH site that would have the added benefit of assisting with gaining planning permission for future development. The Committee acknowledged the significance of vacating spaces occupied by the Trust in beginning to off-set the carbon footprint from new developments.

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. The Committee NOTED at the November meeting the mechanism used and scoring of these. At the January meeting the Committee NOTED that that the work was broadly on plan although costed intentions were behind schedule. Proposals would come to the Business case steering Committee in March 2024 and to the next meeting of Sustainability Committee the end of that month. The Committee discussed the stakeholder communication work that will coincide with this.

The Committee **NOTED** the update and engagement being undertaken with the Divisions through the delivery of the project.

The Committee **NOTED** that the continued work towards the Estates Strategy and how the Trust was working with the Integrated Care System as part of their strategy and aligning to the ICS SMART objectives. .

The Committee discussed the considerable risk arising from the high level nature of the Clinical Strategy which needed to be operationalised as well as future system wide service changes that could impact estates configuration.

The Committee **NOTED** that the Chief Strategy Officer has commenced her role with the Trust and was leading on the implementation and operationalisation of the now agreed clinical strategy which would feed into the Estates master planning work.

The Committee **NOTED** the referral from the Research & Innovation Committee about the risk around a research facility in the estate and the need for its inclusion in the Estate Master Plan if the Trust's research ambitions are to be realised. This will be considered all other estate demands and prioritised in the same way.

Efficiency and Transformation Programme Quarter 3

The Committee **NOTED** the current level of delivery of the year's efficiency programme which is currently adverse to plan. 24/25 activities were in progress to develop a plan for the coming financial year.

Following consideration of the above papers the Committee **supported maintaining the** Sustainability Risk 2.1 of the Board Assurance Framework (BAF) at 20 following its increase to quarter 3 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 3

The Committee **RECEIVED** the Q3 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 behind plan at Month 9 due to external factors outside the Trust control.

The Committee has previously advised the Board that IT costs associated with a data centre incident could add further pressure to the capital plan.

The Committee was **ASSURED** that work to reduce over-programming had shown considerable success. Although the capital programme remains over committed, there is a clear line of sight to delivering the plan in line with the Trust's agreed CDEL limit. This will continue to be managed through the normal business case approval processes, and will be subject to scrutiny, governance, and approval by Capital Investment Group (CiG) and/or Business Case Scrutiny Panel (BCSP).

IM&T Programme update

The Committee **RECEIVED** the Quarter 3 IM&T Programme Report on the Trust's wide-ranging IM&T programme of work. The Committee **NOTED** the update provided by the Chief Information Officer that included project status and the pipeline of work.

Following the two Data Centre incidents leading to a business continuity challenge in June 2023 and January 2024, the Committee discussed the learning from the events and the choices over the future approach that represent an opportunity to improve resilience.

The Committee heard about the Trusts' submission for the Data Security and Protection Toolkit to be delivered by December 2023 and was pleased to note the 'Standards met' declaration.

The Committee **NOTED** that digitising activity within the Trust was beginning to show benefits for care and in clinical communications and the Committee will receive a future report showing the time released for care. There had been considerable progress with the My Healthcare record with 30% of patients signed up able to self-serve and this aids communications and will links with the NHS App. The Committee welcomed the engagement activities taken by the information team across the Trust.

The Committee was **ASSURED** that a Data Quality Group had been established and recognised the contribution quality data has in supported patient care as well as the robustness of financial information.

Electronic Patient Record

The Committee **NOTED** that there had previously been a change to the profile of funding for the Electronic Patient Record (EPR) investment and the Committee had endorsed the mitigating arrangements that had some impact on the cost envelope and capital and revenue expenditure.

The Trust has received a letter of support from the Integrated Care Board as requested by NHSE.

Commercial Activities Update

The Committee **NOTED** the update on the activities of the Commercial Directorate over quarter 3 that were wide ranging and includes leading the innovation work-stream as part of the Research and Innovation strategy. Progress on this is reported to the Research and Innovation Committee.

The Committee **NOTED** that for 2024/25 a commercial revenue pipeline is being collated which will track the financial targets for commercial work-streams. The Committee also reviewed and acknowledged reported procurement and other commercial risks including the potential for missed opportunities.

The Committee **RECEIVED** an update on procurement and supply chain projects and deliverables and the development of the procurement strategy which will be presented for approval by the Sustainability Committee later this year along with KPIs. The Committee discussed developments including the potential introduction of an inventory management system and the benefits this would bring.

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 innovative work in conjunction with universities and entrepreneurs.

Risks and Board Assurance Framework (BAF)

The Committee **NOTED** the quarter 3 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 reviewed the BAF risks it has oversight of, and **AGREED**, having regard to both the BAF summary and the Committee's consideration of the risks considered during the meeting, that the quarter 3 2023/24 scores for risks 2.2 and 2.3. remained unchanged and fairly stated going into quarter 4 at their target risk score. The Sustainability risk at 2.3 remains at its target score reflecting that the Annual CO2 reduction trajectory has now been set to meet Trust Green Plan reduction target for 2025 and monthly reporting against target is in place.

At the January meeting the Committee **AGREED** to maintain risk 2.1 at the score of 20 (following its increase noted at November Board) 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. This recognises both the current performance and the requirement to update the 2023/24 forecast outturn; as a result of Q3/Q4 additional unplanned industrial action and change in elective recovery targets. There also are a number of highly scored supporting risks covering operational pressures and workforce constraints which are impacting on operational costs and productivity.

Referrals to other Committees

The Committee considered the reports and presentations it received at this meeting and **agreed** there were no matters that they wished to refer to other Committees.

Key Recommendation(s):
The Board is asked to **NOTE** the assurances received at the Committee and the actions taken of the Committee within its terms of reference. The Board is asked to **NOTE** the Committee recommendation that the BAF risks 2.1, 2.2 and 2.3, for which it has oversight, are fairly represented.

SUSTAINABILITY COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	**30 November 2023**	**Chair**	Lizzie Peers	**Quorate**	Yes
Meeting Date	**1 February 2024**	**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 3 2023/24 -Updates Provided in November on Month 8	**Nov**	**Jan**	**Presenter** Director of Finance	**Purpose** For assurance	**Outcome /Action taken** Noted position and significant key risks.
Financial Forecast	**Nov**	**Jan**	**Presenter** Director of Finance	**Purpose** For information	**Outcome /Action taken** Noted. Reviewed mitigated forecast outturn and key risks
ICS Financial Report		**Jan**	**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.
National Cost Collection Submission		**Jan**	**Presenter** Director of Finance	**Purpose** For information	**Outcome /Action taken** Noted submission made.
Sustainability Breakthrough Objective Productivity -Updates Provided in November on Month 8	**Nov**	**Jan**	**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 positive performance and continued risks to delivery and the impact of industrial action.
Sustainability Strategic Initiative		**Jan**	**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 continues to require a significant step change to deliver in year
Corporate Project Estates Strategy & Master Planning		**Jan**	**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
Efficiency & Transformation Programme. Updates provided in September on Month 8	**Nov**	**Jan**	**Presenter** Chief Finance Officer in absence of 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 associated risk
Capital Investment Progress Report Q3 2023/24		**Jan**	**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 Q3 end and revised full-year forecast outturn position.	**Outcome /Action taken** Noted the source of funds secured. Noted agreed overprogrammed capital plan has been mitigated significantly
Commercial Progress Report Q3 2023/24		**Jan**	**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 Q3 and how these align to our Trust strategy.
IM&T Programme Progress Report Q3 2023/24	**Nov**	**Jan**	**Presenter** Chief	**Purpose** For information	**Outcome /Action taken**

- Data Centre in November and January - Data Security & Protection toolkit submission 2023/24 (Jan)			Information Officer		Noted the programme update. Noted Network Critical Incident learning and considerations for future opportunities and resilience, with risks and re-instatement. Noted the update and agreed to flag this elevated risk to the Board. Noted Standards Met DSPT submission.	
Electronic Patient Record Programme - NHSE funding rephasing (Nov) - Project Charter (Jan) - Letter of support from NHS Sussex (Jan)	**Nov**	**Jan**	**Presenter** Chief Information Officer	**Purpose** To endorse	**Outcome /Action taken** To Board for Noting revised case. - Noted the letter of addendum and revised timelines for OBC approval by and associated delay to publication of ITT - Noted EPR Charter - Noted letter confirms system support - Noted the progress made to date on engaging staff	
Worthing Heat Network		**Jan**	**Presenter** Director of Estates and Facilities	**Purpose** To endorse	**Outcome /Action taken** Noted financial impacts, benefits and risks and options appraisal. Agreed to support recommendations. To Board for approval.	
Financial Core Gap 2024/25		**Jan**	**Presenter** Director of Finance	**Purpose** For information	**Outcome /Action taken** Noted in conjunction with the Month 9 financial position and roadmap. Noted the next steps in the development of the core gap.	
Trust Risk Register relating to Sustainability		**Jan**	**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		**Jan**	**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 going into quarter 4.	
Items to come back to Committee / Group (Items Committee / Group keeping an eye on)	
Items referred to the Board or another Committee for decision or action	
Item	**Date**
None The proposals for the Worthing Heat Network and update on the Electronic Patient Record Programme are referred to the Board meeting in Private	

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	14.	**Meeting:**	Trust Board	**Meeting Date:**	February 2024
Report Title:	Systems and Partnerships Committee Chair report to Board				
Sponsoring Executive Director:	Bindesh Shah, Committee Chair - Non-Executive Director				
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	N/A	Assurances in relation to risk 5.1, 5.2 and 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 enhanced the frequency of its meetings and met in November 2023 as well as its originally scheduled meeting of January 2024.

The November meeting was quorate, attended by three Non-Executive Directors and the Chair for the first part of the meeting and five executives, the Chief Finance Officer, the Chief Operating Officer, the Chief Governance Officer, the Chief Strategy Officer and the Chief Executive, in attendance to present the relevant performance reporting were the Managing Directors for Planned Care & Cancer and Urgent and Emergency Care. The Director of Performance Information was also in attendance. This meeting received the performance report covering, emergency access, RTT, Cancer and diagnostics. This report covered the Teir 1 improvement actions for RTT and Cancer.

The January meeting was quorate, attended by four Non-Executive Directors and the Chair and three executives, the Chief Finance Officer, the Chief Operating Officer and the Chief Strategy Officer. The meeting was attended by the Managing Directors for Planned Care & Cancer and Urgent and Emergency Care and the Director of Performance. The Director of Strategy and Planning and the Hospital Director for PRH and Clinical Lead for PRH and the Chief of Service attended to provide an update on their respective reports.

The January meeting was a full quarterly Committee meeting and covered all the areas within the Committee's remit including the Q3 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. The meeting also received reports in respect of a recent discharge peer review, an update on the PRH ED improvement projects along with information on the 2024/25 planning guidance and an update on the ICB's approval of the Stroke Reconfiguration Decision Making Business Case. The Committee also received the standing items of the Systems and Partnerships key risks and the Board Assurance Framework and the planned Emergency Planning and Preparedness Response Annual Report.

The key areas of activity undertaken at the Committee is summarised below noting the full breath of the meeting's activity is included within the meeting summary table attached to this 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 December (quarter 3) including a reflection on the challenges impacting on the Trust's operational performance.

The Committee **discussed** the Trust's performance across quarter 3 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 performance worsened for the quarter. The Committee discussed the work being undertaken and the developing detailed action planning where trajectories are developed to bring the performance to the required performance levels. The Committee **noted** the continued oversight over A&E performance recovery and **noted** the joint working with system partners being undertaken 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 Chief Operating Officer and Managing Director for Planned Care and Cancer on the Trust's developed RTT recovery and Cancer delivery plans, and the Committee **noted** that the Trust is meeting its improvement targets, with improved positions for both RTT and Cancer.

In December the Trust's position in respect of the RTT waits saw again a reduction in the total number waiting which had now been sustained for the whole quarter and noted that the actions being taken in respect of Cancer is seeing the Trust achieving the recovery trajectories. The Committee **noted** the actions being taken and the performance reporting including that to NHS E through the tiering meetings and noted that the improving position.

The Committee through the report and presentation was **assured** over the programme of work and oversight being applied to the delivery of performance recovery plans, **noting** the level of risk from operational pressures and should there be any further industrial action and how this supports the strategic risk 5.3 remaining at 20.

3Ts

The Committee **received** an update on this programme, recognsing that the work continues on the development of stage 2. The Committee **noted** the work being undertaken to complete the commissioning of the final elements of stage 1 and that the RSCH Hospital Director is overseeing the delivery of the stage 1 business case benefits and noted that benefit KPIs have been developed for each service who occupy this building along with wider estates benefits. The Committee **noted** that the output of the benefit realisation work will report back to the Sustainability Committee as part of the developed process for approved business cases.

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 gained in the first and second phases and the project is moving now into its third phase which is working through 24 pilot wards to establish standard ways of working to support patients to leave earlier in the day utilising the finding from the earlier phases to secure cultural change within the ways of working. The Committee **agreed** that securing cultural change is important to deliver the project's outcomes. The meeting **noted** the interconnectivity of this project and the reducing length of stay 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 which has seen the development of a discharge standards pack. 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** the expected impact on the reduction to the bed base has not been achieved.

Patient Access Transformation

The Committee **received** a report from the Managing Director for Planned Care and Cancer, as the project Senior Responsible Officer (SRO), on this corporate project. The Committee **noted** the breadth of the project and the developed improvement workstreams and noted the project governance overseeing the delivery of this project. The Committee **noted** the technical challenges encountered in the delivery of the enhanced booking processes which has seen some delay to the programme and **noted** that a further workstream is being added to the programme to ensure that there enhanced validation within the booking processes. The Committee **endorsed** the importance of standardisation of processes to the achievement of the project goals.

Princess Royal Hospital (PRH) Service Improvement

The Committee **received** an update from both the Hospital Director and Clinical Lead for PRH on three improvement initiatives initiated at PRH, these relating to the Ambulatory Clinical Decision Unit and Rapid Assessment and Treatment and Urgent Treatment Centre projects. The Committee reflected on and **noted** how the presentation of these projects aligned to the Emergency Care improvement areas referred to within the routine reporting through to the Committee. The Committee were informed that the UTC pilot had resulted in an increased positive patient experience being reported.

Emergency Planning and Preparedness Response (EPRR) Annual Report

The Committee **received** the Trust's annual report and reflected on the assurance provided by the formal review undertaken by NHS Sussex in respect on the Trust's EPRR processes with their judgement being that this resulted in a substantially complaint rating for the Trust. The Committee **agreed** to recommend to Board for approval (the report is attached as appendix 1)

Discharge Processes

The Committee **received** a report and update from the Chief Operating Officer infirming the Committee that the Trust had taken part in peer review process to drive learning and understand systematic matters within the discharge processes within and without the hospitals to be addressed in the discharge front runner programme. The Committee **noted** the actions being taken from this review and were assured these actions will bring benefit to patients in Sussex along with **noting** the achievements being delivered in the Trust.

Risk and Board Assurance Framework oversight

The Committee reviewed the quarter 3 Systems and Partnership Risk Paper and **noted** the risks detailed within the report aligned to the reports and discussions at the Committee meeting and correlated with the BAF.

The Committee **agreed** that the scores relating to BAF risks 5.1, 5.2 and 5.3 for the start of quarter 4 were fairly represented endorsing that the scores for each of these risks remain at their quarter 3 scores which sees risk 5.3 remain at 20.

Key Recommendation(s):

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

The Board is asked to **NOTE** the Committee recommendation that the BAF risks 5.1, 5.2 and 5.3, for which it has oversight, are fairly represented.

The Board is asked to **APPROVE** the Trust's Emergency Planning and Preparedness Response Annual Report based on the recommendation of the Committee noting the corroborating positive assessment of the Trust's process by the ICB *(appendix 1)*

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SYSTEMS AND PARTNERSHIPS COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	**29 November 2023**	**Chair**	Bindesh Shah	**Quorate**	Yes
Meeting Date	**1 February 2024**	**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 which support the strategic risk score remaining at 20
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 delays in this project and action taken
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 and the positive impact this diagnostic capacity
Strategic Initiative – 3Ts	**Presenter** Chief Financial Officer	**Purpose** For information and assurance	**Outcome /Action taken** Noted
PRH ED services improvement	**Presenter** PRH Clinical Lead and PRH Hospital Director	**Purpose** For information and assurance	**Outcome /Action taken** Noted
Update on 2024/25 planning guidance	**Presenter** Director of Strategy and Planning	**Purpose** For information	**Outcome /Action taken** Noted that whilst the guidance is outstanding there is a need to produce our plan as part of the system plan.
Stroke Decision Making Business case	**Presenter** Director of Strategy and Planning	**Purpose** For information	**Outcome /Action taken** Noted the ICB has approved this case

EPPR annual report	**Presenter** Director of Strategy and Planning	**Purpose** For agreement to present to Board for approval	**Outcome /Action taken** Recommended to Board for approval (appendix 1)
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 systems and partnerships strategic risks for quarter 4 are fairly stated.

Actions taken by the Committee within its Terms of Reference	
The Committee **AGREED** to recommend the opening quarter 4 score for BAF risks 5.1 to 5.3 to the Board, noting the changes to these risk scores in this quarter. The Committee **AGREED** to recommend to the Board for approval the EPPR annual report	
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, but it was asked that the within the reducing length of stay project update how this is not seeing the desired in reduction in beds.	
Items referred to the Board or another Committee for decision or action	
Item	**Who / when**
The Board recommended to the Board that they **APPROVE** the Trust's Emergency Planning and Preparedness Response Annual Report noting the corroborating positive assessment of the Trust's process by the ICB *(appendix 1)*	Board 8 February 2024

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EMERGENCY PREPAREDNESS, RESILIENCE and RESPONSE ANNUAL REPORT 2023

Mark Stevens, Head of EPRR

1. INTRODUCTION

1.1 This report describes the Emergency Preparedness, Resilience and Response activities of University Hospitals Sussex NHS Foundation Trust during 01 January 2023 and 31 December 2023 to meet the requirements of the Civil Contingencies Act 2004 and the NHS England emergency preparedness framework.

1.2 The Civil Contingencies Act (2004) outlines a single framework for civil protection in the United Kingdom. Part one of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparedness and response.

1.3 University Hospitals Sussex NHS Foundation is subject to the following set of civil protection duties:

- assess the risk of emergencies occurring and use this to inform contingency planning.
- put in place emergency plans.
- put in place business continuity management arrangements.
- put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency.
- share information with other local responders to enhance coordination.
- cooperate with other local responders to enhance coordination and efficiency.

1.4 The NHS England emergency preparedness, resilience and response framework requires all NHS organisations to plan for and respond to incidents in a manner which is relevant, necessary, and proportionate to the size and services provided by the Trust to ensure effective arrangements are in place to deliver appropriate care to patients affected during an emergency.

1.5 The NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) are the minimum standards which NHS organisations and providers of NHS funded care must meet to ensure they are able to respond to a wide range of incidents and emergencies that could affect health or patient care.

1.6 In December 2022, the Government published the UK Resilience Framework which sets out an ambitious new vision and approach to the UK's resilience up to 2030, and as such, a full review of the Civil Contingencies Act 2004 is underway.

1.7 Nationally, there is a high level of focus with the increasing amount of guidance and expanding range of threats that organisations must be prepared for. It is essential that there is a continued focus on the Trust's Emergency Preparedness and Business Continuity arrangements. It is important that the Trust maintains and continues to advance its reputation within the EPRR arena and contributes towards the Region's Preparedness.

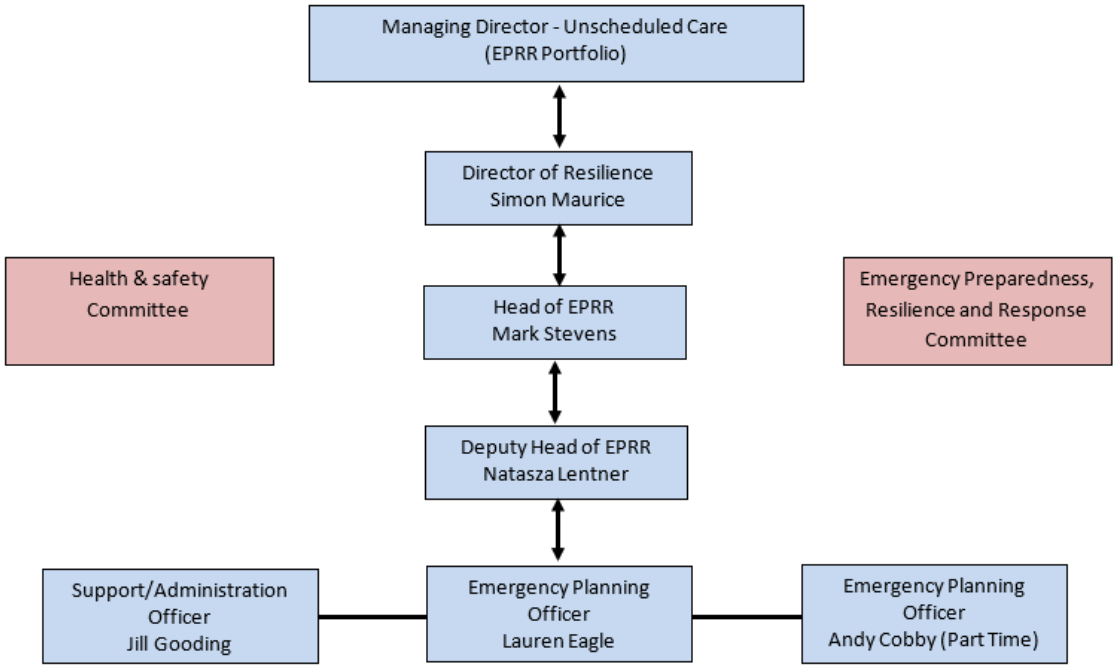
2 CONTEXT

2.1 This report details work undertaken over the last year to ensure the Trusts readiness and resilience in response to any type of disruption or emergency event which may impact upon service delivery and covers the following key areas:

- Risks
- Assurance
- Policies and Plans
- Business Continuity
- Training and Exercising

2.2 It should also be noted that in August 2023, the EPRR team was subject to a restructure with the new structure better aligned to serve the whole of the Trust moving away from the EPRR structures that were carried across from the legacy trusts. The new structure is shown in the chart on the following page.

2.3 New EPRR Team Structure as of September 2023.



3 MAIN REPORT

3.1 Risk

3.1.1 Risk management is covered within the Civil Contingencies Act 2004 and is the first step in the emergency planning and business continuity process. It ensures that local responders make plans that are sound and proportionate to risks.

3.1.2 The National Security Risk Assessment (NSRA) and the National Risk Register (NRR) are reviewed every 2 years. The NSRA was published in autumn 2022 and the NRR was published on 03/08/2023.

3.1.3 The risks included in these assessments are considered at the Local Resilience Forum and plans, policies and procedures are developed in line with the most likely and highest impact risks.

3.1.4 The Government published the updated National Risk Register on Thursday 3rd August 2023; a copy of the document can be found here:

- National Risk Register 2023

3.1.5 This iteration, compared to previous versions outlines many of the Risks the UK faces in much more detail with a lot more transparency. Much of the content and context within this version was previously limited to those who had been vetted to have access to “Official Sensitive” documentation. This marked change is welcoming and will mean that we can share much more detail with our colleagues during training & exercising and with the communities we serve which supports the governments aspirations to become the most resilient nation in the world by 2203 through their vision of a Whole Society approach to Resilience.

3.1.6 The publication of these risks will support the requirements of the Trust to consider these risks corporately in line with the Core Standards for EPRR. An Emergency Preparedness, Resilience and Response Corporate Risk sits on SHE – Assure Risk Management system for Safety, Health and Environment and lists all Trust Emergency Planning and Business Continuity risks in line with risks identified on the National Risk Register and Local Community Risk Register in collaboration with NHS Sussex and Sussex Resilience Forum.

3.1.7 UHSussex is represented by the EPRR Team on both the Sussex Resilience Forum Risk Group and the Local Health Resilience Partnership Risk Task and Finish Group. The EPRR team are also members of the UHSussex Health and Safety Committee.

3.1.8 All Emergency Planning and Business Continuity Risks as cited in the EPRR Corporate Risk on SHE – Assure Risk Management system for Safety, Health and Environment and are listed as individual risks on the IQ Datix system. These risks are reviewed and updated on an annual basis or as required following an incident or update to the risk registers mentioned or any change in relevant national guidance.

3.1.9 Current Emergency Planning and Business Continuity risks on Datix are:

- Pandemic Influenza or other new and emergency pandemic
- Multiple or Mass Casualty Incident
- Incident involving CBRN or Hazardous material.
- Adverse Weather
- Evacuation
- Lockdown
- Business Continuity – service disruption affecting critical services.

3.2 Assurance

3.2.1 The minimum requirements which commissioners and providers of NHS funded services must meet are set out in the NHS England core standards for Emergency

Preparedness, Resilience and Response. The accountable emergency officer in each organisation is responsible for ensuring these standards are met.

3.2.2 As a direct result of the Emergency Preparedness, Resilience and Response team working extensively with NHS Sussex, the EPRR Assurance Process for UHSussex returned a substantially compliant rating which was endorsed and validated by the NHS Sussex EPRR Team with recognition of the Trust EPRR team for the work undertaken in the Assurance process to attain this rating and develop a comprehensive action plan going forward.

3.2.3 Out of the total of 62 Core Standards which are relevant to Acute Trusts, the Trust was fully compliant with 59 of the standards with the remaining 3 being partially compliant as detailed below:

- CS15 Duty to maintain Plans – Mass Casualty. Although the Trust was fully complaint last year with this core standard, and has legacy Mass casualty Plans, which have been reviewed, updated following merger and each plan placed into the Trust format, it has not been possible to merge these plans into a single UHSussex Mass Casualty Plan and so the compliance rating was downgraded to partially compliant.

  To progress this piece of work, a Trust Multiple and Mass Casualty Steering Group has been established and further work is being carried out to add addendum plans to the main plan for specific key clinical areas/departments.

  Further liaison is also being planned with the Sussex Trauma Network to ensure that the Trust Multiple and Mass casualty Plan and the Sussex Trauma Network Mass Casualty Plan are consistent with the EPRR Team attending the Sussex Trauma Network CAG.

- CS16 Duty to maintain Plans - Evacuation and Shelter. The legacy WSHFT Evacuation and Shelter Plan has been updated and redrafted as a UHSussex Evacuation and Shelter plan taking into consideration the recent guidance and updated in line with NHSE Evacuation and shelter guidance for the NHS in England.

  But due the extensive 3T's building work to the further work required to confirm / identify suitable assembly points and evacuation clearing stations at the RSCH site, so this standard was kept at partially compliant with the Evacuation and Shelter Planning Group being tasked to progress this in

line with the agreed action plan and within the time frame specified in the EPRR Work Stream.

- CS49 Business Continuity - Data Protection and Security Toolkit. The Data Security and Protection Toolkit is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards.

  All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly.

  For the EPRR Assurance, the Trusts Information Technology department need to certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.

  The Trust Head of Information Governance & Data Protection Officer confirmed that unfortunately the Trust was not complaint with the DPST and had submitted an 'Approaching Standards DSPT for 2022-23', which was supported by a robust improvement plan which was approved. by the South-East Cyber Security Specialist on the 21st of July.

  As of the 2nd October it was confirmed that the Trust was on target to complete the Improvement Plan by the 31st of December 2023 and on the 11th January the Head of Information Governance & Data Protection Officer confirmed that the Trust had successfully completed the DSPT 2022-23 Improvement Plan which NHS England have moved to 'Standard Met' but not in time to be complaint with the EPRR Assurance Core Standard.

  EPRR have discussed the requirement for the DPST for 2024/25 in order to be compliant with the 2024 EPRR Assurance, and the Trust Head of Information Governance & Data Protection Officer has confirmed that this is due on the 30th June 2024

3.2.4 Although the UHSussex EPRR team has worked with NHS Sussex EPRR to retain a substantially compliant rating for the 2023 Assurance, it was noted that there are a number of advisories and a number of partially compliant standards which have been added to the EPRR Workstream for 2024 to ensure that these are addressed prior to the 2024 Assurance process.

3.2.5 A detailed work plan has been established to deliver the work in good time for the next assessment. It should be noted that for this year's assurance, that there are no core standards that the trust is non-compliant with and only three partially compliant.

3.3 Policies and Plans

3.3.1 The Trust has a mature suite of legacy policies and plans to deal with EPRR Issues and specifically Critical, Business Continuity and Major Incidents as defined by the NHS England Emergency Preparedness Resilience and Response (EPRR) Framework.

3.3.2 All EPRR policies and plans have been reviewed and updated to ensure that they are current and conform to current guidance and legislation and are relevant to UHSussex.

3.3.3 The EPRR Work Stream for 2024 lists all of the EPRR policies and plans with review dates and those required for review and update during 2024 have been identified.

3.3.4 It has long been identified that the Trust did not have a specific On Call Policy, and this was flagged as a concern/advisory during the 2022 EPRR Assurance process, as a result of this, and in liaison with the managing director for Unscheduled Care, EPRR undertook the project to research and develop an On Call Policy which was drafted by the Head of EPRR and was approved at the Trust Management Committee on the 23rd November 2023.

3.3.5 The Senior Management On Call Policy will bring clarification and consistency to the On Call process across the Trust and will enhance the Trusts ability to respond to incidents both during and out of hours.

3.3.6 A chart showing all current EPRR Polices and Plans as listed in the EPRR Policy is shown as Appendix A for information.

3.4 Business Continuity

3.4.1 Business Continuity procedures continue to be embedded in the Trust with clear and comprehensive separate EPRR and Business Continuity Management policies which provide a clear division between policy and operational plans.

3.4.2 The following documents have been reviewed and updated during 2023 and approved for UHSussex:

- Business Continuity Management Policy
- Corporate Level Critical Activities
- Trust Business Continuity Plan

3.4.3 Following the IT Critical Incident in June 2023, Staff awareness with regards to Business Continuity increased and EPRR has been working with individual departments to ensure that business continuity service level plans have been reviewed/updated as necessary following the incident.

3.4.4 There have also been a number of declared business continuity incidents throughout the year which has helped raise staff awareness and identified any areas of concern which need to be addressed.

3.4.5 It is the responsibility of the individual department to update their individual business continuity service level plans and notify the Emergency Preparedness, Resilience and Response team when documents have been updated. However, due to exceptional operational pressures and changes associated with the new operational structures, some departments have further work to carry out to complete their plans and EPRR continue to liaise with these departments in an effort to progress any outstanding plans.

3.4.6 The EPRR team has been focusing on departments specifically affected by the IT Critical Incident in June 2023 and will continue to work through services and meet with identified leads to ensure that all plans are updated.

3.4.7 The EPRR team will continue to focus on the following to ensure that Business Continuity and associated service level plans are up to date:

- Trust wide Template to be reviewed and updated following lessons learnt from recent incidents and feedback from service level leads.
- All service level plans to be transferred to new Trust-wide template at point of next annual review.
- All service-level plans to be merged from separate legacy plans into trust-wide unless inappropriate or not practicable to do so.
- All plans, unless not appropriate to share, to be stored in EP and BC Plans folder on SharePoint.
- Training and exercising programme for BC to be incorporated into EPRR Training and Exercising schedule.
- Learning from Critical IT incident(s) and ongoing review and remediation work to be incorporated into UHSX Business Continuity planning.

- Continue to work with IT to ensure that the IT Disaster Recovery Plan and departmental service level plans are fully developed, reviewed and updated.

3.5 Training and Exercising

3.5.1 With the restructure of the EPRR Team in August 2023, it has been possible to task two members of the team to focus specifically on Training and Exercising in an effort to progress and enhance both these areas and ensure that staff who are required to perform a specific role during an incident have received the necessary training for that role.

3.5.2 As a result of the above, during 2023 and continuing during 2024 the EPRR team have been able to:

- Update current EPRR training for on call staff.
- Provide 7 strategic level courses with 11 senior staff trained,
- Provide 12 tactical level courses with 22 managers trained.
- Develop the exercise schedule for on call staff to enable them to attend an exercise before going onto the on-call rota with tabletop exercises being scheduled monthly during 2024.
- Have on call staff work towards meeting the NHSE minimum occupational standards (MOS) as required by the EPRR Assurance.
- The ICB PHIC (Principles of Health Command Training) course has been made available to all on call managers, directors, and exec staff with a number attending the course during 2023.
- EPRR have also been attending the Manger on Call forums and providing scenario based exercising and training in these forums as requested.
- EPRR continue to work with the Trust Learning and Development Team and move the on-call training theory across to eLearning which will enable staff to access at times to suit individuals and all EPRR training is being moved onto IRIS and will soon have an EPRR training home page with the following EPRR eLearning is currently available to staff:

    - A new induction eLearning package has been created and is available for all staff on the induction welcome page.
    - Due to the increase in services at Southlands, an eLearning package for service/department leads at Southlands Hospital with initial guidance as to how to deal with an incident has been created and available to staff online.
    - eLearning package for reception staff to manage patients who attend with injury/illness due to hazardous materials.

- A guide to writing a service level business continuity plans.
- Additional eLearning packages are in the process of being designed to compliment the practical sessions that are available.

- EPRR have continued to provide loggist training for staff who may act as loggists for the on-call managers and directors during an incident and 5 courses have been run during 2023.

3.5.3 HazMat/CBRN decontamination training for staff has continued during 2023 with training being rolled out to ED staff at both Worthing and St Richards with the following courses being run during 2023:

- WH and SRH - 18 courses with 72 staff trained.
- RSCH and PRH - continue to run their in-house training for their ED staff which is monitored and collated by EPRR.

3.5.4 In June 2023, a HazMat/CBRN decontamination exercise was held at RSCH which was very successful. RSCH are now working through their identified learning to improve their plans going forward.

3.5.5 The EPRR Team continue to provide training when identified for Director on Call, On Call Manager and Loggists where necessary on a 1:2:1 with individuals with classroom-based courses now being planned and phased in.

3.5.6 The NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework requires NHS Providers to undertake a number of specific emergency planning and business continuity exercises and these requirements have been detailed in the EPRR Workstream for 2024.

4 Incidents

4.1 The Trust responded to a number of incidents during 2023 which included the following:

- Adverse Weather
- Business Continuity Incidents
- Industrial Action
- LMB Loss of Water
- Power outages
- Pharmacy Fungal Incident

- IT Critical Incident
- Heating and Hot Water Issues at Worthing
- RAAC issues
- Power/Generator issues at SRH

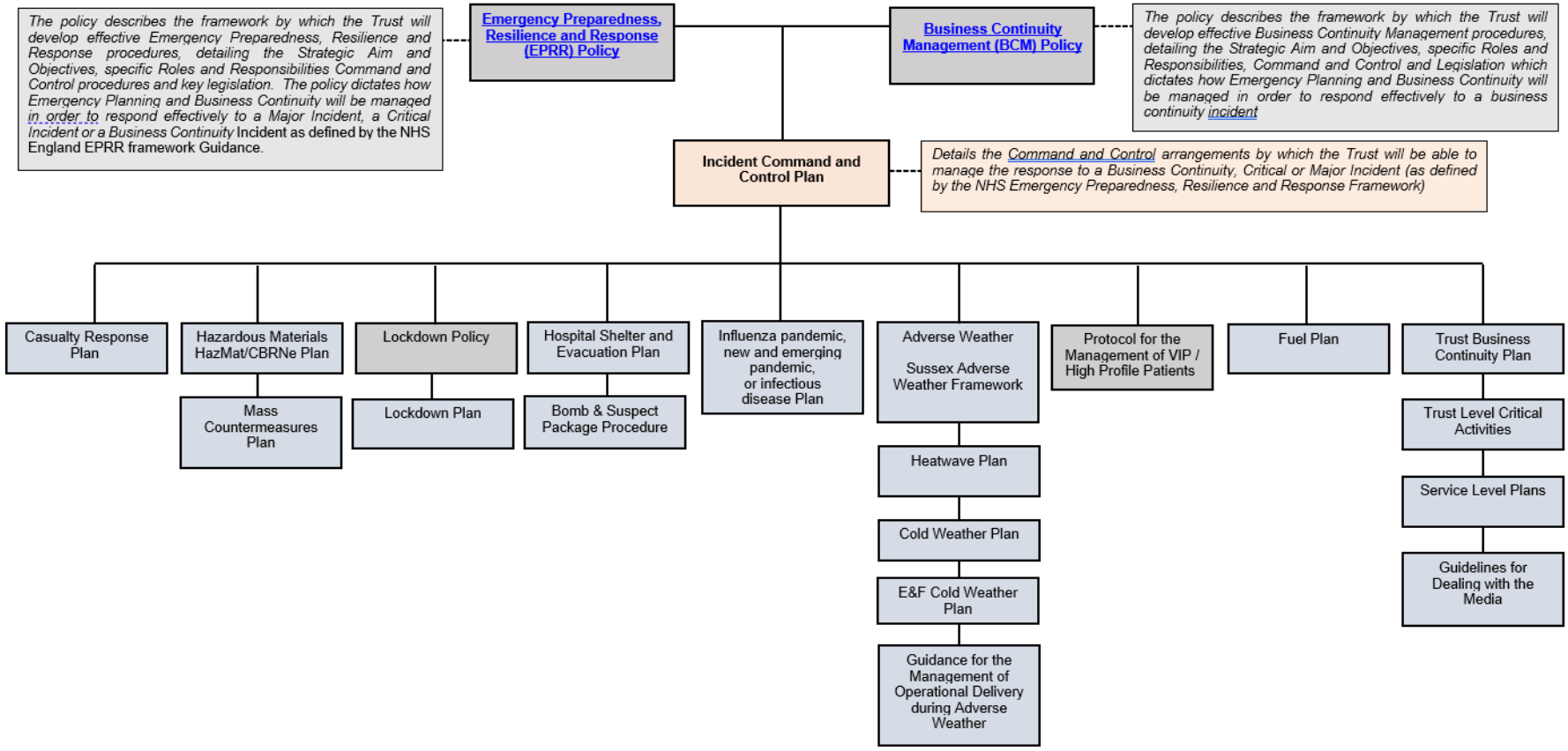
4.2 It has been increasingly difficult to hold specific debriefs following some incidents due to operational pressures and Industrial Action and although some AAR's have been completed, some are still outstanding and due to this, EPRR have circulated debrief Proforma's to key staff for completion and these have then been collated by EPRR and any lessons to be learnt incorporated into training and processes as appropriate.

5 NEXT STEPS

6.1 Key activities for the next year:

- To work through the updated EPRR Work stream for 2024 to ensure that all EPRR Assurance advisories are completed prior to the 2024 Assurance.
- Continue to work with Lockdown Planning Group to progress the Lockdown Plan for UHSussex
- Continue to work with Fire Safety and Estates and Facilities to progress the Shelter and Evacuation Plan for UHSussex for completion for the 2024 EPRR Assurance
- Continue to work with the Mass casualty Sterring group to progress and finalise the Trust Mass casualty Plan and action cards/departmental service plans for completion for the 2024 EPRR Assurance.
- Continue to review and update all EPRR Polices and Emergency Plans as appropriate during 2024.
- Review Business Continuity Service Level plans to ensure that all departments are compliant during 2024.

Appendix A - Current EPRR Polices and Plans as listed in the EPRR Policy:



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Agenda Item:	15.	**Meeting:**	Public Board	**Meeting Date:**	8 February 2024
Report Title:	Report from Quality and Safety Improvement Programme Committee meeting held on 31 January 2024				
Committee Chair:	Paul Layzell – NED and QSIP Committee Chair				
Author(s):	Paul Layzell – NED and QSIP 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	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 QSIP is to secure assurance that the Trust's systems support enhanced patient experience
Sustainability	Yes	The QSIP complements the oversight of the Trust's use of resources
People	Yes	The QSIP is to secure assurance that the delivery of this programme is aligned to the Trust's people plan
Quality	Yes	The QSIP is to secure assurance that the Trust's systems support the provision of high quality care
Systems and Partnerships	Yes	The QSIP is to support the provision of assurance from the Board to external stakeholders
Research and Innovation	N/A	Not directly

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 has entered into a number of undertakings with NHS E and as part of these the Board has agreed to establish robust oversight over the delivery of those undertakings. The Trust is also required to provide assurance of the undertakings delivery and the QSIP committee is integral to flow of assurance over delivery to the Board to then engage with NHS E and the ICB.

Communication and Consultation:

The Quality and Safety Improvement Steering group received the workstream updates from their meetings in January which supported the reporting to this Committee.

University Hospitals Sussex
NHS Foundation Trust

Report:

The Committee met on the 31 January 2024 and was quorate as it was attended by three non-executives and the chairman and all executives with the exception of the Chief Executive who was away from the Trust for this meeting.

The meeting received its scheduled updates from each of the delivery and enabling workstreams along with the programme risk register and the developing programme delivery scorecard.

The Committee received a detailed update on the developing KPI metrics and the delivery scorecards and were assured over their design not duplicating the current quality and performance scorecards used by the other Board Committees. The meeting endorsed that the programme scorecard is to include process improvement metrics with the outcome measures continuing to flow to the other Committees within their established scorecards. The Committee noted that the programme continues to improve the visibility within the Trust's business as usual quality and safety outcome reporting the effectiveness of the improved processes driven through the work of the quality and safety improvement programme.

The Committee received a progress update for each of the programme's four workstreams, noting for each of these appropriate governance and oversight of delivery has been maintained. The Committee noted that each workstream has commenced delivery and was assured that teams were conscious of the dependencies between the workstreams, especially in respect of the cultural improvement work which sits outside QSIP.

The Committee sought a more detailed workstream resourcing plan for the next meeting, recognising that there will be a further resourcing requirement for ongoing, business as usual, maintenance and use of the emerging Compliance Assurance Framework.

The Committee received a report from the Director of Communications and Engagement which provided assurance over the communications plan supporting this programme. The Committee noted the breath of engagement that had taken place across January and the forward plan which focuses not only on communicating what the purpose of the programme, but also how the programme will support the respective teams in being able to know and demonstrate the delivery of the Trust's ambition to provide excellent care every time.

The Committee received the programme risk register and noted that this will be reviewed and updated at the Programme Steering Group.

Recommendations

The Board is recommended to:-

NOTE the development of the programme delivery scorecard and associated workstream metrics which will complement the routine performance and quality scorecards already in use.

NOTE the progress being made by each workstream recognsing that each workstream is at an early stage in delivering it stated objectives.

University Hospitals Sussex NHS Foundation Trust

Agenda Item:	16.	**Meeting:**	Board	**Meeting Date:**	8 February 2024
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 have a functioning and effective audit committee. The Audit Committee is established to support the Board in securing assurance over the Trust's governance, risk management and internal controls systems.

Communication and Consultation:

Report:

The Audit Committee met on the 16 January 2024 and was quorate as it was attended by six Non-Executive Directors. In attendance were the Chief Financial Officer, the Chief Governance Officer, the Chief People 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 Trust's Director of Workforce Planning & Deployment attended in respect of the LCFS proactive exercise report.

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 that the proposed quarter 4 scores had yet to be scrutinised and approved by the respective oversight committees and therefore asked that for the proposed reduced risk for the quarter in relation to People the supporting assurances are tested at the Committee ahead of making a recommendation to the Board. The Committee reflected on the supporting process of Committee oversight and their work in respect of the oversight of actions where risks are not achieving their target score along with the work of the recently established executive led risk oversight group and their review of the BAF. It was agreed that the future report will make these processes explicit along with recording the dates of the latest receipt of key sources of assurance.

The Committee noted the continued process for updating the BAF and recognised through discussion the drivers of the respective continued elevated risks, noting many had been flagged at the last quarterly update.

The Committee noted the positive impact the recently created risk oversight group is having on the level of risk review being undertaken by the respective risk owners albeit there remains work to be undertaken to continue to mature the Trust's risk management processes. The Committee also noted the developing business partnering approach being taken to support divisions with their risk oversight, review and datix update processes.

Internal Audit activity

The Committee noted the positive opinion on the Trust's overseas visitors and private patient income systems along with the positive conclusion in respect to the Trust's processes in support of its year 5 maternity incentive scheme and the advisory recommendations made in respect of the Trust's EDI maturity. The Committee referred the oversight of the delivery of the EDI recommendations and therefore the improvement in the Trust's processes to the People Committee.

The Committee noted the Internal Auditors follow up report continued to show good levels of engagement with Internal Audit to provide the evidence of action delivery or a sound rationale for any date changes. The Committee noted the update from the auditors on the reduced levels of overdue actions and that for each with a revised date the auditors view that these did not pose a significant internal control risk.

Local Counter Fraud

The Committee considered the Local Counter Fraud progress report for Quarter 3 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 proactive work undertaken by the local counter fraud team in respect of the Trust's pre recruitment checks. The Committee received assurance from the Trust's Director of Workforce Planning & Deployment on the actions being taken to address the recommendations.

External Audit

The Committee noted the progress report and the action undertaken in respect of their 2023/24 planning work which was substantively completed prior to Christmas. This has allowed a draft audit plan to be prepared and presented which reflected the External Auditor risk assessment relating to audit risk noting that the significant risks were those standard for all NHS bodies. The Committee noted the work proposed by External Audit on both the financial statements and VFM conclusion and approved the plan. The Committee noted the declaration made by external audit that auditor independence has been maintained.

Accounting Policies

The Committee considered the proposed accounting policies to be applied for 2023/24 and the nationally driven changes. Following their consideration and feedback from external audit the policies were approved**.**

The Committee received the assessment on the consolidation of pharm@sea and the Trust's charity into the Trust's accounts. The Committee agreed to this consolidation, noting this is consistent with the prior years.

Single Tender Waivers

The Committee noted the reported increase in their use over the reporting quarter and endorsed the actions being taken to secure earlier engagement by the respective divisions and budget holders with the procurement team to enable timely advice to be given on the best route to test the market for value for money.

Data Protection Toolkit

The Committee received the report confirming the planned actions had been taken and the Trust had been confirmed as standards met and the Committee noted that work on this years toolkit submission is underway.

Health and Safety Committee chairs report

The Committee noted the update provided and the elevated risks identified linked to the delivery of required improvements identified from two recent inspections in blood sciences and the pathology laboratory at RSCH. For both areas the H&S Committee was overseeing the delivery of the agreed action.

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 risk 5.e by the People Committee.

The Board to note the referral of the oversight of the EDI recommendation delivery to the People Committee and the oversight of the medication management process for drugs stored within fridges at the Patient and Quality Committee.

University Hospitals Sussex NHS Foundation Trust

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate
Audit Committee	16 January 2024	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 that the proposed quarter 4 scores had yet to be scrutinised and approved by the respective oversight committees and therefore asked that for the one risk (people risk 3.4) where the score is being assessed as reducing for the quarter, that the supporting assurances are tested at the Committee. The Committee also requested through the Committee Chair membership of the Audit Committee that within the respective Committees review that they consider the adequacy of the actions being taken against those risks not achieving their target score for the year. The Committee noted the continued process for updating the BAF and recognised through discussion the drives of the proposed reducing risk.
Risk Management Policy Compliance Report	Chief Governance Officer / Deputy Company Secretary	For assurance over Trust's process.	The Committee noted the impact on the Executive Led Risk Oversight Group has had on the level of risk reviews undertaken. The meeting noted that work continues through the partnering of the central team with the services to mature the risk management processes, especially in respect of the datix system updates to reflect the latest position in respect of risk mitigation action delivery.

			The Committee noted the processes being applied and agreed that this report remain an integral companion report to the BAF.
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 Overseas visitor and private patient income systems of internal control. Also whilst not an option report noted the positive conclusions from the work on the Trust year 5 Maternity Incentive Scheme processes, noting this supported the Trust's submission. The Committee received the EDI maturity review undertaken by Internal Audit and following discussion of the developed action plan referred the oversight of the timely delivery of these actions and thus improvements to the People Committee. 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.
Counter Fraud Reports - Activity Progress Report - Pre-Recruitment Checks (proactive review)	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 report detailing the outcome of the proactive exercise undertaken to assess the Trust's pre recruitment checks and its positive conclusions.
External Audit Update including 2023/24 audit plan	GT (External Audit)	To note status of the External Audit work To approve the 2023/24 external audit plan	The Committee noted that the audit update on the preliminary planning work for the 2023/24 audit which allowed for the production of the audit plan for 2023/24.

			The Committee received the 2023/24 external audit plan, noted the audit risks where aligned to those mandated to the sector and approved the plan.
2023/24 Accounting Polices	Assistant Director of Finance	To consider and approve their application for the 2023/24 financial statements.	The Committee considered the proposed accounting polices to be applied for 2023/24 and the nationally driven changes. Following their consideration, the policies were approved. The Committee also agreed the continued consolidation of pharm@sea and charity statements into the Trust's main financial accounts.
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. The Committee noted one loss and sought support from the Patient and Quality Committee in respect of the oversight of the medication management process for drugs stored within fridges.
Tender Waiver Report	Commercial Director	To note the report and the assurance it provides over the Trust's processes.	The Committee noted the increase in tender waivers in the quarter. Through discussion were assured sound processes were applied and endorsed the planned actions to support earlier engagement by budget holders to allow procurement to support them to a better route to market. The Committee noted that the levels of waivers had been benchmarked as very low by RSM (Counter Fraud) when compared to others giving context to the rise in the quarter.
Information Governance and Data Protection Toolkit Progress Report	Chief Information Officer	To note the progress made and receive an update on the Trust; s IG processes	The Committee noted that the Trust's delivered its agreed action plan and has been assessed as "standards met" against the national data protection toolkit. The Committee noted that progress against the current year toolkit has commenced.

			The Committee noted the update from the CIO in respect of the Trust's information governance processes.
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 and noted the changes in risk especially those elevated in the quarter. The Committee discussed how the visibility of this activity could be improved noting the developing Compliance Assurance Framework is planned to support this.

Actions taken by the Committee within its Terms of Reference

The Committee **approved**

- the External Audit plan for 2023/24
- the Trust's 2023/24 accounting polices
- the continuing consolidation of pharm@sea and the charity into the Trust's main financial statements

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

The Committee agreed to retain the risk management policy compliance report as a companion report to the BAF.

The Committee asked that the Executives consider the most effective way to update the Committee on the Trust's review and consideration of areas for action from audit sector updates and that this be weaved into future Committee reporting.

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 risk 5.3	People Committee
The oversight of the Internal Audit EDI recommendations	People Committee
The oversight of the medication management process for drugs stored within fridges given a recent loss.	Patient and Quality Committee

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	17	**Meeting:**	Trust Board in public	**Meeting Date:**	8 February 2024
Report Title:	Royal College of Surgeons' Invited Service Review				
Sponsoring Executive Director:	Dr George Findlay				
Author(s):	Dr George Findlay, Prof Katie Urch				
Report previously considered by and date:					

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	N/A	Link to Trust Annual Plan	N/A

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

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

Regulatory / Statutory reporting requirement

n/a

Communication and Consultation:

n/a

Executive Summary:

This paper includes the report from the Royal College of Surgeons following their invited review, as well as the context to the review, and Trust's responses.

Key Recommendation(s):

The Board is asked to NOTE this report.

University Hospitals Sussex
NHS Foundation Trust

Paper to the Board
Dr George Findlay

When I took up role as CEO in June 2022 I was very clear that we faced a significant number of challenges and areas where we simply weren't doing well enough.

One of these areas was surgical services at the RSCH site.

A number of issues had been raised by previous internal and external reviews into Surgery at RSCH. We used this information to ensure that a comprehensive improvement plan was in place to address the challenges in this service. That plan was agreed in October 2022 and progress has been made since that time, with executive leadership in place alongside strong programme management arrangements, and Board oversight though the Quality Committee.

We are determined to make the improvements that our staff and patients need and deserve. The reason I invited the Royal College of Surgeons (RCS) to come and review matters in May 2023 was primarily to test our improvement plans: Were they correct and focusing on the right areas? Were there gaps we had not spotted? Was there evidence that the plans were making a difference? Were there any immediate safety concerns that we needed to respond to? In addition, I wanted to ensure that staff had the opportunity to raise, in confidence, any concerns they had.

Our Chief Medical Officer Prof Katie Urch has provided a summary of the RCS findings, their recommendations, and our response, and that follows this paper. But first I wanted to provide my reflections on the report of the Invited Review.

There are some tough messages for staff and us as Trust leaders, and for patients - but being clear and honest brings the opportunity to make further significant, positive changes. Problems can't be solved without first being openly acknowledged.

I am bringing this report to the Board in public at the earliest opportunity because it is so important. We received the report towards the end of January 2024 and the detail needs to go through our usual Board governance processes. I know this will go through the Quality Committee very soon, and the Board conversation today can help shape that work.

I am bringing this to Board today as I want to signal a way of working that is important to me and I believe also to staff, patients and stakeholders. This is the first Royal College external review that I have commissioned as CEO and I wanted it to be shared freely with staff, partners and stakeholders in a transparent and open way.

Many of the problems that exist date back many years and sadly cannot be solved overnight. The RCS review recognises our improvement plans and the results they have produced so far. I do believe we have made some significant strides forward and recognise there is much more to do.

The report raises concerns about senior leadership, and I welcome a conversation with Non-Executive Director colleagues on that topic. I was brought into the Trust with a clear expectation that we had to deliver positive change. The executive team has been brought together and all executive directors are now in place. There is a huge amount to do and colleagues have been working in hugely pressured environments for many years. Our executive team is focused on the main, overriding task of improving care, and giving our staff the tools they need to do the job.

Lastly, I wanted to emphasise my message of realistic optimism. There are many areas of progress highlighted in the report and we should be optimistic about that, and use this feedback to recognise the efforts of our staff. However, I am realistic that there is very much more to be done to provide the service that our patients and staff want and deserve.

University Hospitals Sussex
NHS Foundation Trust

Royal College of Surgeons Invited Review

Board Summary

Prof Katie Urch

Introduction

This short paper is intended to accompany the full report from the Royal College of Surgeons (RCS), which was received by the Trust in January 2024.

This paper seeks to summarise the key findings – both positive, and areas of ongoing concern – along with the recommendations being made to our Trust, and most importantly the actions which have been taken, or are being taken, to try to introduce and embed better working conditions, practices, and outcomes. It also follows on from the paper from our Chief Executive Officer Dr George Findlay, offering his perspective on the RCS report.

Context

The RCS conducted the Invited Review into Surgery services at the hospital in late May 2023. Their report was received in January 2024, and follows this paper.

Some findings pose challenges to both the Trust leadership, and members of the Surgery division, and solutions will not be immediate. Surgery in Brighton has faced significant difficulties for more than a decade, and there was a clear recognition from the current leadership group in early 2023 that significant changes – some of which may be long-term in character - were still required to promote better care, better performance, and better relationships.

The known residual challenges included issues regarding physical capacity, workforce capacity and skill mix, and working relationships – both within the teams themselves, and between those teams and the succession of executive leadership groups.

Even within this highly challenged position it was also recognised that the staff were highly committed, skilled, and dedicated to providing the best possible care for their patients.

The RCS review findings

The RCS was specifically asked to look into clinical governance, benchmarked patient outcomes, safety monitoring systems, opportunities to reflect and discuss the delivery of safe care, and culture and behaviours. The areas were chosen specifically because previous assessments had identified them as having deficiencies, or potential shortcomings.

The full findings are set out in detail in the RCS review itself, but some of the key issues highlighted are summarised below.

Positive findings

- All staff were open and engaged with reviewers, and wider staff groups commented positively
- Strengthened governance – improved quality of data for national audits
- Good practice and evidence of learning – regular quality and safety processes, well structured mortality reviews, whole day patient experience meetings, new governance leads and support staff

- New leadership seen as able and effective, and clearly engaged at division, directorate and local levels
- Feedback from junior doctors improved, mandatory requirements meet to enable Health Education England to approve return of trainees
- New Chief of Surgery seen positively, as a good leader

Concerns

- Staffing levels in both nursing and medical roles, including long-term use of locum consultants
- High workload and unequal workload distribution – impacting on cancellation levels, and responsiveness to the (high) level of complaints
- Lack of capacity in terms of the ward environment, leading to high numbers of 'outlier' patients and associated challenges in providing continuity of high quality care
- Surgical capacity for planned work
- Morale – suspension of upper GI cancer resectional surgery had a negative impact on retention, and recruitment is difficult
- Culture – ongoing sense that staff are fearful of speaking up to the executive team, or do not believe such actions will bring about positive change, and as a result are reluctant to raise concerns
- Culture – issues in terms of behaviours within the Surgery teams themselves.

RCS Review recommendations

The RCS made a number of recommendations for the Trust – including the observation as to the importance of this review being acted upon, given the number of previous reviews which have already taken place.

The full set of recommendations are contained within their report, but the key elements for the Board to note are:

- The need to establish a Surgical Assessment Unit, and 'hot' pathways to help insulate planned work from peaks in emergency demand
- Recommendations to restore the surgical bed base, expand theatre capacity, expand outpatient capacity, and ensure sufficient elective capacity is available
- The suggestion that membership of governance meetings should be widened to include teams from elsewhere in the Trust
- A need to continue to focus on inter-professional communication within Surgery, and issues of problematic team working, poor relationships between senior clinicians, and interpersonal behaviours
- The suggestion that executive members spend time, regularly, with the surgical teams, and commit to implementing recommendations from previous reviews.

Responses and improvements

The RCS review provides important insight for everyone involved in the task of delivering better conditions and practices for the Surgery teams – from theatres to the Executive.

It is important to note that the review reflects a moment in time eight months ago, and that much has changed since, without for a moment losing sight of the clear need for further improvements both in terms of infrastructure, workforce, practice, and relationships.

The following actions have either been enacted or are being progressed:

- Successful approval of a business case to expand the number of consultant surgeons and junior doctors, and recruitment is underway

- Approval of a new Surgical Assessment Unit in Brighton – space within the hospital site has now been freed up and plans are fully developed for it to open in 2024, along with the development of new ‘hot’ pathways, as recommended
- The agreement with NHSE for them to approve the re-starting of trainee placements
- Start of an executive-led project to move some planned theatre work to other sites to mitigate capacity pressures – this is a clear recognition of the need to ‘decompress’ the site, which will be a major undertaking
- Commitment to shorter, emergency-only inpatient ward rounds
- Commitment to a review of the surgery bed base, and consultant rota, co-ordinated with re-allocation of elective work
- A Trust-wide drive to examine, and improve culture is underway, with potential for bespoke support to Surgery teams
- Reviews of individual consultant job plans are underway, alongside team work planning
- An identified cohort of surgeons will hold cancer surgery, allowing for stronger opportunities for sharing knowledge, learning, and support better patient care.
- Members of the executive team, working closely with the Chief of Surgery, will ensure greater direct contact between them and the surgical teams, in a bid to strengthen relationships and trust, and encourage open dialogue.

But the recognition remains that the division faces long-term challenges, and that overcoming those challenges must also be considered as a long-term endeavour which will require continued, consistent attention.

Delivering the identified improvements, monitoring their impact, and then being responsive to the need for further new thinking will be essential, alongside the necessity of building trust and a better dialogue both within the Surgery teams, and between them and the Trust leadership.

Recommendation

The Board is asked to note this paper, and the Royal College of Surgeons January 2024 report, following the completion of their Invited Review in May 2023.

Invited Service Review Report

Royal College of Surgeons of England
ADVANCING SURGICAL CARE

Report on the general, (emergency, upper gastrointestinal and lower gastrointestinal) surgical service on behalf of

University Hospitals Sussex NHS Foundation Trust

Review visit carried out on: 24-26 May 2023
Report issued: 17 January 2024

A service review on behalf of:

The Royal College of Surgeons of England

Association of Surgeons of Great Britain and Ireland

Review team:

Mr Richard Guy, FRCS

Ms Karen Nugent, FRCS

Professor Louise Higgins

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Contents

1. Introduction and background

On 26 January 2023 Dr Rob Haigh, Deputy Chief Medical Officer for University Hospitals Sussex NHS Foundation Trust ('the Trust'), wrote to the Chair of the Royal College of Surgeons of England's ('RCS England') Invited Review Mechanism (IRM) to request an invited service review of the Trust's general surgery department, with a specific focus on upper gastrointestinal (GI) (UGI) surgery, lower GI (LGI) surgery and emergency general surgery (EGS).

The general surgery service, alongside UGI and LGI surgery, as well as EGS, operates from two out of the seven hospitals run by the Trust: the Royal Sussex County Hospital ('RSCH') in Brighton, and the Princess Royal Hospital ('PRH') in Haywards Heath.

The request highlighted that the general surgery department was a service which had been under scrutiny for many years, with a history of internal reviews, and concerns being raised by consultant surgeons as well as other members of staff within the department, including through staff surveys, and reviews from external bodies including the Care Quality Commission (CQC) and Higher Education England (HEE).

As a result of the concerns, opportunities were identified to improve the leadership, culture and ways of working, morbidity and mortality (M&M) processes multi-disciplinary team (MDT) processes and practices, and delivery of emergency care.

The Trust therefore commissioned a 12-18 month corporate executive sponsored improvement project in October 2022, to focus on workload, service model of care, culture and behaviours, training and operational delivery. Part of the corporate project involved commissioning an invited service review of the general surgery department.

Within the invited review request, the Trust indicated that they wished for the service review to assess:

- Clinical governance arrangements within the department, with a focus on safety, outcomes, quality, benchmarking against comparative national outcome audits and M&M processes in accordance with RCS England best practice guidelines.
- Whether benchmarked outcomes were within acceptable national standards.
- Whether appropriate systems and processes were in place to robustly monitor safety and ensure high quality outcomes.
- Whether current clinical governance processes allowed standardised and consistent opportunities for the department to discuss, review, reflect and learn.
- The clinical outcomes for the general surgeons and whether they gave rise to concerns about poor outcomes.
- Whether individual and departmental practice was acceptable and safe care was being delivered to patients.
- Cultures and behaviours within the department as a whole.

Prior to requesting the invited service review, the Trust held discussions with staff, conducted reviews of clinical records as well as internal audits and investigations.

This request was considered by the Chair of the IRM and a representative of the Association of Surgeons of Great Britain and Ireland ('ASGBI'), and it was agreed that an invited service review would take place.

An invited review team (the review team) was appointed and an invited service review visit took place on 24-26 May 2023 at the Royal Sussex County Hospital site.

Prior to the review visit, the review team had requested specific background documentation, including M&M information, MDT outcomes and attendance records, and the reports from previous

reviews undertaken, including the Dawson and Edgecumbe reviews[1]. These were not forthcoming prior to the visit, and were either provided during the visit, or subsequently, in June and July 2023.

The appendices to this report list the members of the review team, the individuals interviewed, the service overview information, the documents provided to the review team and the information provided to the review team from the documentation considered and the interviews held.

The Terms of Reference for this review were agreed prior to the review visit, and are set out in section two. The review team's conclusions are based on the information provided to them during interviews and through considering the documentation submitted. These conclusions are set out in section three. Recommendations based on these conclusions are set out in section four.

Overview of the Trust and General Surgery Department

The Trust serves a catchment population of an estimated 985,762[2] people within Brighton and Hove and parts of East Sussex and West Sussex, running seven hospitals in the region:

- Worthing Hospital, Worthing, West Sussex;
- Royal Sussex County Hospital, Brighton, East Sussex;
- St Richards Hospital, Chichester, West Sussex;
- Princess Royal Hospital, Haywards Heath, West Sussex;
- Royal Alexandra Children's Hospital, within the grounds of Royal Sussex County Hospital;
- Sussex Eye Hospital, Brighton; and
- Southlands Hospital, Shoreham-by-Sea, West Sussex.

General surgery, UGI and LGI surgery and EGS are provided across two of the Trust's sites: the Royal Sussex County Hospital (RSCH) [3], an acute teaching hospital located in Brighton, and the Princess Royal Hospital (PRH), an acute, teaching and general hospital located in Haywards Heath.

Hospital services at the Trust are grouped into eight clinician led divisions, which are separated into two areas: unscheduled (emergency) and planned (elective) care. The Trust runs the following divisions:

Unscheduled care:

- Medicine and urgent care (West Sussex)
- Medicine and urgent care (Brighton and Hove)
- Women and children
- Clinical Support Service

Planned Care and Cancer:

- Cancer
- Specialist Services
- Surgery and Critical Care (St Richard's, Worthing and Southlands Hospitals)
- Surgery and Critical Care (Royal Sussex County and Princess Royal Hospitals)

In order to meet the needs of local people, geographical boundaries have been maintained by the Trust.[4]

[1] See pages 7 and 8
[2] Service Overview Information and Estimated Population Growth provided by the Trust in May 2023.
[3] Service Overview Information.
[4] Information up to date as of November 2023: https://www.uhsussex.nhs.uk/

Overview of general and emergency surgery and gastroenterology[5] services within the Trust

General surgery services provided by the Trust include emergency, inpatient and day case care. A wide range of surgical procedures are performed within the service typically involving the chest and abdomen, such as breast conditions, colorectal, UGI, gallbladder, hernias, appendix, transplants and more. UGI and LGI surgeons working within the service are trained to undertake emergency as well as elective surgery[6].

The specialist team within the gastroenterology service treats conditions affecting the oesophagus, stomach, small bowel, colon, liver, bile ducts and pancreas, as well as caring for patients with gastrointestinal conditions[7], in the Trust's combined gastroenterology and surgery ward. The service provides a range of diagnostic and therapeutic techniques, including endoscopy[8] and radiological examinations[9]. The service includes local surgeons, pathologists and microbiologists and the dietician department, and works with specialist nurses who provide support and advice to patients with conditions such as cancer, inflammatory bowel disease, alcohol related disorders and liver disease. As well as having local expertise, the service has links with tertiary centres in London, Surrey and Sussex, and may facilitate referrals for second opinions and/or specialist care when required[10].

Between January and December 2022 the general surgery department, operating across the RSCH and PRH sites, saw over 55,000 outpatients, over 5000 non-elective admissions and over 11,000 elective admissions.

As of May 2023 there were 12 substantive consultant surgeons, three fixed-term contract locum consultant surgeons and an associate specialist grade surgeon on the consultant rota in the general surgery department. There were also two funded UGI vacancies, with scheduled interviews due to take place. Programmed Activities per consultant had ranged from three to 13 in terms of direct clinical care, excluding regular waiting list initiatives activity.

Excessive demand on the on-call consultant rota led to demand and capacity being reviewed. This led to the highlighting of opportunities for the general surgery department to improve its leadership, culture, ways of working, including M&M and MDT processes and delivery of emergency care. A key driver for gaps in performance were the mismatch between current demand for the service (as of May 2023 with a patient tracking list of 7000 patients), and the availability of workforce, physical and infrastructure capacity. In order to deliver such improvements, it was recognised that there would be a need for new models of care to balance the service's management of elective and emergency care, which would enable compliance with the standards of a major trauma and cancer centre, alongside the standardisation of the department's operational management processes. With the department's history, including a decline in reputation for surgical junior doctor training, sustainable improvements would need to be demonstrated across all elements of the department, in order for the placement of surgical trainees to be reinstated.[11]

Previous Reviews

The Trust has a history of internal and external reviews, about which the review team were provided background information as part of this review. The review team did not seek to reach findings on those conclusions and recommendations made by other bodies, which was outside of their remit.

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[5] Also known as digestive diseases.
[6] Information up to date as of August 2023: https://www.uhsussex.nhs.uk/services/general-surgery/
[7] Disorders of the digestive system.
[8] Involves cameras looking into the oesophagus, stomach, colon, small bowel and bile ducts.
[9] Ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI) scans and barium examinations.
[10] Information up to date as of May 2023: https://www.uhsussex.nhs.uk/services/gastroenterology/
[11] General Surgery Improvement Corporate Project, Introduction to RCS Reviewers PowerPoint Slides, May 2023

A summary of the most pertinent reviews in relation to general surgery, UGI and LGI surgery and EGS is provided below.

a) HEE[12]

On 2 July 2021 the Regional Postgraduate Dean wrote to the Chief Executive of the Trust expressing concerns about the safety and effectiveness of the clinical learning environment for foundation trainees in general surgery at the RSCH site, as well as the vulnerability of Foundation Year 1 (FY1) doctors, due to restrictions on their clinical learning opportunities during the COVID-19 pandemic. The General Medical Council (GMC) had previously placed enhanced monitoring requirements on general surgery training in Brighton in January 2016. The Postgraduate Dean's specific concerns related to:

- Rota gaps which risked breaching the conditions the GMC previously placed on general surgery, and it being unclear whether additional support posts which the Trust intended to recruit would be in place by August 2021.
- The department not appointing a dedicated consultant lead for education and training, as per HEE's mandatory requirements to ensure the safety and effectiveness of the clinical learning environment.
- The Trust's response to bullying and undermining comments received in the recent GMC National Training Survey, which suggested that the particular trainee who made the comment acted unprofessionally in raising the concerns, and the Trust was proposing to take this further with the GMC, which was felt to be inappropriate.
- That there would be a significant number of unfilled core and higher specialty general surgical posts as of October 2021 due to trainees specifically not selecting the department for their rotations.
- The August cohort of foundation trainees being considered to be vulnerable given their relative lack of experience and likely reduced exposure to training due to the COVID-19 pandemic.

The Trust put in mitigations, which they described in a meeting on 9 July 2021 (with HEE, GMC, NHS Improvement and NHS England (NHSI&E), Integrated Care Systems (ICS) colleagues with the then Chief Medical Officer, then Medical Director (East) newly appointed Director of Medical Education). This included the recruitment of advanced clinical practitioners, provision of additional junior medical staff until Advanced Clinical Practitioner training was complete, additional out of hours shifts, substantive prescribing pharmacist recruitment and responding to specialist practice registrar trainee feedback. At this meeting it was agreed that the Trust would provide further information and assurance, and a written response would be provided in July 2021 to address the following matters:

- Trainee rotas and support.
- Progress on consultant appointments.
- Progress on prescribing pharmacists.
- Mitigating gaps due to lower numbers of registrars from October 2021.
- Escalation and outreach.
- Educational and welfare supervision of trainees.
- Leadership and surgical educational supervisor.
- Organisational development work on culture with consultants.
- Governance, executive and board monitoring.

[12] Appendices Attachments to Introduction to General Surgery PowerPoint Slides, May 2023: Response to HEE Concerns on Foundation Doctors from the Trust, July 2021; Letter from HEE 9 December 2021; and email correspondence between HEE and the Trust in February 2023 and April 2023.

A Foundation General Surgery Trainee Focus Group was held on 26 October 2021. Following this a meeting was held on 1 December 2021 between the then Medical Director and the Director of Medical Education at the Trust with representatives from HEE, the GMC, NHSI&E and Sussex NHS Commissioners. A letter confirming the conversation and next steps was sent to the Trust on 9 December 2021. This included trainee feedback having indicated improvements to the educational experience, including:

- Measures to address immediate concerns about supervision and support for foundation general surgery trainees out of hours.
- The positive impact of the consultant lead for education and training.
- Praise for the support provided by the Senior Nurse Education Fellow.
- Unprofessional behaviours being addressed promptly by the Trust.

During the meeting on 1 December 2021 information was provided about underlying wider concerns, which whilst impacting on education and training, did not fall within the HEE's regulatory remit. This included: leadership, culture, service pressures and workload, staffing and rota gaps. It was agreed that a broader approach from the Trust would be needed to address these issues in order to support medium and long-term sustainable improvements in the educational and trainee experience. It was agreed that going forward:

- HEE would work with the GMC to revert to routine quality monitoring of educational issues linked to HEE quality standards via the action plan process. The existing action plan would be updated to reflect recent feedback, and to outline requirements and timescales for further monitoring.
- HEE would forward any intelligence received relating to broader concerns to the Sussex Health and Care Partnership for management through their governance processes, with input from the regional NHSE&I team as appropriate.
- Foundation general surgery at RSCH would remain under GMC enhanced monitoring, with previous GMC conditions on the approval of the foundation training programme in the general surgery department, relating to supervision, workload and access to educational opportunities, to remain in place.
- HEE would write to the current cohort of foundation trainees to share the outcomes of this process, and highlight routes to raise any concerns should they arise, acknowledging the significant amount of feedback provided by trainees already. The Trust would also continue to brief trainees on improvement measures being taken locally to address areas of concern identified within the focus group feedback.

On 1 February 2023 HEE wrote to the Trust to inform them of changes to their enhanced monitoring status, as well as acknowledging the comprehensive response provided in relation to the issues that were raised by the HEE leading to the enhanced monitoring process, including College Tutors who had worked hard to improve the experience of doctors in training. Whilst there remained ongoing work and change ahead, it was felt that there was a significant reduction in risk to learning and training, and the HEE indicated they were looking forward to working with the Trust further to address the outstanding issues.

On 29 March 2023 a general surgery work programme meeting was held, which was followed up in correspondence from HEE to the Trust on 25 April 2023. The Trust was informed that all mandatory requirements, which had been issued following an urgent risk review on 19 October 2022, had now been closed. An updated action plan was also provided for the Trust's records. The Trust was informed that the next work programme meeting would take place on 27 July 2023, to focus on work to support the re-introduction of surgical trainees to the general surgery department in October 2023.

b) Edgecumbe review

The Trust's Chief Executive Officer commissioned the Edgecumbe Group[13] to undertake a review, in order to make recommendations to improve culture and the functioning of the consultant team. This review was undertaken, with the final report provided in June 2022. A summary presentation of this report, dated July 2022, was provided to the RCS England invited review team in June 2023, which featured the findings reached, recommendations made, and anonymous quotes from staff.

c) Dawson review

The Trust's Chief Medical Officer asked Professor Peter Dawson[14] to undertake an independent review of departmental culture, junior doctor training and supervision within general surgery in August 2022, due to the long standing concerns raised. A redacted copy of this report was provided to the RCS England invited review team in June 2023.

d) Care Quality Commission[15]

In August 2022 an unannounced CQC inspection took place. An 'inadequate' rating was given and the CQC made the decision to suspend the Oesophago-Gastric (OG) cancer resection services at the RSCH site of the Trust.

Since then, and as part of the 12-18 month corporate improvement project, it is understood that staff have been working towards making improvements and restoring the reputation of this service. This involved communication with the CQC and evidencing the improvements which had been made.

In December 2022 the Trust submitted a response to the CQC, for the return of UGI cancer resection services, and an updated response was submitted in March 2023. There were ongoing discussions with Surrey County Hospital to align Sussex and Surrey OG cancer resection surgery with the Sussex and Surrey Cancer Alliance (SSCA), with a surgical hub at the Royal Surrey County Hospital in Guildford.

It was reported that staff had been under the impression that the CQC would allow this service to return, based on the above responses and prior communication. However, three weeks prior to the RCS England invited review visit, staff were informed that this would not be happening, and in the future, all UGI cancer resections would only take place at the Guildford site.

The CQC's most recent inspection took place in October 2022, with the findings and report being published on 15 May 2023[16], just over a week prior to the invited service review visit at the Trust.

Corporate Improvement Project[17]

A prominent theme of previous reviews, including the Edgecumbe and Dawson reviews, was a lack of meaningful action from the executive leadership team, as well as reporting common/similar key themes on culture and behaviours. Following this, and the revised CQC rating of inadequate in August 2022, as well as the other long standing history of scrutiny within the service over many years, the executive-sponsored general surgery corporate improvement project was launched in October 2022.

[13] https://www.edgecumbe.co.uk/
[14] http://s861800506.websitehome.co.uk/
[15] Information provided to the review team throughout the course of the review, including the Introduction to General Surgery PowerPoint slides, May 2023; and that provided during interviews during the review visit in May 2023.
[16] https://www.uhsussex.nhs.uk/%20https:/www.cqc.org.uk/provider/RYR?referer=widget3
[17] Introduction to General Surgery PowerPoint Slides, May 2023.

The goals of the project were to restore the reputation of the service, to improve culture and behaviour, to secure the return of trainees to the Trust and to reinstate UGI cancer resection services, which were suspended by the CQC in August 2022. The Trust's executive leadership launched the project with a workshop in October 2022, which saw representation across the department with clinicians, nurses and operational staff, to provide staff within an opportunity to feedback on the commissioned reports into culture and behaviours within the service, the steps the executive leadership team were taking and the introduction of the beginning of a new approach to service delivery within the department.

When the invited review request was made, the Trust also provided the RCS England with summary slides of the general surgery corporate improvement project. This included reporting on the progress of the project thus far, as of October-December 2022. At this stage:

- The programme had been fully mobilised, with work stream leads in place, and the department was engaged with the goals of the project.
- A detailed review of M&M processes had taken place, to ensure meetings were well-attended and fit for purpose in the future, which resulted in immediate process change, the appointment of new UGI and LGI governance leads, as a result of which the quality, content and attendance at M&M and governance meetings were reported to have substantially improved.
- A review of the existing MDT meetings had taken place, to benchmark against best practice, with a delivery plan being constructed.
- A new leadership model for the general surgery department had been developed with clinical lead posts advertised for LGI, UGI and EGS, who would report to a clinical director once in post.
- A key focus of the project was the restoration of the UGI cancer resection service at the RSCH site, and therefore was committed to responding to the CQC with evidence of outcomes and strengthened departmental quality governance processes.
- It was also identified that the surgical handover venue was not fit for purpose, and this had been improved by decluttering the space and a standardised handover process was being developed.
- National reporting of NBOCA[18] and NOGCA[19] data had also been submitted for the latest reporting period, in real time data validation, to ensure accuracy was established.

The next focus of the project was to:

- Complete the gateway review.
- Complete the review of demand and capacity in order to inform a proposed new service model.
- Develop a new service model.
- Complete a quality governance maturity review.
- Complete a review of medical leadership and training capabilities, including assessing programmed activities required for delivering training.
- Developing a revised structure for MDT meetings.
- Review training and education requirements and make use of HEE support; and
- Have the RCS England invited service review visit take place.

As part of the invited review visit, a further update was provided in May 2023 regarding the progress of the corporate project, from the executive leadership team. This included:

- The programme progressing across all workstreams and being on track with aligned deliverables in the last quarter.

[18] National Bowel Cancer Audit: https://www.nboca.org.uk/
[19] National Oesophago-Gastric Cancer Audit: https://www.nogca.org.uk/

- Recruitment of new divisional leadership with the posts of clinical leads for LGI, UGI and EGS, who would report to the Clinical Director, having been filled.
- Establishment of access to coaching and mentoring to support the newly formed team in the delivery of their clinical leadership roles.
- The completion of the demand and capacity modelling, to identify gaps and formulate a service and workforce model which would meet the demands of the service and put patients first.
- Completion of a proposed new service and workforce model, which was reviewed in April and March with three options: 1) doing nothing/the bare minimum; 2) increasing consultant numbers to provide a robust EGS service at the RSCH site; or 3) increasing the workforce at a number of levels and moving some elective activity to the PRH site in a phased way. A fourth option was also explored, which would involve addressing the backlog recovery.
- The drafting of a summary of recommendations, based on the proposed new service model, which would form a pre-requisite for a business case to be developed.
- Professor Peter Dawson[20] conducted a visit at the Trust on 11 January 2023, and reviewed the accuracy of the data submitted to NBOCA, and this review demonstrated no major issues with the data. The Dawson review's recommendations were implemented by the Trust as part of a plan to improve data quality and submissions.
- Review of the NELA[21], NBOCA and NOGCA data and quality assurance was in place, with data being continuously submitted on time.
- Completion of detailed review of the relevant NICE guidelines[22], which was circulated to the consultants within the department.
- Compassionate leadership training had been delivered in January and March 2023 to six consultants and registrars, with members of the general surgery department having signed up to attend the next training session.
- Revision of workplan, resource allocation, membership, timeline and risks to be aligned with the project's goals and delivery.
- Review of the directorate's M&M meetings, with reported positive improvement in attendance and engagement. M&M structure and processes had been audited, the outcomes and recommendations from which were incorporated into the UGI and LGI workstream plan.
- Review of the MDT meetings by an external subject matter expert and MDT leads, with one month observation of the UGI and LGI MDTs by the SSCA. Recommendations from this review were incorporated into the UGI and LGI workstream plan. Face-to-face MDT meetings were reinstated to improve their quality and effectiveness, as per the recommendations of the SSCA.
- Review of the UGI and LGI operational policy and standards of care, to support staff with routine and best practice operations, as well as ensuring robust and patient-centred MDT processes.
- Application by HEE for an extended surgical team being successfully approved and revised to include two advanced clinical practitioners. Discussion of the junior doctors training programme with HEE in March 2023, agreed in principle, and now being worked on. FY1 doctors giving positive feedback to HEE during their visit in March 2023 in relation to consultants, registrars, level 9 nurses, improved to take out shifts, simulation days and rota coordinators. In April 2023 HEE indicated a timeline for return of middle grade trainees to the Trust in October 2023.

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[20] A redacted version of this report was provided to the review team in June 2023, after the invited service review visit.
[21] National Emergency Laparotomy Audit: https://www.nela.org.uk/
[22] National Institute for Health and Care Excellence (NICE) guidelines are evidence-based recommendations for health and care within England, and which set out to health and social care professionals the care and services suitable for most people with a specific condition or need, in particular circumstances and settings: https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines

- External consultants reviewed the Dawson and Edgecumbe recommendations and confirmed that the corporate project had considered every recommendation.

At this stage (May 2023), alongside the invited service review visit taking place, the focus for the project over the coming months was the:

- Completion of the ‘good governance maturity’ assessment of the department.
- Completion of a summary of recommendations for the new service model.
- Development of a workforce model to deliver the recommended new service model.
- Continuation of developing standardised LGI and UGI MDT processes and structures, including a written and stratified standard operating policy and standard of care documents.
- Completion of the current recruitment programme for dieticians and clinical nurse specialists.
- Completion of the gateway review for the corporate project.

2. Terms of reference for the review

The following Terms of Reference were agreed prior to the review visit between the RCS England, the Trust commissioning the review and the review team.

Review of the general surgery service at University Hospitals Sussex NHS Foundation Trust ('the Trust') under the Invited Review Mechanism (IRM).

Review

The review will involve:

- Consideration of background documentation regarding the general surgery department, with a specific focus on upper gastrointestinal (GI), lower GI and emergency surgery.
- Interviews with members of the general surgery department, those working with them to provide the service and other relevant members of staff within the Trust.

Terms of Reference

In conducting the review, the review team will consider the standard, quality and safety of care provided within the general surgery department, with a particular focus on upper GI, lower GI and emergency surgery. The review will have specific reference to the following:

1. The effectiveness of current clinical governance practices and clinical leadership within the departments to ensure safe outcomes for patients, including:

a) The standard of outcome measures/audits to uphold patient safety, including complication and mortality rates, and how these compare with regional and national benchmarks, and whether appropriate processes and systems exist to ensure high quality outcomes.

b) The effectiveness of current clinical governance processes, including mortality and morbidity (M&M) meetings, and whether the processes:

i) Provide standardised and consistent opportunities for shared review, discussion, reflection and learning.
ii) Align with best practice guidelines.

2. The quality and safety of surgical care provided at individual and department level, with specific regard to:

a) Whether the management, selection and distribution of cases within the upper GI, lower GI and emergency surgical service is equitable.
b) Whether the clinical decision-making and treatment provided to patients is appropriate and timely.
c) The clinical outcomes for all general surgeons within the department, and whether this gives rise to concerns about poor outcomes.

3. Multi-disciplinary team (MDT) working, communication, behaviours and culture within the department, including:
a) The effectiveness of MDT working and discussions, and documentation of this.
b) The balance between service delivery and junior doctor training, including the effectiveness of rota design to allow adequate training opportunities for trainees during daytime hours.

Conclusions and recommendations

The review team will, where appropriate:

- Form conclusions as to the standard, quality and safety of care provided within the general surgery department, including whether there is a basis for concern in light of the findings of the review.

- Make recommendations for the consideration of the Chief Medical Officer of the Trust as to courses of action which may be taken to address any specific areas of concern which have been identified or to otherwise improve patient care.

The above terms of reference were agreed by the RCS England, the Trust and the review team on 27 March 2023.

3. Conclusions

The following conclusions are based on the information provided to the review team from the interviews held and the background documentation submitted by the healthcare organisation. They are largely organised according to the Terms of Reference agreed prior to the review but also take account of the themes that emerged whilst reviewing this information.

3.1. General conclusions

The review team were made aware that the Trust's history of internal and external reviews, press and public attention and reputational damage, as well as complicated geographical/regional challenges, resulting from a merger between Western Sussex Hospitals NHS Foundation Trust and Brighton and Sussex University Hospitals NHS Trust in April 2021[23] had inevitably had a signficant impact on the morale of staff at the Trust. It was within this wider context which the review team sought to provide their conclusions and make recommendations as to the way patient care and the services being offered could be improved for the benefit of patients, staff, the services and the Trust in the future.

The review team found all staff interviewed during the visit to be extremely engaged, open and helpful. Within the constraints of current challenges they were facing, it was clear that staff worked very hard to offer the best possible service for their patients. The review team heard a number of positive comments from staff about working for the Trust, as well as hearing complimentary comments about various teams, including the consultants surgeons, junior doctors of all grades, nurses, other allied healthcare professionals and various non-clinical and managerial staff. The review team identified concerns regarding staffing levels, recruitment and retention challenges and having an adequate mix of experience and expertise within the teams, including the numbers of clinical nurse specialists (CNSs) and consultants. However, the review team also found that there were sufficient numbers of junior doctors, and that the surgical ward nursing levels were relatively healthy.

Following the review visit the review team were made aware that the police were investigating the deaths of patients within the general and neurosurgery departments between 2015 and 2020, due to concerns which had been previously raised by whistleblowers. The review team were contacted by the Trust on 10 June 2023 to advise them of this matter, which was also reported in the press, including in a Guardian article published on 9 June 2023[24]. Whilst the review team did not seek to draw any findings in relation to this matter, it noted the investigation pertained to a specialty they were reviewing, and sat within the context of information received during interviews and as part of background documentation provided by the Trust throughout the course of this review.

3.2. Effectiveness of current clinical governance practices and clinical leadership to ensure safe outcomes for patients

3.2.1. Standard of outcome measures/audits to uphold patient safety, including complication and mortality rates, and how these compare with regional and national benchmarks, and whether appropriate processes and systems exist to ensure high quality outcomes

With regard to the history of challenges within the general surgery department, including a number of internal and external reviews, the review team found that the introduction of the corporate improvement project by the executive leadership team was a positive step, and this had resulted in improved working practices. The review team considered this to include the appointment of specific governance staff who were responsible for collating, managing and

[23] https://www.uhsussex.nhs.uk/news/landmark-sussex-hospitals-merger-goes-live-today/
[24] https://www.theguardian.com/society/2023/jun/09/police-investigate-dozens-of-deaths-royal-sussex-county-hospital-brighton

inputting data. The review team were of the view that there was good inputting of data into national audits, including the NELA and the NBOCA.

The review team identified that the colorectal cancer outcomes appeared to be acceptable, including within the normal range for 30 day mortality. However, they considered that the NBOCA data showed that there was a disproportionately high rate of urgent or emergency surgery admissions for colorectal cancer patients (54%), which was far higher than the national average (20%) and the regional average. The review team considered that this was likely to be as a result of inadequate capacity for elective colorectal cancer surgery, with reported long waits for elective cancer patients, in some cases necessitating re-imaging and the development of metastatic disease.

The review team considered that the NELA data showed a higher than national average 30 day mortality for emergency laparotomy patients, with poor performance for timeliness of arrival in theatre and involvement of geriatricians in the care of high-risk patients. They were of the view that this reflected sub-optimal care for emergency patients, which was a threat to patient safety. The review team considered that this was likely to be due to poor organisation of ward rounds and emergency theatres.

Major concerns were identified by the review team over high rates of cancellations of elective patients. This was often on the day of surgery, after patients had been waiting for up to seven hours, having prepared for surgery, for example, by not eating and/or drinking. The review team heard about patients being cancelled multiple times and this was causing patients psychological distress.

The review team considered there was an absence of patient survey data and recommend that the Trust starts coordinating and collating this, to consider the patient experience and how this can be improved.

3.2.2. Effectiveness of current clinical governance processes, including M&M meetings

The review team considered that the corporate improvement project had resulted in improved clinical leadership within the general surgery department and the development of better clinical governance processes.

Improvements included holding regular and structured M&M, MDT and Quality Safety Patient Experience (QSPE) meetings. The review team found the appointment of specific governance staff to be positive. They were involved in coordinating preparation, minute taking and management of these processes and meetings. The review team noted that M&M meetings ran collegiately, and provided a standardised opportunity for shared review, discussion, reflection and learning. They were encouraged by the live literature searches which took place at M&M meetings, so that research could support decision-making, with dedicated personnel available to assist with these searches. The review team noted that, whilst these meetings should be in person by default, the practice still existed of people participating online, which resulted in less engagement and a lack of team building. The review team therefore considered that more should be done to ensure these meetings are held with face-to-face attendance to support consultants feeling part of the team. The review team were of the view that best practice and other ways of working could be seen across the Trust’s other sites, and the surgical team should be encouraged and given time to visit and learn from other units in the same Trust.

The review team found that there had been appointments of motivated staff to support better clinical leadership and clinical governance processes. This included the creation and distribution of new clinical leadership roles for EGS, UGI and LGI, to replace the previous system of a clinical lead to cover all of these roles. The review team found the appointment of one of the consultant surgeons to address clinical governance, education, training and EGS to be positive, and considered they had taken up this role with enthusiasm. However, the review team were

concerned about this high level of workload for a relatively new consultant who, at the time of the review visit, was on a locum contract, with no obvious mentorship in place.

The review team considered the appointment of the Chief of Surgery to be positive and this individual was described as being attentive and responsive when staff escalated concerns. The review team noted that staff would not hesitate to bring their concerns to the Chief of Surgery's attention, and it was found without exception that staff felt confident that when they raised concerns, the Chief of Surgery would listen, take these seriously and take robust action.

The review team noted that there was a high volume of complaints from patients[25]. The most common theme of complaints was around communication, in terms of patients having a clear understanding of and expectations of their treatment. The review team were encouraged to hear about effective processes for managing and responding to patient complaints through the Patient Advice and Liaison Service (PALS), which was supported by the newly appointed governance staff. The review team noted there were delays in responding to patient complaints, and a number of reports were overdue. This was largely due to consultants being slow in providing comments for investigations, which impacted on the ability to feedback to patients in line with expected timescales. The review team considered that this was due to the workload of specific consultants, and they were encouraged to hear about governance staff working with clinicians to support them in addressing delays in responding to patient complaints. The appointment of a member of staff to draft outstanding patient safety investigation reports was also considered a positive development by the review team in supporting these processes. The review team considered that consultants should be given protected time to enable them to respond to patient complaints in a timely manner.

3.3. Quality and safety of surgical care provided at an individual and department level

3.3.1. Whether the management, selection and distribution of cases within the upper GI, lower GI and emergency general surgery service is equitable

The review team found there was an inequitable distribution of workload amongst the consultants, including a variation in who undertook on-call duties. A number of consultants appeared to have adjustments in place for health reasons, but such adjustments had reportedly never been reviewed. The review team noted this was causing resentment and unfairness, with no adjustment in pay despite a variation in duties. It resulted in the onus being on a few consultants to provide an emergency on-call service.

The review team considered that there were good attempts by the current LGI MDT lead to distribute cases fairly amongst colleagues with no major concerns. However, they noted that LGI surgery struggled with capacity. The review team found that LGI cancer patients were waiting eight to ten weeks for surgery, thereby missing the 62 day timeframe recommended within the pathway. In addition, they noted that one of the consultants who was trained in robotic surgery was not being supported to use the robot, which had been placed in another Trust site. The review team also noted a reported reluctance of the LGI surgeons at Worthing Hospital to work with the surgeons at RSCH and to look after their patients when referred to them.

The review team were aware of the decision by the CQC to suspend the OG cancer service and that whilst staff were under the impression this would be returning, and they had been working hard to make improvements to ensure this occurred, staff were made aware in the weeks preceding the review visit that the OG cancer service would not be returning. The review team noted that the intention moving forward was for all OG cancer surgery to be undertaken at the Royal Surrey County Hospital in Guildford. The review team considered that this decision had inevitably had a negative impact on the morale of staff, particularly for those trained in OG cancer surgery. The review team noted that this decision had led to resignations, and there were concerns about the ability to attract UGI surgeons in the absence of an OG cancer service. The

[25] Appendix B – Service Overview Form and information provided during interviews.

review team also heard about difficult relationships between the surgeons at RSCH and the Guildford site, with reports that the RSCH surgeons had not been welcomed by those in Guildford. The review team noted that the intention was for outpatient services and patients' post-operative care to be managed at the RSCH, with surgery undertaken in Guildford. The review team noted there was a lack of coordination with respect to benign UGI cases, as well as concerns that 'hot' gallbladder surgery was not being done. The review team considered that a lot of work is required to consider and develop the direction of the OG cancer surgical pathway as a result of the CQC decision, as well as developing better links and relationships across the region. They were of the view that there is a need to ensure a range of work, with robust and interesting job plans, for UGI surgeons, to ensure the Trust can attract and retain personnel within the service.

It was of concern to the review team that the UGI service appeared to have retained all of its operating capacity, despite losing OG cancer resections, whilst LGI surgery struggled with capacity. In order to address this, the review team recommend redistributing some UGI theatre lists to LGI.

3.3.2. Whether clinical decision-making and treatment provided to patients is appropriate and timely

The review team considered that the appointment of a Surgical Liaison Geriatrician was positive, resulting in improved communication and collaboration with surgical staff, better NELA performance data and more thorough and holistic provision of care to elderly and frail patients. However, the review team noted that the capacity of this Geriatrician was stretched and considered that the recruitment of further individuals within this specialty could potentially enhance surgical performance and the ability to review more patients in a timely manner.

The review team had significant concerns about the shrinking of the surgical bed base on ward Level 9A, which was halved from a 70-bedded area to a 35-bedded ward by allowing gastroenterology to use 35 beds. The review team found this resulted in the scattering of emergency surgical patients across multiple non-surgical wards in the hospital, with approximately 30% outliers, and sometimes these patients were reported to be overlooked on ward rounds.

Management of the emergency workload and unselected take was of concern. The review team noted that there had previously been organisation of the surgical teams into three teams (UGI, LGI and EGS), which had been efficient in reducing the number of patients per team, with shorter ward rounds, more patient discharges and more timely decision-making. However, the review team found that this arrangement had been inexplicably abandoned in favour of a return to a two-tier system (UGI and LGI). The review team considered that the new two-tier system, with the halving of the surgical bed base and an increase in the number of surgical outliers, meant that the daily ward rounds by on-call surgeons, which included elective and emergency patients, were lengthy, sometimes finishing as late in the day as 17:00. This impacted on the flow of patients, with a lack of ability to make timely decisions including the discharge of patients. In addition, the review team found there were overburdened CEPOD[26] lists and elective surgical patients, including cancer patients, were being regularly cancelled. In this respect, the review team noted there were cancellations on a daily basis and some patients had been cancelled multiple times, which was causing them psychological distress with an increase in the volume of complaints. The review team also found that these issues were resulting in disgruntlement and disengagement amongst the surgeons.

It was noted that there was no dedicated Surgical Assessment Unit for the assessment and management of acute surgical admissions. This resulted in unwell patients being left in chairs or corridors whilst a bed was found somewhere in the hospital for them. The review team found

[26]). Dedicated theatre lists for emergencies during normal working hours in healthcare organisations. These were introduced into UK hospitals in the early 1990s as a result of recommendations of the Confidential Enquiry into Peri-Operative Deaths (CEPOD).

there was a lack of patient ownership, with the absence of named consultants for patients. This led to a lack of patient continuity, and difficulties in escalating problems in a timely manner when a patient's condition deteriorated. In this respect, the review team noted that when ward staff tried to escalate deteriorating patients, they were met with resistance from surgeons in making prompt decisions regarding patient care. The review team also found that there tended to be poor consultant cover for wards, which also impacted on escalating deteriorating patients.

The review team considered that there should be an urgent review of the two-tier system, with the return to a three-tier system incorporating EGS surgeons, the establishment of a Surgical Assessment Unit and the reinstatement of a 70-bedded space for surgery with the redeployment of gastroenterology elsewhere. The review team considered that the ward rounds for emergency and elective patients should be entirely separate, with dedicated elective surgeons undertaking ward rounds for elective patients, leaving the on-call surgeons to concentrate on emergencies.

The review team had concerns over the management of CEPOD lists, which appeared to be overburdened. They noted there were instances of patients waiting on emergency lists for five days before undergoing emergency surgery. The review team were concerned by this, as this could potentially compromise patient safety and lead to poor outcomes. They found that CEPOD lists were poorly organised, with multiple specialties competing for space. The review team heard that theatre teams had identified that, in order to cater for the workload, two CEPOD lists were required each day, but the review team noted that this rarely occurred. The review team considered that, whilst experienced theatre staff tried to drive the work through the CEPOD list, a lack of engagement from surgeons and no team briefing/huddle at the start of the day meant there was a lack of leadership, coordination and priority setting, resulting in the list being 'chaotic'. The review team were of the view that there should be an urgent evaluation of the CEPOD list function and needs, with two lists available every day, in addition to the practice of an early morning 'huddle' around 08:00/08:30 with all stakeholders including all surgical teams wishing to book cases, in order to determine the priorities for the day.

The review team considered that there were significant delays in the allocation of patients to theatre lists, and then delays on the day of surgery. The review team considered that there was an insufficient amount of theatre space for the number of cases which should be taking place at a major trauma centre. The review team had regard to the reports of regular elective cancellations, with a number of staff expressing the opinion that the RSCH site should be an 'emergency only' site. It was clear to the review team that there was a lack of effective management of elective and emergency case allocations, with a high demand from emergency cases, which impacted on consequent elective cancellations. They considered that a more effective system is needed to ensure elective cases are protected, with matching of the amount of theatre time needed for the emergency and elective cases required to be operated on and allocated accordingly, even if this is on a different hospital site.

The review team were told that when surgeons came onto the intensive care unit (ICU) they did not communicate with ICU staff, who found this caused difficulties and confusion over clinical decisions. ICU staff also reported that it was difficult to find consultants to operate on ICU patients at weekends.

3.3.3. The clinical outcomes for all general surgeons in the department, and whether this gives rise to concerns about poor outcomes

The review team considered that the data from the NBOCA outcomes showed acceptable 30-day mortality rates for colorectal cancer resections.

The review team were told of complications for colorectal resections relating to one of the locum colorectal surgeons, but there was little further detail provided in relation to this.

The review team found the outcome data available from NELA and NBOCA was within normal ranges. However, they noted that local Trust data regarding surgical outcomes was not provided.

3.4. Multi-disciplinary team (MDT) working, communication, behaviours and culture within the department

3.4.1. Team working, communication, behaviours and culture

The review team found there was dysfunctional team working and a lack of cohesion and unity amongst the surgical teams and within the general surgery department. They were told that consultant surgeons were dismissive and disrespectful towards other members of staff and displayed hierarchical behaviours towards allied healthcare professionals, particularly junior members of staff. The review team found that, whilst consultant surgeons were pleasant as individuals, they did not function well as a team and had developed more individualised and silo working practices, which negatively impacted MDT working and had the potential to compromise patient safety.

Reports of negative culture and behaviours within the general surgery department and wider Trust was of concern to the review team. They heard reports of staff witnessing or hearing about instances of bullying and harassment. The review team were particularly concerned to hear reports of two trainees being physically assaulted by a consultant surgeon in theatre during surgery.

The review team were of the view that the lack of unity within the department was partly due to low staff morale as a result of a number of historic and recent challenges within the department and the Trust, including the decision by the CQC in the weeks preceding the review visit with respect to the UGI service. The review team considered that the Trust will need to maintain efforts to address fractured relationships within the department in order to restore unity. In addition, it is imperative that robust action is taken to tackle unacceptable behaviours, given the reports of bullying, harassment and physical abuse.

3.4.2. Effectiveness of MDT working and discussions and documentation of this

The review team found that there were improved MDT practices, particularly with dedicated leadership of the MDT, as a result of the corporate improvement project. However, they were concerned about the lack of ‘ownership’ of patients discussed at MDT meetings, with a lack of named consultants allocated to patients early on in their pathway. The review team found this resulted in variable presentation of patients and consultant attendance at MDT meetings.

It was noted by the review team that LGI surgeons were often unable to participate in MDT due to timetabling and surgeons often had insufficient time to prepare for MDT meetings. This and the lack of patient allocation reduced their participation and engagement in MDT meetings. The review team considered that this was frustrating for other members of staff, in particular the radiologists, who spent significant amounts of time preparing for meetings, only to find that consultants were unaware of specific patients. They found that engagement in meetings was also impacted by virtual attendance at meetings, and considered that in-person attendance should be encouraged as much as possible. The review team considered that there were often too many patients allocated for MDT meetings, which affected the quality of meetings, owing to an inability to discuss all patients in the time allocated.

The review team considered that consultant surgeons should work in small teams, allowing patients to be allocated to surgeons early on in the pathway. They were of the view that this would enable better preparation for MDT, to enable more patients to be presented, as well as more ownership and engagement in the MDT. They considered that this would potentially result in clearer decisions around diagnostic and treatment pathways. The review team were of the view that there is a need to re-define which patients need to be discussed at MDT meetings, given the reports of excessive numbers.

There appeared to be a lack of cohesion amongst the LGI surgeons, and poor leadership demonstrated by the LGI MDT lead in terms of bringing people together. The review team considered that there was a need to re-evaluate the LGI MDT lead role in this respect.

The review team were provided with attendance reports for the LGI and UGI MDT meetings and considered that there was effective record keeping with respect to attendance. However, they were unable to comment further on documentation of MDT discussions, having not been provided with any other documentation, such as meeting minutes.

The review team considered that the effectiveness of MDT working was impacted by reports of a lack of CNSs/MacMillan nurses for UGI and LGI surgery. The capacity amongst the CNS staff had been affected by long-term staff sickness, and some roles within the service being part-time. The lack of CNS capacity meant that it was rarely possible for a CNS to be present in clinics with consultants for newly-diagnosed cancer patients, or to see patients in endoscopy or on the wards. The review team found that whilst there was a focus on CNSs being involved at the stage of diagnosis, more funding would allow CNS support when there was a suspicion of cancer. In addition, the review team found that, due to a lack of capacity, nurse-led clinics, which were important in order to holistically assess patient needs (and had received good patient feedback), had to be stopped. Furthermore, the review team noted that often ‘breaking bad news clinics’ were happening at weekends when CNS staff were not available, and this was another service which would benefit from CNS input. The review team heard that CNS staff did their best to support patients throughout their pathway; when there was sufficient capacity CNSs would provide support to patients at diagnosis, with telephone calls after MDT meetings to go through treatment options, provide support through diagnostic staging investigations, calls ahead of surgery to see how patients were feeling, as well as providing support throughout treatment and post-operatively. However, the review team found that given the staffing issues, the CNSs lacked the capacity to undertake these duties which helped to minimise psychological distress for some patients.

It was encouraging to hear that CNS capacity was improving, with staff returning from long-term sickness, particularly within the UGI service. However, the review team considered there was a need for further CNS support in the LGI service. The review team welcomed the news that funding had been allocated for more CNS staff by the SSCA and considered that such efforts should continue to ensure there are sufficient levels of support and communication for cancer patients throughout their pathway, including CNSs being able to provide support in managing the MDT, including the allocation of patients and giving feedback to patients after MDT meetings.

3.4.3. Balance between service delivery and junior doctor training, including the effectiveness of rota design to allow adequate training opportunities during daytime hours

It was noted that there had been a lack of effective training opportunities for surgical trainees, which had previously led to the withdrawal of trainees by HEE. The review team found there was a disparity in terms of the treatment of Deanery and non-Deanery trainees. Whilst non-Deanery trainees reported being appointed with no difference in terms of balance between service delivery and training in their job plans compared to Deanery trainees, there was a period of time when all training opportunities were given to Deanery trainees, resulting in months where non-Deanery trainees were doing no theatre lists and only undertaking on-call duties.

The review team heard that registrars had no protected time built into their job plans for teaching, training and education. This had resulted in registrars only being used for service delivery owing to the pressures of the service. It was apparent to the review team that trainees’ needs for their annual review of competence progression and any requirements to fulfil this were not being considered.

It was concerning to hear that registrars were not undertaking outpatient clinics. The review team noted that, prior to the COVID-19 pandemic, registrars would undertake clinics with a consultant doing their own clinic next door, meaning that support would be available. With the onset of the pandemic initially there were telephone clinics, with consultants sat next to

registrars. However, consultants then stopped working at RSCH for prolonged periods of time due to health concerns and they were given virtual clinics to be undertaken from home. The review team found that, when the pandemic slowed down, these consultants did not return to on-site working and carried on doing clinics remotely from home. This meant registrars were focused on service provision, including on-call duties, meaning that if they were to return to undertaking clinics this would affect clinical capacity, including ward cover. The review team considered that there was a need to reinstate registrars undertaking outpatient clinics and that this would improve training as well as reducing waiting lists and backlogs. The review team noted that clinic management and attendance was often affected by availability of clinic rooms, and considered there was a need to allocate sufficient clinic rooms for trainees, so that clinics could be held face-to-face, for the benefit of patients and trainees.

The review team considered that there was a lack of provision for endoscopy training for registrars. They were concerned to hear reports of junior doctors having to undertake endoscopy sessions on non-working days in order to gain experience, given the lack of protected time for this. In addition, the review team found that lengthy ward rounds, with 40-50 patients on the list, were not conducive to teaching and training, but were focused on service delivery.

It was noted at the time of the review visit that there was a plan for the return of Deanery trainees to the Trust in October 2023. Whilst the review team had no information as to whether this had been successfully facilitated, they considered that there is a need to urgently evaluate the commitment of the Trust to training, alongside service provision, to ensure the success of any programme of return. A training programme for trainees should be put in place, including teaching ward rounds, clinics, endoscopy and formal teaching of at least two hours per week.

3.5. Other

The review team made observations on the following matters, which formed important context and background to this review.

3.5.1. Leadership within the Trust

Serious concerns about a wide disconnect between staff within the surgical teams and the executive leadership within the Trust were identified. The review team found that there was a lack of visible presence of the executive leadership ‘on the ground’ amongst staff, for example on the wards, and a reluctance to engage with the department, and therefore a lack of true understanding of the challenges affecting clinicians. The review team noted that this was commented upon by a number of interviewees.

The review team were particularly concerned to learn that a ‘culture of fear’ existed amongst staff when it came to the executive leadership team. There were concerning reports of bullying by members of the executive leadership team, with instances of confrontational meetings with individual consultant surgeons, when they were told to “sit down, shut up and listen”, with no ability to express their own concerns, and where they were alone and outnumbered. The review team noted that several consultants had reportedly left the Trust as a result of these issues and others were reluctant to engage with the executive leadership team, including refusal to attend further meetings.

The review team found that staff were reluctant to respond to whistle-blowing requests, given they had experienced instances of other staff members raising concerns through such mechanisms reportedly facing bullying and being dismissed. Whilst the appointment of the Chief of Surgery was found to be positive, as staff felt when they raised concerns they would be taken more seriously, the review team found that the listening stopped at this level, with repeated reports that communication with the executive leadership team was poor.

Several interviewees commented that a number of internal and external reviews had taken place, but there had been a lack of adequate communication about the outcomes, actions and progress in relation to those reviews. The review team heard that staff had several meetings with

senior management, but described these to be ‘all talk and no action’, with nothing changing as a result of those meetings when they tried to raise concerns.

There is a need for the executive leadership team to spend regular time with clinicians within the department, to create more of a visible presence and to truly understand the challenges faced by clinicians and break down the current disconnect which existed. This could involve members of the leadership team spending a day each week on the surgical wards, theatre and outpatients to appreciate the hurdles faced by staff working in the department. The review team considered that having a more visible presence would demonstrate to staff that they are valued and that the executive leadership team want to help them in addressing concerns and challenges. The review team considered that in meetings between clinicians and the executive leadership team there should be more robust action to show that concerns raised have been listened to and that they will be actioned. Those concerns should be documented in thorough meeting minutes, with action points for specific owners clearly defined in the meeting minutes, so that progress can be monitored and followed up at routine intervals.

3.5.2. Internal and external reviews, and reputational damage

The review team found there was a history of an extremely challenged department and Trust, with a number of internal and external reviews having been undertaken, including by the CQC, HEE and other bodies. This had resulted in a negative reputation for the Trust, particularly with a lot of press and media attention. The review team considered that there were common themes in previous reviews around the following: poor leadership, a disconnect between clinicians and management, a negative working culture and poor behaviours. They heard that staff reported receiving no feedback about these reviews, or evidence of change and recommendations being implemented. In addition, a number of staff reported regularly taking issues to management, who appeared to listen but no action was taken as a result. As a result, the review team found many staff were not hopeful that this invited service review would result in change.

It was apparent to the review team that there was a feeling of relative hopelessness within the general surgery department and it was clear that these reputational and cultural issues had affected the morale of many passionate and committed members of staff, some of whom had worked in the Trust for 20-30 years. There had been a loss of long-standing members of staff, and the negative reputation of the Trust was impacting recruitment, meaning that high-quality consultants were unlikely to apply to work in the Trust. The decision of the CQC in the weeks preceding the review visit regarding the UGI service had further negatively impacted the reputation of the general surgery department, reportedly contributing to resignations and also affecting the willingness of surgeons, particularly UGI, to apply and work for the Trust.

The review team concluded that there was an urgent need for the executive leadership team to take seriously the recommendations from all previous reviews, the recommendations from this invited service review, and to take robust action to address the issues identified. The executive leadership team should ensure feedback from reviews and the action which will be taken is provided to staff in a timely manner. Given what appeared to be a history of commissioning further reviews without taking pertinent issues forward, the review team would suggest that the Trust focuses on addressing all issues identified and implementing substantial improvements before requesting any further reviews. The review team concluded that there will need to be commitment from leaders and managers to rebuild an extremely strained department and organisation with sufficient resources dedicated to this.

3.5.3. Staffing and recruitment

It was acknowledged that there had been difficulties in retaining staff, with several resignations reported, as well as difficulties in recruiting permanent and substantive staff. However, the review team considered there was too great a reliance on short-term and long-term locum contracts in order to keep the services and department going. The review team noted there were reports of variable and inconsistent clinical performance from locums, which resulted in a greater burden of responsibility for permanent staff, an inequitable distribution of workload and a lack of continuity of patient care. The review team were also concerned by the fact that the clinical lead

for EGS, who had taken up roles in governance, education and training, was on a locum contract. They considered that there was a need for staff to be rewarded, incentivised, respected and valued when it came to recruitment and retention, and this specific example suggested a lack of reward and value of this individual, in addition to the level of workload, for someone who was a relatively junior consultant.

It was noted there had been a number of UGI consultant resignations following the CQC decision preceding the invited review visit, and the uncertainty regarding the OG cancer service. There appeared to be a lack of plans to recruit UGI surgeons, although the uncertainty regarding the OG cancer service would impact on the ability to attract UGI surgeons. In order to address this the review team considered there to be an urgent need to determine the future OG cancer service pathway and what this will look like in collaboration with the Guildford site.

As previously detailed in section 3.4.2, the review team noted there was a significant lack of CNS staff, meaning that newly diagnosed cancer patients were not being seen and counselled in a timely manner. They considered that there was an urgent need to appoint more CNSs.

The review team noted that there was only one dietician and geriatrician within the general surgery department. The review team heard of the value that both of these individuals provided, but found them to be stretched in capacity. The review team considered that further posts will need to be recruited, which could potentially enhance surgical performance and the ability to see more patients in a timely manner.

3.5.4. HR policies and processes

The review team heard reports about inefficient Human Resources (HR) processes meaning that there were delays in writing to candidates who were successful at interview, resulting in potential appointees reportedly taking up roles elsewhere. The review team heard that one of the consultants had resorted to contacting candidates directly, which was not within their job remit. The review team found that there was a need to ensure all aspects of recruitment are watertight, in order to build safe and sustainable staffing levels across the Trust.

The review team were particularly concerned by reports of a lack of adherence to thorough disciplinary processes, which should be in place to ensure fairness and protection towards employees. The review team heard concerning reports of staff being asked to attend disciplinary meetings without any prior notice, without access to a representative or an accompanying individual for moral support, which resulted in staff feeling intimidated and overwhelmed as a result.

As previously mentioned at section 3.5.1, the review team considered that there was information to suggest that whistle-blowers were poorly treated. They noted that staff were reluctant to raise concerns and utilise whistle-blowing mechanisms given experiences of previous staff who did so reportedly being subject to bullying, disciplinary procedures, referral to their professional regulator and facing being dismissed. The review team considered that the treatment of whistle-blowers supported the reports of a ‘culture of fear’ which existed amongst staff within the general surgery department. The review team were of the view that there is an urgent need to review whistle-blowing and disciplinary policies, to provide training so that all staff are aware of these and their own responsibilities, and this should be monitored to ensure that these policies are closely followed. They considered this to be essential so that clinicians feel able to raise concerns.

4. Recommendations

4.1. Urgent recommendations to address patient safety risks

The recommendations below are considered to be highly important actions for the healthcare organisation to take to ensure patient safety is protected.

1. The Trust should review the contents of this report, and discuss them with all relevant staff within the general surgery department and the Trust. Prior to doing so, the Trust should consider its obligations towards staff in relation to confidentiality, and to patients in relation to GDPR[27].

2. The findings of this report should be brought to the highest levels of the leadership of the Trust for their consideration.

3. The Trust should urgently determine the future direction of the OG cancer surgical pathway. In order to foster collaboration, better links and relationships will need to be developed across the region, including with surgeons at the Guildford site, where OG cancer surgery is now taking place. The Trust will need to ensure there are robust and interesting job plans for the UGI surgeons, in order to attract and retain these individuals within the service.

4. In order to establish better control over the emergency and elective workload, more control and management of ward rounds and the reduction of outliers:

    a) There should be a return to a three-tier system for the general surgical teams (EGS, UGI and LGI).
    b) Appointment of additional EGS surgeons, in order to manage the emergency workload, should take place. Appointment of a minimum of six dedicated EGS surgeons is recommended.
    c) There should be recovery of ward Level 9A as a 70-bedded surgical unit, with the redeployment of gastroenterology patients elsewhere.
    d) A Surgical Assessment Unit, either attached to the accident and emergency department or to ward Level 9A, should be established.
    e) Ward rounds for emergency and elective patients should be separated, with dedicated elective surgeons undertaking ward rounds for elective patients, alongside the on-call surgeons for emergency patients.
    f) Senior decision-makers should see the most unwell patients early on in the day during ward rounds.
    g) There should be efforts to ensure the timely discharge of patients and to encourage patient flow.
    h) An improved system to determine ownership and accountability for emergency patients, to ensure patient deterioration can be appropriately escalated and timely decisions can be made by a consultant regarding their care, should be put in place.
    i) There should be an urgent evaluation of CEPOD list function and needs, with two lists available every day. An early morning huddle around 08:00/08:30 with all stakeholders involved in surgery should be established to ensure a timely start to surgical cases and to determine the priority of cases for the day.
    j) There should be better control of emergency theatres in order to improve flow and free up capacity.

[27] The General Data Protection Regulation (GDPR) 2016: https://gdpr-info.eu/

k) A consistent number of theatre lists to match surgical needs should be maintained by matching the amount of theatre time required for emergency and elective cases and ensuring they are allocated accordingly.
l) Teams of surgeons should work consistently together, with a named team of surgeons to manage the whole patient journey. The consultant surgeons should be run as small teams, with handover between each other, joint ward rounds, cross cover and to enable knowledge of who to contact when patients are deteriorating.
m) Consideration should be given to redistributing some UGI theatre lists to LGI in order to address issues with capacity.

5. To improve team working, communication and the unity of the department:

a) Robust action should be taken to tackle unacceptable behaviours, including addressing hierarchical and unprofessional behaviours and poor communication directly with individuals, and to send a message that this will not be tolerated.
b) Managers and leaders should be invested in addressing poor practices and behaviours, taking appropriate action to respond to concerns and to improve working culture. To assist with this, appropriate training should be given to managers and leaders where necessary.
c) There should be a concerted effort to address fractured relationships in order to promote healing and build cohesion within the department. The Trust could explore external mediation sessions for the consultants and senior management in order to address fractured relationships.
d) Opportunities for face-to-face discussions within the department, on a formal and informal basis, should be maximised.
e) Improvements and achievements within the department should be celebrated, with best practice shared. Effort should be made to ensure positive feedback is given to staff who are doing a good job. There should be consistent efforts to ensure the surgical teams feel respected and valued.

6. In order to ensure the successful return and integration of trainees, as well as a balance between training and service delivery:

a) There should be a reinstatement of registrars undertaking outpatient clinics, with the allocation of sufficient clinic rooms to enable this to take place face-to-face.
b) A training programme for trainees, including teaching ward rounds, clinics, endoscopy and formal teaching of at least two hours per week, should be introduced.
c) There should be a weekly face-to-face meeting between the consultant body and the junior doctors to allocate training opportunities and manage the service requirements.
d) There should be a weekly session where consultants meet registrars, with sufficient teaching and training opportunities, such as joint ward rounds.
e) A lead for Deanery trainees should be appointed to ensure the fair allocation of training, rather than this being subject to consultant preferences.

7. The Trust should ensure all colorectal surgeons are trained in robotic surgery, with opportunities to undertake this at the PRH site.

4.2. Recommendations for service improvement

The following recommendations are considered important actions to be taken by the healthcare organisation to improve the service.

8. The job plans of all consultant surgeons within the general surgery department should be reviewed to check the ongoing suitability of historical arrangements and reasonable adjustments, and to ensure a fairer and equitable distribution of duties, particularly with regards to the on-call rota.

9. Job planning should be undertaken as a whole group of surgeons, rather than individually, to encourage individuals to work together, to break down silo working and to ensure the needs of the service are met.

10. To improve the effectiveness of M&M meetings, these should be held with in-person attendance being the default, in order to encourage greater team building, particularly for consultants who work on different sites so they feel more part of the team.

11. The Trust should encourage the surgical team to visit and learn from other Trust sites, in order to replicate best practice and good ways of working with regard to M&M and clinical governance processes.

12. There should be a fairer distribution of governance duties and workload amongst the different clinical leads. Support should be given to the locum consultant to ensure that additional duties do not impact on their clinical performance, in addition to consideration of their status as a locum.

13. The LGI lead role should be re-evaluated to ensure effective leadership is demonstrated.

14. In order to improve the effectiveness of MDT working:

    a) Consultant surgeons should work in small teams to enable patients to be allocated to surgeons early on in the pathway and so those patients can be presented as cases at MDT meetings.
    b) Consultant surgeons should have sufficient job planned time for preparation of patient cases for presentation at MDT meetings.
    c) Consideration should be given to consultant surgeons' job plans to ensure they have protected time to participate in MDT meetings.
    d) There should be a re-defining of which patients need to be discussed at MDT meetings, to avoid an excessive number of patients on MDT lists. Formal criteria for referral to MDT should be established, written and available to all staff.
    e) CNS staff should support the management of the MDT, in terms of the way patients are allocated and managed, in addition to giving feedback to patients after MDT meetings.

15. Consultant surgeons should be given sufficient job planned time in order to respond to patient complaints in a timely manner.

16. Efforts should continue to increase the capacity of CNS staff through allocation of additional funding for more posts as appropriate, in particular within the LGI service, to ensure that there are sufficient levels of support and communication with cancer patients throughout their pathway.

17. There should be recruitment of at least one additional dietician and an additional surgical liaison geriatrician within the general surgery department, to address current capacity issues and to enhance the ability to see more patients in a timely manner.

18. There should be more effective workforce planning, with efforts to attract, recruit and retain permanent and substantive staff and therefore reduce reliance on locum and other more precarious employment contracts.

19. There should be efforts to foster more collaborative regional links, including developing better working relationships between the surgeons at RSCH, Worthing Hospital and the Royal Surrey County Hospital, Guildford.

4.3. Additional recommendations for consideration

The following recommendations are for the healthcare organisation to consider as part of its future development of the service.

20. To break down the disconnect between clinicians and the executive leadership team:

    a) The executive leadership team should have a more visible and regular presence within the general surgery department. This could involve leaders spending a day each week on the surgical wards, in theatre and in outpatients to greater understand the day to day realities and challenges faced by clinicians. Such shifts should take place within the department over a number of months to that clinicians know that leaders are committed to taking their challenges seriously.
    b) There should be regular meetings between clinicians and the executive leadership team. Leaders should be transparent with feedback from all internal and external reviews and should set up discussion forums for staff about these reviews.
    c) Leaders should show that they are listening and taking concerns seriously with a commitment to robust action, as well as ensuring this is documented thoroughly in meeting minutes, so that action points and progress can be monitored and followed up at routine intervals.
    d) Training should be provided to leaders in taking effective action to respond to concerns, in handling whistle-blowing and disciplinary processes and in addressing unacceptable practices such as bullying and harassment.
    e) Consideration should be given to the suitability, professionalism and effectiveness of the current executive leadership team, given the concerning reports of bullying.

21. The Trust should ensure robust action is taken to address issues and implement recommendations as a result of previous reviews and this invited service review. The Trust should avoid commissioning further reviews until all issues from previous reviews and this invited service review are addressed.

22. The Trust's HR department should review policies and processes to ensure:

    a) Avoidance of unnecessary delays during recruitment of staff, with time limits being set.
    b) All staff are aware of their responsibilities with regards to whistle-blowing and disciplinary policies and processes, and that these are enforced.
    c) Effective support should be provided to whistle-blowers so that they feel psychologically safe in raising concerns. Open discussions should be encouraged.
    d) Exit interviews are conducted for all staff leaving the Trust, and themes are taken on board from feedback for improvements.

23. The Trust should start coordinating and collating patient survey data, in order to consider the patient experience and how this can be improved.

4.4. Responsibilities in relation to this report

This report has been prepared by the Royal College of Surgeons of England and the Association of Surgeons of Great Britain and Ireland under the IRM for submission to the healthcare organisation which commissioned the invited review. It is an advisory document and it is for the healthcare organisation concerned to consider any conclusions and recommendations reached and to determine subsequent action.

It is also the responsibility of the healthcare organisation to review the contents of this report and in the light of these contents take any action that is considered appropriate to protect patient safety and ensure that patients have received communication in line with the responsibilities set out in the Health and Social Care Act 2008 (Regulated activities) Regulations 2014, Regulation 20.[28]

4.5. Further contact with the Royal College of Surgeons of England

Where recommendations have been made that relate to patient safety issues the Royal College of Surgeons of England will follow up with the healthcare organisation that commissioned the invited review to ask it to confirm that it has taken to action to address these recommendations.

If further support is required by the healthcare organisation the RCS England may be able to facilitate this. If the healthcare organisation considers that a further review would help to assess what improvements have been made the RCS England's IRM service may also be able to provide this assistance.

[28] The Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014: http://www.legislation.gov.uk/uksi/2014/2936/contents/made

Appendix A - Information provided to the review team

The following section represents a summary of the information provided to the review team during the interviews held and in the documentation submitted.

This section is largely organised according to the Terms of Reference agreed prior to the review but also takes account of the themes that emerged whilst reviewing this information. Information provided by interviewees during their interviews is presented as it was reported to the review team at the time of their review and circumstances may have changed subsequently. It is summarised in an amalgamated and anonymised format.

The information presented will sometimes reflect the viewpoints of individual staff members and some viewpoints described may be contradictory or may have been expressed in the absence of further, substantiating information. Recording these viewpoints is not intended to imply their factual accuracy. The information in this section does not necessarily represent the review team's opinions, which are provided in the Conclusions section of this report.

1. Effectiveness of current clinical governance practices and clinical leadership to ensure safe outcomes for patients

a) Standard of outcome measures/audits to uphold patient safety, including complication and mortality rates, and how these compare with regional and national benchmarks, and whether appropriate processes and systems exist to ensure high quality outcomes

The review team heard that governance was in the embryonic stages of development with staff hired to manage data coordination and input. They were told that there was a need for better data, with the governance and MDT coordinator needing to sit together and verify data in real time.

The review team were told during the review visit that the NELA and NBOCA data had been submitted without any issues. It was reported that the clinical governance coordinator and Personal Assistant would liaise with the audit coordinator regarding the submission of data. The audit coordinator would cross-check everything to ensure data was accurate, and if there were any issues, they would request clinical notes to double check.

b) Effectiveness of current clinical governance processes, including M&M meetings

Governance

The review team heard that the corporate project identified issues with getting people together in person and a lack of engagement with meetings held online. It was reported that the corporate project had given staff the ability to say things which were being noticed and listened to and that things were changing. The review team heard that there were now more robust governance processes, which were still in development and, if this continued, the service should be able to identify issues straight away.

It was reported that 12 months into the corporate project (at the time of the review visit) there were proper clinical governance processes, including the development of M&M meetings, MDT meetings and consultant meetings, with improvements in culture, teaching and training. The directorate was reported to be better resourced with a governance lead, a Personal Assistant and operational managers. The review team heard that the MDT meetings had good attendance, taking place in person and online. The review team heard that whilst in-person attendance had increased, this was difficult to mandate as it created issues of accessibility. It was stated that the meetings were in person unless individuals had clinical commitments or were on another site.

The review team heard that with the appointment of the Chief of Surgery and the new clinical leads, staff felt their concerns were listened to and acted upon. This included nurses being

listened to and a reported improvement in working relationships across the MDT. It was reported that, previously, there had been issues in escalating deteriorating patients, but this was now acted on, with doctors coming to the nurses to speak about their concerns.

The review team were told that bi-weekly directorate governance meetings were held to go through complaints and serious incident risk registers. There were weekly meetings to go through Duty of Candour letters and delays. It was reported that at the end of these meetings participants would look at learning and try to understand trends.

Complaints

The review team heard that there was a high volume of patient complaints within the directorate, with 45 open complaints at the time of the review visit. It was reported that the most common themes with complaints were:

- Communication, for example around appointment times and patients not understanding their treatment plans;
- Staff attitudes in terms of being patronising, rude and dismissive; and
- Waiting times.

The review team were told that surgeons needed to be clear to patients when delivering news on pathways, treatment and complications to ensure that patients understood and their expectations were managed. In this respect, it was reported that it would be good to have the initial consultant present at the first appointment available after the operation to speak to the patient post-operatively. With two consultants present, one could more easily say what was and was not said; and that if this could not happen, a discussion with two consultants should be arranged. The review team heard that it caused doubt for patients going to see different consultants.

The review team were told that since the Chief of Surgery was appointed there was a clear route to share concerns about staff attitude, and conversations with staff were enabled, along with robust action being taken. The Chief of Surgery was reported to attend patient meetings and to be supportive in liaising with patients' families for difficult complaints.

The review team heard about the complaints process; complaints would be acknowledged within three working days, and patients would be contacted by telephone for an introduction and to understand their expectations. The complaints manager would seek comments from clinicians and investigate the complaint. The review team were told that, whilst the target time for a response to a complaint was 25 days, this was unachievable, and therefore the team worked towards a 40 day deadline. It was reported that a relationship was maintained with the patient, so that they knew the investigation was progressing. The review team heard that patients were called to give assurances and to let them know someone was working on the complaint if they had not heard from anyone in a while, as well as apologising for delays.

The review team heard that having specific governance staff had improved the surgical response to complaints, as there was more support and ownership in reviewing, tracking and progressing complaints. Meetings were reported to be held on a weekly basis to review complaints and identify any glitches in the process. It was reported that there had been a reduction in complaints over time. Individual surgeons' practice had reportedly improved through complaint processes with examples provided. The review team also heard that CNS staff encouraged patients to feedback issues to the PALS to ensure their voice was heard, but beyond that the CNSs were the patient advocates.

Incidents and Investigations

The review team heard that specific governance staff had been appointed to oversee investigation of patient safety incidents and the Duty of Candour process. They would go through complaints and ensure they were responded to in a timely manner as well as looking at learning and action points to feed into governance discussions. It was reported that the resources were previously not in place, so there was no communication with patients and

families about investigations, and some reports and investigations were overdue, with some being outstanding for one year. The review team were also told that surgeons were often not allocated time to respond to complaints and write reports, with one or two of the surgeons having a substantial amount of outstanding complaints, but a high workload. It was mentioned that there were historic serious incident cases which needed reporting on, and a report writer had been employed to work on these reports. The review team heard that these new governance roles would provide the coordination support in order to oversee outstanding reports.

The review team heard that clinicians needed time allocated to get on top of outstanding governance administration and then, once they had, they would only need an afternoon or one day per month. It was reported that there were times where there was no other solution than to reduce clinical commitments or clinicians agreeing to do an additional session in order to complete governance work. The review team heard that surgeons needed clarity on processes for patient safety investigations, in terms of how they arose, were reported, investigated, outcomes, learning and implementation, in addition to training on the Duty of Candour process.

The review team heard that outcomes and learning points from complaints and investigations were fed back at M&M meetings, to ensure learning was complete.

Meetings

Views were expressed that it was positive that meetings had been held virtually since the COVID-19 pandemic, making it easier for people to join, and it was positive that patients could speak remotely to people. However, it was also reported that this had been detrimental for clinical working and the functioning of teams. It was mentioned there were meetings held where some people had cameras off, therefore there was more encouragement of face-to-face meetings, particularly for difficult cases, as it was considered important to meet as a group which was conducive to team working and building. However, the review team heard that whilst many staff would like to mandate in-person attendance, there was an issue of a lack of space.

It was reported that there used to be weekly colorectal and UGI meetings to go through all patients which had worked well but this had stopped. The review team heard that all colorectal surgeons from St Richards Hospital, Chichester and Worthing Hospital had been invited to a hub meeting and, whilst the Worthing Hospital surgeons attended, the Chichester surgeons reportedly did not respond to the invitation.

New Clinical Leads

Historically, the leadership of the surgical department had reportedly not been good, with one surgeon leading the service and covering all governance issues, which was reportedly ‘impossible’ for one individual to do. As part of the corporate project there were now leads for LGI, UGI and EGS, as well as a Clinical Director to distribute leadership. The clinical leads were tasked with issues which had been repeatedly raised, including governance, patient safety, quality of services and behavioural issues. The leads were described as being “dynamic” and it was considered by staff there had been a shift and change. The review team heard that the leads had been effective with respect to MDT meetings and governance and really wanted to help. It was reported that, with the leads in place, there was now a route to raising concerns regarding patients, complications and M&M. It was reported that it had been a positive move giving these lead responsibilities to new individuals, with a ‘fresh pair of eyes’, in order to provide a different perspective. The review team heard that regular meetings were held with the leads, matrons and ward managers to tackle issues, in addition to a senior nurse acting as a voice for the FY1 doctors, speaking with the lead about logistical, practical and behavioural issues.

The review team heard that the leads were starting to receive coaching, as they needed leadership support. A coach had been identified to provide ‘etiquette stability saves lives’ type training. It was reported that the leads would be provided with someone external to speak to in order to develop them as leaders.

It was reported that one of the clinical leads had taken on responsibilities in acute surgery, governance and education. They were a junior consultant, and it was mentioned that usually these duties would not be distributed to such an individual, but no alternative person had been identified as suitable for the position. This individual was described as a 'breath of fresh air' in terms of their style and leadership approach and was doing well with their multiple duties. However, it was reported that there was an issue with this individual's own operative complications, and they had agreed there was a need for mentoring and dual consultant operating. In addition, the review team heard that this individual was a locum, therefore it may be difficult to get 'buy in' from colleagues in terms of improvements. The review team were told that there was too much responsibility for this individual, and the department was not providing support in sharing the workload.

M&M

M&M meetings took place once a month on Fridays and were held for two hours. These meetings were open to the entire department, including clinical, administrative and managerial staff. It was reported that the department would try and ensure everyone was available to attend M&M, but there was pressure with clinical activity, and cancelling commitments could be challenging when they were already struggling to keep up with clinical work. The review team heard that in person attendance was encouraged for more engagement but there was an online option for those with clinical commitments, although there were views that people joining meetings online lost the sense of team building.

The review team heard that consultants would tell the FY1s and clinical assistants about cases and complications, and senior house officers would prepare presentations detailing the sequence of events, issues and learning points which junior doctors would present. This would then be opened up to the group for comments, questions and obtaining feedback. It was reported that consultants would give updates on the ward rounds which the clinical assistants would summarise, and the ward clerks would make notes of cases with complications put forward for M&M.

It was reported that since November 2022 processes had been in place to capture the meeting minutes which were then available on the shared drive. The review team heard that cases had sometimes been presented without notes available, but processes were now in place to ensure the notes were available and that the consultant involved in the patient's care was present to comment where possible. It was mentioned that literature searches could be done live in meetings so there was an evidence base to support decisions. There was a librarian available to go through live articles and research on a database, which provided for analysis of data, results and patient thoughts. It was reported that outcomes from complaints and investigations were fed back at M&M meetings, which ensured there was learning from these meetings.

It was reported that M&M meetings had seen a positive change, with good, healthy discussions taking place. The review team heard that the meetings were helpful and collegiate. There were occasions when there were 'spirited' discussions, but in an open way with explanation of rationale. It was reported that, if there was a complication or problem, staff would feel comfortable in raising it as M&M helped to support challenging cases.

2. Quality and safety of surgical care provided at an individual and department level

a) Whether the management, selection and distribution of cases within the upper GI, lower GI and emergency general surgery service is equitable

The review team heard that there was a need to spread elective capacity. On some days one elective case might be booked for an ICU or High Dependency Unit (HDU) bed, whilst on other days, six cases might be booked. It was reported there was a piece of work ongoing to spread this out, with the expectation that there would be three to four elective cases per day. The review team heard that some general surgery was done at PRH but not complex general surgery or emergencies. It was reported that PRH ICU had capacity to do more work, but a lot of their

services, such as interventional radiology, had been removed, meaning that cases ended up needing to go to RSCH.

It was reported that some surgeons were 'hanging onto' lists, whilst others were doing what they were given on the day. The review team heard that some surgeons had regular lists, protected time and were operating frequently, but that newer staff were 'lucky to have half a list once a week or once a fortnight'.

The review team heard a wide range of reports regarding equitable distribution of duties. These included:

- Some of the more senior surgeons were doing fixed sessions but were not providing on-call/emergency duties.
- Three LGI surgeons did on-call ward rounds, but the rest had issues with health and were taken off the rota.
- The rota was based on how things were during the COVID-19 pandemic, when people came off the rota, but were not put back on. There were 18-19 surgeons, but only seven to eight of the surgeons did emergency duties, including overnight on-calls. These adjustments had never been reassessed, and this had reportedly set a precedent, with half the department not undertaking certain duties. It was reported that a lot of these adjustments and special arrangements suited people due to their age.
- The review team heard that these adjustments led to some consultants doing extra duties, which introduced inequity and unfairness, leading to anger and resentment. In this respect, it was reported that lots of important work was not carried out by three senior surgeons and surgeons were refusing to do things, which led to the resentment of other surgeons given those individuals were fully paid despite not undertaking certain duties.

It was reported that the workload had significantly increased, with a deceleration of elective work. The review team heard that the department would 'pick up the pieces' for emergency work, which had a negative effect on elective work.

The review team were told that the department was under resourced. For example, there was a time where there were 34 all day lists for colorectal, and only one or two lists for UGI. It was reported that ideally there would be four to five colorectal lists a week (one per day). It was reported that, whilst there had been an increase in surgeons, there had not been an increase in theatre lists. The review team heard views that there should be collective/group job plans in order to address any gaps, which staff reportedly were in favour of.

Emergency General Surgery

It was reported that the delivery of EGS had been poor at the RSCH, with ward rounds of 50-60 patients, which was unmanageable. There were plans for a three-'firm' team within general surgery and this had not progressed, but there was a plan to move forward with UGI, LGI and EGS. The review team heard that there needed to be dedicated emergency general surgeons who could manage trauma, rather than getting general surgeons to do this, and that trauma patients would need to go to a dedicated firm and allow on-calls to be separated.

The review team were told that the RSCH was the biggest hospital for EGS, but it was reported that patients could wait four days for an emergency appendicectomy. It was reported that emergency cases impacted on the UGI and colorectal services. The review team heard that there was an issue if 20 additional patients were admitted as emergencies as the service could already have 40-50 patients on the inpatient emergency list at any given time.

Interviewees expressed the view that the RSCH should be an emergency and trauma-only site, with colorectal work going to Worthing Hospital (which had a robot), and UGI going to the PRH, which would require junior doctors to support with post-operative care. The review team were told that there had been a previous decision to bring all elective surgery from the PRH to the

RSCH, but that elective work could be taken back to PRH, and that nursing staff would need to be trained and the consultant set-up rearranged for this.

Upper GI Service

The review team were told that things had previously been going 'well' within the UGI service, which included expansion and receiving cancer cases from Eastbourne and Hastings. It was reported that there had been good outcomes and no mortality. However, in August 2022, following an on-site review, the CQC declared the service to be unsafe and implemented an emergency suspension. This reportedly led to two surgeons resigning. The review team heard that, following this decision, a lot of changes were made, including funding for new CNS staff, dieticians and surgeons and securing more theatre space. It was reported that staff responded to, and met with, the CQC in March 2023, and it appeared to those interviewed that the CQC were happy with the changes made and that things were going in the right direction, after a lot of hard work over the previous nine months. This included the February 2023 NELA data which appeared to show that RSCH results were better than average compared to other units and that the mortality rate was reportedly acceptable.

However, three weeks prior to the RCS England invited review visit, it was reported that staff were told that the UGI service would not be returning, that it would be going to the Royal Surrey County Hospital in Guildford indefinitely and that the RSCH would be a satellite centre managing patients' post-operative care. It was also reported that the hepato-pancreato-biliary service[29] would be going to the Guildford site. Staff were reportedly told that, if they wanted to do UGI work, they could work at the Guildford site. It was mentioned that going forward pre-operative work would be done at the RSCH, with the pathway staying there, but patients would go to the Guildford site for their surgery. The review team heard views that this decision would impact patients, who would have to travel and that their pathway would become 'muddled'. They were told that patients were already unhappy that staging investigations were taking too long for UGI.

This decision was reported by staff to be 'devastating' and 'unfair', and that it led to the loss of two UGI surgeons, leaving one UGI surgeon within the department who could not manage these operations alone throughout the year.

The service was also reported to be unsustainable with a lack of staff, meaning the Trust could not support complex operations, the UGI on-call rota and benign cases.

The review team were told that there was no plan for UGI cancer surgery returning to the RSCH and there would only be benign surgery, and anything more complex would go to the referral centre. It was reported that it would not be possible to attract UGI surgeons, including registrars, without an OG cancer service. The review team heard that the UGI surgeons were frustrated, having not operated since August 2022, and therefore they were not keeping their skills up to date. Interviewees said that management needed to indicate what the plan was, in terms of whether services would be kept or moved to other hospitals.

The review team heard views from some interviewees that the suspension of the UGI cancer service was the correct decision but not for the right reasons. It was explained that it was not that surgery was being performed unsafely or that surgeons were unsafe, but that the MDT function was not working properly, with patients not getting the service they should have on the diagnostic pathway. It was reported that there had been delays from the two week referral, performing CT scans, reporting CT scans and the processes involving the MDT. This also included delays from interventional radiology, endoscopy and access to beds when patients were attending for procedures and radiology. The review team heard that the UGI MDT had not been well led, with too much focus on the MDT supporting the pathway but lacking clinical leadership. It was reported that there was a lack of CNS staff to support patients referred from Worthing Hospital and East Sussex, and that the CNS staff felt unsupported and demoralised, with only one dietician providing full support to the cancer patients.

[29] Diagnosis and treatment of surgical diseases of the liver, pancreas, biliary tract and gallbladder.

It was reported that there were two UGI surgeons who were engaged with getting things ‘back on track’ with a desire and commitment to ‘turn the MDT around’. The review team heard that they had worked hard to amalgamate clinics, so that ‘breaking bad news’ clinics were held at a better time, as well as securing funding for extra full-time CNS staff and a dietician support worker to improve the services. It was considered by some interviewees that focusing on responding to the CQC in order to get the UGI service back would not be the right focus. Instead, some staff considered that it would be preferable to bring the services together and strengthen the surgical team by building links with the Guildford site, in order to build a joint MDT, which would strengthen the quality of the MDT function, and that a joint approach made sense from a patient perspective.

However, the review team heard reports that there was a strained relationship between the RSCH and staff at the Guildford site, with the latter reportedly not supporting joint working, which would make building the pathway a challenge. It was reported that the RSCH UGI surgeons were not given a warm welcome at the Guildford site, and that the Guildford surgeons had undermined the RSCH surgeons with fractious meetings held between them. In addition, it was stated that the Trust leadership did not encourage links with the Guildford site, with their focus and priority being on getting the UGI service back. The review team heard that, given the UGI service had moved to the Guildford site, there was a need to develop good relationships and bridge gaps, with interested parties to operate, teach and train. This would include appointing new surgeons to build those links with the Guildford site and this being recognised in their job plans. The review team were told that in addition to developing a regional MDT between the RSCH and the Guildford site, local MDTs could feed in from Worthing Hospital and Eastbourne. The review team heard that, ultimately, the UGI service needed to return on a joined-up and regional level, and that it did not matter where the operation was done, but that the service needed to deliver a safe pathway for patients. The review team heard views that whilst, in the interim, it was not a bad idea for the service to be suspended, it needed to re-emerge in the longer term in a form capable of attracting excellent clinicians.

The review team heard that the UGI CNS staff would discuss patients at MDT meetings, and if surgery was decided upon, the case would be referred by the MDT coordinator to the Guildford MDT meeting on a Tuesday morning in order to make an informed decision. The review team heard that a patient would see an oncologist at the RSCH, would have any treatment prior to surgery including chemotherapy and radiotherapy, would go to the Guildford site for surgery and then return to the RSCH. However, the review team were told that patients were often not happy about having further investigations in addition to their surgery at the Guildford site, if they could not be accommodated at the RSCH. The review team heard that it was not ideal for patients to meet one surgeon, have someone else do their operation elsewhere and then go back to see the first surgeon for follow-up; therefore it was considered by some interviewees that having the UGI service return to the RSCH would make a difference for patients.

The review team were told that, with the loss of UGI surgeons capable of opening a chest, and a lack of thoracic surgeons, management of chest trauma was compromised. They heard this would be dealt with conservatively, by inserting a chest drain and transferring the patient elsewhere. It was considered by interviewees that it was not ideal for the RSCH to be a major trauma centre without surgeons who electively open the chest on a regular basis. The review team heard that there was a need to decide what UGI surgery was going to look like at the RSCH, and whether this would be a benign service only. It was stated that benign UGI surgery would probably need to involve complex gallbladder surgery.

The review team heard that the CQC decision had made it difficult to advertise for UGI consultants as it was not known what the job plans would look like. It was said that permanent posts would need to be advertised cross-site to do operations at the Guildford site and other surgery at the RSCH. This would involve re-doing job plans and giving people the work they wanted to do. The review team heard from some staff that the only solution was ‘hub and spoke’ working with the Guildford site, with cross-Trust practising privileges. This would involve joint contracts for operating on both sites with the same level of teaching and training.

Robotic Surgery

Some interviewees reported that whilst surgeons at RSCH were involved in purchasing a robot, this was placed at PRH, so it could not be used at RSCH, and there was 'no strategy' for where RSCH surgeons would do robotic surgery. In this respect, the review team heard that robotic surgery had not been embraced at the RSCH. It was reported that robotic surgery had also been invested in at Eastbourne, taking colorectal surgery away from RSCH. The review team heard that at PRH the digestive diseases robotic lists started on time, with the arrival of surgical staff promptly, and that the robotic theatre was one of the most efficient.

b) Whether clinical-decision making and treatment provided to patients is appropriate and timely

The review team heard positive comments in relation to clinical decision-making and treatment provided to patients. It was reported that the employment of a Surgical Liaison Geriatrician had been positive, including the provision of ward cover when they were absent. In addition, the critical care outreach team was said to be good. It was reported that when patients were ill, the critical care and emergency team, consisting of a critical care outreach team nurse and an emergency senior house officer or registrar, would be available straightaway. The review team also heard that advanced trauma was managed well in accident and emergency, that there was an excellent anaesthetic and ICU team and that the nurses and doctors in the HDU were very good.

The review team heard that many staff agreed with the idea of a morning 'huddle' to manage the CEPOD lists. It was reported that, at the time of the review visit, a printed emergency list was used, but it was difficult to determine prioritisation. The review team were told that, whilst a morning huddle was previously agreed and suggested for 08:00/08:15, the surgeons were resistant as they needed to see patients first and undertake handover. It was also reported that it was difficult to have a morning huddle with no set meeting area or room. The review team heard that without a morning huddle taking place to decide on cases based on priority, theatre managers ended up making decisions based on what they thought needed doing but not necessarily in terms of true clinical priority. In addition, the review team were told that a divisional meeting took place at 08:45 on Mondays to Fridays to discuss beds and flow, and that whilst some clinicians engaged in this, surgeons were generally not interested in flow; surgeons reportedly were only interested in whether they would be able to operate and therefore did not attend these meetings.

The review team were told that when reviewing patients on the surgical wards, based mainly on ward Level 9A, the nurses and junior staff were not able to easily find senior support to listen to problems, give advice and to escalate deteriorating patients. It was reported that this had resulted in patients becoming more unwell and reportedly an increase in emergency calls and cardiac arrests.

The review team heard that there was a high emergency presentation for colorectal cancer, with patients with bowel cancer having developed bowel obstruction. It was reported that things had become worse since the COVID-19 pandemic, and that these patients were on elective waiting lists but they were still coming through as emergencies.

The review team heard that there were lots of issues with theatre capacity and flow through the wards, with Level 9A being extremely busy:

- It was reported that there was a lack of room in the emergency department, and there were regularly no beds and physical cubicles for patients, with patients left sitting on chairs in corridors in cramped spaces.
- With patients 'crammed' in corridors, this resulted in delays when on-call consultants were seeing patients.
- There were reportedly long waiting times but a lack of a waiting area for patients to wait. This led to patients becoming agitated, which was not good as their first entry point into the hospital.

- Due to capacity, the sickest patients had to be taken first. There was no surgical assessment area, so patients went wherever they could be fitted in, and if emergency patients were taken in other patients had to be moved elsewhere.
- The review team were told that a Surgical Assessment Unit would make a huge difference, allowing some control over the emergency intake, but this facility had not been factored into plans for the new building. It was reported that if this unit was not put in place the patient experience and surgery would not improve.
- There were views that the accident and emergency department was not fit for purpose for a major trauma centre.

The review team were told that there was an increase in the patient-to-nurse ratio on the wards, meaning that tasks did not get done and observations were delayed. This resulted in accident and emergency patients who needed admission being left to wait on chairs, potentially becoming more unwell before they could be admitted to a ward. It was reported that the whole Trust struggled with managing the flow of patients, being unable to discharge patients at sufficient pace.

The review team heard that ward Level 9A used to be a 58-bedded ward, and this expanded to a 70-bedded ward with an increase in pressure on surgery. There was then a decision to split this into two 35-bedded wards, one for general surgery and one for gastroenterology. This meant that the 70 original surgical beds were halved. The review team heard that this had resulted in difficulty accommodating all surgical patients onto Level 9A, and patients were geographically scattered throughout the hospital, for example on the trauma, neurosurgery, vascular, orthopaedic or gynaecological wards. It was reported that 30% of surgical patients (around 20-30) were outliers all the time, meaning staff had to work across different systems on multiple wards and buildings. Having to visit all these patients meant that ward rounds were inefficient and took far too long and that patients were on wards with an inadequate skill mix making it potentially less safe.

It was considered by some interviewees that Level 9A should be a surgical ward only, and that gastroenterology should be moved elsewhere to accommodate this. It was reported that this was hoped for with the new building, and that this would result in more beds on one unit, the ability to better manage patients and fewer outliers with all surgical patients on Level 9A. The review team were told that having an UGI and LGI side on Level 9A would mean surgeons could own those areas and be responsible for managing those beds. This would reportedly mean more support for juniors in theatre, and make services more effective with fewer cancellations, as well as reducing patients' length of stay.

The review team heard a potential way forward was a three-tier team of UGI, LGI and EGS, with a view to splitting up the responsibility for patients. It was reported that this had been agreed seven to nine years previously as a department, but this was not current practice. The review team were told that it was part of the target operating model of the corporate model to create three teams of eight. At the time of the review visit it was reported there were 17 consultants, and that four consultant fixed term contract posts were being advertised in order to facilitate this model. It was reported that three teams of eight would divide up patients and make ward rounds more manageable. The review team heard that more numbers in each team would mean more rotation on a regular basis, rather than relying on people to cross cover.

It was reported that consultants undertook daily ward rounds of 50-60 patients which was described as 'unmanageable', in that these tended to last all day, finishing as late as 16:00/17:00. The review team heard that this resulted in fatigued decision-making, particularly when seeing patients at the end of the day when surgeons were tired, and that this could potentially result in unsound decisions and compromise patient safety. It was reported that this was impacted by seeing patients who were not on surgical wards, and therefore they had potentially not been managed according to surgical processes and protocols. The review team heard that it had been agreed as a department that such large ward rounds were unsafe and unsustainable with the level of outliers, yet this practice continued to happen. It was reported that consultants had to do their ward rounds quickly, otherwise FY1s would not be released to

do their jobs in the afternoon. With ward rounds ‘rushed’, they would need to be completed by midday, which meant consultants were not being thorough with the patients. The review team were told that with the lack of a three-tier system, the on-call consultant had to see all patients. It was viewed that there needed to be an elective team to see elective patients and an acute team for emergency patients.

The review team heard that, with ward rounds of 50-60 patients, there were insufficient patient discharges. It was reported that it was difficult to make decisions regarding discharge late in the day, and that these decisions needed to be made early in the day. Whilst the review team heard that teams tried to identify patients for discharge the day before, often they were not identified until on the day, meaning the coordination was missing for processes to happen before they were discharged. It was reported that ‘board rounds’, to identify patients ready for discharge early in the day, were not happening; the value of these was not seen with patients scattered around the hospital. It was considered by some that board rounds would make expectations clear at the start of the day. The review team also heard that there were occasions where patients were supposed to be discharged but were missed off the ward round, so that they remained in hospital until the following day. It was reported that an average of a quarter of patients were fit for discharge but were ‘just sitting there’.

The review team were told that there had been a piloting of an EGS team for four days to help with flow, and during those days there were more patient discharges, ward rounds were quicker and more acute patients were seen by the team. It was reported that there were plans to run another pilot for seven days, to see how a whole week including weekends affected patient flow, and that patient surveys would be taken during this pilot. Nurse feedback from the pilot of four days had been positive, particularly due to the increase in patient discharges.

It was reported that there had always been challenges with capacity and the ability to support elective activity, in terms of bed pressures and managing elective and emergency cases. The review team heard that elective surgery cancellation rates were high due to a lack of beds and theatre staff, with many patients cancelled on the day, and often patients were cancelled multiple times. This was reported to be happening on a daily basis, with at least one patient cancellation per day. It was said that patients were often in the theatre waiting area, and were cancelled from theatre admissions before being admitted, having prepared for surgery, which included starvation. The review team heard that sometimes patients were sat waiting for six or seven hours before they were cancelled.

It was reported that there were more theatre cases than could be dealt with, and each week theatre managers had to work out how to keep a list, with a number of lists being cancelled. This affected patients undergoing major surgery, including for bowel cancer, who had had long waits and were acutely ill. It was reported that theatre managers often had to start the day looking at who they were going to cancel. The review team also heard that when nursing and junior doctor strikes were held this resulted in further cancellations.

The review team heard that a ‘hot and cold’ split (separation of emergency work from elective work) would be very difficult. Whilst other sites allowed cancer cases to be protected from acute cases, it was reported that the RSCH had not managed to address this. The review team heard that ‘cold’ beds needed to be ring-fenced on another site so that patients operations could be carried out on the day. The review team heard that sometimes when there was capacity, there were no surgeons available to do a theatre list. It was reported that more lists and beds were needed, in addition to looking at capacity across sites and clinics and job planning appropriately, with job plans being aligned as a group.

It was reported that it was difficult for patients when booking surgery a few weeks in advance, as it was unknown if the surgery would go ahead; patients would plan and get mentally ready, only to have their surgery cancelled, potentially resulting in physical suffering. The review team heard that more patients were being referred for psychological support due to lengthy waits, delays and cancellations. Patients were reportedly in tears after being cancelled a number of times. It was reported that there were a lot of telephone calls from PALS and complaints in relation to cancellations, and a lot of time was spent reporting on reasons why patients had been cancelled.

The review team also heard that the inpatient experience 'was not' good with patients outlying for a while, being late onto the wards, not being picked up quickly and a lack of experienced staff where they were outlying. Pre-operative surgical patients were sometimes on the wrong wards.

In addition to theatre cancellations, it was reported that theatre lists did not start on time, especially when there was no ring-fenced ICU/HDU bed. The review team heard that some lists started without such a bed, which was a potential risk. The review team were told that staff could not get theatre start times to improve as a decision on bed availability was not made until 08:30 at the earliest.

It was reported that the psychological side of preparing for cancer treatment had improved, as previously patients were given one week's notice of surgery, causing psychological distress, but subsequently they were given four to six weeks' notice, with more time to prepare.

The review team heard that staff sometimes felt they were resolving practical surgical problems for patients but not addressing their holistic needs. It was reported that many patients would benefit from psychiatric input, particularly patients admitted under general surgeons following self-harm. However, it was also reported that psychiatry services were constrained.

c) The clinical outcomes for all general surgeons in the department, and whether this gives rise to concerns about poor outcomes

The review team heard that there were no concerns about surgical outcomes and patient safety. It was reported that all staff cared about patients. However, they heard that processes could be better. The review team heard that at the time of the review visit cancer performance had improved over the previous six months in terms of outcomes. It was reported that national audits demonstrated that the department was doing well. The review team were told that patient focused outcomes demonstrated improved leadership in the department.

3. MDT working, communication, behaviours and culture within the department

a) Team working, behaviours and communication

The review team heard from some staff that within the general surgery department there were 'amazing' and caring medical staff, nurses and theatre teams. It was reported that everyone, including the surgeons, cared and was passionate and did everything they could to provide the best service for their patients, amidst resource constraints and other challenges. It was said that the surgeons cared about their patients, colleagues and the profession. It was expressed that the surgeons were a team who could turn to each other for support. This included the colorectal surgeons, who were reported to work well together, providing cross cover, email exchanges, discussion and clarification around prioritisation and decision-making. It was reported that the colorectal surgeons would pick up the telephone and seek help with difficult cases.

However, at the same time the review team heard various reports about divisions, fractions, a lack of cohesion and collaboration and a lack of team ethos within the general surgery department. They were told that there was a lack of collective ownership and pride in the service being provided. It was reported that the consultants worked as individuals, and that the service had evolved from 'a couple of surgeons doing things their way' and never having a team structure. It was said that when consultants were then under pressure they ended up focusing on what they alone were doing. The review team heard that the lack of team identity resulted in a lack of consistency, with one consultant on the ward one week and someone else there the next week, making it difficult to know how patient care would progress.

The review team were told about various issues with team working and communication with the consultant surgeons:

- Consultant surgeons were reported to be 'fine' as individuals, in that staff would get on well with them one on one, and they were approachable, receptive and helpful.

However, it was reported that they were disparate and individualistic, lacking communication skills and there were personality clashes with strong characters.

- There were said to be hierarchical issues with the consultants, in that there was a difference in their communication with more junior staff. For example, it was reported that nurses were not listened to and the behaviours of surgeons towards nurses was dismissive and unprofessional. The review team heard that suggestions raised by nurses would be ignored, but if raised by someone more senior, surgeons would consider them. In addition, nurses often had to resend emails to surgeons to get a response.
- The review team heard that nurses escalated concerns but these were often not heard and dealt with, and they were often shut down by consultants when standing up for themselves.
- It was reported that the surgeons were focused on looking after themselves and fighting their own corners.
- There was said to be dysfunction and a lack of cohesion, meaning that consultants could not work things out together.
- Consultants would become stressed and take things out on each other.
- It was reported that there was public friction between consultants, sometimes in front of patients and nurses and they displayed challenging and unprofessional behaviours, including shouting.
- These issues had impacted on trainees, who were reluctant to take on surgical jobs due to the behaviours of the consultants.

The review team were told that these behaviours and attitudes had been evident for a long time. It was reported that repeated behaviours had not been dealt with firmly enough in the past to prevent their recurrence, with no opposition voice, and there had been no consequences for poor behaviours so things continued as they were with incidents recurring. The review team heard that warnings had been given about formal processes but behaviours were still repeated. It was reported that those who were coming to the end of their careers were reluctant to change, and therefore certain individuals ‘needed to go’ as they would not change their behaviours. In this respect, the review team heard it expressed that new staff needed to come in with new ideas, beliefs and understanding to encourage staff in terms of how they should and should not behave.

The review team were told that the corporate project had started to address historic issues with behaviours, with behavioural contracts, team building exercises and the appointment of certain individuals. It was reported that there had been an investment in HR processes to send a strong message in relation to individual behaviours, for the benefit of the team and the safety of patients. The appointment of the Chief of Surgery had reportedly made a difference, in terms of monitoring and managing these issues, and they were said to be well respected by the team. The review team also heard that the appointment of certain clinical leads had made a difference, as they listened and wanted to make things better. Things had reportedly also improved since new consultants started, who were accessible, friendly and interactive with the team.

The review team heard that during the COVID-19 pandemic it was positive that patients could speak to clinicians remotely, but that this had been detrimental for clinical working and the functioning of teams. It was reported that people joining meetings online lost the sense of team building that was gained from face-to-face meetings. There were views that there needed to be more face-to-face meetings, as it was important to meet as a group.

The review team heard about specific incidents in relation to trainees, including a trainee experiencing shouting and berating from a consultant. Staff reported hearing of incidents of sexual harassment but they had no direct involvement, and that such staff who perpetrated such incidents had since left the Trust. Other trainees, however, did not report experiencing or witnessing incidents of bullying or sexual harassment. The review team also heard reports of a consultant who had slapped the hands of two trainees during theatre, and the incident reportedly

had not been properly resolved. It was reported that this individual had a poor relationship with the junior doctors.

An opinion was expressed that there needed to be a 'rebranding' for a sense of team identity and pride in the team and a need to find a way to work better as a team. Staff reported wanting to see teams work in harmony with more togetherness and less of a divide and 'us and them' mentality. The review team heard that the nursing and non-medical staff were starting to really come together, and it was opined that others should see what non-medical colleagues were doing in order to roll out best practice.

b) Culture

It was reported that there had been historic issues with the reputation and culture of the general surgery department, which had been under scrutiny for some time. The review team heard that the department had a reputation for being challenging and difficult to work in. The culture was described as being 'negative, aggressive and agitated'. One of the biggest issues with regards to culture was the behaviour of consultant surgeons in terms of their interactions and communication amongst each other and their relationship with trainees (see section 3 a) of the report). It was reported that concerns raised by junior doctors had not been listened to and acted upon. The review team heard that the leadership had therefore been minded to remove trainees from general surgery before HEE instructed this to happen. It was described to be humiliating to have the registrars removed from the department, but it was reported that trainees did not want to work in the department due to its history and reputation. The review team heard that the unannounced CQC inspections in 2021 raised significant issues around culture and behaviour in general surgery, with deteriorating team working, negative feedback from trainees and a hands-off approach and poor availability from consultants. This contributed to the decision to launch the corporate project.

The review team heard that some of the most significant issues with the culture of the general surgery department were time pressure and perfectionism. There was time pressure due to a lack of staff and people being overworked. It was reported that the general surgery department lacked an open culture where mistakes could be learnt from and instead there was pressure and negativity and a feeling of a need to be perfect and to not have complications. It was reported that there was a culture of negative relationships with authority, with surgeons refusing to take 'orders' from someone in authority, and a sense of working against authority rather than working together. The review team heard that there was 'firefighting' but a lack of nurturing of the consultants, resulting in many consultants leaving.

The review team were told that it was difficult to be listened to or heard in the Trust. There was reportedly a culture in which there was a lack of change or attempt at solutions when escalating problem issues. It was reported the consultants felt jaded and disengaged with nothing appearing to change until the threat of trainees being taken away.

It was reported that reputation and culture were having an impact on recruitment, and the more that could be done to address this, and to have a department which stood out, the better the applicants would be. The review team heard that coming out of the COVID-19 pandemic there was a sense of change amongst the executive team, due to staff feedback and issues raised by junior doctors. This resulted in the corporate project and it was reported that culture was starting to change for the better since the implementation of the project, although this was very much at the start of the journey.

c) Effectiveness of MDT working and discussions and documentation of this

The review team heard various reports about a lack of patient ownership by consultants:

- 'Hot weeks'[30] were described as being an issue, involving seeing patients one week and then not for another eight weeks, and handing them over to other surgeons. It was reported that this meant there was no formal plan or ownership of patients by consultants following patients throughout their pathway resulting in a lack of continuity. The review team were told that this meant there was a lack of recognition of deteriorating patients, a lack of decision-making and a lack of direction given to nurses, resulting in patients becoming more unwell.
- Some consultants were reluctant to give specific direction for patients who were very unwell.
- It was reported by some staff that no one had any idea who was responsible for the patients and that, when there was an issue, no consultant was willing to take responsibility to escalate and make a decision. This also meant a consultant may be allocated for a patient's surgery as the named consultant, but that the patient may never see them again after the operation. The review team were told that surgeons did not like this as they may be the ones to tell a patient they had cancer, but not the one to operate on the patient. In this respect, it was reported that a traditional firm structure had the advantage of a named person making decisions.
- If there was a consultant ward round, with named consultants for patients, it would enable decisions to be made about patient discharge.

It was reported that patients were on wards for inordinate lengths of time without being checked by the medical team. The review team heard that if issues with patients were raised with clinicians they would advise to continue with the plan but did not make informed decisions. For example, this could result in patients being on antibiotics for weeks without needing them. It was reported that registrars would give a similar response as they considered consultants should be the ones making a decision.

The review team heard that only four out of six surgeons were able to regularly attend MDT meetings. The MDT lead did the preparation, including fifty percent of the administration. Cancer patients were reportedly allocated to the MDT once they were on an operating list. Patients were discussed in order of priority to ensure a critical spread of cancers amongst the surgeons. Surgeons would be allocated patients four weeks in advance so that they could be seen in surgeons' outpatient clinics.

It was reported that MDT meetings were sometimes smooth and at other times they were 'chaotic', and this depended on who was chairing. Meetings lasted for two hours and at times there was an excessive number of patients, sometimes as many as 58 patients. The review team heard that radiologists spent a lot of time reporting and preparing, which was a high volume of work, but reportedly surgeons often were not prepared, and often nobody knew the patients. Without such preparation, patients ended up being 'recycled', as scans were not reported. The review team heard that it felt like 'a waste of time' if clinicians had spent hours preparing for the MDT meeting but the Chair did not know the patients and was not prepared. It was reported to be a long-standing issue in terms of surgeons not having job planned time for MDT preparation.

The review team heard that sound MDT processes were lacking, and there was a need for more formal processes agreed by the MDT. The review team were told that staging investigations were being repeated for patients as they had often already waited for three months in their pathway. The review team heard that there was a challenge in getting through patients in a timely manner at MDT meetings, particularly with not having an identifiable surgeon at the beginning of the patient journey. It was reported that there was a need to identify best practice in MDT pathways and to replicate this.

[30] A surgeon's on-call week, when they do not undertake any elective work, and are available the entire time for emergency surgery, clinics or ward work.

The LGI MDT was reported to be fragmented, with conflict due to a lack of good leadership. It was reported that the LGI MDT lead was ‘strict’, and that staff could only communicate with this individual about what went on the MDT list, even though the LGI MDT lead only knew the patients if they had seen them.

At the same time, the review team heard positive reports about current MDT processes. It was reported that the MDT had evolved from individual surgeons seeing their own patients and bringing them to MDT to a much more integrated approach. There had been a system where a patient was seen in clinic and then everything flowed under that consultant’s care, including outpatients, surgery and post-operative care. It was reported that there was now a system where patients were discussed at MDT meetings, not under a named consultant and, when surgery was decided upon, the patient would go on a list. The MDT lead would speak to theatre managers once a week to allocate patients onto a list, looking at their needs to ensure fair distribution. The list would be drawn up six weeks in advance and surgeons were asked to check this in advance to ensure everything was done for patients and in order to raise any issues.

It was reported there was an evolution to the MDT hearing about cases as soon as the patient was diagnosed with cancer. The CNS would see the patient for an initial nurse-led consultation to go through a holistic needs assessment. It was reported that this speeded up the pathway getting CNS staff involved earlier, as there was usually a wait to see a surgeon and an oncologist. It was reported that when there was CNS capacity there was a proper structure, with clinics for patients to be followed up, patients mapped to scans and going straight to the MDT, which worked well in terms of patients having a clear follow-up template and structures, including when they would have surgery. The review team heard that this had improved the patient experience and timeliness of investigations, and there was excellent patient feedback around meeting a CNS within the first few weeks of diagnosis.

The review team heard that the MDTs were supported by a ‘fantastic’ coordinator, reasonable technological support and good radiology and pathology involvement. It was reported that there was good CNS input which had helped shape the MDT and working patterns. The MDT was reported by some staff to be functioning well.

The review team heard that during the COVID-19 pandemic MDT meetings started to be held online which worked well at that time. However, it was reported that staff would ideally like to return to in-person meetings, but there could be issues with room availability.

CNS Support

The review team heard that CNS staff get involved in patient care at the stage of cancer diagnosis. CNSs support patients through diagnostic staging investigations and treatment, with calls after MDT meetings so patients were aware of treatment options. It was reported that, as soon as a CNS met a patient, they would be given a new patient pack with contact details to contact the CNS if there were any concerns. The review team heard that, as soon as the first diary appointment was made, the patients would be on the CNSs ‘radar’.

There were issues reported with regard to CNS capacity. It was said that three years previously the MacMillan service was fully staffed with a good functioning MDT, but it was reported that there were now staffing issues due to long-term sickness and staff leaving and some CNSs working part-time, resulting in a lack of CNSs. At the time of the review visit the service was reported to be reduced by forty percent with an impact on MDT working and the patient experience. It was reported that the CNSs had to prioritise with community patients over a helpline.

With these workforce issues it was reported that CNS capacity had reduced, resulting in them only being able to manage clinics and outpatients. The review team heard that CNS’ used to book telephone calls with patients ahead of surgery to see how they were feeling, as well as several times throughout their treatment and post-operatively. CNSs would also visit patients on the wards after surgery but, given the staffing issues, the ability to undertake such duties (which minimised psychological distress) was reduced.

It was reported that the CNSs were doing nurse-led clinics, which received good feedback and surgeons were keen on this, but these had to be stopped due to staffing capacity. It was hoped they would return in order for CNSs to undertake holistic needs assessments and that such a first meeting was important to get to know patients. The review team also heard there were issues in securing rooms for nurse led clinics. The RSCH was reported to be an outlier where surgeons were seeing cancer patients without a CNS present and that, in most other units, if cancer was diagnosed, the surgeon would have a CNS with whom to see the patient. This was routinely brought up by surgeons in terms of not having a CNS in their clinics. It was reported that with sufficient CNS capacity they were the mainstay of understanding the patient journey, but with capacity constrained patients were not being seen by either a CNS or surgeon.

'Breaking bad news' clinics were reported to be 'all over the place' and were often held at weekends, when CNS staff were not available meaning CNS staff arrived at work on Mondays to see patients who had received bad news at the weekend. It was reported that patients were waiting longer for support that they needed following bad news. The review team heard that CNS staff had requested consolidated clinics to dedicate time for nurses to see patients.

The review team were told that when CNSs were struggling with capacity, they could allocate nurses from other teams to check messages and respond to patients. It was reported that if patients needed to be seen, CNS staff would try and accommodate this, but the biggest constraint was lacking access to a room to bring patients in regularly.

The review team heard that it was important for CNSs to visit patients, to provide support and continuity; the impact of the capacity issues had been detrimental to patients. The review team heard that the CNS staff appeared stressed and overworked with high caseload volumes, and these issues had impacted CNS morale. It appeared there was less focus on the importance of the CNS role and a lack of investment. It was said that they needed to be an increase in funding in order to get involved at the stage when there was a suspicion of cancer, not just at diagnosis.

It was reported at the time of the review visit that capacity was improving, with staff returning from long-term sickness. In particular, it was mentioned that CNS capacity within the UGI service had improved, but there was a need for more CNS support in the LGI service, although there had been no extra funding for this.

The review team heard that CNSs could have a bigger say in the way patients were allocated and managed in the MDT, but this could be influenced by the consultants. It was reported this would not happen in the LGI MDT due to the poor relationship between the consultants and nurses, the way the MDT was run and nurses not being listened to.

It was reported that a bid had been put in for a CNS rotational development programme to support their progression, training and development.

d) <u>The balance between service delivery and junior doctor training</u>

<u>General</u>

The review team were informed of historical issues with regard to the management of trainees. It was reported that limitations had been placed on working practices by HEE, which impacted all trainees, including those of staff or registrar grades, senior house officers, core surgical trainees and foundation doctors. This included registrars and house officers being removed from the service due to a lack of training and senior support. The review team heard that this had resulted in more temporary and locum staff, which had not been good for long-term planning or strategic thinking.

In relation to trainee capacity views reported included:

- Registrars rarely went to endoscopy lists as there was not enough time, or they ended up doing this on their days off.

- Junior doctors often had to take annual leave in order to undertake training courses.
- Registrars were not doing any outpatient clinics, partly due to a lack of registrars available for ward work and because of a lack of physical rooms for this. It was reported that it was ‘difficult enough’ for consultants to get rooms to see patients, ‘let alone registrars’.
- Registrars could fail exams if they could not attend and speak about what they did in clinics.
- More space was needed in order to arrange a rota for the returning registrars in October 2023.

The review team heard that trainees had been unhappy with the on-call rota and level of training. It was reported that across all levels of trainees there was a lack of cohesion in education and training, with trainees frequently reporting being treated unfairly, feeling demotivated and not getting opportunities to undertake training. The review team heard that one consultant preferred not to undertake education and so did not take junior doctors into theatre with them. Such behaviour reportedly became endemic, meaning other consultants said they would not deliver training. It was reported that trainees were asked by consultants not to be on their ward rounds, were not invited to theatre and were not part of an active teaching programme. The review team heard that consultants were not undertaking educational supervisor roles and therefore did not want to pass on their expertise. This reportedly resulted in junior doctors becoming alienated as they were not getting the experience they needed. The review team also heard that many trainees had been worried about their futures with a senior consultant leaving, and they had been concerned that the supportive culture and learning environment that had developed under this consultant would not continue, so they started looking for other jobs.

It was reported that there was a hierarchy between those who had trained through the UK system and those who had come from abroad through CESR[31] routes, but there was now an active programme for long training registrars to support them getting their CESR. It was reported that some of the consultants were good at engaging with trainees, giving them time for learning and opportunities for discussions and this built a better relationship between consultants and junior doctors, with trainees wanting to learn and consultants being more willing to give their time.

The review team heard that the Trust had been working with HEE and the GMC to ensure that the training environment was fit for purpose. It was reported that foundation trainees had not been fully withdrawn, but had been removed from night working. Middle grades were not formally withdrawn, but were strongly advised not to undertake night duties. Issues had been revealed with previous HEE visits, including reports of bullying, which was also reflected in the national training survey. It was reported that there had been significant improvements over the six months prior to the invited review visit, with assurance provided to HEE about middle grade Trust employed doctors. The review team heard that there had been positive feedback from foundation trainees in January/February 2023 regarding support, mentorship and pastoral care from educational supervisors and middle grades. The review team were told that educational supervision had improved to reflect HEE requirements and engage surgeons in a positive way.

At the time of the review visit, it was reported that HEE took all special measures and monitoring requirements away and recommended trainees returning to the RSCH in October 2023, with four trainees as a core to support each other, and that the Deanery intended for six trainees to return in October 2023 if issues were resolved. The review team heard that in the run up to this there was focus on who would be looking after these trainees, what lists they would be doing and where medical students would go, to avoid those with ‘problematic behaviours’ being paired with the trainees. The Trust was reported to be committed to restoring professional trainees in October 2023, and giving them consistency in terms of experience and a place to base themselves throughout their career.

[31] Certificate of Eligibility for Specialist Registration (CESR). This is a route of entry onto the specialist register for doctors who have not followed an approved training programme.

It was reported that with the planned return of Deanery trainees this needed to involve, and not separate out, non-training doctors, to avoid clashes and trainees not staying for long. The review team heard that the RSCH had a lot of potential as a teaching hospital, with a large cohort of trainees and lots of expertise amongst the surgeons. In this respect, it was reported there was a good medical school with the ability to undertake new projects, an exceptional level of research from fellows and student feedback and engagement within the medical school was very good.

Clinics

It was reported that there was not enough clinic capacity within consultants' job plans to keep up with increased patient demand, and they would need to do three to four clinics a week to keep up with demand and see patients. It was reported that, with the plan for registrars to return in October 2023, they would need to sit with consultants to see patients. The review team heard that, at the time of the review visit, there were no registrar led clinics, but that it would help with capacity if these were held. The review team also heard there were room constraints for clinics.

The review team heard that prior to the COVID-19 pandemic registrars would have an allocated consultant doing a clinic next to registrars doing their clinics. If there were any issues the registrar would wait for the consultant to finish seeing patients and then ask for help, which provided good support. With the onset of the COVID-19 pandemic, it was reported there were telephone clinics for the first two to three months, where consultants sat next to the registrars. Then, due to health concerns, some of the consultants stopped working at the hospital for prolonged periods of time, and they were given virtual clinics to be done from home. Once the COVID-19 pandemic slowed down, these consultants reportedly did not return to on-site working and carried on doing clinics remotely. This reportedly left a period of a time where registrars were constantly doing their on-call commitments and no clinics.

It was reported that when staffing improved the focus was on service provision, so there was no time for registrars to undertake clinics. The review team heard views that it was important for trainees to be in clinics, as they were different from theatres, and it would be difficult to manage clinics as a consultant, if doing so few in training. It was reported that clinics needed reinstating, but staffing was so inadequate that, if registrars were doing clinics, it would not be possible to maintain ward cover.

The review team heard views on outpatient clinics including:

- Outpatient clinics had been cancelled to get consultants to do ward rounds, discharge patients and increase flow, but that this was not necessary for surgery.
- It was considered that consultants could do ward rounds in the morning, but did not need to see patients in the afternoon if there were no major concerns, and that trainees could do this.
- Cancelling outpatient clinics increased the backlog.
- Trainees needed to undertake more clinics to get training, reduce waiting lists and ensure clinical effectiveness, and consultants could be doing their clinic next door in order to provide support (as had previously been the model).
- Trainees could be given a trainee list, with patients they could handle, which would help manage emergency admissions and patient flow. The review team heard that this issue had been raised repeatedly, but had reportedly been rejected by the executive team. However, it was also reported that the executive team was receptive to reducing clinical activity to allow such training to occur when they heard that these issues would be raised in interviews as part of the invited service review.

Non-Deanery Trainees

The review team heard that in non-Deanery trainees' job plans most of their time was allocated to service provision. It was reported that the only teaching was in theatre, which involved doing parts of an operation, but this was dependent on the surgeon. Time off for teaching was not

formalised and these trainees tended to go to whoever they were working with. The review team heard that the training system was not structured in the way it was for Deanery trainees, with no regular meetings with educational supervisors, and not all trainees having an educational supervisor. It was reported that some trainees 'just met with consultants to get things signed off'.

The review team heard that previously there was no difference between Deanery and non-trainees, and the contract was signed on the basis of being treated equally. However, there was then a period of time where all training was given to Deanery trainees, resulting in non-Deanery trainees only undertaking on-call duties. This was reported to be professionally difficult for non-Deanery trainees, with no clinics, teaching or support.

The review team were told that previously consultants had been challenging to work with, but they were now more approachable, engaging and willing to work together. It was reported that non-Deanery trainees were able to reach consultants by telephone, including when on-call in the middle of the night, and they were able to receive the required support. The review team heard that junior doctors tended to go to registrars for support, who, alongside the senior house officers, were accessible and available.

It was reported that some consultants wanted to see all patients on ward rounds, whereas others wanted to see outliers and were happy to delegate other patients to registrars, and then would come together at the end of the ward rounds to compare lists and notes.

The review team heard that ward rounds were not being used as an opportunity for teaching, with most registrars preferring to split the ward round with the consultant and talk through the list at the end. It was reported that if there were questions or something was of interest, the consultant would talk through cases but not routinely. The review team were told that teaching ward rounds used to happen when there were fewer patients, but at present, there were often ward rounds of 60 patients, which made this difficult, and these tended to be service ward rounds rather than teaching opportunities. It was reported that consultants had a clear idea of what they wanted to achieve, so that at the end of the ward round there would be time for discussion, teaching and learning.

The review team heard reports of non-Deanery trainees coming in on their days off to participate in endoscopy lists, as this was not in their job plan and there was no support from the Trust to do such extra activities.

Deanery Trainees

It was reported that the Deanery trainees all had educational supervisors with whom they met to go through and assess progress against objectives, as well as designated protected teaching time each week. The review team heard that Deanery trainees had been able to go into theatre and observe and scrub in when consultants needed someone to assist, with the consultant talking through the whole procedure. It was reported that consultants were approachable, and made time on a Thursday for teaching, and that they would take time to explain interesting cases on ward rounds. The review team heard that Deanery trainees were encouraged to do audits and academic work. They were each allocated an audit to do, and would present in front of the surgical team at clinical governance meetings.

The review team heard that Deanery trainees would approach senior house officers, who were very experienced, for support, as getting hold of registrars could be difficult. If it was difficult getting hold of someone on-call, trainees would message in a WhatsApp group, and one of the on-call consultants would assist. The review team heard that trainees would work with clinical assistants who undertook administrative duties, blood requests, scanning results and updating lists when new patients came in, so that the doctors could focus on their role and seeing patients. Clinical assistants would attend ward rounds, complete pre-ward round sheets and put the information into patients' notes.

The review team were told that Deanery trainees tended to be on the rota in the same place and with the same team for a few days which allowed for more ownership and continuity for patients

and which was better for patient safety and care. The review team heard that there was good senior support on the wards in order to escalate deteriorating patients to senior house officers or registrars. It was reported that concerns about staffing had been addressed, but it was still a struggle to retain staff.

It was reported that FY1 doctors had good support and training and that they were busy but the workload was manageable. They received teaching and training by clinical fellows and dieticians as well as safeguarding teaching. The review team heard that FY1 doctors had protected time within the rota to attend MDT meetings once a month to observe and understand how they worked, as well as a day of protected time to prepare for M&M meetings. It was said that general surgery was good for surgical training as there was a lot of exposure to surgery and therefore the ability to learn from operations.

4. Other

The review team heard information which related to contextual matters and the background to this invited review.

a) Leadership within the Trust

Reported views in relation to Trust leadership included:

- Some staff reported that it was ‘unfair’ that the poor reputation of general surgery had developed, as this was more of a Trust and leadership problem.
- The Trust reportedly lacked strategy, with every change in Chief Executive resulting in a change in plan and direction; such constant change was not good for an organisation.
- There had been poor management of services for over 20 years at the Trust.
- The organisational management was reported to be bureaucratic, giving little autonomy to anyone else, was defensive to new ideas, with the CQC ‘on its back’, and it lacked an individual who could make things work.
- The Trust needed someone from the outside to come in and resolve issues with strategic direction and to reverse the defensive culture.

The review team heard views in relation to previous reviews, including the Dawson and Edgecumbe reviews (the reports of which were provided to the review team as part of the background documentation):

- It was reported that staff, having been interviewed for these reviews, had received no feedback from them, and were not provided with the reports.
- Whilst there were multiple reviews over several years, senior management did not do anything to respond to these reviews. Staff reported feeling doubtful that this invited service review would lead to any change.
- It was reported that a number of meetings were held with senior management but no decisions were made and no action came about as a result.
- Staff reported feeling as though Trust leaders listened but no action was taken, and that the leadership had never really heard the department’s concerns and suggested areas for improvement. In this respect, it was reported that there was no leadership from the Trust, which was described as ‘just a talking shop’.

The review team heard of a long history of a ‘culture of fear’ within the Trust, with whistle-blowers reportedly being badly treated. Staff reported being reluctant to put any concerns in writing, as they would then worry about being victimised, referred for regulatory action and/or dismissed, as they believed this had happened to colleagues. This ‘culture of fear’ was said by some to exist in association with a number of Chief Executives, with their ‘tactic’ being to reportedly pick on someone in the department who spoke up and then to dismiss them. It was reported that staff were offered face to face meetings with the executive leadership team

following the CQC report, but they were fearful and would not attend these. It was reported that this was frustrating for staff who felt they could not escalate issues further.

In this respect, it was reported that members of staff were reportedly invited to attend meetings with members of the executive leadership team and, when attending, they were told to 'sit down, shut up and listen'. Reportedly, whilst the staff members tried to speak up, the leadership team would not listen, and those staff members were blamed for issues within the service. Staff members described such experiences to be 'raw and unpleasant'. The review team heard that the executive leadership team took on a 'divide and conquer' approach with the staff in this respect, holding meetings where individuals would be outnumbered. It was reported that staff had been called into meetings and put under disciplinary processes, without any prior notice, and no opportunity to bring an individual with them to the meeting for moral support or representation.

It was reported by staff that they did not think things would change with the current executive leadership team. The review team heard that this culture had resulted in staff resignations when they were giving their opinions, not being listened to and being told to 'shut up'.

Reported views in relation to the Trust executive leadership team included:

- There was a hierarchical system with the executive leadership team, with an impossibility for staff to go straight to this team with their concerns. Staff often had to speak to a middle person who would then raise it with the executive team.
- It would be better for the leaders to spend time and have a visible presence on the ground with managers and staff and to ask questions.
- Leaders ought to be present to see what it was like to be in theatres, including running lists when there were no beds, and what it was like to be on-call.
- Leaders did not understand the problems, and therefore they should 'come down to the level of staff' to appreciate issues and to stop making unnecessary changes.
- Senior management were extremely difficult to liaise with, with meetings being regularly cancelled.
- Staff wanted to work with senior management, as staff had skills they lacked and vice versa.
- There should be better representation of consultants and staff at executive and Board level meetings in order to get their voice heard.

The review heard that the Chief of Surgery was very committed, delivering a high level of leadership within the surgical division with a number of successes. Whilst it was reported that this individual worked hard to support staff, it was said that if concerns were raised to other leaders nothing would happen.

b) Reputation

The review team heard that press reports about the Trust were usually negative, with patients made aware of waiting list problems and the fact that the RSCH was struggling. It was reported that whilst the Trust had status as a medical school, it lacked the income stream and strategy to develop that type of model. Whilst there used to be funding for academic posts, there was no longer funding for these and academic posts got 'eaten up' into clinical posts and disappeared. The review team were told that the RSCH needed to re-establish itself as a centre of excellence, to lift quality, with cancer care having an equal place at the table as emergency care.

c) Staffing

The review team heard that following the COVID-19 pandemic the Trust had reportedly lost fifty percent of the nursing workforce, but since then had worked hard at retention, and at the time of the review visit there were reportedly a low number of nursing vacancies.

The review team heard views in relation to locum staffing including:

- The general surgery department was run by locums, which should be the exception, and this meant that patient care was impacted.
- Reportedly, fifty percent of consultants were locums and whilst the long-term locums were good, the short-term locums were described as ‘hit and miss’.
- Views were expressed that there was ‘always a problem with these locums’, who ‘did not know the Trust and systems’.
- It was reported that with locums ‘coming and going’ there was no regularity and patients did not know who was looking after them, resulting in poor patient care.

The review team heard that there was difficulty accessing consultants for escalation and decisions with issues of supporting and supervision of the locums, and it was hoped that fixed term/substantive appointments would rectify this. The review team were told that there was a need for more colorectal consultants, ideally eight for an elective service. At the time of the review visit it was reported that the department was advertising for four fixed-term consultant contracts, with a plan to then make those staff permanent.

More generally staffing issues were reported across the board. The review team heard that there were severe skills mix issues, which affected theatre lists. It was reported that prior to the COVID-19 pandemic there was a rich skills mix, so there was no need to worry about where to place staff.

It was reported that there was a lack of junior doctors at senior house officer and registrar level. The review team heard that HR processes impacted this, as, reportedly, candidates were interviewed, but HR then ‘did nothing’ and candidates ended up finding jobs elsewhere. It was reported that one of the consultants had to resort to contacting candidates directly although this was not within their remit.

The review team heard that there was a ‘superb’ dietician consultant, but that having one person for the whole UGI service was not enough. It was reported that the surgical liaison geriatrician would see patients over 80, and those aged 65 and above with certain conditions. This individual was on a half-time equivalent contract, but establishing the service and relationship with patients had taken time. It was reported that the geriatrician would have a FY1 doctor with them each day, with this being a different one each day since December 2022, and that this would be planned in blocks from August 2023, which would be more educationally and clinically effective. It was reported that the geriatrician was stretched in terms of capacity, and therefore there would be added value in more appointments to this specialty. The review team also heard of capacity constraints amongst the CNS staff, and that there was a plan to appoint two or three more Band 7 staff, a Band 6 support worker as well as additional dietetic support.

d) <u>Regional Working</u>

The review team were told that the general surgery department was interested in opportunities to use Trust sites in a more holistic and patient focused way, with new opportunities since merging with Worthing Hospital and St Richards Hospital, Chichester and staff across sites being able to educate each other through collaboration and discussion. It was reported that such collaboration with other sites was important, given the amount of trauma and emergency work at the RSCH, and there needed to be prioritisation for moving elective activity elsewhere. The review team heard that there was ‘fantastic’ capacity at PRH, Worthing Hospital and St Richards Hospital and there was a need to use these sites to their full potential and merge surgical divisions to be more strategic across regions.

It was stated that when booking cases onto other sites staff would need to check with the wards that they could care for patients safely post-operatively. For example, the review team heard that PRH reportedly was not set up in a way for staff at PRH to be comfortable or safe with complex care post-operatively, and so if cases were going to go to PRH some work would need to be done around this.

It was reported that a lot of elective work which was cancelled due to lack of beds at the RSCH was sent to Worthing Hospital, and therefore it was important to use this site, with the main constraint at RSCH being theatre and bed capacity. The review team also heard that some of

the RSCH consultants worked at Worthing Hospital for six weeks, which they enjoyed. It was reported that for some time elective work was moved to Worthing which worked well. However, the review team heard that there were issues with the Worthing Hospital consultants saying they would not look after these patients, and RSCH surgeons saying they would not go there to do post-operative ward rounds. It was reported that it was not a case of an ‘easy lift and shift’ in terms of where the patient would have surgery, but there needed to be some thought about post-operative care. The review team were told that there needed to be meetings between the two sites as well as job planning for the surgeons and agreeing a sensible rota.

The review team were told that if the two colorectal departments at Worthing Hospital and RSCH were to be merged this would require a major ‘re-jigging’ of job plans. The Worthing Hospital colorectal department was reported to work well, with fewer CEPOD cases and a small number of on-call cases, and fewer emergency constraints than at the RSCH. However, it was reported that the Worthing Hospital consultants did not want to merge with RSCH, and therefore there was a need to build better relationships between the two sites, in order to establish and develop regional links.

The review team heard that there were no reported issues with behaviours at PRH, with good relationships between their surgeons and those at RSCH and good communication amongst the teams, with good attendance at surgical briefings and de-briefings. It was reported that the HDU at PRH had more capacity than RSCH, which could be utilised. At the time of the review visit, for instance, it was reported that there were eight HDU beds at PRH, but only three were being used.

Appendix B – Service overview information

Prior to the review visit the healthcare organisation was asked to complete the following 'service overview form'. The information presented below is what was provided to the RCS England in May 2023.

Information request	Number	Additional notes
Local information		
Catchment population	947,857	2020-2021: 472,690 2021-2022: 475,167 Trust population: The UH Sussex Trust Catchment population was defined by the Office for Health Improvement and Disparities (OHID) as being: 970,423 in 2020. Population projections split by age and sex are available from ONS by local authority up to 2043. These cover all the local authorities covered by the Trust. However, for some local authority areas, a smaller proportion of residents would be considered to be within the catchment for the trust, these include areas such as Wealden, Horsham, Mid Sussex and Adur. Using data provided by OHID giving catchment percentages of each Middle-Layer Super Output Area (MSOA), I have applied this to the local authority projections and age profiles by relevant MSOAs to give an annual growth rate for the trust catchment from 2021 up until 2032, adjusting for the proportion of local authority area covered by trust. Also, we know the hospital population is different to the general population, we tend to see older age groups using our services. Therefore I have applied an age weighting to better reflect the aging profile of patients we expect to see - age and sex breakdown of our critical care cohort for 19/20 has been applied to the our Trust catchment projected population profiles until 2032. ONS base population growth within the trust catchment area is expected to increase by roughly 0.5% per year, and by nearly 5% by 2032. Using a weighted population calculation for the critical care cohort, we would expect a figure of demand closer to 1.2% per year and 12.5% by 2032.

<table>
<tr><td></td><td></td><td>Population split by site:

<table><tr><th></th><th>2020</th><th>2021</th><th>2022</th><th>2023</th></tr><tr><td>PRH</td><td>138,986</td><td>139,714</td><td>140,446</td><td>141,183</td></tr><tr><td>RSCH</td><td>331,239</td><td>332,976</td><td>334,721</td><td>336,475</td></tr><tr><td>SRH</td><td>211,175</td><td>212,282</td><td>213,395</td><td>214,513</td></tr><tr><td>Worthing</td><td>289,023</td><td>290,538</td><td>292,060</td><td>293,591</td></tr><tr><td>UH Sussex Catchment</td><td>970,423</td><td>975,509</td><td>980,622</td><td>985,762</td></tr></table>
Further information found within ‘Estimated Hospital Population Growth’ Spreadsheet provided by Trust prior to the review.</td></tr>
<tr><td>Sites providing specialty service</td><td></td><td>Royal County Sussex Hospital (RCSH)
Princess Royal Hospital (PRH)</td></tr>
<tr><td colspan="3">General Surgery Personnel as of 1 March 2023 (the review team were informed of some consultants having left the service since this date during the course of the review)</td></tr>
<tr><td>Consultant Surgeons within specialty service</td><td>16</td><td>As of May 2023:
12 substantive consultant surgeons, 3 fixed term contract locums and 1 SAS grade surgeon.</td></tr>
<tr><td>Consultant Surgeons within specialty service - UGI</td><td>9</td><td>As of 1 March 2023:
P.R. Substantive
A.E. Substantive
S.J. Substantive (left Trust on 23 April 2023)
M.S. Locum (long-term)
M.K. Substantive (left Trust on 15 May 2023)
A.A. Substantive (Clinical Lead for UGI)
G.K. Substantive
K.S. Substantive
A.J. Locum (one year)

As of May 2023:
2 funded Upper GI vacancies with scheduled interviews.</td></tr>
<tr><td>Consultant Surgeons within</td><td>9</td><td>As of 1 March 2023:
M.L. Substantive (Clinical Lead for General Surgery)
A.T. Substantive
C.S. Substantive</td></tr>
</table>

specialty service - LGI		K. A-J. Locum (long-term) J.G. Locum (long-term) (Clinical Lead for Emergency) H.P. Substantive (Clinical Lead for Colorectal Surgery) M.U. Substantive J.C. Substantive E.M. Substantive
Surgeons within wider team		Not provided
Surgical registrar posts		7 registrars on 10 person rota. All registrars are ST6+ One of our 7 registrars has recently handed in notice: leaving end of May 2023 so will be 4 vacant posts Currently 3 vacant posts out to advert
Junior doctors supporting the service		8 SHOs (CT1 and CT2) on a 10 person rota. 3 rotational trainees and 5 fixed term SHOs. 2 gaps which were being recruited to. FY1s – 12 rotational Deanery trainees on a 12-person rota. No gaps but since December F1s have not been allowed to work on the ward at nights, we are covering F1 Night on Call gap every night with locum SHOs. This is an essential provision so locum cover is essential
Details of on-call		
Consultant surgeon on-call		One ward round/on-call week every 6 weeks One UGI Consultant and one LGI Consultant on ward round Monday - Sunday each week Not all consultants within the service currently contribute to emergency general surgery on-call activity.
Surgical registrar on-call		Patterns of on-calls split over 10 weeks 3 consecutive on-calls and 4 consecutive on-calls separated 2 weeks apart 24-7 On Call cover is currently a challenge due to reduced staffing levels Registrars also support CEPOD theatres 7 days per week and assist surgeons in RSCH theatre lists as part of their training Monday - Friday. Safe staffing levels also require a minimum of one registrar supporting the team on the Surgical Ward Monday - Friday
Facilities		
Service dedicated ward beds		Number of wards are spread between the following:
ICU beds		7 ITU beds at PRH. 16 ITU beds RSCH.
HDU beds		15 HDU beds RSCH
Theatres used by the service		There are 7 theatres across both sites in which Digestive Disease (DD) procedures may take place (emergency CEPOD lists or elective lists). 2 of these are dedicated, 1 dedicated to CEPOD. 1 dedicated to DD.

Inpatient elective lists per week		10 weekly (5 at PRH and 5 at RSCH) plus an additional all day list for 2 out of every 4 weeks - average of 0.5 per week. So the number of lists is 10.5 per week on average.
Day case elective lists per week		The lists are not split between inpatient and day case.
Emergency lists per week		There are 8 CEPOD (emergency lists per week - week days only). These are all shared lists.
New patient clinics per week		Not provided
Follow up clinics per week		Not provided
Activity numbers per year for the past two years		
Outpatients seen		January-December 2021 New: 25434 (General: 6674, Breast: 6915, Colorectal: 6762, Upper GI: 3241, Vascular: 1842) Follow Up: 42393 (General: 32895, Breast: 2991, Colorectal: 2836, Upper GI: 988, Vascular: 2683) Total: 67827 (General: 39569, Breast: 9906, Colorectal: 9598, Upper GI: 4229, Vascular: 4525) January-December 2022: New: 23383 (General: 2831, Breast: 6964, Colorectal: 8799, Upper GI: 2842, Vascular: 1947) Follow Up: 31709 (General: 19714, Breast: 3122, Colorectal: 4315, Upper GI: 1393, Vascular: 3165) Total: 55092 (General: 22545, Breast: 10086, Colorectal: 13114, Upper GI: 4235, Vascular: 5112)
Acute admissions	9589	January-December 2021: 4467 (Genera: 3180, Breast: 0, Colorectal: 328, Upper GI: 263, Vascular: 696)

		January-December 2022: 5122 (General: 4043, Breast: 0, Colorectal: 255, Upper GI: 181, Vascular: 643)
Elective admissions	20,661	January-December 2021: 9499 (General: 2477, Breast: 498, Colorectal: 4258, Upper GI: 1462, Vascular: 804) January-December 2022: 11,162 (General: 2490, Breast: 549, Colorectal: 5464, Upper GI: 1618, Vascular: 1041)
Number of patients undergoing surgery – specify total and number of emergency, inpatient and day case procedures	3806	January-December 2021: Total: 1851 (General: 1041, Breast: 370, 77, 133, Vascular: 230) Inpatient: 891 (General: 488, Breast: 103, Colorectal: 32, Upper GI: 77, Vascular: 191) Day Cases: 940 (General: 533, Breast: 267, Colorectal: 45, Upper GI: 56, Vascular: 39) January-December 2022: Total: 1955 (General: 1061, Breast: 385, Colorectal: 194, Upper GI: 210, Vascular: 105) Inpatient: 816 (General: 502, Breast: 92, Colorectal: 67, Upper GI: 78, Vascular: 77) Day Cases: 1140, General:559, Breast: 293, Colorectal: 128, Upper GI: 132, Vascular: 28)
18 week breaches	1223	February 2022: 559 (General: 33, Breast: 27, Colorectal: 253, Upper GI: 209, Vascular: 37) January 2023: 664 (General: General: 25, Breast: 25, Colorectal: 269, Upper GI: 271, Vascular: 74)
Patients on elective waiting list	16,002	February 2022: 7475 (General: 302, Breast: 736, Colorectal: 3709, Upper GI: 2288, Vascular: 440) January 2023:

		8527 (General: 326, Breast: 749, Colorectal: 3631, Upper GI: 3091, Vascular: 730)
Clinical governance arrangement for the past two years		
MDT meeting frequency	Weekly	MDT meets every Wednesday morning from 11:00- 13:00
Time scheduled for MDTs	2 hours	Caseload ranges from 30 - 50+ patients. See comments for more information.
Average consultant surgeon MDT attendance (%)	98.8%-100%	More information provided within MDT attendance reports for Colorectal MDT and Upper GI MDT.
M&M meeting frequency	Monthly	Third Friday of each month.
Time scheduled for M&M	2 hours	8-10 cases typically discussed.
Average consultant surgeon M&M attendance (%)		85-90%
Number of audit days last year		Are staff free of clinical commitments for these? Yes.
Time scheduled for audit days		Not provided

Other regular governance meetings	Monthly Quality Governance (QSPE) cross-site – all day meeting bi-monthly. Surgery Divisional Governance meeting – monthly	
National databases submitted to	National Bowel Cancer Audit (NBOCA) and National Emergency Laparotomy Audit (NELA)	
Complaints, incident reporting and SUIs in the last two years		
Number of incidents	7415	Site specific for surgery: Community: 14 Eastbourne District General Hospital: 1 Hove Polyclinic: 9 Hurstwood Park: 46 Princess Royal Hospital: 1685 Royal Sussex County Hospital: 4899 Sussex Eye Hospital: 317 Sussex Orthopaedic Treatment Centre: 395 The Vale, Haywards Health: 1 Victoria Hospital, Lewes: 11 Worthing Hospital: 3 Trust wide: 3 Other: 31 Severity (from surgery division at RSCH and PRH): Catastrophic: 24 Low: 2059 Major: 53 Moderate: 130 No harm – impact prevented (near miss): 690 No harm – impact not prevented: 4459
Number of SUIs	26	2020-2021: 10 2021-2022: 16
Number of patient complaints	199	2020-2021: 96 2021-2022: 103

Number of never events	4	2020-2021: 3 2021-2022: 1 All 4 Never events have been closed.

Appendix C – Documents received during the review

The following items of documentation were provided to the review team before, during or after the review visit. It is requested that the healthcare organisation responsible for commissioning the review retains a copy of all items of documentation for its own records, and to be in a position to make it available on request and to comply with information access requests. Once the RCS England issues the report, it will not keep a copy of this information indefinitely.

1. Service Overview Information May 2023

2. Introduction to General Surgery Corporate Improvement Project, May 2023 PowerPoint Slides, with the following attachments:

    a) Improving General Surgery at the Royal Sussex County Hospital, October 2022 PowerPoint Slides
    b) Letter from Health Education England to the Trust, dated 9 December 2021
    c) Trust's written response (undated) to concerns raised by Health Education England regarding foundation doctors' training
    d) Email correspondence providing written feedback from Health Education England to the Trust, as well as Trust responses, dated 1 February 2023
    e) Response to Care Quality Commission: Upper GI Surgery at the Trust, dated 16 March 2022, PowerPoint Slides
    f) The Oesophago-Gastric Specialised Cancer Surgery Patient Journey and Service Achievements, 4 July 2022, PowerPoint Slides

3. Proposed Target Operating Model Part 2 General Surgery Department version 5

4. Redacted Report of Mr Neil Cripps in relation to Digestive Diseases Centre, dated August 2017

5. Redacted Report of Professor Peter Dawson (review of departmental culture and junior doctor training and supervision in General Surgery at RSCH), dated August 2022

6. Redacted Edgecumbe Group Report of Feedback from General Surgeons at RSCH to the Chief Executive, dated July 2022

7. Email correspondence from Trust dated 10 June 2023 regarding police investigation into patients deaths within the general and neurosurgery departments between 2015 and 2020
    - This was reported within the press at the time, with reference to the following Guardian article: https://www.theguardian.com/society/2023/jun/09/police-investigate-dozens-of-deaths-royal-sussex-county-hospital-brighton

8. Data and Audits:

    a) Estimated Hospital Population Growth, 22 February 2023
    b) General Surgery Activity Data for 2021-2023
    c) General Surgery Personnel as of 1 March 2023, including information about on-call arrangements
    d) UGI and LGI Crude Mortality Data 1 January 2022-1 May 2023
    e) National Bowel Cancer Audit Results for RSCH and PRH 2020-2021
    f) Rectal Cancer Audit 2011-2021: Pre-operative Decisions and Margin Positivity, presented at LGI MDT September 2022

g) LGI Outcome Data broken down by Surgeons (Mortality, Return to Theatre, Anastomotic Leak Rate and Total Resection Number)
h) Cancellations and Postponements for Digestive Diseases, 2022-2023

9. Mortality and Morbidity Meeting Information:

a) Sample Meeting Agenda dated 24 February 2023
b) Meeting minutes dated 31 March 2023
c) Meeting slides, minutes, logbooks and data for November 2022
d) Meeting slides, minutes and data for December 2022
e) Meeting slides and minutes for January 2023
f) Meeting agenda, slides and minutes for February 2023
g) Meeting slides and minutes for March 2023
h) Meeting slides and minutes for April 2023

10. Complaints and Incidents Information:

a) Quality Safety Patient Experience Meeting Minutes, dated 17 January 2023
b) General Surgery Complaints April 2020-February 2023
c) Surgery Incidents 2020-2023, broken down by site and severity and Datix report summaries

11. MDT Information:

a) UGI Specialist MDT Meeting and Medical Decision Making Diagnostic, Specialist and Hepato-Pancreato-Biliary Outcomes January-May 2023
b) UGI Specialist MDT Attendance Reports for April 2022-March 2023
c) Colorectal Medical Decision Making Outcomes for February and March 2023
d) Colorectal MDT Meeting Outcomes for January-May 2023
e) Colorectal MDT Attendance Report for January-December 2022

12. HR Statement in relation to the Medical Workforce, dated 25 May 2022

13. General Surgery Directorate Governance Structure Chart

14. Trust Divisional Organogram as of 12 April 2023

15. Medical Assurance Appraisal and Revalidation Report for Surgery Division, 2023

16. Other:

a) CQC Inspection Report, dated 15 May 2023
- This was not provided by the Trust but was publicly available, with the link to the report listed on the Trust's website when the report was published: https://www.uhsussex.nhs.uk/ https://www.cqc.org.uk/provider/RYR?referer=widget3

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Agenda Item:	19.	**Meeting:**	Council of Governors	**Meeting Date:**	8 February 2024
Report Title:	Company Secretary Report				
Author(s):			Company Secretary		
Report previously considered by and date:					

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

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

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

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

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

Regulatory / Statutory reporting requirement

Foundation Trust's are required to establish and maintain an effective Board and systems of governance.

Communication and Consultation:

Report:

Non Executives

Two of the Trust's Non Executive Directors retire in the few months, these are Claire Keatinge who retires on the 31 March 2024 and Lizzie Peers who retires on the 10 May 2024. The Council of Governors agreed to seek to appoint their replacements early to allow for a period of handover to occur, following interview and the agreement of the Governors two new NEDs were appointed. Philip Hogan commenced with the Trust on 1 January 2024 and Wayne Orr commenced with the Trust on 29 January 2024.

Schedule of meetings for 2024/25

Board Meetings held in public

The main Board meetings for 2024/25 are scheduled to continue to be held quarterly on a Thursday, and these will continue to be a week behind the supporting Committee meetings, this is to allow for the efficient flow of assurance from these Committees to the Board.

The table below shows the dates and times of these meetings which are all open to the Public, these will continue to be held in the Board Room at Worthing. The Trust will continue to live stream these meetings to allow the public to watch these in real time.

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To allow for the efficient answering of any questions at the Board the Trust will continue to seek questions be emailed two days before the meeting to uhsussex.cosecteam@nhs.net

	May 2024	Aug 2024	Nov 2024	Feb 2025
Board of Directors	**Thurs 2 May 10.00-13.30**	**Thurs 1 Aug 10.00-13.30**	**Thurs 7 Nov 10.00-13.30**	**Thurs 6 Feb 10.00-13.30**

Council of Governors meetings

For 2024/25 there will continue to be four Council of Governors meetings held in public. These are to be held a couple of weeks after each Board meeting thus ensuring the reports to the Council reference the same data set used for the Board and as the Board papers are sent to each governor given the close proximity of the meetings then the provision of duplicate reporting can be removed.

As with the Board meetings the table below shows the dates and times of these meetings which are all open to the Public, as with the Board meetings these are to be held at Worthing but will be live streamed. Questions for the Council can be emailed to uhsussex.cosecteam@nhs.net, again the Trust is seeking 2 days notice to ensure responses can be given at the meeting.

	May 2024	Aug 2024	Nov 2024	Feb 2025
Council of Governors	**Thurs 16 May 14.00 – 17.00**	**Thurs 15 Aug 14.00 – 17.00**	**Thurs 21 Nov 14.00 – 17.00**	**Thurs 20 Feb 14.00 – 17.00**

Annual General Members Meeting

The Trust is provisionally targeting the Tuesday 30 July 2024 for its AGM noting this date is subject to the final year end reporting requirements that have yet to be finalised by NHS Improvement. The location for this meeting has yet to be determined.

Governor elections

There are a number of governors whose terms of office will end in 2024/25, with 5 public and 1 staff governors term ending on 30 June and then a further 2 public ending 30 September and a further staff governor's term ending 31 October. We intend to run elections for all these seats at one time, thus reducing our costs of this process but those successful for the later positions these will not commence until the end of the current governor's term of office.

We will be sending out information to all the members within the respective constituencies in early April 2024, with nominations closing mid May and then voting concluding by mid June. As we did last year we will be offering sessions for interested to members to attend to allow them to better understand the role of a governor.

The positions with terms of office that ends on the 30 June, are Brighton and Hove 2 positions; Horsham 1 position, Mid Sussex 1 position and for East Sussex / Out of Area 1 position and the RSCH staff governor. The positions with terms of office that ends on the 30 September are Chichester 2 positions and the SRH staff governor from 31 October.

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Recommendations
The Board is recommended to **NOTE** the commencement of the two newly recruited Non Executives, Philip Hogan and Wayne Orr. **NOTE** the dates of the Board and Council of Governors meetings open to the public and the proposed date for the AGM. The Board and Council meeting dates will be publicised on our web site as will the AGM date once agreed **NOTE** that the Trust will be running governor elections in 2024/25.